PUBLIC DEFENDER
(OMBUDSMAN) OF GEORGIA

THE IMPACT OF THE PANDEMIC ON THE RIGHTS SITUATION OF WOMEN WORKING IN THE HEALTHCARE SECTOR

PUBLIC DEFENDER OF GEORGIA
2021

AUTHOR: ELENE KAIKHOSROSHVILI

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Introduction

The Public Defender's Office of Georgia is actively exploring and monitoring the impact of the coronavirus pandemic on the realization of human rights, its specific impacts on various groups, including the situation of women's rights.

Since the outbreak of the pandemic, international human rights institutions and women's rights defenders have been actively discussing the challenges created by the pandemic in terms of the realization of women's rights and gender equality.[1] The pandemic has had a disproportionately large impact on women. Due to the isolation and various restrictions, a lot of women became victims of domestic violence and many of them were left alone with their abusers, without personal space needed to seek help.[2] The pandemic also created barriers to women's access to important sexual and reproductive health services.[3] The burden of unpaid care for the family also increased. This is only a short list of gender impacts of the pandemic on women.

Due to the situation created in the healthcare system, women employed in this sector represent a group that need particular attention.

The vast majority of those employed at one of the lowest levels of the healthcare sector are women all around the world. According to the World Health Organization, 24 million of the 28.5 million nurses globally are women. According to the same organization, 70% of those employed in the healthcare sector worldwide are women.[4]

International human rights organizations actively refer to the gender impacts (or potential impacts) of the pandemic specifically on women employed in the healthcare sector. There are reports of nurses/doctors contracting the virus while on duty, due to the lack of adequate provision of personal protective equipment and in some cases women employed in the healthcare sector were evicted by landlords for fear of contagion.[5] It is also necessary to mention the findings of various international studies on the impact of the pandemic on the mental health of people working in the healthcare sector. We actively read articles in international scientific magazines referring to the deteriorating mental health of women working in the healthcare sector and increased risks of suicide due to increased workload and stress.[6]

[1] Information is available at: https://bit.ly/3qZloai last accessed: 14.04.2021.
[2] Information is available at: https://bit.ly/38fQBNQ last accessed: 14.04.2021.
[3] Information is available at: https://bit.ly/3gYMFFs last accessed: 14.04.2021.
[4] Information is available at: https://bit.ly/3my6G7h
https://bit.ly/310gcaz last accessed: 14.04.2021.
[5] Information is available at: https://bit.ly/37TLaWo last accessed: 14.04.2021.
[6] Information is available at: https://bit.ly/3nFfGYY last accessed: 14.04.2021.

It should be noted that one of the small-scale studies conducted at the regional level in Georgia confirmed that women working in the field of healthcare and other essential services were perceived by their family members as vectors of contagion and were forced to leave home or quit their jobs.[7]

In view of the above findings and internationally recognized risks, the Public Defender considered it important to explore the needs of women working in the healthcare sector in the context of the pandemic.

The aim of the present research is to identify the needs of women working in the healthcare sector and the systemic problems they face in the workplace, as well as in other aspects of social life. The aim of the research is also to develop recommendations for the responsible agencies, based on the problems identified as a result of the fieldwork.

Research method and limitations

Within the framework of a small-scale survey, 90 women working in the healthcare sector were interviewed by telephone. This method was selected in order to protect the safety of respondents.

It is noteworthy that initially, a large part of the interviews was conducted in the summer-autumn of 2020, however, it was decided to add interviews after the so-called second wave and increase in the number of patients, in order to explore the rights situation of women employed in the healthcare sector in the context of aggravated working conditions.

Those wishing to participate in the survey were selected through the so-called snowball sampling.[8] Respondents included both nurses and doctors. Representatives of the Public Defender's Office interviewed women working in the healthcare sector, who had direct contact with coronavirus-infected patients and those who did not.

Respondents were interviewed in August and September 2020, as well as in February 2021.

Representatives of the Public Defender spoke to women employed in Tbilisi, Kvemo Kartli, Shida Kartli, Imereti, Samegrelo, Guria, Adjara and Svaneti regions.

[7] Information is available at: https://bit.ly/3r2OqG5 last accessed: 14.04.2021.

[8] The so-called snowball sampling is a non-probability method of selecting survey respondents, when existing respondents themselves refer the survey team to other potential respondents. The explanation is available at the following link: <https://bit.ly/2Pd0iY2> last accessed: 14.04.2021.

The present research represents a qualitative research. Its purpose is to identify and not to generalize problematic trends.

Within the framework of the present research, the Public Defender's Office explored:

- Pay rise in proportion to the increased workload;
- Safety at work:
    - Proper medical protective equipment;
    - Existence/regularity of sexual harassment in the workplace, as well as infrastructure necessary for hygiene managment in the workplace;
    - Existence/aggravation of mental health problems during the pandemic and whether the problem is properly considered by the employer;
- The impact of the pandemic on the social life of women working in the healthcare sector:
    - Public behavior towards people working in the healthcare sector (whether they are discriminated against for fear of contagion).

Key findings

The research revealed a number of difficulties that women healthcare workers face and that have a significant impact on their psycho-emotional condition, as well as on the quality of their professional productivity that is vital to the proper functioning of the country's healthcare system. It is also noteworthy that some of the challenges identified are systemic in nature and had been encountered by the healthcare workers even before the pandemic.

The key findings are the following:

- Access to regular testing was identifyed as problematic for healthcare workers who live/work in one of the highland regions. In particular, according to the respondents employed in one of the highland territorial units, in the absence of public transport, they had to additionally cover transportation costs in order to be tested on schedule;
- People employed in the healthcare sector have a low level of awareness on sexual harassment and its response mechanisms. The lack of awareness, as well as the lack of such mechanisms, leave women working in the healthcare sector vulnerable to the systemic problem of sexual harassment;
- The pandemic significantly deteriorated the psycho-emotional condition of women working in the healthcare sector. At the same time, employers do not respond adequately to this need and no psychologist's service/activities aimed at raising stress management awareness or skills are offered;
- Proper infrastructure in the workplace to allow women to properly manage their menstruation is problematic for some of the women working in the healthcare sector;

- According to the respondents of the stufy, women healthcare workers often became victims of exclusion/discrimination due to being employed in the healthcare sector, as they are perceived by society as vectors of contagion. As a result, women working in the healthcare sector are at higher risk of domestic violence;
- According to the survey, the labour rights of women working in the healthcare sector were also violated during the pandemic. In particular, there were cases when twelve-hour intervals were not observed between shifts or when workers had to work several shifts in a row, without being rested;
- The State has not defined the maximum number of patients per nurse/doctor. At the same time, there is a shortage of nurses in the country. In Europe, there are an average of 2 to 5 nurses per doctor, while in Georgia this figure is 0.6. This issue represents a systemic problem in the country, but in context of the pandemic it became even more important;
- For a large number of women employed in the healthcare sector, the issues that may represent a violation of their labour rights are being considered as usual practice. In particular, the obligation to take care of 40 patients simultaneously and to additionally perform the duties of other staff is normalized.
- Due to the gender distribution of so-called domestic work, burden of care, and the fact that the above work has increased significantly during the pandemic, the burden of women healthcare workers has been doubled, both at home and at work.

1. Workload and remuneration

1.1. General overview

One of the issues to be explored was the increased workload and, in the light of the above, adequate remuneration.

Due to the work specifics of the healthcare sector, the International Labour Organization (ILO) pays special attention to the labour rights in this sector. For example, the organization developed the Nursing Personnel Convention, which sets out various labour rights standards.[9] This Convention is attached by recommendations for the regulation of the relevant field.[10] Although Georgia is not a state party to the above-mentioned Convention and, consequently, it has not undertaken to bring its national labour legislation in line with the standards set out in the above-mentioned documents, it is still interesting to discuss the compliance of Georgian practice with the above standards and recommendations.

[9] Convention is available at: https://bit.ly/3m1ZukS last accessed: 14.04.2021.
[10] Recommendations are available at: https://bit.ly/2QMizfe last accessed: 14.04.2021.

According to the International Labour Organization, decent working time in the health sector is critical to providing quality care and due to the specific nature of work in this sector, the 24/7 work requirements of the profession often expose nursing personnel to long and irregular hours of work, with possible negative consequences for the health and safety of both nurses and their patients,[11] limiting their ability to detect adverse changes in patients in time, to address them and prevent consequences.[12]

As shift work is common among nurses in the Georgian healthcare sector, it is important to briefly review the standards set by the International Labour Organization in this regard.

According to Article 6 of the above-mentioned ILO Convention, in terms of working hours (including shifts), nursing personnel shall enjoy conditions at least equivalent to those of other workers in the country.[13]

According to the recommendations of the same Convention, nursing personnel assigned to shift work should have a period of continuous rest of at least 12 hours between shifts.[14]

The Labour Code of Georgia stipulates that in an enterprise with a specific work regime, where the working process lasts continuously for more than 8 hours, the normalized working period should not exceed 48 hours per week, at the same time, the employees should have a period of continuous rest of at least 12 hours between working days/shifts.[15] According to the same Code, working two consecutive shifts is prohibited.[16] It should be noted that the Decree of the Government of Georgia on the Approval of the List of Fields with Specific Work Regime defines the fields of special regime and not the work directions of persons working in the mentioned fields. Accordingly, the specific work regime applies to the entire "healthcare and social assistance" field (including doctors of all profiles, nurses, etc.).[17]

It should also be noted that Georgia has no specific standard defining the number of patients to be supervised by one doctor or one nurse, which means that there is no state-defined limit on the number of patients that a doctor/nurse can supervise simultaneously.[18] It should be noted that such a standard exists in Georgia neither in relation to coronavirus nor in general.

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[11] The source is available at: https://bit.ly/3tQZ5V2 last accessed: 14.04.20201.
[12] Ibid
[13] Article 6 (a) of the Convention; The document is available at: https://bit.ly/3m1ZukS last accessed: 14.04.2021.
[14] Recommendation 37 (2); Recommendations are available at: https://bit.ly/2QMizfe last accessed: 14.04.2021.
[15] Labour Code of Georgia, Article 24.
[16] Ibid.
[17] Decree No. 329 of the Government of Georgia of December 11, 2013 on Approval of the List of Fields with Specific Work Regime. The source is available at: <https://bit.ly/3swSoqX>, last accessed: 14.04.2021.
[18] Letter No. 01/2468 of the Ministry of IDPs from the Occupied Territories, Labour, Health and Social Affairs, February 19, 2021.

This factor is important, because, as will be discussed later, the survey made it clear that pandemic increased not only the duration and frequency of shifts, but also workload in terms of the number of patients.

It is also important to give a brief overview of the situation in which women workers of the healthcare sector have to work independently of the pandemic.

It should be noted that people working as nurses (and not only) in the health sector face many problems relating to their labour rights, including low pay, late receipt of payment, systematic nature of overtime work, unpaid overtime work and systemic problems relating to the calculation of overtime work, gender pay gap, unequal distribution of work (studies show that nurses are often required to perform the functions of sanitation workers as well), etc.[19]

The study of the situation of nurses in Georgia made it clear that one nurse supervises 10-11 patients simultaneously, while according to international practice, for example, in Portugal, on average, one nurse supervises 3-4 patients and not more than 6 patients during emergency.[20] Such a regulation applies in the United States as well (at the federal level) and it defines the number of patients for different units separately.[21] According to this document, a nurse may be assigned to the maximum number of patients, namely 6 patients, only in the postpartum unit (3 couplets).[22]

1.2. Increased workload in the context of the pandemic

In terms of the workload and remuneration of women employed in the healthcare sector, the present survey identified the following issues.

Womenrespondents employed in the healthcare sector who had direct contact with coronavirus-infected patients noted that their workload increased. In particular, in some cases, the frequency of night shifts increased. For example, before the pandemic, they had to work night shifts once in about 4-5 or sometimes 8 days, while during the pandemic, they have to work night shifts every 4th or every 2nd day, or even for a few days in a row (which is inconsistent with the Labour Code of Georgia).

It is noteworthy that in a number of cases, the duration of shifts also increased. In particular, in some medical facilities treating Covid patients, the duration increased from 16 to 24 hours. In facilities which

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[19] Revaz Karanadze, Neno Charkviani, Sopho Japaridze, Davit Omsarashvili - *Working Conditions of Nurses in Georgia*, Solidarity Network - Workers' Center. Tbilisi, 2019.

[20] Revaz Karanadze, Neno Charkviani, Sopho Japaridze, Davit Omsarashvili - *Working Conditions of Nurses in Georgia*, Solidarity Network - Workers' Center. Tbilisi, 2019, p.32.

[21] For example, it is stipulated that one nurse in the trauma unit shall be assigned to one patient only, in the emergency unit, as well as in the pediatric department - one nurse shall be assigned to 3 patients, etc. The source is available at: <https://bit.ly/3flh2Xz> last accessed: 14.04.2021.

[22] Ibid.

had a system of both 16 and 24-hour shifts, the number of 24-hour shifts increased and the number of 16-hour shifts decreased. Several respondents reported cases when they could not enjoy a 12-hour interval between 24-hour shifts, which is a practice posing a risk of professional burnout and puts both healthcare workers and patients at risk. This practice does not comply with the Labour Code of Georgia either.

The frequency and duration of shifts increased especially during the so-called second wave (November-December 2020), as along with the increased number of coronavirus-infected patients, a high number of medical personnel, nurses and doctors, also got infected, resulting in their temporary incapacity for work. Respondents (both nurses and doctors of various profiles) said that some of their employers failed to mobilize additional staff and so they had to substitute for their colleagues, along with performing their own duties, for the reasons listed above.

It is noteworthy that according to the respondents, the volume of their work in the conditions of the pandemic increased not only in terms of the duration, but also in terms of the workload. According to the survey, two important factors were identified in this direction: First of all, the number of patients who needed simultaneous provision of services increased during the so-called second wave. At the same time, respondents noted that in terms of assessing their increased workload, it is important to take into account not only the increased number of patients, but also the fact that care for patients infected with coronavirus is specific and cannot be compared to the period before the pandemic. They say there have often been cases when the patient's health condition worsened suddenly.

With regard to the **increase in the number of patients**, it was found out that for a large proportion of respondents, it was normalized to be assigned to the number of patients that does not meet the international standards mentioned in the present study.

The answers given by the respondents to a question of how many Covid patients they were assigned to during one shift were quite different from each other. During the pandemic, medical facilities were either completely transformed into Covid facilities or divided, and consequently, the staff working with Covid-19 patients did not have to work with other patients. Due to the above, according to several respondents, the number of their patients decreased to 6-7, whereas previously this number was an average of 10 (a nurse in the Covid unit).

According to the survey results, the number of patients under the responsibility of one nurse ranged from about 3 to 40 during the second wave.

According to infectious disease doctors, the number of patients they supervised during one shift was 70-100 before the pandemic, while during the second wave of the pandemic (so-called peak, as they call it) this number increased to 80-115. According to one of the infectious disease specialists, the clinic was able to adjust the system after the first wave, due to which, she had more patients during the first wave (approximately 20 patients) than during the so-called second wave (on average, 15 patients).

Nurses working in emergency units noted that during the pandemic, the number of patients reduced due to the fear of contagion among population and that they were mostly applied by patients with a fever (about 6-15 patients during one shift).

Respondents found it difficult to answer a question of approximately how much time they were able to devote to each patient. They say that the above is unpredictable and that a patient in serious condition may take several hours, while patients whose condition is mild take 10-20 minutes, on average.

Only few respondents reported a case when due to overcrowding, they could not devote proper time to the patient in need of their attention.

Some of the respondents also mentioned that shift work in the Covid units was also very tiring and stressful for them due to special safety measures. In particular, they said that wearing protective medical equipment (coats, masks, etc.) for several hours was quite stressful and uncomfortable.

Some doctors working with Covid patients referred to frequent cases of heavy workload not only in terms of the working time, but also in terms of performing the duties not provided for in their contract (for example, doctors and nurses mostly mentioned the performance of the duties of a sanitation worker due to the absence of the relevant staff). It should be noted that this practice turned out to be normalized for the majority of respondents. In particular, most of the respondents described the above as the natural specifics of teamwork and did not see any sign of violation of labour rights in it.

It also needs to be noted, that according to a research, which studied labour rights situation of nurses in Georgia in context of the pandemic, for 60% of nurses, working conditions worsened and according to 23.6% of the respondents, situation in hispitals became "uncontrollable".[23]

According to the same research, in the period of the pandemic, average number of patients per one nurse incrsead from 11-19 to 15-24, meanwhile, working hours were prolonged (according to 38.7% of the respondents) and break periods got decreased (35.4%).[24]

It should also be noted that the shortage of nurses is a general problem in Georgia. On average, the ratio of nurses to doctors in European countries is 2 to 5 per doctor, while in Georgia this ratio is 0.6, which results in (both during the pandemic and in general) less productivity of Georgian doctors.[25]

The workload of **women healthcare workers, who did not have direct contact with coronavirus patients,** also increased. Although respondents reported decrease in non-coronavirus-related referrals and ambulance calls during the pandemic (according to a women employed in the ambulance service, calling an ambulance for the so-called trivial reasons was less likely because of the higher risk of

[23] *Corona Virus Pandemic and the Value of the work of nurses,* Union for Health and Service fields "Solidarity Network", 2021, page 23.
[24] Ibid.
[25] Health Sector in Georgia 2020, Galt & Taggart, available at: https://bit.ly/3nvTuS9 [last accessed: 29.04.2021].

contagion), their workload increased and became more stressful. This was often due to their fellow doctors being in risk groups, which led to their temporary incapacity for work and/or self-isolation. The above increased the daily workload of doctors that continued to perform duties.

1.3 Remuneration

According to some of the surveyed doctors, their remuneration depends on the number of patients they provide medical care to. According to doctors with this type of employment contract, their remuneration increased in proportion to the number of patients.
Some of the doctors noted that despite the promise of the employers to raise their pay, they did not keep this promise and their salaries remained unchanged despite the increased workload and performance of additional, qualitatively new work duties in some cases.

"Remuneration was inadequate. The workload was more than usual and the pay was not adequate. Mothers, who had left their children, expected adequate remuneration, but could not receive it"- a survey respondent from Adjara.

"The rights of nurses and sanitation workers are grossly violated, we are being exploited, but we cannot say anything for fear of being fired. [...] My salary is 190 GEL and I have to feed two people with this amount of money" - a survey respondent from Adjara.

According to the information provided by nurses, their remuneration depends on shifts (they receive a certain amount of money during each shift), so the amount of their salary depends on the number of shifts.

Respondents also indicated systemic problems with the timely receipt of payment. According to them, they receive salaries 2-3 months late (e.g. in September they were still waiting for the June salary and in February they were waiting for the December salary, etc.). They say that the timely provision of remuneration is a systemic problem, which had been common in the period before the pandemic as well.

According to the survey, the problems relating to timely provision of payment were common in quarantine areas[26] and those medical facilities that were converted into Covid facilities during the pandemic. It should be noted that these facilities receive state funding during the pandemic.

[26] It is noteworthy that several respondents, in addition to their own practice, stressed that, according to their information, the problems related to the timely receipt of remuneration were large-scale.

Most of the surveyed women see their low remuneration as a systemic problem in the healthcare sector and note that the healthcare sector is undervalued in the country even during the pandemic, when the sector should have acquired special importance due to the situation created all over the world. Survey respondents attribute the lack of remuneration to the underestimation of their profession by society.

According to a research, which studied labour rights situation of nurses in Georgia in context of the pandemic, before the pandemic, average remuneration of the nurses was equal to 250-508 Georgian Lari (GEL), and during the pandemic, it incresead to 283-582 GEL.[27] According to the same study, the said remuneration doesn't respond to the financial needs of nurses, which often causes the nurses to have more than one workplaces, which, according to 31% of the respondents is a hindering factor in terms of fulfilling the job properly.[28]

Against this background, the decision of the State to provide additional remuneration to the medical staff involved in the fight against coronavirus. In particular, according to Decree No. 652 of the Government of Georgia of October 29 is an important and welcome step. According to thi decision additional remuneration will be received by the personnel involved in the management of suspected and/or confirmed cases of the infection caused by the novel coronavirus (the supplement should be not less than 50% of the average salary).[29]

2. Safety at work

The World Health Organization (WHO) pays special attention to the safety of healthcare workers in the face of the pandemic, and notes that the pandemic has highlighted the extent to which protecting health workers is key to ensuring a functioning health system and a functioning society.[30] According to the organization, in addition to physical risks, the pandemic has placed extraordinary levels of psychological stress on health workers, who live in constant fear of disease exposure while separated from family and facing social stigmatization.

According to the same statement, a recent review of healthcare professionals found that one in four reported depression and anxiety, and one in three suffered insomnia problems during the pandemic.[31]

In the present survey, the Public Defender explored whether women employed in the healthcare sector were provided with quality protective equipment against the virus, how regularly the employer tested

[27] *Corona Virus Pandemic and the Value of the work of nurses,* Union for Health and Service fields "Solidarity Network", 2021, page 40.
[28] Ibid.
[29] The decree is available at: < https://bit.ly/31yquPb > last accessed: 14.04.2021.
[30] The source is available at: < https://bit.ly/3rrlvKJ > last accessed: 14.04.2021.
[31] The study is available at: < https://bit.ly/3fzBO6f > last accessed: 14.04.2021.

employees for coronavirus, how respondents' psycho-emotional condition changed and how the employer assisted employees testing positive for coronavirus in dealing with this deterioration.

The Public Defender also assessed how women employed in the health sector were protected from sexual harassment in the workplace.

2.1. Provision of quality protective equipment

Adequate provision of quality protective equipment is directly related to the safety of both those working in the healthcare sector and those who have contact with them (especially patients that belong to risk groups).

The United Nations Committee on the Elimination of All Forms of Discrimination against Women (CEDAW), in its Guidance Note on CEDAW and Covid-19, notes that women's disproportionate burden of caring for children at home and for sick or older family members as well as their high representation in the health workforce expose them to an increased risk of contracting Covid-19. According to the document, for this reason, states parties must address women's increased health risk through preventive measures and by ensuring access to early detection (e.g., regular testing) and treatment of Covid-19, adequate provision of personal protective equipment as well as psychosocial support.[32]

It should be noted that for the purposes of this research, the Public Defender's Office was provided with reports and certificates relating to the compliance of purchased medical glasses, masks, respirators and face shields from the Ministry of Internally Displaced Persons from the Occupied Territories of Georgia.

Respondents noted that the supply of protective equipment was problematic only for a short period of time, at the beginning of the pandemic (spring 2020), when the system was not yet properly prepared and there was a crisis in the supply of protective equipment across the country.

In this regard, one respondent noted that the facility had a problem with the supply of protective equipment through July 2020 and during that period, they were allowed to use only three masks in 24 hours.

According to one of the respondents, who is employed in a highland territorial unit, the facility had not received overalls for a whole month, in November.

According to another respondent, there was a period when, due to problems with the supply of masks, they could use only two masks in 24 hours, while working with 25 patients. It is important to note that this respondent links her infection with the above.

[32] Guidance Note on CEDAW and COVID-19, CEDAW Committee, 2020.

A special problem in the supply of protective equipment was encountered by women employed in the healthcare sector who did not work in the so-called Covid facilities.

2.2. Regular testing for coronavirus

According to the information provided by respondents, they were tested once in two weeks, systematically, and in some cases, once a week.

Problems were identified in this direction in the highland territorial units. According to the information provided by respondents (family doctors) working in the mentioned areas, testing was not available at their place of residence or work and due to the absence of municipal transport (due to restrictions), they had to rent private vehicles to get to a place where testing was available, which was related to significant financial costs (70-150 GEL).

According to the same respondents, there have been cases when they could not be tested, but continued to work at the medical facility, which was risky.

"Medical personnel are generally tested at two-week intervals, but due to the lack of municipal transport [...] I have to rent a car, which costs 150 GEL each time. Literally, my one-month salary is enough for transportation for two testings. I often cannot afford it and for example, I missed testing this week"- a survey respondent from Svaneti.

The survey revealed other shortcomings as well. In particular, according to one of the respondents (an emergency service nurse), the personnel are tested only as a result of her "yelling". She says there have been cases when she had to fight to get her symptomatic personnel tested, as a result of which, some of the workers tested positive for the virus.

In addition, according to another respondent (an emergency service nurse), even though they are tested once in ten days, it turned out that some of the workers were not tested on time. According to her, almost all the employees of the facility contracted the virus at different times.

Respondents did not mention distrust in the reliability of the PCR test results. According to them, frequent testing was a kind of guarantee of peace of mind for them.

2.3. Impact of the pandemic on psycho-emotional condition

According to the definition of the World Health Organization, the right to achieve the highest attainable standard of health includes both physical and mental health. International institutions emphasize the importance of caring for the mental health of healthcare professionals and the role of states in this direction during an extordinary situation such as a pandemic.[33]

[33] Ibid.

Researchers highlight the negative impact of the pandemic-related stress on individuals employed in the healthcare sector.[34] Some researchers also highlight the mental health risks of women working in the healthcare sector during the pandemic and note that they are at increased risks for anxiety disorder, depression and occupational burnout.[35] It is noteworthy that the trainings and preparedness of the personnel for dealing with patients infected with coronavirus was named as the cause of mental health problems among women working in the health sector.[36]

It is also noteworthy that according to one of the studies, frontline medical workers are under an increased psychological pressure than second-line medical personnel.[37]

The vast majority of respondents highlighted the negative impact of the pandemic on their psycho-emotional condition.

Respondents indicated increased stress caused by the fear of getting infected with an unknown virus. They also indicated the stress caused by the fear of putting other people at risk in case of their infection. This is a particularly important factor for respondents whose family members belong to any risk group (due to age or other factors).

Respondents also highlighted increased anxiety, fatigue, insomnia-related complaints and loneliness.

Some respondents mentioned that they often had to be alone for a long time (e.g. because of self-isolation due to having contact with an infected person, etc.), which also had a negative impact on their psycho-emotional condition.

Respondents working directly with patients infected with coronavirus also noted that contact with infected patients was stressful as there were frequent cases when the infected persons did not trust agencies and "did not believe" in the existence of the virus. Some patients did not trust the healthcare providers and treated them aggressively.

According to respondents, increased stress led to communication difficulties among colleagues and even conflict situations in the workplace.

In this direction, the situation of **doctors and nurses employed in the so-called quarantine areas** is particularly worth noting. According to them, there have been frequent cases when persons placed in quarantine spaces had obvious mental health problems, the aggravation of which was related to long-term placement in the isolated space. According to those employed in such spaces, they have often been targets of aggression by persons placed in quarantine spaces, whose mental health was

[34] Natasha Shaukat, Daniyal Mansoor Ali, Janair Razzak, *Physical and mental health impacts of COVID-19 on healthcare workers: a scoping review.* 200, July 2020, available at : https://bit.ly/2IX4B6C last accessed: 14.04.2021.
[35] Information is available at: https://bit.ly/34mglXK last accessed: 14.04.2021.
[36] Ibid.
[37] The study is available at: < https://bit.ly/2QEef1q > last accessed: 14.04.2021.

deteriorating due to isolation, anxiety caused by fear of getting infected and various mental health problems.

According to the information provided by doctors and nurses working in quarantine areas, they often had to perform the function of a psychologist along with their own functions.

According to them, persons placed in the quarantine areas often threaten with suicide. According to one of the respondents, she had a negative experience in terms of communication with the patrol police officer in this situation. She said she had to systematically call the police in connection with suicide threats, but representatives of the police explained that it was not their competence to respond to the suicide threats in the quarantine areas. According to the mentioned respondent, the above faulty protocol was a source of stress for her.

Another source of stress for nurses and doctors employed in quarantine areas was insufficient and often incorrect information of quarantined persons about the period of their placement in the quarantine facilities. The persons placed in the quarantine spaces were not informed that they would have the right to leave the quarantine space 24 hours after the final tests (on the 13th day) and requested the right to leave the space a day earlier (on the 12th day). In similar cases, doctors and nurses often become targets of aggression.

Despite the significant deterioration in the psycho-emotional condition of those employed in the health sector, only one respondent employed in a private medical facility stated that the facility provided psychologist's service and stress management trainings during the pandemic. Despite the obvious need, employers in the healthcare sector do not offer psychologist's assistance to their employees.

2.4. Sexual harassment in the workplace and reproductive health

Women employed in the healthcare sector often become victims of sexual harassment in the workplace. This is evidenced by the studies that show that, for example, 43.15% of women nurses have been victims of verbal, non-verbal, physical or psychological harassment.[38] According to the study conducted in Turkey in 1996, 44% of the sexual harassment cases of female nurses were committed by male colleges, 34% of the cases by patients, 14% by family members of patients.[39] According to a study conducted in Pakistan, 10% of the respondents stated that they became victims of sexual harassment from male doctors when they were students.[40] According to the same study, 23.9% of the respondents (nurses) stated that sexual harassment represents a professional hazard and also, 22.5% of the

[38] Woldegebrief Gebreegziabher Kahsay, Reza Negarandeh, Nahid Dehghan Nayeri, arzieh Hanaspour, *Sexual Harrassment against Female Nurses: a systematic reviw.* The study is available at: https://bit.ly/37qFPFm last accessed: 14.04.2021.

[39] Kisa A, Dziegielewski SF. Sexual harassment of female nurses in a hospital in Turkey. Health Services Management Research, 1996, 9:243–253. Doument is available at https://bit.ly/3FT1oOg Source last visited: 12.10.2021.

[40] Shaikh MA. Sexual harassment in medical profession: perspectives from Pakistan. Journal of the Pakistan Medical Association, 2000, 50:130–131. Soutce available at: https://bit.ly/3lL7nMX Sourse last visited: 12.10.2021.

respondents stated that they know a nurse, who left job because of sexual harassment committed by a male doctor.[41]

It is noteworthy that provision of information about sexual harassment and response mechanisms are of particular importance, as women employed in the healthcare system have to spend more time in the workplace (due to the pandemic). It is also noteworthy that women work at lower levels in the healthcare system, (junior doctors, nurses, sanitation workers) all around the world, while male colleagues are often their supervisors and decision-makers, which makes them more powerful not only in the context of gender but also in terms of their position at work. The above increases the risk of harassment and prevents women from applying appropriate response mechanisms.

It should be noted that Georgian legislation already defines the concept of sexual harassment and establishes relevant remedies.

In this regard, the Labour Code of Georgia stipulates that *before concluding an employment contract during pre-contractual relations, the employer shall inform applicants about the principles of equal treatment and protection mechanisms under Georgian legislation, as well as take measures to ensure the observance of the principle of equal treatment of persons in the workplace, including by reflecting provisions prohibiting discrimination in labour regulations, collective agreements and other documents, and ensure their enforcement.*[42]

It is noteworthy that the survey revealed the low level of awareness of women working in the health sector about the essense of sexual harassment in general and the mechanisms for responding to such cases, while the small number of respondents, who confirmed similar cases and had more information about sexual harassment in general, stated that sexual harassment was a systemic problem in the healthcare sector and there was no woman employed in this sector, who had not become a target of at least sexual ("obscene") comments by male colleagues and/or supervisors.

It should be noted that the majority of respondents are not informed about the available mechanisms for responding to sexual harassment. They stated that the employer had never talked to them about this issue and they had not been informed of the relevant mechanisms available inside or outside the facility. According to them, they will apply to the employer's lawyer if necessary.Given that healthcare workers often have to work longer shifts than usual due to the pandemic, existence of adequate environment at workspace for managing menstruation became important. According to UNICEF, in context of the pandemic, women working in field f health care face additional challenges because of their menstrual management issues. These challenges include: low awareness among healthcare facilities on womens needs in terms of menstrual health and hygene; lack of documented contextual evidence of menstrual hygene experiences; lack/shortage of menstrual hygene material; difficulties of

[41] Ibid.

[42] Labour Code of Georgia, Article 11.2.

following menstrual hygene alongside with special medical protection;[43] non existance/faulty infrastructure of the toilets, which hinders women to manage basic and also, menstrual hygene; challenges of working during painful menstruation.[44]

In response to the abovementioned challenges, the recommendation is to conduct a study on needs of women employers, ensuring a break at least once in every 4 hours, ensuring access to painkillers and resting rooms etc.[45]

It needs to be noted, that indicators on protection of hygene defined on global level for healthcare facilities are basic and they don't cover many important issues[46] (for example, requirement of shower spaces). But in a joint document of International Labour Organization (ILO) and World Health Orgnization (WHO), which covers issues related with health and security of healthcare providers in context of pandemic, it is noted that health care facilities should have resting spaces, inftrastructure needed for proper menstrual hygene management and private spaces, where women could wash themselves.[47]

The survey found that there are frequent cases when medical facilities are not equipped to meet the needs of the employees, for example, in the workspace, doctors and nurses do not have washing spaces or rest areas, which is important for good hygiene, as well as reproductive health.

Since the majority of doctors and nurses are women and good hygiene is of particular importance during the menstrual period, the proper maintenance of the relevant infrastructure is particularly important during the pandemic.

In this regard, respondents highlighted the problem of malfunction or lack of showers and rest areas. In addition, they noted that the use of special medical protective equipment (not-breathable) made working during menstrual days particularly difficult and uncomfortable. In many cases, they change shifts with their colleagues (they say the above is agreed between the employees and they do not have a problem with the management in this regard).

[43] Using Personal Protection Equipment (PPE) makes it for women more difficult to change menstrual products rapidly, whih makes work non-practical during menstruaton and pushes women to skip work or take oral contraception to postpone their menstruation.
[44] Mitigating the impacts of COVID-19 and menstrual health and hygiene, UNICEF Brief (Oct 2020); information available at: https://uni.cf/3aMiWxc Source last visited: 12.10.2021.
[45] Ibid.
[46] WASH in Health care facilities Global Baseline Report 2019; p.44. Source available at: https://bit.ly/3FVZP1O Source ast visited: 12.10.2021.
[47] COVID-19: Occupational health and safety for health workers; interim guidance; 2 February 2021; ILO, WHO, Source available at: https://bit.ly/3AOQZPM source last visited: 12.10.2021.

3. Impact of the pandemic on social life

The World Health Organization (WHO) also pays special attention to the physical safety of healthcare workers during the pandemic, and says that because of the stigma and wrongful belief that they are vectors of contagion in a community, these persons often experience attacks and discrimination.[48] In particular, the organization notes that such attacks may include physical assault, refusal to provide services, eviction from home, cyber attack, attacks with the use of weapons, and so on.[49] According to the organization, the reason for the attacks is stigma, which is often caused by incorrect information about the virus.[50]

It needs to be noted, that at the beginning of the pandemic, in Georgia, there was a problem of low awareness regarding the virus and ways of protection against it. Because of this reason, fear arose towards healthcare providers, which, according to this research was demonstrated via discrimination and marginalization.

According to the majority of respondents, there have been frequent instances when they felt discriminated against and socially excluded on the grounds that they were employed in the health sector, as part of the society perceived them as vectors of contagion.

For example, respondents living in the regions said that such an attitude made it difficult for them to go home after work (often to a neighboring village) when their employer did not provide transportation. They said that locals and even taxi drivers often refused to take them home because of the fear of contagion.

According to respondents, there have been cases when they or their colleagues were asked by public transport passengers to get off the vehicle after they found out that they were employed in a medical facility. Complaints were also expressed by neighbors, when the above respondents entered local shops to buy food. They also received calls from the relatives, who asked them not to attend certain social gatherings.

Respondents who had direct contact with Covid patients say that there have been frequent instances where they were targets of improper treatment by their colleagues. According to them, the colleagues who had no contact with Covid patients complained about the use of shared spaces by those in direct contact with Covid patients.

In view of all the above, it is noteworthy that women employed in the healthcare sector are at an increased risk of being abused both at home and in the public space.

[48] Information is available at: https://bit.ly/31rNj7h last accessed: 14.04.2021.
[49] Ibid.
[50] Ibid.

It should also be noted that due to the gender nature of the distribution of domestic work and burden of care, and the fact that this work has significantly increased during the pandemic, the labour burden of women employed in the healthcare sector has been doubled, both at home and at work.

4. Recommendations

- Ensure that women working in the healthcare sector are informed of the nature of sexual harassment and the available mechanisms for responding to such cases. In the absence of such an effective mechanism in a medical facility, ensure that such a mechanism is developed and information about it is provided to the employees. Make it possible for the employees to send confidential reports about sexual harassment;
- Ensure access to psychologist's service for women employed in the healthcare sector;
- Make women working in the healthcare system, especially those in direct contact with Covid patients, a target group of measures aimed at preventing violence against women and domestic violence;
- Take awareness-raising measures to reduce coronavirus-related stigma in the population;
- Ensure that properly functioning showers and rest areas are included in the license requirements of medical facilities;
- Determine the maximum number of patients per nurse and per doctor for all medical units separately.