Assessment of Community Leader Knowledge and Attitudes about Violence Against Women in Timor-Leste

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Abstract

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Abstract:
This study reports findings from a survey designed to assess knowledge and attitudes about violence against women among community leaders in Timor-Leste. The survey was administered to 271 community leaders who participated in Health Alliance International's Harmonia Activity, a project focused on ending violence against women by shifting attitudes and social norms to support the peaceful resolution of conflict in two municipalities, Ermera and Liquica. Participants reported levels of knowledge about violence and attitudes towards violence that were approximately in the midpoint of possible responses. Participants' knowledge and attitudes differed significantly when disaggregated by gender and by education level. Men and participants with higher education levels reported being more knowledgeable about types and impact of violence and reported having attitudes less consistent with acceptance of violence and victim blaming compared with women and participants with lower education levels ($p < 0.01$). In contrast, women reported having attitudes more consistent with equitable gender roles than those of male respondents ($p < 0.01$). Findings support the timeliness of the Harmonia Activity, as there is potential for growth in both knowledge and attitude constructs among community leaders in these two project municipalities of Timor-Leste.

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Introduction

Violence against women (VAW) is a violation of human rights and freedoms. Violence against women impacts women globally, regardless of age, class, race, and ethnicity. According to estimates by the WHO, nearly 30 percent of women worldwide have experienced physical and/or sexual violence during their lifetime, the majority of which is intimate partner violence (WHO, 2021). Violence against women causes many major physical and psychosocial health consequences and is the leading cause of homicide among women worldwide (The Asia Foundation, 2016). The economic, social, and psychological costs associated with violence against women are significant, and evidence repeatedly shows that violence consistently undermines not only the wellbeing of the victim, but also of the perpetrator and the society as a whole (Wild et. al, 2020). Violence against women stems from gender inequality and discrimination driven by social norms and attitudes that accept and condone violence, traditional beliefs and customs surrounding marriage and gender roles, and a lack of awareness of legal rights and abilities to access justice systems (Gardner, 2014). There has been increasing recognition of the need for public health programming that addresses social norms, attitudes, and beliefs as a mechanism for the reduction of VAW and of the need for effective monitoring and evaluation of these interventions (Ellsberg, 2012; WHO 2010).

In Timor-Leste, the 24-year Indonesian occupation left a legacy of violence that contributes to the impacts of discriminatory social norms and patriarchal traditions. Although there are strong legal frameworks and policies for promoting gender equality and preventing VAW at the national level in Timor-Leste, these laws and processes are not well understood within communities nor easily accessible to survivors. Current research points towards widespread experiences of VAW across the country. In 2016, 59% of women in Timor-Leste reported experiencing physical and/or sexual violence by an intimate partner during their lifetime, with 47% of women reported experiencing intimate partner violence in the past 12 months alone (Health Alliance International, 2021; The Asia Foundation, 2016; Wild et. al, 2020). Previous research conducted in low-and-middle income countries, including Timor-Leste, suggest that levels of knowledge and attitudes towards VAW differ by gender and educational level (Sardinha & Nájera Catalán, 2018; UNICEF, 2020; Wild et. al, 2020; Flood, 2009; Serrano-Montilla et. al, 2020). That research inspired the analysis conducted in this paper.

To date, there has been no dedicated research at the village level in Timor-Leste to ascertain the prevalence of violence against women, the health consequences of violence, or the factors that increase or decrease the risk of violence. Quality data on the prevalence, patterns, and consequences of different forms of VAW at national and subnational levels serves as an important tool in guiding policy decisions and evidence-based preventive programing (HAI, 2021). This report contributes to the evidence base by describing a study of Timorese community leaders' knowledge about and attitudes towards VAW and gendered societal norms.

Overview of Intervention

Harmonia Activity: Community Microplanning Activity Baseline Survey

The Harmonia Activity of Health Alliance International (HAI) is a USAID-funded project that utilizes the People to People (P2P) approach in two municipalities of Timor-Leste. The project aims to shift attitudes and social norms to support the peaceful resolution of conflict, in this case focused on ending VAW. Part of this process will include work to change social and cultural norms and attitudes that have led to a power imbalance between men and women and which, along with a history of violent conflict, has led to a society with high rates of VAW. The Harmonia Activity is among the first interventions to focus on shifting social norms, attitudes, and beliefs at the village level in response to VAW in Timor-Leste.

The Harmonia Activity involves two related interventions in 31 villages in two municipalities in Timor-Leste. The first is a Community Microplanning intervention (CMP), to bring together an inclusive, intergenerational coalition of community members to openly discuss harmful social norms related to VAW and identify solutions that will lead to peace in communities where there is violence and conflict. The second intervention is the provision of training for health providers to increase awareness, knowledge, sensitivity, and counseling skills to support victims of VAW and increase appropriate referrals to support services.

Ermera and Liquica municipalities were purposefully selected due to their high rates of VAW. Within these two municipalities, thirty-one villages (15 in Ermera, 16 in Liquica) were purposefully selected based on information from the Ministry of Social Solidarity and Inclusion regarding which villages had greatest need. After agreeing to participate in the CMP, the local

elected leader in each village nominated approximately 9 additional community leaders from among attendees at local municipal advocacy meetings to participate in the CMP. Inclusion criteria for CMP participation were community leadership (e.g., from local government, religious, educational, health, and youth sectors); ages 17 – 85 (age of consent in Timor-Leste is 17, and Covid-19 guidelines recommend limited contact with individuals over 85); strong youth (ages 17 – 24) and female representation; and inclusion of lesbian, gay, transgender, bisexual, and intersex (LGBTI) people and people with disabilities where possible.

CMP workshops will occur once monthly for twelve months, with workshops taking place in half of the villages in 2021 and in the other half in 2022. The workshops will be led by local HAI staff in Timor-Leste. Participants will collaborate to identify VAW-related problems in their communities and to develop and implement actionable interventions. Participation will be fostered through regular engagement with CMP participants as well as by reimbursing travel costs associated with attending meetings.

This study aims to assess personal knowledge and attitudes relating to gender equality and VAW among community leaders in 31 villages who will participate in HAI's CMP. Findings will be compared against future endline survey data to take place in February 2023 that will support the assessment of the performance and progress of the intervention among participants.

Methods

A baseline survey took place before the initiation of the CMP in thirty-one villages in two municipalities in Timor-Leste. Data collection occurred in February 2021. Data were collected from all community leaders who had agreed to participate in the CMP.

Instrument Development

HAI Harmonia Activity staff outlined topical areas they wished to explore. The survey instrument was drafted in consultation with HAI staff and the project's gender specialist. It was designed in English, translated into Tetum and field tested by HAI Harmonia Activity staff in Dili, Timor-Leste.

The survey included a range of questions to obtain demographic information about participants, including age, gender, educational level, employment, marital and relationship status, and

disability status. Age was measured as a continuous variable and then grouped as a categorical variable in accordance with the Timor-Leste DHS survey, presented in ten-year age brackets for ease (GDS, 2018). Gender was measured by asking the participant to identify as male, female, or other to capture non-binary gender identities. Education level was measured by asking the participant's highest level of school attended. Disability was measured on a four-point Likert scale of ability to perform daily activities such as seeing and concentrating (from "no difficulty" to "cannot do at all"). As data was collected in February 2021, a COVID-19 health questionnaire preceded the initiation of each survey to protect the health of participants and HAI staff. Demographic questions were adapted from the 2016 Timor-Leste DHS (GDS, 2018).

The survey included a number of questions to assess participant knowledge about VAW, including knowledge about types of VAW, the impact of VAW, appropriate behaviors to help a woman experiencing violence, and Timor-Leste's Law Against Domestic Violence. The remainder of the survey included questions to assess social norms and beliefs related to VAW and gender equity, including acceptability of violence, gender roles, separation, victim blaming, and awareness and assessment of community support. Questions about attitudes towards VAW, type and impact of VAW, and appropriate helping behaviors were adapted from WHO (World Health Organization, 2019). Questions about community support and questions about the Law Against Domestic Violence were developed for this survey.

Data collection

Surveys were administered verbally in a private face-to-face location using tablets loaded with the RedCap Mobile app. Enumerators were local HAI staff trained in data collection. Data were saved on the tablets and uploaded to the RedCap server at the end of each survey day. The full survey was administered to CMP participants who provided their verbal consent, did not exhibit more than four COVID-19 symptoms, and who were not waiting to receive results from a COVID-19 test. There were 273 CMP participants; 271 participants were administered the full survey (two consenting participants were excluded from the survey after they screened positive for more than four COVID-19 symptoms. Participant names and survey IDs were recorded and stored in a separate secure location.

Analysis

Related items were grouped into two construct scales and six topic scales for ease of analysis, exploring the results of questions regarding participant knowledge (VAW types, impact, and helping behaviors) and attitudes (VAW acceptability, gender roles, and victim blaming) (Table 1). True/not sure/false questions were scored on a three-point scale, with correct answers scored as three points, "not sure" scored as two points, and incorrect answers scored as one point. Higher scores indicate greater knowledge. Questions asking about level of participant agreement ("strongly disagree" to "strongly agree," with non-answers recorded as neutral) were scored on a five-point Likert scale. Answers most aligned with Harmonia Activity goals ("favorable" attitudes) were scored as 5 points and answers least aligned with Activity goals were scored as 1 point. Higher scores indicate more favorable attitudes towards gender equity and peaceful resolution of conflict. Values for negatively worded questions were reversed, and question values were summed to create scores. Scale reliability was assessed by Cronbach's alpha (Table 2).

Missing data were minimal, and no participants were excluded from analysis on the basis of missing data. Descriptive statistics were conducted to explore knowledge and attitude scores across construct and topic scales. Results were stratified by gender and educational levels of respondents to explore differences in knowledge and attitudes around VAW by these demographic factors. T-tests were used to explore differences by gender and linear regression was used to obtain global p-values across education levels. Analyses were performed in R version 4.0.5 and Microsoft Excel version 16.49.

Table 1: Survey items used to create topic and construct scales

Construct scale	Topic scale	Items in composite scale
Knowledge		
	Types of violence	1. When a husband humiliates or constantly insults his wife, this is a type of domestic violence, 2. When a husband uses his power to control all the family finances, this is a type of domestic violence, 3. For cases of rape in Timor-Leste, the perpetrator is most likely to be a stranger, 4. When a married woman is forced to have sex by her husband, this is not rape, 5. Sexual abuse only happens to girl children
	Impact of violence	1. Women who experience violence tend to need health care more often than women who do not experience violence, 2. If a man drinks alcohol regularly, he is more likely to use violence against his wife, 3. Children who witness violence against women in their homes or communities are not affected unless they are physically abused themselves, 4. A woman who has been raped needs immediate health care, 5. Women who experience violence are more likely to attempt suicide.

	How to help	1. If you suspect that a woman has been subjected to violence, you should ask her about it, 2. Domestic violence is a private matter and people outside the family should not interfere, 3. If you suspect a woman/child has been subjected to violence but they do not want to talk about it, there is nothing you can do to help, 4. If someone tells you about domestic violence or sexual assault that they experienced it is important not to share or discuss her information with anyone unless you have talked to her about it first, 5. You should not pressure someone to tell you about the abuse they have experienced, 6. If you suspect a husband is being violent, you should talk to both the woman and her husband about it together, 7. You should advise victims of violence about what to do because you know what is best for them, 8. You can provide information to a woman who is experiencing violence, but she should make her own decisions, 9. You should tell a woman who is experiencing violence to be patient with her husband and try not to provoke him, 10. You should verify how accurate a woman's story is by asking the alleged abuser or the woman's friends and family, 11. Even when you are not sure what to do to help the woman, one thing you can do is to listen to her closely.
Attitudes		
	Acceptance of violence	Is a husband justified in hitting or beating his wife if: 1. She goes out without telling him, 2. She argues with him, 3. She refuses to have sex with him, 4. She burns the food, 5. He suspects that she is being unfaithful, 6. He finds out that she is unfaithful
	Gender roles	1. Women and men should share authority in the family, 2. A woman's most important role is to take care of her home and cook for her family, 3. It is natural (god intended) that men should be the head of the family, 4. A wife should obey her husband even if she disagrees. 5. A woman should be able to spend her own money according to her own will, 6. It is the wife's obligation to have sex with her husband whenever he wants it, except when she is sick or menstruating
	Victim blaming	1. No woman ever deserves to be beaten, 2. Men cannot control their sexual behaviour, 3. A husband can be excused for beating his wife if he is drunk, 4. It is okay to hit children if they have done something wrong, 5. Sometimes, being abused, assaulted or raped is the woman's own fault, 6. If the woman had defended herself, she could have avoided being raped.

Table 2. Cronbach's alpha score, number of items, and possible range for construct and topic scales

Construct	Cronbach's alpha	no. items	Range of possible scores
Knowledge	**0.36**	**21**	**21 – 63**
Types of violence	0.33	5	5 – 15
Impact of violence	0.24	5	5 – 15
How to help	0.16	11	11 – 33
Attitude	**0.73**	**20**	**20 – 100**
Acceptance of violence	0.75	8	8 – 40
Gender roles	0.17	6	6 – 30
Victim blaming	0.56	6	6 – 30

Results

Sample Characteristics

The interviewers conducted a total of 271 interviews (Table 3), divided almost equally between the two municipalities. Respondents were 60% male, 39% female, 1% other. They ranged in age from 22 to 85, with a median age of 42 for males (interquartile range [IQR] = 36 – 51) and 38 for females (IQR = 31 – 45). The median education level for males was some secondary school while for females it was completion of secondary school. Most participants (90%) were partnered or married and living with their partner. Nearly all participants (98.9%) held a community leadership role; the most common roles were village or sub-village chief (35.8%), village delegate (23.6%), youth leader or representative (10.3%), and women's leader (7.4%). The majority of respondents (60.2%) lived in rural villages, with 21% living in semi-urban villages and 18.8% living in urban villages

Table 3: Characteristics of CMP participants (n = 271)

	N (%)
Age	
17 - 24	9 (3.3)
25 - 34	61 (22.5)
35 - 44	95 (35.0)
45 - 54	78 (28.8)
55 - 64	24 (8.9)
65 - 74	3 (1.1)
85	1 (0.4)
Gender	
Male	163 (60.2)
Female	105 (38.7)
Other	3 (1.1)
Education level[1]	
Primary	49 (18.1)
Pre-secondary	71 (26.2)
Secondary	122 (45.0)
Post-secondary	29 (10.7)
Marital status	
Single	11 (4.0)
Married or partnered, living separately	4 (1.5)
Married or partnered, living together	244 (90.0)
Widowed	4 (1.5)
Divorced or separated	8 (3.0)
Residence	
Rural	163 (60.2)
Semi-urban	57 (21.0)
Urban	51 (18.8)
Community leadership role	
Village or sub-village chief	97 (35.8)
Village delegate	64 (23.6)
Youth leader or representative	28 (10.3)

Women's leader	20 (7.4)
Healthcare	16 (5.9)
Traditional leader/village elder	6 (2.2)
Teacher	5 (1.9)
No role	3 (1.1)
Religious leader	2 (0.7)
Other	30 (11.1)

[1]Education levels (primary: completed primary school or less; pre-secondary: completed all or some middle-school; secondary: completed some or all high school; post-secondary: pursued or attained college degree)

Overall scale scores

Participants' responses to questions regarding knowledge about violence and attitudes towards violence were moderate; all scale scores were about in the midpoint of possible responses (Table 4).

Table 4: Construct and topic scale results, overall (n = 217)

Overall (n = 271)			
Construct	Mean	SD	Observed range
Knowledge	**45.96**	**0.98**	**35 – 59**
Types of violence	10.45	0.99	5 – 15
Impact of violence	12.97	0.80	5 – 15
How to help	22.54	1.0	15 – 31
Attitude	**65.30**	**1.15**	**44 – 86**
Acceptance of violence	27.72	1.09	16 – 40
Gender roles	17.84	1.19	10 – 26
Victim blaming	19.75	1.13	11 – 29

Comparative analysis by gender

Apart from the impact of violence scale, all scale results differed significantly when disaggregated by gender (Table 5). Men (mean = 10.61, SD = 0.98) reported knowing more about types of violence than women (mean = 10.12, SD = 0.99, p <0.01). Men (mean = 22.47, SD = 1.00) reported knowing more about how to help than women (mean = 22.71, SD = 0.99, p = 0.02). Men and women reported similar levels of knowledge about the impact of violence. Men (mean = 28.00, SD = 1.07) reported attitudes less accepting of violence than women (mean = 27.33, SD = 1.10, p <0.01). Men (mean = 20.06, SD = 1.10) reported attitudes less accepting of victim blaming than women (mean = 19.31, SD = 1.17, p <0.01). Women (mean = 18.28, SD = 1.16) reported attitudes more consistent with equitable gender roles than men (mean = 17.52, SD = 1.20, p <0.01).

Table 5: Construct and topic scale results, disaggregated by gender

	Female (n = 105)		Male (n = 163)		Group differences
Construct	Mean	SD	Mean	SD	p
Knowledge	**45.73**	**0.98**	**46.12**	**0.98**	**<0.01**
Types of violence	10.12	0.99	10.61	0.99	<0.01
Impact of violence	12.91	0.81	13.03	0.79	0.23
How to help	22.71	0.99	22.47	1.00	0.02
Attitude	**64.92**	**1.15**	**65.58**	**1.15**	**<0.01**
Acceptance of violence	27.33	1.10	28.00	1.07	<0.01
Gender roles	18.28	1.16	17.52	1.20	<0.01
Victim blaming	19.31	1.17	20.06	1.10	<0.01

Comparative analysis by education level

Higher scores for all construct and topic scales were associated with higher levels of education (global p <0.01) (Table 6). With the exception of the types of violence topic scale, where knowledge level decreases slightly between primary and pre-secondary education levels, higher knowledge and more favorable attitudes were seen for higher educational levels compared with lower education levels.

Table 6: Construct and topic scale results, disaggregated by education level

	Primary and less (n = 49)		Pre-secondary (n = 71)		Secondary (n = 122)		Post-secondary (n = 29)		Group differences
Construct	Mean	SD	Mean	SD	Mean	SD	Mean	SD	p
Knowledge	**44.51**	**0.99**	**44.92**	**0.98**	**46.64**	**0.97**	**48.14**	**0.95**	**<0.01**
Types of violence	10.31	0.99	10.11	0.99	10.48	0.99	11.38	0.96	<0.01
Impact of violence	12.39	0.88	12.96	0.80	13.10	0.78	13.48	0.72	<0.01
How to help	21.82	1.00	21.85	0.99	23.07	0.99	23.28	0.99	<0.01
Attitude	**63.47**	**1.12**	**63.92**	**1.12**	**65.97**	**1.15**	**69**	**1.20**	**<0.01**
Acceptance of violence	27.18	1.06	27.23	1.09	27.85	1.08	29.24	1.11	<0.01
Gender roles	17.33	1.15	17.37	1.14	18.14	1.22	18.62	1.22	<0.01
Victim blaming	18.96	1.11	19.32	1.09	19.98	1.12	21.14	1.24	<0.01

Discussion

This study of community leader knowledge and attitudes resulted in three insights. Knowledge and attitude scores more consistent with an anti-violence and gender equity ideology are described here as “more favorable.” Male participants reported greater knowledge and more

favorable attitudes toward VAW than female participants. Female participants had more favorable attitudes toward traditional gender roles, such as sharing authority, household tasks, and financial decisions. Participants with higher education levels reported greater knowledge and more favorable attitudes. Overall, scale scores indicated moderate levels of knowledge and neutral attitudes that reflect a need for change if VAW is to be reduced. These results underscore the timeliness of the Harmonia Activity and the potential for growth across the different elements of VAW for participants in CMP workshops.

Community leaders' gender and level of education were strongly associated with level of knowledge and favorability of attitudes. Men reported greater knowledge than women overall, for types of violence and for how to help a woman who is experiencing violence. Women and men reported similar knowledge about the impact of violence. Men reported more favorable attitudes for acceptance of violence and victim blaming, suggesting that women were more likely to justify VAW than men. In contrast, women reported more favorable attitudes than men for gender roles. Available literature corroborates less favorable attitudes towards acceptance of VAW among women than men in many low-and-middle-income countries and in Timor-Leste in particular, suggesting that women tend to justify VAW more often than men do (Sardinha & Nájera Catalán, 2018; UNICEF, 2020; Wild et. al, 2020). Given these findings, it is interesting that women reported more favorable attitudes towards gender roles. While these differences are statistically significant, considering the potential for improvement in attitudes and knowledge across genders, the Harmonia Activity would do well to address all topics with participants of all gender identities.

Knowledge and attitude scores differed across education level, with higher level of education associated with greater knowledge and more favorable attitudes. These findings are consistent with global literature and are encouraging given the increasing rate of educational attainment in Timor-Leste (Flood, 2009; Serrano-Montilla et. al, 2020; UNESCO, 2017). In the context of the Harmonia Activity, difference in knowledge and attitudes could be harnessed for programmatic effect by encouraging knowledge-sharing between participants of differing education levels.

Limitations

The findings of this study should be considered within its methodological limitations. Study locations and participants were purposefully selected and are not representative of the larger Timorese population. As such, this study is not intended to generate generalizable information. Survey measures were adapted from validated surveys, but many have not been used in this context and Cronbach's alpha estimates indicate that the knowledge construct items may have low reliability. However, this does not limit our ability to make conclusions about program impact, and this work may provide formative information about how these questions might work for further studies on this topic and in Timor-Leste.

Conclusion

This paper provides evidence for the potential benefits of programs, like the Harmonia Activity, focused on shifting social norms, attitudes, and beliefs about VAW. Future research should work to increase the internal reliability of surveys regarding VAW in the Timor-Leste context, and should explore the difference between women's attitudes about acceptability of violence and victim blaming, which were less favorable than men's, and gender roles, which were more favorable than men's.

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