BASELINE SURVEY ON SRHR ACCESSIBILITY CHALLENGES FOR WOMEN AND GIRLSWITH DISABILITIES IN RWANDA.

REPORT

SUBMITTED

TO

Hope for Single Mothers with Disabilities (HSMD)

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Prepared and submitted by Patrick IRADUKUNDA

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Abbreviations from SRHR Baseline Report

SRHR: Sexual and Reproductive Health and Rights
HSMD: Hope for Single Mothers with Disabilities
WGWDs: Women and Girls with Disabilities
FGDs: Focus Group Discussions
KIIs: Key Informant Interviews
NST2: National Strategy for Transformation
CPRD: Convention on the Rights of Persons with Disabilities
RNADW: Rwanda National Association of Deaf Women
RSL: Rwandan Sign Language
SPSS: Statistical Package for the Social Sciences
STIs: Sexually Transmitted Infections
UPHLS: Umbrella of Organizations of People with Disabilities in the Fight against HIV and AIDS and in Health promotion
OPDs: Organizations of Persons with Disabilities

Executive Summary

This baseline survey report explores complex challenges faced by Women and Girls with Disabilities (WGWDs) in accessing Sexual and Reproductive Health and Rights (SRHR) services in Rwanda. Despite Rwanda's robust legal and policy frameworks promoting health and gender equality, WGWDs continue to encounter significant barriers, including pervasive stigma, physical inaccessibility of health facilities, limited availability of information in accessible formats (e.g., Braille, sign language), and inadequate training among healthcare providers in disability-inclusive communication.

Employing a mixed-methods approach, the study gathered data through structured questionnaires administered to 40 WGWDs in Karongi and Musanze districts, complemented by Focus Group Discussions (FGDs), in-depth case studies, and Key Informant Interviews (KIIs) with disability rights stakeholders.

Key findings reveal that while a majority of WGWDs are aware of SRHR services, significant gaps in access and perceived quality persist, particularly among those in rural areas and older age groups. Barriers include lack of accessible information (75%), fear of stigma (47%), inaccessible facilities (47%), and negative attitudes from health staff (43%). The study underscores that SRHR inaccessibility profoundly impacts WGWDs' overall well-being, leading to developmental stagnation and heightened vulnerability.

The report concludes with actionable recommendations for policymakers, healthcare providers, and community stakeholders. These include reviewing and revising national SRHR policies for explicit WGWDs' inclusion, ensuring physical accessibility of health facilities, strengthening disaggregated data collection, and implementing comprehensive training for healthcare providers on disability awareness and inclusive communication. By addressing these systemic and attitudinal barriers, Rwanda can ensure equitable and comprehensive SRHR access for all women and girls with disabilities.

Key definitions

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity.

Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and wellbeing by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.

Sexual and Reproductive Health and Rights refer to the rights of all individuals to make informed decisions about their sexual activity, reproduction, and reproductive health, free from discrimination, coercion, and violence. It encompasses access to comprehensive sexual and reproductive health services, including family planning, maternal and newborn health care, prevention and treatment of sexually transmitted infections, safe abortion where legal, and education and information on sexuality, reproductive health, and bodily autonomy. SRHR also includes the right to privacy, bodily integrity, and participation in decisions affecting one's sexual and reproductive life.

Reproductive rights are grounded in internationally recognized human rights and national laws, affirming the right of all individuals and couples to decide freely and responsibly on the number, spacing, and timing of their children. These rights include access to information and means to exercise such choices, as well as the right to achieve the highest attainable standard of sexual and reproductive health. Reproductive rights also guarantee freedom from discrimination, coercion, and violence in all reproductive decisions.

Bearing in mind the above definition, reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents.

These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.

CHAPTER I. GENERAL INTRODUCTION

1.1. Background: SRHR for Women and Girls with Disabilities in Rwanda

Rwanda has demonstrated significant commitment to advancing sexual and reproductive health (SRH) through progressive legislative measures, expanded healthcare access initiatives, and national awareness campaigns. The country's dedication is reflected in key frameworks such as the National Gender Policy and the National Strategy for Transformation (NST2), which prioritize gender equality and SRHR. Constitutional guarantees (Article 21) and specific laws, including Law N° 48/2015 on health insurance and Law N° 21/05/2016 on Human Reproductive Health, further solidify the right to health and reproductive autonomy. Additionally, Law No. 68/2018, supported by Ministerial Order No. 002/MoH/2019, permits safe abortion under specific conditions.

Despite efforts to expand sexual and reproductive health and rights (SRHR) services in Rwanda, women and girls with disabilities (WGWDs) remain systematically excluded, facing barriers that put their health, safety, and autonomy at serious risk. These challenges arise from a combination of social, structural, and institutional factors:

- Persistent misconceptions and discriminatory beliefs within families and communities continue to marginalize WGWDs, limiting their ability to seek SRHR information and services.
- Many health facilities, particularly health posts, are not designed to accommodate people with physical disabilities, creating physical barriers to care.
- SRHR information is rarely available in formats that meet the diverse needs of WGWDs, such as Braille, Rwandan Sign Language, or easy-to-read materials, restricting their ability to make informed health decisions.
- Healthcare workers often lack training in disability-inclusive communication and care, including sign language skills, resulting in insensitive interactions, breaches of confidentiality, and reduced quality of services.

Although Rwanda has ratified international frameworks like the Convention on the Rights of Persons with Disabilities (CRPD) and the Maputo Protocol, the implementation of these commitments often overlooks the specific and diverse needs of WGWDs. Community-based organizations, such as Hope for Single Mothers with Disabilities (HSMD) and Rwanda National Association of Deaf Women (RNADW "Umucyo"), have initiated efforts to bridge these gaps. However, there remains an urgent need for stronger, institutionalized, and disability-inclusive policies and services. Addressing existing data gaps and developing tailored interventions are essential steps to ensure equitable and comprehensive SRHR access for all women and girls with disabilities in Rwanda.

1.2. Objectives of the Study

The primary objective of this baseline survey is to explore and document the current SRHR accessibility challenges faced by Women and Girls with Disabilities in Rwanda. The insights gathered will inform the design and implementation of targeted interventions and responses aimed at enhancing effective and inclusive SRHR service accessibility.

CHAPTER II. METHODOLOGY

2.1. Research Design and Approach

This study employed a **mixed-methods, descriptive cross-sectional survey design** utilizing a participatory approach. The research aimed to comprehensively examine the accessibility of SRHR services for women and girls with disabilities (WGWDs) by integrating both quantitative and qualitative data. This triangulated methodology allowed for a nuanced understanding of diverse experiences, identification of systemic barriers, and exploration of intersecting inequalities, ultimately informing context-specific recommendations for improving inclusive SRHR service delivery.

2.2. Sampling Strategy and Field Data Collection

A purposive sampling strategy was employed to ensure inclusivity and capture diverse experiences across disability types, age groups, socio-economic backgrounds, and geographical locations, with Hope for Single Mothers with Disabilities (HSMD) playing a central role in mobilizing participants and fostering trust. Quantitatively, 40 women with disabilities (20 from Musanze and 20 from Karongi) were selected for structured individual interviews, with the sample size determined using Yamane’s formula and proportionally allocated based on district populations. Qualitatively, data collection involved FGDs conducted in accessible community centers to explore collective experiences of SRHR access, KIIs with disability rights stakeholders, health policymakers, service providers, and gender experts to highlight systemic barriers, and in-depth case studies that contextualized individual narratives of exclusion. All interviews, FGDs, and KIIs were facilitated by trained data collectors who were themselves WGWDs, ensuring an ethical, respectful, and inclusive process.

2.3. Quality Control and Data Analysis

To ensure data integrity, inclusivity, and reliability, the study applied a comprehensive quality assurance framework that included intensive training of data collectors on research ethics, KOBO Collect usage, and disability-sensitive communication, with methodological support provided by a data manager and HSMD technical experts. All interactions were conducted in Kinyarwanda, with Rwandan Sign Language (RSL) interpreters engaged for Deaf participants to ensure full participation. Data quality was further strengthened through triangulation of multiple sources (literature review, questionnaires, FGDs, KIIs, and case studies) and secure storage and rigorous cleaning of collected data. Quantitative data was analyzed using SPSS through descriptive statistics (frequencies, means, standard deviations) to identify trends, while qualitative data from FGDs, KIIs, and case studies was coded through a three-stage thematic framework (initial coding, focused categorization, interpretive analysis) to generate overarching themes supported by narratives and direct quotes. A mixed-methods integration process allowed statistical findings to be enriched with lived experiences, providing a holistic understanding of both the prevalence and depth of barriers to SRHR services for WGWDs, with preliminary results validated through feedback sessions with key informants.

2.4. Ethical Considerations

Ethical considerations were paramount at every stage of the study, ensuring voluntary participation and the protection of all personal information. Ethical guidelines were strictly followed to protect participants' rights and dignity.

- **Informed Consent:** Comprehensive information about the study's purpose, objectives, procedures, potential risks, and benefits was presented in a language and format easily understandable to all participants. For Deaf participants, this included clear communication via Rwandan Sign Language (RSL) interpreters.
- **Confidentiality and Anonymity:** Participant privacy was crucial, especially for individuals from marginalized groups who may face stigma or discrimination. All data collected was anonymized to remove any identifying information. Participants were assigned unique codes to ensure their confidentiality throughout the research process.
- **Voluntary Participation:** Participation in the research was entirely voluntary. Participants had the absolute right to decline to answer any question or withdraw at any time without any consequences. Researchers actively fostered an environment of trust and respect to encourage open and honest participation.
- **Respect for Vulnerable Populations and Psychosocial Support:** Special attention was given to the unique vulnerabilities of WGWDs. Data collection methods were adapted to ensure accessibility (e.g., alternative formats, assistive technologies, RSL interpreters). For adolescents, age-appropriate language and methodologies were employed. Data collectors were trained to handle sensitive topics respectfully, and **clear referral pathways to psychosocial support services were established and**

communicated to participants, should any distress or disclosures of sensitive issues arise during or after discussions.

2.5. Limitations of the Study

Despite efforts to make the study comprehensive and inclusive, it faced several challenges:

- **Limited Geographic Coverage:** Due to funding constraints, the study's geographic scope was limited to Karongi and Musanze districts, restricting broader national generalizability.
- **Cultural Stigma:** Cultural stigma surrounding SRHR topics may have led to underreporting or hesitation in sharing personal experiences.
- **Technical Issues:** Occasional technical issues with the KOBO Collect system disrupted real-time data entry, requiring additional manual verification and cleaning.
- **Self-Reported Data Bias:** The study relied on participants' self-reported data, which may have been influenced by recall bias or social desirability bias.

CHAPTER III. FINDINGS AND ANALYSIS

3.1. Socio-Demographic Characteristics of Respondents

The socio-demographic profile of the 40 Women and Girls with Disabilities (WGWDs) who participated in the survey highlights important factors influencing their access to SRHR services. Most participants (80%) were aged 19–35, a critical reproductive health stage, while only 6% were adolescents (14–18), indicating underrepresentation of younger WGWDs. The majority (78%) were single, with smaller proportions married (9%), separated (9%), or divorced (3%). Educational attainment was low: 41% had never attended school, 28% reached secondary education, 6% received professional training, and only 3% completed university, limiting access to SRHR information and services. Additionally, 75% lived in rural areas, where geographic and infrastructural challenges further hinder access to health services.

Two focus group discussions (FGDs) were conducted with health service providers from Musanze and Karongi districts, including nurses, midwives, and health post staff directly involved in SRHR service delivery. In Musanze, participants were drawn from Muhoza Health Center and Mpenge Post de Santé, while in Karongi they came from Karwasa Health Center. Most participants had responsibilities in maternal health, youth-friendly services, or general outpatient care, and both male and female providers were represented. This composition enabled the FGDs to capture diverse perspectives on barriers, service delivery challenges, and community attitudes affecting access to SRHR for girls and young women with disabilities.

3.2. Knowledge, Access, and Perceived Quality of SRHR Services among Women and Girls with Disabilities

3.2.1. Knowledge of SRHR Services and Information among WGWDs

The study highlights that while approximately **66% of WGWDs in both districts are aware of where to access SRHR services**, significant gaps remain, particularly among those in rural areas, older age groups, and unmarried or socially marginalized individuals. Awareness was highest among married and divorced women, likely due to more frequent interactions with the health system, and lowest among single and separated women. Age also influenced awareness, with younger WGWDs demonstrating higher knowledge levels, while limited knowledge was notably prevalent among those aged 36 and above.

Most respondents (69%) first accessed SRHR information through NGOs and community outreach, followed by family, friends, and schools. This indicates the critical, but often unsustainable, role of external actors in information dissemination. The limited influence of social media and the uneven reach of school-based education further underscore the need for inclusive, targeted, and sustainable approaches.

"Being dscuraged by service providers, who docters who mock you 'even you who ine disabled" not not appropiate to seek their services."
— Survey Participant

Qualitative findings from FGDs, KIIs, and literature review further confirm that WGWDs face significant and multifaceted barriers in accessing SRHR information. Participants in both Karongi and Musanze Districts revealed a complex interplay of structural, cultural, and interpersonal obstacles. Many reported exclusions from family discussions on reproductive health, leaving them unprepared during adolescence. Health providers were often described as dismissive or discriminatory, reinforcing internalized shame and deterring care-seeking behavior.

Others spoke of denied autonomy, including forced medical procedures like sterilization, and emotional trauma stemming from sexual violence and rejection. Cultural beliefs, poverty, and limited-service reach, particularly in rural areas, further compounded the challenges. The disconnect between legal rights and everyday realities was poignantly summarized by a participant:

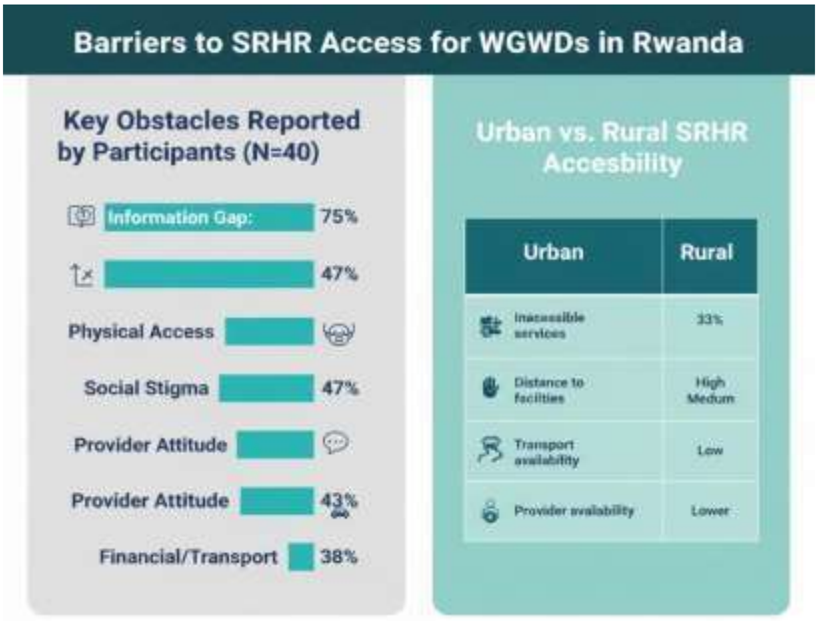
"We are allowed by law, but our families think otherwise."

The real-life consequences of inaccessible SRHR services are heartbreaking. An UPHLS representative highlighted a tragic case:

"One woman with a disability... unknowingly gave birth to an HIV-positive baby because she was never informed that mother-to-child transmission could be prevented with proper medical support. She was never informed of her rights or the services available."

3.2.2. Access to SRHR Services among WGWDs

Despite a promising **88% of WGWDs reporting prior use of SRHR services**, they face a range of intersecting challenges in actual access. HIV testing, family planning counseling, and SRHR education are the most commonly accessed services. However, critical services like abortion care remain entirely out of reach, likely due to legal, cultural, and stigma-related barriers.



These barriers are not just logistical but reflect systemic neglect and social exclusion, with some groups, especially younger WGWDs, facing added judgment around sexual activity and SRHR decision-making. Cultural and religious obstacles persist in both rural and urban settings, though they manifest differently. In rural areas, only 4% of WGWDs reported encountering direct cultural or religious discouragement, in contrast to 38% in urban areas. This suggests that urban settings, while more modern in some respects, may enable more intense moral scrutiny. However, general cultural or religious beliefs were cited equally among both groups (29%), indicating that belief-based limitations aren't restricted to one locale.

The findings underscore that access is not merely about availability, but about creating inclusive, respectful, and empowering systems that truly center the needs and dignity of WGWDs. Several participants expressed frustration with leaders, service providers, and systems that repeatedly ignore their rights and needs, a concern also highlighted in the desk review, FGDs, KIIs, and personal testimonies.

3.2.3. Perceived Quality of SRHR Services among WGWDs

WGWDs perceive the quality of SRHR services as significantly hampered by a complex web of barriers. This includes inaccessible or misleading information, untrained and insensitive staff, long distances to facilities, lack of transport, inadequate infrastructure, absence of assistive tools, and deep social exclusion. These factors leave them feeling ignored, disrespected, and unsupported by health systems, communities, and even their own families. Poverty and lack of emotional support further compound their vulnerability to abuse, poor health outcomes, and developmental stagnation. Social stigma, shame, and mistreatment by service providers further discouraged them from seeking care.

The voices of WGWDs reveal that SRHR inaccessibility is not merely a service delivery gap; it is a deeply rooted barrier to their overall growth and well-being, with consequences that extend far beyond health, affecting their social inclusion and life opportunities. Many respondents emphasized that limited access to SRHR leads to developmental stagnation, missed opportunities, and being left behind in life.

Issues around service availability and physical access continue to be significant. While both urban and rural WGWDs reported encountering inaccessible disability services (38% urban vs. 33% rural), rural women frequently deal with additional layers of geographic isolation, inadequate infrastructure, and limited provider availability – factors that may not be fully captured through self-reported barriers. One of the most frequently cited challenges was distance and physical inaccessibility to health facilities:

"The place where the services are offered is far, and I don't have transport to get there."

The findings also highlighted the absence of essential assistive tools, such as guides for the visually impaired, sign language interpreters, adapted communication methods, and caregivers or support persons to accompany them.

Beyond these logistical and infrastructural issues, key informant interviews revealed that:

"Access challenges are further compounded by the diverse needs and identities of WGWDs, and by deeply rooted informational and attitudinal barriers. Women and girls with disabilities vary widely in age, type of disability, education, and location factors that significantly shape their SRHR experiences. While some have basic awareness of their rights, particularly those in urban areas or linked to Persons with Disability Organizations, many especially those with intellectual, hearing, or visual impairments lack even foundational SRHR knowledge. Health centers often lack accessible infrastructure and trained personnel, and critical information is rarely available in formats such as Braille, audio, or sign language. Alarmingly, some

providers still question the SRHR of WGWDs altogether, displaying discriminatory attitudes and making decisions on their behalf. These barriers are not merely structural; they are also social, driven by stigma, cultural beliefs, and a lack of respect for bodily autonomy" **(Representatives from HSMD, RNADW, and UPHLS).**

3.3. Health Provider Attitudes and Systemic Barriers

FGDs with health providers in Musanze and Karongi revealed critical systemic barriers:

- **Physical Accessibility:** Health posts are often housed in community-constructed buildings that lack ramps and disability-friendly designs. Women with mobility impairments struggle to physically access services. Providers admitted:

"Most of the buildings are regular houses that were built by the community, and they are not disability friendly, making it hard for people with physical disabilities to access services." (Mpenge Post de Santé)

- **Limited Staffing and Time:** With only one nurse or midwife on duty, providers often lack time to adequately engage WGWDs, leading to rushed and insufficient consultations.
- **Communication Barriers:** A recurring issue was the absence of sign language-trained staff, which forces reliance on interpreters and compromises confidentiality.

"Health workers need training in sign language so that patients with hearing or speech disabilities can feel fully included and access services without barriers." (Karwasa Health Center)

- **Youth-Friendliness:** Providers noted the absence of dedicated youth-friendly rooms, particularly in health posts, forcing young women to seek services in open spaces where confidentiality is compromised.
- **Stigma and Norms:** Families and communities often discourage WGWDs from seeking SRHR services, perpetuating harmful stereotypes. Providers reported:

"Parents often don't understand that these children are just like any other and deserve the same rights… We see very few girls with disabilities coming to seek services." (Karwasa Health Center)

- **System Constraints:** Lack of specialized equipment, such as disability-adapted delivery beds, forces providers to physically lift patients, creating undignified and unsafe experiences.
- **Consequences of Inaccessibility:** Health workers recognized that lack of accessible SRHR information exposes WGWDs to **unintended pregnancies, unsafe abortions, higher risks of STIs, and emotional trauma**.

3.4. Key Barriers (Consolidated from WGWDs and Providers)

- Exclusion from SRHR planning and decision-making.
- Discriminatory and judgmental behavior by providers.
- Lack of SRHR materials in Braille, RSL, or easy-to-read formats.

- Long distances to facilities and lack of accessible transport.
- Non-consensual medical interventions and breaches of privacy.
- Weak enforcement of existing inclusive laws and policies.
- Harmful societal narratives that deny WGWDs' sexuality and motherhood.
- Internalized stigma and lack of confidence to seek care.
- Poverty and limited social support, particularly for single mothers with disabilities.
- Psychological barriers linked to past trauma and sexual abuse.

CHAPTER IV. CONCLUSIONS AND RECOMMENDATIONS

4.1. Conclusion

This baseline study highlights a persistent and troubling gap between Rwanda's progressive legal and policy frameworks on Sexual and Reproductive Health and Rights (SRHR) and the lived realities of women and girls with disabilities (WGWDs). Despite the country's commitments to gender equality and disability rights, WGWDs remain largely excluded, underserved, and marginalized in the delivery of SRHR services.

Limited awareness and knowledge, particularly among rural and intellectually disabled individuals, stem from the lack of accessible information formats and a broader culture of silence around sexuality. Systemic barriers, including physically inaccessible health facilities, a shortage of trained and sensitized healthcare workers, and the absence of inclusive communication tools, further hinder service access. Deep-rooted cultural and social norms perpetuate harmful stereotypes, often viewing WGWDs as asexual or unfit for motherhood, which leads to denial of services and institutional discrimination. These challenges are compounded by widespread poverty, economic dependency, and a lack of disability-friendly infrastructure, leaving many WGWDs unable to seek or afford necessary care.

As a result, WGWDs face heightened risks of unintended pregnancies, unsafe abortions, gender-based violence, poor maternal outcomes, and long-term psychological distress. While Rwanda has ratified key international conventions and enacted supportive laws, the implementation, enforcement, and monitoring of disability-inclusive SRHR services remain insufficient. Bridging this gap requires intentional, inclusive programming and systemic reforms to ensure the rights, dignity, and well-being of WGWDs are fully realized.

4.2. Recommendations

Based on the findings of this baseline survey, the following recommendations are proposed to enhance SRHR accessibility for Women and Girls with Disabilities (WGWDs) in Rwanda:

Policy and Legal Frameworks

- Review and revise national SRHR policies, laws, and guidelines (including the National Disability Policy 2021, Law N° 21/2016 on Human Reproductive Health, and Ministerial Order No. 002/MoH/2019) to explicitly address the needs and rights of WGWDs.
- Institutionalize disability-inclusive SRHR within the Health Sector Strategic Plan and strengthen enforcement of inclusive laws.
- Develop disability-sensitive monitoring frameworks to track the accessibility, quality, and effectiveness of SRHR services for WGWDs.

- Strengthen collaboration between the Ministry of Health, Organizations of Persons with Disabilities (OPDs), women's rights groups, and other stakeholders to implement inclusive SRHR initiatives.

Service Delivery and Accessibility

- Improve healthcare facility infrastructure using universal design principles (ramps, adapted delivery beds, accessible restrooms, clear signage).
- Expand SRHR services at health posts and establish youth-friendly rooms with trained staff.
- Provide community-based SRHR outreach in rural and underserved areas to reach WGWDs facing geographic barriers.
- Ensure all SRHR information is available in accessible formats, including Braille, Rwandan Sign Language (RSL), and easy-to-read or visual materials.

Capacity Building

- Train healthcare providers on disability awareness, inclusive communication techniques (including RSL where relevant), rights-based SRHR care, confidentiality, and non-discrimination.
- Integrate disability-inclusive care modules into medical, nursing, and health professional curricula to ensure sustainable inclusive practices.

Advocacy and Awareness

- Conduct public education campaigns via schools, media, and communities to promote positive attitudes, challenge harmful stereotypes, and uphold WGWDs' bodily autonomy.
- Engage families to reduce stigma and encourage parental support for WGWDs' SRHR.
- Support WGWD-led organizations (e.g., HSMD, RNADW) to lead community dialogues, advocacy initiatives, and participation in policy and program development.

Health Systems Strengthening

- Strengthen health information systems to collect and analyse disaggregated data by disability, age, and gender for evidence-based planning.
- Establish mechanisms to report discrimination, abuse, and misconduct in health facilities, ensuring accountability.

Prepared and submitted by Patrick IRADUKUNDA