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Article

The High Cost of Survival: Financial Pressures in Medical Services and Daily Living for Persons with Spinal Cord Injury in Rwanda: A Qualitative Study

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ABSTRACT

Background: Spinal cord injury causes lasting disability and financial hardship. Individuals in low- and middle-income settings like Rwanda face major barriers to affordable long-term services.

Methodology: This study employed a qualitative phenomenological design to gain an in-depth understanding of participants' lived experiences of financial pressures related to medical services and daily living. Purposive sampling was used to recruit participants, and following thematic saturation, the sample size was 12 participants. Data were gathered through in-depth interviews and analysed using thematic analysis.

Results: The study generated two main themes and associated sub-themes. The first theme, financial pressures in daily living, captured the economic strain on family livelihoods, the high cost of daily living, and expensive transportation. The second theme, financial pressures in medical and related services, reflected the high cost of hospitalisation, assistive devices, and other medical services.

Conclusion: These findings underscore the multifaceted financial challenges faced by people with spinal cord injury in Rwanda, both in daily living and in accessing medical services. The cumulative burden of unemployment, costly private transportation, limited insurance coverage, and unaffordable rehabilitation services highlights the urgent need for inclusive policies and financial support systems.

Keywords: High cost of survival, spinal cord injury, medical services, daily living, rehabilitation services, Rwanda.

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INTRODUCTION

Spinal cord injury (SCI) refers to damage to the spinal cord resulting in loss of function, including mobility and sensation. Globally, over 15 million people live with SCI, with an estimated 250,000 to 500,000 new cases annually with most arising from preventable causes (Kassahun Bekele et al., 2023). The study shows that men are disproportionately affected and that most cases occur in low- and middle-income countries (Hu et al., 2023). In Rwanda, a recent study reported an incidence rate of 22.2 per million, with a male-to-female ratio of 3.9:1 and a mean age of 42.5 years at the time of injury (Kanyoni et al., 2024).

The consequences of SCI extend far beyond the initial trauma, often resulting in lifelong disability, dependence, and financial hardship (Merritt et al., 2019). While high-income countries have, to some extent, established systems for acute care, rehabilitation, and social protection, individuals in low middle-income countries (LMICs), particularly in sub-Saharan Africa, including Rwanda, face significant barriers to accessing affordable and comprehensive care (Nielsen, 2011; Oderud, 2014).

The financial implications of SCI are multifaceted, encompassing both direct and indirect costs. Direct medical expenses include emergency transportation, surgical interventions, prolonged hospital stays, rehabilitation services, medications, and the procurement of assistive devices such as wheelchairs, catheters, and pressure-relieving equipment (Malekzadeh et al., 2022; Merritt et al., 2019). In high-income settings, the lifetime cost of managing SCI can exceed one million US dollars per individual, depending on the level and completeness of injury (Malekzadeh et al., 2022). Indirect costs, often less visible but equally debilitating, include loss of income due to unemployment or under-employment, reduced productivity, and the economic toll on family members who assume caregiving responsibilities (Malekzadeh et al., 2022). Currently, over 86% of the Rwandan population benefits from Mutuelle de Santé and have access to basic healthcare services (Rwanda Development Board, 2026). Recent updates to Mutuelle de Santé have further expanded its coverage of medical care services (Africa Press, 2026). However, the cost of care for individuals with spinal cord injury is further compounded by barriers to accessibility, limited social protection mechanisms, and high rates of unemployment among persons with disabilities (Kiregu et al., 2016). Persons with spinal cord injury frequently require high-cost services, including specialised acute care, assistive technologies, extended hospitalisation, and long-term rehabilitation, often placing considerable financial burden on individuals and their families (Clinton Health Access Initiative, 2020).

The high cost of care required for individuals with spinal cord injury to survive and receive hospital-based treatment results in severe economic challenges at both the individual and family levels (Kiregu et al., 2016). Moreover, informal caregiving often provided by spouses, children, or elderly parents disrupts household productivity and imposes substantial emotional and financial strain on caregivers (Kiregu et al., 2016). Consequently, these costs intensify financial hardship, as individuals and families must meet the expenses associated with both medical care and everyday living. The objective of this study was to explore the financial challenges related to medical services and daily living for persons with spinal cord injury in Rwanda.

Study setting

The study was conducted at two specialised rehabilitation facilities in Rwanda: HVP-Gatagara Nyanza Orthopaedic and Rehabilitation Hospital and Gahini Rehabilitation Centre. These institutions are the primary rehabilitation facilities in the country, offering a wide range of services including orthopaedic surgery, physiotherapy, prosthetics and orthotics, and occupational therapy (United States Agency for International Development, 2021; Misago Kizito, 2020; Republic of Rwanda, 2020). Individuals with spinal cord injury travel from different regions of Rwanda to these centres to receive rehabilitation services.

METHODS

This study employed a phenomenological qualitative design (Cerbone, 2010), to explore the financial pressures experienced by individuals with spinal cord injuries in relation to medical services and daily living. This approach enabled an in-depth understanding of participants' lived experiences, revealing the social and economic dimensions of financial hardships, including the costs of rehabilitation, assistive devices, transportation, and daily living needs.

Ethical approval was obtained from the University of Rwanda College of Medicine and Health Sciences Institutional Review Board (CMHS/IRB/498/2023). Permissions were granted by HVP-Gatagara Nyanza Orthopaedic and Rehabilitation Hospital and Gahini District Hospital. Participants provided informed voluntary consent after receiving study information, with opportunities to ask questions. Confidentiality was maintained through anonymised codes, secure use of audio recordings, and non-disclosure of identifying information. The study adhered to the Declaration of Helsinki (World Medical Association, 2013).

The study population comprised individuals with spinal cord injuries who were receiving treatment at HVP-Gatagara Nyanza Orthopaedic and Rehabilitation Hospital and Gahini Rehabilitation Centre. Participants were eligible for inclusion if they had a diagnosis of spinal cord injury, were receiving treatment at one of the specified study settings, were at least one-year post-injury, and were aged 18 years or above. Individuals with cognitive deficits and traumatic brain injury were excluded from the study population.

This study employed purposive sampling methods (Etikan, 2016), whereby participants who met the inclusion criteria were deliberately selected. Following the predefined inclusion criteria, 15 participants were enrolled in the study: seven from Gahini Rehabilitation Hospital and eight from HVP-Gatagara Nyanza Orthopedic and Rehabilitation Hospital. The final sample comprised 12 participants, determined upon reaching data saturation. Interviews were conducted and analysed concurrently during data collection. Saturation was considered achieved when no new themes or insights emerged, indicating that further interviews were unlikely to provide additional information. At this point, the research team concluded that the sample size was sufficient to meet the study objectives.

One-on-one, semi-structured, in-depth interviews were conducted by telephone by the first author (NJ), guided by a structured interview guide. The interview guide was developed based on a comprehensive literature review, the researchers' expertise, and the study's objectives. Interviews were audio-recorded using a digital device. In addition, the interviewer used a shorthand notebook and pen to document key observations and contextual notes during each session.

The interview questions were framed broadly to enable participants to discuss financial issues most relevant to their experiences. Questions explored the costs associated with medical care and daily living, the financial burden of rehabilitation, medications and assistive devices, the impact of spinal cord injury on income and employment, how financial circumstances shaped decisions about seeking medical and rehabilitation services, and any unexpected or hidden costs experienced after injury. Prior to data collection, potential participants were contacted and provided with information about the study's objectives and procedures. They were informed that there were no foreseeable harms associated with participation, that there were no right or wrong answers during the interviews, and that they could withdraw from the study at any time without penalty. Informed consent was obtained from all participants before the interviews commenced. Participants were encouraged to elaborate on their responses, and probing questions were used to gain deeper insights. The interviews were conducted in Kinyarwanda and lasted between 45 and 60 minutes.

Audio-recorded interviews were transcribed in Kinyarwanda by NJ and MV. The transcripts were reviewed several times and checked against the recordings and field notes for accuracy. NJ, with support from KM, MV, PM, and PU, verified the transcripts before sharing them with KM, a rehabilitation and qualitative research specialist. NJ, assisted by MV and PU, then translated the transcripts into English. NJ and KM discussed the study objectives and agreed on the conceptual focus of lived experiences of financial hardship among persons with spinal cord injury. Both independently read and coded the initial transcripts, discussed differences in interpretation, and agreed on the coding approach before analysing the remaining interviews. The final transcripts were imported into ATLAS.ti version 21 to support coding, code organisation, and theme development. NJ and KM produced the final analytical report through discussion and consensus, while the full author team (NJ, KM, PU, PM, and VM) reviewed the coding framework to ensure consistency and resolve discrepancies. Coding differences were addressed by comparing relevant excerpts with the codebook and documenting decisions for transparency. To protect confidentiality, each transcript was assigned a unique identifier, such as P1 to P12, and electronic files were securely stored with backup copies retained to prevent data loss. Trustworthiness was supported using Lincoln and Guba's (1985) criteria of credibility, transferability, dependability, and confirmability through peer debriefing, expert input, clear methodological documentation, an audit trail of the processes followed.

RESULTS

Participants ranged in age from 27 to 58 years, with a mean age of 42 years. Nine participants were male and three were female. Eight participants had paraplegia, while four had tetraplegia. Nine were married, two were single, and one was divorced. Eight of the participants used wheelchairs, two used crutches, and two did not use any assistive device. Regarding employment status, two participants were employed in retail, while nine were unemployed. Table 1 shows the demographic characteristics of the participants. Table 1 shows the demographic characteristics of the participants.

Table 1: Demographic characteristics of the participants

ID	Gender	Age	Marital status	Family members	Level of injury	Employment status	Assistive device
P1	F	43	Married	10	Paraplegia	Retailing	Wheelchair
P2	M	58	Married	7	Tetraplegia	Unemployed	Wheelchair
P3	M	55	Single	0	Paraplegia	Retailing	Wheelchair
P4	M	32	Married	4	Paraplegia	Unemployed	Wheelchair
P5	M	30	Married	3	Paraplegia	Unemployed	Wheelchair
P6	M	33	Married	4	Paraplegia	Unemployed	None
P7	M	44	Married	3	Paraplegia	Unemployed	Crutch
P8	F	44	Married	4	Paraplegia	Unemployed	Wheelchair
P9	M	27	Married	3	Paraplegia	Unemployed	Wheelchair
P10	F	42	Single mother	2	Tetraplegia	Unemployed	None
P11	M	54	Divorced	5	Tetraplegia	Unemployed	Crutch
P12	M	45	Married	7	Tetraplegia	Unemployed	Wheelchair

Two main themes, each comprising three sub-themes, were generated from the study. These themes and sub-themes are presented in Table 2.

Table 2: Themes table

Themes	Sub-themes
Theme 1 Financial pressures in daily living	1.1 Economic strain on family livelihoods 1.2 Expensive lifestyle 1.3 Expensive transportation
Theme 2 Financial pressures in medical and related services	2. 1 High cost of hospitalisation 2.2 Expensive assistive devices 2.3 Expensive medical services

Theme 1: Financial pressures in daily living

Spinal cord injury reshapes the economic fabric of family life, transforming previously stable contributors into financially vulnerable dependents. Participants indicated that the loss of credit access, property sales, and abrupt unemployment signify not merely individual financial difficulties but also a more extensive deterioration of social identity and agency. The inability to sustain employment not only disrupted material support but also symbolised a rupture in dignity and reciprocity within family systems. This shift destabilised household resilience, as families struggled to adapt to diminished resources while confronting the emotional weight of declining health among dependents. The financial struggles experienced by participants were substantial and had significant implications for their occupational engagement, social responsibilities, and overall wellbeing, as reflected in the following participant accounts:

"I could not get the money from the bank, as before I borrowed the money (credits) from the bank for the big tasks in our family and development because of unemployment as I have lost the job after the injury." P1

"I am unable to help anything that can support my family, my children and I see that they are not in good health at the moment unlike before." P4

"…to find something to do today is very difficult because I am not capable of being employed again, and no one gives me the job, so I cannot get the money that can support my everyday life." P3

"I sold the cow or the harvest and even some of my lands so that I can get the money that can help me in this difficult situation. I have to pay for the medical services and hospital, and even my family needs to live so these require a lot of money that I cannot get now." P7

"Life has extremely changed; before I had the properties, but now I have sold my properties to help me and my family. I had the properties." P5

"Before getting into this situation, I was retailing and selling the different goods in a small shop, but now I have sold all of them, including the equipment that I was using, so that I can help myself and my family." P6

Participants indicated that financial strain after discharge from rehabilitation programs transcends physical suffering, altering the lived experience of individuals with spinal cord injury. The inability to purchase critical hygiene supplies, such as diapers and body oil, was seen as the barrier to every day care and also as a representation of diminished autonomy and dignity in self-maintenance. Unemployment and the consequent absence of income disrupted household budgeting, forcing families into cycles of deprivation where basic needs, including food and school fees, became unattainable. These narratives illustrate how reliance on charitable assistance and the incapacity to execute self-care activities undermined participants' sense of agency, exacerbating feelings of vulnerability and emotional discomfort.

"The hygiene activities are a very difficult problem to me because it requires the materials, which are expensive, such as pampa and body oil but also I cannot help myself to wash the body, to go to the toilet, and dress." P10

"The indigence and starving are serious problems of my family; we have met the difficult situation in our family after getting the injury, so we can only get the supplies when the Friends' Charity supports us". P7

"But now, the salary has stopped as long as I used to help my husband with what he also got, so you see that at the moment I have no salary, so you understand sometimes to get the monthly budget at home, such as school fees and home essentials, is very difficult." P1

Transportation challenges profoundly affect the lived experience of the participants. The reliance on costly private transport, necessitated by the absence of accessible public options, was described as a financial burden and a marker of exclusion from social and healthcare participation. Narratives regarding the sale of personal assets to finance hospital trips illustrate the devaluation of mobility, compelling individuals to exchange long-term stability for short-term survival. The intersection of unemployment and high transport costs created a cycle of dependency that restricted access to essential care and reinforced social isolation.

"Getting wherever I need is very difficult for me because it requires a high cost, and remember it is one time; you will need it more times because it is a lifelong circumstance, but I could get to the places nearby as much as I can where my wheelchair can get". P1

"I have to pay for the private transportation, which is also very difficult for me in terms of the cost. For example, I could not go wherever I wanted because of this high cost". P7

"Getting the transportation is challenging as it is very expensive as I rely on the private transportation, so getting the money to pay is difficult as I am unemployed, so this caused me to lose my properties by selling them so that I can go to the hospital for health care services from different places." P6

Theme 2: Financial pressure in medical and related services

This theme, financial pressures in medical and related services, captures the high costs associated with hospitalisation, assistive devices, and other health-related needs. Although core medical services were largely covered, participants reported that gaps in insurance coverage during hospitalisation created additional financial burdens, particularly through the need to purchase non-medical essentials such as hygiene supplies. These hidden costs extended beyond economic inconvenience, affecting participants' dignity, security, and sense of dependence. For families already experiencing vulnerability, the responsibility for meeting these basic needs reflected broader structural inequities in care provision. Participants' accounts suggest that limited insurance protection not only intensified financial strain but also contributed to emotional distress and a deeper sense of marginalisation, where wellbeing and social participation were closely shaped by economic fragility.

"… Even if I use RSSB insurance (RAMA) to pay for medical services such as medication and other health care services, I got the limitation of the high cost of other expenses at the hospital, like those materials for hygiene and other personal care". P1

"When I am hospitalised receiving the medical care, I also need basic hygiene supplies to keep myself clean and healthy. These include Pampas, which are diapers or sanitary pads that are crucial for comfort and personal hygiene. I also need body oil or cream to maintain my skin, so adding this cost to other costs of health care increases the problem of affordability". P10.

Participants reported that the high cost and limited availability of medical equipment, particularly wheelchairs, significantly disrupted the lived experiences of individuals with spinal cord injury. Difficulties affording essential devices and spare parts reflected not only economic strain but also systemic inequities in rehabilitation support. Reliance on outdated or uncomfortable wheelchairs created physical limitations and restricted mobility, autonomy, and social participation. The lack of insurance coverage for assistive devices further intensified vulnerability, placing a substantial burden on families to maintain essential functioning. Access to medical equipment therefore emerged as a lived experience of marginalisation, in which economic insecurity was closely linked to diminished dignity, reduced community engagement, and limited prospects for long-term rehabilitation.

"There are the medical equipments that help me at home, these equipments are all expensive and are not prescribed on the insurance". P8

"The spare parts of the wheelchair are also expensive and rarely available at our market;

moreover, the adapted wheelchair is also expensive, and I cannot afford them." P6

"I couldn't buy the wheelchair since it costs a lot of money, and I can't even buy the crutch because I need it. I got it from a charity, so I can't afford or get it myself. Without that act of kindness, I would probably still be having trouble getting around and suffering daily problems without the basic help that so many people take for granted." P7

Participants reported how the high cost of medical services, particularly ongoing rehabilitation treatment such as physiotherapy, reshapes the life following the spinal cord injury. Participants' accounts of discontinuing rehabilitation for extended periods due to financial constraints reveal more than interrupted care; they signify a profound disruption in the pursuit of recovery and preservation of functional independence. The inability to sustain treatment was due to financial limitation and led to vulnerability, where deteriorating health and physical deformities reflected the consequences of systemic inequities in access to rehabilitation. The cumulative burden of hospital fees and prolonged therapy underscored how affordability becomes a determinant of health trajectory, forcing individuals to negotiate between survival and long-term wellbeing. The high cost of rehabilitation emerges as a lived experience of exclusion, where economic barriers intersect with compromised autonomy, diminished resilience, and heightened risk of secondary complications.

"…Because of the financial issues, I could not go for the rehabilitation services. I remember it is now three years past without physiotherapy service, and also I stopped other health care services, so as I stopped the health care, the problem aggravated, as you see my feet started to get deformities." P1

"Healthcare costs a lot, especially since I need continued physical treatment while I'm in the hospital. The payments have gone up a lot, and this is a really hard position, especially because these prices are adding up with other service fees." P10

The financial challenges associated with daily living costs significantly deplete household resources, leaving families with limited capacity to meet basic needs. When compounded by the high expenses of medical and rehabilitation services, these pressures create a dual financial burden that intensifies vulnerability. For individuals who are unemployed, have sold property following injury, or limited access to financial support systems, the interaction between daily living costs and healthcare expenses becomes mutually reinforcing. This dynamic not only exacerbates the economic strain but also deepens the overall impact of spinal cord injury on wellbeing and social participation.

DISCUSSION

This study explored the multifaceted financial pressures experienced by individuals with spinal cord injury (SCI) in Rwanda, highlighting challenges related to both daily living and access to medical services. Participants described unemployment, limited access to financial resources, and depletion of household assets, which together contributed to financial hardship after injury. These pressures were reflected in the high cost of daily living, transport expenses, and the demands of sustaining an adapted lifestyle. In the healthcare domain, financial strain was associated with the cost of hospitalisation, assistive devices, hygiene products, and rehabilitation services.

Financial hardship following SCI was further compounded by limited access to credit, reduced capacity to support extended family members, and, in some cases, the need to sell family assets to meet basic needs. These difficulties were largely linked to high unemployment among participants, many of whom struggled to secure alternative sources of income after injury. This reflects wider patterns of socioeconomic vulnerability, consistent with studies showing that low-income households, including those in Rwanda, often face substantial barriers in accessing financial resources and credit (Hossain et al., 2020; Kankeu et al., 2013; Shi et al., 2010). Hossain et al. (2020), in a low-income context, similarly reported that individuals with SCI experienced considerable financial hardship due to loss of income and reduced monthly earnings, pushing affected families, particularly those from low sociodemographic backgrounds, into deeper poverty. These challenges are intensified when individuals live with chronic health conditions that require ongoing and costly care.

Participants also reported difficulties meeting the cost of essential hygiene products, particularly after discharge from rehabilitation. Items such as body creams, continence supplies, and sanitary products were necessary not only for health, but also for dignity, social reintegration, and prevention of secondary complications. This finding is consistent with Pacheco Barzallo et al. (2021), who reported that hygiene products become increasingly necessary over time for individuals with lifelong health conditions, particularly where bowel and bladder management needs are significant. Similarly, Spinal Cord Injuries Australia (2023) highlights continence poverty, showing how inadequate access to hygiene products may lead to further health complications and increased healthcare costs.

Transportation costs also emerged as a major contributor to financial strain. Participants required transport to attend healthcare and rehabilitation services, yet these services were often located far from their homes. In the Rwandan context, rehabilitation services remain concentrated at district-level hospitals, with limited availability at primary healthcare level. Public transport systems are often inaccessible for wheelchair users, requiring individuals with SCI to rely on private or specialised transport, which is considerably more expensive. Given the high levels of unemployment among this group, transport costs placed a substantial burden on both individuals and their families. This finding is consistent with Woldemichael et al. (2019), who also reported that transportation expenses worsened the financial capacity of individuals with SCI.

Hospitalisation was another important source of financial stress. Although insurance covered many hospital-based medical services, participants continued to incur out-of-pocket costs for non-medical essentials, including hygiene products and personal care items during admission. These costs added to the overall economic burden and illustrate how gaps in insurance coverage can create hidden costs for individuals and families. This aligns with previous studies by Skinner et al. (2016), Malekzadeh et al. (2022), and Hedrick et al. (2006), which show that lifelong health conditions can deplete financial resources due to prolonged care needs, including personal care requirements during hospitalisation.

The cost and limited availability of assistive devices, particularly wheelchairs, further compounded financial hardship. Participants

reported that wheelchairs and related equipment were expensive, partly because they were not produced locally and were not covered by insurance. Spare parts were also costly and difficult to obtain, creating additional challenges for maintenance and continued mobility. These findings are consistent with Hedrick et al. (2006), who found that people with SCI in low-income countries often face unaffordable costs for wheelchairs and spare parts due to limited local production and availability.

The study further found that rehabilitation services created significant financial pressure because they require prolonged and repeated engagement over time. Unlike one-off medical procedures, rehabilitation involves multiple sessions, specialised professional expertise, appropriate equipment, and access to suitable facilities. In low-resource settings such as Rwanda, rehabilitation is not yet fully integrated into primary healthcare, meaning that services are often concentrated in urban hospitals and rehabilitation centres far from where many people live. This increases not only direct rehabilitation costs, but also transport expenses and time-related burdens. Malekzadeh et al. (2022) similarly emphasise that rehabilitation represents a major direct cost and reflects broader systemic inefficiencies, including limited specialised infrastructure. In low-income settings, these costs are often intensified by restricted service availability and reliance on private healthcare provision.

Overall, the findings highlight the need to strengthen financial protection for persons with SCI within Rwanda's health and social protection systems. Expanding insurance coverage to include rehabilitation services, assistive devices, wheelchairs, repairs, and replacement parts could reduce both direct equipment costs and the indirect costs of repeated travel to specialist centres. In the Rwandan context, where rehabilitation services remain concentrated in specialised facilities, decentralising basic rehabilitation support to primary healthcare and health-centre level could improve geographical access and reduce transport-related financial burdens. Evidence from high-income countries, including the United Kingdom and United States, shows that disability-related financial protection may include coverage for durable assistive devices, mobility aids, home adaptations, and income-support schemes such as ESA, PIP, Attendance Allowance, Universal Credit, and relevant Medicare provisions (Social Security Act, 42 U.S.C. § 1395x; NHS, 2026; GOV.UK, 2026). While these systems cannot be directly transferred to Rwanda without adaptation, they illustrate the importance of integrating rehabilitation, assistive technology, and social protection within a coordinated policy framework. For Rwanda, this would require context-sensitive investment in locally produced assistive devices, expanded insurance benefits, decentralised rehabilitation services, and targeted financial support for individuals and families affected by SCI.

Strengthened social protection could also promote employment opportunities and reduce the broader economic vulnerability experienced by persons with disabilities. In addition, government and private institutions should consider universal accessibility principles in the design of public infrastructure to support inclusion and equitable participation. Social protection strategies may facilitate community integration, reduce financial hardship, and support occupational engagement among persons with disabilities, thereby promoting health and wellbeing through meaningful participation in daily occupations (Muriithi & Gupta, 2025).

Strengths and limitations

This study provides important initial insight into the financial challenges experienced by people with spinal cord injury in Rwanda, particularly the economic burden associated with medical care, rehabilitation, assistive devices, and daily living needs. Its focus on two specialised rehabilitation institutions offers context-specific evidence that may inform policy, service planning, and resource allocation. However, the study was limited to two hospitals and included only participants receiving services at the time of data collection, which may exclude the experiences of those outside formal care. Telephone interviews also limited observation of non-verbal communication. In addition, the qualitative design did not allow precise estimation of direct, indirect, or long-term financial costs. Future nationwide quantitative studies are needed to estimate the scale of financial burden and evaluate cost-effective support strategies.

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CONCLUSION

This study shows that financial hardship among persons with spinal cord injury is not merely an individual economic problem, but a consequence of wider systemic gaps in rehabilitation, social protection, insurance coverage, employment access, and disability-inclusive infrastructure. Following discharge from rehabilitation, participants faced intersecting financial pressures, including unaffordable long-term rehabilitation and healthcare services, the cost of hygiene products and assistive devices, expensive transportation, limited access to credit, and difficulty sustaining household livelihoods within extended family systems. These challenges were compounded by unemployment, inaccessible public infrastructure, and the limited availability of rehabilitation services at primary healthcare level. Addressing these pressures requires coordinated policy and service responses, including targeted financial support, expanded insurance coverage for assistive devices, investment in locally produced assistive technologies, and decentralisation of rehabilitation services to health centres. Future research should include quantitative cost-of-illness studies to estimate the full economic burden of spinal cord injury and evaluate the implementation, effectiveness, and equity impact of proposed policy interventions.

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