

FINAL REPORT

**ASSESSMENT OF COVID-19'S  
IMPACT ON WOMEN IN THE  
HEALTH-CARE SECTOR IN GEORGIA**



United Nations Entity for Gender Equality  
and the Empowerment of Women

The publication was prepared by WeResearch with the support of UN Women, in the framework of the project “Women’s Economic Empowerment in the South Caucasus”, funded by the Swiss Agency for Development and Cooperation (SDC) and the Austrian Development Cooperation (ADC); and the United Nations Population Fund (UNFPA) Georgia Country Office, with the support from the German Government.

The content of this publication does not reflect the official opinion of UN Women, UNFPA, SDC, ADC, or the German Government. Responsibility for the information and views expressed herein lies entirely with the authors.

© 2020 UN Women, UNFPA.

# ASSESSMENT OF COVID-19'S IMPACT ON WOMEN IN THE HEALTH-CARE SECTOR IN GEORGIA



## **UN WOMEN**

Tbilisi, Georgia,  
December, 2020

Authors: Nana Chabukiani,  
Lela Javakhishvili





# TABLE OF CONTENTS

---

<b>ACKNOWLEDGEMENTS</b>	<b>4</b>
<b>ACRONYMS AND ABBREVIATIONS</b>	<b>5</b>
<b>EXECUTIVE SUMMARY</b>	<b>6</b>
<b>1. INTRODUCTION</b>	<b>8</b>
<b>2. RESEARCH AIM AND OBJECTIVES</b>	<b>10</b>
<b>3. METHODOLOGY</b>	<b>12</b>
3.1 Inception phase	13
3.2 Desk phase	13
3.3 Field phase	13
3.3.1 Research instruments	13
3.3.2 Sampling: Target groups and locations	14
3.3.3 Data collection	14
3.4 Synthesis phase	15
3.5 Gender pay gap in the health-care sector: Methodology	15
3.6 Ethical considerations for data collection	16
3.7 Research limitations	16
<b>4. RESEARCH FINDINGS</b>	<b>17</b>
4.1 Working conditions of women in the health-care sector and the impact of the COVID-19 pandemic	18
4.1.1 Increased working hours and workload	18
4.1.2 Breaks and use of vacation	20
4.2 Physical and psychological threats and protective mechanisms during the pandemic period	21
4.2.1 Safety issues during the pandemic	21
4.2.2 Physical health and insurance package	22
4.2.3 Psychological threat and protective mechanism	23
4.3 Support from the State and from the employers for women working in the health-care sector	24
4.3.1 Financial and non-financial support from the State	24
4.3.2 Trainings for medical staff	25
4.3.3 Support from employers	26
4.4 Economic security during the pandemic	27
4.5 Effects of COVID-19 in terms of unpaid care roles and free time	28
4.6 Salaries and the gender pay gap	29
4.7 Harassment and/or violence in the workplace	32
<b>5. CONCLUSIONS AND RECOMMENDATIONS</b>	<b>34</b>
Annex A. Sources and reviewed documents	37
Annex B. Hospital affiliations of the study respondents	39

# ACKNOWLEDGEMENTS

---

The WeResearch team would like to thank the interviewees for the time spent taking part in this research study. We would also like to express our special thanks to the staff of UN Women and UNFPA for their valuable feedback and contribution to this research.

The views expressed in this publication are those of the author(s) and do not necessarily represent the views of UN Women, UNFPA, the United Nations or any of its affiliated organizations or that of the Swiss Agency

for Development and Cooperation (SDC) and Austrian Development Agency.

The report was prepared in the framework of the project “Women’s Economic Empowerment in the South Caucasus”, funded by the Swiss Agency for Development and Cooperation (SDC) and the Austrian Development Cooperation through the Austrian Development Agency (ADC). WeResearch has carried out the research.

## Authors

Nana Chabukiani  
Lela Javakhishvili



# ACRONYMS AND ABBREVIATIONS

---

<b>ADC</b>	Austrian Development Cooperation
<b>CSO</b>	Civil Society Organization
<b>EMC</b>	Human Rights Education and Monitoring Center
<b>FGD</b>	Focus Group Discussion
<b>GEL</b>	Georgian Lari
<b>Geostat</b>	National Statistics Office of Georgia
<b>GoG</b>	Government of Georgia
<b>GTUC</b>	Georgian Trade Unions Confederation
<b>IDI</b>	In-depth Interview
<b>ILO</b>	International Labour Organization
<b>KII</b>	Key Informant Interviews
<b>LFS</b>	Labour Force Survey
<b>MoH</b>	Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs of Georgia
<b>NCDC</b>	National Center for Disease Control and Public Health
<b>NGO</b>	Non-governmental Organization
<b>PCR</b>	Polymerase Chain Reaction
<b>PPE</b>	Personal Protective Equipment
<b>SDC</b>	Swiss Agency for Development and Cooperation
<b>UN Women</b>	United Nations Entity for Gender Equality and the Empowerment of Women
<b>UNFPA</b>	United Nations Population Fund
<b>WHO</b>	World Health Organization

# EXECUTIVE SUMMARY

The overall purpose of the research study was to assess the impact of the COVID-19 pandemic on women employed in the health-care sector. The study was set to explore the extent of protection provided for this group and whether their needs for support were met during the pandemic. With this aim, the research team conducted qualitative research. Specifically, 39 in-depth interviews were conducted with women health-care workers who were first responders to COVID-19: doctors, nurses, sanitation staff and emergency staff. In addition, six key informant interviews were conducted with state and non-governmental sector representatives. The key findings of the study are presented below.

The pandemic had a significant impact on the working conditions of women health-care workers working in the COVID-19 clinics and fever centres. Their work shifts have changed, their working hours increased, the number of patients they had to treat and/or consult with increased, and they had to take on additional responsibilities. The working schedule is so busy that research respondents are not able to have a rest during the day, let alone take their annual vacation leave. The high workload and lack of rest increases the risk of burnout among the women health-care workers. The consequences of burnout can be severe and might lead to increased mistakes made by medical personnel on duty. So far, this issue has not been addressed, neither by the clinics nor by the State.

Women health-care workers face increased physical and psychological threats during the pandemic. The Government of Georgia (GOG) took active steps to ensure the safety of medical personnel by providing the clinics with personal protection equipment (PPE) at the start of the pandemic and by conducting training on safety issues. However, no action was taken to ensure the physical health and psychological well-being of women health-care workers.

The financial support from the State was significant for woman health-care workers to secure their economic conditions. A new ordinance (in October 2020) issued by the GOG implied increasing the salaries for health-care workers. However, the process is developing rather slowly, and not everybody has received the support so far. Those research participants who have not received the increased salary payment note that they do not have enough information about the initiative and that the procedures and timing of the financial support are not clear to them.

The women health-care workers assess the conducted trainings positively. The trainings covered the following topics: prevention and control of the infection; online consultations with those having a fever; management of COVID-19 in severe and critical cases; and PPE usage. According to the research participants, the trainings were informative, practical and useful.

Despite the fact that research participants did not lose their jobs during the pandemic, their economic conditions worsened. There were several reasons behind this. Firstly, despite the State's initiative to provide financial support (discussed above), the research participants still refer to a disconnect between the increased workload of women health-care workers and their salaries. Secondly, before the pandemic, many women health-care workers (doctors, nurses and emergency staff) used to work at two clinics to ensure sufficient income for themselves and their families. During the pandemic, they had to give up one of their jobs. Moreover, the family members of the women health-care workers became unemployed, making them single-earner families.

Women health-care workers have a double burden of paid and non-paid work, and despite their high workload, women still remain responsible for the household duties. The pandemic caused shifts in the distribution of domestic responsibilities. Some of the study respondents note that due to their busy schedule, their family members – e.g. older children, their mothers or in some cases their partners/spouses – took on the responsibilities. During the pandemic, women health-care workers' job-related status became more important than their status as caregivers, mothers and wives. However, it should be stressed that many women health-care workers still struggle with their unpaid care responsibilities and have the burden of both paid and unpaid work.



The salaries in the health and social protection sector are lower in comparison with the national average. This directly affects women, who represent the overwhelming majority of the workers within the sector and also constitute the majority of doctors. In addition, lower salaries disproportionately affect women occupying the lower-ranking positions in the human health subsector – as the gender pay gap analysis has revealed, men, although the minority, occupy the higher positions. The qualitative analysis of female medical personnel has

demonstrated that the salary of health-care workers is low and often not enough to sustain their basic needs – the circumstances are especially dire according to respondents who work in rural areas.

The research participants do not report having experienced sexual harassment in the workplace. However, they do note physical and verbal abuse and aggressive behaviour from their patients, which has increased during the pandemic.

# INTRODUCTION

On 11 March 2020, the World Health Organization (WHO) declared COVID-19 a global pandemic. The first case of COVID-19 was reported in Georgia on 26 February 2020. As of 8 December, there are 174,383 confirmed cases, 27,482 active cases, 145,287 recovered patients and 1,614 registered deaths in Georgia.<sup>1</sup>

As early as January, the GoG had already started taking active measures as a response to the outbreak of COVID-19. The first cases of COVID-19 in Georgia were followed by a strict lockdown, which implied restrictions on transport, trade and service provision (restaurants, hotels, etc.). The lockdown lasted almost until the end of the spring. In the summer, the aforementioned measures were loosened but became strict again in the autumn. Besides the lockdown measures, the GoG took action to ensure the efficient management of COVID-19, to reduce the risk of spreading the virus and to minimize its negative impact on the socioeconomic conditions of people.<sup>2</sup>

The pandemic has had a different impact on different social groups. Those people who are disproportionately exposed to the negative impacts of the pandemic are regarded as belonging to vulnerable groups.<sup>3</sup> Moreover, a person who was not considered vulnerable at the outset of the pandemic can become vulnerable depending on the policy response, restrictive measures or the reach of the benefit packages offered by the Government. Certainly, amid the COVID-19 pandemic, vulnerable

groups are not only elderly people or those with ill health but also people from various demographic and socioeconomic backgrounds who might struggle to cope financially, mentally or physically with the crisis.<sup>4</sup> For instance, evidence suggests that COVID-19 impacts men and women differently. The Rapid Gender Assessment of the COVID-19 situation<sup>5</sup> conducted by UN Women Georgia demonstrated some differentiated impacts of the pandemic on women and men, including effects on their livelihood, their vulnerability and the distribution of unpaid and care work.<sup>6</sup>

Even among women, there are different social groups that are affected more than others. Women from the health-care sector can be considered as one of the groups with high vulnerability in the context of the COVID-19<sup>7</sup> pandemic. According to the WHO, 70 per cent of health-care workers worldwide are women, and they are front-line responders to COVID-19. Moreover, worldwide, women represent the majority of health-care service staff (i.e. cleaners).<sup>8</sup> The number of women in the health-care sector exceeds the number of such men in Georgia too and constitutes 62 per cent.<sup>9</sup> Women employed in COVID-19 hospitals have been front-line responders and, therefore, have been exposed to high risks not only in terms of their physical health but also their psychological well-being. At the same time, they have had to struggle with socioeconomic challenges that followed the pandemic.

---

1 Data available at stopcov.ge (accessed on 30 November 2020).

2 Georgia, *On Amendments to the Resolution No. 674 of the Government of Georgia of December 31, 2019 "On Approval of State Health Care Programs for 2020"* (2020).

3 The Lancet, "Redefining vulnerability in the era of COVID-19", *Lancet*, vol. 395, No. 10230 (April 2020), p. 1089. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7270489/> (accessed on 9, December 2020).

4 Ibid.

5 UN Women, *Rapid Gender Assessment of the COVID-19 Situation in Georgia* (2020). Available at <https://georgia.unwomen.org/en/digital-library/publications/2020/08/rapid-gender-assessment-of-the-covid-19-situation-in-georgia> (accessed on 9 December 2020).

6 Ibid.

7 WHO, *Gender Equity in the Health Workforce: Analysis of 104 Countries* (2019). Available at <https://apps.who.int/iris/bitstream/handle/10665/311314/WHO-HIS-HWF-Gender-WP1-2019.1-eng.pdf> (accessed on 30 November 2020).

8 United Nations, *Policy Brief: The Impact of COVID-19 on Women* (2020). Available at <https://www.unwomen.org/en/digital-library/publications/2020/04/policy-brief-the-impact-of-covid-19-on-women> (accessed on 9 December 2020).

9 National Statistics Office of Georgia, *Women and Men in Georgia* (2019). Available at <https://www.geostat.ge/en/single-archive/3332> (accessed on 9 December 2020).

The background is split horizontally into a blue top half and a green bottom half. Overlapping these sections are several semi-transparent circles of varying shades of blue and green. The text is centered in the blue section.

# RESEARCH AIM AND OBJECTIVES

The overall purpose of this research was to conduct an in-depth, qualitative impact assessment of the COVID-19 pandemic on women employed in the health-care sector – designated COVID-19 crisis responders. The study was set to explore the extent of protection provided for these groups and whether their needs for support were met during the pandemic. The aim was to ascertain necessary adjustments for future response and recovery efforts. The specific objectives of the research study were as follows:

- To study the working conditions and employment practices of women health-care workers (designated crisis responders) and how such circumstances were impacted by the COVID-19 pandemic (e.g. on working hours, vacation and leave, remuneration amount, compensation, etc.).
  - To explore the hazards (physical, psychological and socioeconomic) faced by women who were designated crisis responders during the COVID-19 pandemic.
  - To explore the protective measures that employers offered to women who were designated crisis responders, including the perceptions and attitudes of health-care workers on said measures.
  - To assess the Government’s support provided during the pandemic, including an assessment of the access to information and state-provided services, if any, as perceived by health-care workers.
  - To explore the differentiated effects of the COVID-19 pandemic on women who were designated crisis responders according to different characteristics (e.g. urban or rural; medical or non-medical staff; along the hierarchy of the medical staff – doctor, nurse, etc.).
- To study the needs and coping strategies utilized by women health-care workers who were designated COVID-19 crisis responders in relation to their other social roles and family-related caregiving responsibilities.
  - To study health-care workers’ basic needs and coping strategies to secure economic resources and maintain an adequate household income considering the COVID-19 pandemic, especially in cases of family members losing their income and/or the unforeseen costs incurred because of the pandemic.
  - To explore instances of harassment and/or abuse in the workplace and the possible effect of COVID-19 on such instances.
  - To explore the effects of the COVID-19 pandemic on women during different phases of the pandemic: (a) the lockdown (from March to May); (b) the reduced restrictions (from June to August); and (c) the increased number of cases (from September to October).
  - To analyse/estimate the gender pay gap – i.e. the difference between the wages earned by men and women, expressed as a percentage of men’s wage<sup>10</sup> – specifically in the health-care sector in Georgia.

---

<sup>10</sup> Francine D. Blau and Lawrence M. Kahn, “Understanding International Differences in the Gender Pay Gap”, *Journal of Labor Economics*, vol. 21, No. 1 (January 2003), pp. 106–44.

The image features a split background of blue (top) and green (bottom). Overlapping circles in lighter shades of blue and green are scattered across the page. The word 'METHODOLOGY' is written in white, uppercase letters, underlined, and positioned in the upper left quadrant of the blue section.

# METHODOLOGY

The research activities were carried out in four phases: the inception phase, desk phase, field phase and synthesis phase. Each phase will be discussed separately below.

### 3.1 Inception phase

In the inception phase, the research team developed a detailed design of the study that included an exhaustive study methodology and key approaches for all stages of the study, such as a sampling design/respondent recruitment strategy, data collection tools, data collection methods and procedures, and an analysis strategy.

### 3.2 Desk phase

In order to enhance the understanding of existing knowledge and data on the implications of COVID-19 on women health-care workers, the research team conducted a thorough desk review during the initial stage of the study. The research team analysed existing studies and literature related to the research problem. In addition, in order to provide country context, the team reviewed the country policy documents related to COVID-19 (see Annex A for the list of sources). Based on desk review findings, the research team developed guides for the field phase.

### 3.3 Field phase

The WeResearch team used qualitative research methods throughout the study. Specifically, In-depth Interviews (IDI) and Key Informant Interviews (KII) were applied for data collection purposes. The aim of conducting IDIs was to explore the experiences of the women health-care workers and the manifestation of COVID-19's impact on their everyday activities, while the KIIs were utilized to assess the situation from the perspectives of governmental and non-governmental sector representatives.

### 3.3.1 Research instruments

Prior to conducting the IDIs and KIIs, the research team developed semi-structured research guides according to the research objectives. The research team relied on the recommendations and best practices from the International Labour Organization (ILO) and other organizations during the development of the research instruments.<sup>11</sup>

The research team developed four different guides for different target groups: one IDI guide for women health-care workers; and three KII guides for the representatives of the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs of Georgia (MoH), the National Center for Disease Control and Public Health (NCDC) and the NGO/CSO sector.

The IDI guides included demographic questions and covered the following topics: the working conditions of women health-care workers; their physical and psychological well-being; their economic condition and basic needs; an assessment of the measures undertaken by the State in response to COVID-19; and instances of harassment and abuse in the workplace. The questions were adjusted to the respondents' status (i.e. doctor, nurse, etc.) to explore their specific experiences during the interviews. The KII guides covered similar topics but focused on an assessment of the current situation of women health-care workers.

The open-ended questions offered participants an opportunity to elaborate on their responses based upon their knowledge and experience. Furthermore, open-ended questions allowed the interviewer to not lose the focus of the interview and simultaneously gave the respondents an opportunity to lead the discussion towards the matters that were of particular importance to them.

---

11 ILO, *Qualitative research on employment relationship and working conditions: preliminary guidelines* (2014). Available at [https://www.ilo.org/travail/whatwedo/publications/WCMS\\_248899/lang-en/index.htm](https://www.ilo.org/travail/whatwedo/publications/WCMS_248899/lang-en/index.htm) (accessed on 9 December 2020); Qian Liu and others, "The experiences of health-care providers during the COVID-19 crisis in China: a qualitative study", *The Lancet Global Health*, vol. 8, No. 6 (June 2020). Available at [https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(20\)30204-7/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(20)30204-7/fulltext) (accessed on 9 December 2020); Carla Felice and others, "Impact of COVID-19 Outbreak on Healthcare Workers in Italy: Results from a National E-Survey", *Journal of Community Health*, vol. 45, No. 4 (May 2020). Available

---

at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7242177/> (accessed on 9 December 2020); Jianyu Que and others, "Psychological impact of the COVID-19 pandemic on healthcare workers: a cross-sectional study in China", *General Psychiatry*, vol. 33, No. 3 (June 2020). Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7299004/> (accessed on 9 December 2020); Negin Talaei and others, "Stress and burnout in health care workers during COVID-19 pandemic: validation of a questionnaire", *Nature Public Health Emergency Collection*, 6 June 2020 (1-6). Available at <https://www.ncbi.nlm.nih.gov/>

### 3.3.2 Sampling: Target groups and locations

The research team used a purposive sampling method to identify study participants. The principles of purposive sampling are often applied in qualitative research. The purposive sampling method implies reaching out and selecting study participants by specific characteristics that are based on the research objectives.<sup>12</sup>

The target group of the current research study were women health-care workers who were employed at COVID-19 clinics or fever centres and therefore were the first responders to the pandemic in Georgia. For the purposes of this study, when referring to women health-care workers, we imply **doctors, nurses, sanitation staff and emergency staff**. The research study targeted these particular groups because at the beginning of the study, doctors, nurses, sanitation staff and emergency staff were the first responders among medical staff.

The target locations for the study were Tbilisi, Kutaisi, Batumi, Marneuli and Tetrtskaro. The research team selected Tbilisi, Kutaisi and Batumi because these cities saw the highest numbers of COVID-19 cases. The hospitals in Tbilisi, Kutaisi and Batumi were the first responders to the pandemic; therefore, the impact was higher in their cases. The reasoning behind selecting Marneuli and Tetrtskaro was that they were under quarantine with travel restrictions in the spring, early in the pandemic. The research team aimed to capture this experience too. Besides this criterion, Tetrtskaro was selected as a rural location, and Marneuli was selected as a location with a comparatively high representation of ethnic minorities.

WeResearch hired local recruiters at each location. They were responsible for recruiting medical staff members as

per the detailed guideline provided by the WeResearch team.

### 3.3.3 Data collection

WeResearch conducted the fieldwork from October to December 2020. The research team planned to conduct fieldwork combining online and offline interviews, meaning that half of the interviews would be conducted face to face. However, due to the rapid rise in COVID-19 cases in September, WeResearch made the decision to not risk the safety of both data collectors and respondents and instead to conduct all fieldwork online. Consequently, IDIs as well as KIIs were conducted via the online platform Zoom. In several cases, the respondents did not have access to Zoom or had a poor Internet connection; therefore, phone interviews were conducted instead.

The initial study methodology planned on conducting 25 IDIs with doctors and sanitation staff and eight Focus Group Discussions (FGDs) with nurses and emergency staff. However, the busy schedules of the medical staff made it impossible to arrange meetings in small groups. Therefore, instead of eight FGDs, the research group conducted 14 IDIs. In total, 39 IDIs were conducted. The distribution of interviews according to the status of medical staff is as follows: 18 interviews were conducted with doctors; seven with nurses; seven with sanitation staff; and seven with emergency staff. The youngest interviewee was 25 years old, and the oldest was 67. The list of clinics where the respondents were employed is provided in Annex B.

Table 1 summarizes the number of study respondents based on their status and location.

**Table 1.**  
Distribution of IDIs, by location

	Tbilisi	Kutaisi	Batumi	Marneuli	Tetrtskaro
FGDs	8	3	4	3	0
IDIs	2	1	2	1	1
Sanitation staff	2	2	2	0	1
Emergency staff	2	2	1	2	0

<sup>12</sup> Bruce L. Berg, *Qualitative Research Methods for the Social Sciences* (Boston, Allyn and Bacon, 2001), p. 32.



In addition to IDIs, KIIs were conducted with the governmental and non-governmental sectors. In particular, interviews were held with the representatives of the MoH, the NCDC, the Solidarity Network, the Human Rights Education and Monitoring Center (EMC) and the Georgian Trade Unions Confederation (GTUC). In total, the research team conducted six KIIs.

All interviews were audio recorded with the informed consent of the respondents. After the interviews, the interviewers developed short summaries of each interview, including key issues and quotes.

### 3.4 Synthesis phase

During the synthesis phase, WeResearch analysed the collected data and compiled it with desk review findings. In order to ensure the appropriate integration of desk research with qualitative data analysis and allow for the triangulation of findings, the research team employed a hybrid inductive and deductive thematic coding approach

to the qualitative analysis. Specifically, initial codes were derived from research objectives, and additional codes were generated from the data. The hybrid coding approach allows for some flexibility in qualitative analysis by adding thematic codes as appropriate in order to capture new or unexpected phenomena not anticipated in the research design.

The research team used a time frame for purposes of the analysis. In particular, the analysis covered the time frame before and during the pandemic. The period during the pandemic is divided into three phases: (a) the lockdown (from March to May); (b) the reduced restrictions (from June to August); and (c) the increased number of cases (from September to October). Besides the time frame, the researchers also analysed the data considering the hierarchy of medical staff (doctor, nurse, health-care support staff). Table 2 summarizes the research methodology.

**Table 2.**  
Research design

Method	Qualitative study	
	In-depth Interview (IDI)	Key Informant Interview (KII)
Technique	In-depth Interview (IDI)	Key Informant Interview (KII)
Target group	Health-care workers (doctors, nurses, sanitation staff, emergency staff)	Representatives of the MoH, NCDC, Solidarity Network, EMC, GTUC
Sample size	39	6
Sampling method	Purposive sampling	Purposive sampling
Study area	Tbilisi, Imereti (Kutaisi), Adjara (Batumi), Kvemo Kartli (Marneuli and Tetrtskaro)	Tbilisi
Approximate length of interview	45 min.	70 min.
Fieldwork dates	31 October – 9 November 2020	17 November – 9 December 2020

### 3.5 Gender pay gap in the health-care sector: Methodology

The analysis of the gender pay gap in the health-care sector in Georgia (see Section 4.6) was performed based on secondary data, specifically quantitative data from the 2019 Labour Force Survey and the 2019 Establishment

Survey conducted by the National Statistics Office of Georgia (Geostat). The quantitative analysis of the secondary data involved producing descriptive statistics as well as more advanced statistical techniques (e.g. regression analysis) to estimate the unadjusted and adjusted gender pay gap.<sup>13</sup>

<sup>13</sup> UN Women, *Analysis of the Gender Pay Gap and Gender Inequality in the Labour Market in Georgia* (2020). Available at <https://georgia.unwomen.org/en/digital-library/publications/2020/03/>

[analysis-of-the-gender-pay-gap-and-gender-inequality-in-the-labor-market-in-georgia](#) (accessed on 9 December 2020).

### 3.6 Ethical considerations for data collection

To ensure the ethical treatment of participants in this research, the following steps were undertaken:

- Prior to the IDIs and KIIs, verbal informed consent was obtained from the respondents. The interviewer provided the respondents with all information regarding the objectives of the study and the interview. The respondents were also informed of the process and that they could terminate the interview at any point they wished to.
- The research team maintained the confidentiality of the respondents/participants by not disclosing their name and surname. The information was analysed and presented in a way that minimized all of the characteristics that might make the respondents identifiable.
- The data obtained were shared with other members of the research team for validation purposes based upon the consent of the respondents.
- The research team recorded the meeting with the consent of the participants. The audio recordings were stored until the end of the study period for verification purposes and were destroyed afterwards.
- In addition, in line with the framework of this research, the IDIs and KIIs were conducted using online tools; accordingly, the research team considered ethical issues intrinsic to Internet-mediated research (IMR).<sup>14</sup> Therefore, particular emphasis was made on the following considerations: the confidentiality and security of online data; procedures for obtaining valid consent; procedures for ensuring withdrawal rights and debriefing; levels of researcher control; and implications for scientific value and potential harm.

### 3.7 Research limitations

The circumstances of the pandemic changed significantly during the research period. This led to certain methodological limitations that needed to be considered. First of all, the research team conducted

fieldwork from October to December 2020. The study reflects the situation during this time frame, but the changes and developments that occurred afterwards could not be covered in the report.

Moreover, at the start of the study, the medical staff members who were involved in the COVID-19 management process as first responders were doctors, nurses, emergency staff and sanitation staff. Consequently, these were the groups targeted in the framework of the study. During the study period, the target population widened as more medical staff – i.e. general practitioners (“family doctors”) – became first responders too. However, since they were not included in the initial methodology, the general practitioners were not interviewed in the framework of the study.

Due to the rapid rise in COVID-19 cases, the research team had to conduct the fieldwork online. Online interviews were efficient for the respondents in terms of saving their travel time. However, during online interviews, the communication is mediated by the online tools and affects the dynamic of an interview. Non-verbal communication is especially affected. Some of the participants preferred to not turn the video on, or their video feed was compromised because of a poor Internet connection. The lack of non-verbal communication made it difficult for the interviewer to grasp the emotions and meanings behind the words.

Furthermore, since the number of COVID-19 cases were higher in larger cities and the hospitals there were turned into COVID-19 clinics, the study focuses on urban areas. Due to this fact, rural areas are less represented in the research study.

Finally, this research covers the topic of sexual harassment and abuse. However, it should be highlighted that the time devoted to this topic during each interview was rather limited. As practice shows, unless the study is focused specifically on sexual harassment, this rather sensitive issue is always downplayed by the respondents. More in-depth exploration of the aforementioned topic might necessitate a methodological approach focused specifically on sexual harassment and abuse in the health-care sector.

<sup>14</sup> British Psychological Society, *Ethics Guidelines for Internet-mediated Research* (Leicester, 2017). INF206/04.2017. Available at <https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/>

[Policy%20-%20Files/Ethics%20Guidelines%20for%20Internet-mediated%20Research%20\(2017\).pdf](https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Ethics%20Guidelines%20for%20Internet-mediated%20Research%20(2017).pdf) (accessed on 3 December 2020).



# RESEARCH FINDINGS

This section of the report provides the findings of the study. The topics discussed below are derived from the research objectives and cover the following issues:

- Working conditions of women in the health-care sector during the COVID-19 pandemic
- Threats to their physical, psychological and socioeconomic well-being and corresponding prevention mechanisms
- Support from the State for women working in the health-care sector
- Economic security and coping strategies during the pandemic
- Effects of COVID-19 in terms of unpaid care roles and free time
- Salaries and the gender pay gap
- Sexual harassment in the workplace

A summarizing paragraph is provided at the end of each section.

#### 4.1 Working conditions of women in the health-care sector and the impact of the COVID-19 pandemic

COVID-19 had a tremendous impact on the work schedule of women health-care workers. The interview results showed that changes to the work schedule of the medical staff started at the onset of the pandemic in the spring. The schedule eased during the summer but became very busy again in the autumn. The changes differ according to the status of medical staff members, based on their existing roles and responsibilities (i.e. for doctors and for sanitation staff, the changes are different). The increased workload, rise in working hours and use of vacation will be discussed below.

##### 4.1.1 Increased working hours and workload

In order to minimize the risk of spreading the infection among medical personnel, the MoH introduced two-week work shifts in the COVID-19 clinics.<sup>15</sup> According

to the interview with the state representative, it was a challenge to manage the work schedule of the women health-care workers. To overcome this problem, the clinics developed personnel management plans, according to which women had to work in shifts and alternated with one another. According to the Report on the Measures of the Government of Georgia in Response to COVID-19, special resting rooms were designed for the medical personnel who worked in two-week shifts.<sup>16</sup>

Besides changes to the work shift, the doctors and nurses interviewed in the framework of the study mention an increase in working hours from 8 to 12 hours in September.

---

*“How can there not be a change? The work schedule is very busy. In fact, we work from morning to evening. The phone does not stop even at night; we are constantly on the phone.” (Doctor, 47 years old, Kutaisi)*

---

The duration of working time is defined by the Labour Code of Georgia,<sup>17</sup> and the standard amount of working time is 40 hours per week. However, the medical field is qualified as “an enterprise with specific working conditions”<sup>18</sup> that enable the employer to have longer – 48-hour work weeks. This issue is considered problematic because the existing definition of longer hours is broad and does not specify particular positions, professions or enterprises. The approach is universal for everyone working longer hours, and the specific characteristics of particular positions are not considered.<sup>19</sup> This creates asymmetric power relations between the employer and the employee.<sup>20</sup>

The workload increased significantly for doctors during the pandemic as they had to take on additional responsibilities and to care for more patients than before. Before the pandemic, the responsibilities of **doctors** included leading the patient management process, including treatment and monitoring. During the pandemic, in addition to their work, they had to consult COVID-19 patients by phone and in some cases work for Central Online Clinic,<sup>21</sup> which was created in October

---

15 Georgia, *The Report on the Measures of the Government of Georgia in Response to COVID-19* (2020). Available at [http://gov.ge/files/76338\\_76338\\_444796\\_COVID-19angarishi...pdf](http://gov.ge/files/76338_76338_444796_COVID-19angarishi...pdf) (accessed on 9 December 2020).

16 Ibid.

17 Georgia, Labour Code of Georgia (2010), Chapter V. Available at <https://matsne.gov.ge/en/document/view/1155567?publication=17>.

---

18 Solidarity Network, Working Conditions of Nurses in Georgia (2018).

19 Ibid.

20 Ibid.

21 Information about Central Online Clinic is available at <https://www.moh.gov.ge/en/news/5527/%E2%80%9Ccentral-online-clinic%E2%80%9D-becomes-operational-at-the-ministry-of-health>.

2020 under the MoH as a response to the drastically increased number of COVID-19 cases. The aim of the online clinic was to consult with the COVID-19 patients by phone. Conducting phone consultations was an additional responsibility for doctors and meant a higher number of patients and consequently a higher workload. Besides the increased workload, the doctors interviewed within the study note that phone consultations are challenging in terms of diagnostics and increase the risk of misdiagnosis.

The interviewed **nurses** also speak about increased responsibilities and increased workload.<sup>22</sup> A recently conducted study shows that even before the pandemic, the number of patients treated by nurses was relatively high and constituted 10 to 11 patients per day. This is three times more compared to the number of patients treated by nurses in some European countries.<sup>23</sup> During the pandemic, the number of patients increased even further. Nurses from the rural areas note that sometimes they had to take the place of doctors and treat the patients themselves because of the lack of medical staff personnel. In cases when medical staff become infected, their colleagues (i.e. other nurses) have to take on their responsibilities – the smaller the number of medical staff in the clinic, the higher the additional workload.

The workload for **sanitation staff** increased along with the rise in cases. Their responsibilities included ensuring the cleanliness of the clinics and the hygiene of the patients. Additionally, extra measures were needed from the sanitation staff to manage infectious waste. Finally, in order to minimize the risk of spreading the virus, they have to clean the hospital almost two times more often than before and take extra measures to sanitize it.

The interviewed **emergency staff** members speak of the increased number of calls. The calls had already started increasing rapidly in the spring at the very beginning of the pandemic as people were scared of the virus. The number of calls reduced later in the spring but increased again in the autumn.

If we look at the changes to the workload and working hours in light of three different phases – the start of the pandemic in the spring, the reduced restrictions in the summer and the rapid increase in COVID-19 cases in the autumn – it seems that the impact of COVID-19 on the workload of women health-care workers differed across the time frames. The interviewees note that the changes

to their work schedule started in the spring because the clinics where they worked were transformed into COVID-19 clinics or fever centres. The workload reduced during the summertime. However, it started to increase again in the autumn along with the rise in cases.

---

*“[During the spring], we were working constantly. For two weeks, we worked without leaving [the clinic]. Then, in the spring, we moved back to a normal work shift, meaning that the doctor working during the day was substituted by a doctor on duty. [In the autumn], we continue the same way, but we have to work instead of those doctors who went to work at COVID-19 intensive care units in other clinics. So, now I work during the day but also work in shifts in the intensive care and anesthesiology departments.” (Doctor, 55 years old, Marneuli)*

---

The most common changes that occurred during the pandemic and were identified by the respondents are summarized below:

- The work shifts for doctors changed from every four days to the two-week shifts at the clinics.
- The emergency staff members work every two days, compared to every four days before the pandemic.
- Online consultations were added to the responsibilities of doctors as the management of 112 calls was distributed to the hospitals.
- Remote (phone) examination of patients was added to the tasks of doctors. Remote examinations made the process of diagnostics more difficult for doctors and increased the risk of misdiagnosis.
- The working hours increased for nurses, and they have to work longer hours if needed.
- Due to the lack of the number of medical personnel, the nurses had to take on tasks usually performed by doctors; this was especially the case in rural areas.
- The workload of the sanitation staff increased as they had to clean the hospitals almost twice as often as before the pandemic.

---

22 Solidarity Network, Working Conditions of Nurses in Georgia.

23 Ibid.

#### 4.1.2 Breaks and use of vacation

Due to the additional responsibilities and longer working hours, it is difficult for the study respondents to use their break time during the day. The interviews showed that health-care workers have very limited time for rest, and they use break time only to satisfy their basic needs. According to the respondents, the number of patients is so high that health-care workers cannot afford to have a rest. Medical staff officially have a one-hour rest break per day. However, in practice they can take only 10 to 15 minutes of rest per day during the pandemic. In the case of emergency staff, they note that officially they have 20 minutes of rest after every six calls. Their narrative shows that they do use their official break time in practice too. Furthermore, even after their work shift or during a day off, doctors have to constantly keep in touch with their patients and make phone consultations. This issue became especially problematic in September. According to the respondents, during the spring and summer, they still could have a rest during the day. Having a proper rest during the day is out of the question now.

---

*“We have the right to a one-hour break from work, but saying that we are using it now is a lie.” (Nurse, 31 years old, Kutaisi)*

*“You can leave only to freshen up and to eat very quickly. Of course, you have very limited time – because you cannot leave your colleague alone because she has a lot of work to do and you pity her. You want to help her. You have a very short period of time for yourself.” (Doctor, 25 years old, Tbilisi)*

---

Moreover, the interviewees had limited opportunities to use their annual vacation time. Some respondents planned their vacation during the summer and managed to use it. However, those who were planning their vacation during September had to cancel. The conducted KIIs revealed that the COVID-19 clinics do not have enough staff to let medical personnel take a vacation. As

---

24 Chiara Dall’Ora and others, “Characteristics of shift work and their impact on employee performance and wellbeing: A literature review”, *International Journal of Nursing Studies*, vol. 57, No. 12-27 (May 2016). Cited in Solidarity Network, Working Conditions of Nurses in Georgia, p. 12.

25 Ibid.

26 Amy W. Stimpfel, Douglas M. Sloane and Linda H. Aiken, “The longer the shifts for hospital nurses, the higher the levels of

a result, the women health-care workers cannot have a proper rest and recover from the high workload.

The interviewees have different feelings towards changes brought on by the pandemic to their typical workday. On the one hand, medical staff are so dedicated to work that they perceive the long hours and limited opportunities to use break time and vacation days as a norm during pandemic times. On the other hand, they speak of the increased responsibilities as a huge challenge. They argue that they do not have enough resources to cope with the additional responsibilities that come with the rapidly rising number of patients.

---

*“When the number of patients started to increase... You look around and see that there are too many patients. You look outside [the clinic] and you see the ambulance waiting already. You are in stress. You want to do everything in time. You don’t want to leave anyone without attention. You don’t want anyone to be unsatisfied, [and] you want to provide help to everyone timely. Such situations were fewer before the pandemic, of course.” (Doctor, 25 years old, Tbilisi)*

---

The high workload combined with the lack of opportunity to have a proper rest puts health-care workers at risk of burnout and making mistakes on the job. A variety of research shows that there is a correlation between longer working hours and the following factors: (a) increased risk of making mistakes; (b) weakening cognitive abilities; (c) lower-quality care; (d) violations of patient safety issues; and (e) making mistakes during a course of treatment.<sup>24</sup> On the other hand, breaks help improve concentration.<sup>25</sup> Other studies stress the connection between long hours and burnout – according to them, the longer the working hours, the higher the risk of burnout.<sup>26</sup> Finally, research shows that the chance of getting work-related burnout is higher among women health-care workers.<sup>27</sup> NGO representatives stress the high risk of burnout in the Georgian context too. According to the respondents, the situation with regard to this issue is alarming among the health-care workers.

---

burnout and patient dissatisfaction”, *Health Affairs* (Project Hope), vol. 31, No. 11 (November 2012). Cited in Solidarity Network, Working Conditions of Nurses in Georgia, p. 13.

27 Ruchira W. Khasne and others, “Burnout among Healthcare Workers during COVID-19 Pandemic in India: Results of a Questionnaire-based Survey”, *Indian Journal for Critical Care Medicine*, vol. 24, No. 8 (August 2020), pp. 664–671. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7519601/> (accessed on 9 December 2020).

---

*“The most serious problem is burnout. It is such a horrible feeling that makes you lose empathy. When you want your nurse to feel empathy and if they do not have empathy, I am afraid of what they will do and they have no expectations, no hope. I see burnout [...] as a workplace disease. It may not be seen [physically], but people are so damaged psychologically...” (KII with Solidarity Network representative)*

*“The workload of health-care workers has increased. The salary is the same. The psychological and physical pressure is high. And nobody knows how long this will continue.” (KII with EMC representative)*

---

The state representative also sees this issue as a very challenging one and acknowledges that the medical field may face the fact that one day the personnel will be exhausted both physically and emotionally. However, no action has been taken to address this issue so far.

To sum up, the workload of women health-care workers has been significantly altered by the pandemic. The increased number of patients and the additional work related to meeting safety measures have had an impact on their work schedule and has manifested in longer shifts and working hours as well as additional responsibilities. In addition to their busy work schedules, some respondents did not manage to use their annual vacation leave. Finally, they have very limited time for breaks during the day – only enough to satisfy their basic needs. The high workload and lack of opportunity for a proper rest puts women health-care workers at risk of burnout and making mistakes on the job.

## **4.2 Physical and psychological threats and protective mechanisms during the pandemic period**

### **4.2.1 Safety issues during the pandemic**

The front-line COVID-19 responders are at the highest risk of being infected with the virus. According to the report on the measures taken by the Government, as of June

2020, 13 per cent of the medical personnel in Georgia was infected with COVID-19.<sup>28</sup> In order to minimize the risks, the following actions were undertaken at the hospitals: (1) medical outfits/equipment and disinfectants were delivered to the hospitals; (2) medical staff were tested for COVID-19 regularly using PCR tests; (3) medical personnel moved to two-week work shifts (as discussed in Section 4.1); and (4) trainings were conducted for the medical staff that included safety issues and respective rules (see Section 4.3).

The issues of safety were alarming in the spring when there was a shortage of personal protective equipment (PPE) at the hospitals. Therefore, the MoH took responsibility for providing disinfectants and all needed equipment to the clinics. According to the interviews with health-care workers, since the summer, there has been enough PPE for medical staff members. Nowadays, the interviewed medical staff are satisfied with the quality as well as quantity of the existing PPE and other safety measures that are undertaken in their clinics.

---

*“Safe... look now... I think it is safe because the doctor can receive the patient independently. At the entrance, there is the equipment provided by the State. [...]*

*All doctors are trying to find a way to ventilate [the room], or if any additional measures are needed, to minimize the spread of infection.” (Doctor, 31 years old, Kutaisi)*

---

Despite these measures, a fear of being infected accompanies their everyday work. Their fear has increased over time due to the increased numbers of patients, and they feel less secured.

According to the representative of the NCDC, one of the key factors to assess and therefore manage the risks related to COVID-19 is the policy of COVID-19 testing. Based on the report on the Government’s response to COVID-19, the Government used rapid tests for the personnel of COVID-19 clinics and fever centres and for emergency staff back in April. Since then, medical personnel are tested regularly using PCR tests, which are considered more reliable in determining COVID-19 infection.<sup>29</sup>

---

<sup>28</sup> Georgia, The Report on the Measures of the Government of Georgia in Response to COVID-19.

<sup>29</sup> Ibid.

Despite the undertaken measures, there are certain cases that put the safety of medical staff at risk. This happens when a patient's condition worsens drastically and doctors have no time to put on PPE – and therefore have to treat patients without PPE. Moreover, according to the doctors as well as the emergency staff members, many patients hide their symptoms, so doctors treat them without PPE. Maintaining safety in such cases is very difficult. The MoH representative also stresses this problem.

---

*“There was one case [when] a patient was in very bad condition. We either had to act instantly or [the patient would die]. I was not wearing PPE because I had been on a break. But in this case of course, the patient comes first. I put on a mask, a surgical cap, gloves, but not PPE. Each second was important. In that moment, I was worried that I was not wearing [proper] equipment, but the patient was so important that I could not think of putting on PPE.” (Doctor, 27 years old, Tbilisi)*

*“[Safety issues are] very important for the emergency staff, who do not know where they are going. Of course, the patient does not fully reveal their condition and hides their symptoms.” (KII with MoH representative)*

---

As mentioned in the introduction, the majority of health-care workers are women (70 per cent worldwide<sup>30</sup> and 62 per cent in Georgia<sup>31</sup>). If we compare the vulnerability of women health-care workers based on the area of their residence, it can be argued that women health-care workers from rural locales are more vulnerable. One of the NGO sector representatives argues that even though the number of COVID-19 cases are higher in urban spaces, women health-care workers are less protected in rural areas due to the scarce resources. Such circumstances illustrate that it is important to take into consideration gender and social differences existing in society.

---

30 WHO, Gender Equity in the Health Workforce.

31 National Statistics Office of Georgia, Women and Men in Georgia.

32 Georgia, *On Amendments to the Resolution No. 674.*

---

*“There isn't a big difference between rural and urban areas in terms of work. The only difference is that there are more infected cases in the urban areas and the personnel are more prepared. In the regions, there is less expectation [for a high number of cases].” (KII with MoH representative)*

---

However, the KIIs conducted with the state representatives and the analysis of the state policy documents such as the ordinance “On Approval of State Health Care Programs for 2020”<sup>32</sup> show that the state policy is gender-neutral. In other words, it does not take into consideration existing gender or other social differences, and it is not intersectional in terms of different social groups.

#### 4.2.2 Physical health and insurance package

Besides the risk of being infected, the high workload and the high stress level related to COVID-19 impacts the physical health of the medical staff. Some of the respondents speak of constant headaches, insomnia and loss of appetite.

---

*“It really affects [one's] health, firstly because of the psychological stress; everyone is sick and everyone needs help, and you have to provide [help]. [...] [Stress] can manifest in severe headaches, greed, vomiting, insomnia, and you may be very tired [and] lie down but not be able to sleep.” (Doctor, 55 years old, Marneuli)*

---

Those respondents who have chronic diseases note that their condition has worsened. The emergency doctors complain about constant back pain because when patients are treated at home, the doctors have to carry heavy equipment into the patients' residence. Some respondents do not name any physical health concerns for the time being. However, they are certain that the extremely high workload as well as high stress level will have a significant impact on their health and physical well-being in the future.



---

*“I too want to have a normal old age and not be a burden to my children. In fact, when you spend 16 nights in a month on a 24-hour work shift, your health is so shaken that you may not be able to do anything in old age.” (Emergency staff, 43 years old, Batumi)*

---

It should be highlighted that despite the high risks that the medical staff are facing, the insurance packages have not changed for any of the interviewed health-care workers regardless of their type of insurance; whether it is a state insurance programme or a private insurance company, no changes have been introduced. The interviewees note that they themselves have not thought about changes to the insurance package and have not approached their employer with these issues, nor have the employers initiated any changes. Therefore, in this regard, no attempts have been made to improve the conditions for medical staff members. According to the state representative, private insurance companies will not change their packages, and if the medical personnel is infected, the State is responsible for them.

#### 4.2.3 Psychological threat and protective mechanism

A variety of research studies examine the impact of COVID-19 on the psychological well-being of health-care workers.<sup>33</sup> Research shows that being a front-line health-care worker is “an important risk factor for anxiety, insomnia and overall psychological problems”.<sup>34</sup>

The conducted interviews in the framework of our research also show that due to the high workload and difficulty of the cases, women health-care workers are under tremendous stress, and as a result, their psychological well-being is suffering. According to the respondents, the stressful situations already started to occur in the spring, and since then, their stress level has increased along with the increased number of patients. With the very high number of patients, the medical staff has a feeling that they cannot pay proper attention to every patient. This is one such moment when they think that they cannot continue further and want to quit. Some of the respondents recall moments when they could not deal with the high number of phone calls and had a nervous breakdown.

---

33 Jack Tomlin, Brian Dalglish-Warburton and Gary Lamph, “Psychosocial Support for Healthcare Workers During the COVID-19 Pandemic”, *Frontiers in Psychology*, vol. 11, No. 1960 (August 2020). Available at <https://www.frontiersin.org/articles/10.3389/fpsyg.2020.01960/full> (accessed on 9 December 2020); Liu and others, “The experiences of health-care providers

---

*“There were a lot of calls, about 55 to 60 calls a day only for me – new patients every day... There were patients who had to be transferred; there were no places [in the clinics]; we were very nervous about it. So many calls! The phone never stopped! I did not have the opportunity to talk [about it] like [I am] now; I could not even talk to a family member, I was in such [bad] condition – it was really a crisis situation. If it continued like that for a few more days, I would not have been able to handle it.” (Doctor, 47 years old, Kutaisi)*

---

The work of the medical staff is especially stressful because of the deaths of the patients. The emergency doctors note that the most stressful situation for them is when the patients do not make it to the hospitals and die in the ambulance.

---

*“This woman’s eyes do not leave my mind – the woman who begged us to save her life, and we took her for four hours from street to street, from one hospital to another and finally [took her] back to her family again. Four hours later, the woman died. I think that this woman could have been saved by arriving at the hospital on time.” (Emergency staff, 43 years old, Batumi)*

---

Besides the high workload and difficulty of work performed by the medical staff, the interviewees name wearing PPE, fatigue and low salaries as additional stress factors. The results show that the attitudes towards PPE are twofold. On the one hand, it gives medical personnel a sense of safety; however, it is also a stress factor due to the difficulty of breathing with the equipment and the difficulty of putting it on and taking it off.

The KII respondents note that women health-care workers cannot see their families and children. This creates additional emotional stress for them.

---

during the COVID-19 crisis in China: a qualitative study”; Felice and others, “Impact of COVID-19 Outbreak on Healthcare Workers in Italy: Results from a National E-Survey”.

34 Que and others, “Psychological impact of the COVID-19 pandemic on healthcare workers: a cross-sectional study in China”.

---

*“Women health-care workers are away from their families. [...] They cannot spend time with [their children]. This is an emotional burden.” (KII with MoH representative)*

---

Furthermore, some of the respondents say that their stress is derived not only from the high number of patients but also from the fact that they are constantly tired and have no opportunity to have a proper rest. Finally, some nurses say that their low salary adds to their stress. They do not find their salaries commensurate with the work that they do.

In order to deal with existing stress, the health-care sector representatives prefer to use informal support rather than professional support. According to the interviews, the main supporters for them are their own colleagues. The narrative of the medical personnel shows that when their stress level is very high and they have high anxiety, they turn to their colleagues and in some cases to the clinic management too. The interviewees state that communication with their colleagues and sharing their difficulties with one another is very helpful and that they overcome stress with one another’s support. The analysis of the interview results shows that the informal support system that women health-care workers have created at their respective clinics is quite strong and functional at the moment.

---

*“What I saw here among my colleagues was that we became a better team. When I have a problem, I know that Manana, Soso and Keti are with me, and I am certain that they will help me.” (Doctor, 33 years old, Tbilisi)*

---

Health-care workers do not turn to professional support, i.e. psychological counselling. At several clinics, psychological consultations are available for the medical staff; however, the results show that they prefer not to approach psychologists and instead solve the problem with the help of their colleagues. As the respondents put it, it will take them time to explain their problems to the psychologist, while their colleagues understand them without much explanation as they share the same experience. The state representatives realize the importance of the psychological well-being of the

---

35 Georgia, *On Amendments to the Resolution No. 674.*

health-care workers. However, so far, the State has not taken any active measures in this regard.

To sum up, the research revealed that women health-care workers face increased physical and psychological threats during the pandemic. Significant measures were undertaken by the GoG to ensure the safety of medical personnel; however, the state policy is gender-neutral and is not intersectional in terms of different social groups. Moreover, no activities were implemented to address the current psychological difficulties and future physical health problems of women health-care workers.

### **4.3 Support from the State and from the employers for women working in the health-care sector**

#### **4.3.1 Financial and non-financial support from the State**

The MoH took action to secure the economic conditions of health-care workers. According to the Ministry representative, a new ordinance of the GoG entered into force in October 2020 that implies increased salaries for medical staff involved in COVID-19 management. It was decided to increase the remuneration by 50 per cent of medical staff working in COVID-19 clinics and fever centres.<sup>35</sup> The MoH will transfer money to the clinics, and the clinics will be responsible for increasing the salaries of their medical staff.

---

*“Yes, there were measures with regard to financial support. The Minister’s initiative was to issue a supplement to those employees who are directly involved in the management of COVID-19. A certain supplement has been determined, which we give to the clinics, and the clinics have an obligation to increase the hourly pay according to the specific staff.” (KII with MoH representative)*

---

The financial support is provided to clinics gradually. The IDIs revealed that only some of the doctors and nurses have received payment for overtime. Specifically, they receive an additional GEL 3 for each hour worked. In addition, some of the interviewed emergency staff members refer to one-time financial incentives that they received. The sanitation staff interviewed in the

framework of the study do not mention receiving any financial support. Those women health-care workers who have not received any additional support stress the importance of a salary increase and complain that they have not received anything from the State.

---

*“We have not received any support from the State; in any case, I have not received anything. [...] We put ourselves and our health at risk, and the pay is absolutely the same.” (Doctor, 39 years old, Tbilisi)*

---

As previously mentioned, some of the nurses and doctors have received the additional payment while others have not. According to the respondents, this might be explained by the fact that first the COVID-19 clinics received the financial support, while the fever centres have not received it yet.

The interviews conducted with the women health-care workers show that financial compensation is very important for the economic security of medical personnel. However, the issues related to compensation are rather vague for the respondents. Those who have not received the compensation are waiting for it, but they do not know when and under what conditions the compensation will materialize. According to KII respondents, the State uses different means of sending information to medical personnel, such as websites, electronic portals and official letters. However, it seems that some information is still out of the reach of women health-care workers.

Women in the health-care sector did not receive a non-financial reward or an incentive (e.g. a thank-you letter, days off, etc.), neither from their clinic administration nor from the State. The KIIs revealed that the State does not have any plans to take action in this direction. Several medical staff members interviewed in the framework of the research study mention receiving some rewards from private companies. For example, banks under their corporate social responsibility (CSR) policies rewarded health-care workers with small amounts of money; restaurants provided free food; and one pharmaceutical company sent a thank-you letter.

While assessing the state response to the pandemic, the key informants argue that while developing the

COVID-19 policy, the State has not considered particularly vulnerable groups and that no social groups' specific needs are reflected in the country policy. As a result, the policy is gender-blind.

---

*“I think that the State did not specifically address the needs of any of the social groups. None of the sectors did. And the health sector was no exception, of course.” (KII with GTUC representative)*

---

On the other hand, the state representative believes that the policy should be universal for everyone and that when it comes to COVID-19, the gender of health-care workers does not matter. Just as women are finding it difficult to handle their responsibilities beyond work, so are men.

---

*“Those who work with COVID-19 patients do not go home, neither females nor males. It is a simple rule: they should be quarantined. Therefore, a woman cannot do the housework for their family, just as a man cannot do the housework for their family.” (KII with NCDC representative)*

---

The policy brief “The Impact of COVID-19 on Women” stresses the importance of having gender-sensitive policy.<sup>36</sup> According to the document, both the economic and the social policies of the country should consider the existing gender differences. In particular, the facts that generally women have a lower income compared to men and that they carry the burden of domestic work, should be taken into consideration.<sup>37</sup>

#### 4.3.2 Trainings for medical staff

At the onset of the pandemic, one of the biggest issues was managing the process of patient treatment. As a response to this challenge, the Government started providing training sessions to medical personnel. The initial topics of the trainings included the following: prevention and control of the infection; online consultations with those having a fever; management of COVID-19 in severe and critical cases; and PPE usage.<sup>38</sup> As of June 2020, 90 per cent of urban doctors and 75 per cent of rural doctors were trained. In total, trainings were conducted for 2,500

---

36 United Nations, *Policy Brief: The Impact of COVID-19 on Women*. Available: <https://www.unwomen.org/en/digital-library/publications/2020/04/policy-brief-the-impact-of-covid-19-on-women#view>. Accessed: 09.12.2020

37 Ibid.

38 Georgia, *The Report on the Measures of the Government of Georgia in Response to COVID-19*.

doctors by June 2020. Additionally, the Open Society Georgia Foundation (OSGF) conducted trainings on the management of critical cases in 29 clinics. The MoH continued the trainings in the 29 COVID-19 clinics and in 16 fever centres.<sup>39</sup>

The results show that all medical staff interviewed in the framework of the research study underwent training or were instructed about how to work during the pandemic. According to the respondents, the trainings were conducted in the spring as well as in the autumn.

---

*“[The trainings covered everything], starting with what this virus is and ending with a practical course: in what order to put on PPE, how to take it off, etc. They gave us all the information on what we had to deal with and how we should behave.” (Doctor, 25 years old, Tbilisi)*

---

The trainings were conducted remotely for most of the medical staff members, except for emergency doctors. Conducting online trainings minimized the risk of infection; however, they also brought about some technical problems. Some of the medical staff representatives recall that the State delivered computers to emergency centres, but they did not have Internet access. Consequently, some of the respondents mention that they had to participate in the trainings from home, during their supposedly non-working time. The interviewed emergency doctors did not have trainings. They received instructions and relevant materials from their managers.

Overall, the women health-care workers assess the trainings positively. According to them, it was very informative, interesting and very helpful in their practice. They say that they still continue receiving additional information regarding the new changes.

### 4.3.3 Support from employers

Besides the support from the State, the respondents speak of the support they received from their employers. Some of the interviewees mention that their employers created a resting room for the hospital staff. Others speak of a one-time financial compensation or a promise to increase the number of staff members, thus reducing

the workload for the current employees. The nurses recall receiving medication for free or for a reduced price from the administration.

However, other respondents have not received any support from their employers. This indicates that employer support for the medical staff does not have a systematic approach and entirely depends on the goodwill of the employer.

---

*“You are left alone; you have no support whatsoever. [There is] only support from the senior nurse of the clinic. We do not have support from those who are focused on profit and business.” (Nurse, 50 years old, Tbilisi)*

---

The interviews show that among the women health-care workers, doctors and nurses are more likely to receive support (financial or non-financial) from their employers, while sanitation and emergency staff do not seem to be receiving any support at all.

Besides support from the State and from employers, the KII respondents believe that the biggest reward for medical personnel could be moral support from society. This could be in the form of different campaigns or public performances. For example, in the spring, the performance “Applause of Gratitude” was organized for medical personnel.<sup>40</sup> According to a KII respondent, such moral support is crucial for health-care workers.

---

*“We could support [medical personnel] somehow. For example, I remember the event in the spring when [people] brought flowers to the doctors. This was a big source of motivation for them because people supported them. Everyone needs this kind of support.” (KII with MoH representative)*

---

To sum up, the MoH introduced a new initiative to provide financial support to medical staff representatives. The financial support is being provided gradually; during the study, therefore, not every interviewee had received it. Financial support from the State is very important for

---

<sup>39</sup> Ibid.

<sup>40</sup> Information about the performance can be found at <https://www.interpressnews.ge/ka/article/590723-ekimebis-mxardasacherad-sakartveloshi-madlierebis-tashi-gaimarta/>.

the women health-care workers. However, the process of increasing salaries seems to be going slowly, and information about the increased pay or compensation is vague for the medical personnel.

Besides the financial support, trainings were conducted and/or instructions were provided on how to work during the pandemic for all medical staff members interviewed within the study. The health-care workers assess the trainings positively and found them very informative. However, the women health-care workers did not receive any additional state support during the pandemic. The policy is gender-blind, and no additional services were designed to meet the specific needs women medical workers, such as those that would address their poor economic conditions and their burden of unpaid work.

#### 4.4 Economic security during the pandemic

As discussed in the previous section, the MoH took action to secure the economic conditions of health-care workers, and the salaries of those working in COVID-19 clinics and fever centres are gradually increasing. However, the financial assistance did not improve the economic conditions of women health-care workers because their salaries are generally low. A recent research study conducted among nurses shows that the salary of 84.6 per cent of interviewed nurses is less than GEL 500.<sup>41</sup> According to the narratives of the women health-care workers, their salaries are very low, and there is a disconnect between their increased working hours and their pay.

Even though medical staff members did not lose their jobs and some of them saw their salaries increase, the economic conditions of their families worsened during the pandemic. Before the pandemic, some of the medical staff combined working at two clinics and thus ensured more income.

---

*“We have increased salaries, but if you ask me, the salaries of medical staff in Georgia are very low. The hourly wages are very low and, in the end, many employees work in two clinics, to earn enough to support a family. You do not have the right to take more than a certain number of hours in one clinic. [...] So, we are forced to work [in other clinics].” (Doctor, 29 years old, Tbilisi)*

---

<sup>41</sup> Solidarity Network, *Working Conditions of Nurses in Georgia*.

After the increase in COVID-19 patients, medical staff members were prohibited from working at multiple places. This negatively influenced their income. According to the Ministry representative, it was part of the state policy to ensure that medical personnel worked only at one location during the pandemic to minimize the spread of the virus. The respondent argues that management of the situation would be difficult if doctors worked at several clinics. Therefore, they made a decision to restrict the mobility of doctors among the hospitals and made sure they would work only at one COVID-19 clinic.

---

*“As you know, doctors in Georgia are not employed in only one clinic. It was difficult from an epidemiological point of view, so, we somehow restricted this movement [between clinics] and said that the staff at a COVID-19 clinic should only work at that COVID-19 clinic.” (KII with MoH representative)*

---

Moreover, as one of the NGO representative argues, patients at non-COVID-19 clinics did not want to be treated by doctors who were working at COVID-19 clinics at the same time. This all had a negative influence of the income of women health-care workers.

Because of the low salaries, the interviewees mentioned that they depended on the financial help of their family members and relatives. One of the respondents says that if it were not for the support of her husband and sister, her income alone would not be enough.

---

*“If it were not for support from my sister and my husband, it would have been difficult to rely only on my [income]. But we managed somehow with joint effort.” (Doctor, 43 years old, Marneuli)*

---

During the pandemic, many family members of the interviewees lost their jobs; therefore, many double-earner families became single-earner ones. This had a significant influence on the women health-care workers. Due to this fact, not only did the economic conditions of their families worsen but also an additional burden was placed on women health-care workers, now the sole breadwinner for their families.

---

*“When transport was restricted, my dad had to stay at home. He worked as a driver. The income [of the family] decreased. This was not a huge decrease, but it still reflected [on our economic condition]. I have my income... my dad’s income has decreased... We are trying to make our monthly income meet our needs.” (Nurse, 34 years old, Tetrtskaro)*

---

The data analysis shows that the pandemic had a different impact on medical personnel based on their status. Compared to other women health-care workers, the economic hardships are more visible among the sanitation staff. Firstly, their salary has not increased during the pandemic. Secondly, among the research participants, it was mainly the sanitation staff whose family members lost their jobs.

To sum up, despite the fact that the interviewed medical personnel have not lost their jobs, the economic conditions of the families of women health-care workers have worsened. Despite the financial support from the State, there is still a disconnect between the increased workload of the women health-care workers and their salaries. Many health-care workers had to give up one of their jobs, which had a negative impact on their income. Finally, even when the medical staff themselves maintained their jobs, in many cases, their family members became unemployed. During the economic hardships, the research respondents mainly rely on assistance from their families and relatives.

#### 4.5 Effects of COVID-19 in terms of unpaid care roles and free time

In Georgia, women are responsible for household chores. The amount of unpaid domestic work performed by women is three times higher compared to men and constitutes 45 hours per week.<sup>42</sup> During the pandemic, the demand on care work has increased.<sup>43</sup> Therefore, the domestic burden has increased for women too. Women health-care workers are not exempt here. The study respondents talk about their domestic responsibilities within the family, which includes taking care of the children and elders, preparing food and cleaning. It is difficult for the respondents to indicate the exact amount of time they spend on domestic work, but they note that

---

<sup>42</sup> UN Women Georgia, *Women’s Economic Inactivity and Engagement in the Informal Sector in Georgia* (2018). Available at <https://georgia.unwomen.org/en/digital-library/publications/2018/12/womens-economic-inactivity-and-en->

it requires a lot of their time and that they usually do household chores on a daily basis.

---

*“I live with my husband and two kids. Generally, I do everything at home: the kids go to school, then I help them with homework, and my husband comes home tired too... I try to do everything after work. I don’t know how much time I spend on this, because it never ends.” (Nurse, 38, Tetrtskaro)*

---

Notably, the pandemic has led to shifts in the distribution of domestic responsibilities. While some of the research participants continued to perform household duties along with their increased workload, others either totally gave up their household chores or their family members started to give support and shared the responsibilities with them.

Some of the respondents state that they had to give up their domestic work entirely. In cases like this, the family members take care of the health-care worker, and women do not have any responsibilities at home any more. The most common narrative among the interviewed women health-care workers, however, was the redistribution of tasks and household responsibilities among the family members. Among the family members supporting women are other female family members such as their elder children, mothers and mothers-in-law as well as their spouses.

---

*“I was very lucky. If my husband were not helping me, I would probably be eating only fried eggs and sandwiches.” (Doctor, 52 years old, Kutaisi)*

*“When I’m tired, my sister-in-law does everything at home. I can have a rest and everything. I have this support from my husband, my child and my sister-in-law.” (Sanitation staff, 61 years old, Tbilisi)*

---

Despite the help from family members, domestic responsibilities remain a big challenge for women health-care workers, especially for those who have young children.

---

agement-in-the-informal-sector-in-georgia (accessed on 9 December 2020).

<sup>43</sup> United Nations, *Policy Brief: The Impact of COVID-19 on Women*.

---

*“The more shifts you have, the busier you are; therefore you come home tired, [and] you do not have the energy to do household chores. But I manage to take care of my child. This is most important for me. And my mother-in-law does the rest.” (Emergency staff, 30 years old, Kutaisi)*

---

The women health-care workers who have support from their families and extended family members have managed to minimize their domestic responsibilities. According to the narratives of women health-care workers, their family members accept the reality, understand the toughness of their job and are willing to help. Women see this as a source of support and are grateful; however, to assess the impact of COVID-19 on gender roles and relations in the long term, this perspective will need further observation and analysis.

Many respondents – mainly sanitation staff – say that their responsibilities have not changed and that they still remain responsible for domestic work. Therefore, they have to combine their responsibilities of paid and non-paid work. They do domestic work in the evenings after their workday and sometimes have to dedicate all weekend to household chores. The absence of a change to their domestic duties could be explained by the fact that unlike other medical personnel, work shifts have not changed for sanitation staff. Their work became harder due to the pandemic, but their working hours did not change. Consequently, no changes followed in terms of their domestic work. In cases where women health-care workers do not receive support in household chores from their family members, the double burden of paid and non-paid work is especially obvious.

---

*“The pandemic has not changed anything. I continue with the same schedule as before. I try to plan everything in a way not to harm my family and not to make anyone unsatisfied. I am handling it, more or less.” (Sanitation staff, 46 years old, Kutaisi)*

---

The pandemic impacted the free time of women health-care workers too. Most of the respondents stress that it is very difficult for them to separate their work and free time. They have no time left for self-care, hobbies, leisure activities or checking the news.

---

*“I do not have time to read literature, books, which I loved very much, and it bothers me a lot... Literally, I have no more time for books.” (Doctor, 36 years old, Tbilisi)*

---

They also have no time left for socializing with friends and relatives. This is, on the one hand, due to the lack of time and, on the other hand, due to safety reasons.

---

*“Everyone (my relatives) knows that I work in a difficult place, and I feel that they are a little restrained, and therefore I am a little restrained so as not to hurt them.” (Nurse, 60, Marneuli)*

---

Despite the high importance of the issue, according to the state representative, they did not have any policy related to domestic work. Moreover, according to the respondent, the clinics are privately owned, and they may or may not consider the needs of their employees beyond work.

To sum up, the pandemic created shifts in the distribution of domestic responsibilities. Due to their high workload, some of the interviewed women health-care workers cannot perform their household duties, and their family members have taken on some tasks. During the pandemic, which has been an unusual period of time, the roles of women have changed, with their role as a medical worker outweighing their role as a caretaker, a mother, a wife, a friend, etc. Family members understood the severity of the situation and took on the responsibilities.

#### 4.6 Salaries and the gender pay gap\*

The narratives of women health-care workers have demonstrated that their salaries are very low and that there is a disconnect between their increased working hours and their pay. The low salaries and gender pay gap were already problematic for the health and social services sector and the human health subsector before the COVID-19 pandemic, as shown in the analysis below. Since most of the clinics are privately owned, the State is not in a position to demand a raise in the salaries of the health-care workers; however, it can mandate the sector-specific minimum wage and the economy-wide introduction of the principle of equal pay for work of equal value.

---

\* The analysis of the gender pay gap was performed by UN Women based on the 2019 Labour Force Survey and the 2019 Establishment Survey conducted by the National Statistics Office of Georgia (GEOSTAT)

The average salary in the health and social protection sector was GEL 1,049.50 in 2019, below the national average of GEL 1,129.50 for the entire economy, according to Geostat's Establishment Survey.<sup>44</sup> Considering that health and social protection is a skill-intensive sector, doctors, nurses and social workers need higher levels of education and vocational experience to start their practice, in comparison with the economy-wide average. Therefore, it is obvious that the sector will benefit from the introduction of a sectoral and vocational minimum wage. For the sake of comparison, the majority of jobs in the construction sector do not require a higher education degree, yet the average salary for the same year was GEL 1,631.<sup>45</sup> As previously mentioned, a recent research study conducted among nurses shows that the salary of 84.6 per cent of nurses (mostly women) is less than GEL 500.<sup>46</sup> Considering that health and social protection is overwhelmingly feminized – women constitute 82 per cent of the workers<sup>47</sup> in this sector and 62 per cent of the doctors<sup>48</sup> – the lower salaries call for economy-wide consideration of the concept of equal pay for work of equal value.

The conducted interviews revealed the economic hardships that women health-care workers face. Generally, the salary of medical personnel is rather low and, according to the respondents, often is not even enough for their basic needs. Based on the narratives of the research participants, the pay that they receive is not commensurate with the amount of work they do. The situation seems to be more problematic in the regions outside Tbilisi.

According to some respondents, their salary is barely enough from month to month, while others stress that their salary is hardly enough to meet their basic needs.

---

*“What can I say? We were barely coping with our economic problems, and we still are barely coping. This income is not enough for our needs. But what can we do? We are struggling.” (Emergency staff, 60 years old, Marneuli)*

*“After I pay utility costs, half of my salary is gone.” (Nurse, 31 years old, Kutaisi)*

---

44 Further information is available at <https://www.geostat.ge/ka/modules/categories/39/khelfasebi>.

45 Ibid.

46 Solidarity Network, Working Conditions of Nurses in Georgia.

47 According to UN Women's calculations, based on 2018 LFS survey.

Other respondents stress the pay they receive is not commensurate with the work that they do.

---

*“I wish doctors were respected more and that the salary and the work schedule were appropriate. [It should be acknowledged] that doctors are humans too and that they should have the opportunity to have three days [of rest] according to the law and have sufficient pay. The payment is not at all commensurate with the work that a doctor does.” (Emergency staff, 46 years old, Tbilisi)*

---

The issue of low salary seems to be especially problematic for the medical personnel in smaller cities.

---

*“The salary is very low. Medical personnel in the regions are in a worse situation. [...] More attention is paid to Tbilisi, and the regions lack attention.” (Emergency staff, 60 years old, Marneuli)*

---

The economic hardships women face can be further exaggerated by the gender pay gap. The sector-wide monthly gender pay gap (the difference between the wages earned by men and women, expressed as a percentage of men's wage) in the health and social protection sector stands at 35 per cent, almost equal to the national average of 36 per cent in 2019.<sup>49</sup> Since there is no micro data available from Geostat's Establishment Survey, the Labour Force Survey has been used to shed more light on the gender pay gap in the human health subsector. However, the results of this analysis should be treated with caution since the disaggregation of the data to the subsector does not produce statistically significant results.

The analysis of the Labour Force Survey has produced the raw (unadjusted) and adjusted gender pay gap. While an unadjusted or raw gender pay gap represents a pure difference between men's and women's wages and does not account for the characteristics of the

---

48 According to Geostat.

49 According to UN Women's calculations, based on Geostat's data available at <https://www.geostat.ge/ka/modules/categories/39/khelfasebi>.



individuals used in the comparison, the adjusted gender pay gap considers the differences between men’s and women’s characteristics and accounts for their different endowments, most notably education and work experience, as well as a range of job characteristics – e.g. profession, presence of a permanent contract, etc.<sup>50</sup>

Table 3 presents the raw gender pay gap in the human health activities subsector. The hourly gender pay gap is affected by gender; women in this subsector on average receive lower wages than men in Georgia – 20.8 per cent lower in monthly wages and 9 per cent lower in hourly wages.

**Table 3.**  
Gender pay gap in selected sectors, 2019

	Human health activities			Entire economy		
	Males	Females	Gender gap	Males	Females	Gender gap
	Log wage per month		%	Log wage per month		%
Monthly wages	6.321	6.113	-20.8%	6.443	6.109	-33.4%
Hours	48.4	42.7	-11.8%	48.4	40.7	-15.9%
Hourly wages	0.996	0.904	-9.2%	1.132	0.995	-13.7%
Adjusted gender pay gap			0.2%			-24.8%

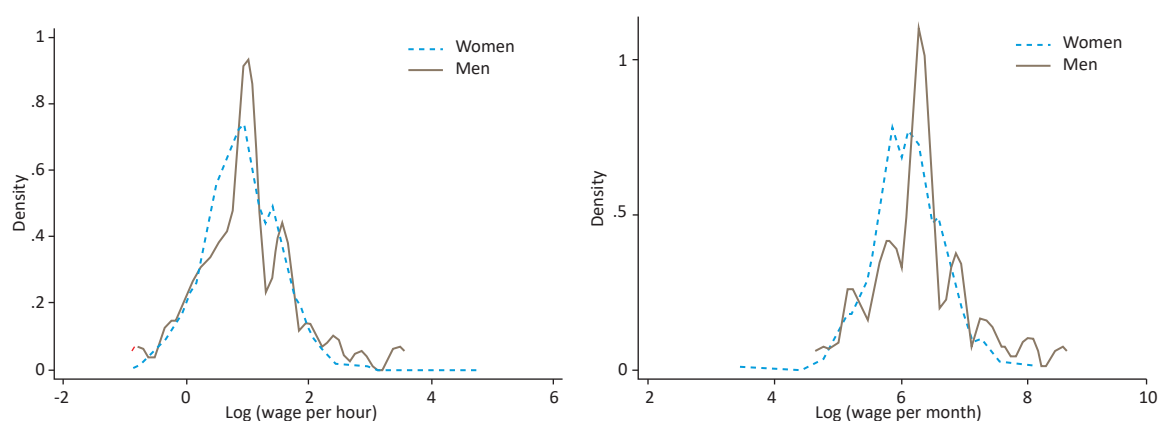
Source: UN Women’s calculations based on LFS. Weights used accordingly.

The monthly gender pay gap is about double in the human health subsector in comparison with the hourly gender pay gap, suggesting that men work longer hours than women. This is observed by the negative gender hours gap in this subsector and the economy in general.

When compared to the wages in the entire economy, the gaps in the human health subsector are smaller. However, further to this, we do not have an indication if such gender

pay differences are statistically significant. To observe the significance, we run a regression of the log wage on gender, and then on gender and the other characteristics. In the latter case, we calculate the adjusted gender pay gap. These are provided in Figure 1 below. Indeed, the raw pay gaps are not statistically significant. However, we should also note that the insignificance (large standard errors) may be driven by the reducing sample size when we disaggregate by sector.

**Figure 1.**  
Distribution of log hourly (left) and monthly (right) wages, by gender and human health activities, 2019



Source: UN Women’s calculations based on LFS. Weights used accordingly.

<sup>50</sup> UN Women, *Analysis of the Gender Pay Gap and Gender Inequality in the Labour Market in Georgia*.

However, the picture gets clearer when we adjust the gap. Adjusting for personal and labour-market characteristics reduces the magnitude of the raw gap or even turns it positive, suggesting that employed men in these sectors have better characteristics than employed women. This is an opposite conclusion compared to what we have concluded for the entire economy, but for the health sector it is logical: men are more frequently found being doctors, while women are more frequently found being nurses and midwives. This indeed suggests that the education and job level may be higher for men employed in the sector. To clarify, this means that although the majority of the aforementioned doctors (62 per cent) are women, within the pool of male workers in the health subsector, there would be a higher proportion of doctors than within the pool of female workers.

The analyses of the gender pay gap in the human health subsector did not point to direct gender discrimination since the adjusted gender pay gap is nonexistent. However, it has indicated sizeable gender pay gaps observed in monthly and hourly wages – men are more likely to have higher positions, work experience and qualifications, indicating the systemic gender inequalities within the feminized subsector. As previously stated, the majority of doctors and workers in the health and social services sector are women. The difference among the monthly and hourly gender pay gap indicated that men can afford to work more paid hours, echoing the findings in Section 4.5 on the challenges of women’s health careers with respect to meeting the demands of domestic work and paid work responsibilities. Although the analysis is statistically insignificant and requires further rigorous exploration of the gender pay gap in the human health subsector, we do not have grounds to dismiss the gender gaps it has identified. As a matter of fact, since the monthly gender pay gap based on official Geostat data is much wider in the health and social protection sector (35 per cent) than the respective gap identified within the human health subsector (20.8 per cent), further analysis may identify greater gender disparities. On the other hand, the lower gender pay gap may be caused by the fact that the human health subsector is feminized.

To conclude, several major problems have been put forward by the analysis. There are lower salaries in the health and social protection sector in comparison with the national average, which directly affects women, who represent the overwhelming majority of the workers within the sector and also constitute the majority of doctors. In addition, lower salaries disproportionately affect women occupying the lower-ranking positions in the human health subsector, as the gender pay gap analysis has revealed that men, although the minority, occupy the higher positions. The qualitative analysis of female medical personnel has demonstrated that the salary of women health-care workers is low and often not enough to sustain their basic needs – the circumstances are especially dire according to respondents who work in rural areas. The wide monthly gender pay gap has been demonstrated within both the health and social protection sectors and the human health subsector, at least suggesting systemic gender discrimination.

To address the identified challenges, it is recommended to introduce a sector-wide differentiated minimum wage and adhere to the principle of equal pay for work of equal value. The recommendations are in line with the obligations taken on by Georgia as a result of ratifying the ILO Equal Remuneration Convention, 1951 (No. 100). In addition, in light of the identified challenges of women health-care workers related to their employment and family responsibilities, it is recommended that the Government of Georgia consider ratification of the ILO Workers with Family Responsibilities Convention, 1981 (No. 156), and implementation of its main principles in the health-care sector in Georgia.

#### 4.7 Harassment and/or violence in the workplace

The WHO World Report on Violence and Health stresses the severity of the problem of sexual violence and sexual harassment worldwide.<sup>51</sup> Different studies focus on the occurrences of sexual harassment in the health-care sector and speak of the harassment of female nurses by male doctors.<sup>52</sup> The issue of sexual harassment is a significant problem in Georgia too.<sup>53</sup> A

---

51 E. G. Krug and others, eds., *World report on violence and health* (Geneva, World Health Organization, 2002). Available at [https://www.who.int/violence\\_injury\\_prevention/violence/world\\_report/en/full\\_en.pdf](https://www.who.int/violence_injury_prevention/violence/world_report/en/full_en.pdf).

52 M. A. Shaikh, “Sexual harassment in medical profession: perspective from Pakistan”, *Journal of the Pakistan Medical Association*, vol. 50, No. 4 (April 2000), pp. 130–131. Cited in Krug and others, eds., *World report on violence and health*; A. Kisa and S. F. Dziegielewski, “Sexual harassment of female nurses in a

---

hospital in Turkey”, *Health Services Management Research*, vol. 9, No. 4 (November 1996), pp. 243–253. Cited in Krug and others, eds., *World report on violence and health*.

53 UN Women, *National Study on Violence against Women in Georgia 2017* (2018), p. 51. Available at <https://georgia.unwomen.org/en/digital-library/publications/2018/03/the-national-study-on-violence-against-women-in-georgia> (accessed on 9 December 2020).

recent study shows that 20 per cent of women report having experienced sexual harassment by a non-partner, including inappropriate staring or leering (15 per cent), intrusive questions about one's personal life (7 per cent), sexually suggestive comments or jokes (6 per cent)<sup>54</sup> and unwelcome touching, hugging and kissing (6 per cent). Moreover, 10 per cent of women report on having experienced sexual harassment in the workplace.<sup>55</sup>

The law on sexual harassment was adopted in Georgia in 2019, and harassment in the workplace is regulated by the Labour Code of Georgia. The Labour Code of Georgia, defines harassment (including sexual harassment) in the workplace as “a form of discrimination, in particular, unwanted behaviour towards a person on any of the grounds referred to in paragraph 1 of this article, with the purpose or effect of violating the dignity of the person concerned, and creating an intimidating, hostile, degrading, humiliating or offensive environment for him/her”.<sup>56</sup> There is evidence that illustrates that increased working hours and workload may influence the rise in the number of sexual harassment occurrences.<sup>57</sup> Therefore, it was important to refer to this issue within the framework of this research study.

The study respondents do not report having experienced sexual harassment and say that they have not heard of any cases related to harassment in the workplace. They point out that there is a family environment at their clinics and that they cannot imagine who could be an abuser or a victim. It should be stressed here that other studies illustrate cultural acceptance of sexual harassment in Georgia and speak of so-called “friendly harassment” from male friends, which is normalized and tolerated.<sup>58</sup>

Some of the respondents recall instances of verbal abuse (obscene compliments) that they have received. However, their memory is vague, and they could not remember any concrete examples. If there were a case of harassment hypothetically, the respondents would consider their colleagues, clinic management and police as their supporters. The state representatives note that no instances of sexual harassment were identified at clinics, but if such a case occurs, it will be investigated.

---

54 Ibid.

55 Ibid.

56 Georgia, *Labour Code of Georgia*, Article 4, paragraph 5.

57 United Nations, *Policy Brief: The Impact of COVID-19 on Women*.

58 UN Women, *National Study on Violence against Women in Georgia 2017*.

---

*“In such a case, the issue needs to be investigated. And until it is proven whether there was indeed sexual harassment, we will not know for sure. Of course, in the event of such an incident, it would have been investigated.” (KII with MoH representative)*

---

The women health-care workers speak of abuse and aggressive behaviour from patients. One of the respondents notes that very often there are cases of verbal and physical violence from the patients. According to her, this happens quite frequently and sometimes even without any particular reason.

---

*“It is very common to be insulted verbally because you are either late or [a patient] is drunk and just in such a bad mood.” (Nurse, 43 years old, Batumi)*

---

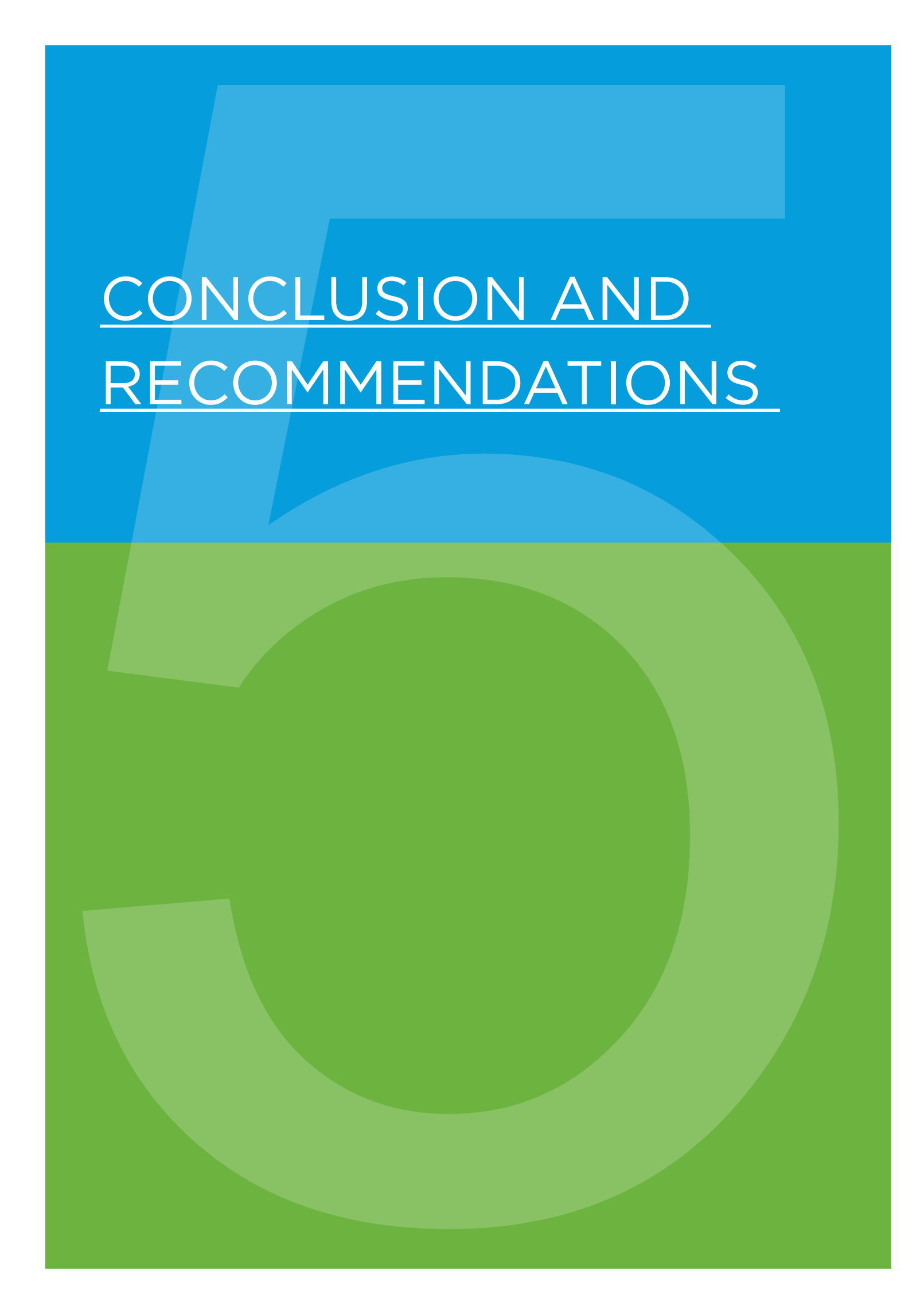
The abuse seems to be especially problematic for the emergency staff. According to emergency staff representatives, there is always a high risk of abuse and even physical violence from the patients. But they stress that during the pandemic, the aggression towards them has increased. On the one hand, this was due to the drastic rise in ambulance calls during the pandemic. On the other hand, they say that people became more aggressive towards medical personnel.

---

*“There have been so many cases of insults from patients, from their family members. But you have to be very calm and solve the problem in a manner that does not turn it into a conflict.” (Emergency staff, 46 years old, Tbilisi)*

---

To sum up, the research respondents say that they have not experienced or heard of any cases of sexual harassment. They compare their work environment to a family and argue that sexual harassment cannot occur in a family-like environment. However, the study respondents note a rise in abuse and aggressive behaviour from patients, especially towards emergency staff.

The background is split into two horizontal sections: a top blue section and a bottom green section. Overlapping these sections are several semi-transparent geometric shapes: a large light blue rectangle in the top left, a light blue circle in the middle, and a light green circle in the bottom. The text is centered in the blue section.

# CONCLUSION AND RECOMMENDATIONS

The research study revealed that COVID-19 has had a significant impact on the lives of women health-care workers (doctors, nurses, emergency staff, sanitation staff), specifically on their paid and non-paid work, their economic condition and their social responsibilities. The conclusions from each section are discussed separately below, and respective recommendations are offered.

### Working conditions of women in the health-care sector and the impact of the COVID-19 pandemic

The pandemic has had a significant impact on the workload of women health-care workers, and it manifested in more responsibilities, more patients, longer working hours and longer shifts. Women health-care workers have very little or no time for breaks during the workday. Additionally, due to the scarce number of medical personnel, the research participants report on not being able to take vacations. The high workload and the lack of opportunity for a proper rest increase the risk of burnout, which in turn creates the risk of affecting the quality of the work performance of women health-care workers.

**Recommendations:** The working hours as well as break times are officially regulated in the clinics. However, women health-care workers cannot make use of their break time. Their working hours should be regulated more efficiently, and it should be ensured that women have enough time for rest.

The GoG as well as clinic administration should take active measures to minimize the risk of burnout among the medical personnel. Precise assessment of the causes and risks of burnout should be carried out, and respective actions should be undertaken to minimize its negative effects.

### Physical and psychological threats and protective mechanisms during the pandemic period

COVID-19 first responders are at the highest risk of being infected with the virus. The GoG took significant measures to minimize the risk. The research participants assess the GoG's measures positively. However, the health-care workers are at high risk when patients hide their true symptoms. Besides being at high risk of infection, women health-care workers face increased physical and psychological threats during the pandemic. The respondents report on extremely high levels of stress,

which affect their physical and psychological well-being. No activities were undertaken by the GoG or by clinics to address this issue, and informal support systems remain key in dealing with anxiety. In addition, no activities were implemented to address the current psychological well-being and future physical health of women health-care workers.

**Recommendations:** The psychological well-being of women health-care workers should be addressed by the clinics by developing and offering respective services. For example, it is recommended that the clinics develop formal support systems, i.e. psychological counselling. Those clinics that already have this service should strengthen this direction and encourage women health-care workers to use the service.

Active information campaigns should be conducted to increase society's awareness about the implications of not being honest about one's symptoms.

### Support from the State and from employers for women working in the health-care sector

The MoH introduced a new initiative to provide financial support to medical staff representatives. Women health-care workers who received financial assistance managed to, more or less, sustain a stable economic condition during the pandemic. However, not everyone has received the assistance so far. The information about the increased salaries or compensation is vague for those who have not received it yet as they do not know sufficient details about the initiative.

**Recommendations:** The GoG should provide women health-care workers with detailed information about financial support, i.e. remuneration packages (including the timing and conditions for receiving it), so that they could calculate their financial risks before they receive increased pay.

Besides the financial support, trainings were conducted and/or instructions were provided on how to work during the pandemic for all medical staff members interviewed within the study. The topics of the trainings included the following: prevention and control of the infection; online consultations with those having a fever; management of COVID-19 in severe and critical cases; and PPE usage. The health-care workers assess the trainings positively and found them very informative.

**Recommendations:** The trainings should continue, and the coverage of the medical personnel should be increased.

## Economic security and coping strategies during the pandemic

Even though the interviewed medical personnel did not lose their jobs, the economic conditions of the families of women health-care workers have worsened. Firstly, the respondents still report on a disconnect between the increased workload and their salaries. Secondly, due to the introduced regulations that prohibited medical personnel from working at two different clinics to minimize the spread of the virus, those women health-care workers employed in several clinics before the pandemic lost additional sources of income. And, thirdly, many families became single-income families as the family members of women health-care workers lost their jobs. This increased the economic burden on the interviewed women.

**Recommendations:** The State has addressed the problem by increasing the salaries for medical personnel. However, it is recommended that the process of providing economic support from the State should go faster, so that women health-care workers could timely benefit from the initiative. The programme should also cover the sanitation staff.

## Effects of COVID-19 in terms of unpaid care roles and free time

The pandemic made changes to the roles of women health-care workers. In response to such unforeseeable circumstances, their professional, job-related status became more important than their status as caregivers, mothers and wives. Their lack of time to perform household chores made shifts in traditionally distributed gender roles, and in the case of some women health-care workers, their family members – e.g. older children, their mothers or in some cases their partners/spouses – stepped in. However, it should be stressed that many women health-care workers still struggle with their unpaid care responsibilities, despite the fact that their families provide support.

**Recommendations:** Special measures to address the double burden of unpaid care work of health-care workers can be designed to accommodate for the emerged needs of health-care workers during the pandemic, especially in terms of childcare services. In addition, in light of the identified challenges of women health-care workers related to their employment and family responsibilities, it is recommended for the Government of Georgia to consider ratification of the ILO Workers with Family Responsibilities Convention, 1981 (No. 156), and implementation of its main principles in the health-care sector in Georgia.

Further research should be conducted to better assess the impact of COVID-19 on the distribution of gender roles and responsibilities.

## Salaries and the gender pay gap

Several major problems have been put forward by the analysis. There are lower salaries in the health and social protection sector in comparison with the national average, which directly affects women, who represent the overwhelming majority of the workers within the sector and also constitute the majority of doctors. In addition, lower salaries disproportionately affect women occupying the lower-ranking positions in the human health subsector, as the gender pay gap analysis has revealed that men, although the minority, occupy the higher positions. The qualitative analysis of female medical personnel has demonstrated that the salary of health-care workers is low and often not enough to sustain their basic needs – the circumstances are especially dire according to respondents who work in rural areas. The wide monthly gender pay gap has been demonstrated both within both the health and social protection sectors and the human health subsector, at least suggesting systemic gender discrimination.

**Recommendations:** To address the identified challenges, it is recommended to introduce a sector-wide differentiated minimum wage and adhere to the principle of equal pay for work of equal value. The recommendations are in line with the obligations taken on by Georgia as a result of ratifying the ILO Equal Remuneration Convention, 1951 (No. 100).

## Harassment and/or violence in the workplace

The research respondents do not report having experienced or heard of any cases of sexual harassment in the workplace. However, the study respondents do make note of increased abuse and aggressive behaviour from patients. This is particularly relevant for emergency staff.

**Recommendations:** Even though the research study did not reveal cases related to sexual harassment, it is recommended that the clinics develop and support sexual harassment reporting mechanisms to enable the anonymous reporting of cases of sexual harassment in the workplace.

Awareness about sexual harassment among medical personnel should be raised.

A support mechanism to protect women health-care workers, especially emergency staff members, should be developed to protect them from the abuse and violence from patients.

# ANNEX A.

## SOURCES AND REVIEWED DOCUMENTS

### Policy documents

Parliament of Georgia. *Labour Code of Georgia*. 2010. Available at <https://matsne.gov.ge/en/document/view/1155567?publication=17>.

\_\_\_\_\_. *On Amendments to the Resolution No. 674 of the Government of Georgia of December 31, 2019 “On Approval of State Health Care Programs for 2020”*. 2020. Available at <https://matsne.gov.ge/ka/document/view/5025938?publication=0>.

\_\_\_\_\_. *The Report on the Measures of the Government of Georgia in Response to COVID-19*. 2020. Available at [http://gov.ge/files/76338\\_76338\\_444796\\_COVID-19angarishi...pdf](http://gov.ge/files/76338_76338_444796_COVID-19angarishi...pdf). Accessed on 9 December 2020.

### Research reports

Dall’Ora, Chiara, and others. Characteristics of shift work and their impact on employee performance and wellbeing: A literature review. *International Journal of Nursing Studies*, vol. 57, No. 12-27 (May 2016). Cited in Solidarity Network, *Working Conditions of Nurses in Georgia*, p. 12.

ILO. *Qualitative research on employment relationship and working conditions: preliminary guidelines*. 2014. Available at [https://www.ilo.org/travail/whatwedo/publications/WCMS\\_248899/lang--en/index.htm](https://www.ilo.org/travail/whatwedo/publications/WCMS_248899/lang--en/index.htm). Accessed on 9 December 2020.

Khasne, Ruchira W., and others. Burnout among Healthcare Workers during COVID-19 Pandemic in India: Results of a Questionnaire-based Survey. *Indian Journal for Critical Care Medicine*, vol. 24, No. 8 (August 2020), pp. 664–671. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7519601/>. Accessed on 9 December 2020.

National Statistics Office of Georgia. *Women and Men in Georgia*. 2019. Available at <https://www.geostat.ge/en/single-archive/3332>. Accessed on 9 December 2020.

Que, Jianyu, and others. Psychological impact of the COVID-19 pandemic on healthcare workers: a cross-sectional study in China. *General Psychiatry*, vol. 33, No. 3 (June 2020).

Solidarity Network. *Working Conditions of Nurses in Georgia*. 2018.

United Nations. *Policy Brief: The Impact of COVID-19 on Women*. 2020. Available at <https://www.unwomen.org/en/digital-library/publications/2020/04/policy-brief-the-impact-of-covid-19-on-women>. Accessed on 9 December 2020.

UN Women. *Analysis of the Gender Pay Gap and Gender Inequality in the Labour Market in Georgia*. 2020. Accessed on 9 December 2020.

\_\_\_\_\_. *National Study on Violence against Women in Georgia 2017*. 2018. Available at <https://georgia.unwomen.org/en/digital-library/publications/2018/03/the-national-study-on-violence-against-women-in-georgia>. Accessed on 9 December 2020.

\_\_\_\_\_. *Rapid Gender Assessment of the COVID-19 Situation in Georgia*. 2020. Available at <https://georgia.unwomen.org/en/digital-library/publications/2020/08/rapid-gender-assessment-of-the-covid-19-situation-in-georgia>. Accessed on 9 December 2020.

UN Women Georgia. *Women’s Economic Inactivity and Engagement in the Informal Sector in Georgia*. 2018. Available at <https://georgia.unwomen.org/en/digital-library/publications/2018/12/womens-economic-inactivity-and-engagement-in-the-informal-sector-in-georgia>. Accessed on 9 December 2020.

WHO. *Gender Equity in the Health Workforce: Analysis of 104 Countries*. 2019. Available at <https://apps.who.int/iris/bitstream/handle/10665/311314/WHO-HIS-HWF-Gender-WP1-2019.1-eng.pdf>. Accessed on 30 November 2020.

## Articles

Blau, Francine D., and Lawrence M. Kahn. Understanding International Differences in the Gender Pay Gap. *Journal of Labor Economics*, vol. 21, No. 1 (January 2003), pp. 106–44.

Felice, Carla, and others. Impact of COVID-19 Outbreak on Healthcare Workers in Italy: Results from a National E-Survey. *Journal of Community Health*, vol. 45, No. 4 (May 2020).

The Lancet. Redefining vulnerability in the era of COVID-19. *Lancet*, vol. 395, No. 10230 (April 2020), p. 1089. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7270489/>. Accessed on 9 December 2020.

Liu, Qian, and others. The experiences of health-care providers during the COVID-19 crisis in China: a qualitative study. *The Lancet Global Health*, vol. 8, No. 6 (June 2020). Available at [https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(20\)30204-7/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(20)30204-7/fulltext). Accessed on 9 December 2020.

Stimpfel, Amy W., Douglas M. Sloane, and Linda H. Aiken. The longer the shifts for hospital nurses, the higher the levels of burnout and patient dissatisfaction. *Health Affairs (Project Hope)*, vol. 31, No. 11 (November 2012). Cited in Solidarity Network, *Working Conditions of Nurses in Georgia*, p. 13.

Talaei, Negin, and others. Stress and burnout in health care workers during COVID-19 pandemic: validation of a questionnaire. *Nature Public Health Emergency Collection*, 6 June 2020 (1-6). Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7275852/>. Accessed on 9 December 2020.

Tomlin, Jack, Brian Dalgleish-Warburton, and Gary Lamph. Psychosocial Support for Healthcare Workers During the COVID-19 Pandemic. *Frontiers in Psychology*, vol. 11, No. 1960 (August 2020). Available at <https://www.frontiersin.org/articles/10.3389/fpsyg.2020.01960/full>. Accessed on 9 December 2020.



## **ANNEX B.**

# **HOSPITAL AFFILIATIONS OF THE STUDY RESPONDENTS**

### **Tbilisi**

1. The First University Clinic
2. Central Republican Hospital
3. David Tatishvili Medical Center
4. Tbilisi Sea Hospital
5. Bokeria Tbilisi Referral Hospital
6. Tsitsishvili Children’s New Clinic
7. Infectious Diseases, AIDS and Clinical Immunology Research Center
8. Jerarsi Clinic

### **Adjara (Batumi)**

9. Batumi Polyclinic N1
10. Batumi Medical Emergency Center
11. Batumi Maritime Hospital
12. Batumi Republican Clinical Hospital
13. Medical point of Sarpi Customs Checkpoint
14. M. Iashvili Batumi Maternal and Children’s Central Hospital

### **Imereti (Kutaisi)**

15. Kutaisi D. Nazarishvili Family Medicine Regional Training Center
16. Emergency Situations Coordination and Urgent Assistance Center – Kutaisi
17. Medical City – Kutaisi

### **Kvemo Kartli (Marneuli and Tetrtskaro)**

18. Geo Hospitals – Marneuli
19. Marneuli Medical Emergency Center
20. Tetrtskaro Clinic
21. Tetrtskaro “Regional Health Center”



United Nations Entity for Gender Equality  
and the Empowerment of Women

UN Women Georgia Country Office  
#3 Kavsadze street,  
office suite #11, 0179  
Tbilisi, Georgia  
Tel: (995 32) 222 06 04;  
(995 32) 222 08 70

[www.unwomen.org](http://www.unwomen.org)  
[www.georgia.unwomen.org](http://www.georgia.unwomen.org)