Perceptions and knowledge of health care professionals towards domestic violence against women in Georgia

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Abstract

Background. Georgia is a state with a high prevalence of domestic violence. The health industry has a significant impact on the reaction to domestic abuse. It should concentrate on a number of issues, including spending, health regulations, and specialized training for medical personnel. Because doctors and other healthcare professionals are the first in line of contact with victims of violence, they should be prepared and well-trained to detect and respond to domestic abuse. They should be able to spot the warning signs and give their patients the first care they need.

Aim. Our study aims to determine how health professionals in Georgia perceive and act on domestic violence against women.

Methods. During the study, we have surveyed doctors from two big cities in Georgia -Tbilisi and Gori, and two major types of methods conducted: online survey and desk research. Within the online survey, e-questionnaires were sent to all participants. IBM SPSS version 22 used for data analysis.

Results. Study revealed that physicians surveyed in our study affirmed not to have appropriate knowledge and perception to identify domestic violence/intimate partner violence victims. They do not feel comfortable to talk about gender violence with a patient and have difficulties to find a proper referral service due to the lack of awareness or lack of service availability in the country. Our study has indicated an overall difference between knowledge about IPV in the capital city and another big city, medical practitioners from Tbilisi have higher knowledge about the problem than medical practitioners from Gori.

Conclusions. More action on domestic abuse needs to be taken by the health system, including referral networks, coordination, protocols, and guidelines, as well the relevant training of doctors. **(TCM-GMJ December 2024; 9 (2): P29-P37)**

Key words: domestic violence, violence against women, health care professionals, IPV - intimate partner violence

Introduction

Domestic violence remains a major problem in Georgia, but the situation changed after the Law of domestic violence was adopted in 2006 (1). From May 2012, domestic violence became criminalized to the Georgian Penal Code (2). Extremely increase in femicide numbers in Georgia, in 2014, increased involvement of police and other relevant low authorities which turned out more effective in investigating domestic violence cases (3). Public awareness regarding domestic violence now has increased, but the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs of Georgia (MoLHSA) has minimal involvement in the fight against domestic violence. The Georgian Ministry of Internal Affairs launched a campaign to raise public awareness of violence against women (4).

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Between 2007 and 2014 (January-June), there were 1102 registered cases of violence involving 2223 individuals. The majority of offenders were men (1014), with women accounting for 82 offenders. During this period, 1010 women and 117 men were identified as victims of domestic violence. Physical assault was the most common type of domestic violence at 47.2%, followed by psychological pressure at 42.8%, and other forms of violence at 10%. In the first six months of 2013-2014, investigations were initiated under articles 11 and 126 against 310 individuals, of which 289 were men and 21 were women. A total of 648 individuals were registered as victims, including 96 men and 352 women (5).

According to the data provided by the Ministry of Internal Affairs of Georgia (MoIA), in 2014 the Emergency and Operative Response Center "112" received 92901 notifications associated with domestic violence/family conflict (6). However, these data only represent initial information, while the data on the particular situation at the scene as a result of the response by the authorized services isn't being processed by Ministry of Internal Affairs of Georgia.

Healthcare professionals have a huge role to identify recognize intimate partner violence (IPV), or domestic violence (DV). With the appropriate recognition, they can offer victims useful help and support. For this action, healthcare professionals need appropriate knowledge of the subject (7). Doctors rarely ask directly about the type of violence, especially about domestic violence, even if they find out some evidence of IPV/DV, they do not fill in written documentation about it. If doctors detect diagnosed intimate partner violence or domestic violence in Georgia, then they should fill the special form called: form of documenting gender-based violence / sexual violence against women (Form №IV-300/B) provided Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs of Georgia, but this form is used only in Emergency department and is not used by the Family Physicians (8). However, fully documented gender-based violence cases are way to an important. It improves support services and access of better care. It also helps to increase response from justice services and to analyze the problem (9).

Several studies identified some barriers, which address why health professionals have troubles to identify abuse or violence. To identify domestic violence, healthcare professionals faced different kind of barriers, started with sociocultural barriers, continued with personal barriers, professional and institutional and legal barriers. Socio-cultural barriers combine several subjects, the first is societal tolerance of violence. Children, who grow up in violation and under regular punishment, consider violence as a norm. Most of the time it is common in society to "Blame the victim" and inadequate distribution of power in family, as well as inequities in relationships. These reasons make barriers for healthcare professionals to find out domestic violence victims because mostly victims believe is that violence in the family is a norm or they feel ashamed to talk about the subject. The barriers that physicians encounter is a lack of knowledge of the subject and inadequate attention. Inadequate skills to recognize or report domestic violence creates a barrier for victims to receive the proper care from medical facilities (10).

Methods. Our study aims to identify the perceptions and knowledge of health professionals in Georgia concerning domestic violence against women. In order to accomplish this goal, the following tasks must be carried out:

1. Research on the medical staff's knowledge and readiness regarding the domestic violence;
2. Research the crucial role of medical personnel in identifying violence.
3. Research the nation's medical system's involvement in detecting domestic violence in terms of training medical staff.

The study population are doctors in two fields of medicine - family physician and emergency room (ER) physicians—as well as residents and junior doctors from the emergency room. Chosen Medical staff should be able to speak Georgian. Additional criteria include age more than 18 years old, working in health care institutions in Tbilisi, and Gori. This will give us a general view of perception and knowledge towards domestic violence against women among medical staff.

During the study, the following types of methods were used: online survey and desk research, literature review. Within the survey, questionnaires sent to all participants online. The study used the PREMIS tool, which is a specially designed questionnaire, for checking healthcare workers' knowledge toward the IPV (11). The research questionnaire consists of four sections. Each section contains close-ended questions with single or multiple-choice answers. The first section is the respondent's profile which contains demographic questions: age, gender, marital status, field of practice, monthly income, working place. Background section contained questions about participants' attendance on the training about intimate partner violence. The third section was about healthcare worker's knowledge about intimate partner violence, which included close-ended questions with single or multiple-choice answers. And the last, fourth section contained questions about practical issues. This section had close-ended questions with single or multiple-choice answers as well (11). For data analysis of our study used IBM SPSS version 22.

Study limitations: In 2021 there was a state of emergency in Georgia, as well as in the world, due to the COVID-19 pandemic. We have followed all the instructions and recommendations given by authorities, to reduce the risk of transmission for both sides: for study participants and the investigator. Because of the regulations, the research questionnaire was sent online, which cause trouble to find enough number of respondents during research.

Results and discussion. A total study population included 140 medical staff from 22 different hospitals of Tbilisi and Gori, Georgia. Most of the study sampled respondents worked in Tbilisi (86.4%). According to the results of socio-demographic characteristics (**Table 1**), we can see that most of the study participants were female (70.0%).

Age distribution started from 24 years and most frequent age group among study participants was 24-29 (45.7 %) which was almost the half of the study population, the second most frequent age group was 30-39 (30.7 %), followed by 40-49 age group with15 % and +50 with 8.6%. More than half (54.4%) of respondents were married, second most frequent study group was single (38.6%) and less than 5% of the study participants were widow (2.9%) or divorced (2.1%). More than half (50.7%) of the study population were working as resident doctors (n=71), 25.0% were working as family physicians (n=35), 24.3% were ER doctors (n=34).

Majority of our study sample had working experience from 6 to 10 years (36.4%) and only 19 (13.6%) study participants had more than 15 years of working experience. The most of the study participants had less than 20 patients per week (33.6%), second group was from 20 till 39 patients per week (29.3%), third group had about 60 or more patients per week (24.3%) and only 4.3% of participants have not had patients' visits per week (Table 1).

In our study, the initial inquiry regarding participants' understanding of intimate partner violence (IPV) issues was whether or not they had had any prior training about the subject, and if so, how intensively. 74.3% of study participants (n=104) reported not having read any protocols, attended any training sessions, or watched any educational videos about domestic violence by an intimate partner, 15.2% of participants (n = 21) read the institution's protocol, 6.5% (n = 9) watched an IPV video, 10.7% (n = 15) went to an IPV lecture or discussion, and 6.5% (n = 9) went to a skills-based training or workshop (**Chart 1**).

When asked what was the strongest risk factor for becoming a victim of intimate partner violence, 67.4% of study participants mentioned that strongest risk factor to became victim of domestic violence is abusive partner. 60.9% of research participants thought that alcohol or drug abuse increases the risk factor of intimate partner violence, more than a half of study participants (51.6%) thought that partner, who experienced violence in family became batterer/abuser with partner as well, 37% of respondents thought that gender, particularly-female increases the risk to became a victim of violence and only 4.3% thought that young age (<30 years) is a risk factor of becoming a victim of domestic violence (**Chart 2**).

We asked our study participants, about what was warning sign that a patient may have been abused by partner (6), 80.4% of participants answered that main sign is depression, 65.2% thoughts that it is anxiety and the same amount of the participants (65.2%) thought that it is frequent injuries, 54.3% thought that it is substance abuse and only 26.1% thought that it is chronic unexplained pain (**Chart 3**).

We asked to the study participants, to choose from the following opinions about domestic violence/intimate partner violence, which is generally true about the subject, 89.1% of respondents thought that there are common non -injury patterns associated with intimate partner violence, 45.7% of study participants thought that there are specific areas of the body which are most often targeted in IPV cases, 37% of them thought that there are behavioral patterns in couples that may indicate IPV, 32.6% of respondents thought that injuries in different stages of recovery may indicate abuse and 28.3% of them thought that there are common injury patterns associated with IPV (**Chart 4).**

From the research finding it was interesting to see how geographical characteristics and opinions about domestic violence distribute. From the Table 2 we can see that majority of the study participants thought that there are common, non-injury presentations of abused partners, among them 78,6% male and 93.9% female participant chosen this answer as the "true" about intimate partner violence. From our research, we found out that the same opinion was chosen by participants from different working position, by 82,4% ER doctors, by 100% of Family physician and by 87.3% of Resident doctor. Second most frequent answer was "specific areas of the body are most often targeted in IPV cases", and gender distribution in this answer was- 50.0% male and 40.4% female. But distribution of opinion in working position was quite different, 44.1 % of ER doctors and 45.2 % of Resident doctors thought so. Second most common opinion about IPV is that there are behavioral patterns in couples that may indicate IPV, therefore 60.0% of Family Physician and 44.1 % of ER doctor thought that second most frequent answer is that "Specific areas of the body are most often targeted in IPV cases", The less frequent opinion was that there are common injury patterns associated with IPV, only 17.6 % of ER doctors, 42.9% of Family physician and 21.1% of Resident doctors thought that it could be generally true about intimate partner violence (**Table 2**).

When we talk about identifying IPV victims by the healthcare workers, then we should underline the importance of need to know how should they specifically address and ask their patients whether they are victims of intimate partner/domestic violence or not. From our research, we found that majority of the study participants avoid to ask direct question whether patient is victim of violence, only 13.0% of study participants asked directly to the patients if they were a victim of DV/IPV, the majority of respondents (60.9%) thought that most appropriate way to ask to the patient about IPV is to ask whether they ever been afraid of their partner, 43.5 % of study participants thought that most appropriate question to ask about IPV is to ask to the patients, whether their partner ever hurt or threatened them or if their partner ever hit or hurt them (**Chart 5**).

The next interesting topic was protocols for dealing with intimate partner violence (IPV) at their practice/clinic. We asked to the study participants, if they have special protocol for dealing with the IPV on place when they identified IPV. 54% of the participants are not sure whether they have any protocol or not, 25% of the participants mentioned that they have protocol for dealing with IPV, but use it only for some extent, 6 % mentioned that they have it, but they are not using it, 2% mentioned that they have and use widely, 4% of participants do not have it, for 9% it is not applicable for their patients' population (**Chart 6**),

only 20% of the study participants are aware of the guidelines of their institution regarding the screening and management of IPV victims and 68% of them are not aware of the guidelines of their institution regarding the screening and management of IPV victims (**Chart 7**).

From the **chart 8** we can see how study participant healthcare workers refer intimate partner/domestic violence victims, 17.4% of respondents mentioned that they call the police/or other local law enforcement, 15.2% of them said that they referred IPV/DV victims to the special shelters for domestic violence victims, or support groups or National DV/IPV hotline, 8.5% of study participants referred them to the social worker/advocate, 6.5% of the study participant mentioned that they referred victims to the alcohol/substance abuse council, 4.3% of respondent healthcare workers referred IPV/DV victims to the individual/couples therapy, 52.2% of study participant have not referred or have not had IPV victims (**Chart 8**).

According to the chart 8 medical practitioners conduct referral services when they identified IPV/DV cases. The last question of our study research questionnaire was, if study participants had adequate knowledge about referral resources in community for IPV/DV victims and only 21.4% of them mentioned that they had adequate knowledge about subject and 29.3% of participants mentioned that they do not have knowledge about referral services in community for IPV/DV victims. Better situation is with IPV referral resources for patients at research participants work site (including mental health referral service), 24.3% of study participants mentioned that they have IPV referral resources at their workplace and 22.1 % of them do not have information about IPV referral resources at their worksite (**Chart 9**).

The result of the study showed that knowledge toward an intimate partner or domestic violence is dangerously low among healthcare workers from 3 different working position groups: ER doctors, family physicians, and resident doctors from 22 different hospitals of Tbilisi and Gori, Georgia. Our study has indicated an overall difference between knowledge about IPV in the capital city and another big city, medical practitioners from Tbilisi have higher knowledge about the problem than medical practitioners from Gori. Also, this difference is visible between working positions, from Table 2**.** We can see that ER doctors are more actively involved in any activity about IPV training than the Family physician or Resident doctor and healthcare workers, who have more than 60 patients per week are more conscious about the subject. Only 17% of study participants indicated that some or any of their coworkers from their workplace attended an IPV training course.

The hardest part for healthcare workers was how to asked patients about current intimate partner/domestic violence, what is a better, choose direct way to ask a question or find a proper words. The majority of the study participants avoid to ask direct question whether patient is victim of violence and they prefer to ask whether they ever been afraid of their partner or not and other most appropriate question from study participants opinion was- whether their partner ever hurt or threatened them or if their partner ever hit or hurt them.

From result section we find that 54% of the study participants are not sure whether they have any protocols for dealing with IPV at their practice/clinic, 25% of the participants mentioned that they have protocol for dealing with IPV, but use it only for some extent, 6% of respondents mentioned that they have it, but they do not use it, 2% of them mentioned that they have and use widely. But even there exists a protocol for dealing with intimate partner/domestic violence, only 20% of the study participants were aware of the guidelines of their institution regarding the screening and management of IPV victims and 68% of them were not aware of the guidelines of their institution regarding the screening and management of IPV victims.

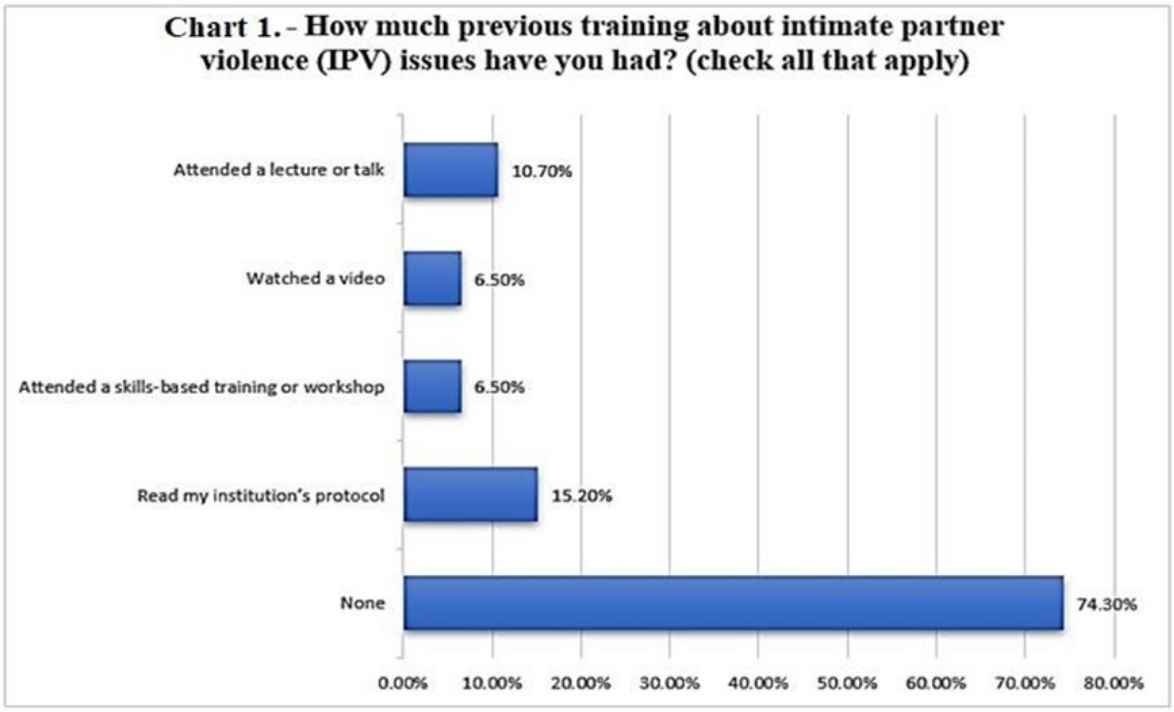
To help Intimate partner/domestic violence victim, the main is to have a proper referral service in country and also healthcare worker should have informed how they can conduct this action. When we asked to the study participants if they have adequate knowledge about referral resources in community for IPV/DV victims, only 21.4% of them mentioned that they had adequate knowledge about subject and 29.3% of participants mentioned that they do not have knowledge about referral services in community for IPV/DV victims and almost the same amount of the study participants: 24.3% of them mentioned that they have IPV referral resources at their workplace and 22.1% of them do not have information about IPV referral resources at their worksite. But if they offer to the IPV/DV victims about referral services, it contributes like that: 17.4%of respondents said that they call the police/or other local law enforcement, 15.2% of them said that they referred IPV/DV victims to the special shelters for domestic violence victims, or support groups or National DV/IPV hotline, 8.5% of study participants referred them to the social worker/advocate, 6.5% of the study participants mentioned that they referred victims to the alcohol/substance abuse council, 4.3% of surveyed healthcare workers referred IPV/DV victims to the individual/couples therapy, 52.2% of study participants have not referred or have not had IPV victims.

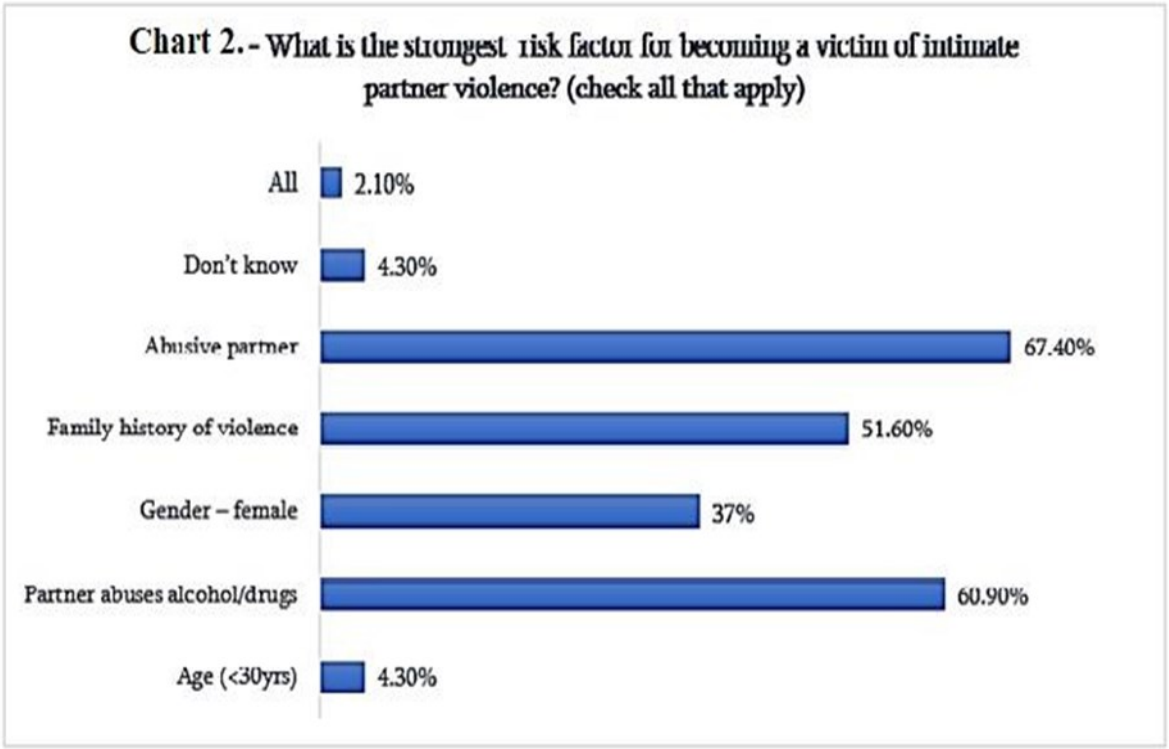
Conclusion. From our study we have found that healthcare workers' involvement into the intimate partner/domestic violence trainings is very low. They do not have appropriate information about identification and documentation of IPV/DV victims. Additionally, the most of the medical facilities do not have specialized protocols for dealing IPV/DV, even if they have any protocol/guideline associated to the DV/IPV, it used only for some extent or does not use at all. The same problematic situation is with referral services for IPV/DV victims. Most of the healthcare workers do not have information about referral resources. But if they mentioned that they have information, most of the study participants said that there is not enough and adequate services for IPV/DV victims.

We can conclude that, in general, physicians interviewed in our study affirmed not to have appropriate knowledge and perception to identify domestic violence/intimate partner violence victims. They do not feel comfortable to

talk about gender violence with a patient and have difficulties to find a proper referral service due to the lack of awareness or lack of service availability in the country.

More action on domestic abuse needs to be taken by the health system, including referral networks, coordination, protocols, and guidelines, as well as the relevant training of doctors.





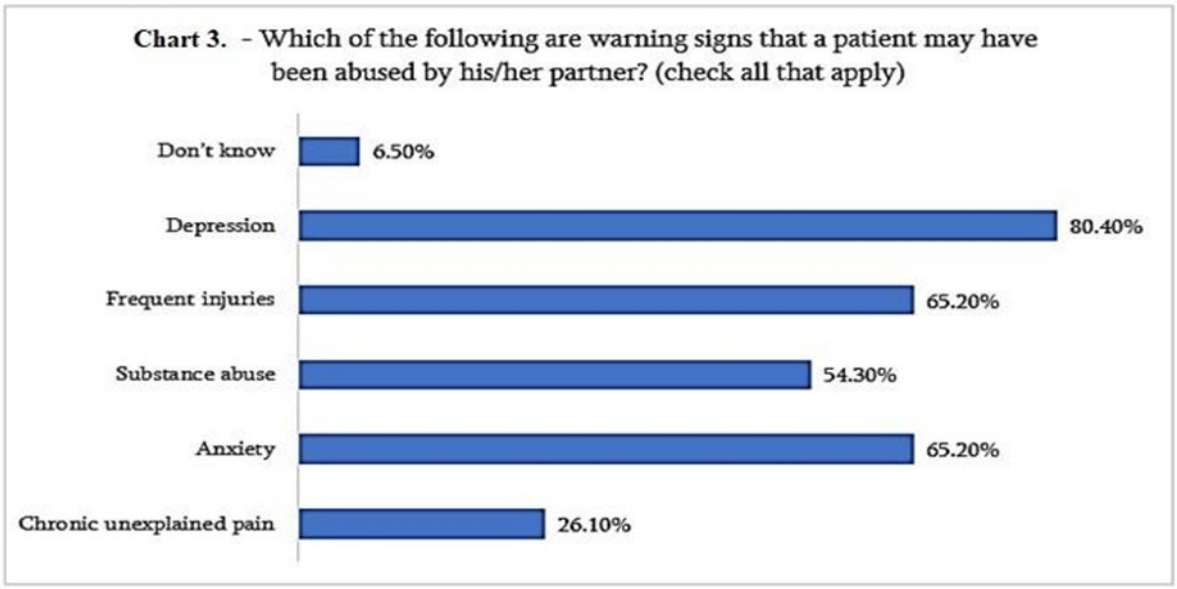


Chart 3. - Which of the following are warning signs that a patient may have been abused by his/her partner? (check all that apply)
Don't know
6.50%
Depression
80.40%
Frequent injuries
65.20%
Substance abuse
54.30%
Anxiety
65.20%
Chronic unexplained pain
26.10%

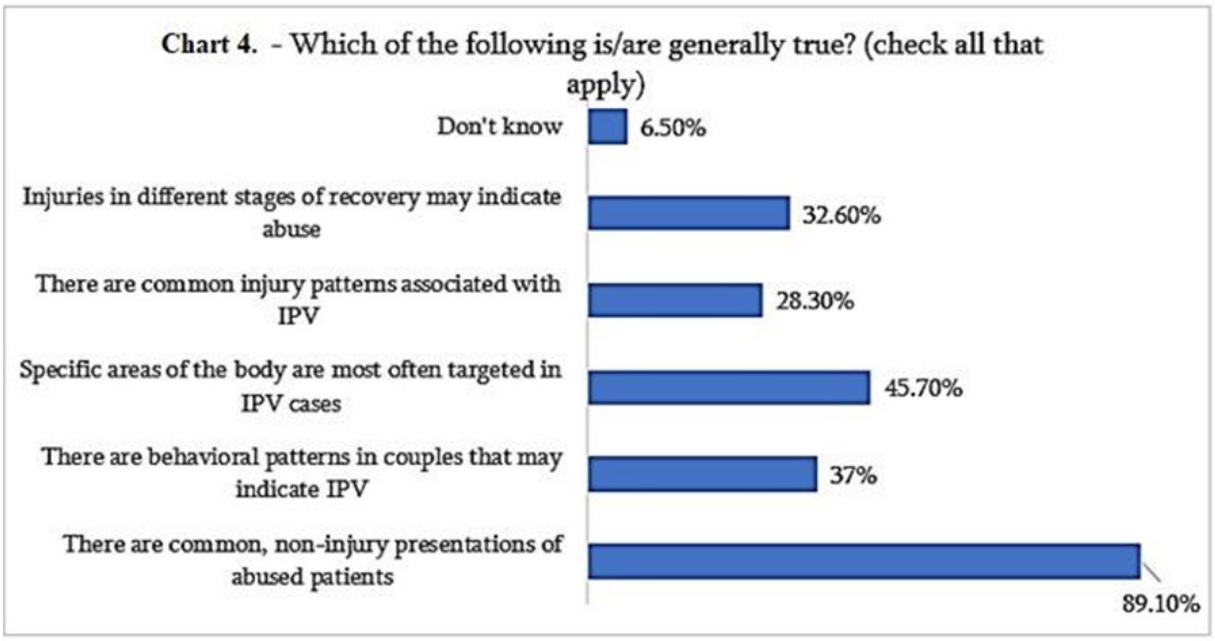


Chart 4. - Which of the following is/are generally true? (check all that apply)
Don't know
6.50%
Injuries in different stages of recovery may indicate abuse
32.60%
There are common injury patterns associated with IPV
28.30%
Specific areas of the body are most often targeted in IPV cases
45.70%
There are behavioral patterns in couples that may indicate IPV
37%
There are common, non-injury presentations of abused patients
89.10%

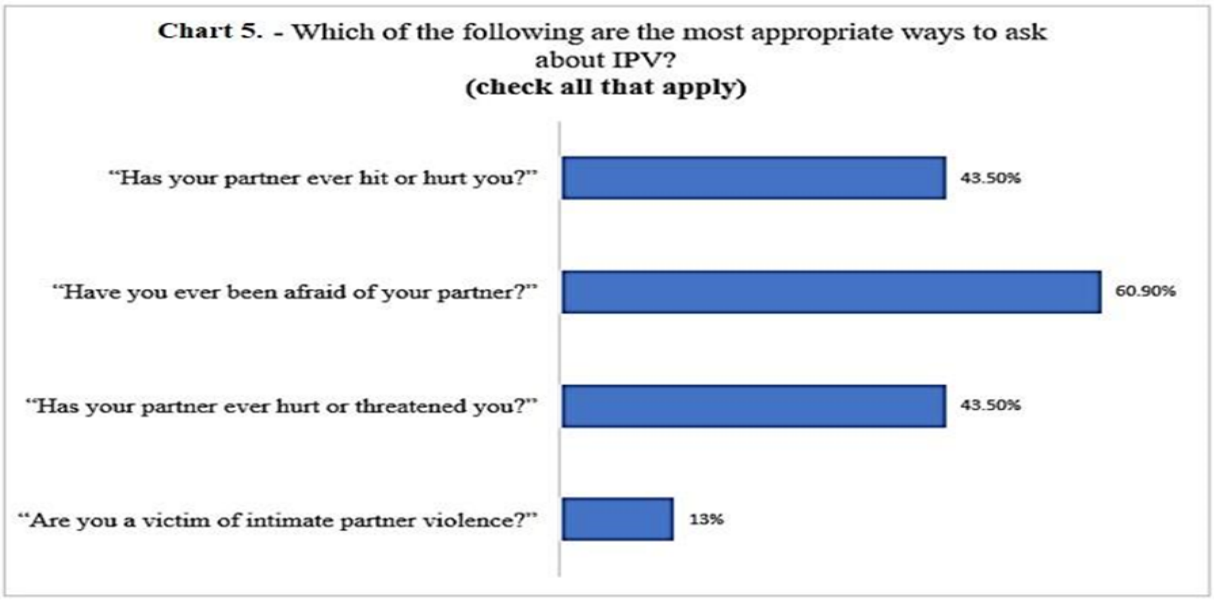


Chart 5. - Which of the following are the most appropriate ways to ask about IPV?
(check all that apply)
"Has your partner ever hit or hurt you?"
43.50%
"Have you ever been afraid of your partner?"
60.90%
"Has your partner ever hurt or threatened you?"
43.50%
"Are you a victim of intimate partner violence?"
13%

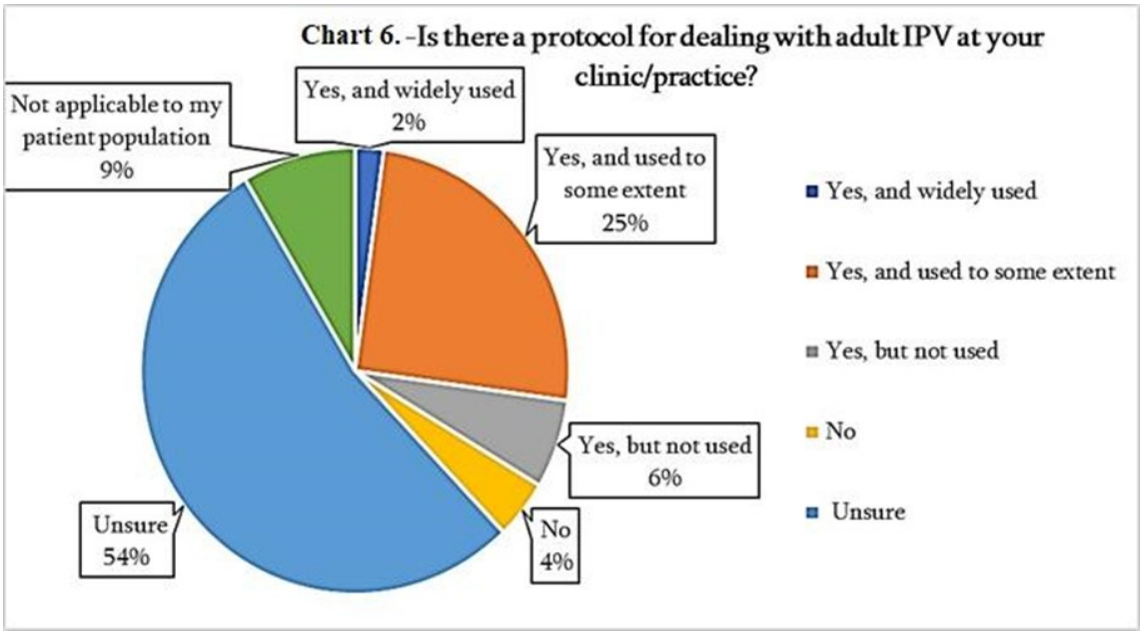


Chart 6. -Is there a protocol for dealing with adult IPV at your clinic/practice?
Not applicable to my patient population 9%
Yes, and widely used 2%
Yes, and used to some extent 25%
Yes, but not used 6%
No 4%
Unsure 54%
Yes, and widely used
Yes, and used to some extent
Yes, but not used
No
Unsure

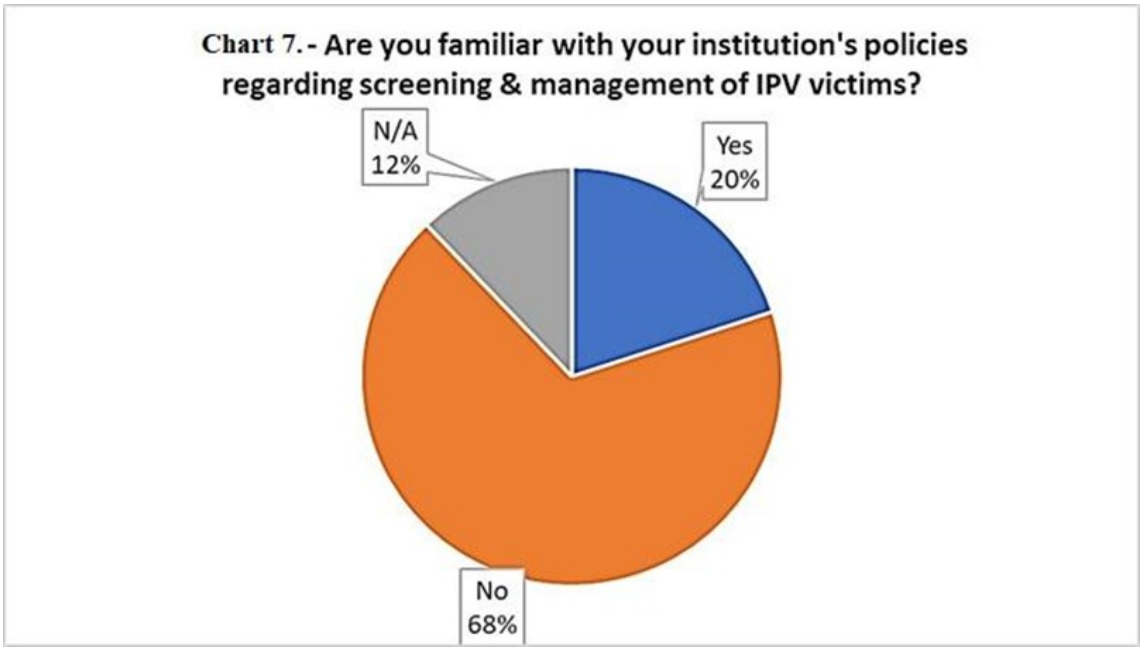


Chart 7. - Are you familiar with your institution's policies regarding screening & management of IPV victims?
N/A 12%
Yes 20%
No 68%

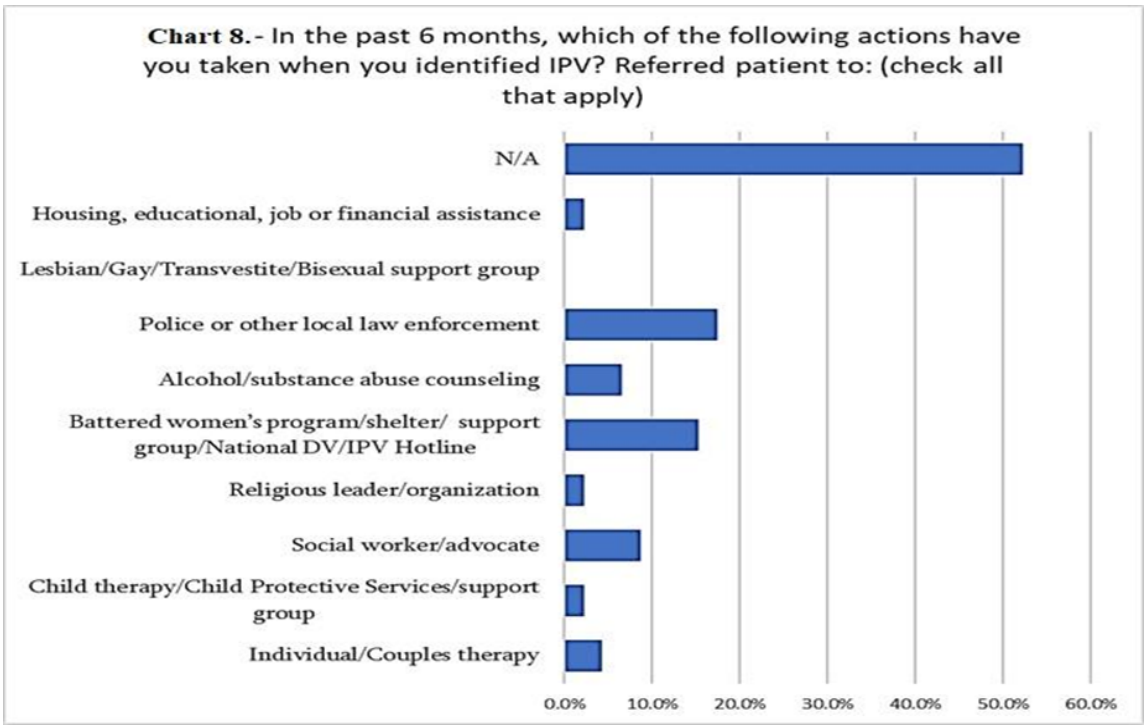


Chart 8. - In the past 6 months, which of the following actions have you taken when you identified IPV? Referred patient to: (check all that apply)
N/A
Housing, educational, job or financial assistance
Lesbian/Gay/Transvestite/Bisexual support group
Police or other local law enforcement
Alcohol/substance abuse counseling
Battered women's program/shelter/ support group/National DV/IPV Hotline
Religious leader/organization
Social worker/advocate
Child therapy/Child Protective Services/support group
Individual/Couples therapy
0.0% 10.0% 20.0% 30.0% 40.0% 50.0% 60.0%

Chart 9.- knowledge and existence of referral services/resources for IPV victims.

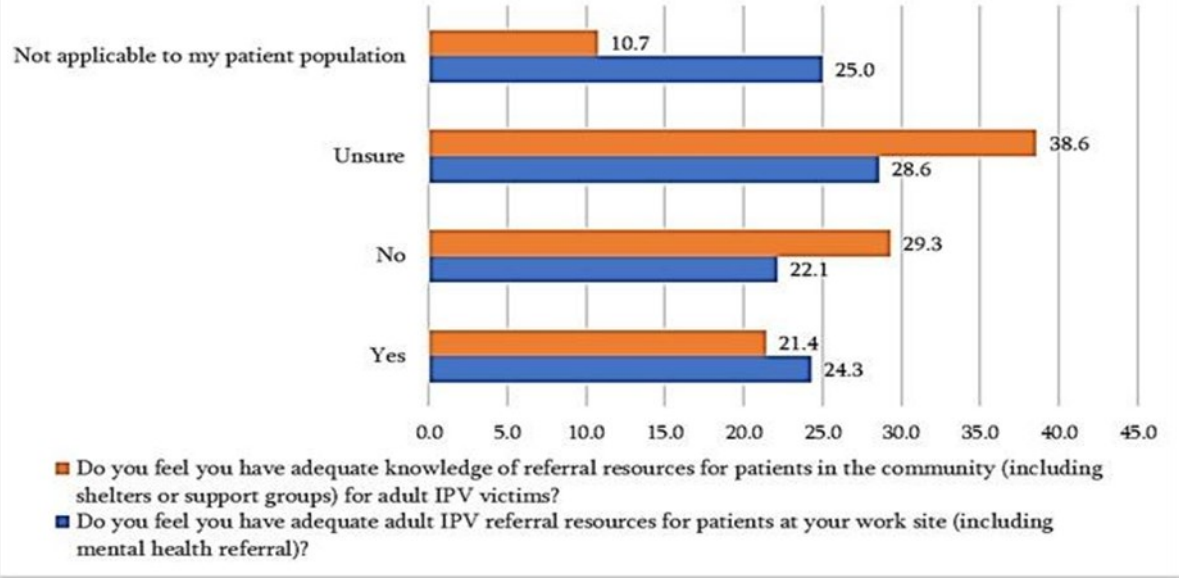


Table 1 Socio-demographic and Work-related Characteristics

Characteristic	Total Number (n=140)	Percentage	Cumulative Percentage
Sex			
Female	98	70%	100
Male	42	30%	30
Marital status			
Single	54	38.6%	97.1
Married	79	54.4%	58.6
Divorced	3	2.1%	2.1
Widow	4	2.9%	100
Age			
24	3	2.1 %	2.1
25-29	61	43.6%	45.7
30-34	37	26.4%	72.1
35-39	6	4.3%	76.4
40-44	18	12.9%	89.3
45-49	3	2.1%	91.4
50-54	9	6.4%	97.9
55+	3	2.1%	100.0
Working place			
Tbilisi	121	86.4%	86.4
Gori	19	13.6%	100
Working Position			
Family Physician	35	25.0%	49.3
ER doctor	34	24.3%	24.3
Resident Doctor	71	50.7%	100
Working Experience			
1-5 Years	46	32.9 %	32.9
6-10 Years	51	36.4%	69.3
11-15 Years	24	17.1%	86.4
More than 15 years	19	13.6%	100.0

Table 2. Geographic characteristics and Oppinions about domestic violence.

	Total N	There are common, non-injury presentations of abused patients	There are behavioral patterns in couples that may indicate IPV	Specific areas of the body are most often targeted in IPV cases	There are common injury patterns associated with IPV	Injuries in different stages of recovery may indicate abuse
Gender						
Male	42	33 (78.6%)	21 (50.0%)	21 (50.0%)	15 (35.7%)	12 (28.6%)
Female	98	92 (93.9%)	35 (35.7%)	40 (40.4%)	21 (21.4%)	32 (32.7%)
Working Position						
ER doctor	34	28 (82.4%)	15 (44.1%)	15 (44.1%)	6 (17.6%)	12 (35.3%)
Family Physician	35	35 (100%)	9 (25.7%)	21 (60.0%)	15 (42.9%)	16 (45.7%)
Resident Doctor	71	62 (87.3%)	32 (45.2%)	35 (35.2%)	15 (21.1%)	16 (22.5%)

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