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Mental Wellness Challenges among Women with Physical Disabilities in Kenya

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Abstract

This study aimed to examine the mental wellness experiences of women with physical disabilities in Kenya, guided by the hypothesis that these women encounter multifaceted mental health challenges. Utilizing a survey research design, data was collected via questionnaires from a convenience sample of 41 women with physical disabilities, recruited across 13 counties during a community program enrolment initiative. Descriptive statistics revealed a mean participant age of 33.98 years (SD = 11.97). Employment status was distributed as follows: 17.1% employed, 26.8% self-employed, and 56.1% unemployed. Mobility dependence on wheelchairs was reported by 63.4% of participants, while 85.4% relied on other people for household activities. Thematic analysis of mental wellness sentiments identified 48 theme entries, with prevalent issues including mental overload (71%), stress linked to financial dependency (85.4%), burnout and fatigue (54%), anxiety and uncertainty (42%), loneliness and isolation (54%), low self-esteem (25%), and feelings of discrimination (19%). Adoption of coping strategies for mental wellness was noted in 23% of entries. These findings corroborate the Social Model of Disability and Intersectionality Theory, particularly through the interconnected concepts of ableism and social exclusion. The study concludes that mental wellness challenges among women with physical disabilities in Kenya extend beyond individual impairments, being profoundly influenced by socioeconomic disparities and gendered inequalities.

Keywords: *Mental Wellness, Challenges, Women with Physical Disabilities*

1. Introduction

The World Health Organization (WHO) data shows that, approximately 15% of the world's population lives with some form of disability including mobility impairments, chronic pain conditions, or sensory limitations (WHO, 2022). Mental wellness represents a critical dimension of overall population health, encompassing emotional, psychological, and social balance (Smith, 2024). For persons with disabilities (PLWDs), achieving mental wellness is often compounded by multifaceted barriers that extend beyond individual experiences to societal structures (Biswal & Mishra, 2025). Globally, Women are disproportionately affected by both disability and its mental health repercussions (WHO, 2022). The risks of mental health disorders among these women primarily include depression, anxiety, and post-traumatic stress, due to intersecting factors like discrimination, limited access to resources, and systemic inequalities (Burns, 2013). These challenges are both additive and multiplicative, as gender norms amplify the vulnerabilities associated with disability.

Mental wellness challenges among women with disabilities stems from environmental inaccessibility such as physical barriers in public spaces and inadequate healthcare facilities (Matin et al., 2021). These challenges include body image concerns, internalized shame and reduced self-esteem, heightened chronic stress risks and a sense of marginalization among these women (Burns, 2013). Sifat (2022) shows that these women experience unemployment rates up to twice that of their non-disabled counterparts, resulting in financial instability and dependency that erode mental resilience. They are also prone to intimate partner violence, with research showing that they have a 40% higher risk of domestic abuse compared to women without disabilities, due to perceived vulnerability and limited escape options (Mathisen Olsvik, 2006). Violent experiences inflict direct trauma and perpetuates cycles of anxiety and helplessness among these women. Moreover, women with physical challenges are more exposed to healthcare disparities as a result of dismissive attitudes from providers or inaccessible medical equipment, delay in mental health interventions, leading to untreated conditions like somatic symptom disorders.

The challenges draw upon Intersectionality Theory, which posits that overlapping social identities, including gender, disability, race, and class combine to generate unique modes of discrimination and privilege in the society (Wickenden, 2023). In the context of mental health, women with physical disabilities navigate compounded oppressions, connecting directly to two key ableism and social exclusion concepts. Ableism encapsulates a systemic devaluation of disabled bodies, where physical disabilities are viewed as deficits rather than diversities, intensifying mental distress through stigma and aggressions (Brown & Ciciurkaite, 2022). Women with physical disabilities may internalize narratives that equate physical limitations with unworthiness, fostering mental wellness. The social exclusion concept posits that structural and relational barriers that isolate individuals from community networks, employment, and support systems amplify loneliness and limited access to support systems (National academies of Sciences et al., 2020). In the mental wellness context, these factors may interact to reduce access to protective factors like social support, eroding women's mental wellness. The main aim of this research was to examine the mental wellness subject among women with physical disabilities from the selected counties in Kenya.

2. Methods

2.1. Research Design

This research article explores these dynamics through qualitative narratives from 41 women with physical disabilities in Kenya, aiming to highlight finance-mental-wellness pathways and bridge theory with lived experiences. It underscores the need for inclusive policies that address these interconnected challenges, ultimately advocating for a holistic approach to mental wellness that empowers rather than pathologies. This study employed a cross-sectional survey design to examine the experiences, challenges, and support needs of women with physical disabilities who use wheelchairs in Kenya. The survey approach was selected because it enables systematic data collection from a defined population and allows both quantitative and qualitative insights to be captured efficiently.

2.2. Study Location

The research was conducted in 12 counties in Kenya. Local churches served as community mobilization points for the Zaidi ya Mama Program implemented by Necessio Wellness Community. The congregants were asked to refer people who could need support as outlined in the Zaidi ya Mama Program. As a result, the churches served as the main community settings where beneficiary identification and program mobilization were undertaken.

2.3. Study Population

The target population consisted of adult women with physical disabilities who were wheelchair users across various counties in Kenya. These women were either potential or actual beneficiaries of the wheelchair-distribution initiative by Bethany Kids. The focus on women emerged from preliminary observations during program sensitization, beneficiary referrals, and recruitment where women appeared disproportionately represented among individuals with physical impairments in need of these services.

2.4. Sampling Strategy and Sample Size

A prospective purposive sampling strategy was used to recruit participants. This sampling method was appropriate considering the study's focus on a specific, hard-to-reach population. Recruitment occurred during community sensitization visits to local churches, where congregants referred potential beneficiaries to the researchers. A total sample of 41 women who met the eligibility criteria, being 18 years or older with a physical disability, and using a wheelchair was obtained.

2.5. Data Collection Procedure

Data collection was integrated into the participants' voluntary involvement in the Zaidi ya Mama Program. Once referred individuals were identified, the researcher introduced the study objectives and invited eligible women who wanted to be enlisted in the program to participate in the survey. Structured questionnaires were administered to gather qualitative data on demographic characteristics, types of disabilities, access to assistive devices, and support systems. Additionally, open-ended questions were included to elicit narrative accounts of participants' lived experiences, social challenges, and unmet needs.

2.6. Data Analysis

Data analysis involved a combination of descriptive statistics and thematic analysis. Quantitative data from the structured survey items were analysed using descriptive statistics, including frequencies and percentages, to summarize participant characteristics and service-related experiences. Qualitative data obtained from open-ended responses were analysed thematically. This involved familiarization with the data, coding responses, generating themes, and interpreting emerging patterns related to barriers, support needs, and program experiences.

2.7. Ethical Considerations

This study adhered to core ethical principles of informed consent, anonymity, and transparency. Prior to participation, all respondents were informed about the purpose of the study, the voluntary nature of their involvement, and their right to withdraw at any time. Informed consent was obtained verbally or in writing, depending on participants' preference and accessibility needs. To protect confidentiality, no identifying information was recorded, and all responses were anonymized during data handling and reporting. Transparency was maintained by clearly communicating to participants that the information collected could be used to inform future research and support resource mobilization for program improvement.

3. Findings

Table 3.1

Respondent characteristics by county

County	Frequency	Percent (%)
Bungoma	1	2.4
Homabay	1	2.4
Kajiado	3	7.3
Kiambu	4	9.8
Kisumu	1	2.4
Kwale	1	2.4
Machakos	4	9.8
Mombasa	2	4.9
Murang'a	1	2.4
Nairobi	21	51.2
Nandi	1	2.4
Tharaka Nithi	1	2.4
Total	41	100.0

The distribution of respondents by county in table 1 indicates that the sample was heavily dominated by participants from Nairobi County, which accounted for 21 respondents (51.2%). Kiambu and Machakos each contributed 4 respondents (9.8%), while Kajiado had 3 respondents (7.3%) and Mombasa had 2 respondents (4.9%). The rest of the counties (Bungoma, Homabay, Kisumu, Kwale, Murang'a, Nandi, and Tharaka Nithi) contributed 1 respondent (2.4%) each. Thus, the data on respondent distribution by county depicts a highly uneven distribution, with Nairobi being significantly more represented than all other counties, suggesting that most of the female persons with physical disabilities are likely to be found in more urbanised areas.

Table 3.2

Respondent age

Mean	Median	Mode	Std. Deviation
33.9756	32	20.00[a]	11.96973

The age distribution of the respondents in Table 2 shows that the average age of the female persons with physical disabilities was 33.98 years, while the median age was 32 years while the mode was 20 years. This suggests that half of the participants were younger than 32, with respondents aged 20 being the most in the dataset. A standard deviation of11.97 implies a notable variation among respondents in terms of age, as the spread of ages around the mean age was relatively wide.

Table 3.3

Respondent employment status

Employment status	Frequency	Percent
Employed	7	17.1
Self-employed	11	26.8
Unemployed	23	56.1
Total	41	100.0

Table 3 findings show that more than half of the respondents were unemployed**,** representing more than half of (23) of the participants (56.1%)**.** The self-employed participants accounted for 11 respondents (26.8%)**,** while 7 respondents (17.1%) reported being formally employed**.** The percentage of the unemployed and self-employed respondents accounted for 82.9% of the respondents. Generally, the results signal that most of the female persons with physical disability respondents that participated in this study were unemployed, while the least proportion was employed.

Table 3.4

Wheelchair dependence for mobility at home

	Frequency	Percent (%)
Do not depend on wheelchair mobility at home	15	36.6
Depends on wheelchair mobility at home	26	63.4
Total	41	100.0

Table 4 findings show that a majority of the females with physical disability respondents that participated in this study were dependent on wheelchair mobility at home, with 26 participants (63.4%) reporting that they use a wheelchair in their home environment. The remaining 15 of the respondents (36.6%) stated that they do not rely on a wheelchair at home. Overall, the results suggest that wheelchair dependence at home is popular among the selected participants.

Table 3.5

Whether the respondent does not depend on anyone in their home activities

Independent?	**Frequency**	**Percent**
No	6	14.6
Yes	35	85.4
Total	41	100.0

Table 5 results indicate that the vast majority of females with physical disabilities that were the respondents of this study considered themselves independent, with 35 participants (85.4%) indicating that they can perform their daily tasks without needing any help. Only 6 respondents (14.6%) reported that they were dependent on others to perform those activities. Overall, the findings suggest that despite being dependent on wheelchairs for mobility, reliance on others for help to perform daily tasks is low among the study's participants.

Table 3.6

Mental wellness Themes among the Selected Respondents

Theme	Indicators from the responses	Rate
Mental overload	• Feeling depressed due to financial hardship • Loss of hope, feeling useless • Feeling like life is too difficult to manage • Statements indicating emotional despair or worthlessness • Overthinking due to financial pressure • Feeling overwhelmed by multiple responsibilities • Emotional overload from physical limitations • Difficulty coping with daily demands	34/41 (71%)
Stress driven by Financial Dependency	• Relying on caregivers for food, hygiene, mobility • Living fully supported by family or well-wishers • Emotional burden of dependency • Stress & depression from financial instability • Feeling hopeless about income • Burnout reducing productivity • Mental health affecting ability to work or run business	41/48(85.4%)
Burnout and fatigue	• Difficulty setting boundaries • Mental exhaustion from caregiving or dependency • Tiredness from constant survival mode • Emotional fatigue from navigating inaccessible systems	26/48(54%)
Anxiety and Uncertainty	• Fear about future income • Worry about mobility issues (wheelchair, caregivers) • Anxiety over medical conditions or health deterioration • Concern about business survival	20/48(42%)
Feeling discriminated	• Experiencing discrimination in workplaces • Gender-based violence and stigma toward PWDs • Emotional pain from being excluded or undervalued • Internalizing societal biases	9/48(19%)
Low self-esteem	• Feeling undeserving (“I don’t deserve to be alive”) • Feeling useless due to inability to provide financially • Shame around dependency • Lack of confidence due to disability discrimination	12/48(25%)
Loneliness and Isolation	• Inability to visit loved ones • Social isolation caused by mobility issues • Feeling emotionally unsupported • Being home-bound due to disability or cost	26/48(54%)
Mental Wellness coping strategies	• Reading books • Journaling • Exercising • Speaking out to friends or support groups	11/48(23%)

Table 3.6 results reveal that the female respondents with physical disabilities experience substantial financial challenges that are linked to their state of mental wellness, with each theme extracted from the dataset showing how economic hardship and psychological distress are deeply intertwined in their daily lives. Money and income barriers, were mentioned in 32 out of 41 entries (67%). Having limited or no income sources, unstable or irregular earnings, and a complete lack of reliable financial support, struggling to navigate high cost of living, to the extent that even affording one meal a day was difficult were mentioned. Some respondents attributed their financial challenges to employer discrimination, liming their access to job opportunities, while others attributed their experiences to overdependence on caregivers, who may not have a stable income source themselves.

The challenge of money management appeared in 21 out of 41 entries (44%), with respondents reporting difficulties in saving, frequent unplanned expenses, and challenges with budgeting. The respondents also alleged that limited financial literacy, especially in investing, budgeting, and identifying opportunities was preceded financial mismanagement or debt, contributing to long-term financial insecurity.

The high cost of assistive devices appeared in 19 out of 41 entries (40%). The respondents cited spending a large portion of their income on medical treatments or essential assistive devices like wheelchairs, diapers, and hygiene items. Others indicated that they could not replace worn-out wheelchairs, and were sometimes forced to hire someone to push them, indicating that the financial strain was considerable. Additionally, the respondents without the ability to use public transport due to accessibility limitations incurred higher expenses to do so, as they relied on taxis or TukTuks.

Financial limitations also hindered entrepreneurship, with 17 out of 41 entries (29%) reporting financial access limits as a significant barrier business starting and sustenance barrier. Respondents noted that although they possessed relevant skills, they lacked capital, access to loans, or market linkages. Some struggled to maintain small businesses such as footwear repair or second-hand clothing (mutumba) sales due to insufficient financial support. Additionally, 12 out of 41 entries (25%) indicated that financial challenges that were experienced significantly affected their mobility. This was indicated by the notions that they often had to pay extra fares because of their wheelchairs, rely on caregivers for mobility assistance, or budget for additional transport-related costs, which further contributed to their overall financial instability.

The financial pressures that these females with physical disabilities reported were closely tied to mental wellness concerns. Mental overload was reported in 34 out of 41 entries (71%), reflecting widespread feelings of depression, hopelessness, and emotional exhaustion. Many expressed that their lives felt overwhelming due to the constant struggle of managing financial hardship alongside physical limitations. Emotional despair, overthinking, and difficulty coping with daily responsibilities were common experiences. The most widespread mental wellness challenge was stress driven by financial dependency, reported by 41 out of 48 entries (85.4%). High dependency on caregivers or family for food, hygiene, or mobility, led to emotional burdens, feelings of inadequacy, and reduced productivity.

Burnout and fatigue due to constant survival-related stress appeared in 26 out of 41 entries (54%). Anxiety and uncertainty was identified in 20 out of 48 entries (42%). These stemmed from concerns about future income, mobility limitations, or health deterioration. Additionally, 9 out of 41 entries (19%) depicted feelings of discrimination, while 12 out of 48 entries (25%) illuminated low self-esteem. Loneliness and isolation further compounded their mental health challenges, for respondents who were home-bound due to mobility constraints or financial limitations. Despite these difficulties, 11 out of 41 respondents (23%) reported using positive coping strategies such as reading, journaling, exercising, or seeking support from friends or groups.

4. Discussion

The findings from the demographic, financial, and mental wellness data in this study reveal a complex interaction between physical disability, gender, and socioeconomic vulnerability among women. We find that the respondents' financial and mobility challenges affected women with disabilities who depended on wheelchair mobility at home, unable to buy and maintain assistive devices, spending a significant portion of their income on medical or mobility-related expenses, and unable to replace worn-out wheelchairs or pay caregivers.

The patterns can be best understood through the Social Model of Disability (SMD) and Intersectionality Theory, both of which illuminate how structural inequalities shape the lived experiences of women with disabilities. Precisely, it corresponds to SMD's argument that disability is a product of both physical impairment and environmental, economic, and social barriers (Camilleri Zahra, 2023). In this research, various constraints to mental wellness emerge, highlighting how inaccessible infrastructure and costly assistive technologies function as mental health disabling barriers, rather than the impairment itself.

Intersectionality Theory further deepens this understanding by explaining how gender and disability intersect to produce heightened disadvantage. These women with disabilities face not only mobility and financial barriers but also gendered discrimination, stigma, and social exclusion (Pal, 2011). The finding that 19% experienced discrimination, including gender-based violence and negative societal attitudes depicts how gender and disability identity overlap to intensify vulnerability. Women also reported emotional burdens linked to dependency on caregivers, with 85.4% experiencing stress from financial dependency, a finding strongly tied to gendered expectations around economic productivity and caregiving roles. Drawing from Camilleri Zahra (2023), the SMD explains how society disables through barriers, while Intersectionality Theory explains how gender compounds these barriers.

The patterns of the women's challenges spilled over to the domain of financial independence. Although 85.4% of these women described themselves as independent in daily life, a majority faced significant economic hardship: 67% entries cited unstable or no income, 44% acknowledged struggles with money management, and 29% expressed lack of access to capital needed to put their entrepreneurship ideas into practice. The study attributes these financial barrier patterns to both personal limitations and deep lying structural exclusions that restrict women with disabilities from fully participating in economic life. As an illustration, discriminatory practice that limit recruitment of PLWD at workplaces and lack of accessible financing options perpetuate systemic inequities that amplify disability's economic impact.

These structural disadvantages had profound mental wellness implications. 71% of the entries captured mental overload, 54% of the entries were about burnout and fatigue, and 42% signalled feelings of anxiety and uncertainty about income, health, and mobility. Such emotional distress is not merely an internal psychological issue but a reflection of external pressures created by inaccessible environments, discrimination, poverty, and social isolation. These outcomes reinforce both theories by illustrating how economic, social, and cultural systems shape the disability experience discourse among women with disabilities. Overall, the findings show that the challenges faced by women with physical disabilities are deeply rooted in structural inequalities. They also illuminate the concept of intersectionality in this discourse by demonstrating how ableism and social exclusion intersect with gender to produce distinct mental health burdens among women with physical disabilities.

5. Conclusion

The findings of this study demonstrate how the mental wellness challenges faced by women with physical disabilities in Kenya are real and extend far beyond individual impairments and are deeply shaped by socioeconomic and gendered inequalities. Financial instability, limited access to assistive devices, and restricted entrepreneurial opportunities are common among these women, revealing structural barriers that hinder their independence and participation in society. These barriers also

significantly impact mental wellness, contributing to high levels of stress, burnout, depression, and anxiety. The study establishes that when viewed through the Social Model of Disability and Intersectionality Theory, it becomes evident that physical disability among women is produced through the interaction of physical limitations with discriminatory social environments, gender norms, and economic exclusion.

Addressing these challenges therefore requires holistic, multi-level interventions that promote accessible infrastructure, financial inclusion, and gender-sensitive support systems. These efforts are pivotal for strengthening social protection, expanding disability-friendly services, and challenging discriminatory attitudes are essential steps toward improving the quality of life and autonomy of women with physical disabilities.

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