CULTURAL-HUMANITARIAN FUND "SUKHUMI"

THE ROLE AND INVOLVEMENT OF THE REPRESENTATIVES OF MEDICAL INSTITUTIONS IN THE PROCESS OF IDENTIFICATION, RESPONSE AND REFERRAL OF VIOLENCE AGAINST WOMEN AND DOMESTIC VIOLENCE

STUDY

2019

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BRIEF SUMMARY OF THE STUDY RESULTS AND RECOMMENDATIONS

Violence against women and domestic violence are complex and multilayered problems which require that the state adopt comprehensive policies and take large-scale, timely and effective measures. On the one hand, we observe considerable progress in fighting domestic violence in Georgia, but on the other hand, there still remain a number of challenges and weak links in the referral system, which are less effective in protecting women against violence. Realizing the roles of the actors of the referral system, coordination and cooperation among different actors still remain as challenges. Attitude to the problem of domestic violence and violence against women, lack of an effective and comprehensive victim-protection strategy in the health care system and among the medical personnel are among these challenges.

Starting from 2016 the Ministry of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Affairs of Georgia and LEPL State Fund for Protection and Assistance of (statutory) Victims of Human Trafficking have worked on the

changes aiming at overcoming deficiencies in the health care system. However, as of 2019 this reform is still only at a piloting stage. **Protracted trainings of doctors and other medical professionals, delaying introduction of guidelines** have negative impact on the process of combating this social evil, as timely assistance to the victims of violence is often of crucial, even vital importance. Violence against women and domestic violence are often hidden. Victims are often unwilling to disclose such facts due to different reasons. A doctor or other medical staff are frequently the only persons who they can confide in. Therefore, it is important that the victim receives sympathy and support from health care system and he/she receives needed services and avoids becoming **the object of secondary victimization.**

The study carried out by Fund "SUKHUMI", which explored the level of involvement of the representatives of medical institutions in the process of identification, response and referral of violence against women and domestic violence, has discovered that **doctors realize the gravity of the problem of violence against women and domestic violence,** which in itself is a significant step forward. However, as the study results suggest the main problem is inadequate reaction to incidents of violence against women and domestic violence from the medical personnel, which is caused by a number of objective, and subjective reasons, most important of which are:

- **Lack or inaccessibility of educational or other resources on the topic of combating domestic violence and violence against women;**
- **Lack of gender sensitivity;**
- **Lack of awareness of one's personal role and ethical responsibility;**
- **Underestimating the scale and gravity of the problem;**
- **Indifference from doctors;**
- **Shortage of time;**
- **Low pay (especially in the regions);**

- **Personnel shortage;**
- **Lack of consistent standards and approaches for responding to the cases of violence against women and domestic violence;**
- **Incomplete forms for documenting the cases of violence;**
- **Insufficient coordination and cooperation between different actors of the referral process;**
- **Feeling of being unprotected from the abuser.**

Correction of the deficiencies requires timely response and proactive measures from state institutions, civil society and all stakeholders.

Medical staff play a crucial role in the system of protection from violence and referral of the victims of violence against women and domestic violence. Despite existing challenges, there are still quite a few highly professional, attentive, ethical doctors or medical staff who, regardless of many difficulties and heavy workload, still perform their duties, take on additional responsibility and in many cases support the victims at their own personal risk. Such cases should not be exceptions and should not be dependent on the goodwill of individual doctors. Fighting violence against women should be among the top priorities of the health care system.

In the process of working on the present document, it became clear that doctors are prepared to accept the challenges, to receive more knowledge and to contribute to the fight against violence against women and domestic violence conducted by the state.

Based on the analysis of the study findings we can conclude that in order to fight violence against women and domestic violence more effectively it is necessary to work more closely with the medical staff, to provide them with more information, training and up-to-date knowledge, which will help them to tackle the cases of domestic violence and violence against women they come across in their practice. We believe that the following steps should be taken in order to achieve these goals:

1. It is desirable to intensify the reform in health care system in order to ensure timely and effective involvement of health care institutions in combating gender-based violence and violence against women;
2. The Georgian government should adopt a document on “National referral procedures for identification, protection and rehabilitation of the victims of violence against women and domestic violence” without delay;
3. The Ministry of IDPs from the Occupied Territories, Labour, Health and Social Affairs of Georgia should take timely steps to ensure awareness raising of medical staff about the problem of the violence against women and domestic violence, the methods of fighting violence and their roles in this process. The Ministry should, as soon as possible, implement the documents that have already been adopted (“Standard Operating Procedures (SOP) on the principles of identification, treatment and referral of cases of physical, psychological and sexual violence against women”, annexes to the ambulance call record (form NIV), ambulatory record (form 41/N) and hospital record (form 108/N), and pilot educational/training programs.
4. The Ministry of IDPs from the Occupied Territories, Labour, Health and Social Affairs of Georgia should provide clear and precise recommendations to the medical staff throughout the country in order to set up uniform practice of fighting against violence. The document should include information on identifying and treating the victims, standards for documenting the incidents of violence, the rules of cooperation with different actors of the referral process. It should also include the response mechanisms and measures of responsibility in case of failure to fulfill the duties by the medical staff
5. Incentives should be provided to doctors and other medical staff for efficient work with victims of violence against women and domestic violence and for overtime work; they should have guarantees of security from abusers.

6. Strengthening the coordination between the medical personnel and the actors of the referral system should be stimulated. It is advisable to introduce joint training programs;
7. It is necessary to refine the practices of referral of patients to relevant institutions to receive needed services, which would prevent a patient from addressing the personnel of various institutions (except for the cases when another medical specialist is needed), thus increasing the risk of secondary victimization.
8. The Ministry of IDPs from the Occupied Territories, Labour, Health and Social Affairs of Georgia should take steps to increase the number of phsychologists, especially in the regions that have shortage of these professionals, which makes it impossible to provide psychological assistance to the victims of violence against women and domestic violence and impedes their rehabilitation.
9. It is advisable that the The Ministry of IDPs from the Occupied Territories, Labour, Health and Social Affairs of Georgia appoint a focal point (from the list of existing personnel or, if needed due to hugh demand, to allocate a new staff member) in each medical institution who will be responsible for collecting information and data about violence against women and domestic violence, for raising awareness of the medical staff and for cooperation with relevant bodies;
10. It is desirable to strengthen the cooperation between the representatives of state institutions and NGOs in order to increase qualification of medical staff, exchange information, improve monitoring and also, to give qualified local organizations the possibility to share experience, be involved in the reform process and assess its implementation and results.

CHAPTER 1. RELEVANCE OF THE STUDY, NATURE OF THE PROBLEM

Although the state has taken considerable steps in combating violence against women in recent years, which was reflected in large-scale changes in legislation in 2017 aimed at harmonization with the Istanbul Convention, there still remain a number of challenges and weak links in the referral system which are not very efficient in protecting women from violence. Attitude of the **medical staff** to the problem of domestic violence and violence against women and lack of effective, comprehensive victim-protection strategy are among these challenges.

Due to the nature of their work, doctors and other hospital staff are frequently in touch with victims of all types of violence including domestic violence. Any type of violence is connected with physical or psychological trauma to the victims and the consequences are often so grave that they could not be hidden. Thus, the victims have to ask for medical services. Therefore, it is crucially important that the victims who have managed to overcome the fear, the shame, obstacles created by the abuser and other possible barriers (including economic, geographic) and have addressed a medical institution are met by sympathetic individuals who are aware of the problem of violence against women and who are able to provide qualified assistance and offer all needed services.

The above-mentioned is particularly important as secondary violence and secondary victimization are global problems which prevent victims from disclosing incidents of violence and asking for support. This increases the risk of expanding the scale of violence and incurring irreparable damage to the victim.

The problem of secondary victimization is discussed in the

Istanbul Convention of the Council of Europe[1]. We can find several variations of this term[2] and it is well researched in the academic community. It implies insensitive, indifferent attitudes towards victims from the professionals who have to deal with incidents of violence (including social services system, representatives of judicial, medical, psychological health spheres: police, prosecutors, doctors, social workers, etc.), also blaming the victim for causing violence or triggering violence in some way[3], which is an additional trauma to the person whose condition is already grave. Having failed to receive support from the persons who are to care for their protection and rehabilitation, many victims refuse to share their experiences, refuse to testify and cooperate with the investigation. This situation further hampers prevention of violence, protection/ rehabilitation of victims, punishment of the abuser and in general, solving the problem is delayed.

Thus, it is urgent to train and educate individuals who are or could potentially be directly and frequently in touch with victims or potential victims in order to overcome the problem of violence against women and domestic violence.

Violence against women and domestic violence are among the most prevalent problems in Georgia. According to the statistics of the Ministry of Internal Affairs of Georgia[4] in 2018 police issued

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[1] Council of Europe Convention on preventing and combating violence against women and domestic violence, art. 15.1
https://www.coe.int/fr/web/conventions/full-list/-/conventions/rms/090000168008482e

[2] renewed victimization, revictimization, double victimization, secondary victimization, secondary violence, secondary discrimination

[3] What is secondary victimization? Article: "Secondary Victimization of Rape Victims: Insights from Mental Health Professionals Who Treat Survivors of Violence"
https://mainweb-v.musc.edu/vawprevention/research/victimrape.shtml

[4] This statistics are published on the Website of the Ministry of Internal Affairs: see:: https://police.ge/

7646 restraining orders that were endorsed by the courts. As of 14 March 2019, 1768 orders have already been issued.

As for criminal cases (statistical data for domestic crimes which are covered by the articles 11'-108, 11'-109, 11'-117, 11'-118, 11'-126', 126' of the Criminal Code of Georgia) in total 4791 cases have been recorded, 3036 have been solved which comprises 63% of the total number. As of 14 March 2019, 1072 cases were recorded, 508 cases were solved (47%).

In terms of the geographical coverage, the results for 2018 are the following:

Samegrelo-Upper Svaneti – 1 murder, 2 health injuries, 143 other cases of violence, which in total comprise 3% of similar crimes recorded throughout the country. In this region as of 14 March 2019, 1 health injury and 34 other types of violence have been recorded.

Imereti and Racha-Lechkhumi – 2 murders, 6 health injuries, 748 other cases of violence, which in total comprise 3% of similar crimes recorded throughout the country. In this region as of 14 March 2019, 2 murders, 1 health injury and 123 other types of violence have been recorded.

Guria – 1 murder, 2 health injuries, 156 other cases of violence, which in total comprise 3.3% of similar crimes recorded throughout the country. In this region as of 14 March 2019, 31 other types of violence have been recorded.

The results of the violence mainly affect women's physical and psychological health, which is negatively reflected in different fields of social life and is directly related to public health and indirectly to social welfare and social injustice[5]. According to the study (2008) conducted by "Anti-Violence Network of Georgia" 31% of inter-

[5] National study on violence against women in Georgia p. 50. see: https://youngsupporters.files.wordpress.com/2012/03/annual-geo1.pdf

viewed doctors and 39% of doctors of primary healthcare state that they meet the victims of systematic domestic violence in their daily practice. A small-scale study conducted by Fund “Sukhumi” in West Georgia for monitoring of the implementation of the law of Georgia “On Elimination of Domestic Violence, Protection and Support of Victims of Domestic Violence” has clearly demonstrated the challenges in the field of medical services for women who are victims of violence and the difficulties that face medical staff in their daily activities when they interact with victims or abusers. Solution to this problem, which will be further elaborated below, requires that the state take immediate steps on legislative and practical levels in order to eradicate the barriers on the arduous road to eliminating all types of violence against women which the professionals working in this field face while fulfilling their duties and to equip them with adequate intellectual or other resources.

CHAPTER 2. THE OBJECTIVE AND METHODOLOGY OF THE STUDY

Following ratification of the Istanbul Convention and other legislative innovations, the Cultural-Humanitarian Fund "Sukhumi" has conducted a study under a pilot project that aimed at:

- Studying the practical implementation of the law "On Elimination of Domestic violence, protection and Support of Victims of Domestic Violence" and other relevant legislative acts in the medical sphere and investigating response mechanisms applied in practice by the medical staff to the problem of violence against women and domestic violence;

- Discovering existing shortcomings and elaborating recommendations for overcoming them;

- Actively communicating with relevant state institutions, interested international organizations and representatives of local civil society and advocating solution to the problem.

The study was conducted in January-February of 2019 and it covered 7 municipalities and 2 self-governing cities, in particular: Zugdidi, Tskaltubo, Terjola, Khoni, Lanchkhuti, Senaki, Ozurgeti, Kutaisi and Poti.

Quantitative as well as qualitative methods of research were used in the present study, including questionnaire, face-to-face survey, in-depth interview, focus group interview. Existing legislative framework, international legislation as well as legislative acts adopted by the Georgian Parliament and studies conducted by different organizations on the topic of violence against women and domestic violence were analyzed through desk research.

150 representatives of medical institutions, including doctors, nurses and administrative staff of medical institutions were interviewed. Family doctors, as well as doctors of different profiles from emergency services, ambulatories, hospitals and polyclinics,

including physicians, gynecologists, neurologists, cardiologists, traumatologists participated in the study. Among the participants 35% were doctors from ambulatory institutions, 17% - hospital doctors, 18.4% - family doctors. Emergency staff comprised 9% and other respondents – 20.3%.

The distribution of the respondents according to work place and regions is the following:

	Emergency Services	Ambulatories	Family Doctors	Hospitals	other
Senaki	4	19	7	5	4
Tskaltubo	4	15	1	6	0
Zugdidi	1	14	4	8	3
Kutaisi	6	14	15	10	5
Ozurgeti	3	9	10	5	10

2 focus groups and 2 in-depth interviews with doctors and medical staff were held, covering 20 respondents overall.

In total, 170 respondents participated in the study, with 86% women and 14% men.

Although the study does not claim to provide a thorough picture of attitudes and practices of medical staff in relation to the issues of violence against women and domestic violence, it is still possible that it spots many important aspects and challenges which require attention and timely response. These challenges will be further elaborated in the following chapters.

CHAPTER 3. LEGAL ASPECTS OF MEDICAL STAFF RESPONSE TO INCIDENTS OF VIOLENCE AGAINST WOMEN

The legal basis of responsibilities and responses of the professionals of different fields to the issues of violence against women and domestic violence are outlined in several legal acts. In 2006, the law "On Elimination of Domestic Violence, Protection and Support of Victims of Domestic Violence"[6] came into force in Georgia and based on this law the state has set eradicating violence against women and gender discrimination among its priorities. Although the law was a significant step forward, there still remained a number of shortcomings to overcome. Lack of effective mechanisms of prevention, indifference of professionals involved in the referral mechanism, gender insensitive attitudes still remained among the challenges.

Implementation of state policies against violence against women moved to a qualitatively new stage after Georgia ratified the Council of Europe Convention "On Preventing and Combating Violence against Women and Domestic Violence" (Istanbul convention) in 2017[7]. Consequently, it became necessary to harmonize Georgian legislation with the norms of Istanbul convention. In the process of harmonization about 20 packages of legislative changes have been elaborated[8]. This time we focus on the legislative innovations that cover the relations between victims or potential victims of violence and medical institutions as well as responsibilities of the medical staff in these relations.

By ratifying the Convention Georgia undertook a number of specific commitments that imply implementing effective mecha-

[6] See the initial version of the law at https://matsne.gov.ge/ka/document/view/26422?publication=0

[7] The Council of Europe 2011 **Convention** "On Preventing and Combating Violence against Women and Domestic Violence" (Istanbul convention) https://matsne.gov.ge/ka/document/view/3789678?publication=0

[8] Announcement of the Ministry of Justice. See: http://www.justice.gov.ge/Ministry/Index/483

nisms to ensure proper cooperation of state institutions in order to protect and support the victims and witnesses of all forms of violence[9], as well as to provide victims with medical services offered by the medical staff who have been adequately trained to assist victims and refer them to the appropriate services[10]. In order to fully comply with these commitments the convention obliges the signatories to provide or strengthen appropriate training for the relevant professionals dealing with the victims of all forms of violence covered by the convention in order to prevent secondary violence[11].

The law of Georgia "On Elimination of Domestic Violence, Protection and Support of Victims of Domestic Violence" ("The law against violence against women and domestic violence") is the fundamental legislative act against violence against women and domestic violence, which requires close collaboration between different institutions [12], including the Ministry of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Affairs of Georgia ("Ministry of Health of Georgia") [13], in order to prevent and combat violence against women.

According to the legislative requirement Inter-Agency Commission [14] on Gender Equality, Violence against Women and Domestic Violence has been established in order to ensure systematic and coordinated work of all state institutions. This commission represents an integrated coordination mechanism and is respon-

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[9] The Council of Europe 2011 Convention "On Preventing and Combating Violence against Women and Domestic Violence" (Istanbul convention) article 18.2

[10] Ibid article 20.2

[11] Ibid, article 15

[12] The law of Georgia "On Elimination of *Domestic Violence*, P*rotection and Support* of *Victims* of *Domestic Violence"* article 2.d-e
https://matsne.gov.ge/ka/document/view/26422?publication=14

[13] Ibid. 7.1

[14] Georgian law "On Gender Equality", art. 12.6
https://matsne.gov.ge/ka/document/view/91624?publication=8

sible for coordination, implementation, monitoring and evaluation of policies and measures that are aimed at prevention and elimination of all forms of violence.[15] The Deputy Minister of Health is a member of this commission.[16]

It is noteworthy that the Convention imposes notification obligation on certain professionals, including representatives of medical institutions, regardless of the principle of confidentiality, in cases when they have reasonable doubt that the act of violence has been committed[17]. This standard was reflected in legislative changes adopted in 2017, in which doctors, lawyers, teachers are obligated in special circumstances to notify law enforcement agencies about the cases or possible cases of violence against women or domestic violence.[18] The law explicitly states that the notification obligation is imposed among other actors, on the authorized representatives of medical institutions. [19]

In order to ensure adequate implementation of the law against violence, on 11 April, 2018 Georgian Government adopted a national action plan for 2018-2020[20], which details the actions to be carried out in the field of health care in order to effectively com-

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[15] Regulation of Inter-Agency Commission on Gender Equality, Violence against Women and Domestic Violence , article 4 k
https://matsne.gov.ge/ka/document/view/3698004?publication=0

[16] Decree of the Government of Georgia #286, 12 June, 2017 „On Creation Inter-Agency Commission on Gender Equality, Violence against Women and Domestic Violence and Adopting its Regulation", article 1
https://matsne.gov.ge/ka/document/view/4488017?publication=0

[17] ibid, article. 28

[18] Declaration of the Ministry of Justice of Georgia, see:.:
http://www.justice.gov.ge/News/Detail?newsId=5346

[19] The law of Georgia "On Elimination of *Domestic Violence*, P*rotection and Support* of *Victims* of *Domestic Violence"* article 9^1

[20] Decree N175 of the Government of Georgia on "adoption of 2018-2020 action plan of the measures to combat the violence against women and domestic violence and protection of the victims", see:
http://gov.ge/files/496_64833_426270_rotated_175.pdf

bat violence against women and domestic violence and clearly defines responsible persons and implementation timeframe. The planned actions include the following: implementation and evaluation of the results of the pilot program of introducing standard operation procedure aiming at strengthening the response of health care system to violence against women and domestic violence; designing an electronic training module and its integration in lifelong medical education programs; developing and implementing manuals for standardization of psychological, social and economic rehabilitation of victims, etc. It should be noted that the work in this direction started in 2016 by the Ministry of Health. However, effective implementation of this reform and nationwide application of these activities is still delayed and has not been accomplished.

According to the legislative changes, primary identification, protection, support and rehabilitation of the victims of violence against women and domestic violence and timely coordinated action of state institutions and other actors for these purposes are prescribed by the "**National referral procedures** for identifying, protecting, supporting and rehabilitating victims of violence against women and domestic violence", which should outline specifics of integrated procedures for protecting victims and the role of each state institution in this process. The Georgian government was responsible for passing subordinate legislation and adopting the referral procedures within a month from the date when the law came into force.[21] According to the document produced by the Parliament of Georgia, the Georgian Government has not fulfilled this obligation and has not adopted the referral procedures.[22] However, detailed description of these procedures is necessary

[21] The law of Georgia on changes to the law "On Elimination of *Domestic Violence*, P*rotection and Support* of *Victims* of *Domestic Violence"* see.: https://matsne.gov.ge/ka/document/view/3975127?publication=0

[22] Tasks specified by Transitional provisions of Georgian Laws and decrees of the Parliament of Georgia whose deadlines expired in February, 2018 see.: http://www.parliament.ge/uploads/other/87/87686.pdf

for all the actors of the referral process to realize their roles and fulfill their obligations effectively.

According to the information provided by the representative of the Ministry of Health to Fund "Sukhumi" under this study, elaboration of the referral procedures was commenced in 2016 under USAID project[23] which was implemented by LEPL State Fund for Protection and Support of Victims and Persons Affected by Human Trafficking (State Fund)[24] with participation of state institutions and representatives of NGOs. In the summer of 2018 due to structural changes related to merging/division of certain ministries changes to the project and its revision became necessary. According to our information, the work on this project will last until April-June of this year and as expected, the final version will be ready by July 2019.

It should be noted that starting from 2016 the State Fund with partnership and support from UNFPA has been implementing a pilot project[25] aiming at improving protection and support mechanisms to the victims of domestic violence and gender-based violence through adequate training of healthcare personnel. In 2016 under this project, the State Fund in active collaboration with the Ministry of Health elaborated:

a) "**Standard Operating Procedures** (SOP) for identifying physical, psychological and sexual violence against women, principles of treatment and referral" intended for primary and secondary healthcare professionals, which implies effective identification and evaluation of the cases of violence against women and domestic violence, ensuring provision of quality services, proper

[23] USAID project in 2016 - "Reduction of Domestic Violence in Georgia"

[24] State Fund (hereinafter "Fund") for Protection and Support of Victims and Persons Affected by Human Trafficking is a Legal Entity of Public law and it is controlled by the Ministry of Labor, Health and Social Care of Georgia. See the decree of the Legal Entity of Public Law State Fund for Protection and Support of Victims and Persons Affected by Human Trafficking at http://atipfund.gov.ge/res/docs/fondis_debuleba_2017.pdf

[25] Project – Health Care Response to Domestic Violence / Gender-based Violence, short summary of 2016, see:
http://atipfund.gov.ge/res/docs/UNFPA.pdf

documenting of violence and improving coordination for collecting evidence for further follow-up; However, countrywide implementation and application of these procedures has not been accomplished yet.

b) For improved documenting of the incidents of violence, based on the SOP annexes to ambulance call record (annex IV), to ambulatory record (form 41/n) and hospital record (form 108/n) were elaborated. Piloting of these forms with the aim of their future application started from September, 2018.

According to the information obtained by the Fund "Sukhumi", the project is being piloted only in Kakheti – with participation of village doctors of Telavi, Akhmeta, Kvareli, Sagarejo, Lagodekhi, Signakhi and Dedoplistskaro municipalities, also in Telavi Avtandil Kambarashvili Clinic and in Tbilisi Clinic "Curatio". At present observation and monitoring of the pilot project is underway. The evaluation of the project will start in November 2019 and the effectiveness analysis will be completed by December 2019.

Within the project the training module "On identifying physical, psychological and sexual violence against women, principles of treatment and referral" was developed and from 2016 to 2018 more than 300 healthcare specialists were trained in Tbilisi and Kakheti based on this module.

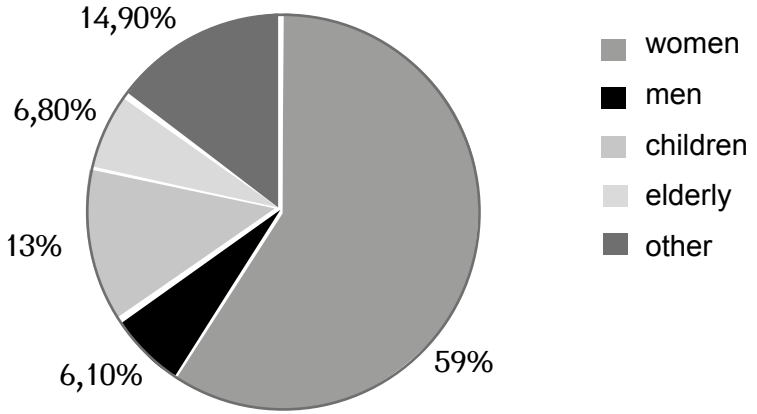
Thus, it is clear that the government, the ministries and other bodies have long been working in this direction in order to ensure that the healthcare system responds effectively to domestic violence/gender violence. However, the present study has shown that the awareness of doctors is not sufficient yet, only a small number of doctors have been trained and the majority do not understand their roles and responsibilities in the referral system. Despite the objective reasons (legislative and governmental changes) which delayed adoption of the final version of the referral documents, it is advisable that the process of forming and implementing the legislative base be advanced by the state. All bodies working on the reform should realize that each day of delay in changes might cost the victims of violence against women and domestic violence their health and lives.

CHAPTER 4. MAIN FINDINGS OF THE STUDY

4.1. Attitudes of the Staff of Medical Institutions and Awareness of their Role in the Issues of Violence against Women and Domestic Violence

The study has revealed a high level of awareness of the problem of violence against women and domestic violence among the surveyed doctors. 96.6% of the participants believe that violence is a ***very serious problem***. Only 0.6% disagree with this and 2.8% find it difficult to answer this question. Gender difference affects the responses only insignificantly; 97% of women and 95% of men recognize the gravity of the problem.

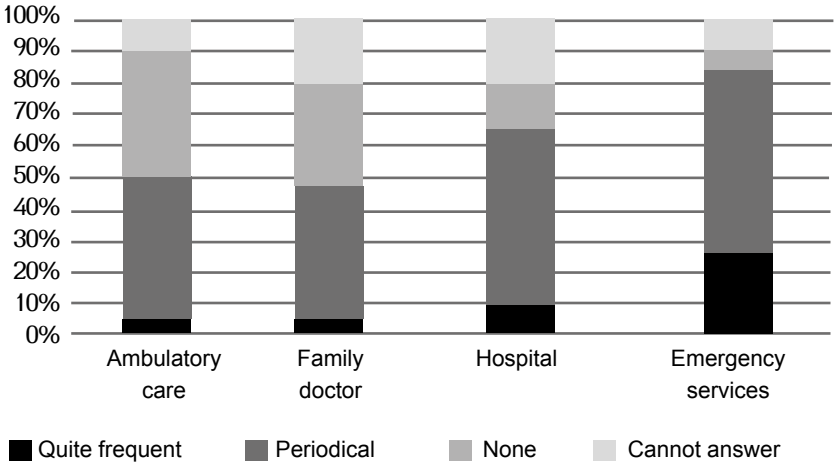
As expected, the experience of the medical staff confirms that women are the most frequent victims of domestic violence (59%), in the experience of 13% of doctors the victim is frequently a child.



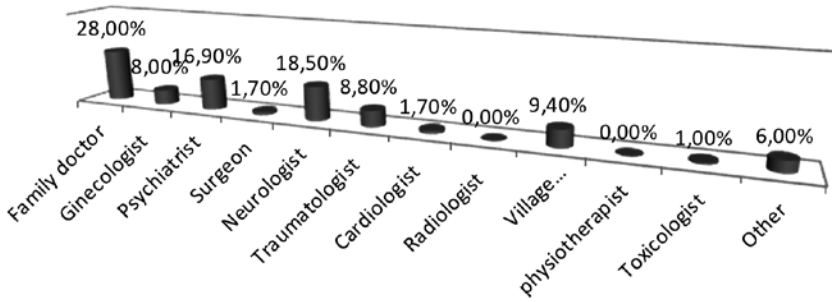
12.2% of surveyed doctors frequently encounter domestic violence in their practice, 49% do so periodically, 25.2% have never had this experience, and 13% cannot answer the question. The first indicator was similar across regions. The level of periodical encounters of violence was highest in Tskaltobo and Senaki, 64%

and 60% respectively. Negative answers were most frequent in Ozurgeti (52%) and Zugdidi (48%).

According to the findings of the study, it is ambulance doctors who have the most frequent contact with the cases of domestic violence and violence against women. Their 25% often and 60% periodically encounter such cases in their practice. The findings of the study in this respect can be summarized as follows:



As for the distribution of encounters with violence for various medical specialists, the study has shown that the frequency is highest for family doctors (28%), neurologists (18.5%), psychiatrists (16.9%), doctors of village ambulatories (9.4%).



Doctors' **awareness of their ethical responsibility** in combating violence against women and domestic violence is an important dimension. 25.3% of the study participants believe that medical staff have ethical responsibility to reveal the cases of domestic violence. 22.9% believe that their duty lies in treating physical and psychological effects of violence, 24.3% see their ethical responsibility in working with the victims to persuade them not to put up with violence, and 25.3% say their duty is to contact social/ legal services so that the victim receives adequate assistance and counselling.

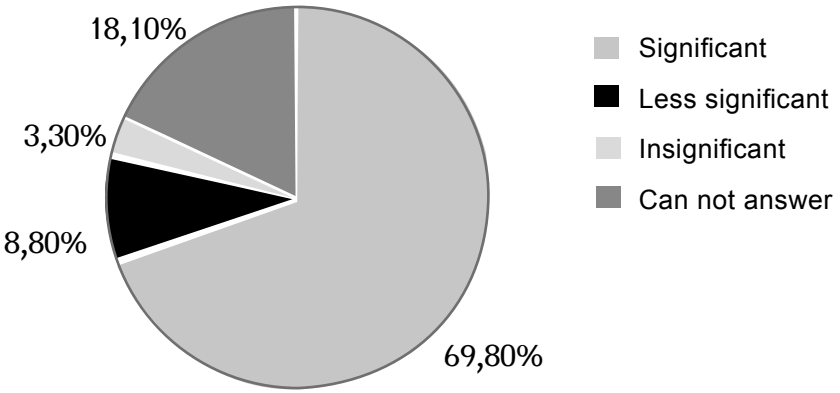
With regard to their involvement in combating violence, 28.4 % of doctors see their role in prevention. Problem identification and case evaluation are seen as a doctor's obligation by 18.3%. 16.9% believe they should document and record cases of violence, while minimizing the trauma of the victims is viewed as their main duty by 10.1%. In the opinion of 10%, medical staff need to support victims in gaining access to available services, and 20% support integrated approach and believe that all these measures need to be taken simultaneously.

A number of doctors believe that their role in combating violence is less significant than that of law enforcement agencies and social workers, but still recognize that medical staff is an ***important link in the referral mechanism***. Quite often, a doctor is the first and possibly the only representative of the referral mechanism who has personal contact with the victim. Besides, the interviewees remarked on the nature of doctor-patient relationship: "*Often victims trust their doctors more than the police or social workers because there are fewer psychological barriers in their relationship. A doctor is viewed as a rescuer.* "

As it was mentioned above, doctors recognize that violence against women and domestic violence are serious problems, but special attention has to be given to how far this attitude is reflected in the ***approaches established in practice***, how sensitive the

medical staff is to these issues, how much time and attention they give to patients who have suffered from violence. Declarations are one thing and reality is another. The latter looks much less encouraging.

While 96.6% recognize ***gravity of this problem, doctors' role in combating violence against women and domestic violence*** is believed to be significant by 69.8% and insignificant by 3%. The responses are summarized in the diagram below:



The study has revealed that doctors' ***response to possible victims of violence*** varies in practice. In particular, 31.7% try to find out the details of the case, while 50% refrain from questioning and investigating the details, which is indicative of rather low degree of responsiveness. 11% cooperate with relevant bodies (social services, police, educational institutions, prosecutor's office, local self-government), and 7% take other measures, e.g. talk to someone close to the possible victim or to the possible abuser.

Doctors of ambulatories and hospitals appear to be relatively active in finding out the condition of a possible victim and circumstances of the case. Their 29% try to investigate the details, while only 22.6 % of ambulance doctors do the same.

High number of ambulance doctors (32.2%) refrain from questions, for hospital doctors this number is 25.8%, family doctors – 22.6% and ambulatory doctors – 19.6%.

Geographical spread of the answers is also informative: 65% of doctors working in cities try to find out the details, while for villages, only 25% of the doctors do so. 25% and 40% respectively refrain from asking questions. These findings can be explained by limited access to information and resources for village doctors on the one hand and on the other, by the fact that they live in a small community where most people know one another and the dominant view is still that "family matters" do not concern outsiders; thus, they try to avoid interfering in the sensitive issue of domestic violence.

4.2. Barriers to Identifying Violence against Women and Domestic violence

Until recently, doctors seldom involved themselves with the issues of violence against women and domestic violence. Even when the symptoms were evident, they did not demonstrate necessary enthusiasm and effort in taking action against the problem. The study has revealed the main challenges and reasons that prevented doctors from asking questions, investigating details and thus, interfered with effective performance of their duties.

In the opinion of the study participants, **level of qualification of the medical staff and lack of relevant knowledge** are the main obstacles for effectively combating violence, as in this case we are not dealing only with their medical skills, but also their ability to identify possible cases of abuse of their patients, assess them, offer quality services, document facts of violence and refer them to relevant bodies, the activities that require specific knowledge and skills. 58% of surveyed doctors admit that they do not have

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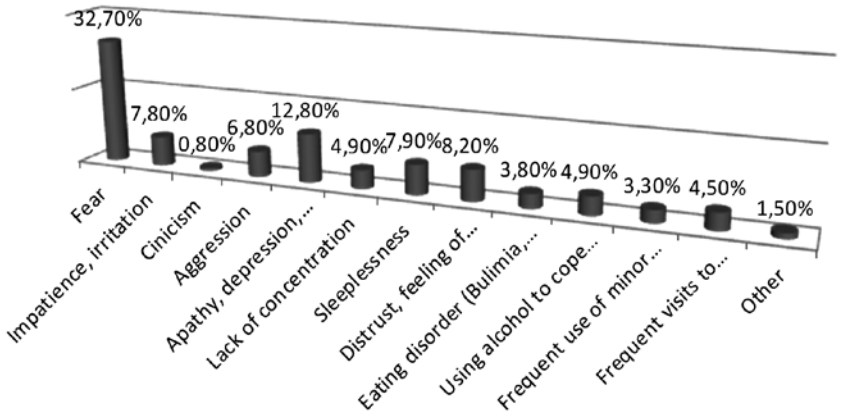
adequate experience/knowledge/skills required to respond to cases of domestic violence, and 28% cannot answer the question. Only 14% assess their own competencies in this area positively and 7% have received relevant training.

From gender perspective, the findings are as follows: 71% of surveyed men and 62.1% of women believe they lack necessary knowledge, experience and skills to offer adequate response to violence.

The small number of doctors with some training in combating violence have received this service from non-governmental sector and not the state. The doctors claim that they have not been offered any training programs or educational resources in these issues by the Ministry or any other governmental bodies. They name the issue of **victim identification** as one of the challenges. It is not always possible to identify a victim of violence just by a look. Doctors and other medical staff need special knowledge in order to see the signs of violence, select an appropriate strategy for interacting with the victim and collaborate with investigating bodies.

The doctors identified fear as the main characteristic of a victim; they also mentioned chronic fatigue and depression, suspicion and feeling of isolation.



The above data clearly demonstrate that the surveyed doctors often lack competence required to work with victims of violence against women and domestic violence and provide adequate response. It is important that the participants speak about this openly. Identifying victims of violence and conducting interaction with them in an appropriate manner requires proper preparation and knowledge as very often signs of abuse are not visible on the surface. Doctors and all medical staff need to be better informed about the mechanisms of victim protection, assistance and response to violence. It is necessary to provide doctors with support, training programs and guidelines for this purpose.

In focus group discussions, doctors were unanimous on the need for introducing training programs for them. For instance, participants from Lanchkhuti say: "*I have no information on what my duties are in effectively combating violence…*", "*There is demand; our doctors have not been trained; however, there are a lot of cases of violence and we need to know what to do*".

Often, doctors **are not informed** on how to act if they discover cases of violence in practice. When asked if they had relevant information concerning the mechanisms of protection from violence and programs of victim protection, only 32% of the participants respond affirmatively; 22.7% have no information and 45.3% are only partially informed.

In terms of gender distribution, 40% of female respondents have this information whereas for male doctors this indicator is only 28%.

In spite of our attempts, the monitoring process failed to find any instructions, guildelines or other types of official documents that representatives of healthcare institutions should follow at present in providing response to cases of violence against women and domestic violence. 54.6% of surveyed doctors have no knowledge of such a document and consequently, do not use it. This can be explained by the fact that Standard Operating Procedures

developed by the State Fund against Trafficking in cooperation with the UNFPA in 2016 has not been implemented yet; it is still at a piloting stage only in Kakheti region and has not extended to the whole of Georgia. 15.3% of the participants, who claimed that they used standards, when questioned further clarified that they used old standards that required they notify the police if they discovered evidence of physical injury.

Recording and documenting cases of violence is also problematic. Only 17.8% consider this important, but the study has revealed that there is no special standard practice of documenting cases of violence. Some clinics do not have a system that would allow them to record violence against women and domestic violence and handle the case of the victim in an appropriate way.

According to the information obtained during research, special forms were designed based on Standard Operating Procedures under UNFPA project in 2016. In particular, annexes were designed for ambulance call records (NIV), ambulatory (form 41/N) and hospital (form 108/N) records. These forms are also being piloted in Kakheti.

Doctors claim that they include a detailed description of physical and somatic condition of a patient in the patient history record, because they are accountable for a full realistic description of the patient's condition in the case of possible contact with law enforcement bodies. According to a participant from Lanchkhuti, they have no special document for victims of violence; however "medical record has a section for the information about abuse of the patient, especially in the case of underage patients", which they try to fill in.

Majority of participants, namely their 55.3%, attribute doctors' low responsiveness to cases of violence to **low awareness of the scale and gravity of the issue**. In addition, 17.3% note that medical staff lack knowledge of the ways of offering help to victims of violence.

14.3% of the surveyed consider that these issues **do not concern doctors**, which is an indication of certain **negligence** on the part of the doctors. A participant from Terjola said that in the beginning of the professional career he could guess at the source of the patient's injuries, but never tried to find out the details, because he believed that this did not concern him. A number of doctors believe that a very clear and specific document is required from the Ministry of Health that would outline doctors' duties with regard to violence against women and domestic violence and would also provide detailed procedures. "*If the requirement and instruction for this [adequate response] does not come from the Ministry and doctors have a feeling that this information is not interesting for anyone, they will not make the effort. Identifying and documenting the facts of violence should not be left to their 'goodwill'* " (Interview in Poti).

Statistics indicating doctors' low response rate to cases of violence appears to contradict the above-mentioned data showing that 96.6% admitted the gravity of the issue. This indicates that there is a big gap between declared viewpoints and practice and this gap would take a lot of effort to fill. This implies implementation of modern standards of combating violence and victim protection in doctors' everyday practice.

Interestingly, doctors claim that their failure to respond to cases of violence is frequently connected with concerns for their ***physical and psychological safety*** as mentioned by 14.7% of the participants. The interviewees cited cases when doctors were physically attacked after they had notified law enforcement agencies of incidents of violence. Doctors can also suffer from psychological pressure. To quote one of the respondents, "*One abuser still calls me 'a policeman without epaulettes' when he sees me in the street*" (focus group, Lanchkhuti). The doctors also note that the police is not always effective in protecting doctors from such abusers.

Shortage of time was referred to by 6% of the respondents. They believe that discussing their patients' psychological and social issues would take a lot of the working time in the conditions when a doctor's time for communicating with each patient is very limited. In addition, due to ***low pay*** doctors have to work in several clinics at the same time and adding to their workload in the conditions of limited time and low salary would be unfair. This environment does not encourage doctors to take on new responsibilities. One of the participants talks about doctors being overworked and their work being tightly scheduled – *"They cannot always be racking their brains trying to decide if their patient is a victim of violence or not. Working with them takes a lot of time and doctors have long queues of patients waiting at their doors."*

Interestingly, ***distrust of the victim*** was mentioned by 11.3%, which in some doctors' words implies interpretation, manipulation of the issue on the part of a possible victim. 6.7% of the participants blame the victim for not leaving the abuser and 18.5% believe that the woman provokes violence. This indicates that preconceived negative attitudes towards victims and practice of stigmatizing and attributing blame can be found among medical staff.

In the doctors' opinion, it is also problematic that frequently victims are unwilling to pursue the case after the immediate danger has passed. They fear that if the abuser is arrested, they will lose the breadwinner (Lanchkhuti focus group).

Regional distribution of responses is presented below:

According to the participants, it is a challenge that as a rule, victims ***hide the real cause of injury, trauma***. However, many comment that an experienced doctor can easily distinguish cases of domestic accidents from results of violence. A participant from Lanchkhuti commented that a patient seldom admits the truth, so questions have to be selected carefully.

These findings clearly indicate doctors' insufficient and inadequate awareness of the mechanisms and practices of respond-

ing to violence. This has to be remedied immediately as each case when a doctor fails to show necessary attention and readiness to fully examine a patient's condition may result in a severe injury or even lead to a fatal outcome.

4.3. Coordination – Collaboration of the Representatives of Medical Institutions with Other Actors of the Referral Mechanism

According to the respondents, recently they have started to process and forward the information on the issues of violence against women and domestic violence. The study has proved that participation of the representatives of medical field in the **referral mechanism is connected with some difficulties,** for example, it is often impossible to contact the needed professional, there is a shortage of personnel or they are overloaded with work. The doctors note that psychological services are inaccessible and therefore, it is impossible to refer the victim to a psychologist or psychiatrist for assistance. As a result, attending physicians often have to perform the functions of a psychologist as well. As a study participant has noted, this increases the pressure on other medical specialists who are not professional psychologists; they should not have to worry that they might bear moral and legal responsibility in case if the victim harms herself. Thus, it is necessary that a multi-profile team be involved in the work on such a complex issue. As a study participant from Khoni has noted, appropriate environment should be created for victims in order to help them open up and ask for support. Psychological assistance is crucially important when identification of the victim is problematic.

More than half of the surveyed doctors (50.2%) believe that collaboration of **the medical staff** with social workers is the most important and effective way of providing proper response to in-

cidents of violence, 29% gave preference to the police, 3.3% - to public prosecutor's office, 5.2% - to educational institutions. Only 3.9% consider that it is important to cooperate with the local government.

The study participants think that the response to the fact of domestic violence is more adequate if the emergency call is recorded as a domestic conflict or domestic violence from the start, as in this case law enforcement agencies, social workers and doctors are all involved. In emergency services, they noted that they cooperate with the police and the immediate response mechanism is operational. If there is a risk to the security of the victim or the doctor, the doctor pronounces the code word "Ambulance" by which the police is notified about the danger and police officers are immediately sent to the place.

A participant from Poti stated that the doctors and nurses working with him fully realize the significance of the records and importance of details when there is even the smallest suspicion of violence as this information might be helpful to the police in the investigation or as needed.

The doctors attach little significance to coordination with the other actors of the referral process as a mechanism of response to violence against women and domestic violence. Only 1% of the family doctors and 30% of the hospital doctors have cooperated with appropriate institutions. The highest level of cooperation (50%) with other actors of referral mechanism was recorded among the ambulance doctors, which can be explained by the peculiarities of their work as in the case of suspected violence they arrive at the place together with the police and social workers.

One of the respondents admitted that he/she did not realize the value of cooperation with other institutions and importance of coordinated action: "I believed that only police is interested in the cases of violence and the information should be collected only for them and cooperation with other institutions is of less importance.

Now I realize that this information has social nature that should be analyzed in detail and it requires involvement of other institutions. It would be useful to have a special focal point in the medical institution who will be responsible for analyzing the information and adequate response to it." (Interview from Poti)

It is clear from this data that insufficient awareness the actors of the referral system have of the roles and functions of different links in the system and of the ways of cooperation are the main reasons for the low level of coordination.

4.4. Vision of the Representatives of Medical Institutions on Solutions to the Problem

Responses to the question on how doctors' role could be increased in combating the violence against women and domestic violence were distributed in the following way: 40.8% believe that it is necessary to ***introduce various training programs for doctors.*** The doctors noted that these programs should include the information about the legislative mechanisms and the work of referral system, as well as about the roles and functions of doctors, their responsibility in the process of responding to violence and about identification of the cases of violence. According to the respondents, it is necessary that the ministry should have an unequivocal approach; it should elaborate clear and precise instructions and implement needed mechanisms. The doctors believe that it is desirable to conduct educational programs / training courses together with those actors of the referral mechanism with whom they cooperate, including police officers and social workers.

20.6% consider that it is necessary ***to implement awareness-rising campaigns*** on the roles of the healthcare system personnel in responding to the incidents of violence.16.4% of the respondents prioritized ***improving the system of coordination*** between

the representatives of the medical field and other actors of referral process.

Introduction of punitive measures for ensuring proper response by the medical staff was supported by 7.8% of the respondents. Some of the respondents believe that it is necessary to introduce disciplinary penalties for the medical staff for concealing the facts of violence against women and domestic violence.

12.9% of the doctors believe that **appointing focal points** in medical institutions who would be responsible for analyzing and responding to the facts of violence identified by doctors would promote improvement of existing practices.

We can summarise the answers of the doctors by the regions in the table below:

Work place	Introducing various educational programs	Promoting a coordination system	Awareness-Rising campaigns	Introducing disciplinary penalties	Appointing focal points for responding to incidents of violence	Other
City	60%	20%	30%	5%	5%	0
Village	80%	45%	40%	20%	15%	0

To summarize, the study has highlighted the main challenges of the healthcare system related to the involvement of doctors in the process of combating violence against women and domestic violence. We hope that the identified problems will draw the attention of the leadership of the system and the reform implementation will proceed in a faster and more transparent way.

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