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Financial Barriers Limiting Healthcare Access among Women Living with Disabilities in Kenya

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Abstract

This study investigated the financial difficulties that could adversely affect the healthcare access among women living with physical disabilities in Kenya. It was grounded in the hypothesis that these women encounter diverse financial challenges directly or indirectly associated with their physical disability status that undermine their healthcare service access. Employing a survey research design, data were collected via questionnaires from a convenience sample of 41 women with physical disabilities, recruited across 13 counties during a community program enrollment 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 48 theme entries derived from participants' statements revealed prominent financial barriers, including difficulties in navigating income and monetary access (67%), challenges in money management (44%), high costs of assistive devices (40%), restricted financial access as a barrier to entrepreneurship (29%), and spillover effects of financial constraints on transport and mobility (25%). These findings illuminate the Social Model of Disability and Intersectionality Theory, highlighting how socioeconomic disadvantages intersect with gender and disability to exacerbate health vulnerabilities among this population.

Keywords: *Healthcare Access, Women Living with Disabilities, Financial Barriers*

1. Introduction

The double jeopardy concept suggests that gender and disability intersect to intensify economic exclusion, and cumulative disadvantage among marginalized groups (Hussein, 2025). Based on this concept, barriers in education, employment, and health accumulate over the life course, perpetuating poverty cycles among people. Persons living with disabilities (PLWDs) encounter profound challenges rooted in systemic inequalities that intersect gender, disability, and socioeconomic structures, potentially undermining their search for health services (Shafik, 2025). Poverty, unemployment, and other unjustifiable economic challenges tend to be higher in women with disabilities than both nondisabled women and men with disabilities worldwide (Emmett & Alant, 2006). Buettgen et al. (2015) indicate that these disparities manifest in persistent pay gaps, limited access to employment, elevated out-of-pocket healthcare costs, and barriers to financial services, and are often exacerbated by discrimination and inadequate social supports.

The Intersectionality Theory, pioneered by Kimberlé Crenshaw and extended in feminist disability studies, frames inequalities among women living with disabilities as overlapping oppression systems, including sexism and ableism (Frederick & Shifrer, 2019).. According to Wolbring and Nasir (2024), these systems combine, generate and perpetuate unique, compounded financial difficulties that could prevent these women from seeking health services. In light of this, women with disabilities tend to be increasingly predisposed to high joblessness rates, nearly double those of nondisabled women, lower earnings when employed, and greater reliance on means-tested benefits that impose asset limits, discouraging savings and workforce participation, limiting their ability to afford care (Buettgen et al., 2015). Mitra et al. (2017) contend that additional costs of living with disability, including the persistent need for assistive devices, accessible transportation, and medical care further strain limited incomes, pushing many into financial fragility.

According to Ackerman et al. (2025), healthcare access challenges among women living with disabilities become more acute due to mobility-related barriers. For instance, the need for specialized transportation methods among these people increases travelling expenses while specialized healthcare needs surge out-of-pocket expenditure burdens (Prada & Pizarro,2024).. These environments and gendered expectations like caregiving roles disproportionately amplify the physically-disabled women's double jeopardy, resulting in cumulative disadvantage: reduced lifelong earnings, diminished retirement security, and entrenched poverty that can limit access to care (Shafik, 2025). The main goal of this research was to examine the financial challenges that women living with physical disabilities face that could limit their access to healthcare.

2. Methods

2.1 Research Design

This study employed a cross-sectional survey design to examine the experiences, challenges, and support needs of women living 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 across 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 living 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 living 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 researcher. A total sample of 41 women who met the eligibility criteria, being 18 years or older, living with a physical disability, and using a wheelchair—was obtained.

2.5. Data Collection Procedure

Data collection was integrated into the researcher's 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 3.1 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 based on the counties from which the respondents were drawn, 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 urbanized 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 3.2 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 3.3 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

Do you depend on wheelchair mobility at home?	Frequency	Percent
No	15	36.6
Yes	26	63.4
Total	41	100.0

Table 3.4 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 3.5 results indicate that the vast majority of females living 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

Themes on financial challenges that women living with disabilities face

Financial Challenge Theme	Components defining these themes in the survey	Rate
Money and income barriers	i. Limited or no income sources ii. Irregular/unstable earnings iii. No reliable source of income iv. High cost of living v. Difficulty affording basic needs (even one meal a day) vi. Discrimination leading to loss of job opportunities vii. Overdependence on caregivers leading to financial strain	32/48(67%)
Money Management problems	i. Inability to save ii. Unplanned expenses disrupting financial plans iii. Difficulty budgeting iv. Lack of financial literacy (investment, budgeting, opportunities) v. Difficulties in avoiding debt	21/48(44%)
High costs of Assistive Devices	i. Spending all income on medical treatment ii. High cost of assistive devices (wheelchairs, diapers, hygiene items) iii. Unable to replace worn-out wheelchair iv. Needing to pay someone to push wheelchair v. Additional transport costs when using TukTuk or taxi instead of cheap public transport	19/48 (40%)
Financial access limits as a major barrier to entrepreneurship.	i. Lack of capital ii. No access to funding/loans iii. Skills exist but no financing to monetize them iv. Difficulty running small businesses (shoe business, Mitumba) v. Lack of market linkages or support networks	17/48 (29%)
Financial challenges spilling over to transport and mobility	i. Paying extra fare due to wheelchair ii. Needing assistance translating to extra cost iii. High mobility-related expenses increasing financial instability	12/48 (25%)

Table 3.6 findings highlight the multifaceted financial challenges that women with physical disabilities face, which affect their independence, mobility, and overall well-being. Money and income barriers were the most prevalent financial issue emerging in 32 out of 48 responses (67%). Participants reported having limited or no income sources, unstable or irregular earnings, and no reliable financial support means. These income challenges were compounded by the high cost of living, limiting access to basic necessities like meals. Discrimination in employment opportunities and overdependence on caregivers for financial support aggravated the economic strain. Combined, these results demonstrate that structural inequalities exacerbate the impact of physical disability on economic stability.

Closely related to income issues were money management challenges, picked from 21 out of 48 entries (44%). These included difficulties saving money, managing unplanned expenses, and creating or adhering to budgets. Many participants indicated a lack of financial literacy, including knowledge of investment, budgeting, and economic opportunities as a significant financial challenge. The inability to manage finances effectively made them gravitate towards debt and disrupted financial planning, reinforcing a cycle of economic vulnerability.

Another critical financial challenge was the rising cost of assistive devices, appearing in 19 out of 41 entries (46.34%). Participants reported that much of their income was spent on medical treatments and essential devices, such as wheelchairs, diapers, and hygiene items. Some were unable to replace worn-out wheelchairs, while others had to hire individuals to push their wheelchairs, further increasing financial pressure. Additionally, transport costs rose due to the need for taxis instead of more affordable public transport, highlighting how mobility and financial challenges are intertwined.

Limitations on carrying out entrepreneurship opportunities emerged as one of the primary financial challenges, with 17 out of 41 entries (41.46%) reporting restricted access to capital or loans. Despite possessing relevant skills, many women could not monetize their abilities or sustain small businesses due to a lack of financing, market linkages, and support networks. Finally, 29.27% of respondents (12/41) indicated that financial challenges directly affected transport and mobility, as additional costs associated with wheelchair use and reliance on assistance increased their overall financial instability.

4. Discussion

. The findings on financial challenges reveal how structural and societal factors interact with individual impairments to create significant barriers to independence and well-being among women with physical disabilities. The study found that 67% of entries experience money and income barriers, citing limited or unreliable income, discrimination in employment, and overdependence on caregivers. Some of these are key hindrance to accessing medical care among these women. Ideally, these challenges can be effectively analysed through the lens of the Social Model of Disability (SMD), which posits that disability is socially constructed when societal barriers prevent individuals from fully participating in economic, social, and cultural life (Barnes, 2019). Ideally, society's structural limitations play a bigger role in disabling these women by restricting access to economic opportunities and income security than physical impairment.

Closely linked to income insecurity were money management challenges, reported by 44% of entries, including difficulty saving, budgeting, and avoiding debt. Inadequate or lack of financial literacy and unplanned expenses further constrained the women's ability to achieve financial stability, potentially limiting access to care. The SMD could frame these limitations as environmental outcomes that restrict equitable access to financial education, support services, or inclusive economic systems, as opposed to deficiencies inherent to the women themselves (Oliver, 2013).

The high cost of assistive devices, reported in 40% of the entries, further underscores the structural barriers they face that can limit their access to care. Wheelchairs, hygiene products, and mobility support required significant financial investment, with some participants unable to replace worn-out devices or relying on others for assistance. The need to pay for accessible transport also corresponds to Mitra et al's (2017) view on how societal infrastructure and systems amplify the disabling impact of physical impairments among women living with disabilities. Inaccessible transport options and the high costs of assistive devices project environmental constraints as the major disabler, as opposed to the physical limitations themselves.

Financial barriers also extended to entrepreneurship, with 29% of entries depicting inability to access capital, loans, or market networks to support their businesses despite possessing skills. This indicates that these women may be restricted from taking on the current self-employment opportunities as a result of unfriendly financial systems consistently with Emmett and Alant, 2006) perspective. With 25% of

entries reporting that mobility-related financial challenges, including extra charges on transport in public service vehicles and reliance on assistance, it is evident that physical and societal barriers intersect to restrict participation, which corresponds to intersectionality theory (Moodley & Graham, 2015). This serves as a critical indicator that limited financial access prevents women with disabilities from economic empowerment, reinforcing cycles of dependency and vulnerability, which spill over to reduced healthcare access.

5. Conclusion

In sum, the findings highlight that financial challenges among women with physical disabilities exist in Kenya, potentially limiting their healthcare access, and are largely driven by structural and societal barriers rather than individual impairments. Issues such as unstable or limited income, high costs of assistive devices, difficulty managing finances, and restricted access to entrepreneurial opportunities create persistent economic vulnerability. Dependence on caregivers and additional mobility-related expenses further exacerbate financial strain among women living with physical disabilities. The Social Model of Disability explains how these challenges arise from inaccessible economic systems, discriminatory practices, and inadequate support structures, rather than from the women's physical limitations.

The findings of this study underscore the interaction of social, economic, and infrastructural factors to disable women with physical impairments from accessing healthcare as suggested by SDM. Addressing the financial challenges requires systemic interventions that include accessible financial services, inclusive employment opportunities, and subsidized assistive technologies. Targeting structural inequities rather than focusing solely on the individual's physical limitations can reduce the barriers that create disability in practice and enhance the autonomy and quality of life of women with disabilities.

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