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Study and Evaluation of Access to Medical Services for Girls and Women with Disabilities in Georgia

შეზღუდული შესაძლებლობის მქონე გოგონებისა და ქალებისთვის სამედიცინო მომსახურებაზე ხელმისაწვდომობის შესწავლა და შეფასება საქართველოში

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Abstract

Introduction. In Georgia, women and girls with disabilities face intersecting barriers rooted in gender, disability, and socioeconomic disadvantage. Despite legal commitments, systemic obstacles, shaped by post-Soviet legacies and institutional neglect, limit equitable healthcare access, particularly in reproductive services. This study investigates these challenges, revealing a persistent gap between policy frameworks and the everyday healthcare experiences of disabled women. **Methodology**. A cross-sectional pilot study was conducted in February 2025 to assess healthcare access among 50 women (aged 18–65) with physical or sensory disabilities in Georgia. Using purposive sampling, participants from various regions were interviewed via structured questionnaires addressing accessibility, finances, transport, insurance, and communication. Data were collected through face-to-face or phone interviews, following ethical standards. Results were contextualized using comparative data from UN, WHO, and UNFPA. **Results and Discussion**. This study identified widespread barriers to healthcare for women and girls with disabilities in Georgia, including physical inaccessibility, transport issues, and financial exclusion. Discrimination by providers and lack of accessible information, especially in reproductive health, further hindered access. Most participants were unaware of public programs and had limited involvement in medical decisions. The findings underscore how societal attitudes and institutional neglect perpetuate healthcare inequities beyond infrastructure alone. **Conclusion.** The study shows that women and girls with disabilities in Georgia face multiple barriers to healthcare, including inaccessibility, financial strain, discrimination, and lack of information. These intersecting issues highlight the urgent need for inclusive policies, better infrastructure, and disability-sensitive medical training to ensure equitable care and uphold their rights.

Keywords: Women with disabilities; Access to healthcare; Discrimination; Gender inequality; Accessibility; Georgia.

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აბსტრაქტი

შესავალი. საქართველოში შეზღუდული შესაძლებლობის მქონე ქალები და გოგონები ერთდროულად რამდენიმე სახის დისკრიმინაციას აწყდებიან — გენდერული, ფუნქციური მდგომარეობის და სოციალური დაუცველობის ნიშნით. მიუხედავად არსებული სამართლებრივი რეგულაციების და საერთაშორისო ვალდებულებებისა, მათთვის სამედიცინო სერვისებზე თანასწორი წვდომა მნიშვნელოვნად იზღუდება სისტემური დაბრკოლებებით, რომლებიც პოსტსაბჭოთა მემკვიდრეობით, დაბალი ინსტიტუციური სენსიტიურობითა და ჯანდაცვის პოლიტიკის პრაქტიკაში განუხორციელებლობითაა გამოწვეული. განსაკუთრებული სირთულეები იკვეთება რეპროდუქციული ჯანმრთელობის სერვისების მიღებისას. წარმოდგენილი კვლევა მიზნად ისახავს არსებული გამოწვევების დეტალურ ანალიზს და გამოყოფს ხარვეზს მარეგულირებელ ნორმებსა და შეზღუდული შესაძლებლობის მქონე ქალების რეალურ, ყოველდღიურ სამედიცინო გამოცდილებებს შორის. **მეთოდები.** კვლევა განხორციელდა 2025 წლის თებერვალში და არის ჯვარედინი შესწავლის დიზაინზე დაფუძნებული საპილოტე კვლევა. მისი მიზანი იყო საქართველოში ფიზიკური ან სენსორული შეზღუდვის მქონე 50 ქალის (18-დან 65 წლამდე ასაკის) ჯანმრთელობის სერვისებზე ხელმისაწვდომობის შეფასება. მონაწილეები შერჩეულნი იყვნენ მიზნობრივი მეთოდით, რეგიონული წარმომადგენლობის გათვალისწინებით. მონაცემების შეგროვება განხორციელდა სტრუქტურირებული კითხვარების მეშვეობით, რომლებიც ეხებოდა კლინიკური სივრცის ფიზიკურ ხელმისაწვდომობას, ტრანსპორტს, ფინანსურ რესურსებს, ჯანმრთელობის დაზღვევას და ექიმთან კომუნიკაციის ხარისხს. ინტერვიუები ჩატარდა როგორც პირადად, ისე სატელეფონო ფორმატით. კვლევის ფარგლებში დაცული იყო ეთიკური ნორმები. მიღებული მონაცემები დამუშავდა გაეროს, ჯანმოსა და UNFPA-ის შესაბამის საერთაშორისო ინდიკატორებთან შედარებით. **შედეგები და განხილვა.** კვლევამ დაადგინა, რომ შეზღუდული შესაძლებლობის მქონე ქალები და გოგონები საქართველოში ჯანდაცვის სერვისების მიღებისას აწყდებიან მრავალ ბარიერს. სირთულეები მოიცავს სამედიცინო დაწესებულებებში ფიზიკურ ბარიერებს, ტრანსპორტირების პრობლემებს და ფინანსურ ხელმისაწვდომობას. მნიშვნელოვანი გამოწვევაა სამედიცინო პერსონალის მხრიდან არასათანადო დამოკიდებულება და დისკრიმინაციული ქცევები, რაც განსაკუთრებით შესამჩნევია რეპროდუქციული სერვისების მიღებისას. ინფორმაციის ნაკლებობა – განსაკუთრებით სახელმწიფო პროგრამების შესახებ – წარმოადგენს კიდევ ერთ მნიშვნელოვან ბარიერს, რომელიც ზრდის მოწყვლადობას და ამცირებს მონაწილეთა ჩართულობას გადაწყვეტილების მიღების პროცესში. კვლევამ აჩვენა , რომ ქალთა უმრავლესობა არ ფლობდა ინფორმაციას უფასო ან ხელმისაწვდომი ჯანდაცვის სერვისების შესახებ, რაც მნიშვნელოვნად ზღუდავდა მათ აქტიურ მონაწილეობას საკუთარი ჯანმრთელობის მართვაში. ამ კვლევის შედეგები ადასტურებს, რომ ჯანდაცვის სერვისებზე ხელმისაწვდომობის პრობლემები არ შემოიფარგლება ინფრასტრუქტურული შეუსაბამობებით. ეს პრობლემა ფესვგადგმულია ღრმად ჩამოყალიბებულ სტერეოტიპებში, საზოგადოების დამოკიდებულებაში და ინსტიტუციურ გულგრილობაში. **დასკვნა.** წარმოდგენილი კვლევა ცხადყოფს, რომ საქართველოში შეზღუდული შესაძლებლობის მქონე ქალები და გოგონები ხვდებიან რთულად გადასალახავ ბარიერებს ჯანმრთელობის დაცვის სისტემაში: მათ შორის არის ფიზიკური ხელმისაწვდომობა, ფინანსური დაბრკოლებები, დისკრიმინაცია და ინფორმაციის დეფიციტი. ეს პრობლემები ერთმანეთთან მჭიდროდ არის დაკავშირებული და ქმნის გადაუდებელ საჭიროებას, რათა სახელმწიფომ უზრუნველყოს ინკლუზიური პოლიტიკის ჩამოყალიბება, სერვისების ინფრასტრუქტურული გაუმჯობესება და სამედიცინო პერსონალის ტრენინგი. მხოლოდ ამგვარი კომპლექსური რეაგირებით იქნება შესაძლებელი ქალებისა და გოგონების უფლებების სრული დაცვა და ჯანდაცვის სისტემაში თანასწორი მონაწილეობა.

საკვანძო სიტყვები: შეზღუდული შესაძლებლობის მქონე ქალები, ჯანდაცვაზე ხელმისაწვდომა, დისკრიმინაცია, გენდერული უთანასწორობა, ხელმისაწვდომობა, საქართველო.

რეკომენდირებული ციტირება: სურმავა ი, ზარნაძე ი. (2025). შეზღუდული შესაძლებლობის მქონე გოგონებისა და ქალებისთვის სამედიცინო მომსახურებაზე ხელმისაწვდომობის შესწავლა და შეფასება საქართველოში. *ჯანდაცვის პოლიტიკა, ეკონომიკა და სოციოლოგია,* 9 (2). DOI: https://doi.org/10.52340/healthecosoc.2025.09.02.07.

Introduction

Women and girls with disabilities are among the most marginalized and vulnerable social groups. Women and girls with disabilities constitute one of the most disproportionately marginalized segments of the global population, a status shaped not solely by their impairments but by a complex interplay of social, economic, and structural disadvantages. Across both developed and developing contexts, these individuals face compounded vulnerabilities that emerge at the intersection of disability and gender. The United Nations Population Fund (UNFPA) and the World Health Organization (WHO) have emphasized that this intersectionality amplifies health disparities and social exclusion, as women with disabilities are often subject to double discrimination—based on both gender and physical or cognitive impairments (UNFPA Georgia, 2020; WHO, 2023). These forms of marginalization are not merely additive but mutually reinforcing, creating a layered system of exclusion that limits access to essential services and undermines fundamental rights.

In Georgia, as in many other countries transitioning from Soviet-era healthcare and welfare systems, the confluence of gender-based stereotypes, inadequate disability services, and infrastructural inaccessibility contributes to entrenched health inequalities. The traditional perception of disability as a private tragedy or charity issue persists in public discourse, often overshadowing rights-based approaches that emphasize dignity, autonomy, and equal participation. This sociocultural backdrop exacerbates the challenges faced by disabled women, who not only struggle with architectural and physical inaccessibility in healthcare settings but also face dismissive attitudes, gendered assumptions, and widespread informational barriers. These realities are compounded by limited public awareness, inadequate data collection, and insufficient representation of women with disabilities in healthcare decision-making (UN Women Georgia, 2021; Office of the Public Defender of Georgia, 2022).

According to the WHO World Health Report (2023), approximately 16% of the global population lives with a disability. This burden is not evenly distributed: women comprise a disproportionately higher share—19.2%, compared to only 12% for men. A similar gender disparity is evident in Georgia, where the National Statistical Office reports that approximately 18.2% of the population lives with a disability, with women outnumbering men by a ratio of approximately 1.5 to 1 (UNDP, 2021). These figures underscore the urgent need for gender-sensitive healthcare strategies that take into account both the prevalence and the lived experiences of disabled women. Public health policies that fail to engage with the gendered dimensions of disability risk perpetuate systemic inequality, even as they nominally aim to promote inclusion.

In response to both global human rights obligations and domestic advocacy, Georgia has taken significant legislative steps in recent years to improve the status of persons with disabilities, with increasing attention to the specific vulnerabilities of women and girls. The ratification of key international instruments—including the Convention on the Rights of Persons with Disabilities (CRPD), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and the Convention on the Rights of the Child (CRC)—signaled the country's commitment to aligning its national legal framework with internationally accepted standards for the protection of marginalized groups (UN Women, 2021; United Nations, 2006). Furthermore, Georgia's alignment with the Beijing Platform for Action and the 2030 Agenda for Sustainable Development has placed gender equality and the inclusion of persons with disabilities at the heart of national development priorities.

These commitments were further solidified through the adoption of the Law on the Rights of Persons with Disabilities in 2020. This law represents a legal and symbolic milestone, introducing the notion of disability not as a medical or charitable condition but as a rights-based social issue. Notably, a dedicated article within the legislation addresses the unique needs of women and girls with disabilities—an explicit recognition that their lived experiences require tailored policy approaches rather than generic solutions. The law mandates the state to ensure equal access to services, promote social inclusion, and safeguard the autonomy of disabled individuals, with particular emphasis on gender-sensitive programming (Law of Georgia on the Rights of Persons with Disabilities, 2020).

Nevertheless, while these legal instruments mark crucial progress, their implementation has faced substantial limitations. The translation of legislative intent into concrete action has been uneven, with critical gaps in service delivery, data monitoring, and inter-agency coordination. National-level strategies, such as the State Healthcare Strategy 2021–2027, acknowledge the inclusion of persons with disabilities as a policy goal but lack the specificity needed to operationalize this inclusion for women and girls, particularly in rural and underserved areas (Georgia Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs, 2021). Reports by the Public Defender of Georgia have repeatedly emphasized that systemic oversight, underfunding, and the absence of disaggregated data impede the realization of rights for this group (Office of the Public Defender of Georgia, 2022).

Moreover, despite these legislative frameworks, there is a notable absence of mechanisms for participatory policy-making that would empower women with disabilities to influence the systems that directly affect their lives. Without institutionalized platforms for their engagement, policy remains top-down and disconnected from lived realities. As a result, the progressive language of the law often fails to translate into equitable outcomes, highlighting the disjuncture between normative advances and structural change.

Despite the establishment of a progressive legal and strategic foundation, multiple international and local studies indicate that women and girls with disabilities in Georgia continue to encounter serious obstacles when seeking healthcare services. These challenges go beyond isolated shortcomings and instead reveal systemic dysfunctions rooted in infrastructural, financial, informational, and attitudinal deficiencies (Matin & Williamson, 2021; Saleeby & Hunter-Jones, 2016; Ganle et al., 2020).

A recurring issue in both urban and rural healthcare settings is the inadequacy of physical infrastructure. Although some medical facilities are labeled as “accessible,” this often refers only to minimal physical modifications—such as the presence of a ramp at the entrance—without considering comprehensive accessibility needs. For instance, consultation rooms may not accommodate wheelchairs, restrooms are often inaccessible, and communication services such as sign language interpretation or accessible signage remain rare. This limited conceptualization of accessibility undermines the broader goal of creating an inclusive healthcare environment that addresses diverse needs and fosters patient autonomy (WHO Europe, 2022).

Financial barriers further exacerbate the situation. A significant portion of women with disabilities in Georgia live below the poverty line and rely on inadequate state disability benefits. These financial constraints limit their ability to cover out-of-pocket expenses for diagnostic procedures, medications, or specialized consultations. In some cases, even transportation costs to clinics become insurmountable, especially in rural or high-mountain regions where health facilities are few and far between (UNFPA Georgia, 2020; World Bank, 2020). Consequently, many women delay or entirely forgo necessary medical interventions, contributing to avoidable complications and a deterioration in overall health outcomes.

Compounding these issues is a widespread lack of disability awareness and gender sensitivity among healthcare personnel. Medical education curricula in Georgia seldom include mandatory modules on working with persons with disabilities, particularly from an intersectional perspective that addresses both gender and disability. As a result, providers may exhibit unconscious bias, fail to communicate effectively, or disregard patients’ autonomy and informed consent. These deficiencies are not just professional oversights but constitute violations of human dignity and can lead to delayed diagnoses, inappropriate treatment, or outright neglect (Parish et al., 2006; WHO, 2022).

Furthermore, the problem is not only infrastructural or technical but deeply cultural. The prevailing societal perception of disability, particularly as it intersects with gender, is often rooted in paternalism and exclusion. Women with disabilities are frequently regarded as dependent, asexual, or incapable of parenthood, which impacts how medical staff approach topics such as reproductive health, family planning, or maternity care. In clinical settings, such assumptions may result in the withholding of services, lack of respectful communication, or even denial of reproductive choices—all of which violate core principles of human rights and bodily autonomy (UNFPA, 2021; WHO, 2021).

Sexual and reproductive healthcare represents one of the most neglected areas for women and girls with disabilities in Georgia. While international human rights instruments unequivocally assert that all individuals have the right to make autonomous decisions regarding their sexual and reproductive lives, this right remains largely unrealized for disabled women. Structural discrimination, compounded by social taboos, continues to marginalize this population within public health discourse and practice (UNFPA Eastern Europe and Central Asia, 2021; UN Women, 2020).

Numerous studies have revealed that women with disabilities often lack access to information about their reproductive rights, contraception, and safe motherhood options. This is partly due to the scarcity of information in accessible formats—such as plain language brochures, audio materials, or Braille—but also reflects the deeply ingrained assumption that disabled women are either not sexually active or are unfit to become mothers (UNICEF, 2013; WHO, 2021). As a result, healthcare providers frequently fail to initiate discussions about sexual health, family planning, or gynecological screening, thereby perpetuating informational deprivation and disempowerment.

Moreover, in some clinical settings, providers may bypass informed consent procedures, assuming that women with cognitive or sensory impairments are incapable of making autonomous decisions. In extreme cases, women have been subjected to forced sterilization or denied access to fertility treatment based on prejudicial criteria. These practices are not only ethically indefensible but also contravene international obligations under the Convention on the Rights of Persons with Disabilities and the Convention on the Elimination of All Forms of Discrimination Against Women (UN Committee on the Rights of Persons with Disabilities, 2016; United Nations, 2006).

Compounding these challenges is the virtual absence of comprehensive sexual education programs for girls with disabilities. Educational institutions rarely integrate inclusive content into their curricula, and teachers are often untrained in delivering sensitive topics in adapted ways. As a result, many girls enter adulthood without basic knowledge of their reproductive systems, their legal rights, or how to access medical support. This lack of preparedness not only places them at higher risk of unwanted pregnancies or abuse but also reinforces lifelong patterns of disempowerment and health inequity (OHCHR, 2018; UN Women, 2020).

The invisibility of disabled women in national reproductive health programs and strategies further entrenches these inequalities. National maternal and child health plans in Georgia have historically adopted a one-size-fits-all approach, with little recognition of the specific barriers faced by women with disabilities. Budget allocations rarely prioritize disability-inclusive services, and program indicators seldom disaggregate data by disability status. As a result, progress reports present an incomplete picture of reproductive health outcomes, masking the disproportionate burden borne by disabled women (Georgia Ministry of Health, 2021; Office of the Public Defender of Georgia, 2022).

This invisibility in policy, combined with stigma in practice, creates a hostile environment where reproductive autonomy is undermined at every stage—from accessing a clinic to making informed decisions. The issue is not merely about physical access to gynecological care, but about inclusion in the full spectrum of rights-based, patient-centered reproductive services. Without targeted reforms that address both the structural and attitudinal dimensions of these barriers, Georgia’s commitments to gender equality and disability inclusion will remain aspirational rather than operational.

Despite the persistent challenges faced by women and girls with disabilities in Georgia, international experiences demonstrate that substantial progress is achievable when inclusive strategies are implemented systematically and in consultation with affected communities. Across various countries, targeted initiatives have succeeded in improving healthcare access, ensuring patient dignity, and institutionalizing disability-sensitive service provision. These cases offer valuable insights for Georgia’s ongoing reforms and underline the importance of moving from legal recognition to practical realization (European Commission, 2021; World Health Organization – Europe, 2022).

For instance, in Finland and Estonia, national health systems have integrated barrier-free communication technologies into primary care settings. Sign language interpreters, visual aids, and telehealth platforms designed with accessibility in mind have enhanced patient-provider interactions and improved service satisfaction among disabled populations. In Canada, health equity is institutionalized through the inclusion of disability advocates in local and provincial health boards, where they actively participate in shaping clinical protocols and evaluating service outcomes (OHCHR, 2018; UN Women, 2018).

Some Central and Eastern European countries, such as Croatia and Romania, have implemented monitoring mechanisms that disaggregate healthcare data by disability, gender, and region. These systems allow for real-time assessment of service disparities and enable policymakers to allocate resources more equitably. In Poland, municipalities provide specialized transportation for individuals with mobility impairments, ensuring that physical distance from healthcare facilities does not translate into de facto exclusion (European Disability Forum, 2019).

These innovations share several common features. First, they adopt a rights-based approach that recognizes disabled women not as passive recipients of care but as active agents whose input is crucial to system design. Second, they prioritize cross-sector coordination—linking health, education, transportation, and social protection services in a cohesive framework. Third, they commit to sustained public investment in both infrastructure and human capacity development, recognizing that inclusion is not a one-time expenditure but a continuous process of adaptation and accountability (UNICEF, 2013; WHO, 2021).

Equally important is the shift toward participatory methodologies in public health planning. In several jurisdictions, including parts of Canada and the Netherlands, health institutions have adopted co-creation models, where women with disabilities collaborate with professionals to co-design sexual health campaigns, develop training curricula for providers, and evaluate patient experience metrics. These efforts not only enhance the relevance of health programs but also foster a sense of ownership and trust among marginalized populations (UNFPA Eastern Europe and Central Asia, 2021; International Disability Alliance, 2022).

For Georgia, the lesson is clear: legislative reform is only the beginning. True transformation requires embedding inclusive values into the daily operations of the healthcare system—through participatory governance, universal design, accessible communication, and accountability mechanisms. By drawing on these global practices and tailoring them to local realities, Georgia can move closer to fulfilling its obligations under the Convention on the Rights of Persons with Disabilities and ensuring that no woman is left behind.

Although Georgia has demonstrated formal commitment to international human rights instruments and adopted national laws designed to guarantee equality and access to services, the translation of these commitments into effective implementation remains uneven. Women and girls with disabilities often encounter a healthcare system that is structurally unprepared to meet their specific needs—despite legal guarantees to the contrary. This disconnect between policy rhetoric and practical outcomes exposes deeper issues related to governance, accountability, and institutional culture (Office of the Public Defender of Georgia, 2022; UN Women Georgia, 2021).

One of the core challenges lies in the fragmented nature of service delivery. The division of responsibility across multiple government agencies—without effective coordination or referral mechanisms—creates administrative confusion and leads to gaps in care. For example, although primary care centers may provide certain basic services, the lack of integrated pathways to specialized diagnostic or rehabilitative support often results in missed or delayed treatment. For individuals managing chronic conditions or seeking reproductive care, such delays can have serious health consequences (Disability Rights International, 2020; WHO, 2022).

Even when infrastructure improvements have been made—such as installing ramps or accessible bathrooms—the broader service environment often remains exclusionary. Medical professionals are frequently untrained in disability-sensitive care, and there are few national protocols to guide respectful and inclusive communication. Furthermore, routine consultations frequently assume verbal fluency and visual literacy, effectively excluding patients with hearing or cognitive impairments. The absence of assistive technologies, alternative communication formats, and privacy accommodations continues to compromise both the quality and dignity of care (UNFPA, 2021; WHO Europe, 2022).

Another systemic limitation is the near-total absence of participatory mechanisms for women with disabilities in healthcare planning and oversight. Without their direct input, policies risk reproducing ableist assumptions and overlooking the diverse and intersecting realities of this population. As highlighted in global best practices, the meaningful inclusion of affected individuals in decision-making processes is not only a matter of democratic legitimacy but also a prerequisite for designing effective interventions (OHCHR, 2018; European Commission, 2021).

In addition, the rural–urban divide exacerbates existing inequalities. While women with disabilities living in urban areas may at least theoretically have access to more specialized facilities, those in rural or high-mountain regions often face compounded obstacles—ranging from geographic isolation to cultural taboos that discourage their independent health-seeking behavior. In such areas, healthcare access is further constrained by unreliable public transport, a shortage of qualified providers, and a lack of outreach programs tailored to their needs. This multidimensional exclusion reinforces cycles of poor health, economic dependency, and social invisibility (UNFPA Georgia, 2020; World Bank, 2020).

Ultimately, the failure to bridge the gap between legal norms and lived experience reflects a broader neglect of structural and cultural determinants of health. A rights-based and gender-sensitive transformation of the healthcare system requires not only policy reform but also institutional restructuring, provider training, accessible infrastructure, and ongoing public engagement. Without this, the promise of equality will remain aspirational rather than transformative.

In light of these multilayered and intersecting challenges, it becomes increasingly evident that formal commitments alone are insufficient to ensure meaningful access to healthcare for women and girls with disabilities in Georgia. Rather than being treated as passive recipients of welfare, these individuals must be recognized as rights-holders with unique needs, perspectives, and entitlements. A transformative approach requires that disability be reframed not as a technical issue of infrastructure or clinical diagnosis, but as a complex social condition shaped by structural injustice, policy neglect, and cultural invisibility (World Health Organization, 2011; UN Committee on the Rights of Persons with Disabilities, 2016).

A key starting point lies in dismantling the pervasive social stigma and institutionalized assumptions that continue to frame women with disabilities as incapable, asexual, or dependent. These misconceptions not only influence public attitudes but also permeate clinical settings and policy decisions, leading to the systematic exclusion of this population from health promotion, sexual and reproductive health services, and patient empowerment frameworks. Overcoming these deeply entrenched barriers calls for a robust, multisectoral, and gender-transformative strategy—one that integrates legal reforms, inclusive education, financial protections, and meaningful public participation (UN Women, 2020; UNFPA EECA, 2021).

Moreover, the monitoring and evaluation of health interventions must move beyond aggregate indicators and incorporate disaggregated data collection that accounts for gender, disability type, geography, socioeconomic status, and age. Only through such nuanced approaches can the hidden layers of exclusion be revealed and addressed. International examples demonstrate the value of embedding intersectionality within data systems, allowing governments to tailor services to real-life conditions rather than to generalized policy assumptions (European Disability Forum, 2019; UNICEF, 2013).

Finally, the research presented in this study aims not merely to document the barriers faced by women and girls with disabilities but to center their voices, experiences, and priorities in the ongoing conversation about healthcare equity in Georgia. Through a mixed-method approach, the study seeks to analyze both the systemic shortcomings and the lived realities that shape health access. The ultimate goal is to generate actionable insights and policy recommendations that will support the development of a healthcare system that is not only technically accessible but also ethically inclusive and socially just.

Methods

The study was conducted as a descriptive, cross-sectional pilot study aimed at assessing access to health services among girls and women with disabilities in Georgia. The primary purpose of this pilot study was to explore existing patterns and barriers to healthcare access and to generate evidence that could inform the development of a larger, more comprehensive analysis.

A structured questionnaire, developed specifically for the study, included both closed-ended and open-ended questions. It was designed to investigate multiple dimensions of healthcare access, including physical accessibility of medical facilities, infrastructural and environmental limitations, transportation-related challenges, financial affordability, access to health-related information, health insurance coverage and experiences with healthcare personnel.

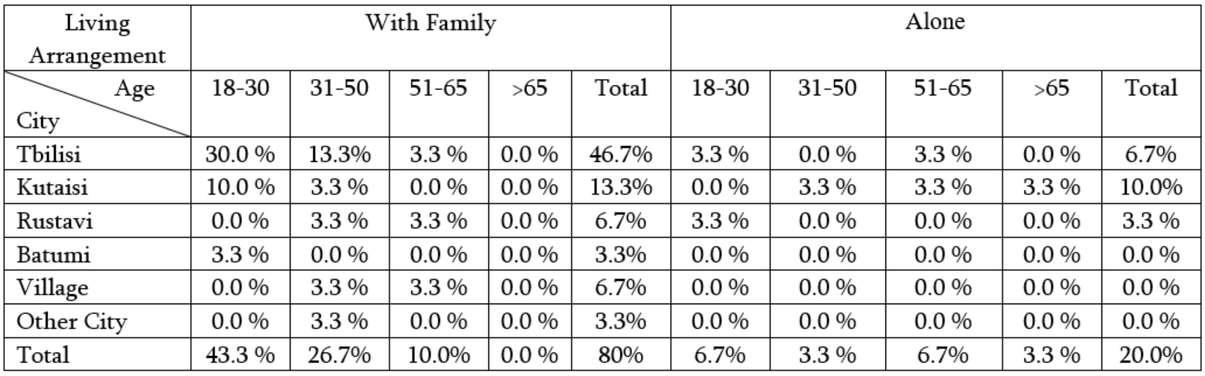
The study employed a non-probability purposive sampling method. Participants were selected according to specific inclusion criteria: having a physical or sensory disability, female sex, age between 18 and 65 years, and at least one recorded interaction with the healthcare system within the past twelve months to ensure that participants' experiences reflected recent and relevant encounters with the health system.

A total of 50 women were enrolled in the study. Participants were recruited from various regions of Georgia, including urban areas as well as rural and semi-rural (non-urban) localities, in order to reflect geographic and contextual diversity. Data collection was carried out in February 2025 through face-to-face or telephone interviews, based on participants' preferences and accessibility requirements. The study was conducted by established ethical standards. Before participation, all individuals were provided with detailed information regarding the objectives and procedures of the study, and verbal informed consent was obtained. Participation was entirely voluntary, and confidentiality and anonymity were strictly maintained throughout the research process.

In the second phase of the study, the findings were compared with international data to place the results within a broader global context. Secondary sources included reports and publications from organizations such as the United Nations (UN), the World Health Organization (WHO), the United Nations

Population Fund (UNFPA), UN Women, and other institutions working in the fields of disability rights and inclusive healthcare.

Table 1. Socio-Demographic Characteristics of Participants

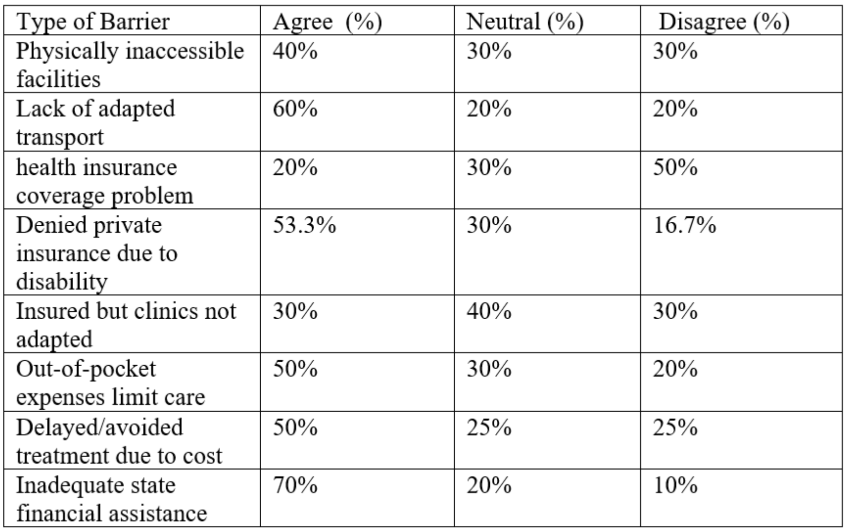


Living Arrangement	With Family					Alone				
Age / City	18-30	31-50	51-65	>65	Total	18-30	31-50	51-65	>65	Total
Tbilisi	30.0 %	13.3%	3.3 %	0.0 %	46.7%	3.3 %	0.0 %	3.3 %	0.0 %	6.7%
Kutaisi	10.0 %	3.3 %	0.0 %	0.0 %	13.3%	0.0 %	3.3 %	3.3 %	3.3 %	10.0%
Rustavi	0.0 %	3.3 %	3.3 %	0.0 %	6.7%	3.3 %	0.0 %	0.0 %	0.0 %	3.3 %
Batumi	3.3 %	0.0 %	0.0 %	0.0 %	3.3%	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %
Village	0.0 %	3.3 %	3.3 %	0.0 %	6.7%	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %
Other City	0.0 %	3.3 %	0.0 %	0.0 %	3.3%	0.0 %	0.0 %	0.0 %	0.0 %	0.0 %
Total	43.3 %	26.7%	10.0%	0.0 %	80%	6.7%	3.3 %	6.7%	3.3 %	20.0%

Results

The findings of this study underscore a multifaceted and deeply entrenched set of obstacles that women and girls with disabilities in Georgia encounter when attempting to access healthcare services. These are not isolated inconveniences but systemic barriers that permeate every aspect of the healthcare experience—ranging from architectural inaccessibility to socio-cultural exclusion. Physical constraints are compounded by infrastructural limitations, social stigma, financial insecurity, lack of accessible information, and insufficient professional competencies.

Table 2 – Distribution of Participant Responses Regarding Structural and Financial Barriers to Healthcare Access



Type of Barrier	Agree (%)	Neutral (%)	Disagree (%)
Physically inaccessible facilities	40%	30%	30%
Lack of adapted transport	60%	20%	20%
health insurance coverage problem	20%	30%	50%
Denied private insurance due to disability	53.3%	30%	16.7%
Insured but clinics not adapted	30%	40%	30%
Out-of-pocket expenses limit care	50%	30%	20%
Delayed/avoided treatment due to cost	50%	25%	25%
Inadequate state financial assistance	70%	20%	10%

Such a constellation of disadvantages results not only in diminished access to healthcare but also in a compromised ability to benefit from preventative measures, early diagnostics, and person-centered, respectful care. These findings align with broader global observations that underscore the intersectionality of health, gender, and disability as a critical axis of inequality (UNFPA Georgia, 2020; WHO, 2021).

One of the most pronounced obstacles identified through the study is the inadequacy of physical infrastructure. Merely 10% of respondents reported that medical facilities met accessibility standards in full. A striking 40% rated the accessibility of facilities at the lowest end of the scale. This gap was particularly evident in rural areas, where architectural challenges, such as outdated Soviet-era buildings, steep staircases, narrow hallways, and the absence of elevators or ramps, render clinics physically inaccessible. The problem is not simply architectural but emblematic of a health system that was never designed with inclusivity in mind. As one woman from the Kakheti region expressed, her arrival at a clinic in a wheelchair was met not with assistance, but with an expectation that she "somehow climb the stairs." The system's failure to accommodate even the most basic mobility needs signals a disregard for the presence and dignity of disabled patients.

Transportation emerged as an equally formidable barrier. A significant 60% of participants reported being unable to reach medical facilities due to the unavailability of transport services suitable for people with mobility impairments. In rural areas, this challenge is compounded by long distances, infrequent public transportation, and the absence of any specialized or subsidized options. A particularly revealing narrative came from a woman in Samtskhe-Javakheti who recalled giving birth without ambulance access, relying instead on her family to organize transportation, despite not having sufficient funds. Such scenarios highlight how geographic marginalization, poverty, and disability intersect to create a healthcare desert for large segments of the population.

Age was another important axis of inequality revealed in the study. Younger women (ages 18–30) generally demonstrated higher levels of digital literacy and greater familiarity with available services, often due to exposure through educational institutions or online resources. In contrast, older women (ages 50 and above) reported significantly higher levels of social isolation, diminished autonomy in medical decision-making, and limited support networks. A 63-year-old participant recounted how her gynecologist dismissed her concerns on the grounds of age, stating that she no longer "needed" gynecological care. This paternalistic framing exemplifies how ageism compounds gender and disability-based marginalization, rendering older women invisible within the healthcare system.

Financial constraints constitute another profound and recurring theme in the narratives collected. For women with disabilities, healthcare costs are not merely economic burdens—they represent structural exclusion. A full 20% of participants reported having no health insurance coverage whatsoever, while 53.3% stated that private insurance companies had denied them coverage explicitly due to their disability status. Even among those with formal insurance, multiple respondents described circumstances in which coverage proved illusory. One woman explained that although her package included gynecological services, she was told upon arrival that "the clinic doesn't have equipment for wheelchair users," effectively nullifying her entitlement. Such examples illustrate how financial discrimination intersects with infrastructural inadequacies, transforming formal rights into inaccessible promises.

Beyond formal insurance coverage, out-of-pocket expenses, ranging from transportation and medication to diagnostic tests, often exceed the financial capacity of disabled women, many of whom are unemployed or rely on minimal state benefits. Several participants noted that they had postponed or entirely foregone medical consultations due to cost concerns. This dynamic further exacerbates health inequalities by delaying diagnosis and treatment, particularly for chronic conditions or reproductive health concerns that require regular monitoring.

Equally troubling were the widespread reports of negative experiences with medical personnel. Half of the respondents (50%) had, at least once, been explicitly denied care based on their disability. While denial of service is the most extreme form of exclusion, subtler forms of discrimination were no less damaging. 46.7% of participants reported violations of their privacy or medical data protection, while 26.7% characterized their interactions with healthcare providers as emotionally distressing or humiliating. One woman recounted a consultation in which a gynecologist bluntly asked: "Why do you even need sexual medicine?"—a question that not only dismissed her needs but also invalidated her identity and personhood. Such incidents are not isolated acts of insensitivity; they reflect systemic biases in medical training, where little to no emphasis is placed on disability rights, communication ethics, or inclusive care models.

These findings point to a healthcare environment that frequently fails to meet the standards of dignity, respect, and autonomy to which all patients are entitled. They also highlight a broader cultural issue—where medical knowledge is perceived as hierarchical, and the voice of the patient, particularly a disabled woman, is minimized or dismissed. In this context, healthcare becomes not a site of healing, but of power imbalance, exclusion, and harm.

A particularly pervasive theme that emerged during the analysis was the lack of accessible and comprehensible health information. This deficit operated at both systemic and interpersonal levels. A staggering 90% of respondents reported being unaware of any state-supported health programs or specific services designed for people with disabilities. Even more striking, 96.7% stated that they had never encountered sexual and reproductive health materials presented in accessible formats—such as plain-language brochures, Braille documents, or sign-language videos. These communication gaps not only limited their ability to make informed health decisions but reinforced a broader sense of exclusion and marginalization.

Table 3 illustrates the extent of informational deprivation and emotional exclusion experienced by participants during their healthcare journeys.

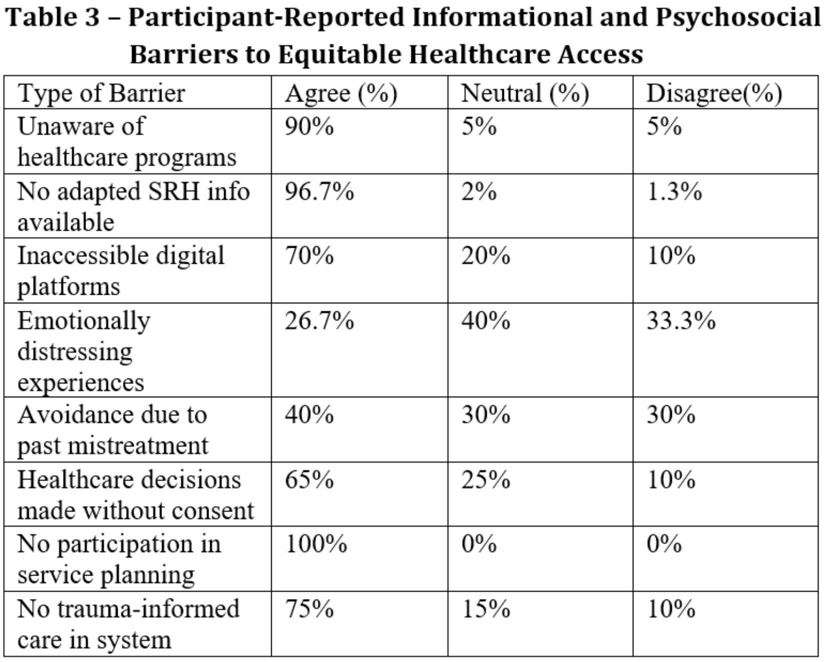


Table 3 – Participant-Reported Informational and Psychosocial Barriers to Equitable Healthcare Access

Type of Barrier	Agree (%)	Neutral (%)	Disagree(%)
Unaware of healthcare programs	90%	5%	5%
No adapted SRH info available	96.7%	2%	1.3%
Inaccessible digital platforms	70%	20%	10%
Emotionally distressing experiences	26.7%	40%	33.3%
Avoidance due to past mistreatment	40%	30%	30%
Healthcare decisions made without consent	65%	25%	10%
No participation in service planning	100%	0%	0%
No trauma-informed care in system	75%	15%	10%

Several participants expressed frustration with digital health resources, which are often promoted as tools for improving access. In practice, however, many of these platforms are designed without consideration for individuals with sensory, cognitive, or technological limitations. As one woman from Adjara put it, “I can’t read websites, and no one explains what it’s about.” This quote encapsulates a larger problem: digital exclusion, far from being a neutral oversight, actively compounds informational inequalities—particularly in a healthcare system increasingly reliant on online appointments, electronic records, and remote consultations.

Beyond information deficits, emotional detachment from the healthcare system emerged as a recurring narrative. Many women described a profound sense of mistrust, fear, and resignation when engaging with medical professionals. This emotional distance was not rooted in irrational fear but in repeated experiences of dismissal, misunderstanding, or humiliation. As one participant explained, “I don’t go for check-ups anymore—I’ve learned that my concerns won’t be taken seriously.” Such sentiments suggest a dangerous cycle in which alienation leads to avoidance of care, which in turn contributes to deteriorating health outcomes.

This emotional disconnection is not simply a psychological reaction; it reflects systemic deficiencies in the healthcare system’s responsiveness and inclusivity. A truly inclusive healthcare model must go beyond architectural access and address the relational and affective components of care—namely, trust, empathy, and mutual respect. Without these elements, formal accessibility remains insufficient, and health equity becomes unattainable.

These findings also underscore the limitations of standard healthcare quality indicators, which often fail to capture patient experience, satisfaction, or perceptions of dignity. A facility may technically meet national accessibility standards, yet still alienate patients through impersonal service, rushed consultations, or culturally insensitive attitudes. Such experiences are particularly detrimental to disabled women, who already navigate intersecting stigmas and power imbalances in medical encounters.

Another core finding of this study was the minimal level of participation that women and girls with disabilities had in decisions concerning their own healthcare. Chart 3 highlights key indicators regarding access to reproductive services, trauma-informed care, participation in health-related decisions, and availability of adapted information.

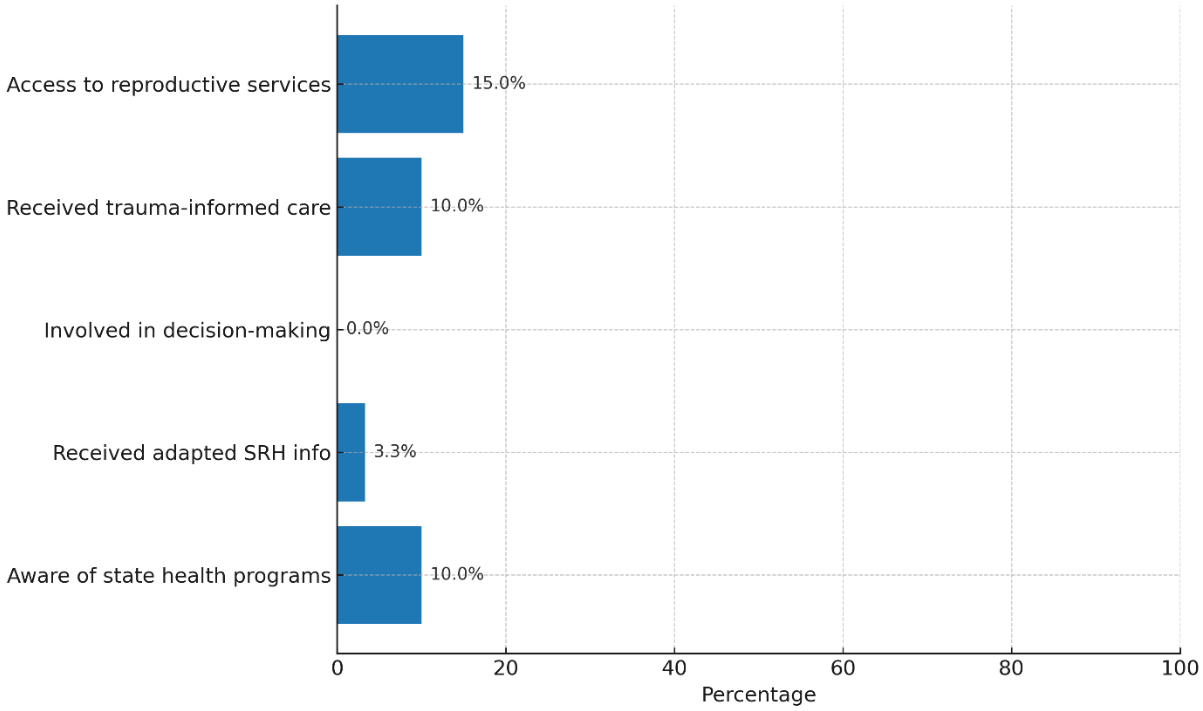


Chart 1. Positive Access to Health Information, Decision-Making, and Reproductive Services among Women with Disabilities

This absence was evident at two levels: first, in the clinical sphere, where patients are often excluded from discussions about their treatment options; and second, in the broader healthcare planning and policy process. Across interviews, many respondents reported that healthcare decisions were made on their behalf—by family members, caregivers, or medical staff—without their informed consent or active involvement.

One participant recalled, “No one asked me whether I would prefer to give birth at home or in the hospital. They simply said: The hospital is not for you.” This kind of paternalism reflects deep-seated societal assumptions about the capabilities and autonomy of disabled women, which not only disempower them but also violate the ethical principle of respect for persons. Genuine participation in health-related decisions requires not only the presence of choice but the availability of clear, accessible information and supportive communication.

On the institutional level, no participants reported being consulted in the design or evaluation of medical services. This lack of representation stands in contrast to international best practices, where participatory approaches—such as advisory boards including disabled individuals or community-based feedback mechanisms—are used to tailor services to real needs. The absence of such models in Georgia limits the healthcare system’s ability to evolve in inclusive and responsive ways.

Compounding the issue of limited participation is the pervasive lack of specialized services. Many participants shared experiences in which their medical concerns were dismissed or “collapsed” into their disability. Instead of receiving individualized diagnostics or treatment, their symptoms were attributed to their disability as an undifferentiated category. For example, women with mobility impairments who reported gynecological discomfort were often told that “pregnancy would be too dangerous” without further investigation into the underlying health issue.

This clinical reductionism fails to recognize the diverse health needs of women with disabilities and underscores the urgent need for training medical professionals in intersectional, rights-based care. Currently, specialized services—especially in reproductive and mental health—are either concentrated in urban centers or lacking altogether. In smaller towns and rural areas, women often have no access to gynecologists trained to work with people with disabilities, nor are there programs that offer psychological support tailored to their lived experiences.

One woman reported, “I went to the clinic for a routine checkup, but the doctor didn’t even speak to me directly—he asked my sister everything, as if I wasn’t there.” This erasure of voice and agency contributes to a broader pattern of exclusion that extends beyond the medical encounter and permeates social institutions more broadly.

Beyond the tangible and logistical challenges outlined above, the study illuminated deeper structural inequalities that fundamentally shape the healthcare experiences of women and girls with disabilities in Georgia. These inequalities are embedded not only in the healthcare system but also in the broader cultural and institutional frameworks that govern social life. They manifest in subtle yet powerful ways—in how needs are defined, how resources are allocated, and whose voices are deemed worthy of inclusion in policy discourse.

For example, while many clinics may technically offer "universal" services, the reality is that these services are standardized around an able-bodied, male-centric norm. Such default assumptions render the needs of disabled women invisible. As one respondent put it, “Everything is set up for a ‘normal’ patient. If you don’t fit that mold, you’re on your own.” This institutional design bias reinforces exclusion and normalizes neglect, as services are not proactively adapted to the diversity of patients they are meant to serve.

Moreover, cultural stigmas surrounding both disability and gender continue to restrict the autonomy and social integration of these women. Participants repeatedly emphasized that societal narratives often depict them as dependent, fragile, or asexual. These reductive views are internalized not only by the public but also by healthcare providers, policymakers, and even the women's own families. As a result, their health concerns are deprioritized, their reproductive choices questioned, and their pain frequently dismissed.

This culture of disregard has real-world consequences. Some women described avoiding clinics altogether, not because they lacked physical access, but because they feared humiliation, judgment, or mistreatment. Others mentioned being reluctant to disclose their symptoms or concerns, particularly when related to sexual or reproductive health, due to a lack of trust in the system. In this context, healthcare becomes not a site of healing, but one of vulnerability and marginalization.

The emotional toll of this experience is substantial. Feelings of alienation, fear, and powerlessness permeated many of the interviews. These emotions are not incidental—they are the product of sustained exclusion from institutions that are meant to serve the public good. When a woman cannot access routine care without fear of being shamed or silenced, the principle of health as a human right is severely compromised.

Taken together, these findings underscore that access to healthcare is not solely a matter of ramps, elevators, or digital interfaces. It is also about inclusion in the social contract. When women with disabilities are excluded from that contract—through underfunded policies, untrained personnel, inaccessible communication, and a pervasive culture of low expectations—then health equity becomes impossible.

A recurring theme throughout the study was the emotional and psychological impact of exclusion, humiliation, and invisibility within healthcare settings. Many participants described their encounters with the medical system not just as physically difficult or financially burdensome, but as deeply wounding experiences that eroded their sense of self-worth and autonomy. This layer of emotional harm adds a critical dimension to our understanding of healthcare inequality—one that quantitative indicators alone cannot capture.

Several women recalled being infantilized during medical consultations. Others were met with silence, indifference, or overt disbelief when expressing symptoms or requesting reproductive care. These interactions often left long-lasting scars. As one participant from Imereti noted: “It wasn’t the stairs or the lack of ramps that hurt the most, it was when the nurse looked at me like I didn’t belong here.” This comment exemplifies how infrastructural exclusion is often accompanied and compounded by symbolic violence.

This form of psychological marginalization is not an accidental byproduct of underfunded systems; it is embedded in the ethics—or lack thereof—of professional practice. Many healthcare providers lack training in respectful, inclusive communication and often make harmful assumptions based on gender and disability. For instance, one woman described being asked, “Why are you worried about gynecology? That’s not your problem.” Such remarks are not just dismissive; they are forms of epistemic injustice—denying the person’s right to be taken seriously as a knower of their own body and needs.

The failure to uphold informed consent protocols was another deeply troubling finding. Participants with intellectual or sensory impairments frequently reported situations in which decisions were made on their behalf without proper explanation or acknowledgment of their agency. This not only violates international legal standards such as those outlined in the Convention on the Rights of Persons with Disabilities (CRPD), but also undermines basic principles of medical ethics—autonomy, beneficence, and justice.

Additionally, the near-complete absence of trauma-informed care frameworks in the Georgian healthcare system was evident. Several women disclosed prior experiences of abuse or institutional neglect, yet found that their histories were never acknowledged or addressed by clinicians. This lack of recognition perpetuates re-traumatization and leaves already vulnerable individuals feeling unsafe in environments meant to promote healing.

The emotional distancing that results from these patterns of exclusion has a chilling effect on health-seeking behaviors. Many women reported avoiding care altogether, even when in pain, due to previous negative experiences. This creates a feedback loop: exclusion leads to disengagement, which in turn exacerbates health inequalities.

From an ethical perspective, these findings point to a failure not only of technical provision but of moral responsibility. Healthcare systems are not neutral bureaucracies; they are expressions of collective values. When they fail to include the most marginalized, they signal that certain lives are less valued, certain voices less heard. This is why health equity cannot be pursued solely through infrastructure or policy reform. It must also involve a cultural transformation in how dignity, empathy, and justice are embedded in everyday care practices.

A particularly significant aspect of the findings is the near-total absence of women and girls with disabilities from decision-making processes—whether at the level of individual medical care, institutional governance, or national policy formulation. Participants repeatedly emphasized that they were not consulted about their treatment preferences, birth plans, or follow-up care. Instead, decisions were often made for them, based on generalized assumptions rather than individualized assessments.

This exclusion is not merely procedural—it is deeply political. It reflects the structural power imbalances that define the relationship between healthcare institutions and marginalized groups. One participant from Samegrelo recounted: “They told me the hospital wasn’t safe for someone like me. So they decided I would stay home. I didn’t agree, but they didn’t ask.” This experience underscores a broader reality: medical care is frequently designed and delivered in ways that presume passivity on the part of disabled women, denying them the status of active agents in their health journeys.

Institutionalized paternalism—especially in reproductive care—was a recurring theme. Many participants described situations in which their reproductive choices were preemptively judged or limited. Some were advised not to have children based solely on their disability status. Others were offered permanent contraceptive methods without thorough discussion of alternatives or future implications. Such practices reflect not only a lack of medical nuance but also a failure to respect legal and ethical standards around bodily autonomy and reproductive justice.

Moreover, the absence of women with disabilities from institutional and political forums ensures that their needs remain invisible in health policy design and implementation. Despite the existence of legal frameworks that mandate inclusion, practical mechanisms for participation remain weak or symbolic. Very few healthcare boards or committees include representatives of the disabled community. Even fewer initiatives provide accessible consultation formats—such as easy-to-read materials or sign language interpretation—that would enable meaningful engagement.

This lack of participatory infrastructure exacerbates policy blind spots. Health strategies are developed based on the majority needs and generalized indicators, with little recognition of intersectional vulnerabilities. For example, while Georgia’s national health strategy (2021–2027) emphasizes maternal and child health, it lacks specific goals or metrics related to women with disabilities. This omission perpetuates cycles of exclusion, as invisible problems are rarely prioritized in budget planning or service development.

Additionally, community-level support systems—such as patient advocacy groups, self-help collectives, or local health councils—are either non-existent or poorly integrated with national healthcare agendas. Women with disabilities who seek to organize and voice their concerns often face logistical, financial, or social barriers, further weakening collective advocacy capacity. This fragmentation undermines the potential for transformative change.

These dynamics collectively amount to structural marginalization. They show that barriers to healthcare are not accidental or isolated but are embedded in institutional norms, bureaucratic procedures, and political hierarchies. The effect is a systematic denial of agency, voice, and presence in spaces where critical health-related decisions are made.

To redress this imbalance, it is not enough to “include” disabled women as passive beneficiaries of reform. Instead, they must be recognized and empowered as co-creators of healthcare systems—through inclusive planning, accessible policy platforms, and participatory monitoring mechanisms. Without this shift, even the most well-intentioned policies risk reproducing the very inequalities they aim to eliminate.

Conclusions

This study demonstrates that access to healthcare for women and girls with disabilities in Georgia is hampered not only by visible physical barriers, but also by deeply entrenched social inequalities and institutional neglect. The challenges identified point to structural failures in a system that, in its current form, is unable to fairly reflect diversity.

This reality highlights that simply referring to legal frameworks and international conventions is not enough. As long as these standards are not actively translated into political strategies, medical practices, and societal attitudes, they remain ineffective for those who need support most.

Critical is the recognition that discrimination is not always loud or visible – it often operates through silence, through a lack of communication, through the passive ignoring of individual needs. When women with disabilities are structurally excluded from decision-making processes, when their perspectives are missing from planning, care, and communication, then equality becomes an empty promise.

Healthcare is a reflection of societal values. When patients are reduced to objects, they not only lose their status as citizens with rights, but also their self-efficacy as agents in their own lives. This is precisely why a systemic response is needed – one that sees institutional inclusion not as an add-on, but as a prerequisite for quality.

It is not enough to simply remove barriers. It is important to create spaces where participation is actively promoted – through accessible information, through trained and empathetic professionals, and through targeted programs for disadvantaged groups. Only in such a framework can women with disabilities experience healthcare as something that is not distant, abstract, or degrading – but accessible, fair, and respectful.

The conclusion of this study is therefore not purely academic: it is a call for responsibility – at the political, institutional, and societal levels. Health must not be negotiated based on gender, disability, or socioeconomic status. It must be treated as a universal human right – concrete, binding, and inclusive.

Recommendations

After analyzing the existing challenges, it becomes clear that Georgia needs more than political declarations of intent – it needs concrete, systemically embedded measures to effectively improve access to healthcare for women and girls with disabilities. The recommendations presented here are based not only on the findings of this study, but also on best international practices and existing commitments under human rights conventions.

A key area of action is the structural accessibility of medical facilities. Accessibility must not be viewed as a voluntary measure but must be enshrined in law as a binding standard. This includes ramps, adapted entrances, tactile guidance systems, and accessible sanitary facilities. In countries such as Romania and Croatia, systematic modifications have been implemented with the support of the European Commission, leading to a significant increase in the use of medical services by people with disabilities (European Disability Forum, 2021).

The issue of limited mobility, especially in rural areas, requires special attention. Many women simply cannot reach medical facilities. In Poland, municipal transport services specifically for people with disabilities were introduced, significantly increasing participation in planned medical interventions (UNFPA, 2020). A similar model could also be implemented in Georgia – for example, through cooperation between municipalities and civil society organizations.

Another focus is on training medical professionals. The study's findings demonstrate a lack of sensitivity and knowledge in dealing with patients with disabilities. This affects not only practical procedures but also fundamental attitudes towards sexual and reproductive health. The WHO's guidelines emphasize the need for mandatory training for professionals who address the needs of people with disabilities (WHO, 2022). Such training should become an integral part of medical education and professional development in Georgia.

Access to understandable information also urgently needs to be improved. 96.7% of the women surveyed reported never being informed about their reproductive rights or existing programs – certainly not in accessible formats. Finland and Estonia are demonstrating how things can be done differently: Materials in simple language, with symbols, and in Braille have sustainably strengthened the health literacy of people with disabilities (UN Women, 2021). A similar offering is also needed in Georgia, both online and in local facilities.

In addition to structural changes, greater political participation is also needed. In Croatia, an indicator-based monitoring system was introduced that regularly assesses access to healthcare and feeds into policy planning processes (European Commission, 2021). Such an evidence-based steering instrument could also help Georgia not only document progress but also drive it forward in a targeted manner.

Ultimately, it is clear that the implementation of these recommendations is not possible without a long-term political commitment. If Georgia is willing to undertake comprehensive structural and educational reforms, a health care system can emerge that not only appears inclusive on the surface but respects the rights, needs, and dignity of all citizens – regardless of disability, place of residence, or social status.

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