‘HAPARA VIOLENSIA DOMESTIKA HANESAN BE NE’EBE MAK TURU BA FATUK – BEBEIK NO TO IKUS RAHUN/NAKFERA’

STRENGTHENING THE CAPACITY OF HEALTH PROFESSIONALS AND LAWYERS TO UNDERSTAND AND APPLY THE NEW PENAL CODE AND DOMESTIC VIOLENCE LAW USING A HUMAN RIGHTS FRAMEWORK

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Front cover: Dr Rui de Araujo teaching workshop participants about their duties and responsibilities working with victims of domestic violence. Senora Carmen da Cruz sits in the audience. Dili, 2010

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EXECUTIVE SUMMARY

AusAID awarded Judicial System Monitoring Programme a human rights grant in 2010. This project had three main objectives: to provide professional development to increase knowledge of police, health professionals and lawyers of the new Penal Code and Domestic Violence Law; to build the capacity of participants to understand and fulfil their responsibilities under the new laws; and to improve access to justice and medical treatment to victims of domestic violence. This project achieved its objectives.

A work-plan was designed in conjunction with Dr Belton and Mr Yogaratnum, academics from Charles Darwin University, Australia. A survey was designed to explore knowledge, beliefs and practice of health and legal professionals. The survey was conducted in July and August 2010. The survey was administered by purposive sampling at multiple meetings with health professionals and lawyers in the districts of Dili, Baucau, Oecusse and Suai prior to the workshops. The survey outcomes were used by JSMP and the research team to assist with designing a syllabus that suited the learning needs and context of professionals in Timor Leste. A workshop on adult learning techniques was given to JSMP trainers prior to conducting the first training, which was provided to medical professionals and lawyers in Dili in September 2010. The training was implemented to prepare JSMP's trainers on more engaging teaching methodology for adult learners. The training was provided by Dr. Belton from Charles Darwin University. Mr Yogaratnum worked with JSMP team to critically analyse the content of the new Domestic Violence Law (7, 2010) and its relationship with the Timor Leste Penal Code.

Four one-day workshops were conducted in the target districts by experts in the areas of health and legal issues. All guest speakers and trainers were Timorese. The workshops were popular and more people attended than was originally hoped for. Many participants requested more time to consider the topic of domestic violence in their workplaces. Feedback was collected from participants and is presented in this report.

In order to investigate the impact of the workshop on health professionals and lawyers, all participants were invited to give a follow-up interview on their knowledge and practice. JSMP staff participated in training on how to conduct research interviews and record data. Dr Belton and Mr Yogaratnum provided support on research techniques and staff conducted many of the interviews once they gained confidence and skills. An analysis of the interviews is also presented in this report.

During the period of the grant there has been media coverage on domestic violence and JSMP has written press releases, and conducted interviews for the media, as well as publishing legal analyses on the new domestic violence law. In addition, JSMP and the research team have been active in transferring knowledge on domestic violence in Timor Leste to a wide national and international audience. A list of meetings and conferences attended by all members of the team is provided later in this report. Furthermore, practical reference aids for professionals have been developed and distributed.

Conclusion & Recommendations

This project to provide professional development in four districts about the Domestic Violence law was successful and JSMP demonstrated that it can mobilise professionals to attend educational training. Overall the professionals were keenly interested in domestic violence and how the law applied to them. The surveys, workshop interaction and follow-up interviews demonstrated that local ideas about domestic violence are beginning to form but are not clearly thought through and not always integrated with the formal justice sector or comprehension of human rights. Indeed many respondents, particularly nurses and midwives felt that the traditional justice system and the family were better able to deal with the problem. Placing doctors, medical students, nurses, midwives, lawyers, paralegals and administrators together to explore this issue was beneficial and well-received. There was an increased understanding of the issue and the law however, a one day workshop was not enough time to thoroughly explore domestic violence and the implications for each work practice. The law is relatively new and untested and we found that many lawyers and doctors were not confident in articulating all aspects of their responsibilities and duties. As many nurses and doctors were unaware or had very low comprehension of general human rights and legal mechanisms, more institutional support is needed to assist them with their work of protecting women and children. There were few policies or systems in place to support professionals in the workplace and administrators need to take this challenge on. As no judges attended the training session, special invitations need to be extended to these individuals. It would be important to review the curriculae of current medical students, law students, nurses and midwives to assess how they are being taught about domestic violence and how to respond to it in a professional manner.

- Professional skills development should be offered through professional associations and workplaces to increase capacity in the workforce.
- Students of law, medicine, nursing and midwifery need to have domestic violence included in their teaching plans and learn how to deal with it in a professional manner.
- Further advocacy is needed to remind the government of their commitment to write policy and provide budgets for the services that victims of domestic violence are entitled too.

- Local police also need in-service training regarding their duties and obligations under the law.
- A national process to socialise the domestic violence law into the *succo* and *aldea* levels is of national importance considering the reported levels of domestic violence in the National Health and Demographic Survey.

PROJECT OBJECTIVES

This project had three main objectives:

- **Professional development to increase knowledge of health professionals and lawyers of the new Penal Code and Domestic Violence Law;**
- **To build the capacity of participants to understand and fulfil their responsibilities under the new laws;**
- **To improve access to justice and medical treatment to victims of domestic violence.**

Neither lawyers nor health workers had received comprehensive training on the content or implications of these two laws for their professions. JSMP was well placed to conduct the training needed by health and legal professionals. In 2004, JSMP created a Women's Justice Unit (WJU) to focus on cases involving women victims of domestic violence. We knew that an understanding of the content and application of these two pieces of legislation would be a valuable exercise in professional development.

This project was innovative as it bought together professionals who work with the survivors of domestic violence. Health workers are generally not well trained to detect or manage domestic violence in Timor Leste, and while they are capable of treating the symptoms such as rape or physical damage, less emphasis is placed on the social–emotional needs of their patients. We knew that many health professionals were not aware that the new law which forbids domestic violence existed, and did not realise that medical records of a patient's condition were important for a successful prosecution. We also understood that they could feel fearful about appearing in court to give evidence, and did not necessarily understand the process to be able to reassure their patient and support them.

Nurses and midwives work closely with survivors of domestic violence but had little if any training about the legal context of their work and would benefit from understanding more about domestic violence, the new laws, and sharing ideas on how to recognise and support survivors who wish to proceed through the judicial process. Research from other countries suggested that patients who disclose information about their domestic violence experiences to health care providers often were not well supported (Belton, 1996; Morier-Genoud, Bodenmann, Favrat, & Vannotti, 2006; Othman & Mat Adenan, 2008).

Many legal professionals had not yet been able to study and apply the Penal Code and Domestic Violence Law. We felt they would benefit from scrutinising the legislation, participating in hypothetical cases and from sharing information with their colleagues and with other professionals about how best to aid the plight of domestic violence survivor. The expected outcomes were that doctors, nurses and midwives would better understand the legal and social implications of domestic violence and that lawyers would better understand the legal medical and social implications of domestic violence. We originally thought about 100 people would participate. However, 142 people completed the surveys, 216 people attended workshops in Suai, Dili, Bacau and Occusse, and 34 people agreed to follow-up interviews (note some people may have participated multiple times).

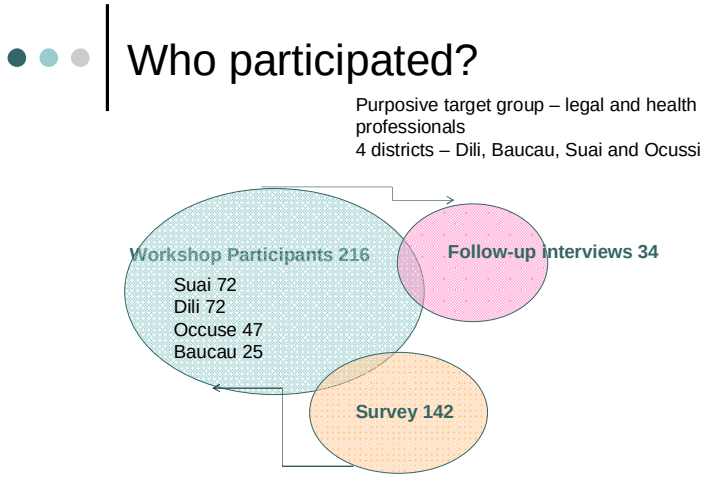

Figure 1Who participated in the domestic violence professional development project?

Together JSMP and Charles Darwin University developed a survey and training curriculum following initial consultations with stakeholders. After testing, the survey was distributed in four districts where courts exist (Dili, Baucau, Suai, Occusse) and during 2010-11 four one day workshops were conducted in the same target districts. Participants were invited to complete short pre and post evaluation forms and were recruited at the time of the workshop to join follow-up interviews some months after training. At all stages the sampling and recruitment was purposive, in that only health and legal professionals in the targeted districts were approached.

Domestic violence is a problem experienced largely by women and children (Watts & Zimmerman, 2002; World Health Organization, 2005) and in Timor Leste it is very common (Committee on the Elimination of Discrimination against Women, 2009). We use the term 'domestic violence', as opposed to 'family violence', as it most closely aligns with the adopted Tetun *violènsia domestika*. Timorese were able to identify and classify domestic violence prior to its codification in formal law, however minimised it. For example rape in marriage, verbal abuse, husbands beating their wives to educate her, and forms of hitting were considered light (UNFPA, 2007). While there have been several studies that have attempted to measure and describe the pervasiveness of domestic violence and gender-based violence (Alves, Sequeira, Abrantes, & Reis, 2009; Hynes, Robertson, Ward, & Crouse, 2004; Joshi & Haertsch, 2003), the recent Demographic and Health Survey is the most expansive attempt to date (National Statistics Directorate, Ministry of Finance, & Democratic Republic of Timor-Leste, 2010).

The Demographic and Health Survey (National Statistics Directorate, et al., 2010) is the first time that a nationally representative sample of nearly 3,000 Timorese women have been asked about physical, emotional and sexual violence. The methodology used internationally recognised indicators of violence, considered ethical issues, and ensured that women were able to stay safe in their houses while answering the questions. About nearly 40% of women responded affirmatively to experiencing physical or violence since the age of 15.

Table 1Is domestic violence a problem?

Is domestic violence a problem?

Table 16.5 Experience of different forms of violence

Percentage of women age 15-49 who have experienced different forms of violence, by current age, Timor-Leste 2009-10

Age	Physical violence only	Sexual violence only[1]	Physical and sexual violence[1]	Physical or sexual violence[1]	Number of women
15-19	28.5	0.2	1.8	30.5	700
15-17	28.2	0.2	0.1	28.5	446
18-19	29.1	0.1	4.7	33.9	254
20-24	33.9	1.5	0.9	36.3	513
25-29	44.9	0.8	3.1	48.8	403
30-39	40.0	1.4	3.6	45.1	765
40-49	34.5	1.3	2.0	37.8	570
Total	35.8	1.0	2.3	39.2	2,951

[1] Includes forced sexual initiation

Source: National Statistics Directorate, Ministry of Finance, & Democratic Republic of Timor-Leste. (2010). *Timor-Leste Demographic and Health Survey 2009-10*. Dili: Timor-Leste and ICF Macro, Calverton, Maryland, USA

The violence occurred often and it affected women from all socio-economic categories. Urban areas had a higher rate than rural areas. The districts with the highest prevalence are Manufahi, Dili, Occussi, Covalima, Lautem and Baucau. The rates range from 75% (Manufahi) to 10% (Aninaro). Domestic violence affected women who had been married, who were currently married as well as the never married. In this survey women who were wealthier,

urbanised and educated reported higher rates of violence. The authors speculate that these women were more able to recognise violations to their human rights and that they transgress cultural sexual norms, therefore triggering violent responses from their husband and family.

Overwhelmingly husbands and fathers were the most frequent perpetrators; however step-mothers and mothers, boyfriends and siblings were also perpetrators. Women reported that husbands and boyfriends were largely the perpetrators of sexual violence and only 4% of all sexual violence was perpetrated by strangers. Pregnancy did not deter domestic violence and the prevalence ranged from 2.4% to 4.9%. Various types of controlling behaviours were reported by about one third of women. Men in Dili (30%), Emera (22%) and Lautaum (16%) were more likely to exert controlling behaviours over their wives. Women experienced physical violence (33.5%), sexual violence (2.9%), and emotional violence (8.3%). Women aged 25-29 were most at risk. However women (6%) sometimes initiated domestic violence against their husbands.

In summary, domestic violence occurred in all socio-economic strata and was slightly more prevalent in urban areas than rural. While this survey probably under-reports domestic violence, it remains sobering to consider the number of women and children who experience violence in their homes in Timor-Leste.

DOMESTIC VIOLENCE LAW 2010

This section gives a brief overview of the Domestic Violence Law promulgated on 07/07/2010 as Law no. 07/2010. For a deeper analysis of law please see (Judicial System Monitoring Programme, 2011; Judicial System Monitoring Programme & Fokupers, 2009). The domestic violence law was the result of over 10 years of advocacy based on Timor Leste's obligations under international law. The Timorese Constitutional guarantees of human rights and family integrity and acknowledges the harm caused by domestic violence to individuals, families and the entire community, and the law states that it is the Government's responsibility to protect its citizens from violence and facilitate assistance to victims.

Article 1 states the objectives are to: prevent domestic violence, protect victims of domestic violence and assist victims of domestic violence. Domestic violence is defined as a public crime, which means criminal prosecution does not depend on the victim's complaint or continuing consent to prosecute. The concept of family is defined broadly to include people who have lived like spouses, and people who live in the same context of dependency or family economy. There are four types of domestic violence; physical, sexual, psychological and emotional.

The role of the government is to raise public awareness (art.9); to distribute material about domestic violence to the community (art.10); to include material about domestic violence in education curriculae (art. 11); to develop and coordinate a National Action Plan (art.13 and 14), the Ministry of Social Security is to support and assist victims (art.15); and also to support the reintegration of victims into the community (art.33). Specifically there will be support centres for victims (art.15) and provision of direct assistance, shelter including, psychological/medical/social/legal assistance (art.16). Article 22 states that medical services should include specialised hospital services; assistance and medical follow-up; preservation of evidence relating to possible crimes and undertaking of medico-legal examination; information regarding rights and possible remedies; referral to police or prosecution service; preparation of a report and submission to competent authorities; and referral to shelter houses.

The role of the specialised police service (VPU) is outlined as to inform the survivor of his/her rights; to refer the survivor to a shelter house; to ensure the survivor receives immediate medical and psychological assistance; to ensure a mental health evaluation is done so that the survivor receives the necessary support; to prepare and submit reports to prosecution service; and to inform Office of Public Defence if the victim cannot pay for legal services.

Lawyers professional responsibilities include provide legal counselling; reporting domestic violence cases to police and public prosecution; advising victims on legal proceedings; contacting relevant community groups to assist the survivors; monitoring the treatment given by police, prosecution service and the courts; advising victims, witnesses and family on progress of judicial proceedings; and monitoring cases.

There are further important articles which cover the principle of consent (art. 5), confidentiality (art. 40), maintenance/alimony provision (arts. 29-32), coercive measures beyond Criminal Procedure Code (art. 37) concerning the removal of the accused from family home and prohibiting contact with victim (for up to 3 years) and the protection of witnesses (art.39).

In summary it is a well rounded law that clearly articulates the roles and responsibilities of the government, the police, lawyers and doctors, with its roots in Portuguese law. It is largely aspirational in 2011 in that the government is yet to enact policies and budgets to implement and socialise the law. Shelter houses and trained staff are yet to appear in many districts that could offer support to women and children. And perhaps the most worrying, the judicial system continues to struggle to deal with the number and complexity of the cases already on the waiting lists; there remain many barriers to justice.

SURVEY RESULTS

Health workers and lawyers in the target districts were approached to fill in a survey. We were able to reach our target audience. Forty-four nurses [31%], 27 para legals [19%], 21 doctors or medical students [14.8%], 21 lawyers [14.8], 14 other categories of workers [10%], 3 counsellors [2.1%], and 4 administrative and finance officers filled in the survey. The survey consisted of demographic information; attitudes and opinions; defining victims; help seeking; previous training; presence of domestic violence in personal networks; and services for survivors. 142 people responded to the surveys however, many did not answer all the questions. The youngest participant was 20 and the oldest 57 years of age. The majority of respondents were in their 30s. 71 women (50%) and 65 men (46%) completed the survey and all were Timorese except one. Under half 57 [41%] lived in the towns and others 75 [54%] lived in surrounding villages.

Regarding previous training, 92 [65.7%] people said they had never had any type of training regarding domestic violence and 42 [30%] people said they had some previous training. Many doctors and medical students (11) had received training during their medical studies. The majority of respondents believed that domestic violence was not common and they agreed that it affected all society, not only the poor and uneducated. People were of the equal opinion about whether alcohol caused domestic violence and that it is tradition for men to control women. They also equally thought that women could leave the situation if they wanted to and that women provoked domestic violence. The majority felt that if someone in your family hit you then it was domestic violence and that domestic violence was justified at times. At times there were high levels of ambivalence in answering some questions.

Respondents were asked to identify helpful people in the community for people to approach regarding domestic violence (see Table 1). Local police, women's NGOs, family members, female lawyers, the Catholic Church, female doctors and JSMP were considered helpful. Male friends, male lawyers and male doctors were perceived as less helpful and traditional leaders even less. Very few people believed it to be a completely private matter.

Table 2 Who could victims of domestic abuse contact for help?

Helpful person	Number	Percentage
Local Police	116	[82.9%]
Women's NGO	82	[58.6%]
A family member	68	[48.6%]
Female Lawyer	59	[42.1%]
Church	59	[42.1%]
Female Doctor	51	[36.4 %]
UN Police	44	[34.1%]
JSMP	43	[30.7]
Female friend	36	[25.7%]
Male Lawyer	30	[21.4%]
Nurse or Midwife	29	[20.7%]
Male Doctor	24	[17.1%]
Male friend	20	[14.3%]
Traditional leaders	5	[3.9%]
No-one it is a private matter	2	[1.4%]
I am not sure	1	[0.7%]

* Note multiple answers possible

When respondents were asked what would stop people reporting domestic violence, they stated that embarrassment, fear of prejudice, fear of losing their children or home, not being believed, and a desire to protect their partner or family would be inhibitive (see Table 2).

Table 3 What would stop people reporting domestic violence?

Inhibiting factor	Number	Percentage
Embarrassment	81	[57.9%]
Fear of prejudice	78	[55.7%]
Fear of losing children or home	69	[49.3 %]
Fear of not being believed	62	[44.3 %]
Desire to protect the partner/ family member	66	[47.1%]
Concern about confidentially	34	[24.3%]
Unclear of where to go for help	31	[22.1%]
Nothing	18	[12.9%

* Note multiple answers possible

Respondents were asked if they personally knew anyone who was affected by domestic violence, and many disclosed knowing close family members and friends (see Table 3).

Table 4 Do you know anyone who is affected by domestic violence?

Who?	Number	Percentage
A current or previous romantic partner	73	52.1
A female colleague	50	35.7%
A female family member	48	34.3%
A male family member	37	26.4%
Friend	36	25.7%
A male colleague	21	15.0%
Not sure	18	12.9%
I would rather not answer	16	11.4%
No one I know	10	7.1%%

* Note multiple answers possible

Regarding services for survivors, the respondents (130) said that survivors should be provided with legal advocacy (56 people), medical assistance (47 people), victim support (24 people), motivation and training (15 people), safe houses (6 people) and investigation and prosecution services (5 people). They stated these types of services should be provided by the government, women's organisations, the UN, police, lawyers, doctors, other health personnel, JSMP, Pradet and community leaders.

In interpreting this survey it must be remembered that this was not the general public, but rather a select group of educated Timorese working in the fields of law and health. This survey enabled us to develop a useful curriculum and also served the purpose of sensitising our target groups to seek more information regarding domestic violence.

CONTENT OF THE WORKSHOPS

The syllabus included a legal definition of domestic violence, understanding domestic violence and its effects, legal framework, and professional obligations, identifying victims, documenting and services for survivors. Please see the attached full syllabus that has been submitted to the Council of Lawyers for accreditation. The content was delivered by a panel of expert guest speakers who were all Timorese. Attendees included 79 nurses and midwives (37%), 60 administrators of health and legal services (28%), 39 doctors and medical students (18%), 29 lawyers (13%) and 9 paralegals (4%). Comments were collected from participants and their statements are reported in the next section of this report.

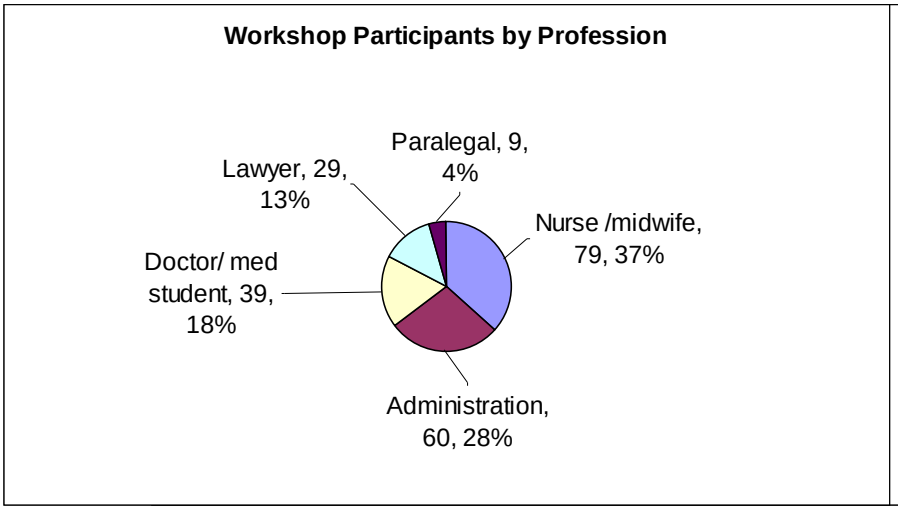

Figure 2 Workshop participants by profession

Participants were encouraged to interact in groups to define the different types of behaviours that constitute domestic violence. This picture shows some of that group activity.

Photograph 1 Group activity during a workshop

In order to test the increased knowledge and its application to professionals' daily work practices feedback was sought from participants immediately after and several months after the workshops.

Definition of domestic violence, understanding violence and its effects:

> *'The domestic violence always happened but often victims don't want to tell other people because they feel ashamed.'*
>
> *'Domestic violence is a crime; it is an attitude against women's rights and interests, implemented by force.'*

Legal framework and professional obligations:

> *'Domestic violence is a public crime that occurs within the family.'*
>
> *'I know more about the role of lawyers and doctors.'*
>
> *'Through justice we can help those who experience domestic violence.'*
>
> *'The health professions responsibility is to provide mental support and medical treatment if there is injury.'*
>
> *'The legal professions responsibility is to stop and to solve the case through the formal justice sector.'*
>
> *'When I see it (DV) in my community I need to report it to a competent authority.'*

Identifying victims, documentations and services for survivors:

> *'Wives, children and housemaids are most affected by domestic violence.'*
>
> *'Interviewing (of victims) should be done in private.'*

General comments:

> *'Not enough time to learn about this.'*
>
> *'This workshop is really important for us. Please keep going so our community will understand the law more.'*
>
> *'I want to know more about domestic violence.'*

An important point raised by both doctors and lawyers was that the law was only available in Portuguese and this hindered their comprehension; they wanted to access it in Tetun. Furthermore, many respondents wanted to spend much longer to discuss and understand the topic deeper. By assessing written comments before and after the workshop a change in knowledge had occurred, however it must be noted that this was not a formal examination process.

To assess whether the workshops had improved access to justice and medical treatment of domestic violence, interviews were conducted with 34 people who had attended the workshops. Medical students, nurses, midwives, administrators, doctors, paralegals and lawyers from the four districts spent 30 minutes to 1 hour discussing domestic violence and their workplace and the challenges they face.

FEEDBACK DURING FOLLOW-UP INTERVIEWS

Thirty four people responded to the request to provide a follow-up interview several months after attending the workshop. All four districts were represented. The following table shows the professional affiliation of the respondents. Many administrators were senior nurses taking on management roles. Interviews were conducted by JSMP and academic staff and lasted for 30 minutes to more than one hour. Interviews were conducted in Tetun, English or Bahasa Indonesian depending on the language skills of the respondents and interviewer. Most interviews were recorded and transcribed. It must be noted that this was not a random sample, that people volunteered and this may have implications for interpreting results.

Table 5 Numbers of follow-up interviews after workshops

Respondent	***Number***
Doctors and medical students	10
Lawyers and para-legals	9
Nurses/ midwives	8
Government representative	1
Pharmacist	1
Administrators	5

THEME 1 – APPRECIATION OF PROFESSIONAL DEVELOPMENT

Overwhelmingly people appreciated being offered professional development and joining with a multi-disciplinary group of colleagues to learn about domestic violence and the new law. They stated that domestic violence had not been covered well in their basic training. Respondents felt that the topic and content were challenging and very interesting; most stated that a one day workshop was not enough to absorb the material. One of the objectives of the interviews was to assess how the material presented in the workshop changed anything for the professionals. The interviewers asked how the workshop had changed their practice and one doctor said:

Doctor 3: 'Ok, it is true. Before the workshop I said it's true that I haven't found many cases of domestic violence but after I attended the workshop and because of my courage to find out, then I saw many cases on domestic violence appear. For example, there was a case about a girl who was bitten by her husband. First she didn't come to me but she got treatment from a different person but I think this person didn't know about the law of domestic violence, so they didn't do anything much for her to help. So then the girl came to me and helped her based on the law. I saw bruises in her hands, feet and her face. I also explained to her about her rights to take her case to justice and to the police and my obligation to report her case to my supervisor because it is important to take her case to the police. I made a report to my supervisor and I am not sure if my supervisor really reported this case. I still have doubts because until now I still didn't see anything. I think we will talk about this later. For my part, I have done what I learned in the workshop. This girl keeps coming for treatment because she is still sick. I offered to her to help her and take her to somewhere else. She said she didn't want to because it's a case inside the family and she had sorted out but she would like to continue to see me and get care.'

This vignette is important in that it demonstrates a heightened awareness of domestic violence led this doctor to have the courage to explore cases of domestic violence and take action on behalf of her patients. The doctor was able to respond appropriately and this was due to the workshop. However, as in many domestic violence cases the woman felt that it was a private family matter and more positively she developed a trusting relationship with her female doctor.

The lawyers were very appreciative to get clear information in their mother tongue from expert speakers as well as reference documents. Lawyers appreciated the clear information they received. This lawyer stated:

Lawyer 2: 'Because… when we didn't have the domestic violence law, in the penal code there were only a few articles which mentioned about violation within the household. But now the new law has explained clearly who the actors of domestic violence are, not only wives, husbands; not only to the children but within the extended family! We knew that domestic violence was about husband hits wife, but in the new law it is more specific.'

THEME 2 – COMPREHENSION OF DOMESTIC VIOLENCE

Nearly all doctors, nurses, midwives and medical students could provide examples of treating patients who had suffered domestic violence. They recounted cases of physical, sexual and psychological violence directed against women and children. Occasionally mothers were the perpetrators against children. They reported cases of extreme violence such as machete hackings, intentional burnings, beatings, bitings, pregnancy loss due to violence and rapes. Some lawyers were not practicing in the area of domestic violence and therefore had not taken any cases of this type. Many respondents could not recall all four types of violence mentioned in the workshop: physical, sexual, psychological and economic. Our respondents had several ways of explaining the root causes of domestic violence which included the pervasive nature of violence in Timor Leste due to colonisation/ decolonisation processes, traditional Timorese practices and the rapidity of change in society.

Culture of violence and silence – people spoke of the past and the colonisation of Timor Leste which had unleashed violence, as well as inculcating a culture of suffering in silence. People drew parallels between the past and current social mores as they reflected on the issue of domestic violence. As people talked about domestic violence they conflated all types of violence occurring in their milieu, and they found it difficult to separate what occurred outside the house or family with what occurred within the house and family. People spoke of the martial arts street gangs and the fear this engendered in their daily life. One respondent spoke of street violence which entered the health centre and intimidated the staff and patients. Another respondent talked at length about the dynamics of village life where jealousies can escalate and curses are cast in hatred. A director general of a health facility stated:

> *Administrator 3: 'Based on my thirteen years experience in his hospital, we dealt with many cases of domestic violence but we didn't really understand. We thought that it was normal in Timor to fight, but now based on the law, we realise that this act is against human rights!'*

Barlaki (bride price) – this was most commonly mentioned as the root cause of domestic violence. Many people said that men perceived women to be their possessions to do with them as they wish. Furthermore, the burdensome ongoing debt added stress to marriage which at times erupted into violence. Large families with many children burdened men and women and led to stress and sometimes violence.

Globalisation and modernisation – poverty in a cash economy was perceived as very stressful for families and the cause of many family disputes. The desire for consumer goods, particularly by men who had the power to control household budgets, caused friction between husband and wives. Some respondents were cognisant of changes that were taking place globally. One administrator mused:

> *Administrator 3: '…since our grandparents' times' man has always been considered the one who knows better. Today, in 21st Century, there are many changes in lives. Women have opportunities to work, to equip themselves to study and to go to trainings. I think it is time to adjust. We have to adjust our culture. Not to change but to adjust. Because now we have many sources of information such as from the radio, internet, etc. it is not like in the past, everything was so isolated. I think to apply the way of the past to our lives now; it is hard and can create lots of problems. We don't put away our culture but we need to adjust it and keep our identity.'*

THEME 3 – ABILITY TO RESPOND PROFESSIONALLY TO DOMESTIC VIOLENCE IN THE WORKPLACE

Respondents stated that until this workshop they had had very little information about the new domestic violence law – called colloquially 'Number Seven Seven' due to it being Law No. 7 and its promulgation in July. There was no official translation available in Tetun language. Many lawyers particularly called for the articles in the law to be translated from Portuguese into Tetun and distributed to them.

The impression of the interviewers was that in this group of professionals there was a strong desire to prevent domestic violence in their community, to provide better quality services to survivors and to continue to work in this field with their colleagues, however knowledge remained inconsistent. These doctors articulated their disgust of violence and feelings of personal empowerment to be able to respond against violence.

> *Doctor: 'I feel angry because I see this happen. I could imagine if this happened to me and if it is my brother or my uncle is violent towards me. I would feel very sad. I would feel very sad because in XXX, in this hospital I still see many young women experience domestic violence. So this makes me sad. How we can prevent this from happening? Maybe we cannot stop this but I think we can reduce the number.'*
>
> *Doctor 2: 'The first thing this workshop showed us what the rights of women and children who have no power and that we can help the women to achieve dignity. The second was that we can implement international law to teach people to respect other people's dignity.'*

The lawyers spoke of domestic violence being categorised as a public crime with clear definitions of family members who could be defined as victims of domestic violence; which not only included wives but others such as children, servants, ex-spouses and boy/girl friends. Some lawyers were aware of the interplay and tensions between the Penal Code and the new domestic violence law, sentencing, evidence and so forth, however, there was a large variation in the quality of knowledge retained by the lawyers in our sample. This may have been due to interviewing inexperienced lawyers.

Mandatory Reporting – this surprised and confused many respondents, and they were often conflicted on this point. The professionals were highly aware of their duty of confidentiality. Many lawyers understood the definition of a public crime and that the victim did not need to give consent to prosecute. However there were barriers for women seeking justice. One lawyer complained about police interference:

> *Lawyer 2: 'Ok because many cases [of domestic violence] happen and the police always ask this 'Do you want peace or do you want to proceed with the case?' Actually they should not ask this sort of a question because it weakens the resolve of the victim and stops the process at the police station. The question should be avoided…It is up to the victim. The police have no right to close the case.'*

Most health professionals were able to discuss the medical management of cases of domestic violence, but did not know their legal responsibilities prior to the training; the workshop added a new dimension for their practice. They were much more conflicted by the notion of reporting the case to the police if their patient had requested

confidentiality and for many it depended on their assessment of the seriousness of the assault and victimisation on whether they would report it to the police.

Referral and Support Services – unfortunately despite speakers from referral organisations presenting at the workshop, many respondents were unable to name referral services other than the police or JSMP. Professionals were unsure where to send their clients for extra support, some knew of NGOs, others mentioned safe houses but it was not consistent. One lawyer knew of his local support services and noted that it did not always solve the problem.

> *Lawyer 4: I think they will face problems in the shelter houses because I have experienced it with PRADET. When the women live in the shelter, their husbands always come to terrorise them. Shelter houses need good security and coordination with the police to be able to provide adequate security for the women.'*

Adat (customary law) – for many respondents trying to solve domestic violence was best dealt with by the extended family. Many professionals reported that their clients believed it and at times they did too. Many nurses and midwives particularly felt that it was better to send the woman home to her family and let them resolve it through *adat*. Lawyers were more reluctant to consider *adat*, although they admitted that the *adat* process was quicker than the formal legal process. Lawyers reported the delay in processing cases was a barrier to justice. One nurse explained:

> *Interviewer: 'Yes, so when you manage these difficult cases and the woman says please don't tell anyone I am frightened, do you tell the police or do you not tell the police?*
>
> *Nurse 1: There are many cases like that coming to us and we ask what they want us to do and also which way they prefer to solve their problem; with the legal process, traditional justice or which one is the best for them. And mostly the problem that comes to us is between husbands and wives but most of the time the victims want their problem to stop. They are afraid that their husband or wife will hit them again or leave them, therefore when it happens like that, we approach their family to find the best way to seek justice for the victim.*
>
> *Interviewer: So, you are suggesting that it is best to deal with domestic violence inside the family in the traditional system, is that correct have I understood this?*
>
> *Nurse: Yes.'*

However, health professionals also reported that patients were bought into the health centres by police and notification in the formal legal system had already occurred by the time they treated the patient.

Our respondents felt that domestic violence may be increasing but were unsure if that was because it was more publically visible in that women's ability to access services was increasing. One administrator of a health clinic described her experience:

> *Administrator 1: 'In 2010 domestic violence increased, many victims came very often to our clinic. Sometimes the women were crazy about their husbands' behaviour and sometimes the husbands' were crazy too, and we argued with them within the clinic, but now it starts to decrease. Cases came to our clinic almost every day, sometimes the cases came two up three times and we had to record domestic violence in their records. This year (2011) I notice that it's decreasing; strange because now many people want to report it. People used to be afraid to report it (domestic violence) but nowadays people are not afraid to report.'*

Despite this possible trend Sen. Carmen da Cruz, Minister for Social Welfare and Equality, is on the public record stating "*Hapara Violensia Domestika hanesan be ne'ebé mak turu ba fatuk- bebeik no to ikus rahun/nakfera*" which means that to stop domestic violence will be gradual process similar to water trickling over a stone that eventually breaks it down.

In summary, the professionals who came to the workshops and who gave interviews were extremely pleased and grateful to receive information and knowledge about domestic violence. They were enthused to be involved in offering better quality services to their clients and patients; however during interviews it became apparent that their knowledge was inconsistent and some remained convinced that there were cases that were best dealt with in the traditional legal system. From self-report it appeared that professionals were better able to respond to their clients and patients and used the domestic violence law as a framework. However, few professionals reported an institutional response such as policy or assistance with referring victims to appropriate services. It would seem there is much more work to be done by government and non-government organisations to break the rock of domestic violence

CONCLUSION & RECOMMENDATIONS

This project to provide professional development in four districts about the Domestic Violence law was successful and JSMP demonstrated that it can mobilise professionals to attend educational training. Overall the professionals were keenly interested in domestic violence and how the law applied to them. The surveys, workshop interaction and follow-up interviews demonstrated that local ideas about domestic violence are beginning to form but are not clearly thought through and not always integrated with the formal justice sector of comprehension of human rights. Indeed many respondents, particularly nurses and midwives felt that the traditional justice system and the family were better able to deal with the problem. Placing doctors, medical students, nurses, midwives, lawyers, paralegals and administrators together to explore this issue was beneficial and well-received. There was an increased understanding of the issue and the law however a one day workshop was not enough time to thoroughly explore domestic violence and the implications for each work practice. The law is relatively new and untested and we found that many lawyers and doctors were not confident in articulating all aspects of their responsibilities and duties. As many nurses and doctors were unaware or had very low comprehension of general human rights and legal mechanisms, more institutional support is needed to assist them with their work of protecting women and children. There were few policies or systems in place to support professionals in the workplace and administrators need to take this challenge on. As no judges attended the training session, special invitations need to be extended to these individuals. It would be important to review the curriculae of current medical students, law students, nurses and midwives to assess how they are being taught about domestic violence and how to respond to it in a professional manner.

- Professional skills development should be offered through professional associations and workplaces to increase capacity in the workforce.
- Students of law, medicine, nursing and midwifery need to have domestic violence included in their teaching plans and learn how to deal with it in a professional manner.
- Further advocacy is needed to remind the government of their commitment to write policy and provide budgets for the services that victims of domestic violence are entitled too.
- Local police also need in-service training regarding their duties and obligations under the law.
- A national process to socialise the domestic violence law into the *succo* and *aldea* levels is of national importance considering the reported levels of domestic violence in the National Health and Demographic Survey.

APPENDICES

APPENDIX A – LIST OF CONFERENCES AND MEETINGS

- Belton, S. (2011). Providing training in law to legal and health professionals in Timor-Leste 2010-2011. Prevention of Violence Against Immigrant and Refugee Woman, Darwin, Australia, General Practice Network NT.

- Belton, S. and F. da Silva (2011). Providing training in law to legal and health professionals, problems and challenges / Fornese treinamentu lei ba professional legal no saude, problema no dezafiu. Communicating New Research on Timor Leste, Dili, Timor Leste, Timor Lest Studies Association.

In 2010, JSMP provided staff development on the new domestic violence law to legal and health professionals. The majority of respondents had never had any type of training in the field of domestic violence. Over 200 doctors, nurses, paralegals and lawyers attended a series of one day workshops. The syllabus covered the definitions of domestic violence, human rights, understanding domestic violence, the legal framework and working with survivors of domestic violence. This paper will present the syllabus and training methods. Evaluation was conducted during the workshop and several months afterwards during interviews. This paper reports respondents' statements on how they apply new knowledge to their legal and health practices. And how professionals perceived issues on reporting domestic violence, the knowledge of domestic violence and its presence their personal networks, and services to survivors.

- Kapur, A. and M. Fernanda (2011). Challenges to implementation of the Domestic Violence Law – A victim's perspective/ Dezafiu implementasaun lei kontra violensia doemstika husi perspetiva vítima. Communicating New Research on Timor Leste, Dili, Timor Leste, Timor Lest Studies Association.

Timor Leste has obligations under international law and now domestic law to ensure human rights are universally respected. However, many women and children in Timor Leste continue to be abused in different ways within their homes. In 2010, the Timorese Parliament approved a Law Against Domestic Violence to better prevent domestic violence, and protect and assist its victims. This paper focuses on case studies of domestic violence drawn from the experience of JSMP's Victim's Support Service. These case studies will illustrate the challenges that will arise in implementing this formal legal frame work to provide genuine protection for victims of domestic violence.

- Kapur, A. and V. da Silva (2011). The Domestic Violence Law – its Content and Objectives / Lei kontra Violensia domestika ninia konteudu no objetivu. Communicating New Research on Timor Leste, Dili, Timor Leste, Timor Lest Studies Association.
  In July 2010 the Timor Leste Government promulgated the Law Against Domestic Violence. This is part of a constitutional promise to improve protection of human rights for women and children. Inherent in this development is the shift from traditional dispute resolution system to the formal justice system. This paper examines the legal framework of the new domestic violence law and the impact on the stakeholders in delivering their legal obligations to promote women and child security in Timor Leste.

- Yogaratnam, J. (2010). Workshop on Stabilisation and Development in Asia Pacific. Flinders University, Adelaide, Australia.

- Yogaratnam, J. (2010). International Domestic Violence Conference. Kuala Lumpur, Malaysia.

- Yogaratnam, J. (2010). NIEW International Conference 2010 – The Health and Well-Being of Displaced Women. Kuala Lumpur, Malaysia.

- Yogaratnam, J. (2011). Charles Darwin University - Law, Education, Business and Arts Seminar series. Darwin, Australia.

- Yogaratnam, J. (2011). Seminar on Prevention of Violence against Immigrant and Refugee Women organised by the Multicultural Centre for Women's Health (Victoria). Darwin, Australia.

- Yogaratnam, J. (2011). Parliamentary Roundtable, Gender Violence in Asia Pacific. Canberra, Australia.

- Yogaratnam, J. (2011) Global Alliance for Justice Education Conference. Valencia, Spain.

Mr Yogaratnam spoke at each of these conferences on 'Improving Access to Justice for Women in Timor Leste: Developments in Domestic Violence Law'. The outcome has been the circulation of the conference paper in all conferences and for the Parliamentary Roundtable it has been an adoption of two recommendations tabled during the session.

The Roundtable Recommendations adopted:

- Ensure that strong engagement by all stakeholders, including members of parliament, civil society and NGOs, is recognised as a fundamental element of violence elimination strategies and best practice and support for this engagement is a priority part of development programming.
- Work with local communities and leaders to implement the best standards laid out by international treaties within the local and cultural context.

This is the communiqué from the Parliamentary Group of Population and Development, held in Canberra, Australia.

Parliamentary Group on Population and Development
Parliamentary Roundtable on Ending Gender Based Violence in the Asia Pacific Region
Communiqué

9 May 2011
Parliament House
Canberra, ACT Australia

We, the Parliamentarians of the Australian Parliamentary group on Population and Development (PGPD) gathered together with Members of Parliament from Papua New Guinea and Samoa, Ambassadors, High Commissioners, representatives of the international community, representatives of Australian non-government organisational community and other stakeholders for the *Parliamentary Roundtable on Ending Gender Based Violence in the Asia-Pacific Region* on 9 May 2011 to engage in learning and discussions on the multifaceted impacts of, and avenues for, addressing gender based violence.

The dialogue and the presentations gave evidence to and outlined the links between gender based violence (GBV), human rights and gender equality, the relationships

between GBV and health outcomes, examined the role of policy and legislation as a tool for ending GBV, and highlighted promising practices and community responses throughout the region. Discussions demonstrated the complex nature of this issue, the challenges, and successes experienced by individuals and those working to end GBV. Arising from these presentations a series of recommendations was compiled.

The recommendations are founded on a number of principles including that we, as members of the PGPD, cannot accept the high rates of GBV throughout the region and recognize that GBV is a violation of human rights and a barrier to sustainable development. Therefore, we acknowledge and support that:

- Violence against women and girls should be addressed through the lens of human rights based approaches and the Australian Government should embed human rights in their development program and more broadly across foreign policy;
- Violence is taught and learned and without appropriate support for children who experience or witness violence such violence is likely to cause inter-generational harm and further undermine efforts in eradicating violence; further support for comprehensive and age appropriate school- and non-school based education on respectful relationships which addresses violence is a critical aspect of a violence elimination strategy;
- Consequences of violence are numerous and multifaceted and require a comprehensive and complex system of interventions at all levels of the social-ecological model to address and eliminate gender based violence. Such programs must be long term initiatives and require predictable and recurrent resources and support;
- Women need to be heard at all levels of government. When women are involved as leaders in decision-making processes, decisions reflect women's needs and experiences;
- National Governments and the global development community need to find new opportunities to address gender inequalities and integrate women's empowerment into all aspects of policy, programming and service delivery;
- Culture and customary law plays an important role in the development, implementation, and evaluation of formal policy.
- When communities are in stress, including from high population growth, poverty and burdened resources, GBV can be exacerbated and addressing this must include an emphasis on delivery of reproductive health services and family planning.
- Women are at greater vulnerability to climate change risks resulting from social and cultural circumstances including inadequate access to resources, displacement, and family responsibilities.
- Gender equality must be considered central in all program and service delivery.
- Violence prevention activities should include culturally and contextually appropriate responses to address substance use, including alcohol
- Recognize the important role of the health care system and ensure that health professionals are trained and supported to respond to GBV and its severe physical and psychological effects over a lifetime.
- GBV is linked to sexual and reproductive health (SRH) and efforts to support SRH and GBV should be pursued together.
-
- We commit ourselves to the following actions:
-
- Duly acknowledge the multifaceted impacts of violence and promote and support interventions occurring at all levels of the social-ecological model—individual, familial, communal and societal;
- Mobilize our Parliamentary colleagues and members of our constituencies to speak out against gender based violence and support innovative and effective anti-violence programming that engages men and boys, communities and religious groups, women and young women, and other key stakeholders across all sectors of society;
- Support the amendment of old, adoption of new, or removal of sexual offence and domestic violence legislation to align national laws with what is international best

practice standards represented by the principles of international human rights treaties and instruments in the Asia-Pacific region;

- Work with local communities and leaders to implement the best standards laid out by international treaties within the local and cultural context.
- Ensure all women have access to sexual and reproductive health and family planning services
- Publicly support the importance of, and promote opportunities for investing in young women's leadership;
- Support education, economic, and health sector initiatives that are founded on the principles of gender mainstreaming;
- Hold our own and partner Governments accountable to their international, regional, and national commitments made to promote gender equality and end gender based violence;
- Ensure that strong engagement by all stakeholders, including members of parliament, civil society and NGOs, is recognized as a fundamental element of violence elimination strategies and best practice and support for this engagement is a priority part of development programming.
- Endorse the creation of an Ambassador for Women's Rights or Special Envoy to the Prime Minister, with a remit to address gender disparity in our region and a focus on women's leadership;
- Continue to prioritize the response to and prevention of violence within Australia, particularly, among Aboriginal and Torres Strait Islander communities.
- Support the implementation and resourcing of the National Action Plan on Security Council Resolution 1325. This should be done in consultation with civil society in a transparent and participatory fashion. An Action Plan would acknowledge the delay in processes and opens huge potential for addressing issues of women's participation in conflict and post-conflict reconciliation, identified in the region.
- Monitor the implementation and resourcing of the *National Plan to Reduce Violence Against Women and their Children 2010-2022* as a unified strategy that highlights Australia's commitment to protecting human rights and contributes to a global effort to reduce violence
- Prioritize responses to and prevention of, violence against women in the Asia-Pacific region as part of international development assistance and national planning to promote women's rights and achieve sustainable development outcomes including the Millennium Development Goals and the ICPD PoA;
- Prioritize GBV, including sexual assault, when responding to conflict, natural, and humanitarian disasters and provide assistance, treatment, and protection for survivors.
- Support funding and collaboration to improve the timely, reliable, and comparable collection and use of data on GBV in the Pacific using internationally proven methodologies, including data prevalence and causes and consequences of GBV to Pacific economies. Gathering this data according to best practice will help to ensure that a countries' work to eradicate violence can be considered in a multi-dimensional development index or other compilations of data traditionally drawn upon to measure a countries' relative poverty and development levels
- Ensure that robust monitoring and evaluation of programs and their impacts is undertaken and properly resourced including through time-series data-collection and the involvement of wives and children in any qualitative evaluations of behavior-change.

APPENDIX B –LIST OF MEDIA COVERAGE

Below is the list of media coverage during grant period 2010-2011 :

1. Workshop Atendimentu Professional Saúde no Advogada ba Violénsia Doméstika iha Distrito Suai
2. JSMP partisipa iha painel ba konferensia hato`o peskiza foun kona ba Timor
3. JSMP realiza workshop kona ba atendementu husi professional saúde no Advogadu ba asuntus lei Kontra Violensia Domestika Iha distritu Dili (workshop primeiru)
4. JSMP provides training to NGO Luzero which provides services to the Lautem District (JSMP hala`o treinamentu ba ONG Luzeiro ho nia rede servisu iha Distritu Lautem
5. JSMP realiza workshop kona ba atendementu husi professional saúde no Advogadu ba asuntus lei Kontra Violensia Domestika Iha distritu Oecusse (workshop Terceiru)
6. JSMP launches a Report about Domestic Violence in East Timor

APPENDIX C – SYLLABUS OF THE WORKSHOP

Contents

The whole syllabus is contained in the following pages.

PART 1: SCOPE AND RATIONALE OF WORKSHOP

1. WORKSHOP GOALS AND OBJECTIVES

Goal

The course goal is to strength the capacity of health and legal professionals to understand and apply the new Penal Code and Domestic Violence Law using a human rights framework.

Learning Objectives

Enable health professionals and legal professionals to:

- understand East Timor's legal framework concerning domestic violence;
- acquire the skills needed to investigate, analyse and document abuses; and
- understand the importance of their professional role in tackling domestic violence.

2. DOMESTIC VIOLENCE AS A CRIME

Domestic violence is internationally recognized as being against human rights

- Convention on the Elimination of Discrimination Against Women (CEDAW) was created, calling on all countries to end discrimination against women. This has been interpreted to include: violence that is directed against a woman because she is a women or that affects women disproportionately. It includes acts that inflict physical, mental, or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty. Timor Leste has ratified this Convention and is thereby bound to comply with it.
- The Declaration for the Elimination of Violence Against Women, adopted in December 1993 by the United Nations General Assembly:
    - Called on countries to condemn violence against women and not to invoke any custom, tradition or religious consideration to avoid their obligations with respect to its elimination. States should pursue by all appropriate means and without delay a policy of eliminating violence against women.
    - Called on countries to exercise due diligence to prevent, investigate and, in accordance with national legislation, punish acts of violence against women, whether those acts are perpetrated by the State or by private persons.

The Law Against Domestic Violence in Timor Leste

- Sensitive to the widespread phenomenon of domestic violence in East Timor, the legislators approved in May 2010 a law against domestic violence which created a legal regime for the prevention, protection and assistance to victims of domestic violence, with some penal provisions included. This law is a milestone in the evolution of Timorese law concerning women's rights, since domestic violence is in the majority of cases gender based violence.

- In 2009 Law 17/2009, The Penal Code, was passed, creating the crimes of spouse abuse (Article 154) and child abuse (Article 155). Spouse abuse carried a sentence range of 2 – 6 years of imprisonment, and child abuse carried a maximum of 3 years imprisonment. If the abuse results in death, the maximum sentence becomes 15 years.

- In 2010 Law 7/2010, The Law Against Domestic Violence was passed, creating a legal regime for the prevention, protection and assistance to victims of domestic violence, with some penal provisions included. This law is a milestone in the evolution of Timorese law concerning women's rights, since domestic violence is in the majority of cases gender based violence.

- The structure of the law is:
  - Chapter I – General Provisions, which provides the scope of the law and the concept of domestic violence
  - Chapter II – Fundamental Principles
  - Chapter IV – Support and Assistance to Victims
  - Chapter V – Criminal Provisions

- The Law enshrines the following principles:
  - Equality – every individual has a right to human dignity, to live without violence and the right to their physical and mental integrity.
  - Consent - any intervention to assist and support the victim should only take place after the victim gives his/her free and fully informed consent, with special provisions applying for victims below 12 years old, and between 12 and 16 years old
  - Information - the state, through the criminal police, prosecutor, public defender's office, and medical and social services, ensures to the victims adequate information to protect their rights.
  - Ethical rules - any intervention of specialized support to victims should be conducted in compliance with the professional standards and obligations, codes of conduct, standard operating procedures, universal principles of human rights, and the rules of conduct governing the specific case.

3. DEFINITION OF DOMESTIC VIOLENCE IN TIMOR-LESTE

Article 2.° of the Law Against Domestic Violence defines it as:
Domestic violence is any act or a sequence of acts committed within the family context, with or without cohabitation, by a member of the family against another member of the family, where there is an ascendency, namely physical or economic ascendency; or by a person against the person with whom the perpetrator had an intimate relation causing physical, sexual or emotional suffering, economic abuse, including threats, intimidation, physical harm, assault, coercion, harassment or deprivation of freedom of movement.

a. Breakdown of different types of abuse

a. *Article 2(2)(a): Physical violence, understood as any conduct which offends the integrity or the physical health.*

Physical abuse is the most obvious type of domestic violence and involves causing physical (external or internal) harm to the victim. Physical battering includes kicking, hitting, biting, choking, pushing, hair pulling, throwing across the room or down on the floor, and assaults with weapons. Sometimes, particular areas of the body are targeted, such as the abdomen of a pregnant woman, or areas that are not normally visible in public.

b. *Article 2(2)(b): Sexual violence, understood as any conduct that obliges a person, to maintain or participate in unwanted sexual relations, even during the marriage, through intimidation, threat, coercion or use of force, or which limits or nullifies the exercise of sexual and reproductive rights*

Sexual violence includes physical attacks on the victim's breasts or genitals, sexual sadism, and forced sexual activity or behaviors. Sexual violence comprises acts of aggression in which sex is the method used to humiliate, hurt, degrade, and dominate the victim.

c. *Article 2(2)(c): Psychological violence, understood as any conduct that causes emotional damage and reduced self-esteem in order to degrade or control the actions, behaviors, beliefs and decisions of others by threat, embarrassment, humiliation, manipulation, isolation, constant vigilance, systematic persecution, insult, blackmail, ridicule, exploitation, limiting the right to travel or otherwise adversely affecting the psychological health and self-determination*

Psychological abuse can be just as traumatic as physical abuse although there are no visible injuries. The effects of psychological and emotional abuse are long lasting. Emotional abuse is not just a verbal argument. It is the systematic destruction of an individual's self-esteem and includes actions, gestures, insults, and threats to the children. The perpetrator may belittle or degrade the victim or the children as a means of harassing or humiliating the victim.

d. *Article 2(2)(d): Economic violence, understood as any conduct that involves retention, partial subtraction, or total destruction of personal items, work tools, impossibilities to work inside or outside the home, personal documents, goods, values and rights or economic resources, including those designed to meet the personal needs and the needs of household*

Economic violence is where the victim has no control over the income and outcome of the household. The victim may be reprimanded for what she purchases or sells at the market and she may have no control of the land she lives on. Her farming animals or tools may be destroyed or controlled by her partner. The victim may be discouraged from learning to read or getting more education.

Learning Activity

Learning Outcomes for Participants

At the end of this workshop participants will be able to:

- Identify the different types of domestic violence;
- Understand the nature of domestic violence in East Timor;
- Relate common behaviours to the new law.

PART 2: UNDERSTANDING DV AND ITS EFFECTS

4. WHY DOES DOMESTIC VIOLENCE HAPPPEN?

- For reasons of statistical prevalence violence by men against women is rightly taken as paradigmatic of domestic violence.

- 1 in 3 women around the world have been beaten, coerced into sex, or otherwise abused in their lifetime. Domestic violence is an extreme manifestation of gender inequity, targeting women and girls because of their subordinate social status in the family and society.

- Societies historically rank sexes in such a way that women are generally unequal in power, resources, prestige or presumed worth. When this occurs, both sexes are denied the full range of human and social possibilities. The more rigidly people believe in traditional gender roles, the more likely they are to support a male using violence toward a female in an intimate relationship.

- Poverty, alcohol and many other things often listed as causes may be contributing to domestic violence, but domestic violence is most often caused by a difference in status between women and men. It is the lack of value and worth given to women, the idea that women experience domestic violence because society assigns a low value to women.

- The practice of barlake has evolved so that some people believe that a husband can treat his wife as he wants, and it is a "kanuru no bikan" issue, and that no one else can say what should happen in the home. This is not the meaning of barlake, and nothing can ever justify the use of violence in the home.

5. WHO SUFFERS DIRECTLY FROM DOMESTIC VIOLENCE?

a. Who are the victims?

According to Article 3 of the Law, the definition of family for domestic violence includes:

- Spouses or former spouses;
- People who live or have lived in conditions analogous to those of spouses, even without cohabitation;
- Ascendants and descendants of both or only one spouse or whoever is in the situation described in the preceding paragraph, provided they are in the same context of dependency and family economy;
- Any other person who is in the same context of dependency or family economy, including whoever carries out a continuous and subordinate domestic-labor activity.

Battered victims and aggressors come from all economic and education levels, all racial and cultural groups, all religions, and are of all ages.

b. Women are particularly vulnerable to domestic violence

Violence against women considerably increases women's risk of poor health.
The World Bank (1993) estimates that rape and domestic violence account for

5 per cent of the healthy years of life lost to women aged 15-44 years in developing countries. Assessments studies suggest that women frequently mention mental tension, depression, unwanted sex, abortion, STIs and HIV/AIDS resulting from gender violence.

- **1 in 3 women** around the world have been beaten, coerced into sex, or otherwise abused in their lifetime.

- In Timor-Leste, many organizations report that domestic violence is disturbingly common, but that it is difficult to make accurate estimates because of low rates of reporting. Even so, there are high rates of women going to hospital, the Vulnerable Persons Unit and support services because of domestic violence.

- Domestic violence is a significant public health problem. The public health impact of domestic violence is compounded by the fact that the violence escalates in frequency and severity. Without appropriate interventions, these women are at high risk of developing serious, complex medical and psycho-social problems, including suicide attempts. Some women are murdered by their partners.

- Domestic violence poses a **higher risk** to women 15 to 44 than cancer, motor vehicle accidents, war and malaria.

- Women who have experienced physical violence are **48% more likely to be infected** with HIV than those who were not.

- Women who are abused have a much higher rate of alcohol and drug abuse, depression, suicide, anxiety, and miscarriage.

6. WHO SUFFERS INDIRECTLY FROM DOMESTIC VIOLENCE?

- Violence against women and girls also compromises the social development of other children in the household.

- Domestic violence may increase in frequency, and is more harmful, when women are pregnant, putting the mother and the unborn child at risk of injury and death.

- The cost to the community includes lost wages, sick leave, non-productivity, and absenteeism. While financial costs are calculable, the emotional costs of domestic violence are immeasurable. Communities, like individuals, experience a collective loss of safety when domestic violence occurs and is not addressed.

7. MYTHS ABOUT DOMESTIC VIOLENCE

- **Myth: If the victim didn't like it, she would leave.**

Fact: Victims do not like the abuse. They stay in the relationship for many reasons, including fear. Most do eventually leave.

- **Myth: Domestic violence is a loss of control.**

Fact: Violent behavior is a choice. Perpetrators use it to control their victims. Domestic violence is about batterers using their control, not losing their control. Their actions are very deliberate.

- **Myth: Most domestic violence incidents are caused by alcohol or drug abuse.**

Fact: Many people have alcohol and/or drug problems but are not violent, similarly, many batterers are not substance abusers. How people behave when they are "under the influence" of alcohol and/or drugs depends on a complex combination of personal, social, physical and emotional factors

- **Myth: Domestic violence is often triggered by stress, for example, the loss of a job or some financial or marital problem.**

Fact: Daily life is full of frustration associated with money and work, our families and other personal relationships. Everyone experiences stress, and everyone responds to it differently.

- **Myth: Most domestic violence occurs in lower class or minority communities.**

Fact: Domestic violence occurs at all levels of society, regardless of their social, economic, racial or cultural backgrounds.

- **Myth: The victim did something to provoke the violence.**

Fact: No one asks to be abused. And no one deserves to be abused regardless of what they say or do.

Learning outcome:
Participants must be able to:
Understand the prevalence and incidence of DV;
Describe the way domestic violence impacts the health of victims,
Understand the negative impact of DV on children

PART 3: THE ROLE PROFESSIONALS PLAY IN COMBATING DV

Under the new law, health professionals and legal professionals are delegated the role of raising awareness, informing/counselling the victims, but more importantly informing the police or the public prosecution office of cases of domestic violence.

Usually emergency medical staff, and health professionals in general are the first to come in contact with victims of domestic violence, therefore they are a very good source of support and advice for women experiencing DV.

8. SERVICES FOR VICTIMS

- **Support centers and shelters:** the government is required to establish a national network of support centers for victims of domestic violence, which are responsible for direct assistance, shelter and counseling to victims (Article 15(1)). Support centres include reception centres and safe houses (Article 15(2)). The safe houses provide temporary accommodation, psychological/medical care, social assistance and legal support, and personal, professional and social skills to help victims (Article 16(1)). Users and minor children in safe houses have rights to accommodation, food, privacy, autonomy, a safe and healthy space inside the house, and access to the closes school. They have the responsibility to comply with the rules of the safe house (Article 17).

- **An emergency service:** with telephone lines, with the purpose of providing information concerning rights, options and social and legal services at their disposal (Article 20).

- **Specialized services to attend victims of DV:** to assist and guide victims within hospital services and the support network (Article 21.°)**.**

- **Specialized services in health centers and hospitals:** (Article 22.°). The obligations of these services are explained below

- **Specialized police force:** which refers victims upon request to a safe house or support center, takes action so medical and psycho-social assistance is provided (Article 24.°).

- **Legal assistance:** including legal advice, counsel regarding legal proceedings and facilitating access to information (Article 25.°).

- **Witness protection:** procedural measures to protect witnesses, victims and people with knowledge of relevant facts (Article 39. °).

9. HEALTH PROFESSIONALS HAVE RESPONSIBILITIES

Health professionals can make an important contribution to tackling domestic violence:

- by asking women directly about whether they have experienced abuse;
- by enabling women to access specialised services; and
- by supporting them in changing their situation.

- Clinical diagnosis or patient disclosure of domestic violence triggers the intervention of specialized hospital services (Article 22. °):
  - Provide assistance and medical follow-up
  - Proceed with preservation of evidence relating to possible crimes, including completing examinations or forensic test or otherwise
  - Inform the victim of his/her rights and remedies, and the obligation of the hospital authorities to state those facts to the police
  - Immediately report the facts to the police or the prosecutor
  - Prepare a report on the situation and steps to be taken and send it to competent authorities
  - Refer the victim to a safe house if warranted AND victim requests

10. LEGAL PROFESSIONALS HAVE RESPONSIBILITIES

- Under Article 25, victims of domestic violence must be accompanied by a lawyer who:
  - Provides legal advice
  - Reports the occurrence of domestic violence to the police and prosecutor, where it does NOT breach confidentiality
  - Counsel victims, witnesses and family members about the progress of legal proceedings
  - Monitor attention given by law enforcement officials and judiciary officials
  - Contact relevant entities, agencies and community groups
  - Advice victims about access to other services
  - Facilitate access by parties to information related to cases and other legal provisions

- The Public Prosecutor must also provide assistance, inform victims of rights and refer them to the hospital or safe houses (Article 28).

- The current process and available services are:

In general, the existing referral network in Timor Leste are namely:

- National Police of Timor Leste, especially Vulnerable Person Unit (VPU)
- VSS Unit that provides legal assistance of non- litigation
- Fokupers provides shelter center
- Casa Vida provides safe house or shelter center to the victims of domestic violence and sexual violence who are underage .
- Pradet provides medical assistance to the victims in order to recover their physical and physiological health. Pradet also works to undertake medical exams of violence that victims suffer and this result of examination would be considered as evidence in the court that could give advantage to the victims.

11. PROFESSIONALS ARE BOUND BY ETHICAL RESPONSIBILITIES

- Technical and non-technical staff in reception centres, safe houses and specialized assistance services must maintain confidentiality regarding facts they know because of their professional relationship with victims. Confidentiality ceases when the victim voluntarily consents if the professional is requested to testify or provide other information to law enforcement agencies. (Article 40)

- Provision 22.º d) of the Law states that every time that a patient revels to be a victim or be diagnosed as a victim of domestic violence it should be immediately reported to the police or public prosecutor's office. The extent of such information goes as far as - "A" is a victim of domestic violence. Whatever "A" tells to the health professional concerning events of her life which comprise domestic violence cannot be reported. Only physical evidence of abuse documented by the health professionals should accompany the communication the domestic violence case. Conversations with the patients can not/should not be documented, since such can only be considered evidence if and only if the victim decides to testify in court.

- The content of conversations between patient and doctor, victim and social assistant, and victim and lawyer cannot be revealed unless the victim testify, telling her story. If the victim decides not to testify, health professional, lawyers and social assistants cannot reveal whatever information they have.

- So, reporting domestic violence is mandatory for health professional and lawyers with professional ethic rules limitations.

- **Article 40.º of the domestic violence law** clearly states that all the technicians involved are under the privileged information ethic rule, unable to provide information about the content of conversations held with victims unless the victims explicitly consent for the professionals to testify.

Learning Outcomes

Participants must be able to:

1. Understand resources available to victims within the community and the legal system;

2. Understand the role of health and legal professionals to lower domestic violence.

Activity – list the different services in TL victims can access?

Learning Actions
Need to discuss mandatory reporting
How to provide practical advocacy and support to women and children
How to make a safety plan with a woman
How to maintain good inter-professional links with police, lawyers and health professionals for advice and support
1) Practical advocacy – establish referral mechanisms to support services, education seminars, creation of community support groups among women DV sufferers

2) Safety plan – a) brainstorm different relatives/friends to stay with at short notice in case of violence; b) identify closest police station and hospital; c) think of alternative ways to support family if required; d) discuss whether counseling of abusive family member is possible.
3) Inter-professional links – monthly social event with local guest speakers from different professions, establish email group of contacts within each profession who act as disseminators (including of new laws, policies, organizations, news issues)

PART 4: DEALING WITH DOMESTIC VIOLENCE VICTIMS

12. IDENTIFYING VICTIMS OF DOMESTIC VIOLENCE

Many victims of domestic violence will not volunteer specific details about their abuse.
Battered women often create barriers to prevent others from recognizing that they are victims of domestic violence. Victims may be reluctant to disclose the true nature of their injuries –for many reasons. They may be embarrassed or ashamed. They may feel they have somehow "asked for it." Many victims of domestic abuse have low self-esteem and believe they don't deserve help. Some may be afraid of retribution. Finally, some battered woman may still love their male partners and may lie to protect them from arrest.

Once battering begins, however, it usually escalates – both in frequency and severity. Domestic violence can include bodily injury, destruction of property, intimidation, coercion, revenge, and punishment. Threats of violence lay a foundation of fear – all of which are methods to control the partner.

Signs and symptoms of domestic violence

- ✓ Explanations do not match injuries;
- ✓ Unusual interaction between victim and accompanying partner;
- ✓ Very nervous/ frightened;
- ✓ Facial injuries, bruising on the body, injuries to the extremities;
- ✓ Multiple injuries in different stages of healing;
- ✓ History of miscarriages, premature labour, fractures to the fetus;
- ✓ Very guarded, evasive;
- ✓ Depression, anxiety, self-harm;
- ✓ Partner would not leave victim side and answers questions directed to woman;
- ✓ Disclosure by relatives;
- ✓ Disclosure by patient;
- ✓ Repeated presentations;
- ✓ Inconsistent stories;

13. INTERVIEWING VICTIMS APPROPRIATELY

While victims of domestic violence may not offer details on their own initiative; they may discuss it if asked simple, direct questions in a non-judgmental way and in a confidential setting.
The victim should be interviewed alone.

Ask the victim direct, non-threatening questions in an empathetic manner, emphasizing that these questions are asked of all trauma patients.
You may want to think of sample questions ahead of time so that you will be comfortable and ready when the situation arises.
Some sample direct and non-judgmental approaches:

- Because domestic violence is so common in today's world, I've begun to ask about it routinely. Has your partner done this to you?
- We often see people with injuries such as yours, which are caused by someone they know. Could this be happening to you?
- You seem frightened and anxious. Has someone hurt you?
- Are you afraid of anyone if you're household?
- Has any household member physically hurt you or threatened to hurt you?
- Do you feel **SAFE** in your relationship?
- Should I be concerned for your **SAFETY**?
- Are there situations in your relationship where you have felt **AFRAID**?
- Has your partner ever threatened or **ABUSED** you or your children?
- What happens when you and your partner disagree or **ARGUE**?
- Are your **FRIENDS** aware that you have been hurt?
- Do your **FAMILY** members know about the abuse?
- Would **FAMILY** or **FRIENDS** be able to help or support you?
- Do you have a safe place to go in an **EMERGENCY**?
- If you needed to leave now, do you have an **ESCAPE** plan?
- Would you like to talk with a counselor to develop an **EMERGENCY** plan?

It may help to explain that questions of this sort are asked to all injured patients and that these questions are part of your protocols.

Learning Actions
How to ask difficult and probing questions and thinking through what to do?
Use of case studies for workshop participants to discuss in groups

14. SAFE DOCUMENTATION OF DOMESTIC VIOLENCE

Documentation of domestic violence is determinant as evidence.
So, throughout the delivery of medical care, personnel need to be sensitive to preserving or documenting evidence that may be used in bringing charges against a perpetrator. Successful prosecution of the case depends to a great extent on the quantity and quality of evidence gathered at the crime scene. Well-documented cases are more likely to be pursued by public prosecutors and are more likely to result in appropriate legal actions against the offender.
Besides the obvious evidence of medical and police reports, documentation includes descriptions of damage to the house and statements from witnesses who heard or saw the abuse. If law enforcement has been called to the scene, the information in the medical form supports the police documentation.

The law on domestic violence makes documentation an obligation to health professionals and social assistants in provision 22.º and 23.º

Health professionals must be particularly careful to document, preserve and collect evidence through medical and forensic exams. Due to lack of witnesses, most of the times, medical and forensic reports is all the evidence that the prosecution has in order to get a conviction, and most of the time is not enough to establish that it was the partner that committed the crime.

Learning Actions
What is forensic evidence?
Samples of photographs and body charts
How to write for court

Learning Outcome

Participants must be able to:

1. List signs and symptoms of DV.

2. Discuss appropriate documentation of cases of DV.

3. Develop skills to interview victims.

15. PRACTICAL TIPS

Good practice tips

- Be aware of the different forms of domestic violence
- Be aware of how women may present to you
- Believe and reassure your client
- Keep good quality records in case you are called into court
- Assess the level of risk by asking direct questions
- Make a simple safety plan that the woman can use
- Do not assume she will leave her husband or take legal action
- Be very patient as it can years for women to have the courage to leave a violent relationship.
- Use 'post-it' notes containing the phone numbers for the local domestic violence support agencies, police etc to prompt questions about DV.

What are the tips that lawyers have for working with DV?
Lawyers tips are similar: awareness, keeping confidentiality of client, keeping accurate records of all dealings, including observations of physical injuries, provision of contact information of relevant services, never perform role of mediating between parties, prepare client for lack of support they may experience in the system.

Learning Activity

Participants generate list based on workshop

Facilitators supplement list with factors on p.27

Learning Outcome

Participants must be able to:

1. Demonstrate knowledge of DV.
2. Know how to identify and action concerns in practice

APPENDIX D – INTERVIEW SCHEDULE FOR HEALTH WORKERS

Introduction

Hello my name is …..I am a representative of JSMP, an organisation that works with victims of violence. We are working with Charles Darwin University in Australia doing research on the new law against domestic violence in East Timor, which was passed by government in July 2010. We are interested in your experience at the JSMP workshop in 2010 and providing health care services to the survivors of domestic violence. We would like to ask you some questions. We ensure that the information provided by you will be confidential and your name will not be recorded. You do not have to answer the questions that you don't want to and you can stop anytime. Do you agree to be interviewed today?

Verbal Consent Yes[ ] No []

Demographics

1. Role/ profession

Doctor [ ] Midwife [ ] Nurse [ ] Other Health Worker [ ]

2. Sex

Male [ ] Female [ ]

3. Length of time working in the health sector

1 to 3 years[ ] 4 to 10 years[ ] 11 to 15 years[ ]
more than 15 years experience[ ]

Knowledge and experience of DV

4. What types of domestic violence do you see in your patients? Can you give examples?

5. How do you know that your patient is suffering from domestic violence? What are the effects on a woman's health?

6. Can you remember a case of domestic violence and explain to us how you managed it? Since completing the JSMP workshop have you changed your practice in any way?

7. If you have NOT seen a case, since completing the workshop, how do you think you would manage it?

8. What would make you hesitate to get involved in a domestic violence case?

JSMP workshop feedback and law

9. Which parts of the workshop did you find most useful?

10. What surprised you most about the content of the workshop?

11. What did you learn about the DV law?

12. How will the DV law prevent DV; protect women from DV; and assist DV survivors?

13. Do you think doctors/health workers should report DV cases?

14. How will this law affect the private doctor-patient relationship?

15. What do you think about mandatory reporting by the medical profession?

16. Do you have a special unit in the hospital to deal with DV cases?

17. What does the law say specifically about the duties of health providers?

18. What supports are there for women (and children) in the community? Would you refer your patient to any?

Cultural Norms and Expectations

19. What causes domestic violence in East Timor?

20. What role should doctors/nurses/midwives play in working in domestic violence?

21. Can you suggest further ways to assist health professionals work better with survivors of domestic violence?

22. How can doctors work well with lawyers?

APPENDIX E – INTERVIEW SCHEDULE FOR LAWYERS

Introduction

Hello my name is …..I am a representative of JSMP, an organisation that works with victims of violence. We are working with Charles Darwin University in Australia doing research on the new law against domestic violence in East Timor, which was passed by government in July 2010. We are interested in your experience at the JSMP workshop in 2010 and providing health care services to the survivors of domestic violence. We would like to ask you some questions. We ensure that the information provided by you will be confidential and your name will not be recorded. You do not have to answer the questions that you don't want to and you can stop anytime. Do you agree to be interviewed today?

Verbal Consent Yes[ ] No [ ]

Demographics

23. Role/ profession

Lawyer [ ] Prosecutor [ ] Paralegal [ ] other [ ]

24. Sex

Male [ ] Female [ ]

25. Length of time working in the legal sector

1 to 3 years[ ] 4 to 10 years[ ] 11 to 15 years[ ] more than 15 years experience[ ]

Knowledge and experience of DV

1. How will the role of the legal profession change/adapt as a result of the DV Law?

2. Have you dealt with victims of domestic violence as a lawyer before/after the DV Law was passed?

3. If so, what are the professional challenges you have faced with these clients?

4. How do you think the DV law affects your role as a lawyer? Have you experienced this change with clients?

Interplay between the Penal Code and DV law

1. Before the DV law, could crimes under the Penal Code committed in a domestic context be prosecuted? If yes, then why were they not prosecuted?

2. How do you think the Penal Code and DV law relate to each other?

3. What are the positive and negative aspects of this relationship?

Understanding of DV

1. Who are included in the definitions of victims of domestic violence?

2. Do domestic violence victims include:

   Ex-spouses - YES/NO Cousins who live in the same household – YES/NO
   Maids – YES/NO Long term girlfriend living with family – YES/NO

3. Does police or prosecution intervention require consent of the DV victim?

If YES, and a victim refuses intervention, what can the police or prosecution do?

DV Law and prosecution

1. What challenges do DV victims face in the prosecution of DV crimes?
2. How does the DV law affect the prosecution of domestic violence crimes?
3. What support services are available during the trial process for victims of DV?

DV Law and sentencing

1. Should DV offences which are similar to Penal code offences be sentenced the same or differently?
2. What are the available penalties for people convicted of DV crimes? Which do you think are appropriate and why?

DV Law & Courts

1. Is the formal or traditional justice system more appropriate for dealing with DV cases? Why?
2. Do you think the courts will apply sentences consistently for both Penal Code and corresponding DV law offences? Why or why not?
3. Who in the legal system needs more training and support to better work with the new DV law? Why?
4. How can we improve access to justice for DV victims in rural areas?

DV Law and shelter houses

1. What are your views on shelter houses and reception centres in protecting survivors?
2. Have you dealt with DV victims who have used these services?
3. Do you think DV victims will be willing and able to use these services? Why or why not?

DV Law and Civil Societies

1. How do civil societies assist the legal profession in DV cases?
2. Do you think the civil societies you have dealt with are adequately trained to deal with DV cases?
3. Do you think that civil society services expedite access to justice in DV cases?

Improving the DV Law

1. In your experience, what aspects of the DV law need to be improved/ reconsidered?
2. In your experience, how useful are the orders in the DV law to protect victims?
3. How will the DV law affect access to justice for victims of DV? In 2 years/5years/10years/more?

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