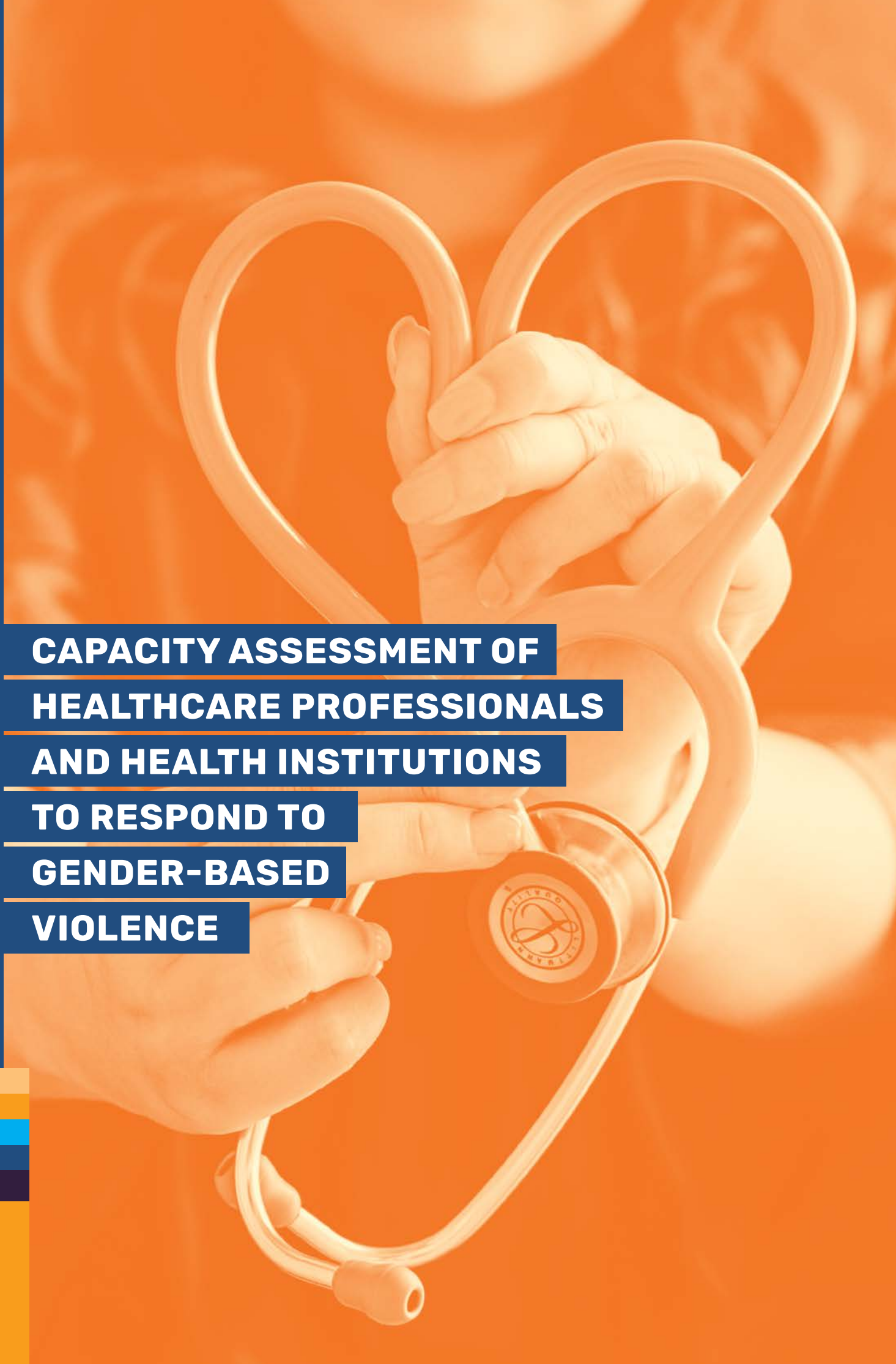

CAPACITY ASSESSMENT OF HEALTHCARE PROFESSIONALS AND HEALTH INSTITUTIONS TO RESPOND TO GENDER-BASED VIOLENCE

REPORT

CAPACITY ASSESSMENT OF HEALTHCARE PROFESSIONALS AND HEALTH INSTITUTIONS TO RESPOND TO GENDER-BASED VIOLENCE

Research Results

Authors:
Prof. Dr Bosiljka Đikanović
Prof. Dr Bojana Matejić
Doc. Dr Željka Stamenković

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Nenad S. Lazić

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The joint action of United Nations agencies and governmental bodies contributes to the solution of problems of domestic violence and intimate partner violence, enhances support for women, girls and their families and creates an environment that does not tolerate violence. The project is implemented with support of Government of Sweden.

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BACKGROUND

Health institutions are often the first and sometimes the only institutions to which gender-based violence (GBV) survivors, most often women of all ages, turn to. The focus then is on attending to their health-related needs, whereas exposure to violence easily goes unrecognized and unaddressed. Lack of communication about violence represents a missed opportunity to provide assistance to survivors and create a supportive environment, which would also make a difference in the overall social response to violence. Healthcare professionals have a professional duty to protect violence survivors in an adequate way, which requires multi-faceted professional competency.

Since 2015, the United Nations Population Fund Country Office (UNFPA CO), in cooperation with the Ministry of Health (MoH) and the professional team gathered around the partner organization, the Women's Health Promotion Center, has been providing continued support in building the capacities of the health sector to respond to GBV.

Since 2016, these training have been organized as part of UNFPA activities within the Joint Project on Integrated Response to Violence against Women and Girls in Serbia (Phase II and III), implemented by the Government of Serbia with UN Agencies, and supported by the Government of Sweden.

The training methodology developed by VAWE and UNFPA Regional Office is adapted to the national context, and in cooperation with the Women's Health Promotion Center, several basic and advanced training courses have been implemented in various districts of Serbia.

During the current, Phase III of the Joint Project, and with the aim to further strengthen the capacities of the healthcare system to respond to violence against women and girls (VAWG), including new challenges in the context of the COVID-19 pandemic, UNFPA in Serbia seeks to:

- Conduct a detailed assessment of the current capacities and needs of health professionals/institutions to respond to GBV at the national level;
- Map key challenges faced by healthcare professionals in identifying GBV and providing comprehensive support to GBV survivors, including during the COVID-19 pandemic;
- Identify key factors contributing to successful GBV response by health institutions; and
- Assess the existing models of supervisory and other forms of support available to healthcare professionals in responding to GBV.

To this end, a comprehensive national study was conducted, the methods (qualitative and quantitative) and results of which are presented in detail in this Report, as are recommendations for further action to enhance the capacities of healthcare professionals and health institutions to respond to GBV within their professional responsibilities.

QUALITATIVE RESEARCH SUMMARY

The qualitative part of the research was conducted using structured interviews with six healthcare professionals with a minimum of 15 years of experience, four of whom were 'Chosen Doctors' (General Practitioners, GPs) working in primary healthcare, and one was a specialist in social medicine, employed with the Public Health Institute of Serbia, who had provided the perspective of the system. All interviewees had a high level of personal and professional competencies to respond to GBV. As the most critical prerequisite to responding to GBV in their practice, the healthcare professionals (doctors) listed attending specialized training and education courses on several occasions, during which they had been sensitized to this issue, empowered to respond, and capacitated to apply the Special Protocol of the Ministry of Health of the Republic of Serbia for the Protection and Treatment of Women Exposed to Violence.

The interviews show that in some health institutions, during the last ten years or so, Multi-Sectoral GBV Prevention and Protection Teams had been established, but their functioning varied, ranging from a proactive approach and implementation of activities on all three levels of prevention to but a formal existence, relying on the activities of a single person. Multi-sectoral cooperation with the police and centers for social work (CSW) also varies. In some areas, it is described as excellent. In contrast, in others, there is an evident lack of shared understanding of GBV issues and the perception of security-related risks for the survivors. The lack of involvement of the health sector in the integrated GBV response and lack of feedback on the status of reports on suspected violence is found to have an adverse effect on the motivation and enthusiasm of healthcare professionals to respond.

In their response to violence, healthcare professionals primarily relied on informal peer support and contacts established during training courses. GBV cases registered in their clinical practice related solely to the explicit confirmation of current physical violence, while all other forms of violence (continuous psychological violence, threats, intimidations, economic violence) most often remained completely unaddressed, whether because the survivor was not willing to discuss them on her own; or because of the high number of patients and the extremely short time available during the visit to the doctor, meaning that only the "burning" health-related needs could be addressed. Other mentioned reasons are the lack of sufficiently efficient mechanisms to respond to GBV in the community and society and to protect and support GBV survivors.

During the COVID-19 pandemic and altered working conditions, the interviewed healthcare professionals had significantly fewer patients presenting with GBV-related issues, which were still responded to as a priority, the same as before the pandemic. The interviewees felt that continuous capacity development of health institutions to respond to GBV was required, with continuous education delivered to younger staff, in particular, as well as good-quality and efficient networking among healthcare professionals at the local level with other sectors providing protection, which was crucial for an adequate integrated response to GBV.

QUANTITATIVE RESEARCH SUMMARY

The quantitative part of the capacity assessment of healthcare professionals, associated professionals, and health institutions to respond to GBV was conducted using a questionnaire filled out online, the link to which was distributed in March 2022, during a relatively calm period in the COVID-19 pandemic. A total of 1,686 healthcare professionals participated in the research, of which 83% were women, and 17% were men. The average age of research participants was 46.2 (+/- 11 years). The regional distribution was relatively balanced: nearly 30% of healthcare professionals came from the Belgrade region; somewhat fewer (28.5%) from Vojvodina, 20.9% from Šumadija and West Serbia, followed by 19.6% from South and East Serbia, while 19 healthcare professionals (1.1%) stated they were working on the territory of Kosovo and Metohija.[1] The sample comprised 61.4% doctors, 34.8% medical nurses/technicians, and 3.9% associate professionals. Of the healthcare professionals participating in the research, 61.2% were employed in primary healthcare; 32.6% in secondary or tertiary healthcare, and 6.2% worked in private practice.

Nearly one-half of healthcare professionals (46.9%) reported seeing over 30 patients every day at their usual place of work. The burden on their workplace was described with a score of 9 or 10/10 by nearly one in three healthcare professionals (30%) under usual working conditions. During the COVID-19 pandemic, the proportion of healthcare professionals who assessed workplace burden with these high scores was nearly twice as high (59.3%).

Six out of ten (60%) respondents stated that they had never before attended a lecture, training, seminar, or course related to GBV / domestic violence / intimate partner violence / violence against women (VAW). The remaining 40% confirmed attending courses, most often once (23.4%), followed by twice or thrice (12.6%). Attending four or more courses was reported by 3.5% of healthcare professionals. In line with this, more than one-half of healthcare professionals assigned relatively low scores

1 All references to Kosovo and Metohija shall be understood in the context of UN Security Council Resolution 1244 (1999)

(1-3/5) when self-evaluating their preparedness to recognize (53.6%) and then respond (59.1%) to GBV in their practice.

Two-thirds (66.7%) of healthcare professionals encountered GBV cases in their practice at least once a year, under usual conditions, i.e., before the COVID-19 pandemic. When it comes to the assessment of the impact of COVID-19 on GBV in society in general, as many as 44.4% of healthcare professionals feel that the frequency and intensity of GBV increased during the pandemic. Even though the healthcare system resources and the focus of healthcare professionals were predominantly on attending to COVID-positive patients or administering COVID-19 vaccines (which was mentioned by the interviewees), it is indicative, and in line with the above estimate, that almost one in three healthcare professionals (31.1%) reported a higher frequency of suspicion of GBV among their patients during the COVID-19 pandemic, compared to the usual conditions, i.e., before the pandemic. When it comes to the attitudes of healthcare professionals regarding communication with patients about GBV, the highest percentage (47.9%) agree that it would be useful to ask each patient about her exposure to violence (screening), while 42.8% consider there are no conditions for that.

A written protocol, i.e. guidelines on how to proceed in GBV cases at their workplace, is not available to nearly half of the healthcare professionals (49.7%), whether they explicitly stated that the guidelines do not exist (18%) or that they do not know of them (31.7%).

Keeping records in health institutions on suspected GBV cases is a legal requirement, which was unknown to at least one-half of healthcare professionals (54.6%), whether they explicitly denied keeping records (21.1%) or did not know about this obligation (33.5%).

As many as 64.8% of healthcare professionals did not know of the existence of a GBV Protection Team at the level of their health institution, whether they explicitly denied the existence of the team (31.3%) or responded with “I do not know” (33.5%).

Regarding initiating communication about GBV, a little over one-third of healthcare professionals (35.1%) had never started a conversation on GBV with their patients without direct cause, while 47.7% of research participants had done so sometimes or often. However, in the case of suspected violence, and 72% of healthcare professionals have confirmed that they sometimes or often suspected GBV against their patients, as many as 66.3% of them (or 91.8% of the above number) responded to it and started a conversation about it with their patients. The pervasiveness of this response (initiating a conversation in over 90% of suspected violence cases) is also consistent with the qualitative research findings, which indicated that attending and addressing GBV cases was prioritized in health institutions once they were recognized. However, in practice, these cases represent only the tip of the iceberg when it comes to the frequency of and exposure to various forms of GBV in the family and society.

The above data on the low level of preparedness to recognize and respond to GBV (53.6% and 59.1%), as well as unfamiliarity with best practice principles and response procedures (63.7%), indicate a high degree of uncertainty among healthcare professionals on how to respond to GBV. Clearly, there is a lot of room to establish and improve the currently non-existent mechanisms for GBV response monitoring and supervision. This finding is also consistent with interview findings, where doctors stated that due to a lack of feedback on the quality of their work and the lack of peer support, i.e., monitoring and supervision, they were not sure how well they responded to GBV recognized with their patients and that periodical education in this area would be crucial and valuable. As many as 55.9% of healthcare professionals stated that the problem and cases of GBV were not discussed at regular and collegial meetings within the institution, whereas 37.2% of healthcare professionals did not talk about this topic with their colleagues, even informally.

Responding to recognized GBV, 80% of healthcare professionals said they verbally condemned all forms of violence, expressed their understanding, and supported their patients who had experienced violence. A somewhat lower share (69%) spoke to the survivors about their safety, and even fewer, 54%, provided instructions and information about the sources of support available to GBV survivors. Contacting relevant services (police, Centers for Social Work (CSW), women's shelters), sometimes or often, was reported in 46.1% of the cases, while nearly 30% of healthcare professionals had never contacted these services. Multi-sectoral cooperation and support were evaluated as insufficient by as many as 41.4% of healthcare professionals (scores 1-2/5), which is also in line with interview findings, and indicates that community resources often do not exist and/or are not functional, that is, the sectors are not efficiently interlinked. Poor or very poor cooperation with the police was mentioned by 34% of healthcare professionals, while as many as 40.3% mentioned the same of the CSW. The existence of specialized organizations providing support to GBV survivors was reported by 30.8% of healthcare professionals, and good cooperation with them was established by 9.4% of them.

More than one-half of healthcare professionals working at the primary healthcare level (51.5%) did not know of the existence of the service "Attending to a person exposed to violence", defined in the Rulebook on the Nomenclature of Healthcare Services at the Primary Healthcare Level. In line with this finding, 39.1% of those working at the primary healthcare level reported never having recorded the provision of the service "Attending to a person exposed to violence". Furthermore, one in four healthcare professionals (27.2%) had never entered a patient's report on exposure to violence in her personal health records. One in three healthcare professionals (34.8%) had never documented injuries on the body map. Taking photographs of the injuries was the least common practice by healthcare professionals: it had been done sometimes or often by 10.4% of the respondents, while 57.8% had never done it. GBV is under-recorded in current practice, compared to how often it is identified,

which indicates considerable room for improvement in healthcare professionals' response to GBV in their clinical work in this aspect as well.

When it comes to the existence of written/printed information on GBV, and sources of assistance and support, nearly one in four healthcare professionals had never given instructions or information on sources of support available to GBV survivors (24.4%). More than one-half of healthcare professionals (52.8%) reported no written informational content regarding GBV in their institutions. If there was, this was more often in waiting rooms (25.9%) than in doctors' offices (18.1%). Again, this finding indicates a need for adequate system support for healthcare professionals in health institutions regarding primary and secondary GBV prevention.

Three-quarters of healthcare professionals (74.9%) consider that support from the management of the health institution is important or very important in response to GBV. However, at least one in three (36.3%) stated that the management of their health institution did not pay enough attention to this issue. The importance of the support provided by the management of health institutions was also highlighted in the interviews with healthcare professionals. Where it existed, it created a big difference in the overall capacity of the health institution, not only to respond to GBV but also to promote gender equality and zero tolerance to violence.

In a final, open-ended question of this study, many healthcare professionals used the opportunity to comment (should they wish to) on the research or any of its aspects they felt were relevant. In their qualitative responses, they expressed the need to bring up gender inequalities within healthcare institutions, and exposure to sexual harassment and sexist comments by male colleagues (at the secondary and tertiary healthcare levels, particularly in surgical wards). In addition, they wrote about their exposure to verbal violence and aggression by patients, especially toward female healthcare professionals, at the primary healthcare level. These phenomena are the reflection of the overall societal attitude towards women, which indicates that work also needs to be done in healthcare institutions to raise awareness about gender-based abuse and harassment and ensure that they are no longer tolerated, whether they are coming from colleagues, other healthcare professionals, or from patients. Many comments also highlight the need for continued education in this area and the importance of multi-sectoral cooperation.

QUALITATIVE RESEARCH: IN-DEPTH INTERVIEWS

Research Method

The qualitative part of the research was conducted using structural in-depth interviews with healthcare professionals (from now on: interviewees or participants, will be used interchangably), whose characteristics are described in more detail in the section below (Qualitative Research Participants). Two experts in qualitative content analysis conducted interviews with research experience in the field of GBV and health service response, using a naturalistic paradigm and best practices in qualitative research implementation.

The interviews were conducted online using the Zoom communication platform. During each interview, detailed notes were taken. The interviews were audio recorded, with the participants' consent, and transcripts were made from these recordings. The notes and the transcripts were used as the basic units for the qualitative content analysis, which was conducted in line with the framework method for the analysis of qualitative data in multi-disciplinary health research. [2]. The qualitative content analysis was conducted through an iterative process of reading the transcripts, identifying topics and categories, coding and indexing contents, and finally, interpretation. A programming package, i.e., MAXQDA software, was used for qualitative data management.

Qualitative research participants

Five healthcare professionals, identified as "Best Practice Champions" based on their previous experience, participated in this part of the research. They were not only very competent in responding professionally to gender-based violence in their clinical practice (all five of them), their competence went above and beyond: one healthcare professional was an activist, community mobilizer, and founder of numerous civic initiatives in her town working to improve the position of women and to provide support to vulnerable population groups. All interviewees had a minimum of 15 years of civil healthcare service. Most of them (four out of five) attended several specialized training and education courses on GBV and response in health institutions. Four out of five were General Practitioners, employed as 'Chosen Doctors' in their respective Health Centers, with the Health Care Services for Adult Population. The regional distribution and professional characteristics of the interviewees are presented in Table I.

2 Gale, N.K., Heath, G., Cameron, E. et al. (2013) Using the framework method for the analysis of qualitative data in multi-disciplinary health research. BMC Med Res Methodol 13, 117. https://doi.org/10.1186/1471-2288-13-117

Tabele I. The regional and professional structure of interviewed healthcare professionals

Region	n (N=5)
Belgrade region – central urban municipalities	1
Belgrade region – suburb municipalities	1
Šumadija and West Serbia	2
South and East Serbia	1
Occupation	
General Practitioner, 'Chosen Doctor'	4
Healthcare professional – associate	1
Healthcare level of employment	
Primary healthcare level	4
Secondary healthcare level	1
Prior education in GBV (attended accredited training sessions)	
Yes	4
No	1

Except for these five explorative interviews conducted with healthcare professionals involved in clinical practice and direct contact with patients, another additional explanatory interview was conducted with a medical doctor employed in the Public Health Institute of Serbia, who was directly involved in the design and implementation of system solutions for improving the provision of healthcare to persons exposed to GBV, as well as other forms of inter-personal violence relevant to public health (e.g., child abuse and neglect). Considering that this interview and the questions asked differ to some extent from the others, the most important findings of this interview will be presented in the analysis sporadically, wherever additional explanation or broader perspective is required.

QUALITATIVE RESEARCH RESULTS

The qualitative analysis of the contents of the conducted interviews revealed four dominant themes:

A. Preconditions for responding to GBV in healthcare institutions

B. Response practice and experiences

C. Challenges in providing adequate responses and

D. Recommendations for improving the response of healthcare professionals regarding GBV prevention and protection

A number of topics and sub-categories have been identified under these four main themes, which are described and documented in detail below.

Preconditions for responding to GBV in health institutions

When it comes to the preconditions for a professional and high-quality response to GBV in everyday clinical practice, three categories of answers are highlighted as particularly important, and each of them is described in detail below:

1. Regular attendance at multi-day education and specialized training courses on GBV
2. Support provided by the healthcare institution management
3. Availability of the GBV Protection Team and existing internal procedures.

Regular attendance at multi-day education and specialized training courses on GBV

Nearly all interviewees are proud to report having had the opportunity to acquire their competencies, knowledge, and skills in this area at specialized education and training courses, not only once but typically several times, from various organizers. They attended specialized programs, which sometimes lasted for more than a day, greatly impacting their professional formation and preparedness to respond when they encountered gender-based violence. Training and education also helped them become personally empowered to leave the cycle of violence they had been exposed to. Teamwork and small group discussions, meeting and networking with colleagues from different sectors within the same local community, were all experiences that permanently imprinted on their personal and professional identities, which they have kept as a significant capital that they continued to use as motivation for work, as well as attitudes and

values of zero tolerance to GBV. They acquired their first formative experiences in GBV over 15 years ago, at education courses they evaluated as high quality.

> *"Well, this was in 2003, 2004, 2005, yes, yes, we had education courses at the local level, and this is when we made the teams (…) We sort of remained as teams, good and cooperative."*
>
> (Interview #5)

> *"The first time, maybe in 2005 or 2004, I think we had a seven-day training in Hotel Park, Monday to Sunday. It was fantastic; Divna, Lukrecija, Otašević were there, and another psychologist. It was a nice and interesting team, and we were captivated by the topic for seven days. All of us who were invited then came back with deeply rooted attitudes on the topic.".*
>
> (Interview #2)

Professional competencies formed in this way represent a starting point for an adequate professional response, which all interviewees agreed on. For some of them, the established contacts and communication with the facilitators during the seminars and training courses have been a significant source of support to this day, giving them someone they can consult informally should they need to:

> *"When there is something I don't know, I need to ask people higher up (…) so I'd call doctor, professor Savić, to ask about some elements (…).".*
>
> (Interview #5)

It is typical for our interviewees that there had not been just one training. As mentioned above, they had several opportunities to deepen their knowledge and acquire skills and empower each other for synergies in action and response to GBV in their practice and the broader community. The adequate length of individual education courses (they feel it is ideal if they last several days) and the sufficient total number of training courses attended (interviewees recommend periodical knowledge updates), represent the best preconditions for an adequate response to the extraordinarily complex and sensitive issue of GBV. Educated in this way, some healthcare professionals have become the most significant resource in the healthcare system. They are 'islands of knowledge' capacitated and empowered to instruct their colleagues in ripples or act as educators in their environments.

> *"I was part of the education in 2010 when the Women's Health Promotion Center started with the education. We were also there for the promotion of the Ministry of Health Protocols… I participated in all education courses several times… also in 2011… there was a three-day seminar, before COVID started, in Niš (…)*

then I participated in the one organized by OSCE, on the topic of Gender and Security (…) three modules, three days each, related to violence against women and security in general. Again, this was about the South of Serbia, it was in Niš, Leskovac, and I also think in Pirot".

(Interview #1)

Support provided by the healthcare institution management

The interviews shed light on the fact that regular training and education for health-care professionals existed particularly in environments where there was interest in, and support provided by the healthcare institution management on the topic of gender equality and gender-based violence. Some healthcare institutions were led by managers described by the interviewees as "sensitized" and "engaged", with a genuine desire to implement all recommended standards and recommendations for action in case of violence:

"Yes, our Director is, so to say, gender-sensitized, in the sense that she has a high level of awareness about it, that we should talk about it, that education is needed, I can also confirm that she follows all protocols, all recommendations and tries to follow up on the administrative and organizational level: the Chief Nurse in the Health Center, also, she is the one reporting for the last several years, as you know, we have reported to Batut on the number of cases of violence against children and gender-based violence (…).".

(Interview #3)

The interviewees reported that support from the healthcare institution management was necessary for several terms: not only when it comes to giving permission to be absent from the job and to attend the workshop and seminars (ideally to several of them, with the aim to build a team), but also for establishing teams of experts within the healthcare institution for the protection of women from GBV.

"(…) we also have good cooperation with the management, I must say because whatever we planned, they would always meet us halfway (…)."

(Interview #1)

Availability of the GBV Protection Team and existing internal procedures

From the interviews, we found out that GBV Protection Teams existed in several health institutions. They included healthcare professionals of different profiles, and our interviewees were often either the heads or members of these teams.

> *"We have been functioning in continuity since 2012, we made the team, so we have all representatives (…) two general practice medical doctors and main general practice nurse (…) a doctor and a nurse from gynecology since they are included in working with women, so sometimes they are the first to see some things, for example, maybe those related to sexual abuse. Then we have the patronage service and patronage service nurse because there have been a lot of reports from the field, during her visit there were also a few reports of violence against new mothers… we have a psychologist and a social worker, and the Chief Nurse in the Health Center is our support, making it easier to put everything into action."*
>
> (Interview #1)

We found in the interviews that the functioning of GBV Protection Teams within the health institutions was not uniformed at all. They depended mainly on the capacities built within the health institution, i.e., the number of educated healthcare professionals who were able and willing to form a coherent team. In some environments, we found teams that functioned very well, which had organized internal education sessions for their colleagues, and made use of their competencies built during seminars and training in the best possible way. Supported by the management of their healthcare institutions, team members use their knowledge, motivation, and enthusiasm to considerably increase the capacities of staff within their institutions to respond to GBV, which is described by the following:

> *"All our team members went through education: first, we had a "training of trainers" course, and then they participated in all our courses as trainers in their respective areas. When we established good cooperation with the center for social work, with the prosecution office, with the police, we organized these multi-sectoral seminars, with the participation of both the center for social work, NGOs and the prosecution office, the police… we tried to have everyone there, also professors of forensic medicine… we called them to help explain injuries, to fill out the forms correctly, more precisely describe the injuries so they would be qualified correctly in the court (…) We even put up the telephone numbers of these on-call services, so that when you find yourself in such a situation you can immediately call."*
>
> (Interview #1)

In these settings, owing to good leadership, management support, and the presence of a critical number of socially engaged healthcare professionals with a keen eye to recognize gender inequalities and willingness to go the extra mile, the process of raising awareness of citizens about the importance of zero tolerance to GBV spreads like ripples in water. Health promotion actions organized and implemented in the community represent excellent examples of both primary and secondary prevention of violence, which is best described by the following quote:

> *"Every year on 10 December[3] we organize an activity in the Health Center, print flyers, and distribute them to women there. Before COVID started, we made a theatre performance in the hall of the Health Center and played a film on violence against women. It was organized very nicely, for half an hour, maybe more, with some excerpts from a performance on violence against women. We also gave away badges saying "You are not Alone" and "Stop Violence against Women". So, every year, before COVID, we organized it really well, from the beginning of the campaign, 25 November [4] to 10 December. We also tried to keep talking about it throughout the year and keep reminding people, to educate them on violence, so it's not forgotten, so it's always there."*
>
> (Interview #1)

Observing teams' activities within various health institutions, we realized that they had not been unified or continuous. In some environments, they were the most intense ten or more years ago, which correlates with the time when the Special Protocol of the Ministry of Health for the Protection and Treatment of Women Exposed to Violence was issued, which later on enthusiasm waned. Gender-based violence was then discussed in collegial meetings when we were given instructions for action. The doctors who were employed at the time remember these; however, since the topic was later mainly not discussed or even mentioned at all in collegial meetings, the newly employed healthcare professionals were left to find their own way, consult with older colleagues, considering that they did not have the opportunity to hear this "first hand" (see more in the section on Challenges).

> *"Some ten years ago, we had a professional meeting with peers, and each supporting institution with its contacts was listed. We received an official notice with telephone numbers and the responsible names of officers (…). Maybe I can still find it somewhere, and it certainly made things easier for us. Now we mostly know this, but the question is whether younger doctors know as*

3 International Human Rights Day, Author's remark.

4 International Day for the Elimination of Violence against Women and the first day of the global campaign 16 Days of Activist against Gender-Based Violence, Author's remark.

well, those who have just been hired. They know there is a reporting procedure and a sequence of actions to be undertaken, and they can certainly call me to consult."

(Interview #4)

"There are so many young colleagues now, there is a whole generation of colleagues that are retired (…) I think around 20 new young doctors came, who don't know anything about this topic."

(Interview #2)

In some cases, individually empowered healthcare professionals acted very efficiently, even without their formal participation as team members, so it can be concluded that while acting within a team is easier and safer, its formal existence, without necessary action, cannot contribute to improved GBV response. This finding reaffirms the fact that the system is primarily made up of people, qualified professionals with built professional competencies, who need to be nurtured and supported:

"It is only a matter of either seeing oneself appointed on a paper or actually wanting to do this and to make a difference (…) since many people know me around the town (…) they come to me privately, or as colleagues who know I am still volunteering, in the sense of assisting."

(Interview #5)

One of the results of this teamwork is the creation of internal procedures for action in the case of GBV, which were distributed to all clinics, as mentioned by two interviewees who are also team coordinators in their health centers (Interviewee #1 and #3).

"The team, headed by me, formulated the internal procedure. All phone numbers that used to be a big issue when acting were now stated in the procedure. The procedure was distributed to all clinics, so this was a critical step. It seems that in this way, all ambiguities are eliminated."

(Interview #3)

Response practice and experiences

The interviews also shed light on what the practice of providing assistance and protecting GBV survivors could be like. They shared the things that the doctors are encountering in their daily work, especially when it came to multi-sectoral cooperation, as well as whether there had been any changes during COVID-19. Their answers, and the most important findings, can be classified under the following topics:

1. Priority attendance to cases of physical GBV, while all other forms of violence often remain unrecognized and neglected.
2. Documenting violence and keeping records
3. Variable quality of inter-sectoral cooperation
4. Relying on personal contacts of healthcare professionals with experts of different profiles
5. Response during COVID-19.

Priority attendance to cases of physical GBV

Interviewed doctors, without exception, reported that when a GBV survivor came to the reception, whether explicitly or implicitly identified as such, she was given priority care and attendance. However, they also reported that the most severe cases of physical or sexual violence mainly did not come to them, as 'Chosen Doctors' at the primary level, but were medically taken care of in emergency rooms, or at the secondary or tertiary healthcare levels. Such a level of priority was also preserved during the COVID-19 pandemic, although they reported that during the last two years, since March 2020, they had mainly not been seeing violence-related cases (more on the work during the COVID-19 pandemic in a special part dedicated to this topic).

> *"We will do anything to protect this person… even stand in front of someone (perpetrator)."*
>
> (Interview #4)

Psychological violence is the most common but hidden form of GBV, which leaves long-lasting effects on overall women's health. However, psychological violence most often remains unrecognized and underinvestigated, even when there is reasonable suspicion of it, by healthcare professionals. Due to a lack of time to deal with it in more detail, as well as a lack of resources to help, there is most often silence around this topic, by both patients and doctors, even when it comes to the "Best Practice Champions", as our interviewees are:

> *"A patient complains, or I suspect, even more often than once a week … but neither do they expect us to nor do we have the time to pay attention (…)."*
>
> (Interview #4)

"Maybe sometimes I even miss something, when she (the patient) tells me something (that might indicate violence), and I don't have the strength to pursue it further (…)"

(Interview #2)

All this indicates that recorded cases of violence against women represent the "tip of the iceberg", and that it is actually much more common in all its, most often multiple forms, such as continued exposure to psychological violence, with occasional physical violence, with or without economic violence, including taking away the survivor's personal earnings. Such an everyday life context is linked with frequent use of sick leave and various health-related issues, which were described in more detail in the work of a doctor during the COVID-19 pandemic (described in more detail towards the end of this topic).

Documenting violence

Acting according to the Special Protocol of the Ministry of Health also entails documenting injuries inflicted as the result of violence, i.e. filling out the form on suspected violence and reporting it to the Registry of Suspected Abuse of Women[5] (hereinafter: the Registry), which is mandatory, according to the Law on Health Records and Statutory Records in the Field of Health Care[6]. Keeping records confidential is imperative, and all interviewees were unanimous about it being so in practice. However, one doctor was not informed about the existence of the Registry, nor has GBV been mentioned at official meetings at her workplace.

Only the team coordinator will typically have access to the GBV-related records within the Registry and the chief nurse in the healthcare institution, who reports to the Public Health Institute about the annual number of reported cases. The way the Registry is operationalized varies: in some places, it is organized by the survivor's name, somewhere it is coded, and somewhere it is classified by the year in which the document was created. In any case, access to the document is strictly controlled: it can be given only to the GBV survivor (photocopy), or judicial authorities, upon the request of the Deputy Public Prosecutor, during court proceedings.

"The Registry is available only to me and to her (Chief GP Nurse). She keeps records of all reports collected by the team and beyond since in our healthcare center there are over 60 clinics in villages… But, to have information about what

5 Pravilnik o obrascima i sadržaju obrazaca za vođenje zdravstvene dokumentacije, evidencija, izveštaja, registara i elektronskog medicinskog dosijea, Official Gazette RS, No. 109/2016, 20/2019.

6 Zakon o medicinskoj dokumentaciji i evidencijama u oblasti zdravstva. Official Gazette RS, No. 123/2014, 106/2015, 105/2017, 25/2019 (Article 24, Paragraph 16).

goes on there, each doctor, after filling out the protocol (Report on Suspected Abuse of Women, Author's remark), brings us (the team) the report, so that we can use it when the court or the prosecution office asks us, or the woman herself. We can find it easily because it is in alphabetical order (…)."

(Interview #1)

Interviewees said that during the preparation of the report on suspected abuse of women, doctors often consulted among themselves so they would fill out the form correctly. This is where our two interviewees were most often contacted by their colleagues, considering they were recognized as persons who knew about GBV more than others, so they acted as a support. On the other hand, two interviewed doctors who were not coordinators or team members also knew the necessary procedures very well and did not need any support with reporting. However, they were unfamiliar with what happened after the report was filled out and confidentially achieved in the Registry (the importance of cooperation and consulting experts will be elaborated in the section on Challenges). One doctor said that "it would be good to make uniform approach at the national level and to have unique internal protocols." (Interview #1).

The sixth interview with the doctor employed by the Public Health Institute of Serbia provided information about the recently launched application for automatic reporting of GBV-related reports. Online training for the use of this application was conducted on 6 April 2022. The application is currently in the piloting stage, and all publicly funded healthcare institutions (i.e. those within the state Health Institution Network Plan) are participating in the pilot. Its successful implementation is expected, which will greatly contribute to improved monitoring of the number and content of the collected reports of abuses.

Best practice elements also entail responsible coding of mental health disorders, which are directly or indirectly linked to exposure to GBV. Responsible coding means awareness of violence having effects on the health of the survivor and preferable coding of the cause (violence) rather than the outcome (mental health disorder), as the latter may harm the survivor and expose her to additional and unnecessary stigma, which could be an aggravating factor during the court proceedings. One doctor, the interviewee, had such an adverse experience, and said the following:

"(…) now we come to it being my fault for referring her to a psychiatrist because he is now using it as proof of her being unstable. What the psychiatrist wrote was that she complained that she did not know how to cope with her emotions in the process, she was anxious. That medical report was completely misused by her violent partner, and now when they come to me with mental health problems, they're saying like 'don't send me to the psychiatrist, because it will be misused in the court'."

(Interview #2)

A high level of sensitivity to the importance of the contents of medical reports was also mentioned by the interviewed doctor who recently (4-5 years ago), attended a specialized training course for healthcare professionals on GBV response, which once again confirmed the importance of attending education on this topic.

> *"In the classification of diseases, as an official diagnosis, there is domestic violence, violence against women, and that should be written down. Why would we write some other diagnosis just because we are sending her to a psychiatrist, if the woman is suffering violence, the effect, the cause… actually it is all related to violence she is going through… the consequence is that she is currently disturbed, maybe depressed, but if she leaves the cycle of violence and everything settles down, she will not have psychological issues… she is not a psychiatric patient for us to characterize her as one (…). We applied this model to prevent these women from being further hurt, so we don't put them in some unpleasant situation, only because of that."*
>
> (Interview #1)

Multi-sectoral cooperation

Healthcare professionals represent a very important link in the chain of support provided by the institutions within the system made up of the police, the prosecution office, CSWs and other social protection institutions, as well as specialized agencies for assistance and support regarding GBV. Efficient and high-quality multi-sectoral cooperation at the local level is the basis for survivor protection and for ensuring their short- and long-term safety. However, interviewed medical doctors and healthcare professionals have had varying experiences in this respect.

One of the doctors explicitly expressed her dissatisfaction and decline of enthusiasm after the Law on the Prevention of Domestic Violence was enacted in 2016 (quote below), which did not include healthcare professionals in the composition of the coordination and cooperation group at the local level. The Law, however, did prescribe that the "meetings can, as needed, be also attended by the representatives of educational and health institutions and the National Employment Service, representatives of other legal entities and associations and individuals providing protection and support to victims"[7]. It is interesting that the other interviewed healthcare professionals did not mention this law, and were not aware of this legal amendment and its implications. They did not know about the existence of coordination and cooperation groups, formed within the jurisdiction of each Basic Public Prosecution Office, either. This points to the fact that the health sector is not adequately recognized or sufficiently involved in the provision of an integrated response to VAW. It

7 Zakon o sprečavanju nasilja u porodici (Law on the prevention of domestic violence). Official Gazette RS, No. 94/2016, Articles 25-26.

is a missed opportunity to contribute to higher-quality protection of women, and a higher degree of confidence of healthcare professionals in the implementation of the Special Protocol of the Ministry of Health for the Protection and Treatment of Women Exposed to Violence. Teamwork and the feeling of belonging to a group (the team) represents a great inspiration and motivation to act within their own sector, within their capacities:

> *"The Law on Domestic Violence left away healthcare professionals and put an end to very nice and constructive meetings and multi-sectoral teams on violence (…) they no longer exist (…) new teams have been consisting of the prosecution office and the police, these sectors remained, but professionals from health not, except in specific cases. This is when I lost my enthusiasm, and there was simply no more room for being as active as I was earlier, at the community level. Maybe I unconsciously transferred that dissatisfaction into my own healthcare center, where the meetings became more infrequent, as well as education plans…".*

(Interview #3)

Regardless of these legislative changes with the reflections on the practice, doctors have had various experiences when it comes to multi-sectoral cooperation and communication with other professionals, particularly the police. Their experiences ranged from "excellent communication, we know by name the person we are looking for, who can help us to react on a violence case", to "communication was awful, we could hardly understand each other", when police officers asked doctors a series of questions that resembled a safety assessment of the survivor, but in a clumsy way. If there is no violence at that particular moment, some police officers tend to underestimate the need for action, as noted by the interviewees:

> *"They (the police), if they could, would most gladly shun it all, all these milder forms of violence (…)."*

(Interview #3)

> *"I can't even reach an inspector. A person in the police station answers and asks me why I am calling, and asks: 'Is he beating her now? Is he there?', that sort of questions. And then two police officers come and take notes. What happens afterwards, I don't know."*

(Interview #2)

A very good illustration of how communication with the police can unfold is presented in the quote below, which also indicates a lack of common understanding of a need to respond, of the roles of various sectors in the system, as well as a lack of a

mechanism for sharing information, which would ensure better cohesion in providing an integrated response to violence against women.

> *"We have one phone number, and then we are being put forward to the competent person (…). It goes like 'Hello, hello, I wish to report a case, a have a patient in my office…' This is just hypothetical speaking, I just want to give you a realistic image of what it is like… 'My name is Dr xxx, and I am calling because I would like to report the violence. The patient is going back home, but I am not certain there won't be an escalation of violence. Based on what she has told me, this is domestic violence. What do you propose, should the patient wait here until you arrive? How should we deal with this?'. And then he asks me: 'Where do you work again, which clinic, when do you finish work? Could she come here?' So, this one contact that I have, for an officer, I wasn't lucky with whom I'd come across. It was difficult to understand each other (…)."*
>
> (Interview #3)

One interviewee mentioned a negative experience in contacting a woman police officer, who said "I don't have time for this", which was very surprising for the interviewee. She attributed it to the feeling of fear of female police officers, regardless of her official role. Regarding the policewoman's reaction, the interviewee made an adequate comparison with the survivor's reaction, and the impact this could have on the entire situation: "(…) but imagine the victims who are scared, intimidated, and when a person like this (policewomen) doesn't respond, how are we, doctors, to help them then?" (Interview #5) [8]

On the other hand, there are examples of the healthcare sector having established, on their own initiative, very good and functional communication with the local coordination and cooperation group, which is made up of the police, the CSW and the District Public Prosecution Office. Good communication between these stakeholders represents a considerable step forward in increasing the protection and safety of violence survivors, which is described in the following quote:

> *"We've reached an agreement with the police that, if the violence is acute, they would come immediately, and if it is chronic violence, we write a report so they can investigate more thoroughly (…) We even reached an agreement with the prosecution office later on, so that they can issue an order to find out more about the violence, if the woman is not willing to report it (…) then we report to the prosecution office and the police so they can investigate a little further what it is about."*
>
> (Interview #1)

8 Regardless of that, the interviewee knew the procedure to follow, and managed to report violence to the police officer in charge and her boss (Author's remark).

Also, it has been emphasized that the modality of cooperation with someone you know "by the name" is characteristic of smaller communities, where it is generally possible to respond to violence more quickly and efficiently, an protect the survivor:

> *"Cooperation with the police is excellent, I know as many as four officers by name, whom I can contact if I need to."*
>
> (Interview #4)

> *"The speed of response is a characteristic of a smaller community, the people in the chain of support to the victims of violence know each other better, and this is an advantage compared to Belgrade."*
>
> (Interview #2)

When it comes to the Centers for Social Work, they are perceived by the doctors as sluggish and relatively unresponsive institutions, which are not capacitated for rapid response in attending to and protecting survivors. They often have almost no contact with them, precisely because they have not had positive experiences. It is interesting that where we found dissatisfaction with cooperation with the police, there was also dissatisfaction with CSWs.

> *"Center for Social Work is a sluggish institution, they are willing, but the procedure, the requirements to be met, the organization, it's all sluggish."*
>
> (Interview #3)

Specialized Civil Society Organizations (CSOs) for the protection and support to violence survivors, where they exist, are a very powerful and high-quality resource, with accumulated knowledge and skills to provide direct support to GBV survivors. However, the interviews have shown that in the settings where the interviewed doctors work, these resources mostly do not exist, or the doctors are not informed about their activities. A relative exception is one interviewee, a healthcare professional, who is an activist and the organizer of numerous civil society initiatives in her community. She informed us that women from her community are coming to her informally to help them deal with the violence. They recognize her as a reliable person who can help them "as a human being", with understanding and empathy for the situation they find themselves in. She is able to provide them with suggestions and advices for concrete actions, whether they are seeking help for themselves or their proxies. This interviewee acts in her private capacity, not as a representative of the institution in the system, whose past personal experience with violence qualifies her for this, as does her attendance at numerous education courses. She has been through a personal empowerment process that enabled her to finally leave the cycle of violence. In addition to it, she is also knowledgeable of the institutions in the system and the way they respond:

"Believe me, they are coming to my door. Recently, it was one mum, who recognized domestic violence with her daughter and even the husband, her son-in-law, took her daughter away to another town (…) she came to me, she remembered me, because she watched a show I appeared on talking about my experience with violence, she knew where I worked. She came to ask what to do, and how to get her child back from her abusive partner and other town, so the abuse would stop. I did everything according to the protocol, of course, meaning that I contacted the police, center for social work (…), then I called the doctor, professor Savić to ask about some elements that are relevant for reporting of violence (…)."

(Interview #5)

Personal contacts and support from colleagues

Although all interviewees are well-informed and motivated to apply good practices when dealing with GBV cases, they also need continuous peer support and consultations. In environments where multi-sectoral cooperation is well developed, they often have a sufficient level of confidence in the implementation of the necessary activities. The existence of the team for dealing with GBV within the healthcare institution is also an important resource for mutual support. Even in the settings where it no longer formally functions, the capacities that had been previously built remain in the form of empowered colleagues, and their availability gives a sense of confidence:

"I am not certain that the Domestic Violence Team still exists, but I have people to lean on, people to call, in situations when I have a dilemma. It is not bad that I have the option to call my colleagues or any of the psychiatrists. They are my first line for consultations, both personally and professionally."

(Interview #4)

In addition to it, the interviewees mentioned their personal contacts with experts of various profiles (the above-mentioned prof. Savić, for example), and their availability for ad hoc consultations. These contacts were most often first formed during the interactions between lecturers/facilitators and participants at specialized education and training courses. The relationships were further strengthened with each following training cycle. The importance of these interactions is huge, both for personal growth and overcoming issues in their private lives, as support in daily work with patients, or informal support in the community. In addition to it, the interviewees mentioned their personal contacts with experts of various profiles (the above-mentioned prof. Savić, for example), and their availability for ad hoc consultations. These contacts were most often first formed during the interactions between lecturers/facilitators and participants at specialized education and training courses. The rela-

tionships were further strengthened with each following training cycle. The importance of these interactions is huge, both for personal growth and overcoming issues in their private lives, as support in daily work with patients, or informal support in the community.

> *"I was empowered by the Autonomous Women's Center, (AWC), in Belgrade, and my hometown, through this training. And believe me, I was no different than the victims (…)".*
>
> (Interview #5)

> *"I do everything that is up to me. Not just what's up to me, but everything. I even call doctor Stanislava and tell her that the patient needs to go to trial, and she is completely distraught (…) get me a good psychologist to prepare her how to behave at the trial. For a few patients, we even searched for legal aid. So, I have people I can turn to, to help survivors, even though there isn't a supporting system in my healthcare center. I don't feel frustrated by it, but I feel sorry that it doesn't exist in a broader scope."*
>
> (Interview #2)

Sometimes contacts with professionals at the local level also come from identifying common causes and spontaneous synergetic action, which is mentioned by one doctor:

> *"My support is a lawyer, Mr Biočanin, who is involved in this topic and provides free legal advice to persons exposed to violence."*
>
> (Interview #3)

Such examples of good practice indicate a great need for continuous professional support in dealing with GBV, even when it comes to trainers of trainers, i.e. the most educated healthcare professionals who are identified as "Best Practice Champions".

Response during COVID-19

The COVID-19 pandemic has been ongoing since March 2020 and has spread around the entire world, inevitably influencing both the phenomenon of and the response to GBV. Anti-pandemic measures aimed at preventing the spread of the virus also included lockdown recommendations, especially at the beginning of the epidemic. In Serbia, the state of emergency (including lockdown) was introduced on 15 March and lasted until 6 May 2020. During this period, absolute movement restrictions were in force for persons over 65 years of age, and any activities including multiple individuals in one place ceased. Altered living and working conditions, including spending longer periods in enclosed domestic spaces with other family members, often led to escalations of

tensions and manifestations of violence. It was also reflected in the increased number of calls received by the National SOS Line in the period since March 2020, compared to January and February of that year, before the pandemic started.[9] International organizations also warned of an increase in violence against women under these new circumstances.[10]

The experiences of healthcare professionals in this period were rather similar, with all the interviewees talking about completely changed working regimes. From the start of the pandemic, the focus was placed entirely on COVID-19 health-related needs: work in COVID clinics, testing suspected COVID-19 cases and attending to sick patients. Later on, they worked on vaccination points, which was both a psychologically and physically exhausting experience:

> *"For a whole year I did not write anything down into the patient records (…). I spent ten months on the vaccination point, five of which without a single day off (…)."*
>
> (Interview #3)

> *"During COVID, the system of work of the 'chosen doctor' was disrupted (…) many doctors replaced each other, and I often worked with somebody else's patients".*
>
> (Interview #4)

The interviewees stated that all the other activities that made up the work of doctors and general practice services were in second place, which includes the identification and response to women with GBV. They also said that the continuity of meetings with team members was lost during COVID-19 and that they did not observe an increased number of GBV-related cases in their practice. It was rather on the contrary: the number of women with complaints related to GBV considerably decreased. For comparison, the reported frequency of GBV cases before and during COVID-19 is presented in Table II, clearly showing the described trend.

9 Postupanje nadležnih institucija i službi za suzbijanje nasilja u porodici u Republici Srbiji tokom Covid-19 epidemije, posebno u periodu vanrednog stanja. Research Report. Victimology Society of Serbia (Viktimološko Društvo Srbije, VDS): May 2021, p. 14

10 UN Women (2020)

Table II. Frequency of violence-related cases, before and during COVID-19

	Before 2020	During COVID-19
Interviewee #1 (Coordinator of the GBV Protection Team in her Primary Healthcare Center)	30-40 cases annually (entered into records at the institutional level)	2020: 25 women 2021: 10 women (by 25 November)
Interviewee #2	2-3 women annually (only the interviewee)	No cases during the pandemic
Interviewee #3 (Coordinator of the GBV Protection Team in her Primary Healthcare Center)	Several women annually	She did not work in her office, and she did not have cases
Interviewee #4	At least 1 a week (only the interviewee)	2020: 21 women on records 2021: 15 women
Interviewee #5		Around 20 women in 2020 and 2021 (only consulting her

According to our interviewees, each suspicion of violence was given priority in response and attendance, equally as before COVID-19. They feel that in the current pandemic situation, the frequency of violence against women in society has not decreased. However, fewer women come to them reporting GBV, which probably reflects changes in the work of 'Chosen Doctors' and their different availability in regular practice. In that context, women who have been exposed to violence probably would rather turn to the police than to healthcare professionals.

One doctor mentioned the practical experience she encountered during the pandemic. Her female patient of many years, whose husband had died recently, felt the need to share with the doctor what she had been going through while her husband was alive, and that she was actually exposed to violence. It was a patient who is visiting this doctor for many years, complaining about non-specific issues and dissatisfaction projected onto her work, often asking for sick leave. During the pandemic, and after her husband died, that patient for the first time now reflected on her problems with her abusive husband. Prior to it, the doctor had only partially known about her dysfunctional family relations. This experience shows the high level of trust that patients have in their doctors, but it also sheds light on the complex nature of long-lasting exposure to violence, and the lack of capacities of the survivor to address these extremely complex issues, which requires efficient social support at all levels.

"(…) I know her from before, she'd come very often, unhappy, asking for sick leave, looking for problems in her work environment (…) I remember once she mentioned she wanted to quit her job and that she got upset by everything at home… now I realize what was her main problem, looking back, after her husband died of COVID-19… when she told me she had to take a picture every day in front of the hospital, as proof that she was there because he would say that no one visited him and they forgot about him and left him for dead. When he was released home, the woman describes this period as a very, very difficult one."

(Interview #2)

Challenges in providing an adequate response

Interviews revealed challenges in providing an adequate response and dealing with GBV that can be classified under several categories:

1. Inadequate working conditions, primarily in terms of being overburdened by the number of patients (but also lacking technical equipment)
2. Lack of continuity and education to deal with this topic; lack of continuity of best practices and transgenerational knowledge transfer in multi-sectoral teams, as well as the lack of mechanisms for monitoring and evaluation of GBV response
3. Personal attitudes of healthcare and other professionals related to GBV

Inadequate working conditions

Being overburdened with the number of patients was emphasized as a significant challenge in everyday work. All interviewees, without exception, mentioned that the number of appointments was usually above 40 patients a day, sometimes even reaching 60, in situations when they have to take over the patients from an absent colleague. In their working setting, the focus is on clinical work and attending to acute health disorders, so that the health-related needs of a large number of patients every day can be addressed.

"So, instead of the total of 2,200 patients, currently (during COVID, Author's remark) I have to take care of 4,400 patients… and I can admit that the quality of my work at the beginning and the end of the shift is not the same…" .

(Interview #2)

"We have around 5-6 minutes per patient, I think this is a very short time to be able to get a thorough look at the patient and do everything related to the examination."

(Interview #1)

Reacting to acute cases of physical violence is a priority, and this has already been described in the previous findings. However, all other activities, which are not "burning", but are still important and related to GBV, often remain unaddressed. This refers to the lack of attempts to initiate a conversation about violence, in case the doctor intuitively feels this could be a problem that affects women's health and well-being. These findings indicate that the number of reported cases of suspected violence in the health sector and general is just the tip of the iceberg, under which there is a much higher number of women who suffer psychological violence on a daily basis, which, not infrequently, escalates into physical violence:

"Often there are women who come to the doctor frequently, sometimes as emergency cases, somatic presentations, vertigo and similar conditions, but if they do not talk about it themselves, it really takes a certain amount of time, and it is hardly ever possible to find out anything during the first contact, to get the woman to speak about it. Unfortunately, these women very often will not open up to you unless there is a concrete problem, that is, they won't ask for help (…)."

(Interview #4)

Except for this, some interviewees stated that in remote areas they often lack basic work tools such as computers, and in such conditions, it is very difficult to provide basic services. However, 'Chosen Doctors', as the only available resource in these smaller communities, have to address a wide range of needs of patients living and/or working on that territory, including psychosocial support in crises:

"Not a day goes by that someone does not cry in the office."

(Interview #4)

An additional reason for relative hesitation to establish a conversation on this topic can also be that multi-sectoral cooperation is not equally developed in all communities and that contacting and communicating with officers in police stations frequently represents a source of stress for 'Chosen Doctors'. That communication is often marked by a lack of mutual understanding, posing irrelevant questions from the other side, and showing a lack of interest to respond, which was previously mentioned as one of the findings of this research. It all indicates the importance of (re)establishing multi-sectoral cooperation and adequate and functional response mechanisms, which will be described in more detail below.

Lack of mechanisms for continued cooperation, education, monitoring and evaluation

Lack of continuity of good practices and transgenerational transfer of knowledge in multi-sectoral teams is a specific challenge discussed by the interviewees with a long institutional memory of GBV response in their communities. Looking back on the past, educated professionals from all sectors in local communities received highly specialized trainings fifteen years ago, or even more. They made up teams whose members knew each other well, precisely because they attended together these specialized trainings. During trainings, they were sensitized about GBV and motivated to take on professional responsibilities, each in his/her own domain. Such teams were the forerunners of best practices that were institutionalized in the form of special sector-specific protocols for action in cases of violence against women, as well as the memoranda of understanding in local communities with the aim to respond to violence. However, with the change of generations and retirement, or services change, the initially established contacts and functional cooperation were lost, and new teams were simply not built. The interviewees felt it was a large gap that should be bridged through a new cycle of joint multi-sectoral education courses.

> *"There are many new young colleagues now, a whole generation of older colleagues retired, and I think there are around 20 new young doctors now who know nothing about this topic."*
>
> (Interview #2)

> *"I have not read the protocol recently, so I cannot recall whether everything's been done according to the protocol (…) we haven't spoken about this topic in a long time, and we need someone to take us back to this topic (…)".*
>
> (Interview #2)

Even though the legal framework for responding to violence has significantly improved in the last 15 years, and numerous professionals' guidelines have been adopted in order to systematically improve the institutional response to violence, the greatest "capital" of the system is educated individuals in a team, who are collaborating well between themselves.

Research results also indicate the lack of mechanisms for monitoring and evaluation of the response to GBV in medical practice, i.e. feedback on the quality of their work, and possible implementation of certain corrective measures, in order to ensure the best possible protection of violence survivors and multi-sectoral cooperation:

"You know what, no one here restricts you, you do everything according to your conscience, but there's really no feedback. Whether what you did was good, whether you should continue with that kind of work; or, I keep asking myself, what happens when I report it. How I am perceived here, no one has ever spoken about this, whether I am seen as a doctor who meddles in things, who panics, who reports things 'for nothing' (without real reasons, author's remark), even though these things are not 'for nothing'… And it really bothers me, because I feel isolated (working in a clinic in the field, not in the head building, author's remark), I don't have any communication with my doctors from the Primary Healthcare Center, not even during the break… We haven't had meetings in a long time, and when eventually they were held, we from the field clinics were not there. Maybe we had a collegial meeting, but this (GBV, author's remark) was not the topic, nor was the collegial meeting convened to present maybe some problems and cases, so to say, that we could discuss… To say: "Colleagues, I had the incident, the situation, the issue of dealing with GBV, and here's how we solved that problem. So, if you should find yourselves in such circumstances, you can do something like that, or you can call me, so I can tell you what I did in that case."

(Interview #2)

Personal beliefs, attitudes and values relevant to GBV

Negative personal attitudes and denial of professional responsibilities regarding dealing with GBV response were mentioned as specific challenges encountered by colleagues in their work. It typically happened at the beginning, ten years ago or so, with the introduction of the Special Protocol of the Ministry of Health for the Protection and Treatment of Women Exposed to Violence, when it became clear that healthcare professionals have the role and professional responsibility to protect and care for GBV victims. However, awareness about the issue of GBV among healthcare professionals, and the need to respond to it, cannot be always assumed, unfortunately. In interviews, we found that younger colleagues, who did not attend specific education sessions, do not really recognize their professional responsibility (which has been already mentioned in this analysis), and it is questionable what their attitudes on the issue of GBV are.

"I feel like I am alone on a deserted island. Healthcare professionals' attitudes and their awareness are very different, and if we would all share a similar view, things would be better…"

(Interview #3)

Interviewees discussed that there is often apathy and a lack of interest to act professionally. One of the interviewees states that this topic is "shunned and pushed into a corner", as well as that "male colleagues are prone to minimize the issue" (Interview #3), and that there is "a lack of empathy and motivation to help and support the victims" (Interview #5).

> *"Not all doctors are sensitized to GBV, and not all understand the problem. For some of them, it is even better if their female patients do not mention it. Not all doctors have completed the training."*
>
> (Interview #5)

Recommendations for improving healthcare professionals' GBV prevention and protection response

In addition to the challenges stated in the previous part, which should be systematically addressed, the interviewees also provided some additional recommendations on how to improve GBV response practices. They are related to several aspects, and these are:

1. The need for continuous work on improving health professionals' knowledge and skills related to GBV response,
2. Implementing activities on raising awareness on gender equality and GBV, at the primary, secondary and tertiary levels of prevention,
3. Improving multi-sectoral cooperation at the local level, engaging the local self-government and the local media,
4. Improving teaching curricula.

Continuous work on improving healthcare professionals' knowledge and skills to respond to GBV

One of the most important recommendations aimed at improving healthcare professionals' GBV practice pertained to the need for continuous knowledge and skills updates in the field of GBV. It has been especially relevant for younger staff, recently employed, who have not built the necessary competencies to respond to violence during regular schooling, considering the low representation of such content

in teaching curricula [11]. Moreover, they have not had yet the opportunity to attend education or training on this topic. This recommendation was given by all five interviewees (which is also notable in previously elaborated results):

> *"Young doctors, beginners, are not prepared to respond when they encounter the problem of violence with their patients."*
>
> (Interview #4)

> *"It would be useful to organize the same education courses for younger staff, like the ones we used to have."*
>
> (Interview #5)

The need for continuous education in this area does not only relate to younger staff: all healthcare professionals should update their knowledge from time to time, so they can become familiar with the latest national developments, but also to mutually exchange experiences and best practices in responding to GBV. For example, one interviewee reports that the majority of healthcare professionals are not familiar with the fact that the provision of service to a person exposed to violence has been introduced in the Rulebook on the Nomenclature of Healthcare Services at the Primary Healthcare Level[12], with a detailed explanation of everything that constitutes this service (taking patient history, physical examination of organs and systems following the symptoms and the doctor's evaluation, referral to laboratory analyses, diagnostic procedures, specialist consultations, hospital treatment as needed, making a working or final diagnosis, determining treatment, entering data in medical records in line with the relevant protocol, treatment in line with the protocol – report to the prosecution office and the competent CSW, under the protocol, as well as to the team of experts in the institution).[13]

The sixth interviewee in this research, a colleague working with the Public Health Institute, reported that, from the perspective of the system, introducing this service was a big step towards institutionalization and identification of the provision of GBV-related healthcare services, which enables monitoring its frequency and performing a detailed analysis.

11 Strategija za sprečavanje i borbu protiv rodno zasnovanog nasilja prema ženama i nasilja u porodici za period 2021-2025. godine. Opis stanja i analiza problema (Part 6.1.3. Obrazovanje). Official Gazette RS, 47/21.

12 Pravilnik o nomenklaturi zdravstvenih usluga na primarnom nivou zdravstvene zaštite. Official Gazette RS, No. 70/2019, 42/2020 and 74/2021. Article 4, Preventive, dijagnostičke i terapijske usluge, No. 72. "Zbrinjavanje osobe izložene nasilju".

13 Ibid.

Activities on raising awareness of gender equality and gender-based violence

One of the interviewees emphasized that the activities related to GBV are basically related to secondary prevention of violence i.e. providing care to the victim while working on primary prevention of GBV was largely lacking. She perceives primary GBV prevention as a continuous activity with the participation of all segments of society, by promoting good communication and partnership relations, characterized by mutual respect and appreciation:

> *"(…) it's important not only to talk about violence against women and its effects but also to promote good intimate partner relations. What "good" means, how to nurture it, I would distribute such flyers to women and men. This is primary prevention."*
>
> (Interview #4)

The importance of primary prevention becomes particularly notable when it comes to younger persons, who they feel are more aware and will not put up with violence:

> *"Younger women would sooner decide to change something, while older women, especially the ones from rural areas, are used to suffering. Also, women who are financially dependent on their husbands, will far less frequently decide to make any changes."*
>
> (Interview #4)

Printed informational materials such as brochures, leaflets and posters, can be a very useful source of information on GBV. Publishing contact details for assistance and support reduces the sense of isolation, fear and desperation among the survivors, which would be secondary violence prevention. The interviewees feel that the presence of educational printed material in healthcare institutions would be very useful for long-term raising awareness on zero tolerance to violence, having in mind that "not all leaflets are for all women", and that in some cases, these materials could have an adverse effect on woman's safety:

> *"Not all leaflets are for all women. It is really very important to be cautious if we are afraid for a particular woman… someone (the perpetrator) could see it in her home, and then she could be in trouble."*
>
> (Interview #4)

In the context of tertiary violence prevention, i.e. continuous empowering of women who have experienced violence in all aspects, the interviews also mention the

proposal to establish self-help groups, which would typically be led by women who had been through violence and succeeded to break the cycle. Their example would encourage others to persevere:

> *"(…) I think that living examples of people who have been through it, and who are now empowered, are the best model. They would have the most empathy and compassion for the women going through it now. I'm not saying that others don't have it, but this compassion is somehow particularly important, just to be clear (…)".*
>
> (Interview #5)

Improve multi-sectoral cooperation at the local level, engaging the local self-government and the local media

Educating the general public via media has also been emphasized as a very important segment. In addition, interviewees felt that the local self-governments (LSG) should have their part of the responsibility in the efforts to improve the integrated social response to GBV. They should be involved in the provision of specific (financial and other) support to activities (for example, for educating a certain group of professionals, or for printed materials). Including the local media as a platform for conversations about GBV would be very useful. In addition to it, there was also mentioned need to educate the media about sensitive reporting on GBV and gender equality (GE), as well as a public announcement of the criminal sanctions for the abusers: "it would be good if media announced the sanctions issued against the perpetrators" (Interview #5).

> *"Dealing with GBV could be improved by forming a better network of all stakeholders at the local level. Inter-sectoral cooperation, a better, higher quality of it, primarily through joint education, problem identification, sensitization, competent and good-quality staff in key positions… I think this would contribute the most to a higher-quality response to gender-based violence." .*
>
> (Interview #5)

Improve teaching curricula

In the context of primary prevention of GBV, one of the recommendations also referred to the necessity to improve teaching curricula in primary and secondary schools. All interviewees stated that it would be necessary to talk about gender equality and building intimate partner and family relations with mutual respect and appreciation. In this way,

new generations of youth would be brought up, having built proper attitudes, which would, in the long term, be the greatest contribution to building a society with zero tolerance for GBV:

> *"I think we should start talking about it in primary schools, and high schools, it should exist within the particular subject, whether it is biology, chemistry, wherever they place it, there should be the talk of domestic violence, and children should be involved from a very young age in identifying it."*
>
> (Interview #5)

QUANTITATIVE METHOD: QUESTIONNAIRE

In the period between 10 March and 3 April 2022, quantitative research was conducted using a questionnaire administered online, on the RadCap platform of the Medical School, University of Belgrade. The link to the questionnaire was disseminated to the target group, i.e. healthcare professionals of all profiles, by using several different mechanisms and communication channels:

- Sending out an invitation letter to participate in the research to the addresses of ALL health institutions from the Network Plan, i.e. public health institutions, several times, typically once a week (sender: UNFPA);
- Sending out an invitation letter to participate in the research to professional associations, i.e. chambers of healthcare professionals and associates;
- Sending out an invitation letter to participate in the research to the professionals in the field, i.e. healthcare professionals who have numerous contacts with their colleagues in the field, especially at the primary healthcare level, who also personally promoted the research in this way.

QUANTITATIVE RESEARCH RESULTS

Socio-demographic and geographic structure of the sample

As of 3 April 2022, the electronic database contained a total of 1,741 entries. Out of this number, 55 persons or entries did not meet the criteria for further movement through the questionnaire (informed consent for participation in the research). Excluding them, the number of valid and fully filled out questionnaires was 1,686.

Age structure

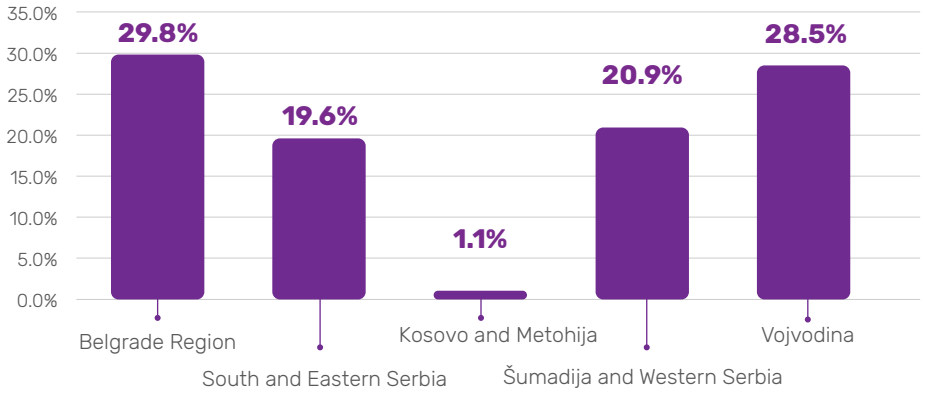
The average age of research participants was 46.2 years (SD 11 years); the highest number of participants (mod) was also 46 years old, and the ages ranged from 18 to 77 years.

Gender structure

A total of 83% of women (1,400) and 1of 7% men (286) participated in the research, which is an approximate reflection of the gender structure of employees in primary healthcare, which was the focus of this research.

Geographic distribution of the research sample

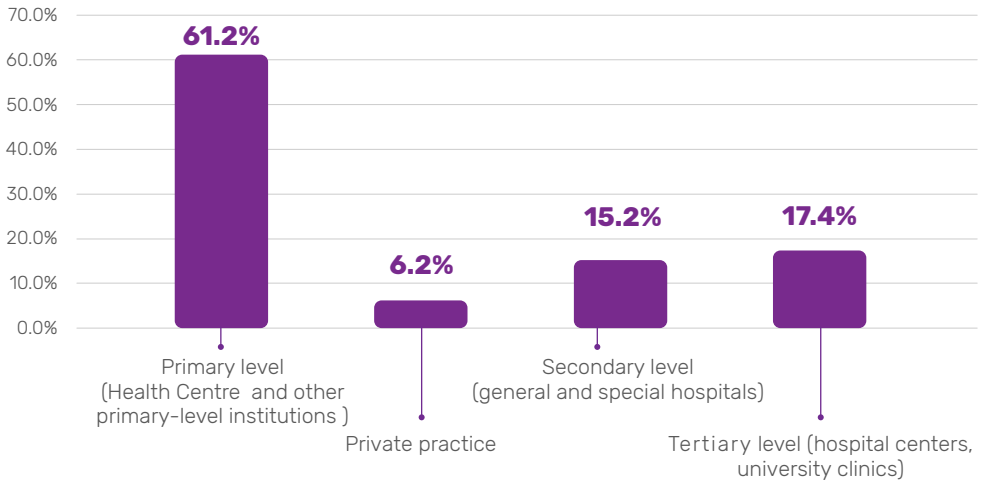
Nearly 30% of healthcare professionals came from the Belgrade region, somewhat fewer (28.5%) from Vojvodina; nearly one in five participants came from Šumadija and West Serbia (20.9%) or South and East Serbia (19.6%), while 19 healthcare professionals (1.1%) stated Kosovo and Metohija[14] as their location (Graph 1).



Graph 1. Geographic distribution of respondents

Research participants' professional profiles

In this research sample, 1032 healthcare professionals or 61.2% were employed in the primary level of healthcare institutions; 15.2% were employed at the secondary and 17.4% at the tertiary level. Private practices employed 6.2% (Graph 2).



Graph 2. Distribution of respondents by healthcare levels

14 All references to Kosovo and Metohija shall be understood in the context of UN Security Council Resolution 1244 (1999).

The sample comprised a total of 61.4% medical doctors (specialists accounted for 38.5%; general practitioners 14.2% and 8.7% were doctors in specialty training), 34.8% medical nurses/technicians, and 3.9% associated professionals. Among the associated professionals, the most common profiles included social workers (18/65 or 27.7%) or psychologists (15/65 or 23.1%), and other profiles (25/65 or 38.5%[15]) (Tables 1 and 2).

Table 1. Professional profiles of all research participants

Professional profile	n	%
Doctors on specialization training	146	8.7
General Practitioner	240	14.2
Specialist Doctor	649	38.5
Medical Nurse/Technician (high school, college or university level)	586	34.8
Associated professional	65	3.9

Table 2. Associated professionals' profiles

Professional profile	n	%
Speech Therapist / Special Education Teacher / Special Pedagogue	3	0.2
Psychologist	15	0.9
Social Worker	18	1.1
Healthcare professional – other	25	1.5
Associate professional in the area of public health	4	0.2

Relative to the whole sample of 1,686 participants, the distribution of employees at the primary healthcare level according to the service of employment shows that the

15 Most probably administrative and technical staff, although it was not detailed; considering they are not in direct contact with patients, they were not the focus of this research.

highest share is employed with the Healthcare Service for Adult Population (518 or 30.7%), followed by the Healthcare Service for Pre-School/School Children with Development/Youth Counselling Centre (115 or 6.8%), Emergency Medicine Service (76 or 4.5%), Patronage Healthcare Service (73 or 4.3%), and Healthcare Service for Women (41 or 2.4%) (Table 3).

Table 3. The structure of healthcare professionals at the primary level of healthcare

Service employing healthcare professionals at the primary healthcare level	n	%
General Practice (Healthcare Service for Adult Population)	518	30.7
Pediatrics (Healthcare Service for Pre-School/School Children with Development/Youth Counselling Centre)	115	6.8
Emergency Medicine Service	76	4.5
Patronage Healthcare Service	73	4.3
Specialist Consultation Service	54	3.2
Gynecology (Healthcare Service for Women)	41	2,4
Occupational Medicine	26	1.5
Home Care and Assistance Service	17	1.0
Dentistry Healthcare Service	21	1.2
Physical Medicine and Rehabilitation Service	4	0.2
Laboratory Diagnostics Service	9	0.5
Service for Legal, Economic and Financial Affairs	2	0.1
Radiology Service (X-ray and Ultrasound Diagnostics Service)	9	0.5
Other	67	4.0

The structure of employees in specialist consultation services (54 or 3.2%) indicates that the highest number of employees (22/54 or 40.7%) were employed with the Department for Mental Healthcare (Table 4).

Table 4. Structure of healthcare professionals by specialist consultation services at the primary healthcare level

Specialist Consultation Services in the Health Centre	N	%
Internal medicine	9	0.5
Department for Mental Healthcare	22	1.3
Ophthalmology	3	0.2
ENT	6	0.4
Social Medicine	4	0.2
Other	10	0.6

Of the participants employed at the secondary or tertiary healthcare level, most worked at the Internal Medicine Department (112 or 6.6%), followed by Surgical Department (66 or 3.9%) and Psychiatric Department (58 or 3.4%); however, the highest percentage chose the option "other" (11.3%) (Table 5).

Table 5. The structure of healthcare professionals by services at the secondary and tertiary healthcare levels

Department/service where respondents were employed at the secondary or tertiary level of healthcare	n	%
Internal medicine	112	6.6
Surgery (general and other)	66	3.9
Psychiatry	58	3.4
Gynecology and obstetrics	40	2.4
Diagnostic services	54	3.2
Pediatrics	22	1.3
Emergency services	8	0.5
Other	190	11.3

PART I – HEALTH PROFESSIONALS' SELF-ASSESSMENT OF THEIR RESPONSE TO GENDER-BASED VIOLENCE

Working conditions

The highest proportion of healthcare professionals (46.9%) provides services for over 30 patients per day in their regular practice, while 41.4% of research participants between 6 and 30 patients (Table 6).

Table 6. The average number of patients seen per day

The average number of patients received by healthcare professionals per day	n	%
Up to 5	77	4.6
6–30	698	41.4
31–40	285	16.9
41–50	250	14.8
51–60	110	6.5
Over 60	146	8.7
I do not work with patients	120	7.1

Even before the COVID-19 pandemic, as many as 30% of healthcare professionals rated the level of demands and workload at their workplace with the highest score of 9 or 10 out of 10. Almost every fourth (23.7%) rated it as 8/10, and a similar proportion (25.9%) rated it as 6 or 7/10. Almost every fifth healthcare professional (19.5%) rated it as 5/10 or below (Table 7).

Table 7. Assessment of the demands and burden at work BEFORE COVID-19

Demands and burdens at work BEFORE COVID-19	n	%
1 (lowest burden)	22	1.3
2	10	0.6

Demands and burdens at work BEFORE COVID-19	n	%
3	34	2.0
4	42	2.5
5	237	14.1
6	144	8.5
7	293	17.4
8	399	23.7
9	241	14.3
10 (highest burden)	264	15.7

Prior education on GBV

When it comes to sources of information about gender-based violence, the largest percentage of health workers (92.4%) cites the media, followed by reading literature (76.5%), as well as work in practice (69.1%). One in four healthcare professionals (26.8%) reported having attended a seminar on GBV, and nearly one in three healthcare professionals (31.9%) learned about GBV during professional meetings or conferences (Table 8).

Less than one-half of healthcare professionals (46.9%) found out about GBV through the experience of people close to them, which also reaffirms the well-known fact that GBV is very common. It is present in the immediate surroundings, and healthcare professionals are witnessing it, whether directly or indirectly.

Table 8. Main sources of information on GBV

Source of information on GBV	n	%
Through the media	1558	92.4
Through the experience of people around me	791	46.9
Reading literature	1289	76.5

Source of information on GBV	n	%
Attending seminars on GBV	452	26.8
At professional conferences, meetings	538	31.9
Through practical work	1165	69.1
During regular schooling (in high school/at university)	745	44.2

These findings are consistent with the responses to the question: "Have you attended a lecture/training/seminar on GBV/domestic violence/intimate partner violence/violence against women so far?", where 60% of research participants denied participation in such events. Nearly one in four healthcare professionals (23.4%), had attended such events at least once, while 16.1% reported having participated twice or more (Table 9).

Table 9. Attended lectures/training/seminars on GBV/domestic violence/intimate partner violence/violence against women

Attended lectures/training/seminars on GBV/domestic violence/intimate partner violence/violence against women	n	%
Yes, once	394	23.4
Yes, several times (2-3 times)	213	12.6
Yes, many times (4 times and over)	59	3.5
No	1020	60.5

Among those that have participated in educational events, over two-thirds of healthcare professionals (67.7%) evaluated their usefulness highly, giving them a score of 7/10 or above, with more than one-third (36.5%) giving them the highest scores, 9 or 10 (243/666, Table 10).

Table 10. Evaluation of the usefulness of education for the participants' practice

Evaluation of the usefulness of GBV education for practice	(N=666)	%
1	11	1.65
2	12	1.8
3	30	4.50
4	24	3.60
5	97	14.56
6	41	6.15
7	88	13.21
8	120	18.01
9	66	9.90
10	177	26.57

Self-assessment of preparedness to respond to GBV

When it comes to the self-assessment of health professionals' preparedness to identify GBV in their everyday work, as high as one in five (20.6%) reported not being prepared, or not being at all prepared for it (score 1 or 2). One in three people (33%) rated their preparedness with 3/5, while the remaining 46.4% self-assessed their preparedness to identify violence with scores of 4 or 5/5 (Table 11).

Table 11. Self-assessment of knowledge and preparedness to identify GBV in everyday work

Self-assessment of knowledge and preparedness to identify GBV in everyday work	n	%
1 (I don't know how to identify GBV)	119	7.1
2	228	13.5
3	556	33.0

Self-assessment of knowledge and preparedness to identify GBV in everyday work	n	%
4	459	27.2
5 (I know how to identify GBV)	324	19.2

Self-assessment of the personal level of knowledge on adequate action in case of GBV was even lower: 29% rated their knowledge as low as 1 or 2/5; 30.1% chose the score 3/5, while the remaining 41% opted for scores 4 or 5/5 (Table 12).

Table 12. Self-assessment of preparedness to act in case of GBV

Self-assessment of preparedness to act in case of GBV	n	%
1 (I do not know how to act adequately)	192	11.4
2	297	17.6
3	507	30.1
4	389	23.1
5 (I know how to act adequately)	301	17.9

When it comes to the level of priority given to GBV in everyday work, nearly one in four healthcare professionals (24.6%) reported this as the highest possible level of priority (10/10), which together with the priority level 9/10, accounts for 35.7% of healthcare professionals highly prioritizing this issue (Table 13). However, it is a matter of concern that an identical share of healthcare professionals (35.7%) assigns a low level of priority to GBV in their work (scores 1 to 5/10), although these findings should be interpreted according to the workplace and service where these healthcare professionals work (if they are in direct contact with patients or not. However, considering how frequent this phenomenon is, it is quite certain that at least some of the female patients could be expected to be exposed to acute or chronic violence.

Table 13. Assessment of the level of priority of GBV in the health professionals' work

Assessment of the level of priority of GBV in the health professionals' work	n	%
1 (least possible level of priority)	73	4.3
2	56	3.3
3	99	5.9
4	86	5.1
5	288	17.1
6	102	6.0
7	173	10.3
8	207	12.3
9	187	11.1
10 (highest possible level of priority)	415	24.6

Impact of COVID-19 on GBV

The global pandemic of COVID-19 presented an enormous challenge for all humanity and all structures in society to face. The greatest professional burden was borne by health workers, who were "on the front line" in the fight against this vicious disease. In this research, 59.3% of healthcare workers assessed the level of demands and workload at the workplace during the COVID-19 pandemic with the highest scores (nine or ten). It was almost a double increase compared to their workload in regular working conditions (30%). Merely 11.7% indicated a workload of 1 to 5/10, which is a lower proportion than under regular conditions (Table 14).

Table 14. Assessment of the demands and burden at work DURING COVID-19

Assessment of the demands and burden at work DURING COVID-19	n	%
1 (lowest burden)	16	9.0
2	18	1.1
3	25	1.5
4	22	1.3
5	116	6.9
6	81	4.8
7	145	8.6
8	264	15.7
9	350	20.8
10 (highest burden)	649	38.5

Somewhat over one-third of respondents said they did not work in COVID clinics, i.e. inpatient institutions treating exclusively COVID-19 patients, while one in four respondents said that they worked under these conditions many times or almost all the time (Table 15).

Table 15. Work in COVID clinics or departments treating exclusively COVID-19 patients

Work in COVID clinics or departments treating exclusively COVID-19 patients	n	%
Yes, once	90	5.3
Yes, many times/almost all the time	425	25.2
Yes, several times/more than once	550	32.6
No	621	36.8

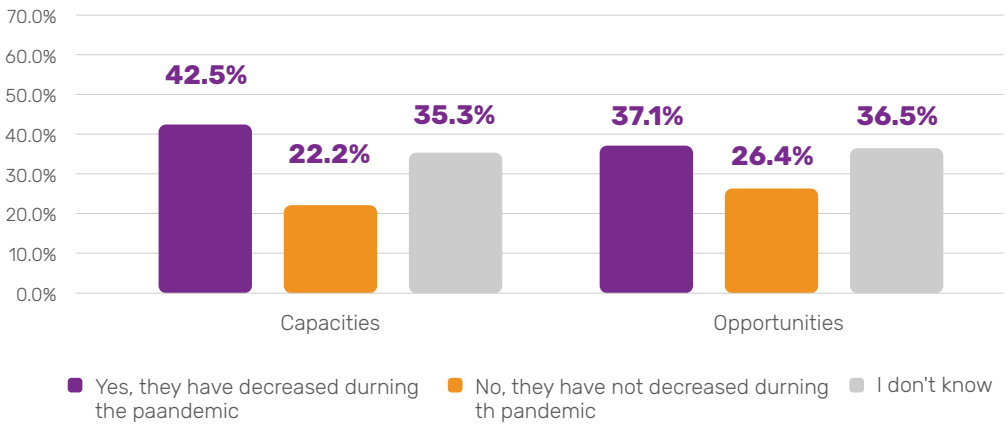
When asked about the impact of the COVID-19 epidemic on the frequency and intensity of gender-based violence in society in general, the largest proportion of health

workers (44.4%) estimated that violence increased during the epidemic, while more than one in five (22.8%) believed it remained the same. Almost every third respondent chose "I do not know" (31.8%), while the smallest proportion of respondents believed that violence decreased during the epidemic (1.0%) (Table 16).

Table 16. Assessment of the impact of the COVID-19 epidemic on the frequency and intensity of gender-based violence in society in general

Impact of COVID-19 on the frequency and intensity of GBV in society in general	n	%
Violence is the same as before COVID-19	385	22.8
Violence increased during COVID-19	748	44.4
Violence decreased during COVID-19	17	1.0
I don't know	536	31.8

When asked about the capacities[16] and opportunities[17] of healthcare workers to recognize and respond to gender-based violence, most stated that both capacities and opportunities were lower during the COVID-19 epidemic (Graph 3).



Graph 3. Attitudes of healthcare professionals about the capacities and possibilities to recognize and respond to GBV during the COVID-19 epidemic

16 Capacity – workplace conditions during COVID-19 to address and pay attention to violence

17 Opportunity – everything at their disposal as additional assistance and support in the response to GBV

Attitudes towards GBV screening

When it comes to the personal level of comfort in talking with patients about their exposure to gender-based violence, 27.2% of respondents indicated that they did not feel comfortable or prepared to talk about it (score 1-2/5), together with 33.6% of healthcare professionals who opted for the neutral mark of "3", make up 60.8% of healthcare professionals who feel uncomfortable regarding this issue (Table 17).

Table 17. The personal level of comfort to discuss exposure to gender-based violence with a patient

The personal level of comfort to discuss exposure to gender-based violence with a patient	n	%
1 (I am not at all prepared)	203	12.0
2	257	15.2
3	566	33.6
4	345	20.5
5 (I am fully prepared)	315	18.7

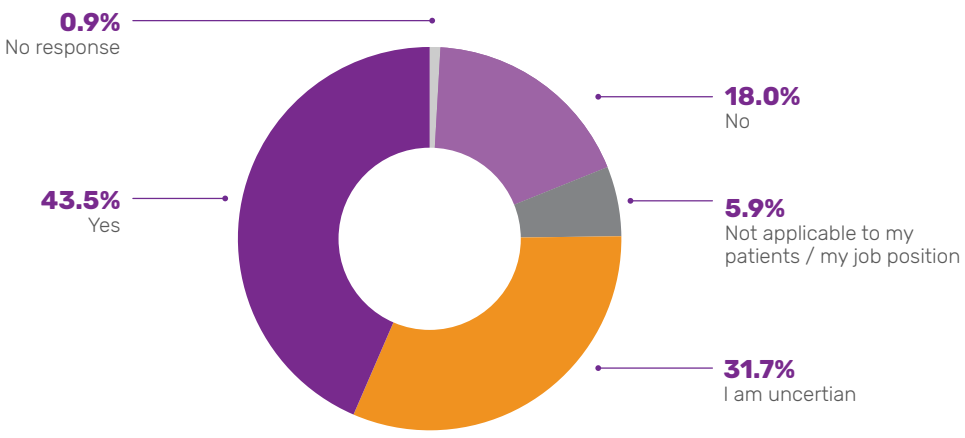
When it comes to the healthcare professionals' attitudes on various aspects of exposure to GBV, it is important to emphasize that the highest percentage (47.9%) agrees that it is useful to ask every female patient about their exposure to violence (grades 4-5/5). On the other hand, a smaller percentage (36.6%) believes that it is not feasible to ask every patient about it (grades 1-2/5). When we talk about how feasible it would be to ask every patient about their exposure to violence (screening), the opinions are also divided: 42.8% do not agree with the statement that this would be feasible under current working conditions (grades 1-2/5), while 29% of respondents believe the opposite (grades 4-5/5) (Table 18).

Table 18. Attitudes about different aspects of communication about exposure to GBV

	1 (I fully disagree)	2	3	4	5 (I fully agree)
It is useful to ask every female patient about her exposure to violence (screening)	8.7%	15.4%	27.9%	15.2%	32.7%
It is feasible to ask every female patient about her exposure to violence	14.8%	21.8%	31.0%	14.9%	17.6%
The working conditions in our settings allow us to ask every female patient about her exposure to violence	20.9%	21.9%	28.2%	12.7%	16.3%

Familiarity with protocols and best practice principles

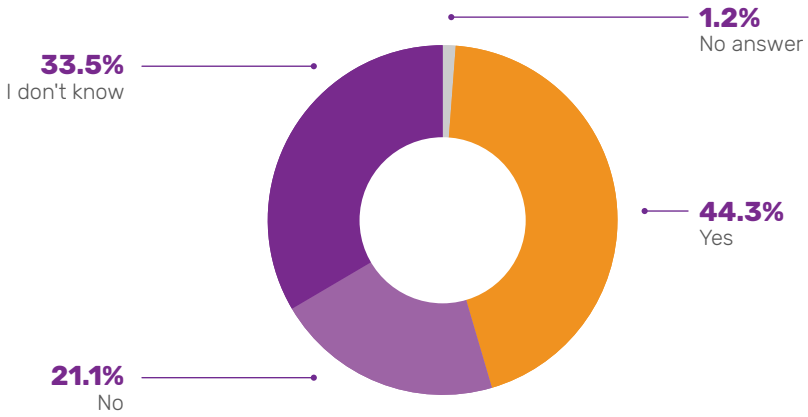
The following part will present the results of the research related to practices, i.e. identification and response of healthcare professionals to GBV. When asked whether there are protocols in clinical practice, i.e. written instructions for dealing with adults who are victims of gender-based violence, 43.5% of respondents answered in the affirmative, while close to one-fifth of respondents (18%) stated that they did not exist (Graph 4).



Graph 4. Existence of protocols (i.e. written instructions) for the treatment of adult GBV survivors

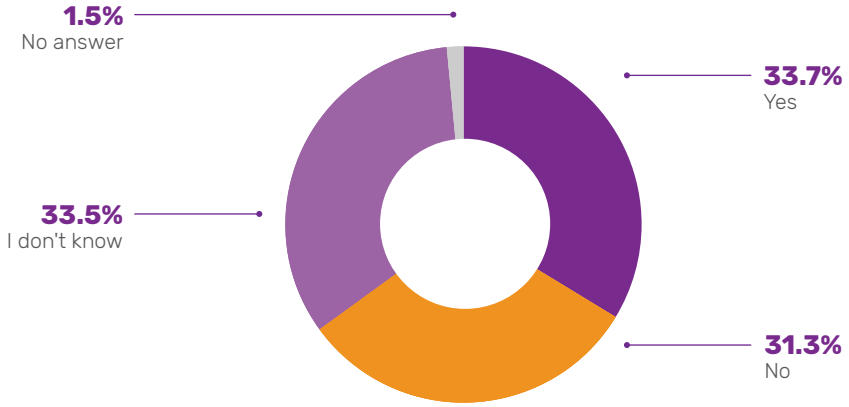
A very similar pattern of frequency distribution is also observed in relation to the question: "Does your institution keep internal records of cases of gender-based vi-

olence (independent of the electronic record)?", where 44.3% of respondents stated that records were kept, and 21 % did not keep the records. What is a matter of concern is the fact that one-third of respondents (33.5%) did not know if internal records on GBV cases were kept or not (Graph 5).

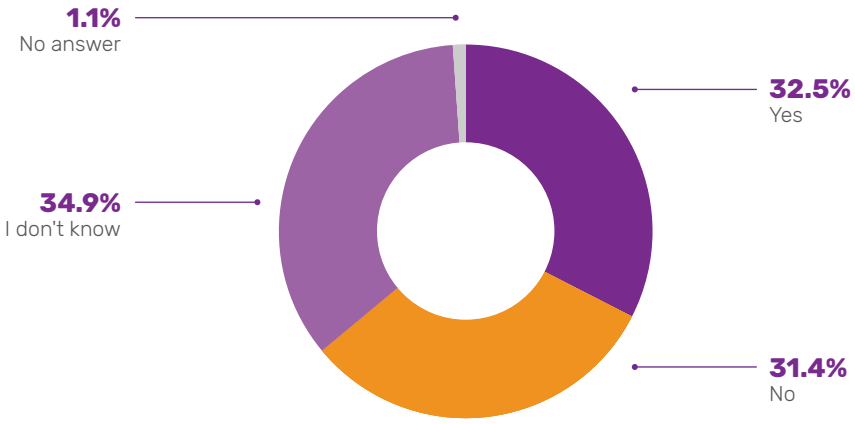


Graph 5. Keeping internal records on reports of suspected gender-based violence (independent of the electronic health record)

One-third of respondents (33.7%) reported that there was a Team for the Protection of Women Exposed to Violence in their institutions, while almost the same proportion (33.5%) did not know if there was one, or explicitly denied it (31.3%) (Graph 6). When it comes to the Team for the Protection of children exposed to violence, almost the same pattern was observed (Graph 7).



Graph 6. Existence of the Team for the Protection of Women Exposed to Violence in the respondents' institution



Graph 7. Existence of the Team for the Protection of Children Exposed to Violence in the respondents' institution

When asked about knowledge of the principles of best practice and procedures related to responding to gender-based violence, 38.4% of health workers stated that they did not know the principles and procedures, while slightly more than a third (34.6%) stated that they were familiar with best practice principles and response procedure (Table 19).

Table 19. Knowledge of the best practice principles and procedures related to responding to gender-based violence

Knowledge of the best practice principles and procedures related to responding to gender-based violence	n	%
1 (I am not familiar with the best practice principles at all)	419	24.9
2	227	13.5
3	426	25.3
4	282	16.7
5 (I am completely familiar with the best practice principles)	302	17.9
No answer	30	1.8

Among the respondents who work in primary health care, the largest percentage (48.5%) stated that they knew that a particular service called "Care for a person exposed to violence" existed for coding in the Rulebook on the nomenclature of health services on the primary level of health care. Somewhat fewer (41.9%) did

not know if such a service existed for coding, and 9.6% stated that it did not exist (Table 20). On the other hand, among health professionals who are employed at the secondary or tertiary level of health care and deal with coding i.e. entering patients' disease/health status codes as a part of their work, 36.1% knew that code related to violence or abuse existed in the International Classification of Diseases (ICD), while 63.9% did not.

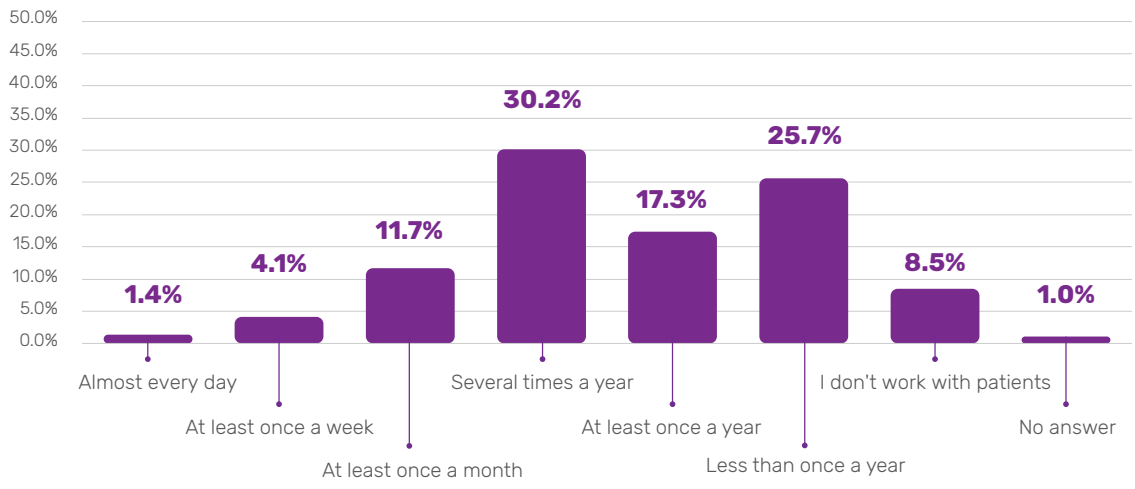
Table 20. Awareness of the existence of the "Care for a person exposed to violence" service among health workers employed in primary health care

Awareness of the existence of the "Care for a person exposed to violence" service	n	%
Yes, it exists	536	48.5
I don't know	463	41.9
It doesn't exist	106	9.6

PART II: PRACTICES – IDENTIFYING AND RESPONDING TO GBV

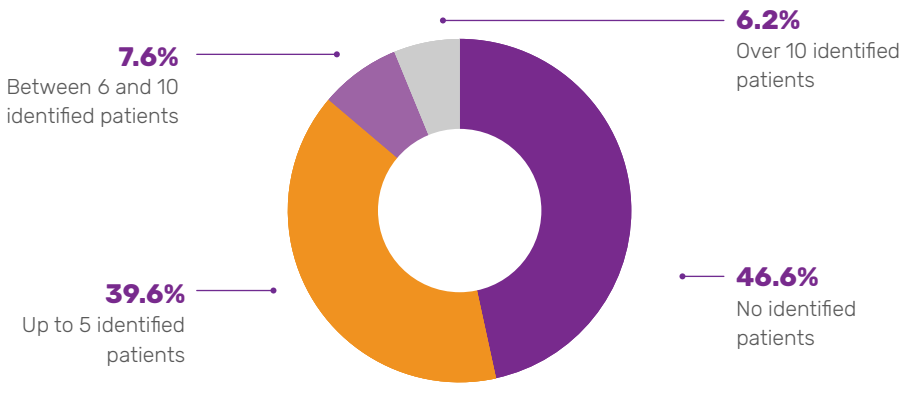
Frequency of identifying gender-based violence in practice

The highest percentage of healthcare professionals (30.2%) are in a situation to identify GBV several times per year, 17.3% at least once a year, while one-quarter of respondents, 25.7%, are in a situation to identify GBV less than once during the year (Graph 8).



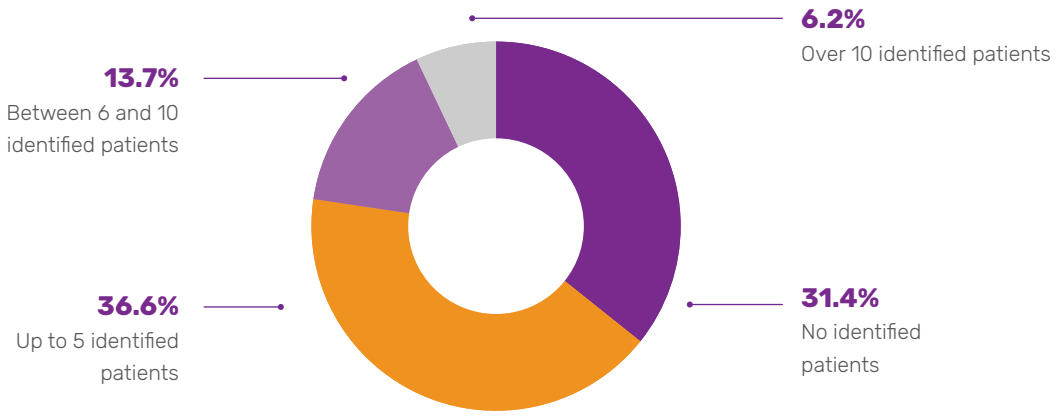
Graph 8. Frequency of identifying GBV in practice

During the previous year (2021), among healthcare professionals who work with patients, 39.6% identified up to five patients who had been exposed to gender-based violence, 7.6% identified between 6 and 10 patients, while 6.2% were in a situation to identify more than 10 patients exposed to GBV (Graph 9).



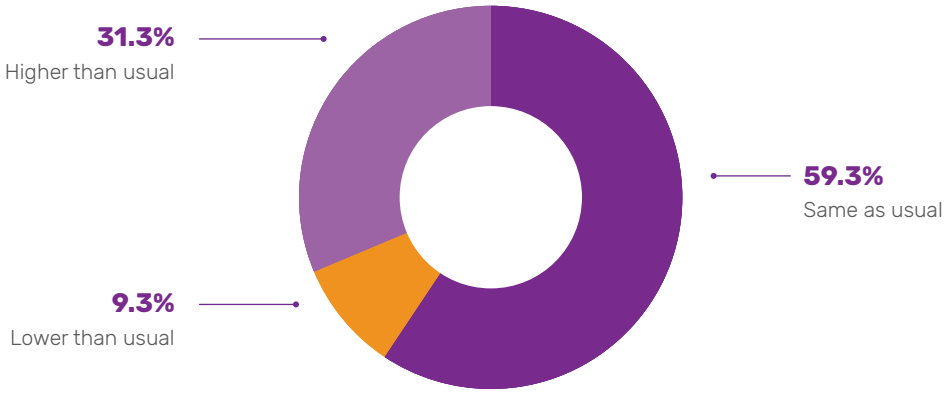
Graph 9. Frequency of identifying patients exposed to GBV during the previous year (2021)

During the last 5 years, 36.6% of respondents identified up to 5 patients exposed to GBV; 13.7% identified between 6 and 10 patients, while 18.3% were in a situation to identify over 10 patients exposed to GBV (Graph 10).



Graph 10. Frequency of identifying patients exposed to GBV during the last five years

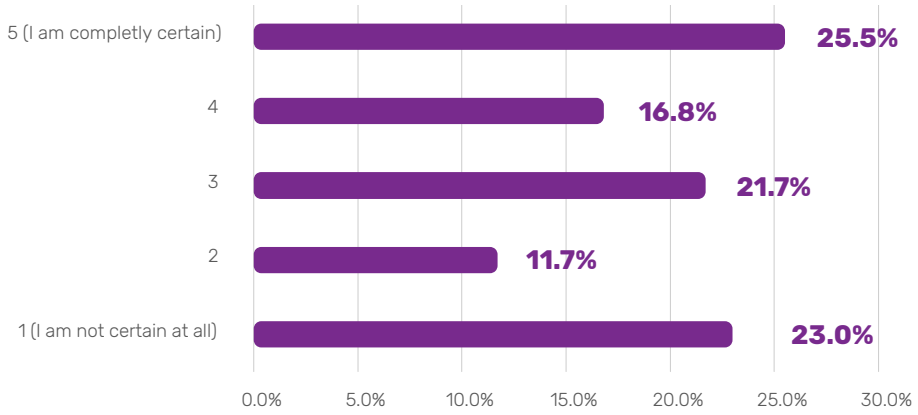
Comparing the period before and during COVID-19, healthcare professionals who work with patients assessed whether the number of identified female patients with experience of violence was the same, lower or higher than usual. The majority of respondents (59.3%) believed that the number of female patients has not changed significantly during the COVID-19 epidemic compared to the period prior to it, while 31.3% believed that this number was higher than usual. Only 9.3% estimated that the number of patients exposed to GBV was lower during the epidemic compared to before (Graph 11).



Graph 11. Healthcare professionals' assessment of the number of patients exposed to GBV during the COVID-19 epidemic compared to before the pandemic

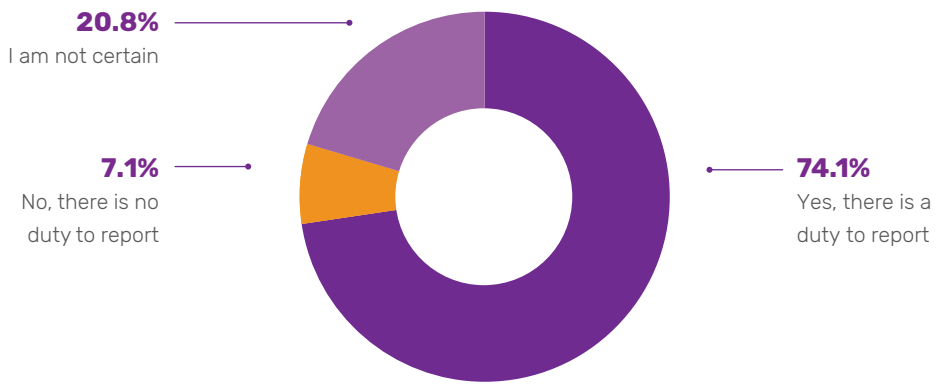
The self-assessment of the healthcare professionals' knowledge and certainty of how and to whom they should report identified GBV cases is presented in Graph 12. It can be observed that 34.7% were not certain (or not at all certain) that they knew it

(score 1-2 out of 5), while 42.3% of respondents stated being certain about the procedure for reporting suspected violence (score 4-5 out of 5) (Graph 12).



Graph 12. Self-assessment of the knowledge and certainty of how and to whom health professionals should report suspected GBV cases

When asked whether it was mandatory to report GBV cases identified by healthcare professionals in adult patients, 74.1% answered by confirming it, 5.1% negated, and as many as 20.8% were not certain (Graph 13).



Graph 13. Duty of healthcare professionals working with patients to report GBV cases identified among adults

Best practices

Best practices in the process of identification and response to GBV in clinical work with patients include several points presented in Table 21. In this research, healthcare professionals reported on how often (never, sometimes, often) they had the opportunity to apply them in their work. It is important to note that not all of the listed items are relevant for all profiles of healthcare professionals. In cases where the listed item was not applicable, healthcare professionals selected the answer "not applicable in my practice", while some healthcare workers simply skipped such questions (column "No answer").

Establishing communication about GBV (Table 21, Rows a, b, c). Somewhat over one-third of healthcare professionals (35.1%) had never initiated a conversation on GBV with their patients without a particular reason, while 47.7% of respondents had done it sometimes or often. However, when it comes to suspected violence, the results are different: if there is suspicion of exposure to violence (72.2% confirmed suspecting violence sometimes or often), the majority of healthcare professionals (a total of 66.3%) started a conversation about it. This reaction (starting a conversation) in more than 90%[18] of the cases of suspected violence is also consistent with the findings from the qualitative research, which indicated the practice of priority in addressing GBV cases.

Verbal feedback on a patient's experience with violence (Table 21, Rows d, e, f, h, l). In most cases, over 80%, of healthcare professionals verbally condemned any form of violence (among whom 59.4% did so "often") and expressed understanding and support to the violence survivor (among whom 65% did so "often"). A somewhat lower share (69%) spoke to the victim about her safety (among whom 38.5% "often"). Somewhat over one-half of healthcare professionals (53.9%) provided instructions on the sources of support for the victims of violence (among whom, one in four healthcare professionals, or 26%, did so often, but also almost one in four or 24.4%, never did). This result is also consistent with the findings in the qualitative research and indicates that there are no resources in the community and/or they are not functional, or that the sectors are not interlinked adequately. Contacting the competent services (police, CSW, women's shelter) was mentioned somewhat less frequently (by 46.1%, out of which as many as 25.6% of respondents did so "often"). This frequency is similar when it comes to the provision of information on sources of support, which confirms, again, that multi-sectoral cooperation existed in as few as one in four cases). Nearly 30% of healthcare professionals (29%) have never contacted competent services.

18 66.3% / 72.2% = 91.8

Registering experiences with violence (Table 21, Rows g, i, j, k). Despite recognizing and providing verbal feedback on the experienced violence in over 80% of the cases, only one in three healthcare professionals (33.1%) recorded the service "Attending to a person exposed to violence" as provided sometimes or often, while 39.1% had never done it. A somewhat higher percentage of healthcare professionals (42.3%) reaffirmed that they sometimes or often entered the medical finding (including patients' statements on survived violence) in the patients' medical records, while at least one in four healthcare professionals (27.2%) had never done it.

Documenting injuries on the body map was performed "sometimes" or "often" by one-third of healthcare professionals (33.5%), while almost the same number (34.8%) had never done it. Photographing injuries was the healthcare professionals' most infrequently used practice: this was done sometimes or often by 10.4% of the respondents, while 34.8% had never done it.

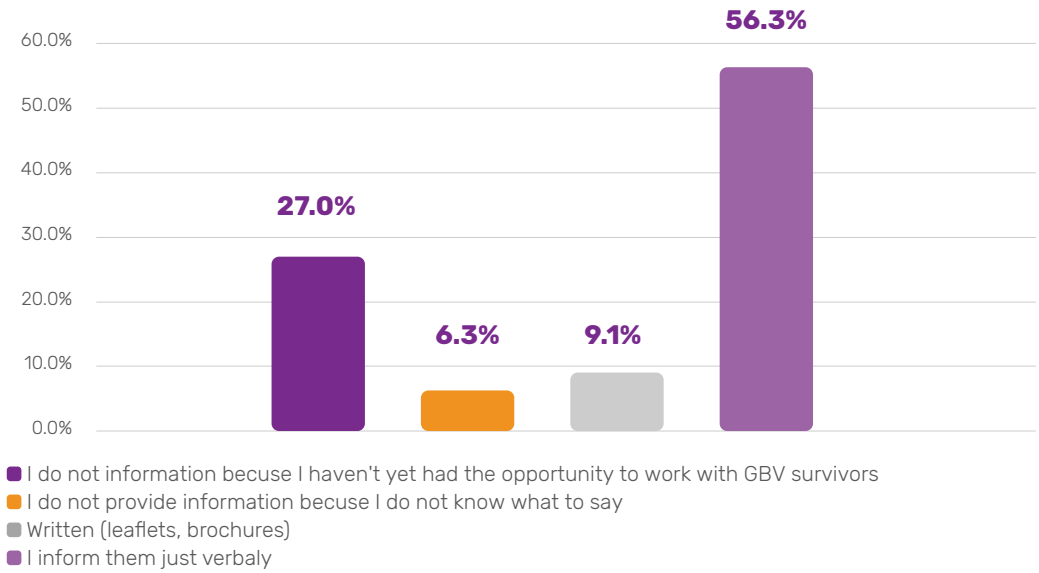
Table 21. Frequency of certain GBV-related practices among healthcare professionals

In your practice, how often have you…	NEVER (%)	SOMETIMES (%)	OFTEN (%)	N/A (not applicable to my practice (%)	No answer (%)
a. Initiated a conversation about gender-based violence with patients, without any special cause?	35.1	41.2	6.5	16.5	0.7
b. Suspected that a patient was exposed to gender-based violence, even if she said nothing?	13.7	60.6	11.6	13.3	0.9
c. In case of suspicion of violence, have you asked the patient about it, in an adequate way?	16.5	36.9	29.4	16.1	1.2
d. Verbally condemned any form of violence?	7.3	20.8	59.4	11.4	1.1

In your practice, how often have you…	NEVER (%)	SOMETIMES (%)	OFTEN (%)	N/A (not applicable to my practice (%)	No answer (%)
e. Expressed understanding and support to a victim of violence?	4.6	15.8	65.0	13.2	1.4
f. Spoken to a victim about her safety?	13.0	30.5	38.5	16.8	1.2
g. Recorded the provided service "Attending to a person exposed to violence" within the health information system?	39.1	18.7	14.4	26.4	1.5
h. Provided instructions and information on the sources of support available to the victims of violence?	24.4	27.9	26.0	20.4	1.2
i. Entered the patient's statement of survived violence in her medical records?	27.2	17.9	24.4	29.3	1.2
j. Used the body map to document the patient's injuries?	34.8	14.8	18.7	30.4	1.3
k. Photographed the patient's injuries?	57.8	6.8	3.6	30.2	1.6
l. Contacted relevant services (police, center for social work, women's shelter)?	29.0	20.5	25.6	23.4	1.4

Availability of printed material on GBV

A description of the availability and use of printed material on GBV will be given below. Healthcare professionals (56.3% of respondents) most often inform patients exposed to GBV about additional sources of support only verbally (Graph 14).



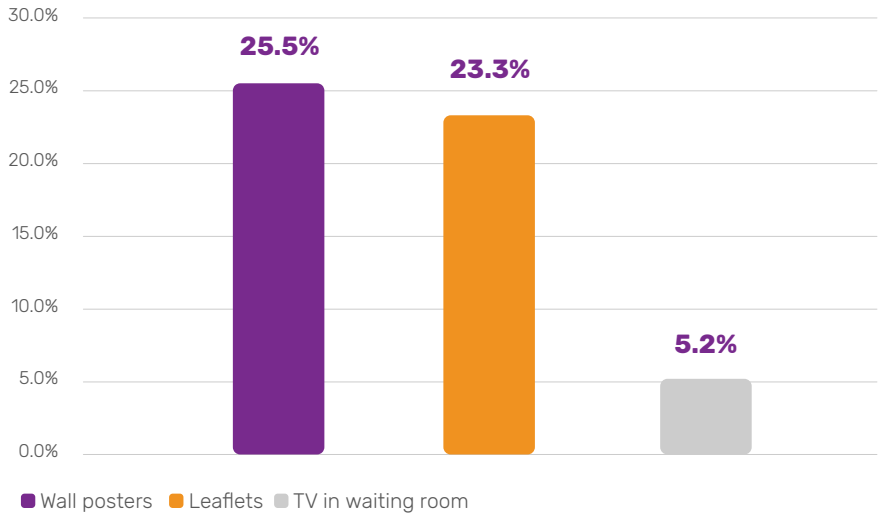
Graph 14. Predominant way in which healthcare professionals inform patients exposed to GBV about additional sources of support

Over one-half of healthcare professionals (52.8%) reported that there were no written information materials in their institution regarding GBV, while 30.4% of institutions had such materials, more often in waiting rooms (25.9%) than in doctors' offices (18.1%) (Table 22).

Table 22. Availability of informative materials on GBV in health institutions

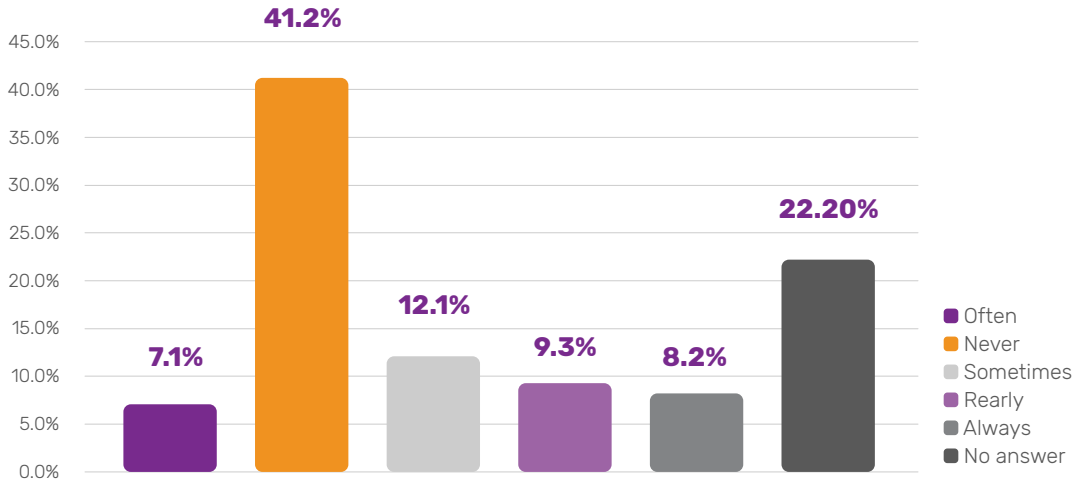
Are there information materials on GBV in the respondent's institution?	n	%
Yes, there are…	513	30.4
in the waiting room	436	25.9
in the doctor's office	306	18.1
No, there are not	891	52.8
Not applicable to my workplace	258	15.3

In the institutions where there are informational materials related to GBV, they are most often in the form of wall posters (25.5%), leaflets (23.3%), and contents displayed on the TV in the waiting room (5.2%) (Chart 15).



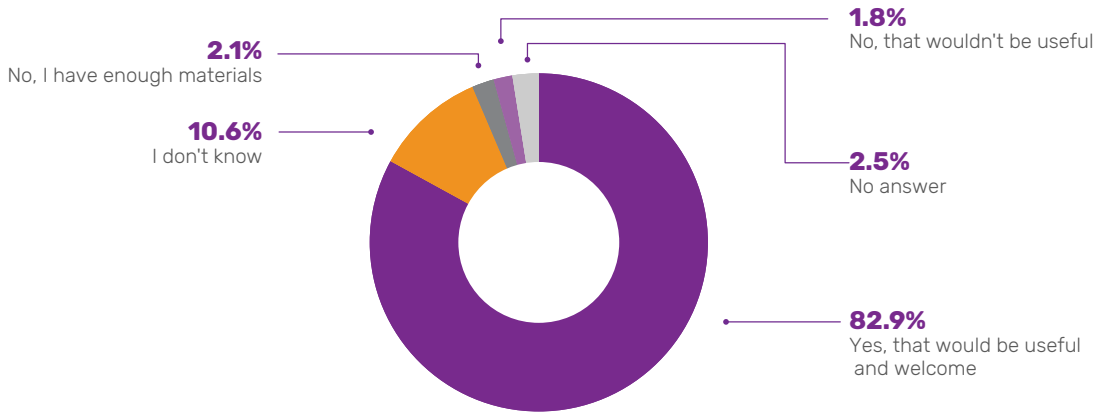
Graph 15. Most common types of information materials on GBV that can be found in health institutions (waiting rooms and doctor's offices)

Even when there are promotional materials on GBV in health institutions, and when healthcare professionals have these materials, a large percentage of them have never handed these materials to female patients (41.2%) (Graph 16).



Graph 16. The frequency of giving printed promotional material on GBV (brochures, leaflets) to patients

When asked whether health professionals should have more printed informational material with GBV-related content (leaflets, brochures, posters and similar), as many as 82.9% answered it would be useful and welcome (Graph 17).



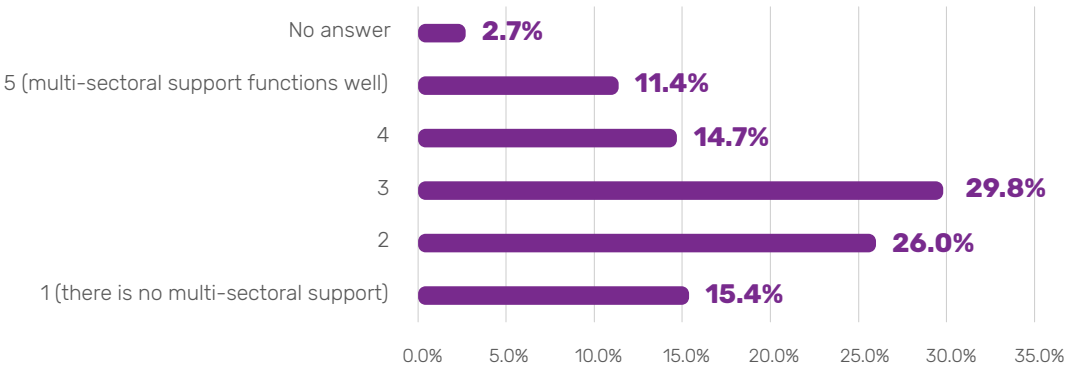
Graph 17. Healthcare professionals' assessment of whether they need more printed material on GBV

Research participants had the opportunity to write their comments regarding the availability and relevance of printed informational material on GBV. Their comments often went beyond the above-mentioned topic and included the expressions of various opinions, views, experiences and practices regarding the phenomenon of violence in general, in the family, society, and workplace. Although they already had the opportunity (in the previous, closed-ended question) to say whether they would like to have more written information on GBV, some of them additionally pointed it out, stating that such materials would be very useful to them. There were also some comments that some women were afraid to keep such material and bring it home. Also, it was mentioned that healthcare professionals who were going to households and working with the family usually did not have enough privacy and opportunity to have a moment alone with the woman and give her the leaflets. They did not feel safe enough to address this topic as it was too delicate and personal. There was an interesting comment made by a healthcare professional, who stated that it would be practical to have all the information together, online, on the computer or the Internet, and print it out and hand it out to women when needed:

> *"Honestly, I'd rather have a web page to access and record violence, with complete guidelines and brochures that I can print out as needed and hand out to violence victims than have a pile of papers anywhere, which would only take up space, and end up somewhere or even be thrown out because they're just sitting there and taking up space."*

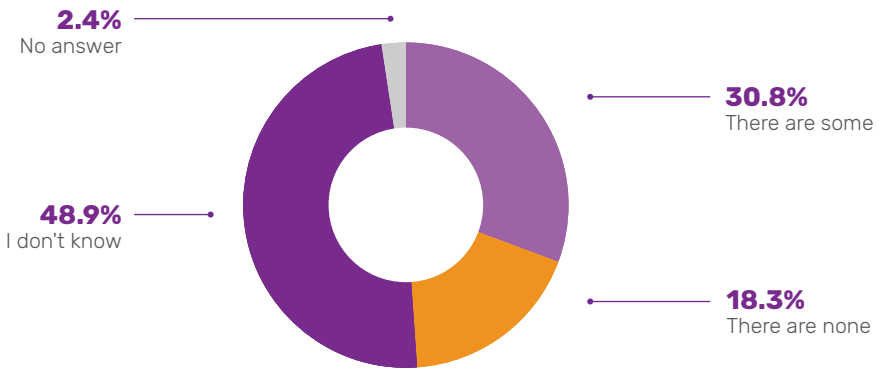
Cooperation with other sectors and community organizations

Cooperation with other sectors and community organizations is of crucial importance for addressing the issue of GBV efficiently, both in the short and long term. Healthcare professionals were asked to assess to which extent there was multi-sectoral cooperation and what is the quality of it the provision of adequate and comprehensive support to women experiencing GBV. On a scale from 1 (there is no multi-sectoral co-operation) to 5 (multi-sectoral co-operation functions well), one in four healthcare professionals (26.1%) gave this cooperation a grade of 4 or 5, while 41.4% scored it low (scores 1 or 2) (Graph 18).



Graph 18. Assessment of the existence and functionality of multisectoral collaboration in the community regarding the protection of GBV survivors

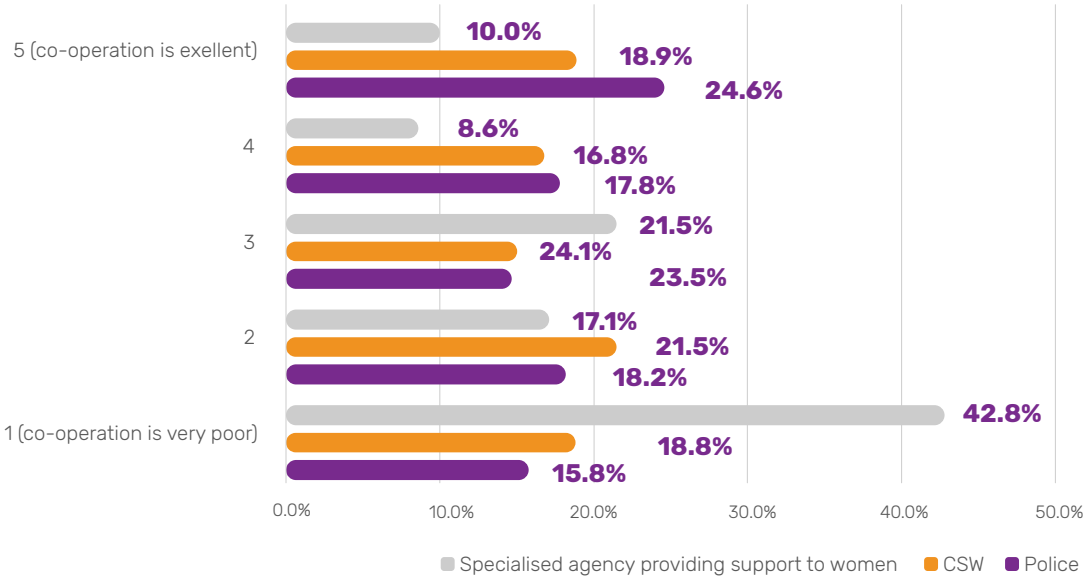
When it comes to specialized organizations for help and support in case of violence to which the healthcare professionals could refer their patients, as many as two-thirds (67.2%) were unaware of them, either stating that there were none in their settings (18.3%), or they did not know about them (48.9%) (Graph 19).



Graph 19. Existence of specialized organizations for assistance and support in violent cases to which healthcare professionals could refer their patients

The respondents also had the opportunity to evaluate their cooperation with other sectors relevant to GBV, on a scale of 1 (poor) to 5 (excellent) (Graph 20).

When it comes to cooperation with the police, 34% of healthcare professionals reported this cooperation being poor or very poor (score 1-2/5), while almost one-quarter mentioned excellent (24.6%) or medium (23.5%) quality of cooperation with the police. A very similar pattern can be perceived in the cooperation with the CSW, where poor cooperation was mentioned by as many as 40.3% of healthcare professionals; medium level of cooperation by 24.1% and excellent or very good by 35.7% (Graph 20). The situation is somewhat different when it comes to cooperation with specialized agencies providing support to women: the highest share, as many as 42.8%, reported that there was practically no cooperation, while 18.6% assessed it as good or excellent (rates 4 and 5). When taking into account that 30.8% of respondents (Graph 18) confirmed that such organizations existed in their settings, this percentage of 18.6% actually makes a valid percentage of 61% (Graph 20).



Graph 20. Cooperation with other sectors (police, CSW and special agencies providing support to women)

Support for the GBV response within the health institution

Healthcare professionals had the opportunity to answer the questions related to support for GBV response within their own healthcare institutions (Table 23). Nearly 40% of healthcare professionals (39.3%) agreed that the management of their healthcare institution paid attention to the issue of GBV, and directly or indirectly supported various activities related to that, while 36.3% felt the opposite. However, more than

one-half, or as many as 55.9% of healthcare professionals, reported that the issue of GBV was not discussed at regular meetings and professional collegial meetings within the institution. 37.2% of healthcare workers do not even discuss this topic informally, while a slightly higher percentage (38.1%) stated the opposite. One in three healthcare professionals (35.4%) do not know about or cannot reach colleagues they can turn to regard GBV, while it is encouraging that a larger number of them (43.2%) do know and can reach their colleagues who have knowledge about GBV, so they can turn to them for advice or help (Table 23).

Table 23. Support to GBV response within their own healthcare institution

	1 (I fully disagree)	2	3	4	5 (I fully agree)
The management of my healthcare institution pays attention to the issue of GBV and directly or indirectly supports various activities related to it	20.3	16.0	24.4	13.8	25.5
We discuss at regular/professional collegial meetings how to address GBV cases	36.6	19.3	19.2	9.4	15.5
In informal contacts with colleagues, I exchange opinions and good practices regarding responding to gender-based violence	18.8	18.4	24.7	16.9	21.2
I know of and I can reach colleagues who know more about GBV than I do, and whom I can turn to for help if I have any dilemmas	21.0	14.4	21.3	13.5	29.7

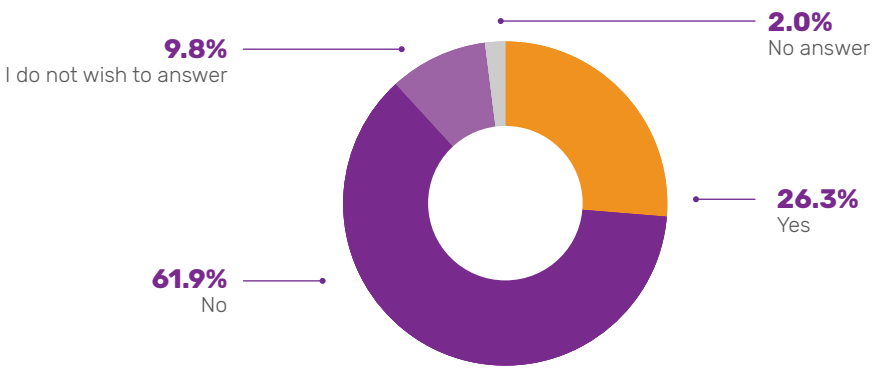
The importance and the role of organizational and collegial support to identify and respond to GBV in daily practice were assessed by healthcare professionals using a scale of 1 (not at all important) to 5 (very important). What needs to be emphasized is the considerable share of respondents who feel that support is important at all levels in identifying and responding to GBV (72% feel that support from colleagues is important, 74.7% feel that support from an immediate supervisor is important and 74.9% feel that support from the management of the health institution is important) (Table 24).

Table 24. The importance and the role of organizational and collegial support to identify and respond to GBV in everyday practice

	1 (not important at all) %	2 %	3 %	4 %	5 (very important) %
Availability of colleagues who have more experience and knowledge in this area	4.7	7.7	15.6	12.5	59.5
Support of immediate supervisor (chief, head)	4.4	6.5	14.3	12.7	62.0
Support of the health institution management	5.3	6.8	13.1	12.6	62.3

Personal experience with violence

In addition to attitudes and practices in the domain of identification and response to GBV, healthcare professionals had the opportunity to answer questions related to their personal experience with violence. As many as one in four, or 26.3%, reported that they had also been exposed to GBV at some point(s) during their lifetime, while 9.8% did not want to answer this question (Graph 21). When looking at the distribution of answers to this question in relation to gender, it is observed that almost twice as many women (28.4%) compared to men (15.7%) confirmed exposure to violence (relative to the total number of women, or a total number of men), and this difference is statistically highly significant ($p<0.001$) (Table 25). Therefore, at least one in four female healthcare professionals reported they had been exposed to GBV.



Graph 21. Have you ever been exposed to GBV yourself, whomever the perpetrator?

Table 25. Exposure to GBV by gender

	Men N (%)	Women N (%)	Total N (%)
Yes	45 (15.7)	398 (28.4)	443 (26.3)
No	204 (71.3)	839 (59.9)	1043 (61.9)
I do not want to answer	27 (9.4)	139 (9.9)	166 (9.8)
No answer	10 (3.5)	24 (1.7)	34 (2.0)
Total	286 (100)	1400 (100)	1686

p<0,001

Among those who confirmed that they were exposed to gender-based violence, they most often stated that the violence occurred in their private life (17.3%); slightly fewer that it occurred at the workplace (16.9%), and every tenth respondent stated that it occurred in a public place (10.9%) (Graph 22). In all mentioned places, female healthcare professionals were statistically significantly more often exposed to violence than male healthcare professionals.

Graph 22. Settings in which healthcare professionals were exposed to GBV

FINAL COMMENTS PROVIDED BY RESEARCH PARTICIPANTS

At the end of the online questionnaire, the research participants had the opportunity to provide their comments on the research topic, and 7.2% (n=122) did so. The comments they left were very diverse and related to their experiences, opinions, and attitudes regarding violence in general and gender equality in all settings, not only the family but also the workplace and the community. A number of comments included praises for conducting research on this topic, while fewer indicated an essential lack of understanding for this phenomenon and the fact that although both sexes could be exposed to violence, violence against women and men differed considerably by its roots and intensity, frequency and effects.

A qualitative analysis of the content of these comments indicates several prevailing topics, namely: (1) gender (in)equality and gender-based insults, belittling and sexual harassment, especially within the healthcare institution, among employees; (2) lack of personal security in contact with aggressive patients; (3) lack of security regarding responding to violence as part of professional responsibilities; (4) the need for continuous education in this area; and (5) the importance of multisectoral cooperation.

Understanding (grasping) gender (in)equality

Although examining healthcare professionals' attitudes toward GBV was not the focus of this research, but rather their experiences, practices and challenges in the response to GBV as part of their professional responsibilities, the analysis of the comments indicated that a certain number of healthcare professionals still an essential lack of understanding of the phenomenon and the interpretation of gender equality.

Lack of understanding was more often displayed by male healthcare professionals, which was also reported during the interviews. This indicates that the work on attitudes must be an indispensable part of all future education delivered in this area, given that attitudes form the basis for an adequate response to violence.

Gender-based violence within healthcare institutions

Some participants' comments indicated that gender inequality and gender-based humiliation, denigration, harassment and misogyny were very well present in healthcare institutions, the place where patients expect help, care and comfort for a broad spectrum of health issues they might have. At the same time, healthcare professionals who should provide them with this are also themselves either the victims or

the perpetrators of various forms of GBV, whether by their colleagues and/or chiefs/directors. Mobbing and sexual harassment within surgical departments were particularly singled out, which is detailed in the following comment:

> *"Every day, sexist comments by colleagues, denigrating comments, jokes, name-calling, inappropriate sexual comments about women in general, mobbing directed exclusively at women, longer volunteering periods if you are a woman, longer waiting times for permanent employment contracts, sexual offers by chiefs in exchange for a permanent employment contract. It is about the surgical department and the treatment of the female colleagues from the anesthesiology department, who are the majority working in these positions, including the treatment of nurses. This happens EVERY DAY."*
>
> Female, specialist doctor,
> 40 years old, tertiary healthcare level

Healthcare professionals reported that their female colleagues themselves were also sometimes suffering violence and that the abusers were persons of high social reputation, which makes them even more untouchable in response:

> *"The patients are not the only victims of violence, but also colleagues exposed to psychological torture, and possibly even physical violence every day. The saddest thing is that the perpetrators of such violence are persons renowned and respected in their professions, and more broadly, even in the public sphere."*
>
> Female, Specialist in training,
> 34 years old, private practice

The following comment speaks about the frequency of such experiences and the lack of protection for women:

> *"I think that every woman in Serbia has been privately or professionally exposed to psychological or physical (violence) at least once in their lives, mobbing at work, but could not turn to anyone for assistance for fear that she would lose her job. Especially divorced (single) women and young women."*
>
> Female, Healthcare professional,
> 53 years old, primary healthcare level

Exposure to violence by patients

In a certain number of comments, healthcare professionals reported being exposed to various unpleasant experiences and verbal threats of violence, both by the patients and/or persons accompanying them, whereas they noticed that this type of behavior was much less often expressed towards male colleagues. This finding is also confirmed by the result that 17.8% of women compared to 12.6% of men confirmed exposure to violence in the workplace (Graph 22).

In this respect, they feel quite unprotected and this is not an occasional, but rather a pervading experience, especially in primary healthcare, predominantly employing women. This problem occurs as a result of an imbalance between patients' expectations and the capacity of the healthcare system to respond to them in the way patients expect, which is why some patients allow themselves to behave aggressively toward women healthcare professionals. It is also a form of gender-based violence and it was supported by evidence provided in a number of comments:

> *"It is a well-known fact that patients are aggressive towards female healthcare professionals, regardless of their level of education, while never towards the male colleagues, they withdraw in front of them."*
>
> Female, specialist doctor,
> 49 years old, primary healthcare level

> *"As a female doctor, I have often been the target of gender-based verbal abuse. I have been considered not capable enough to do my work because I am a woman, and have even been exposed to threats if I didn't want to fulfil the patient's unrealistic demands (...)"*
>
> Female, specialist doctor,
> 33 years old, primary healthcare level

> *"The only place I sometimes feel unprotected is my workplace. We all need training on how to cope with, primarily, verbal violence.".*
>
> Female, specialist doctor,
> 51 years old, primary healthcare level

> *"When I am exposed to this form of violence at work, there is NO protection, except using personal connections and resourcefulness, so I cannot help other women because I am myself unprotected."*
>
> Female, specialist doctor,
> 54 years old, primary healthcare level

Such comments indicate that raising awareness about zero tolerance to violence, recognizing qualitative and quantitative differences between GBV against women and men, as well as the need to promote respectful relationships between genders, are of great importance for fostering an institutional and social culture that would not tolerate violence in any of its forms.

The need for more intense education on gender equality and violence

It is indicative that most of the comments were provided by female doctors, which shows a high level of awareness about this problem, and the need for a comprehensive social response to it.

> *"Excellent topic. Professionals should be organized and educated to identify and respond to these problems.".*
>
> Female, specialist doctor,
> 65 years old, secondary healthcare level

> *"Training should be included in regular university education. People working with this population of patients should be better protected by the system."*
>
> Female, specialist doctor,
> 56 years old, tertiary healthcare level

> *"Any novel knowledge regarding the prevention and faster response to gender-based violence is always welcome."*
>
> Female, doctor, general practitioner
> 63 years old, primary healthcare level

> *"The topic is excellent, thank you for the questionnaire, it made me realize how much more I should learn about this topic, which is very important to our work and the society as a whole."*
>
> Female, doctor, general practitioner,
> 51 years old, primary healthcare level

The importance of multi-sectoral cooperation and comprehensive support for GBV survivors

The comments provided by healthcare professionals show they are aware that professionals and services are only a part of the system of protection and support for violence survivors, and that multisectoral cooperation is of extreme importance for an adequate response to GBV:

> *"We need complete cooperation among all structures in the community to focus on gender-based violence, that is the team, police, social protection, lawyers, judges, mayor, women's shelters, Red Cross, priests… it's not all up to the doctor."*
>
> Female, specialist doctor,
> 52 years old, primary healthcare level

> *"Considering the nature of work and working in a tertiary-level institution, I have not encountered these issues before, which does not diminish their importance. I consider there is not enough support for persons experiencing gender-based violence in our society and there is no adequate cooperation among the relevant services. On the other hand, lack of trust and fear of the victim also influence the provision of assistance and required support. Primary healthcare is the first step in identifying these people. Appropriate education of healthcare professionals, in the form of seminars, as well as promotional materials in offices, can raise awareness and assist in addressing this serious problem, which is very common in our modern times today. I hope that your survey will help to find the best possible solution."*
>
> Female, specialist doctor,
> 50 years old, tertiary healthcare level

RECOMMENDATIONS

Based on the qualitative and quantitative results of this research study, recommendations have been formulated which would improve healthcare professionals' competencies and the healthcare system's overall capacity for protection and response to GBV. The recommendations include the following:

1. Continued and comprehensive education of healthcare and associated professionals about GBV and its roots, especially younger colleagues who have just started to work in practice, so they would build attitudes of zero tolerance to violence, become able to identify violence and become empowered to respond to it, within their professional responsibilities.

2. Regular knowledge and skills updates on GBV prevention and protection; learning about the novel developments and regulations in the national GBV response, such as the obligation to document violence; relevant legislative and normative acts, rulebooks, and the Special Protocol for the Protection and Treatment of Women Exposed to Violence, including their ability to adequately fill out the Form for Documenting Suspected Violence, on paper and electronically, and regular use of the electronic form to report suspected violence to the Public Health Institute, following defined procedures, and respecting best practice principles.

3. Raising awareness and improving understanding among the management of healthcare institutions on the importance of their support to GBV protection and response teams in the healthcare institution, as well as individuals trained to respond to GBV.

4. Restore GBV protection and response teams in healthcare institutions and establish mechanisms for the continuous support of their functioning.

5. Create mechanisms for participatory monitoring and collegial support for GBV prevention and response so that healthcare professionals can get feedback on their work in practice, based on which they could improve their response to GBV. These collegial support mechanisms would also serve as a method to gain insight into best practices, promote them, inform healthcare professionals about them, and inform other key stakeholders at the local, national, and regional levels.

6. Establish and develop mechanisms for mutual communication regarding GBV, consultations, and exchange of best practices, within the healthcare institution and the local community.

7. Revise the legislative framework defining the roles of stakeholders in coordination and cooperation groups to ensure higher inclusion of healthcare professionals and reinforce their role.

8. Strengthen inter-sectoral cooperation at the local and national levels, in terms of establishing stronger and higher-quality links between the healthcare sector and the police and CSW, based on (improved) legislation. Establish mechanisms for cooperation and feedback on the reported suspicion of violence in order to provide adequate support and protection at all levels and in all sectors.

9. Provide written and/or electronic instructions and protocols for healthcare professionals on the action in cases of suspected violence, including the Protocol on the Protection and Treatment of Women Exposed to Gender-Based Violence of the Ministry of Health of the Republic of Serbia, as well as locally developed protocols, following the standard general protocol. Written instructions should include all best practice steps, including adequate communication and asking questions about exposure to violence; security risk assessments; documenting suspected violence; intersectoral cooperation; and contacting relevant authorities for safety protection.

10. Ensure and increase the availability of printed and electronic sources of information for the patients (leaflets, brochures, posters, including infographics) on primary, secondary, and tertiary GBV prevention in order to increase awareness of this phenomenon and its various expressions: psychological, physical, sexual, economic violence. Increased availability of information materials will contribute to faster identification of all forms of violence and not accepting violent behavior (primary prevention), raising awareness about the existing sources of assistance and support in cases of exposure to violence (secondary prevention), as well as rapid response in cases of violence escalation and safety threats (contacts of women's shelters and helplines, which are tertiary violence prevention measures). Sharing information in this way will reduce the feelings of isolation and stigma among violence survivors and support them.

11. Improve teaching curricula at all levels of education, including medical universities and schools, with contents related to understanding gender equality, developing zero tolerance to violence and responding to it, as well as developing good partnership relations, and nurturing mutual respect and appreciation.

12. Enhance gender equality among the health institution's staff and establish response mechanisms in cases of gender-based abuse, denigration, and sexual harassment among employees, including mobbing healthcare professionals.

13. Improve the safety of healthcare professionals in the workplace and establish the mechanisms of their protection from external attacks (patients and their family members).

14. Conduct a secondary data analysis from this research to be able to, as adequately as possible, review all the specific needs and challenges in response to GBV, in specific types of healthcare institutions (primary, secondary/tertiary levels) and specific health professional profiles ('Chosen Doctors' / pediatricians/ gynecologists, psychiatrists, medical specialists at the secondary/tertiary level, medical nurses/technicians, associated professionals of all profiles and other), and to allocate resources accordingly, but also look at the best practices in some health institutions, which could serve as a model for improving the capacities to respond to GBV in other places as well.