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Lived Experiences of Quality of Life Among Makonde Immigrants in Kenya During and After the COVID-19 Pandemic

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2024

Abstract

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Herzing University, 2017

BS, Wayland Baptist University, 2014

Dissertation Submitted in Partial Fulfillment

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Abstract

The COVID-19 pandemic affected Makonde immigrants' health and quality of life around the world more than any other previous event. This descriptive qualitative study aimed to contribute knowledge and understanding of the lived experiences of Makonde immigrants and their health and quality of life during and after the COVID-19 pandemic. Shye's systematic quality of life model served as the theoretical basis for the study, along with Wilson and Cleary's conceptual model of health quality of life. Semi-structured interviews were conducted with ten participants recruited through social media and flyers posted in Kilifi and Kwale counties. Subjects were interviewed face-to-face and via Zoom. Transcripts were analyzed using Colaizzi's descriptive analysis method. The results of this study indicated four themes: (a) Psychological trauma, (b) physiological disorders, (c) social-economical interruptions, and (d) the role of religion and culture. The findings have implications for positive change for the Makonde government to establish immigrant health centers that support linguistic and culturally preventive health care and funding to serve immigrants. Findings may also be used to establish policies that increase and expand insurance coverage for immigrant families.

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Dedication

I am dedicating this dissertation to all the members of the health community who served during and after the COVID-19 pandemic. I also express my love for all immigrants all over the world who face numerous challenges, be they settled or undocumented immigrants in their host countries. From this dissertation and my exploration, the life of an immigrant is never easy and pandemics such as COVID-19 make life hard. I am taking time also to be thankful to all the participants of this study from Kilifi and Kwale counties in Kenya who from their own experiences gave me the benefit of the doubt to conduct and write this dissertation.

I am also dedicating this dissertation to my father who passed on in the year 2004. He suggested to me to go on and attend college and read and utilize what I learned in college for the common good. I do not forget my 92-year-old mother still strong but aging gracefully. They never attended college, but they were a source of inspiration. I am also contented that they brought me up in the countryside and trained me well before I embarked on my college and working life away from the village. I strongly feel to mention Jeremiah my eldest brother who listened to me when I told him I wanted to get out of the village, go work, and get myself into college but never lived long to see me graduate. I am grateful for your support, and I am happy.

Acknowledgments

The journey to write this dissertation has been a challenging one indeed. Nelson Mandela said, “It always seems impossible until it is done.” I have always believed in moving little steps forward. I have eventually arrived here. I have been incredibly blessed to have a supporting family, my wife Lilian, son Brian, Calvin, and Jeremiah.

I also want to thank the chair Dr. Martin and assistant Dr. Bailey for their overwhelming support during the process. Your patience, motivation, your immense knowledge, and guidance were beneficial to this study. Not forgetting other members of Walden University for their overwhelming support. I am extremely grateful to have both as committee members. I could not have arrived here this soon without the input from both of you. Thank you.

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Chapter 1: Introduction to the Study

Since the outbreak of COVID-19 and its subsequent declaration as a pandemic, the pandemic has caused social, health, and economic havoc around the world not only to the indigenous people but also to settled Makonde immigrants in Kenya (Amoako & MacEachen, 2021). According to T. Hui et al. (2023), the COVID-19 pandemic was caused by the SARS-Cov-2 virus, which first appeared in Wuhan, China in December 2019 and spread to many countries. The virus causing COVID-19 was not well understood and many policies were enacted by both national and local governments to manage the spread of the virus yielding positive outcomes while other measures such as quarantine, lockdown, social distancing, and restrictions on traveling in and out of the countries affected thousands of lives including people who are immigrants (T, Hui et al. (2023). According to Doan et al. (2021), settled Makonde immigrants were proportionally affected by working in an environment where social distancing was not possible, living in substandard housing conditions, overcrowding, lack of space to keep social distance from each other, lack of public resources, unemployment, and inability to access health care and other financial constraints during the crisis.

This study aimed to describe the lived experiences of settled Makonde immigrants who were affected during and after COVID-19. Little or no research attention has been paid to the Makonde immigrants' quality of life during and after the COVID-19 pandemic. According to the World Health Organization (WHO, 2022), the first cases of COVID-19 in Kenya were reported in January 2020. By June 2020, 343, 537 cases were confirmed. By June 2020, 5,689 deaths caused by the pandemic were reported. A total

number of 23,750,431 vaccine doses had been administered countrywide by April 2023. The results of the current study may help government and nongovernment organizations develop strategies and interventions that could be applied in future pandemics to relieve suffering and pain.

Mcfann et al. (2021) explained that the COVID-19 pandemic impacted people's physical health, mental health, and social and emotional well-being, thereby affecting the quality of life of patients and their families. People affected by the disease continued to have health issues after recovering. Persistent dyspnea, fatigue, insomnia, anxiety, and depression are among the symptoms that have been cited as most affecting patients during and after the pandemic, thereby affecting the quality of life.

In this context and with the emergence of health and social issues and economic problems, particularly explored the health quality of life among Makonde immigrants in Kenya during and after the COVID-19 pandemic outbreak. I explored participants' lived daily experiences and how these experiences impacted the health and quality of life of settled Makonde immigrants during and after COVID-19. This study was important because its findings may inform healthcare providers, governments, policymakers, health international organizations, nongovernment organizations, local and international church organizations, and other stakeholders on how to assist other groups such as Makonde immigrants during and after similar pandemics.

Preview of Major Sections of the Chapter

In this chapter, I provide the introductory material and a background section in which I briefly summarize the literature reviewed in Chapter 2, identify the knowledge

gap, and discuss why the study was needed. I also include the problem statement, purpose of the study, research question, and conceptual foundation for the study. The chapter also includes the nature of the study, definitions, assumptions, scope and delimitations, limitations, and significance before concluding with a summary of the chapter and transitioning to Chapter 2.

Background

In summarizing the literature relevant to this study, I start with Wilson and Cleary's health quality of life and its domains of physiological and biological functions, symptoms status, functional status, general health perceptions, and overall quality of life. Research using the model of health quality of life is also discussed. In the current study, quality of life was defined and measured by health care research, how the immigrant population defined health quality, the quality of life among immigrants, and health quality of life in Kenya and African countries. Wilson and Cleary's conceptual model encompasses the five domains, which are multifactorial approaches to define the health quality of life and can be used to find strategies for intervention against diseases, social problems, and economic problems. In my study, the model was used to describe the lived experiences of settled Makonde immigrants in Kenya during and after the COVID-19 pandemic.

This was a qualitative descriptive study to explore the lived experiences of Makonde immigrants' health and quality of life and their lived daily experience with the COVID-19 pandemic in Kenya. The United Nations and Human Rights Organization (UNHCR, 2021) approximated Makonde immigrants in Kenya to be around 6,000

persons. These immigrants originated from Tanzania and Mozambique to work in sisal and sugarcane plantations in Kenya in the 1930s due to political and economic conflicts (Paolo, 2020). They settled in the coastal towns of Kilifi and Kwale counties in Kenya.

COVID-19 has had unprecedented effects on both health care and non-health-care-related outcomes around the world and exposed some health care problems in the health care system that have persisted after most pandemic restrictions ended in the spring of 2022 (Moore & Trottier, 2023). In addition to the impact of COVID-19 on the health care system, complications of long-term COVID-19 infections are unknown. Three years after the start of the COVID-19 pandemic, the fragile health care system continues to face many challenges. The effort to strengthen the health care system should continue, and the current study was needed to better understand the impact of the virus on quality of life. Problems with structural inequities and social determinants have an impact on health care delivery. During and after the COVID-19 pandemic, several studies showed disparities, limited resources, and poor health outcomes among immigrants and other marginalized communities including people from different backgrounds, races, and ethnicities (Golshani & Akhlagi, 2022).

In this study, I explored the gap in knowledge of the lived experiences of Makonde immigrants during and after the COVID-19 pandemic because there was limited knowledge of the lived experiences of Makonde settled immigrants in Kenya and their health quality of life during and after the COVID-19 pandemic. Since the COVID-19 pandemic outbreak, there have been studies describing the impact of the COVID-19 pandemic on other immigrants in Europe, America, and Asia (Mien& Thi, 2021). I was

unable to find any published studies on the lived experiences of Makonde immigrants and their health-related quality of life during and after the COVID-19 pandemic in Kenya.

Bustamante et al. (2022) explained that COVID-19 worsened the inequity faced by immigrants around the world and their communities. One factor that affects morbidity and mortality among immigrants is the labor market. Immigrants predominantly are in low-income groups and are unable to pay for medical expenses. Their status also denies them medical insurance. Most immigrants were affected by COVID-19 because they worked and lived nearby and were unable to keep their distance from each other. The study of the lived experiences of Makonde immigrants in Kenya during and after the COVID-19 pandemic may lead to a better understanding of how to access quality health services to be in good health, save lives, protect immigrants and the host population, and lower the cost of medical expenses, thereby leading to positive changes by having healthy, and thriving citizens.

Problem Statement

The study focused on the lived experiences of Makonde immigrants in Kenya during and after the COVID-19 pandemic. According to the WHO (2022), the first cases of COVID-19 in Kenya were reported in January 2020. A total number of 23,750,431 vaccine doses had been administered countrywide by April 2023 with few cases positive cases being reported around the country.

The COVID-19 pandemic is caused by the SARs-Cov-2 virus, and the first case was reported in 2019 in Wuhan China and soon after spread to other parts of the world, becoming a pandemic. COVID-19 causes severe symptoms ranging from pneumonia to

respiratory distress as it affects the lungs, causes multiorgan dysfunctions, and leads to death. The symptoms caused by the COVID-19 virus affect quality of life. Even though Makonde immigrants have experienced various problems as other immigrants do, little was known about the impact of COVID-19 on their quality of life. The current study of the quality of life was needed because the findings may be instrumental in planning health promotion efforts and strategies to improve the quality of life of similar populations or groups of people or make life better for individuals or groups of individuals in similar contexts.

According to Gonzales et al. (2021), health quality of life is defined as concepts that include the perception people have regarding their life experiences, such as cultural, emotional, social, and physical well-being. It is imperative to study various circumstances surrounding individuals to ensure that the quality of their lives is affected for the better. Rocha et al. (2021) explained that the pandemic affected every sphere of daily life and impacted marginalized groups such as refugees and immigrants equally.

According to the UNHCR (2021), the lockdown imposed by governments across the world affected migrants and refugees who depend on hard labor to support their families, resulting in increased risks of diseases, malnutrition, and domestic violence. During such lockdowns, families were forced to stay at home, resulting in the loss of income which worsened the condition of the immigrants. Machado and Goldenberg (2021) found that the COVID-19 pandemic affected the quality of people's lives by causing fear, anxiety, and depression. Yurteri and Sarigedik (2021) discovered that anxiety, fear, and social isolation affected emotional health, the immune system, and

academic performance among students, causing poor sleep quality and mood swings due to fatigue. The COVID-19 pandemic has been implicated in affecting the quality of life of people around the world. However, I did not find any studies involving Makonde communities who are residing in Kilifi and Kwale counties in Kenya. A gap in the literature existed regarding the quality of life of the Makonde immigrant community during and after the COVID-19 pandemic.

Purpose of the Study

This qualitative descriptive study aimed to explore the lived experiences of health and quality of life of Makonde immigrants in Kenya during and after the COVID-19 pandemic. COVID-19 affected people's health and disrupted their financial and social lives worldwide, thereby becoming a determinant of quality of life worldwide. To address this gap, I explored the factors associated with Makonde immigrants' perception in the context of health, culture, and values in which they live about their goals, expectations, standards, and concerns in their daily lived experiences. This study was significant because it provided knowledge that may be incorporated by governments, nongovernment organizations, policymakers, and health care providers to develop programs that promote quality of life not only for Makonde immigrants but also for people who are impacted by pandemics such as the COVID-19 pandemic.

Research Question

The research question guiding this study was the following: What are the lived experiences of Makonde immigrants living in Kenya regarding their health and quality of life during and after the COVID-19 pandemic?

Theoretical Framework

The theoretical basis for this study was Shye's (1989a) model of systemic quality of life. According to Shye, the theory of systematic quality of life model measures the quality of life in its extensive sense including the cultural, social, physical, and mental well-being of individuals. Shye described the systemic quality of life model from which 16 human function modes, as well as stable observations, may be derived. Recognizing that human individuals are complex systems with large numbers of interacting characteristics, the theory is based on a more general action system. The quality of life of human beings is defined as the extent of effective functioning in the modes that are involved in the theory of systemic quality of life. Shye partitioned the four subsystems of personality, which are mental, physical, social, and cultural. Each subsystem was further partitioned into another four subsystem function modes, which are adaptation, integrative, expressive, and conservative (see Table 1).

Table 1

Shye's (1989) Theoretical Model of Systemic Quality of Life

Subsystem modes	Personality	Physical	Social	Culture
Expressive	Personal aspiration	Material power, control	Social status, interpersonal influence	Cultural values, educational influence
Adoptive	Resources for recreation	Compatibility, resources, comfort	Role fulfillment, social institutions	Value compatibility with the environment
Integrative	Peace of mind, reducing anxiety, reducing stress	Health, balanced body process, feeling well or fit	Social disposition, intimate friendship	Agreement among various values and beliefs held
Conservative	Stability, confidence	Stable body structure, no threats	Stable social network, social trust, and belonging	Stability of belief structure, adherence to basic values

Note. Based on the conceptual model and methodological criteria, the systematic quality of life model (*Shye*, 1989a) has been evaluated as the highest in a review of 68 quality of life models published in the 37 years from 1965 to 2001 (Taillefer et al., 2003).

Shye (1989a) explained that the systemic quality of life model has made it possible to assess the quality of life of different populations in different situations and different cultures. The well-being or health quality of life can be defined as the effective functioning of the individuals in each of the modes in this model. Shye's systemic quality of life model has become an important construct of the effect of diseases and their management. The systemic quality of life model is a multidimensional construct

encompassing symptoms of the diseases, treatments, side effects, and general perception of health status to the health caregivers and other health stakeholders to find ways to improve patients' health, thereby effecting social change. Shye's model served as a valuable paradigm for understanding the lived experiences of health and quality of life of Makonde immigrants in Kenya during and after the COVID-19 pandemic.

Conceptual Framework

In this qualitative descriptive study, I used the health-related quality of life conceptual framework. Wilson and Cleary (1995) developed this conceptual model to address the domains that affect the quality of life. The domains in the conceptual model have been used in research and in a clinical setting to measure life expectancy, causes of diseases, and death and to focus on what impacts the health status of individuals. Wilson and Cleary proposed the conceptual model of health-related quality of life to promote the well-being of patients in the clinical setting, emphasizing physical, mental, and social resources that would enhance and foster quality of life. The domains in this conceptual model are applicable to monitor the health-related well-being of individuals, thereby improving quality of life. This model provides a conceptual framework to understand the quality of life based on perceptions, cultural beliefs, expectations, standards, and concerns of individuals, and was an ideal conceptual model to explore the lived experiences of Makonde immigrants in Kenya during and after the COVID-19 pandemic.

The major concepts in the conceptual model include measures of patients and social perspectives regarding the impact of illness to improve efficacy, safety, and shared decision making that will improve the health of patients and individuals. Wilson and

Cleary's (1995) conceptual model have become important because it focuses on the components of well-being, which are affected by progressive changes in health status, health care, social support, and other aspects of life, thereby effecting social changes among affected patients and individuals. This conceptual model is described in more detail in Chapter 2.

Nature of the Study

In this qualitative study, I used a descriptive approach. A qualitative descriptive design has been widely used in research to explore the lived experiences of an individual or a particular group of people in research (Barnabishvili et al., 2016). A qualitative design provides an opportunity for a researcher to explore the lived experiences using personal interviews and observations to gather data that are reported from the point of view of the objectives in a qualitative study. Descriptive qualitative research also describes the experiences, views, attitudes, and actions of participants in their perceptions and understanding of a particular study (Barnabishvili et al., 2016).

The qualitative descriptive design was appropriate for the current study because it allowed me to explore the experiences of Makonde immigrants in Kenya about their quality of life during and after the COVID-19 pandemic. Wilson and Cleary's (1995) conceptual model were used to guide data collection and analysis because it focuses on health-related quality of life during and after health crises caused by diseases or pandemics such as COVID-19. Ten participants over 18 years of age who met the criteria of women and men residing in Kwale and Kilifi counties in the coastal towns of Kenya who were impacted by COVID-19 were selected through purposeful sampling.

Participants who had fallen sick were recruited for the study. Data were collected via in-depth interviews with open-ended questions. Interviews were conducted in English because English is the national language in Kenya and Makonde immigrants in Kenya speak and understand English. Data collected from participants were analyzed using Colaizzi's (1978) qualitative descriptive approach, in which codes, categories, and themes emerged to describe the daily lived experiences. I traveled to the counties of Kilifi and Kwale to recruit participants from Makonde communities to participate in this study. I also stayed in the two counties to collect data on the Makonde immigrants' perception of their health-related quality of life during and after the COVID-19 pandemic.

Definitions

Acculturation: Shewamene et al. (2021) explained that acculturation is the process in which individuals move from their birthplace to settle elsewhere and adopt, acquire, and adjust to the new cultural environment. The impact of culture on health-related beliefs is complex, and a person's attitude about health and disease is shaped by the culture to which they belong.

Culture: The culture of a group or class includes the meaning, values, and ideas reflected in the institutions, social relationships, system of belief, customs and traditions, use of objects, and material life. Culture is the shape in which this material and this social organization are expressed. Culture is the way through which relationships of the groups are structured and shaped, but it is also the way they are experienced, understood, and interpreted (Rico-Troncoso, 2021).

Ethnic group: Harris (2020) described ethnicity as a community characterized by a sense of belonging and loyalty to a group of perceived sameness usually based on common ancestries and identity markers such as language, lifestyle, morality, behavior, and a shared historical past.

Immigrants: Persons who move from their native home to make a home in a host country (Nshom et al., 2022).

Marginalized groups: People who are a minority in society and have been described as sidelined, harassed, and disregarded. Marginalized people in society have limited access to social resources such as housing, income, employment, education, social support, and health care (Prebe et al., 2013).

Quality of life: Health-related quality of life integrates both the biological and psychological health outcomes about models of physiological factors, system status, functions of health, general health perceptions, and overall quality of life. Health-related quality of life also embraces the social science paradigm that focuses on functioning and overall well-being. Health-related quality of life also considers the patients, the social context in which individuals live, and the system by which society can deal with the disruptive effects of illness (Wilson & Cleary, 1995).

Assumptions

According to Armstrong and Kepler (2018), in qualitative research assumptions ensure that the researcher will not draw a false conclusion from the analysis. The ability to draw credible inferences from data relies on untestable assumptions. Assumptions

guide the study on what might be expected during the process of collecting data and interviewing the participants to reach a meaningful conclusion.

The principal assumption in the current study was that I would be able to find a wide range of participants who would be willing to participate in this study both in Kilifi and Kwale counties in Kenya. I also assumed that the participants who will be recruited would remember the lived experiences of their health and quality of life during and after the COVID-19 pandemic. I also assumed that the participants would provide me with detailed responses that would generate rich data for this study. I also assumed that the lived experiences of the participants would be grouped into similar categories to generate themes and subthemes to answer the research questions. Finally, I assumed that once I recruited the participants, there would be mutual trust between me and the participants and that there would be truthful and accurate information generated to have enough data to satisfy the purpose of this study.

Scope and Delimitations

The study was limited to English-speaking Makonde immigrant community members residing in Kilifi and Kwale counties in Kenya who had been sick and affected by the COVID-19 pandemic. The participants were recruited via social media and on the ground. Exclusion criteria included people who were not Makonde immigrants and members of the Makonde community who were not affected by the COVID-19 pandemic.

The boundary of this study was Shye's (1989a) systemic quality of life. The model was selected because it aligned with the subsystems and modes that can be useful

in measuring quality of life. The theory defines, conceptualizes, and measures the human quality of life in its widest sense including the cultural, social, physical, and mental well-being of individuals. This model has been used to measure the quality of life of many patients who have been affected by chronic diseases, including COVID-19.

A theory that was not chosen was the quality-of-life theory derived from Maslow's development perspective. Tripathi (2018) explained that self-actualization can be instrumental in stimulating and kindling people to become healthy and attain a better quality of life because a person is always becoming and never remains static; therefore, in self-actualization, a person comes to a meaning to life that is important to them.

Maslow's quality of life theory focuses on the hierarchical need satisfaction level. The higher the needs satisfaction of people in any given society, the greater the quality of life in the society. Maslow's quality of life theory does not identify the subsystems and modes that evaluate how people function effectively to assess health quality of life (Tripathi, 2018).

The findings of the current study may be transferable to Makonde immigrants in Kenya and other immigrants and ethnic groups around the world who were affected by the COVID-19 pandemic. According to the WHO (2022), millions of refugees and migrants lived in vulnerable situations, especially where living and working conditions were substandard. Refugees and immigrants are among the most vulnerable and neglected members of societies around the world. Studying the lived experiences of the Makonde immigrant community during and after the COVID-19 pandemic was intended to provide insight into how immigrants in different parts of the world were affected by

the pandemic. I recruited participants from Kilifi and Kwale counties to support potentially transferable findings around the world.

Limitations

A potential limitation of this study was researcher bias. I needed to understand and appreciate participants' views and take an objective stance as a researcher. Bias allows the researcher to influence the data, and the study lacks impartiality (De La Cuesta, 2021). To minimize my personal bias, I bracketed my expectations and assumptions about the Makonde people and their experiences as immigrants. I also created an audit trail and obtained feedback from my committee to ensure the trustworthiness of the data I collected and analyzed.

I also reduced the risk of bias by asking my committee members to review the coding to ensure consistency between interpretations every time I conducted an interview and completed the process of coding (see Creswell & Creswell, 2018). In this study, I took notes to acknowledge my assumptions and preconceptions during the interview and coding process (see Creswell & Creswell, 2018). The transferability of this study's findings may be limited by the recruitment strategy, which may encourage more research on immigrants and their health and quality of life, thereby affecting social change among immigrants.

Significance

The purpose of this qualitative descriptive study was to understand the lived experiences of quality of life among Makonde immigrants in Kenya during and after the COVID-19 pandemic. It was crucial to explore the participant's experiences to

understand how COVID-19 impacted their quality of life. This research may provide new knowledge that could be used to improve the quality of life among Makonde immigrants and ethnic minority groups around the world by encouraging stakeholders to direct resources and implement policies and programs that promote quality of life.

Many studies were identified that addressed the quality of life of immigrants in other countries such as the United States of America, Canada, China, Asia, and some countries in Europe (Tran et al., 2020). Although the information in these studies was helpful, it was not known whether the results were transferable to Makonde immigrants in Kenya. Findings from the current study may impact nursing practices by providing insight into the experiences of Makonde immigrants and their health and quality of life during and after the COVID-19 pandemic. Additionally, the study may contribute to strategic planning to address the immediate and long-term impact of pandemics such as COVID-19 on immigrants around the world and may aid in preparing for subsequent pandemics.

The study may contribute to positive social change by providing evidence of the lived experiences of Makonde immigrants regarding their quality of life during and after the COVID-19 pandemic, which may lead to a better understanding of the impact of pandemics such as COVID-19 on immigrants and other ethnic groups around the world. Understanding the immediate and long-term implications of the pandemic on the health and quality of life of Makonde immigrants was vital because it may contribute to a better understanding of how to address pandemics such as COVID-19 to improve the health and quality of life of immigrants. Addressing how pandemics such as COVID-19 can be

managed to address depression, anxiety, mental health, and the physical health of immigrants around the world may lead to positive change through the implementation of strategies to improve treatments and health quality of life of patients (see Nguyen et al., 2020).

Summary

This chapter included an overview of the current study. Background information was given to provide details regarding the knowledge gap. The problem statement indicated the challenges immigrants face during times of crisis in terms of their health and well-being. The purpose of the study and the conceptual framework that guided the study were documented. Key terms were also defined. The significance of the study was also established in this chapter. In Chapter 2, I review the relevant literature. The literature review includes COVID-19 and how it has affected immigrants and other ethnic minorities around the world. This chapter also includes the conceptual model that guided this study.

Chapter 2: Literature Review

The purpose of this qualitative descriptive study was to explore the lived experiences of the quality of life of Makonde immigrants during and after the COVID-19 pandemic. During my literature review, I found no published literature that focused on the lived experiences of Makonde immigrants in Kenya during and after the COVID-19 pandemic. However, some studies addressed the health and quality of life of immigrants in the United States of America, Asia, and Canada (Rhemani et al., 2023). In the current study, I conducted semi structured interviews to explore the lived experiences of Makonde immigrants in Kenya during and after the COVID-19 pandemic.

In early 2020 a novel coronavirus (SARS-CoV-2) began to spread through global communities resulting in a pandemic. The virus initially affected international travelers and their close contacts. Later it started ravaging many disadvantaged communities. Among the communities that were affected were immigrants from many countries. Many immigrants had limited access to health care, and poverty, fear, and legal consequences placed immigrants in a vulnerable position. Immigrants and their economic situation required them to continue to work despite social distancing and stay-at-home orders, thereby increasing their risk of contracting the disease. Many immigrants stayed in crowded homes, making it possible to contract the disease (Mahic et al., 2023).

Wilson and Cleary's (1995) health-related quality of life conceptual model was used to inform the current qualitative study. This literature review involved examining previous studies regarding the effect of COVID-19 on immigrants and their quality of life around the world. I also addressed the effect of the pandemic on mental health, physical

health, and socioeconomic challenges due to the outbreak of the COVID-19 pandemic. Literature relevant to this study involved cultural, religious, and geographical factors as perceived by immigrants, thereby impacting their daily lived experiences and their quality of life. This chapter includes a review of studies related to the overall quality of life as impacted by the COVID-19 pandemic on immigrant populations.

Ekwonye et al. (2021) explained the impact of COVID-19 on immigrants around the world and its impact on their quality of life. The pandemic and the infections worldwide caused a high rate of mortality. The lockdown and social distancing measures that were enacted by various governments caused worries, depression, anxiety, fear, and social isolation among undocumented and documented immigrants. The fact that many workplaces were closed increased the poverty level among immigrants, thereby affecting personal meaning, personal growth, life satisfaction, and quality of life.

According to Romate et al. (2021), immigrants were more affected due to the cessation of daily income due to the lockdown of their employment. COVID-19 also exposed healthcare disparities among socioeconomic and healthcare facilities whereby immigrants suffered due to their inability to access healthcare. I sought to alleviate the suffering of immigrants by investigating, understanding, and analyzing the hardship they experienced during and after the outbreak of the COVID-19 pandemic.

The Organization for Economic Co-operation and Development (OECD, 2021) which is an international organization that tracks the impact of COVID-19 on immigrants, reported that 30% of immigrants live in poverty compared to 20% of native-born citizens. Immigrants are more likely to live in substandard accommodations. About

23% of immigrants were found to live in poor standard housing compared to 19% of native-born citizens. The OECD (2021) also reported that 17% of immigrants were found to live in overcrowded conditions compared to 8% of native-born citizens, and this factor increased the likelihood of contracting COVID-19.

The current study aimed to explore the lived experiences of the quality of life of Makonde immigrants during and after the COVID-19 pandemic. The study was guided by Wilson and Cleary's (1995) health-related quality of life conceptual model and focused on examining the effects of COVID-19 on immigrants' mental health, physical health, and socioeconomic challenges. The review also addressed the cultural, religious, and geographical factors that may have impacted immigrants' daily lived experiences and quality of life. The literature search for this review included a variety of full-text databases and focused on qualitative studies that explored the quality of life of immigrants around the world during the COVID-19 pandemic. I found several articles on the topic, with a focus on more recent and relevant studies. The literature revealed that immigrants had been disproportionately affected by the COVID-19 pandemic, experiencing higher rates of poverty, substandard housing, and overcrowding, which contributed to decreased quality of life. The review also revealed that immigrants faced unique challenges related to access to health care and social isolation during the pandemic.

Literature Search Strategies

I conducted a literature search using full-text databases including Search Complete, Medline, EBSCOHost, Google Scholar, PubMed, ProQuest database,

Searchgate.com, and Elsevier.com. These databases allow access to peer-reviewed journals, scholarly articles, and books. All literature materials were written in English. Most of the literature reviewed included qualitative studies that focused on other populations of immigrants around the world. I used the following terms*: immigrant* and *quality of life, immigrants, Makonde immigrants in Kenya, immigrants* and *citizenship, immigrants* and *Covid-19, challenges facing immigrants, Covid-19 among immigrants, immigrant status, immigrants' quality of life, immigrants around the globe, health-related quality of life, health conceptual models,* and *quality of life*. While performing database searchers, I used a combination of terms to identify relevant literature on the lived experiences of immigrants around the world during the COVID-19 pandemic: *COVID, SARS-CoV-1, immigrants during and after COVID pandemic, Phenomenology,* and *health quality of life*. Publications from January 2020 were used during this study.

My literature research revealed 207 articles on the quality of life of immigrants, but only recent and relevant articles were documented in this study. These articles were based on the quality of life of immigrants around the world during the COVID-19 pandemic. During the literature review, I found that many immigrants, especially those who live in host countries, face hardship due to their immigrant status. Their immigrant status makes it hard for them to acquire documents that will enable them to access health care and other basic needs. The COVID-19 pandemic affected more immigrants and ethnic individuals around the world.

Theoretical Foundation and Conceptual Foundation

In qualitative research, theories are used to design research questions, thereby leading researchers to select relevant data, interpret the data, and propose an explanation of the underlying causes or influences of the phenomenon under study (Rodgers, 2000). In the current study, Shye's (1989a) theory of systematic quality of life was used to provide ideas on how to approach participants. The theory of systematic quality of life and Wilson and Cleary's (1995) conceptual model of health quality of life were used to understand the health quality of life among Makonde immigrants in Kenya during the COVID-19 pandemic.

Theory of Systemic Quality of Life

The theoretical basis for this study was Shye's (1989a) model of systemic quality of life. According to Shye, the model of systematic quality of life measures the quality of life in its extensive sense including the cultural, social, physical, and mental well-being of individuals. The model of systematic quality of life has been used to study the health quality of life of immigrants and other groups of people around the world. Shye explained that immigration to a new country involves changes in all areas including economic, cultural, social, and psychological. Although some people may think that moving from one country to another contributes to personal or individual development, others are frustrated by the process of immigration. According to Shye, the model of systemic quality of life identifies the field of functions and the modes of functions as two distinct facets of a person's quality of life. These fields are psychological, physical, social, and cultural. Shye explained that all human acts can be identified and located in

the framework of the four fields. These modes refer to how people adopt and function in each field.

Expressive Mode

This refers to the way individuals deal with events that emerge within the person and are actualized in the external world and the surroundings. This includes self-actualization and self-expression in the psychological field, the person's impact on the physical environment in the physical field, the effects on other people in the social field, and the expression of value in the cultural field (Shye (1989).

Adaptive Mode

This mode is concerned with the way individuals adapt to the environment and how they negotiate in the environment to maintain mutual adjustment. The adaptive mode includes the ability to adapt to and manage stressful events and the ability to relate and rest in the psychological field, the condition of the individual in the physical field, the ability to relate with others and the social field, and the ability to integrate into the cultural products and events in the cultural field (Shye, 1989).

Integrative Mode

This mode is applied by individuals to adjust and readjust the universe of internal events to each other to maintain internal equilibrium. This includes the ability to maintain mental health, physical health, and social balance in the role and the ability to maintain the norms and values in the field (Shye, 1989).

Conservative Mode

This mode refers to how individuals preserve their identity in the field. The conservative mode involves loyalty to the internalized structural patterns. This mode can be self-identified in the psychological domain, the genetic code in the physical domain, the code of values in the cultural domain, or social trust in the social domain (Shye, 1989).

Shye (1989a) explained that the systemic quality of life model has made it possible to assess the quality of life of different populations in different situations and different cultures. The well-being or health quality of life can be defined as the effective functioning of the individuals in each of the modes in this theory model. Shye's model served as a valuable framework for understanding the lived experiences of health and quality of life of Makonde immigrants in Kenya during and after the COVID-19 pandemic.

Kaman et al. (2023) explained that there is increasing empirical evidence of psychological distress among people who were affected by the pandemic. The review described doubling people's clinically elevated anxiety, depression, sleep disorder, and posttraumatic stress syndrome. Individuals were isolated and advised to stay at home affecting many social events. Many people would not work from home and were financially affected especially immigrants. COVID-19 affected the lungs, and this caused the inability to breathe. These factors lowered health and quality of life among the individuals affected by the pandemic.

The COVID-19 pandemic caused sickness and death to many people worldwide. The COVID-19 pandemic caused the deterioration of personal health also to healthcare workers who were taking care of sick people during the pandemic. Individuals suffered from emotional and psychological distress due to fear and anxiety during the pandemic. The affected patients suffered physical functions since they would no longer be able to care for themselves. Physical exhaustion in performing the family caregiver role was reported by family members. Unfavorable social and family relationships that included violence led to physical and emotional injury thus affecting health and quality of life (Chan et al., 2022).

The theory of systemic quality of life has been put into use in qualitative research. Benish-Weisman and Shye (2011) used the theory to find out the quality of life among Russian immigrants in Israel. Immigration to another country is believed to be involving many challenges in all areas of life for immigrants. Changes that include cultural, social, economic, and psychological challenges often are faced by immigrants. People rate the quality of life as a move from one city to another or a movement of individuals from one country to another. Academic research rated the quality of life in fields such as medicine, psychology, economics, and sociology.

Following political and economic changes around the globe, it became clear that while financial success matters in one's quality of life does not capture other relevant aspects of life quality like education, employment, health, and crime level. The social measure gives broader definitions of an individual's quality of life. This notion was

subjective thus ignoring one's perspective of what quality of life means (Benish-Weisman& Shye, 2011).

During their study (Benish-Weisman and Shye (2011) administered a questionnaire that contained four questions designed to measure participants' subjective success. The systemic quality of life questionnaire had items from the functioning modes including health, personality, adaptive, social, and culture.

Participants were able to answer according to the questions presented. In this study, it was believed that the transition from a totalitarian society in Russia to Israel made it easier for some of the immigrants to improve their expressive functioning in all subsystems. Immigrants who were able to take advantage of this possibility experienced successful immigration (Benish-Weisman& Shye, 2011).

Hu et al. (2023) also conducted a study using the theory of quality of life on patients with systemic Lupus Erythematosus which is a progressive and recurrent ailment that does not have medicine to cure it and is a cause of death in women. SLE is accompanied by various clinical manifestations and treatment complications including joint pain, malar rash, nephritis, and atherosclerosis. These symptoms cause physical changes and psychological distress among patients. These symptoms also cause pain, fatigue, and anxiety. Patients with SLE may find it hard to disclose their pain to family and healthcare workers due to the invisible nature of these symptoms.

Hu et al. (2023) wanted to find out if avoidance and limited disclosure of pain caused by SLE symptoms had negative effects. Self-disclosure is the process by which individuals voluntarily tell others about themselves and consciously share their intimate

thoughts and feelings. The study wanted to find out if demographic, clinical, and psychological status were the influencing factors of self-disclosure and the effect of self-disclosure on the quality of life of patients with SLE. The result of the study showed that higher levels of social support were associated with high levels of self-disclosure. Depression was associated with a lower level of self-disclosure (Hu et al, 2023).

Therefore, Shye's (1989) theory of Systemic quality of life will provide the framework for the study guiding the lived experiences of the health quality of life of Makonde immigrants in Kenya during and after the COVID-19 pandemic.

Conceptual Model

The conceptual model of health-related quality of life was developed by Wilson and Cleary and has been used both in research and clinical trials in the process of acquiring information and evidence that measures the health-related quality of life of patients and have shown that the measures are valid, reliable, and responsible in clinical trials to bring clinical changes in improving patients' quality of life (Wilson & Cleary, 1995). The conceptual model of health-related quality of life had been therefore used as a tool to assess patients' health status in nursing and health care settings. The conceptual model was developed to focus on the components of well-being that can be affected by changes in health status, healthcare, and social support (Wilson& Cleary, 1995).

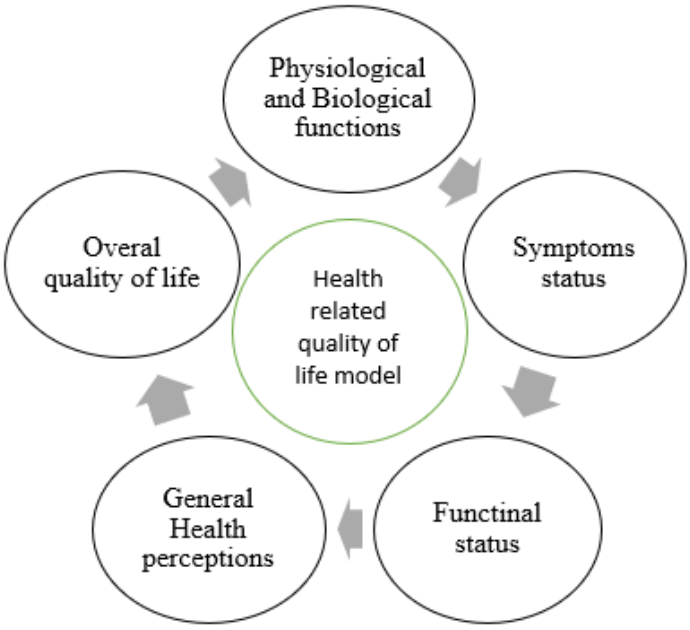
When developing this conceptual model, Wilson, and Cleary (1995) described the health-related quality of life as a dimension that includes physical functioning, social functioning, role functioning, mental health, and general health perceptions where

measures of biological and physiological functions such as the diagnosis, and patient's reported symptoms are also included.

Relationships Within the Conceptual Model

Figure 1

Wilson and Cleary's (1995) Health-Related Quality of Life Conceptual Model



Note. Adapted from Wilson and Cleary's (1995) conceptual model, concepts, and the relationship within the conceptual model.

Literature Review

This literature review presents the current evidence related to experiences with the quality of life during the COVID-19 pandemic among immigrants around the world. In detail, I explored what is known about Wilson and Cleary's health and quality of life conceptual model. I also explored the recent research related to the health quality of life

model, how the quality of life is measured in health care research, how the immigrant population defines the quality of life, quality of life among African countries, quality of life among Kenyan immigrants and lastly the literature related to the health of the immigrant population.

Wilson and Cleary's Key Concepts

Biological and Physiological Functions

Wilson and Cleary described biological and physiological factions as the most determinant when assessing patients' health status. Biological and physiological factors are associated with the functions of the cells, organs, and body systems in the body. Before any diagnosis is given to the patient, there should be a thorough assessment of the body system including the pulmonary functions which can explain the lungs which are made of cells that ensure the health of the lungs and their ability to function, laboratory values that can explain the blood cells and their functions. Red blood cells can be used to assess if the patient is anemic or has other health problems associated with the cells in the body like cancer. Physiological functions are important in assessing patients. Patients with physiological problems will have difficulties breathing and will have edema or splenomegaly indicating health problems (Wilson & Cleary, 1995).

Symptoms

According to Wilson and Cleary (1995), patients come to healthcare centers when they have symptoms of sickness. Patients will have symptoms when their cells and organs start malfunctioning. Symptoms are perceptions of how patients feel about their state of body functioning. When patients have perceptions regarding the symptoms, they

cause patients to want to see healthcare providers thus entering the healthcare system and affecting the cost of medical care. Patients with perceptions of the symptoms may prompt patients to have a judgment on decisions to seek medical attention. The decisions can be based on demographic and cultural standing points of view on seeking medical attention.

Wilson and Cleary (1995) also described medical problems and conditions that may not show symptoms like depression. It is therefore important for the clinician to be able to identify clinical and non-clinical factors that may be represented by the patients. Research that explores the determinants related to reported symptoms such as physiological factors, the way patients would like to be treated for their symptoms, social factors, and patient-and-physician relationships would health clinicians to address both the clinical and nonclinical factors related to the symptoms reported by the patients.

Functioning

One important factor in good health is whether an individual can be functioning. Functioning means the ability to do and carry out certain tasks of daily living without any problem. For an individual to be able to function, one needs to have energy that emanates from the cells functioning in the body. An individual should also have the motivation to carry out the task. People who are more determined to carry out the task are more likely to function at a higher level. Certain social and environmental factors may have an impact on an individual's ability to function. People with supportive family members are more likely to be motivated to function. A good example is an elderly woman without a car who can have a family member drive to a grocery store to buy groceries (Wilson & Cleary, 1995).

Clinicians are more likely to know if patients can function as individuals and independently in society and that determines the level of care needed. Part of the assessment is social life at home, especially for older patients who can be exploited. Healthcare givers, therefore, are more concerned with the domain of physical functioning, social functioning, role functioning, and psychological functioning to determine the health status of patients (Wilson & Cleary, 1995). As discussed before, for other medical cases where it is not easy to have biomarkers for measurable symptoms to determine the medical problem, there is a need to better understand how conditions affect the ability of an individual to function.

General Health Perception

Wilson and Cleary (1995) asserted that every individual has their perception about her or his health and according to research, there is a common consensus that perception would be the most eventful predictor, especially for use in the general medical and mental health services. Other recent studies have also shown that General perception of health is associated with functional health because of its close association with biological and physiological factors affecting health. When patients decide to go see a medical doctor, it is because of how they feel and what perception they have regarding their health. Healthcare givers use these perceptions to start assessing patients to find health-related problems as described by the patients (Wilson& Cleary, 1995).

Overall Quality of Life

Clinicians and healthcare givers during their assessment of patients are expected to ask patients about the general quality of life in the past and the present as well as new

symptoms and changes in function. Researchers have also in the past assessed participants subjectively on their quality of life based on well-being and whether they were happy and satisfied with their life. Responses of overall quality of life will emanate from the lived experiences of the participants according to what they perceive as a good quality of life. It is important to note that, responses or measures of whether individuals are satisfied with their overall quality of life will differ and change due to people's expectations in society (Wilson& Cleary, 1995).

Research Using Health-Related Quality of Life Model

The quality-of-life conceptual framework proposed by Wilson and Cleary (1995) has widely been used in research showing its versatility. In one of the studies, Brunault et al. (2015) conducted a cohort study on obesity to determine the postoperative change in various quality-of-life dimensions using the quality-of-life model. The model was effectively used, and the researchers obtained various results. Key among them is the improvement in the quality of life connected to the psychosocial factors that were connected to higher weight loss, the severity of binge eating, and lower preoperative depression severity. The research also revealed that there was enhanced comfort with food connected to the lower preoperative binge eating extent.

Da Costa et al. (2019) found that health-related quality of life is a holistic measure that is related to biological, social, and emotional well-being and that it is a complex health indicator that is composed of different dimensions such as physical and psychological well-being. Engaging in physical activities showed that many cardiometabolic diseases can be avoided both in adults and children. Healthcare providers

always advise patients to have physical activities for normal blood circulation or to shed extra weight. Physical activities improve the health and quality of life and have a significant impact on adolescent's life providing a positive adoption to their organism as well as activities that support social-emotional development and improvement of life skills.

According to Wu et al. (2021), the study on the health-related quality of life model was used to explore the quality of life among the residents of Nanning City in China. The participants of this study recorded traumatic daily experiences that affected their physical health, and mental health and disrupted their social lives. This conceptual model will also apply to explore the health-related quality of life among Makonde immigrants and how COVID-19 impacted their daily life experiences.

Sousa and Kwok (2006) found that ethnicity/race, gender, and age are part of overall perceived health. This research was conducted on heart failure as a chronic condition to determine the overall perceived healthy quality of life. According to this study, the model was key in studying various factors connected to overall perceived health. Race, particularly being white or black, symptom stability, comorbid burden, social functioning, and perceived income sufficiency were found to affect people's quality of life.

Eilayyan et al. (2015) also conducted a study based on the quality-of-life model to identify the indirect and direct predictors of perceived asthma control in a chosen population. By using the model as a foundation, this research revealed various important points regarding asthma. For instance, they found out that asthma symptoms are

influenced by self-efficacy while emotional status is impacted by self-efficacy and symptoms. In addition, while physical activity was impacted by self-efficacy, emotional status, and symptoms, the perceived asthma control at the baseline was influenced by smoking, self-efficacy, physical activity, and asthma symptoms.

The conceptual model framework that grounds this study of the health-related quality-of-life categorized patient outcome measures depending on the underlying health concepts that they depict and puts for the causal relationships between various health concepts (Wilson & Cleary, 1995).

Even though spiritual, cultural, political, and economic factors can impact an individual's life quality, healthcare professionals focus more on the clinical aspects (Wilson & Cleary, 1995). The proponents of this conceptual framework, therefore, proposed various domains such as general health perceptions, mental health role functioning, social functioning, and physical and biological function. Therefore, this model is key to understanding the impacts of COVID-19 on various life aspects of the Makonde immigrants. This model can effectively be applied by healthcare professionals concerned with offering care to patients impacted by pandemics and various outbreaks such as COVID-19. The implication is that the healthcare professionals would have a better understanding of the real impacts of the condition and formulate better interventions, methods, or strategies that can be used in addressing the problem.

The logical connections between the framework presented and the nature of my study include the alignment and concepts within the framework in the quality-of-life conceptual framework. The research question is aligned in the essence that the concepts

within the model can be used to effectively unveil the daily lived experience of the Makonde immigrants during the COVID-19 pandemic. Therefore, this conceptual model will be used to provide the framework and guidance in this study.

According to Nangia and Gingrich (2020), immigrants have been identified in the literature to be more likely to be at risk of having diminished health and reduced healthcare access, thus affecting their quality of life. The COVID-19 pandemic outbreak around the globe led to several measures to curb its spread, among them working from home, unemployment because people would not access the workplace, curfews enacted, and transport halted. These activities led to several stressors such as the economic downtown and the inability to access basic needs due to curfews. The quality-of-life model can be used to further gain insight into the resultant impacts, particularly among the Makonde immigrants.

According to Sousa and Kwok (2006), the health-related quality-of-life conceptual model can effectively be applied in studying ethnicity/race, gender, and age on overall perceived health. This research was conducted on heart failure as a chronic condition to determine the overall perceived health predictors. According to this study, the model was key in studying various factors connected to overall perceived health. Race, particularly being white or black, symptom stability, comorbid burden, social functioning, and perceived income sufficiency were found to be independent predictors of the overall perceived health.

Concerning this study and physiological functions, COVID-19 affects physiological functions that also have everlasting complications in physical body

functions (Zhao et al., (2020). The virus causing COVID-19 invades and affects the lungs and respiratory tract tissues and all the cells of the organs of the body and negatively impacts them the consequences are a severe systematic failure in all COVID-19 patients. Physiological functions lead to failure in physical functions.

Zhao et al. (2020) also explained that for example, in the process of protecting from contracting COVID-19, people wear masks. This process affects internal and external respiration. Internal respiration is the process responsible for oxygen consumption that occurs at the cell's function level. external respiration is the process that occurs in transporting oxygen from the outside of the body to the cells that need oxygen for their functions while at the same time getting rid of carbon dioxide from the cells to the atmosphere.

Sousa and Kwok (2006) described physical functioning as the ability of an individual to be able to be mobile and to carry out activities of daily living. Medical problems limit people from going to work, going shopping, going to work to meet their friends and family, dressing, cooking, and self-care. Sick people may not have the ability to be independent and depend on others to assist them in carrying out their activities of daily living. Patients may become anxious and depressed with their medical problems because they do not know when they will get better and be able to be independent again. Sickness also causes unprecedented pain that leaves patients suffering. This is because the diseases attack the body's physiological function level. According to Markovic (2020), a lockdown was imposed by governments around the globe and restricted people from moving from one place to another to stop or reduce the spread of COVID-19. The

sick people would not venture out to buy medication because most shopping centers were closed. The fear and anxiety caused by these restrictions increased the risks of individuals getting depressed. Depression and anxiety would affect people's long-term quality of life. The additional myth about the pandemic and further misinformation and the quarantining of travelers abroad away from home caused anxiety, feelings of isolation, and financial hardship.

Chowdhury et al. (2021) described the effect of COVID-19 on the body system and how it affected people who contracted the disease. The disease attacks major organs of the body like the lungs, liver, and kidney. Many patients were reported to have pneumonia-related symptoms like difficulty breathing and the x-ray, showed ground-glass opacities in the lungs. The pandemic also left many patients weak because the disease affected their appetite, and they would not eat. The fact that COVID-19 pandemic made patients weak dysfunctional and immobile thus affecting their physical function. Immobility and lack of physical functions lower the quality of life.

Quality of life can be impacted when a disease manifests in an individual body. Once the disease is in the system, individuals start complaining that they are not at their utmost functional level in their daily life experiences. According to Fisher et al. (2021), some people may be sick but be asymptomatic. However, many of the patients can report the symptoms of how they feel. COVID-19 is known to affect the lungs and many of the patients were either treated with oxygen deprivation or pneumonia. Yet, other patients who went to see a doctor reported having fever, cough, weakness, lack of appetite, and chills.

The goal for every clinician is to maintain functional health for their patients. Choi et al. (2021) described functional health status as the ability to take part in daily life experiences and activities including walking, eating, cooking, maintaining self-care, and visiting friends and family. Functional health can be enhanced either in the health care setting or at home-by-home health services. For a patient who has been sick and is weak, Dumitru (2021) explained that occupational therapists can help them strengthen their neuro-muscular area which includes the reflexes, muscle tone, fine mote skills, coordination of movement, and articulatory movements that involve the use of the language. To be successful in achieving functional goals, the therapist will make an assessment, make the plan for the intervention needed, carry out the interventions, and help the patient to get involved with the activities of daily life to increase the functions in the performance in the sensory-motor, cognitive and psychosocial areas.

Rehabilitating patient who has been sick back to their functional status has improved in recent times with the introduction of telerehabilitation. According to Levey et al., (2015), this is the introduction and application of consultative preventive, diagnosis, and therapeutic services at home or over long distances because it is an alternative to traveling over longer distances by clinicians or patients.

Naghizadeh and Mirghafourvand (2021) also discussed the impact of relations of fear on quality of life. When one family member contracted the disease the rest of the family members tended to keep a distance. The misinformation also causes defamation and social exclusion increasing the risks of depression and anxiety about COVID-19. Many patients who went to the hospital were kept in isolation leading to many patients

getting depressed and feeling lonely in their isolation rooms thus affecting their quality of life.

Quality of Life as Defined and Measured in the Health Care Research

The physical, mental, and social well-being of individuals all contribute to their overall quality of life. Measuring the effectiveness of medical interventions and treatments is a common goal of healthcare research, and quality of life is frequently used as a proxy for this goal. Researchers have developed a variety of definitions and metrics for quality of life based on the context and population under study. In healthcare research, the WHO (2022) definition of quality of life is frequently used. A person's quality of life, according to the definition, is determined by their "perception of their position in life in the context of the culture and value system in which they live, as well as about their goals, expectations, standards, and concerns." This definition acknowledges that everyone’s sense of well-being is unique and influenced by their circumstances as well as those of their peers and community. It also demonstrates the importance of considering a person's hopes, expectations, and concerns when assessing their happiness.

According to Chuasuwan et al. (2020), medical researchers have developed several indicators of life satisfaction. The use of standardized quality-of-life instruments such as the Short-Form 36 Health Survey (SF-36) and the EuroQol 5-Dimension (EQ-5D) questionnaire are common methods for doing so. These instruments can assess physical health, mental health, social health, and overall well-being, to name a few dimensions. The SF-36 is a 36-question questionnaire that assesses health-related quality of life across eight dimensions (physical and social functioning, emotional well-being,

etc.). The EQ-5D, on the other hand, measures well-being across five dimensions: mobility independence, ability to care for oneself, regular activities, pain level, and absence of emotional distress.

Patient interviews, focus groups, and subjective well-being scales can also be used to assess the quality of life. Through interviews, researchers can learn more about a patient's quality of life from the patient's point of view. Participants in quality-of-life focus groups share and discuss their perspectives on the subject. This provides a more complete picture of the concept at hand. Subjective well-being scales such as the Satisfaction with Life Scale and the Positive and Negative Affect Scale ask people to rate their levels of happiness and sadness.

Lake et al. (2019) conducted a meta-analysis on the topic of quality of life and discovered that it is influenced by a wide range of internal and external factors, such as one's health, happiness, social network, and natural surroundings. According to the review, healthcare services and interventions such as medication management, assisting people in getting back on their feet, and providing emotional and social support were found to improve people's quality of life. According to the study, factors such as chronic illness, disability, and isolation can harm a person's quality of life.

How Immigrant Populations Define Quality of Life

There have been several studies that have aimed to determine how immigrant populations define the quality of life and the factors that contribute to it. These studies have found that the concept of quality of life is often shaped by cultural, social, and economic factors, as well as individual experiences and priorities. Weiler et al. (2017)

conducted a study in Canada and found that immigrant populations often define the quality of life in terms of the ability to meet basic needs, such as food, shelter, and safety. The study also found that immigrants place a high value on social connections and relationships, as well as access to education and employment opportunities. Another study conducted by Cain et al. (2018) in the United States found that immigrant populations often define their health and quality of life in terms of their ability to achieve their goals and achieve a sense of personal fulfillment. This study also found that immigrants place a high value on access to healthcare, education, and employment opportunities.

Quality of Life Among Immigrant Populations

Various studies have aimed to measure the quality of life among immigrant populations. These studies have used a variety of methods to assess the quality of life, including standardized quality-of-life instruments, patient interviews, and subjective well-being scales. Ngo-Metzger et al. (2019) conducted a study in the United States using the SF-36 Health Survey to measure the quality of life of immigrant populations. The study found that immigrant populations had lower scores on several dimensions of quality of life, including physical functioning and social functioning, compared to the general population. The study also found that certain factors, such as access to healthcare and social support, were associated with higher quality-of-life scores among immigrant populations.

Another study by Poder et al. (2020) in Canada found that immigrant populations had lower scores on several dimensions of quality of life, including mobility and self-

care, compared to the general population. The study also found that certain factors, such as access to healthcare and social support, were associated with higher quality-of-life scores among immigrant populations.

Quality of Life in African Countries

Magai & Koot (2019) used the SF-36 Health Survey to measure the quality of life of the general population of Kenya, Tanzania, and Uganda. The study found that the population had lower scores on several dimensions of quality of life, including physical functioning and social functioning, compared to other countries. The study also found that certain factors, such as access to healthcare and social support, were associated with higher quality of life scores. Another study conducted in Africa by Ekwunife et al. (2016) found that the population had lower scores on several dimensions of quality of life, including mobility and self-care, compared to other countries. The study also found that certain factors, such as access to healthcare and social support, were associated with higher quality-of-life scores.

Quality of Life Among Immigrants in Kenya

Muthuri et al. (2020) conducted a study on the quality of life of immigrant populations. The study found that immigrants had lower scores on several dimensions of quality of life, including physical functioning and social functioning, compared to the general population. The study also identified specific factors that were associated with higher quality of life scores among immigrants, such as access to healthcare and social support. Another study by Szaflarski & Bauldry (2019) found that immigrants had lower scores on several dimensions of quality of life, including mobility and self-care,

compared to the general population. The study also identified factors that were associated with higher quality of life scores among immigrants, including access to healthcare and social support.

Literature Review Related to the Health of Immigrant Populations

In one recent study, Agudelo-Suarez et al. (2019) conducted a study to determine the health-related quality of life and connected factors among immigrants in Spain. This source described the factors related to the quality of life of immigrants, including socioeconomic, political, and environmental factors. From their analysis, the researchers found that some of the factors that affect the quality of life of immigrants are unemployment, immigration status, and lack of medical insurance coverage (Agudelo-Suarez et al. 2019). This is important to the current study because it supports my research question by explaining the factors that affect the health and quality of life of immigrants.

In a similar study, Sanchez-Ojeda et al. (2020) conducted a study with the aim of attitudes toward the immigrant population. Part of the study focused on immigrants around the globe and their reasons for emigrating. Among the prominent reasons discussed in this article include the urge for better health and quality of life and the reasons why immigrants decide to relocate from their homeland. The researchers also argue that the problems facing immigrants can be addressed from various perspectives. For example, various contents should be included as part of the curriculum for nursing students to help them develop a better and more positive attitude towards immigrants. Some of the contents they describe include cultural competence, interculturality, cultural diversity, and migration. When taught in schools and colleges, these concepts can be

instrumental in eliminating stereotyped and prejudicial attitudes toward immigrants, hence contributing to improved quality of life among immigrants (Sanchez-Ojeda et al., 2020). As in the previous study, the findings of this study are important because they support my research that immigrants immigrate to improve their quality of life and what can be done to improve their quality of life.

Zhiwen et al. (2020) also conducted a study focusing on Asian immigrants, especially Vietnamese and Koreans. These researchers focused on health literacy, health status, and quality of life. These researchers conducted an analysis using structural equation modeling. Several factors were found to affect the life quality of these individuals, for example, health status, health literacy, utilization of health services, health insurance, English proficiency, marital status, education, and demographic differences. From the accomplished analysis, the researchers noted that communication about health could alleviate health illiteracy (Zhiwen et al., 2020). Besides, they also noted that immigrants and ethnic people are likely to have health illiteracy due to lack of information, language barriers, or miscommunication. These factors were a detriment to seeking medical care thus affecting their quality of life. The study also revealed that individuals from the Asian continent are all usually referred to as Asian immigrants; however, the perceived quality of health differs from one group to the next. For example, the immigrants from Vietnam and Korea explored in this study were found to present different aspects, indicators, or factors that contribute to health and quality of life. They include health insurance, English proficiency, education, visiting doctors, colorectal screening, self-perceived health status, and health literacy (Zhiwen et al., 2020). This

study is also important because it will seek to find the perceptions of health and quality of life among Makonde immigrants in Kenya during and after the COVID-19 pandemic thus supporting the qualitative research question in this study.

In another recent research, Kim et al. (2019) conducted a study to examine the connection between social capital, living conditions, and quality of life among older immigrants of Chinese origin. From the analysis, it was noted that these older Chinese immigrants' quality of life is substantially impacted by various factors such as whether they have children and spouses or not (Kim et al. 2019). Other factors noted include political participation, community partnerships, trust, and social capital. In addition, various findings were noted from the study. For example, quality of life encompasses factors that affect socioeconomic, well-being, religious, and environmental factors (Kim et al., 2019). Also, social capital is described as connecting with the community, the government, and the public. Therefore, this research is equally important because these factors touch on the quality of life, which is also an area of focus for this study among Makonde immigrants in Kenya.

Another study also focused on the impact of isolation on older immigrant individuals. Lai et al. (2020) carried out this study to explore the impact of a peer-based intervention when used in reducing social isolation and loneliness and enhancing older Chinese immigrants' psychosocial well-being. The researchers focused on immigrants and their problems in settling down in their host countries due to cultural and language issues. Various solutions were found to be instrumental in addressing the problems. For example, peer-based groups can help address issues such as depression, isolation, and

helplessness (Lai et al.,2020). Peer-based groups address issues of self-maintaining, physical activities, and health behavior like avoiding drinking and smoking. The findings of this research are important since they support the qualitative research question by describing factors that can improve the quality of life among immigrants.

Prapas & Mavreas (2019) explored the quality of life of some immigrants living in Greece, focusing on life satisfaction, psychological well-being, and quality of life among Pontic Greeks and Albanian immigrants. The researchers looked at what is perceived as the quality of life and the daily life experience in the communities, friends, neighbors, and the surrounding. From the analysis, the researchers found that quality of life includes physical health, mental health, relationships, and personal beliefs (Prapas & Mavreas, 2019). Again, the researchers noted that connecting immigrants with communities impacts the quality of life. In addition, this research also revealed that governments enhance access to resources that support the improvement of quality of life among immigrants, highlighting the importance of government support programs. The relevance of this study to the current research is that it gives evidence as to why immigrants need resources to improve their quality of life.

Urzua et al. (2017) also carried out a study to determine the impact of acculturation strategies on immigrants' quality of life. The study focused on Peruvian and Colombian immigrants living in various cities in Chile. From the analysis, the quality of life is impacted by social and psychological factors. One of the factors that are more beneficial to the individuals is those factors that enhance the retention and maintenance of the homeland culture. The study found that lack of or insufficient strategies for

maintaining the homeland cultural practices are connected to a lower quality of life among these Peruvian and Colombian immigrants (Urzua et al., 2017). Again, the marginalized strategy was also seen to be closely connected to reduced quality of life. The study also focused on the general issues of immigration and immigrants and documented that the immigration process can bring fear, loneliness, and longing problems. One of the consequences of immigration is isolation and isolation, which can cause depression and alter normal connections, thus affecting relationships (Urzua et al., 2017). Therefore, the study explored several factors that can hinder the quality of life among immigrants. Therefore, it also supports the focus of the current research.

Molina & Yalcinkaya (2020) also conducted a study focusing on immigrants. The study focused on the reasons why people migrate from one part to another and some of the factors that may make an individual or group of individuals seek naturalization and citizenship. One of the major reasons is to settle down in the countries of destination and to seek citizenship. Various factors motivate immigrants to seek citizenship in their host countries. For example, immigrants would like to be citizens in their host countries to be eligible to own properties, access healthcare, and be involved in the voting process (Molina & Yalcinkaya, 2020). In addition, this research found out that immigrants also usually seek naturalization to be recognized. Indeed, acquiring citizenship helps immigrants to have a better quality of life. This study is also important because it brings forth the issues of immigrants and the process of being citizens and the factors that can improve their quality of life, thus supporting the current research.

Tuohy (2020) discussed the relationship between immigration, healthcare, and healthcare disparity. The author argues that immigrants and ethnic groups are more likely to have problems accessing healthcare due to immigration status, thus affecting the quality of life. In some cases, immigrants get restrictions when trying to acquire valid papers or documents that can make them stay legally in the host countries. The authors also argue that undocumented immigrant adults who managed to arrive in the USA as children are similar in various ways to the immigrant children born in the USA (Tuohy, 2020). However, they face more barriers in terms of integration; hence care access is caused by a lack of legal status. The enactment and application of the Obama Care or the Affordable Care Act have been playing a key function in improving access to care for immigrants hence improving their quality of life (Tuohy, 2020). Therefore, the government and policymakers should enact policies that are non-discriminatory towards immigrants in accessing healthcare. This study is also relevant and important because it supports the notion of the need for high or better-quality care for immigrants. Therefore, the study supports qualitative research.

Albert (2009) also performed a study to explore the citizenship status role in the possibility of immigrants living in poverty and the possibility of getting various social benefits. From the analysis, this paper found out that the children with citizenship but being taken care of by immigrants have more possibilities of experiencing poverty, fewer chances of getting cash assistance, and are more likely to receive lunch subsidies than those with caretakers with citizenship (Albert, 2009). Besides, non-citizen children being taken care of by non-citizen caretakers are the highest likely to live in poverty and far less

likely to receive cash assistance, hence the lowest quality of life. The implication is that such children end up having a low life quality as compared to others, indicating the importance of factors like caretaking on the perceived quality of life among immigrants (Albert, 2009). Besides, the paper focused on challenges immigrants face, such as poverty, unemployment, and social isolation. They also lead tougher lives as the income among immigrants appears to be lower than the income of the native population. The author also argues that factors such as unemployment and poverty can affect the quality of life as individuals lack enough money to access healthcare services and eat healthy foods (Albert, 2009). The findings of this research are important because they present factors that can affect the quality of life of immigrants, thus supporting the study of the quality of Makonde immigrants in Kenya.

Again, Parsuad (2020) focused on the problem of immigrants and the challenges they meet in their host countries. The author argues that government should strive to help immigrants to access healthcare for a better quality of life. Even though COVID-19 impacted everyone negatively, undocumented immigrants and various ethnic minorities were most affected during the outbreak of COVID-19. The implication is that better efforts and improved strategies should be applied to ensure that immigrants and ethnic minorities get enough assistance during such times. The findings from the research are relevant and important because this article provides evidence that immigrants around the globe were severely affected and that policies and laws need to be enacted to support them, thus supporting my research topic.

Recently, Cleaveland and Waslin (2021) studied COVID-19 concerning vulnerability and threat among Latina immigrants. The authors observed that the rates of death and infection from COVID-19 have been distributed inequitably in the United States of America, which as a result, has produced adverse health outcomes among vulnerable populations such as Latina immigrants. Central to such a trend is insufficient access to health care and health insurance as well as low-paying jobs. Therefore, this paper focused on the vulnerability of immigrants and their problems with accessing healthcare. From the findings, the researchers noted that the government could help immigrants access healthcare and health insurance for better life quality (Cleaveland & Waslin, 2021).

A problem for immigrants with accessing healthcare can affect their quality of life and make them vulnerable to diseases like COVID-19. This article discusses the vulnerability of immigrants to be more likely affected by a pandemic like COVID-19 and therefore supports my qualitative questions, which are looking at Makonde immigrants and their quality of life with and after the COVID-19 pandemic.

Damle et al. (2022) explained that Covid-19 affected the quality of life of many immigrants around the globe. Immigrants experience xenophobia which is a driver of anti-immigrant sentiment thus resulting in health inequalities and outcomes. Ethnic and minoritized groups also experience discrimination across several social determinants of health and domains of life, including the workplace, education, and accessing and receiving health care services. Many immigrants who contracted Covid-19 reported symptoms that adversely affected their quality of life. They reported fatigue and lack of

energy that prevented them from carrying out their daily life activities. Immigrants reported difficulty of breathing and loss of appetite, and this lowered their health and quality of life.

Sato and Luo (2021) used a cross-sectional design to study health quality of life and risk factors among Chinese women in Japan during COVID-19 and found that the lockdown imposed by the Japanese government reduced the general population's physical activities which harmed their physical health. Chinese women in Japan had considerably low mental health status. The effect of COVID-19 on mental health has been addressed in many studies involving various populations. Although restrictions to stay at home helped the spread of the disease, people's socioeconomic activities were significantly affected.

In this study, a total of 203 Chinese women living in Japan were interviewed using an online questionnaire. Among the participants, 10 (4.9%) did not participate. The participants were recruited from online groups of Chinese residents in Japan using WeChat social media. The limitation of this study is that there was the possibility of bias since the samples did not cover all the regions of Japan which may have affected the generalizability of the study findings (Sato& Luo, 2021).

Sato and Luo (2021) also explained that a cross-sectional design also proved to be a limitation and needs a follow-up using qualitative research design which is more applicable to studying the health quality of Chinese immigrants and their lived experiences with Covid-19.

Lorthe et al. (2023) Used the health quality of life conceptual model to study socioeconomic conditions and children's mental health and quality of life during the COVID-19 pandemic. The conceptual model includes multidimensional constructs that include physiological, psychological, social, and functional aspects and well-being. Adolescents aged 14 years and older answered pediatric quality of life inventory containing 15 items and linearity transformed on a scale of 0-100 and the highest score indicating a better healthy quality of life. Children's mental health difficulties were also measured using the French version of strength and difficulties. Therefore, the health-rated quality of life conceptual model was most applicable.

The finding of the study found a specific social pattern. A poor financial situation was associated with all dimensions of low health and quality of life. From this study, there is evidence that adverse outcomes caused by pandemics like Covid-19 if not properly addressed through policy and community-level interventions, the social crisis created by the pandemic may further increase health problems and health inequalities in the medium and long term. Future research should shed light on psychological resources, resilience factors, and coping strategies that will help children, adolescents, and families navigate the pandemic (Lorthe et al., (2023).

Another study was conducted on immigrants in Norway and their perception of COVID-19 by Mahic et al. (2023). The study uses exploratory and interpretive design on hermeneutic methodology to explore the lived experiences of Somali and Pakistan immigrants in Norway. An exploratory approach is relevant when knowledge of the topic is limited and new angles and information on the topic are desired. The findings found

that the semi-structured interview shows that the participants used different sources and platforms to get information about COVID-19.

Mahic et al. (2023) explained that other immigrants, however, found it difficult to keep up with the information about the pandemic that was coming from the authorities and relied upon friends and media to get the information. Somali immigrants formed their own website that translated the information given by the Government. The strength of this study was that it managed to include people from immigrant groups that had the highest incidence of infection in Norway. Another strength is that the study had the opportunity to use an interpreter for all the groups that were interviewed. The weakness was that the study only recruited participants from religious and organizational networks meaning that some most vulnerable participants were missed out (Mahic et al., (2023).

Another research was done on the impact of COVID-19 on Muslim older immigrants in Edmonton Alberta by Rehmani et al. (2023) The study was part of the larger community-based participation research. The study used mixed methods and rapid qualitative design. Participants were recruited through convenience sampling by calling the phone numbers of older adults who attended religious and social programs at the mosque.

Quantitative findings from the survey were reported through descriptive statistics and summary statistics were performed using Excel and Stata. Qualitative interviews were thematically analyzed with NVivo 12 software. Qualitative interviews were essential for understanding the needs of this population. The strength of this study was found to be conducting on community-based participatory research project with a local

mosque with older adults was challenging, however obtaining reach data was successful and interviews were effective in collecting data by connecting with isolated locals in the community. However, it was difficult to get a higher number of older participants and a way to connect with the oldest old participants during a crisis like COVID-19 should be investigated in the future and this posed a weakness in this study (Rehmani et al., 2023).

Sayad et al. (2023) studied self-reported key information about the impact of COVID-19 socialization restrictions on the familial and social support system among aging Middle Eastern/Arab American immigrants. A quantitative approach was used as it contributes to a deeper understanding of lived experiences and captures cultural norms and perspectives among participants. Semi-structured focus group interviews provided a quick and conventional technique to collect qualitative data from multiple people simultaneously while also permitting an exchange of opinions on the subject (Sayad et al., 2023).

Focus groups allow participants to engage in more open conversations about their personal experiences and lifestyle changes due to COVID-19 while permitting them to exchange various opinions on the matter. This study sheds light on how multiple stressors were conducted by an immigrant community. Its findings have implications for both research and policy including the need to incorporate ethical factors to better understand health disparities and inform future policies to better meet needs when naturally occurring supportive systems are jeopardized (Sayad et al., 2023).

A potential weakness of this focus group includes recall bias linked to the recollection of the COVID-19 pandemic experiences. A recall bias may lead participants

to overestimate or underestimate their experience during the COVID-19 pandemic, which would subsequently affect the study. Another weakness, this study only recruited participants from the Detroit area which is home to the largest and largest visible Middle East/Aab immigration in another part of the country thus leaving other participants from another part of the country and this decreased the validity of the study (Sayad et al., 2023).

Dresden et al. (2019) carried out a study on perceptions and expectations of health quality of life among geriatric patients seeking emergency care. Health quality of life encompasses social, emotional, and physical well-being and can be measured in chronic conditions like cancer, asthma, congestive heart failure conditions, and fatality. The objective of this study was to describe which aspects of the health quality of life domains are most effective in measuring the quality of life of elderly patients using the emergency department.

Dresden et al. (2019) used a qualitative design from a focus group of geriatric emergency departments from urban, academic emergency departments with over 88,000 total annual visits. The participants discharged from the emergency department discussed how their illness or injury caused physical symptoms, but also impacted their relationship and mental health. They expressed feelings of anxiety and uncertainty and identified the interpersonal effects of health quality of life mediated by social health, and individual experiences of health quality of life mediated by mental health.

Further studies are needed to find out how geriatric patients in the emergency department can overcome anxiety during emergency department visitation. This will

improve the elderly patients with their health and quality of life and thus be meaningful (Dresden et al.,2019). Qualitative design can be used to study the quality of life among Makonde immigrants during and after the COVID-19 pandemic by using Health quality of life domains to measure their lived experiences. The result from the study will be used to improve their health and quality of life with similar pandemics in the future thus making qualitative design meaningful to use during this study.

O'Mahony et al. (2023) studied the use of participatory action to support Syrian refugee mothers in the resettlement period in Canada. Refugees often experience physical and mental health challenges upon resettlement and beyond. Poor language skills, inadequate housing, and health services, lower perceived control, and lower perceived social support burden refugees for several years after settlement. Refugees although they need support, they fear coming out due to fear of being deported.

This was a qualitative design consisting of in-depth interviews and social demographic surveys of participants' Syrian mothers reported inability to find and maintain job security. Syrian mothers reported several major hindrances that disrupted coping with life in Jordan. Economic instability was a common hindrance. Many women's husbands participated in heavy labor and /or precarious work, and payment for this work was unpredictable. Many of the Syrian mothers felt that the work conditions were discriminatory. They described their own experience in Jordan as discriminatory, they did not feel like they believed (O'Mahony et al., 2023).

This study shows that COVID-19 was a significant source for Syrian mothers. They feared that they might become seriously sick and were reluctant to access

healthcare during the peak of the COVID-19 pandemic. Refugees and migrant workers are more likely than Canadian-born workers to be affected by the loss of income and healthcare insecurity during a pandemic making this study meaningful ((O'Mahony et al., 2023).

Using qualitative descriptive design to learn the lived experiences of Makonde immigrants in Kenya during and after the COVID-19 pandemic may lead to the implementation of healthcare, social, and financial services from stakeholders and the Government thus improving health and quality of life. Improving health and quality of life for similar ethnic groups around the world with similar pandemics will be meaningful.

What Remains to be Studied

The Covid-19 pandemic caused many sicknesses and deaths around the globe. It may be possible that the studies that have been completed in other countries around the world would yield similar results about the experiences of immigrants and their health and quality of life. It is also understandable that not many countries had the resources to fight the COVID-19 pandemic. For example, Russia, China, and the United States of America were able to manufacture Vaccines (Ravindranath & Balakrishnan, 2023.). While the vaccines were distributed, many countries received these vaccinations later, and not many people had access to the vaccination.

The impact of vaccination and the reduction of COVID-19 infections needs to be studied since t it is not well understood (Ravindranath & Balakrishnan, 2023.) COVID-19 vaccination remains controversial since many people declined the use of the vaccinations

because some people developed allergies and were believed to cause strokes among the few individuals who were vaccinated. COVID-19 and its origin are still controversial since there are sources that indicate that it was manufactured in a laboratory. The fact that the pandemic caused havoc among the older and elderly population is still not to be investigated. While children were affected, a greater number of populations that were affected were older compared to children (Costantino et al., 2021).

Bhangu et al. (2023) explained that qualitative research methods refer to investigation techniques that rely on nonstatistical and nonnumerical data collection, analysis, and evidence collection methods. Qualitative research techniques provide a lens for learning about nonquantifiable phenomena such as people's experiences, language, histories, and culture. Qualitative techniques can also contribute to a better understanding of social, cultural, political, and economic dimensions of health and illness. Social scientists and scholars in the humanities can rely on a wide range of methods, including interviews, surveys, participants, observations, focus groups oral history, and archival research to examine both structural conditions and lived experiences of individuals and groups of people.

Bhangu et al. (2023 further explained that qualitative methods remain the most effective method to explore the health and quality of life of Makonde immigrants in Kenya. Qualitative research methods should not be seen as tools that can be applied independently of theory; these tools need to be based on more than just methods. Departing from a reductionist psychological model of individual behavior that often

blames people for their illness, social theory focuses on relations – disease happens not simply in people but between people.

This type of theoretically informed and empirically grounded research thus examines not just patients but interactions between a wide range of actors (e.g., patients, family members, friends, neighbors, local politicians, medical practitioners at all levels, and from many systems of medicine, researchers, policymakers) to give voice to the lived experiences, motivations, and constraints of all those who are touched by disease thus making qualitative design the most effective to use in exploring the health quality of life of Makonde immigrants in Kenya during and after Covid-19 pandemic (Bhangu et al., (2023).

Summary

In this chapter, I presented scholarly literature focused on health-related quality of life around the globe and how the COVID-19 pandemic affected many people, especially immigrants. I did not come across any research detailing the Makonde immigrants in Kenya and how they were impacted by the COVID-19 pandemic. Exploring the lived experiences of Makonde immigrants during and after COVID-19 will require a qualitative design that applies to recording and analyzing the feelings, behavior, attitudes, and the environment thus covering the lived experiences in depth and detail. I also explored Wilson and Cleary's (1995) health-related conceptual model and explained the concepts within the model and its application in research and clinical settings to assess patients' health status. My study will fill the gap in knowledge by documenting the lived experiences with quality of life among Makonde immigrants during and after the

COVID-19 pandemic. In Chapter 3, I will explain the study process and methodological approach that will be used for this study.

Chapter 3: Research Method

The purpose of this qualitative descriptive study was to explore the lived experiences with the quality of life of Makonde immigrants in Kenya during and after the COVID-19 pandemic. This chapter includes a summary of the methodology I used to conduct the study. I describe the participants and the setting of the research, instrumentation, data collection, data analysis, role of the researcher, and ethical considerations in this study. This chapter also addresses matters of trustworthiness including credibility, transferability, dependability, and confirmability.

Research Design and Rationale

The research question guiding this study was the following: What are the lived experiences of Makonde immigrants living in Kenya regarding their health and quality of life during and after the COVID-19 pandemic? The central phenomenon in this study was the health-related quality of life related to the COVID-19 pandemic. Health-related quality of life is defined as the individual's perception of their physical, mental, and emotional health as well as their status regarding contributors to and consequences of being healthy, such as functional status, social support, and socioeconomic status (Centers for Disease Control and Prevention, n.d.). COVID-19 is a coronavirus disease that broke out in 2019 and was believed to have originated in Wuhan province in China; the WHO declared it a pandemic by March 2020 (La et al., 2023). According to Ngere et al. (2020), the first case of COVID-19 in Kenya was reported on March 13, 2020, by a person who traveled from the United States of America via London to Kenya. By July 30 of 2020, 17,975 cases and 285 deaths were reported. The WHO (2023) reported that as of

March 2023, 23,359 vaccination doses had been administered in Kenya; however, positive cases continued to be reported among older people with underlying health conditions such as diabetes and hypertension. Even though the number of new infections has been declining throughout the country, the impact of COVID-19 on Kenyan society has been significant (Barasa et al., 2021), but information on the impact on Makonde immigrants was lacking.

In this study, I used the qualitative descriptive research tradition. The qualitative descriptive paradigm has its roots in social science and has been widely used in recent social science studies (Creswell & Creswell, 2018). Qualitative research is a constructive method that focuses on experiences and perceptions, while quantitative researchers employ the use of numbers and statistical analysis (Rothberg & Bouikidis, 2018). The qualitative descriptive design is a common form of qualitative research in which data are collected through interviews, observations, documentation, and analysis of the data collected from the interviews. The questions asked during the current study were guided by the conceptual model of the study. Analysis of the data consisted of identifying repeated patterns of the data that were grouped into themes to answer the research question (see Rothberg & Bouikidis, 2018). My overall interpretation of the data was based on the data derived from the participants' interviews. According to Patton (2015), a descriptive qualitative design allows for an in-depth exploration of people's lived experiences. Participants in the current study were allowed to share their perspectives about their experiences with health and quality of life during and after the COVID-19 pandemic. I used a descriptive phenomenological approach to understand the experience

of Makonde immigrants because little was known about their health-related quality of life. By obtaining rich descriptions from members of the Makonde immigrants' community, I provided findings that may inform further research.

Role of the Researcher

In this study, I was the main researcher. My role was to recruit participants who met the selection criteria, collect the appropriate data, analyze the data, and report the results. According to Fink (2000), the researcher is the main instrument in a qualitative study. A qualitative researcher is not only an observer but also someone who interacts with participants during the interview process (Fink, 2000). Karagiozis (2018) explained that the role of a researcher in qualitative research is to promote, maintain, and balance dialogue between the participants and the researcher by using questions related to the research question. As the main researcher and instrument in the current study, my main roles were to recruit participants and conduct interviews. I used open-ended questions that allowed participants to discuss their lived experiences during and after the COVID-19 pandemic as settled Makonde immigrants in Kenya.

To ensure integrity, the qualitative researcher must address their bias while collecting and analyzing data (Galdas, 2017). I had no prior relationship with the Makonde immigrant community. Therefore, the chance of recruiting participants with whom I had prior relationships was limited. However, if anyone with whom I had a personal or professional relationship would have responded to my recruitment material, they would have been excluded from participation but thanked for their interest in the study. During my nursing work, I experienced firsthand the role and responsibilities of a

caregiver caring for immigrants facing health problems. My experience increased the potential for personal bias to exist based on my interaction with immigrants as a healthcare provider in various healthcare departments. Also, the fact that I was born in Kenya might have resulted in personal bias regarding Makonde immigrant communities. Sorsa et al. (2015) described scientific bracketing in qualitative research as a situation in which a researcher suspends assumptions, theories, and previous experiences to describe the lived experiences of participants in the study. Bracketing allows the researcher to become aware of their feelings and put aside their presuppositions to capture the lived experiences of the participants in the study. I used bracketing to mitigate presuppositions and/or biases regarding the topic and target population of this study. To support my ability to obtain a sufficient sample size to achieve data saturation, and as a token of appreciation for agreeing to participate in this study, I gave a $10 gift card for volunteering and participating in the study.

Methodology

Participants Selection Logic

The target population for this study was Makonde immigrants living in Kenya. I chose this population because of their increased risk for COVID-19 infections due to their high incidence of unemployment, overcrowded housing conditions, and concentration of jobs where physical distancing is difficult (see Langellier, 2020). I used a homogenous purposeful sampling strategy because it would yield a sample from which relevant information would be learned. Patton (2015) described purposeful sampling as a qualitative method used to select information-rich cases from which a researcher can

learn a great deal about issues of central importance in a study. The inclusion criteria for the current study were adults over 18 years of age who were members of the Makonde community in the Kwale and Kilifi counties of Kenya. Participants were required to speak English because English is the universal language in Kenya. Participants were also required to have been sick with COVID-19 by testing positive or through hospitalization due to COVID-19 infections at any time since the beginning of the pandemic in March 2020 in Kenya. Exclusion criteria included my family, friends, and people with whom I had a professional relationship as well as Kenyans who did not belong to Makonde immigrant communities.

Participants from Makonde communities who were affected during and after the COVID-19 pandemic were recruited for the study. Recruitment occurred by placing flyers on social media, local stores, and restaurants in Kilifi and Kwale counties (see Appendix B). I contacted relevant facilities in the area to gain permission to recruit participants by posting flyers on their premises. Snowball sampling would have been used, if necessary. Flyers contained eligibility criteria for participants, a guarantee of confidentiality, and my contact information. I ensured the eligibility of those who responded to my flyer by administering a screening questionnaire on first contact (see Appendix A). A time and place of meeting was arranged for an interview.

Participants who were unable to meet in person for the interview were allowed to have a telephone interview. Consent forms were completed by email or in person, and interviews commenced after participants signed the consent form. I anticipated a sample of 10–15 participants to reach data saturation. According to Nicholas et al. (2021) and

Patton (2015), this sample size is reasonable for a qualitative descriptive study. Data saturation is reached when the collection of data becomes redundant and no new information is likely to emerge from the interview questions (Nicholas et al., 2021; Patton (2015). Because I was a novice researcher, I consulted my chair to determine when saturation was reached.

Transcription of the interview data occurred immediately after each interview, and the initial coding of the data was completed. All interview data were maintained as confidential and kept under lock and key. Digital data collected via audio recording were stored on a password-protected computer. Recorded interviews that were transcribed to spreadsheets were also securely stored on a password-protected computer and in a password-protected file. Participants' confidentiality was protected by giving them pseudonyms to protect their privacy.

Instrumentation

A demographic questionnaire was used to collect descriptive data on the gender and age of the participants (see Appendix A). Demographic data were collected as pertinent to the situation and experiences being described by the participants. The demographic data included the sex, occupation, location, and age of the participants. The demographic data were crucial to this study because people came from different cultural, occupational, and economic backgrounds and had different experiences on how COVID-19 affected their health and quality of life.

I developed an interview guide that was used in this study (see Appendix C). The interview questions were designed to prompt participants to share their lived experiences

related to their quality of life during and after the COVID-19 pandemic. In-depth interviews were flexible, interactive, and responsive. The questions were worded to encourage the participants to provide detailed responses in their own words. The interview guide included welcoming comments, the questions to be asked, and comments thanking the participants for coming for the interview.

Other data collected during the study were field notes taken by me during the interview. Field notes described the environment, my feelings and thoughts as the researcher, my perceived impressions of the participants, and the interview process. Detailed field notes were written during each interview and analyzed along with the transcripts. Field notes are important to refresh the researcher's memory of the session during the analysis of the data and may also help in revealing the emergent themes (Burgess, 2020). I developed the interview guide based on the extant literature on health-related quality of life, the conceptual framework guiding the study, and my experiences as a health care provider at the bedside of COVID-19 patients.

Field Test of the Instrument

To increase the credibility and reliability of this qualitative study, I conducted a field test with an expert panel to review the interview questions to ensure that the study would have the rigor of qualitative research. Field testing of an instrument involves the researcher selecting three to five people who have expert knowledge about the population and research topic to provide feedback on the appropriateness of the proposed questions that will be asked to the participants (Patton, 2015). Feedback from the field test is used to improve the interview questions before using them in the study. The selected member

panel also determines whether the questions have any limitations (Patton, 2015). If the questions have any limitations, corrections should be made.

Procedures for Recruitment, Participation, and Data Collection

Before conducting this study, I sought permission from the Walden University Institutional Review Board (IRB Number 03-12-05689441). This permission relied on adherence to strict protocols such as informed consent. In this study, written informed consent was used.

Recruitment

About 10-15 adult men and women participants over 18 years of age were sought for this study form among Makonde immigrants from Kwale and Kilifi counties in the coastal town of Kenya. My initial contact with the participants in the recruitment process was sought through the flyer (Appendix C). Once the Walden University IRB granted permission to conduct the study, I traveled to the destination where Makonde immigrants reside, introduced myself as a student and asked for permission to use their premises, like churches and shopping centers, in the process of recruiting participants. I also posted flyers on social media like Facebook. I requested that interested volunteers contact me through my email and telephone number for further arrangements for a meeting and screening for eligibility to be part of this study. If they passed the screening questionnaire process, they were introduced to the study and the informed consent.

Recruitment began by placing flyers in the local stores and restaurants in Kilifi and Kwale Counties. Flyers contained specific criteria for participants from the target population, a guarantee of privacy, and contact information. I contacted relevant facilities

within the area to gain permission to recruit participants by posting flyers on their premises. Participants from Makonde communities who were affected during and after the COVID-19 pandemic were recruited for the study. Recruitment, consent forms, and interviews of the participants were conducted in English. Recruitment of volunteers for this study started by using posters on-site and on social media, and snowballing. The flyers contained specific criteria for eligibility for the study. These included being from the Makonde community and having been impacted by the COVID-19 pandemic. My telephone numbers and e-mails were included for contacts. A place of meeting will be arranged for screening and interview arrangements followed (see Appendix B).

Participation

The process for informed consent of the participants must comply with the ethical research requirements identified by Walden IRB. Those who wished to participate signed an informed consent form (Appendix E). Those who consented had the opportunity to complete the interview at that time or to arrange the place, date, and time for the interview. Participants were informed of the location to choose the location that affords them privacy. Only one member from the family was recruited to the study where there was more than one qualified family member participant.

Data Collection

The main researcher is considered the instrument in the process of data collection and analysis in qualitative research (Patton, 2015). Semi-structured open-ended interviews were utilized to provide the participants the opportunity to share their lived experiences during and after the COVID-19 pandemic. The participants were assigned a

pseudo-ID to protect anonymity. A digital recorder on my iPhone was used to capture interviews.

Temi.com (2017) software was used to transcribe digitally recorded audio interviews; this software has been used in interviews by graduate students and press conferences to transcribe recorded interviews to texts for easy coding (Temi.com,2017). NVivo 12 software was used to organize the data and facilitate analysis (NVivo, 2018). All software in this study required usernames and passwords to use and access data. I also physically reviewed the transcripts to confirm the data (Richards, 1999).

The participants impacted by the COVID-19 pandemic included those who either tested positive or tested positive and were hospitalized. About 10-15 adult men and women participants over 18 years will be sought for this study from among Makonde immigrants from Kwale and Kilifi Counties in the coastal town of Kenya. Data were collected via in-depth interviews with open-ended questions in the English language. A purposeful sample allowed me to acquire participants who can share experiences that will help me answer the research question (Suri, 2011). Data collected from participants were be analyzed using Colaizzi's descriptive qualitative approach, where themes and categories will be analyzed to bring forth the essence of a lived experience (Jesmi et al., 2021). It is important to note that even before the outbreak of the COVID-19 pandemic, the Makonde immigrants in Kenya were already experiencing various problems that were impacting their quality of life. Therefore, by using the descriptive qualitative research design, the lived experiences and health quality of life among the Makonde immigrants weree described specifically concerning the COVID-19 pandemic outbreak.

As a doctoral student, I was the sole main researcher in this study. I interviewed the participants and collected data from Makonde immigrants. Data were recorded using an iPhone capable of requiring interviews. I continued advertising and recruiting participants till saturation was reached.

Debriefing Procedures

After conducting debriefing sessions with each of the participants and thanking them for their time and effort to attend the interview, I provided each of the participants with my name and contact information in case they had follow-up questions. I also requested they provide their contact information in case there was a need for follow-up and clarifications concerning the study.

Data Analysis Plan

Data were analyzed using Colaizzi's (1978) descriptive exploratory analysis method. To analyze the qualitative data, the I followed the seven-stage process as outlined by Colaizzi (1978) including familiarization, identifying significant statements, formulating meaning, clustering themes, developing an exhaustive description, producing fundamental structure, and seeking verifications of each fundamental structure by strictly referring to the Colaizzi's conceptual model in analyzing qualitative data. I used a thematic inductive approach to analyze the participant's responses to the interview questions. The questions developed were used to prompt participants to share their experiences from their reflections. To avoid discrepancies in this study, I allowed time for participants to be independent and be treated with respect. Allowing enough time for

participants to explain their lived experiences and ensure that the interviews and results are accurately recorded in the literature helps to avoid bias.

Data Collection

Data werecollected through face-to-face interviews. I will be the sole interviewer in this study and transcriber. I recorded the interviews using an iPhone. I manually transcribed these recorded interviews on to Excel spreadsheets, after listening several times to become familiar with the clarity and understanding of the interview recordings. I also used Temi.com transcript software. This service allowed for easy downloading of the recorded interviews. This software produces 60-minute transcripts in less than 5 minutes and the cost to transcribe a 60-minute recording is $0.25 per minute of transcription. As with the transcription, a researcher still must verify the transcriptions against the recorded interview. I will transfer the transcribed files to Excel spreadsheets. I then compared them and I manually transcribed them for accuracy. This process took place with participants one at a time.

The next step is to transfer the data to a Microsoft Excel spreadsheet in addition to the interviewee ID and Question/Response column. The purpose of transferring these items to Excel spreadsheets is to start the process of sorting out the codes and themes. Temi software can have a Word document. These transcripts were transferred to Excel spreadsheets and were compared for accuracy.

To start the laborious process of coding, each interview response was examined, and the content was broken into small segments to easily identify codes or themes in them. From the spreadsheets, I looked for words and phrases that capture the health and

quality of life during and after the COVID-19 pandemic. This process was done manually for every participant. The spreadsheet was filed securely for identification purposes for references. The Codes were transferred to a Word document and then saved securely for future reference, comparison, and analysis in the process of finding categories and themes after reaching saturation in this study. For the accuracy of the data collected from the participants, the transcripts were saved in a Word document and were analyzed using qualitative data analysis NVivo 12 software to ensure clarity of the codes and themes. The process of coding and looking for themes will be checked from the eyes of different experts (member check from Walden University. According to Elliott-Mainwartin (2021), the NVivo 12 software is used to analyze unstructured text, audio tapes, and image data. The software is commonly used in qualitative research and was published in 2013. NVivo 12 was used to facilitate coding in this study. During this period of analyzing data, I continued to maintain reflexivity and audit trail.

Issues of Trustworthiness

According to Ellis (2019), it is pertinent for qualitative researchers to establish the researcher's findings to be credible, transferable, confirmable, and dependable. Establishing trustworthiness creates rigor in the research process thus ensuring that the research is valid, reliable, generalizable, and authentic. To enhance trustworthiness in qualitative research, this study adhered to the following strategies: direct and prolonged engagement with participants through field note-taking, supervision, and data auditing (Hui et al.,2021).

Credibility

To strengthen credibility within the research study, I used member checking by sharing my impression of what I am learning through the interview and asking if I am capturing their experiences accurately. I also created an audit trail that will help to verify the validity of the research findings after reaching saturation. I also sent transcripts of the first few interviews to the committee chair for feedback on how I am progressing in capturing the perspectives of the participants (Hui et al.,2021). Triangulation is another method to strengthen credibility in the qualitative research study (Fusc et al.,2018). Data from transcripts, observation notes, and journal entries were utilized. Prolonged contact and engagement with the participants was to ensure in-depth rich data in this study. Continuing data collection and analysis until saturation is reached was another strategy that will establish and strengthen credibility. Reflexivity is another self-check of the research process and was critical in strengthening credibility (Fusc et al.,2018).

Transferability

Transferability refers to the study's ability to be generalized to other settings (Ellis, 2019). This step was achieved by my transparency in providing the reader with the contest, location, and participants. A qualitative researcher must provide a clear and concise iteration of the research steps and process to the leaders of the study. I provided detailed description of the findings developed from the study (Ellis, 2019), I also recorded the interviews and create detailed notes from the interviews with the participants. Transferability was obtained within this study in that it can be replicated if needed. This study provided rich, detailed descriptions of the locations, contexts, and

groups of people that will be studied. By providing this information, the reader can determine if the original research applied or can be replicated in the new field of study.

Dependability

Dependability means accurately capturing the experiences and perspectives of the participants (Tuval-Mashiach, 2021). Dependability also refers to whether the evaluation of the findings, the interpretations, and the recommendations of the study are supported by the data collected from the participants from the Makonde community. As a researcher of this study, I ensured dependability by maintaining the audit of the process logs of the interviews, field notes, and debriefing with the participants. A study and its findings are auditable when another researcher can follow the decision made in the study. To ensure dependability, the audit trail was represented by including the original quote and other data that were used to inform the researcher's interpretations so that the readers of the research can confirm that given the same data, they will have arrived at the same conclusion of this study (Ellis, 2019).

Confirmability

Confirmability refers to the extent to which the result of the study can be confirmed or corroborated by other researchers (Ellis, 2019). I recruited participants according to the guidelines of qualitative methods that will support the findings of this study. I followed the protocol in recruiting and interviewing participants in the process of avoiding personal bias. I conducted self-reflection throughout the study to prevent my values, beliefs, and assumptions from interfering with the study and this should help to ensure that the findings are shaped by the participants and not the bias of the researcher.

Reporting of the research findings was done transparently and accurately so that does not harm the confidentiality of the participants within the study (Ellis 2019). Through the examination of the trail records, the reader of this study will be able to determine if the findings are supported by the research and derived from the data.

Ethical Procedures

In this qualitative descriptive research study, I obtained approval from the Institutional Review Board (IRB) at Walden University. I complied with the IRB's requirements to complete the training for research on human subjects. To satisfy the ethical concern surrounding the recruitment of the participants, I provided full disclosure of the purpose of the study. Participants were informed that they will not be pressured to participate in this study and that participants' benefits will be provided to them (Creswell& Creswell,2018). Informed consent was provided along with the disclosure of the intent of the research and an assurance that they could withdraw from the study without any penalty. Participants were informed of their rights to confidentiality and that their names will not be used and that I will remain confidential (Goulart et al., 2018).

Consent forms, data, and transcripts obtained from interviewing the participants were also be stored in different digital files separately using different synonyms to protect participants of this study using a username and password to which only the researcher has access. Participants were informed that the data and all the transcripts obtained from the interviews will be digitalized and secured immediately (Cooper, 2016). All study materials will be kept for five years and destroyed by shredding documents and deleting files following institutional practices. Lastly, in this qualitative descriptive research, no

personal, professional, or friends were recruited in the study since this would compromise the very intent of the study cause a conflict of interest and create a bias that may dimmish the quality of the study (Creswell& Creswell,2018).

Summary

The purpose of this qualitative descriptive study was to gain an understanding of the quality of life of Makonde immigrants in Kenya during and after the COVID-19 pandemic. This study will included ten participants who were interviewed to share lived experiences during and after Covid-19. This study is needed because understating such experiences may provide knowledge that can be used and that it can be incorporated into programs that will ensure resources and other help are sent and are available during times of crisis and pandemic like COVID-19.

This chapter contained the purpose of the study, research question, methodology, dependability, confirmability, trustworthiness, and ethical procedure in research. In Chapter 4, I will provide the findings of this study, including the data collection and analysis process.

Chapter 4: Results

This qualitative study aimed to understand the lived experiences of Makonde immigrants who reside in Kilifi and Kwale counties regarding their health and quality of life during and after the COVID-19 pandemic. In this study, I used a qualitative approach. I collected data through face-to-face and Zoom video conferencing with open-ended questions addressing the participants' lived experiences during and after the COVID-19 pandemic.

In this chapter, I describe the setting, provide demographic information for the participants, and discuss the data collection and analysis process. Additionally, I present the evidence of trustworthiness and the results addressing the research question. The research question I sought to answer was the following: What are the lived experiences of Makonde immigrants in Kenya regarding their health and quality of life during and after the COVID-19 pandemic?

Setting

Recruitment for the study took place between October 22 and November 23, 2023, after obtaining IRB permission to start the process of collecting data. I posted the study flyer on Facebook and LinkedIn. The flyer contained my email address and telephone numbers where I could be reached by the people who wanted to participate in this study. Additionally, I traveled to Kwale and Kilifi counties where I placed the flyers in restaurants, community buildings, markets, and shopping centers. Thirty-two people responded to the survey and 21 people met the inclusion criteria. I contacted them, and

each one informed me where they could be met for further screening and information about the study.

Twenty people turned up, and all of them passed the screening. During the screening process, participants were informed that they were participating voluntarily and that they could end the interview if they did not wish to continue with the study. If they became distressed during the study, I provided resources and referrals to seek mental support and treatment free of charge. I explained the intent of the study and explained that they needed to sign the consent form and were to be recorded during the interview. None of the interviews needed to be stopped or discarded due to stress, and no referrals were made during the interviews. All interviews proceeded as planned, and there were no unexpected events.

Demographics of the Participants

I interviewed 10 participants for this qualitative study. The participants lived in Kwale and Kilifi counties in Kenya. Participants' ages ranged from 18 to 64. The inclusion criteria included participants who had been sick with COVID-19 and were hospitalized due to the virus. Regarding gender, there were eight women and four men. Regarding occupation, there were three nurses, five farmers, and two unemployed individuals. Table 2 includes demographic information for the participants.

Table 2

Demographic Information of Participants

Demographic	Category	Number
Gender	Male	6
	Female	4
Age	18–25	3
	25–35	0
	35–45	5
	45–55	2
	55–65	2
	> 65	0
Setting	Kilifi	7
	Kwale	3
Occupation	Nurse	3
	Farmer (small-scale farming)	5
	Unemployed	2

Data Collection

Participants

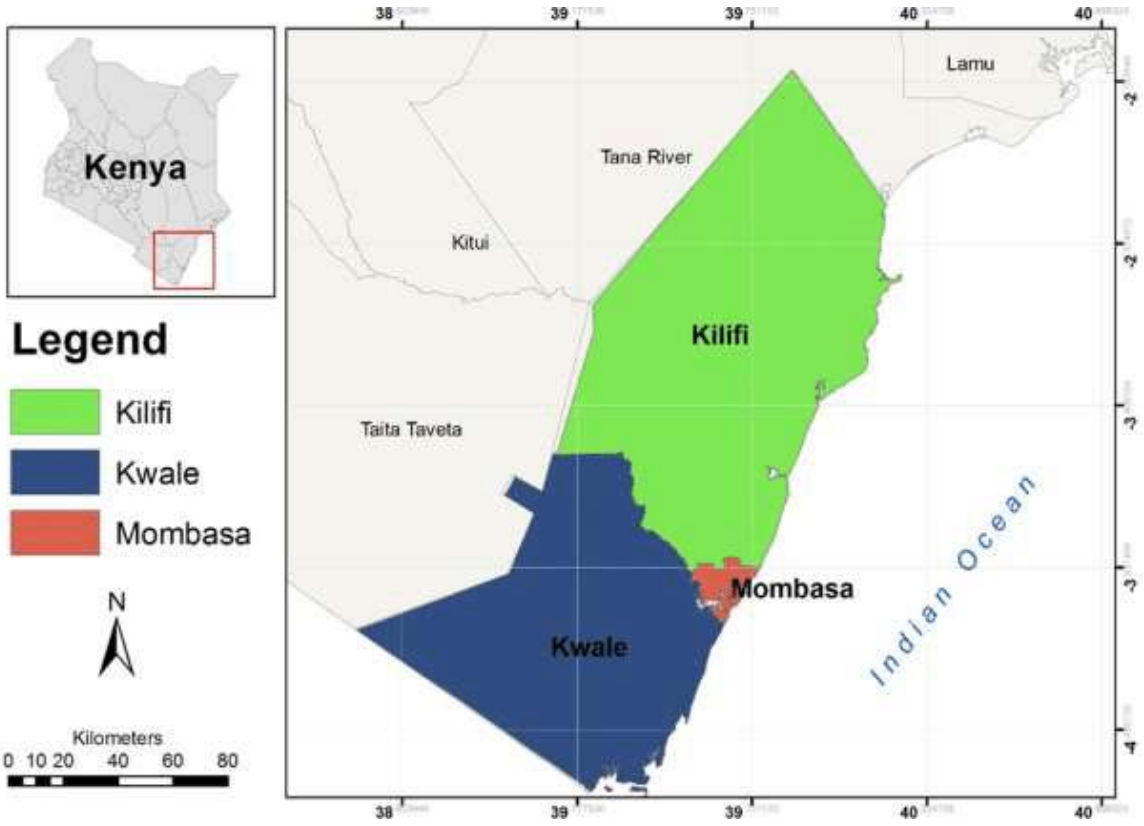
During the recruitment process, I posted flyers on Facebook and LinkedIn. I traveled to Kwale and posted the flyers on the restaurant premises after obtaining permission from the owners. I also posted flyers in public offices and medical faculties. I traveled to Kilifi and did the same with the permission of the stores' managers. I did not get any response from Facebook or LinkedIn. I started receiving calls from people in Kwale and Kilifi counties who had seen the flyers a day after I posted the flyers. Of the 20 participants who had agreed to participate in this study, 10 people proceeded to complete the interview, and one excused herself from the study.

Location, Frequency, and Duration of Data Collection

Preceding recruitment for this qualitative descriptive study, I received permission from the IRB at Walden University to obtain data from participants. The study approval was granted on October 20, 2023. I recruited participants from Kilifi and Kwale counties (see Figure 2) who were impacted by the COVID-19 pandemic because they passed the questionnaire and inclusion criteria. The flyer included my contact numbers and emails. Once the participants passed the questionnaire and agreed to be part of the study, they were explained the nature of the study.

Figure 2

Site of Participants and Data Location



The place of the interview was decided by the participants. All participants agreed that the community library was safe and quiet for interviews. During the interview day, participants were explained the study again and were given a consent form to sign. They were also informed that the interview was voluntary that their names and identities would be kept secret, and that they were to be given pseudonyms to protect their identity. Appendix A, B, and C contain the screening questionnaire, recruitment flyer, and interview guide. I interviewed 10 participants from the counties. All ten interviews occurred between November 24 and December 15, 2023. Interviews ranged from 30 to

45 minutes. Open-ended questions were used to encourage genuine responses from the participants.

Interview Questions

1. How did COVID-19 affect your physiological, mental social, and biological function during the pandemic? Probe: To effective organization, metabolism, responsiveness, movement, and production.
2. Tell me, how did you manage the symptoms of COVID-19 during the sickness? Probe: lived experiences before the COVID-19 pandemic, expectations of daily life and goals in daily life, and function during the pandemic such as weakness, difficulty walking, talking, and breathing.
3. How would you describe the experience with natural functions status during the COVID-19 pandemic? Probe: functional status, the ability to stay healthy, positions in society, and adaptation to changes during and after the pandemic. Fulfilling roles and maintaining health and well-being.
4. How would you describe the overall quality of life now after the COVID-19 pandemic? Probe: Overall perception of life, health, financial situation, social lifestyle, culture, religion, and beliefs.
5. Is there anything you have not described related to your experiences during and after COVID-19? Probe: Financial situation, goals in life, social life, culture, and traditions.

During the interview, I followed with clarification questions. I also asked questions for more details on certain issues not clarified or understood during the

interview. See Appendix C for questions and probing questions used. All interviews were completed face-to-face and were recorded using an iPhone. The recording was downloaded to Temi.com (2017) for transcription. I read over the transcripts multiple times while listening to the recordings to make sure what was captured was correct and to make revisions on medical technology that was not recognized by Temi.com.

Throughout the interview sessions, I made field notes about each interview and journaled my thoughts and feelings about the responses and the interview. Following the review of the accuracy of the transcribed interviews, I asked to share one more meeting with the participants at the same place to ensure that what was captured was correct. They had to come in person because most of them did not have access to the internet and did not have email addresses. Only nine participants came back to clarify the transcripts. The participant who did not turn up for clarification of the transcripts was clarified over the phone. The audio recordings were kept secure inside a protected iPhone and laptop and temi.com (2017) software. All journals were stored in a separate file on my password-protected laptop.

Variation in Data Collection

I recruited participants and conducted interviews between November and early January 2024. I conducted interviews face-to-face for eight participants and via Zoom for two participants who could not come to the meeting due to their busy schedules. Recruiting the participants occurred by posting invitation flyers through Facebook and Twitter. There were no technical difficulties during the interviews. Only one participant did not attend the interview meetings.

Data Analysis

The process of coding started immediately after the interview had been completed. The recording was completed using an iPhone. During the interview, field notes were also written to record the most relevant information and to keep a trail of the interview. The interview audio recordings then were downloaded to Temi.com (2017) for transcription. As the researcher, I listened to the audio recording and read the transcripts several times to capture the essence of the interview. I compared the recordings and the transcripts. I also referred to the field notes making sure no information was left out.

Data analysis was based on Colaizzi's (1978) descriptive analysis method, which includes familiarization, identification of significant statements, formulating meaning, clustering themes, developing an exhaustive description, producing fundamental structure, and seeking verifications and meaning of the interviews. An inductive approach was used to analyze the participants' responses to the study questions. I transferred the transcript to Excel spreadsheets to start looking at repeated words and phrases with similar meanings. The Excel spreadsheets contained columns for participants' numbers, comments, codes, and themes. These repeated phrases became codes and themes. The next stage was to transfer the transcripts to NVivo 12 software (NVivo.com, 2018) so that I could check and compare my manual coding. After that, I sent the transcripts to my chair for further direction and clarification.

During the data analysis process, I preferred hand coding first. I treated all the data collected equally, carefully read the transcripts, and listened to the interviews many times. On the Excel spreadsheets, I started by color-coding the phrases that were repeated

to create thematic codes, and different colors were used to specify codes and words that were repeated. The significant statements found in the Excel document promoted the creation of clusters that enhanced the resulting themes (see Colaizzi, 1978). Color-coding data using Excel assisted with reduction and elimination helping to separate constituents of the experiences from the redundant information. In the Excel document, the constituents from each participant were identified with specific thematic colors. The significant statements in the documents promoted the creation of clusters resulting in themes for the study (see Colaizzi, 1978).

Four themes emanated from the data analysis: (a), Psychological Trauma (b) Physiological disorders (c) Social-economic Interruptions(d) (e) The Role of Religion and Culture**.** During the data analysis process, categories and codes were generated from transcripts and the codes were combined to generate themes, ensuring the themes accurately represent the lived experiences of Makonde immigrants during the COVID-19 pandemic. The textural structural narrative helped me summarize the data presented during the interviews to understand the lived experiences of Makonde immigrants during and after the COVID-19 pandemic. To ensure validity, I used member checking. I requested them to come to the meeting after the interview to review the transcripts for accuracy and, if needed, provide any information for clarifications and corrections. Nine of the ten participants verified accuracy based on the information they provided during the interview. I also sent the recordings, transcripts, and Excel spreadsheets with finalized codes, themes, and categories to my committee chair to review the data analysis process and for clarifications and corrections.

Codes, Categories, and Themes

Data saturation was achieved with ten interviews. Four themes emanated from the data: psychological trauma, physiological disorders, social-economic interruptions, and the role of religion and culture. Each participant narrated their lived experiences during and after the COVID-19 pandemic. Open-ended interview questions allowed each participant to recollect their own unique individual experiences and their experiences while sick from COVID-19 sickness and express to me in their way as they felt important to them.

Psychological Trauma

During the interview, all the participants expressed symptoms of being traumatized during the COVID-19 pandemic. The most common threads among all the participants included being depressed, fatigued, sad, sick, anxious, and feeling that tomorrow will never come. These experiences were checked during the Excel spreadsheet data analysis and then reached with NVivo software to ensure the themes represent the participants' experiences. Participant 1. Stated, “The disease made me ashamed of myself because not even my family members wanted to get near me because of fear of contracting the disease. I become depressed with my sickness to the point of no return.” The comment indicates that depression and an everyday experience with all the participants. Getting worried and having high anxiety levels surfaced more often during the interview. Participant also noted, “I was worried that my husband and children were going to be infected.” This comment suggests not only going through trauma but also being uncertain of what to expect next as the participant is sick and worried about her

own family wondering if all family members were going to be sick. Participant 3. Expressing the traumatic experience stated, “I never even attended church; I found myself stranded at home and in my room by myself and had no energy to cook for my children.”

The comments also indicate despair experienced by the participants who were sick from the Covid-19 pandemic. Participant 4. stated, “So I was at home for two months and I felt kind of stagnant with my life.” Participant 5. also stated, “I went through periods of tension, anxiety, terror, melancholy, loneliness, and insomnia throughout the COVID-19 pandemic.” Participants 6. Expressed, “I felt sorry for myself and the situation I was in.” Participant 7. Expressed, “I stayed in my room all the time and avoided contacting anyone.” Participants 8. Stated, “I was so worried because there were updates all the time from the radio and many people were becoming sick and others lost their lives.” Participant 9. explained during the interview, “My friends became infected, and I was worried because the information was scanty on the disease, we were told that the disease did not have any medicine, and I was anxious about what would happen to me and some of my friends who contracted the disease, I would not sleep well because wondered what would happen next.” Participant 10. Stated, “It affected my health and those around me, especially my kids.” These comments align with the participant's lived experiences with the sickness of the COVID-19 pandemic. Their expression lays bare the categories of despair, depression, fatigue, sadness, anxiety, and sickness that translate into the theme of vicarious traumatization.

Physiological Disorders

The most common theme that emanated from the interviews was related to physiological symptoms that affected the quality of life of the participants. Physiological symptoms were some of the attributes that caused the suffering of the COVID-19 patients. Common phrases that formed categories were the feeling of pain, fatigue, and headaches. As Participant 1 stated, “The COVID-19 pandemic time was a very challenging one. I believe because of COVID-19, I contracted pneumonia too and it drained me to the point that it was difficult to breathe normally. I felt I was losing the will to breathe.” Participant 2. Expressed himself, I needed a cane to walk, I had fever and chills that caused fatigue to the point that I needed a cane to walk, I did not have the energy to do anything, and Breathing became a problem, I could not stand without feeling dizzy or the feeling that I was losing the will to breathe.” Participant 3. Shared, “I needed a cane to walk, I had fever and chills that caused fatigue to the point that I needed a cane to walk. I did not have the energy to do anything. Breathing became a problem. I could not stand without feeling dizzy or the feeling that I was losing the will to breathe.” Participants 4. Had to say, “I needed a cane to walk, I had fever and chills that caused fatigue to the point that I needed a cane to walk, I did not have the energy to do anything, breathing became a problem, I could not stand without feeling dizzy or the feeling that I was losing the will to breathe.”

Also, when asked about the physiological functions during COVID-19, Participant 5 expressed, “My body felt broken and pain all over the body from the joints of the legs to the shoulders. I was sweating and always living with headaches.”

Participant 6. Explained, “My body felt broken and pain all over the body from the joints of the legs to the shoulders, I was sweating and always living with headaches.” Participant 6. also added, “Before COVID-19, I was well, when I contracted the disease, I became physically weak, I did not have any desire to eat. I lost the sense of smell, and every food was tasteless.” When asked about the loved physiological lived experiences during the COVID-19 pandemic, participant 7 stated, “Physiologically the effects of the disease were a slight fever which would result in mild migraine and a little bit of coughing.” Participant 8. also explained his situation as follows, “I suffered physiologically in terms of being unable to be normal in my well-being, I lost a lot of energy because I lost my appetite to eat. I was informed that energy comes from the food we eat, if we do not eat, we do not gain any energy to function, I remember not being able to eat at all.” Participant 9. Also explained that” “I started with a headache, sometimes I felt hot and cold. I started coughing and I thought it was a common cold.” Here is what the participants 10. Had to share, “I did not have any feelings in my mouth so I would not test anything, I developed headaches, especially in the morning, very severe headaches that made me shake with pain when standing up, I felt like my heart was racing.” While analyzing data from these participants, these lived experiences emerged and are aligned with the theme of physiologic disorders caused by the COVID-19 pandemic.

Social-Economic Interruptions

The most common theme that emerged from the field from the participants was impaired social and economic networks. Many participants reported the inability to go

anywhere because they were sick and feared to spread of the disease. For example, participant 1. Stated, “My kids stayed home, and I told them to stay away from me and I was worried that the children and my husband were going to be infected. I would not go out of my room to do anything.” Participant 2. shared, “I felt like was not wanted and embarrassed with my situation, I did not want to tell my family members about my situation because I did not want to have them worried about me, it was only my doctor who knew about my sickness.” and, “I never even told my neighbors because knew they would panic and avoid me altogether, I just stayed in the house and rarely went out.” Participant 2 comments align with the comments of Participant 1. “I was worried about infecting my kids and felt I had to stay away from everyone till I got well.” Participants 3. Expressed himself, “I never even attended church, I found myself stranded at home and in my room by myself and had the energy to cook for my children.” and, “I work with county government and the county was locked down therefore, even if I was well, there was no place for us to go. So, I stayed home in isolation to avoid spreading the disease. Luckily, my family members live in the countryside, and I did not have anyone with me in the house, I was at home for two months and I felt stagnant with my life.”

Participant 4. Stated, “My social life was negatively impacted by the steps taken to stop the COVID-19 pandemic and break the chain of virus transmission because it was nearly hard to contact other people, my relationships with my circle of friends and the people I interact with have been severely impacted by the COVID-19 pandemic crisis, which has caused widespread unrest in society and unprecedented changes in lifestyle, work, and social interactions. Additionally, the pandemic has caused an increase in social

distance." Participant 5 retorted, "I would not travel anywhere after testing positive for fear of giving it to someone else." Participant 5 also had to report, **"**No one was going anywhere, and I became stuck in the house. I only communicated using the phone because I did not want to infect anyone with the disease." Participant 6. Stated, "I was a student at Nairobi University. The school was closed by the government in the process of containing the disease. I reside in a remote part of the country and the internet here is poor even though I wanted to sign up for online classes." Participant 7. Expressed herself, the disease affected me socially because of lost so many close to me especially old and elderly this resulted in a poor social life as I would not interact with people." "Our life has turned back to normal after the pandemic, we do not have any restrictions or social distancing again." And "Business is now booming, now that the pandemic has gone, it has taught us a lesson, we also learned to live a healthy life and check one another." Participant 8. Stated, "Thank God I did not have much to do during the pandemic and I was the only one in my house. I stayed at home and isolated myself."

The participants who participated in this study also expressed a lack of money and recourse to combat covid-19 pandemic. Most places of employment were closed, and most people did not have the meaning of earning a living from their employment. During the pandemic, the participants expressed a loss of employment, lack of money to buy medicine, and inability to acquire PPEs that would have prevented the spread of COVID-19. As Participant 1 stated, "Most people in the market did not have masks and this made it possible to be infected. Masks were introduced after few months from the time the disease was announced over the radio." Participant 2 said, "I work with county

government, and the county was locked down therefore, even if I was well, there was no place for us to go." Participant 3 stated, "We were financially unstable because most people in the community depended on selling their produce to get money." Participant 4 stated, "Most adults had seen at least a partial decline in income despite the numerous government initiatives to support individuals, because of the closures and limitations placed on people and businesses during the pandemic era. Since the pandemic started, many people have been seeking unemployment benefits, and these individuals are surely more likely to be experiencing financial difficulties and this comprises those who have lost their jobs and are either in receipt of Job Seekers Allowance."

Participant 5 also stated, "Many businesses closed, and many people lost their employment and do not have money and the ability to buy and sell. Financially, I believe I am not the only one struggling, the county depends on tourism since the country was shut down due to COVID-19, and the financial situation worsened." Participant 6 also reported, "Much better, the government closed the country altogether. In this County, we depend on tourists, No one moved, no one went anywhere." And "No one went to work during the pandemic and most people lost their source of income causing poverty and helplessness." The comment of Participant 1 aligns with Participant 7, "I hope that in the continent of Africa, we can manage resources. Foreign governments donated many resources including money to help the continent with the pandemic. The resources I believe never reached the people in the countryside. Even in this county, we lacked the basic needs to manage the disease. Vaccinations came way later." Participant 8 also

stated, “It affected us because it was a surprise so were worried and we were forced to adopt the changes to fight the virus. It also affected our businesses.”

Participant 9 retorted, “Poverty level is also a problem in some of the communities in this county. Families could not afford masks, and they faced the inability to afford medical care. Medical bills become overwhelming to families. Burial expenses for loved ones become a problem.” Participant 10 had to say, “We still must donate food to the community. The community was affected because many people lost employment sources of income and the ability to earn a living. Some people who were affected severely are still struggling with medical bills. The church through donations is trying to help but we are still struggling. But still, life is much better than during the time of the Covid-19 pandemic.” These statements from the participants expressing themselves about their social and financial situation like loss of employment and income due to lock down, being sick, inability to go open and conduct their business, farmers, and difficulties accessing the market for their produce and lack of essential tools like masks to wear during the COVID-19 pandemic led to the theme of social-economic challenges during and COVID-19 pandemic.

Role of Religion and Culture

The last common theme that emerged had to do with the impact of religion, the culture of Makonde immigrants, and social issues and social issues about their lived experiences during the COVID-19 pandemic. The participants who were sick and survived are thankful to God because many people lost their lives from the pandemic. Because there was no known medication to treat COVID-19, participants expressed

themselves on how they fought the pandemic using alternative remedies to help alleviate the symptoms of COVID-19. At the center of the pandemic, social issues emerge that affect the community. Participants share a common belief in taking medication to treat their medical conditions. Farming is also part of the culture among the participants. It is also part of the culture to assist one another as part of family life. Participant 1 stated, “I believe Panadol helped me to eradicate pain.” and, “My husband did much of the work and I felt sorry for him because I would not help.” and, “My husband made lemon tea mixed with ginger.” “I wake up early in the morning to start my daily life, I feed my cows; I have since increased the number of my goats to seven, I have two cows that need to be fed and milked twice daily. I sell milk to the local restaurants.” and, “There is a demand for milk in the morning and evening.” Participant 2 expressed, “Thank God. I am no longer angry at the disease for disrupting my life and causing so much pain and suffering for so many people, I am happy and no longer isolated.”

Participant 3 stated, “My daily routine is waking up early in the morning and taking care of my cows and goats, I would not be able to get up and carry these functions. I never even attended church.” Participant 4 stated, “In my community, we were given vaccination and I believe it helped a lot. I believe the herbs I took also helped to cure the disease. The situation is getting better. I now attend to my roles in my house and my cows, goats, and chickens. I am not attending church services every Sunday as I used to before COVID-19, I go to the market to sell chicken and eggs.” Participant 5 said, “The COVID-19 pandemic crisis, which has caused widespread unrest in society and unprecedented changes in lifestyle and work” and, “After two weeks my pain and the

situation improved a lot with taking the herbs. I also took lemon tea and that hydrated me." Participant 6 stated, "I started drinking boiled water mixed with citrus fruits and slowly started improving my breathing." and, "I attend church service because I believe God saved me from the disease, I lost friends to the disease and I am thankful to God that I am still alive, I attend our go-around meetings and contribute to the organization." Participant 7 also stated, my family suggested I use some herbs, but I do not know any herbs and I do not know if the herbs work and how would I get them." and, "I have since found a girlfriend, I would like to marry and raise a family., the pandemic taught me a lesson that I should not wait to do certain things now and I am thankful that though I was sick, God helped me to heal fully from the disease."

Statement from Participant 1 and Participant 6 aligns with Participant 8, "I believe the medicine that I took to cure the symptoms helped but I am not sure because there are many theories on what cured or not cured the disease." Statements from Participants 1, participants 2, participants 6, and participants 7 align with Participant 9, "I also used home remedies like lemon and honey to boost my immunity." and**,** "We also learned to live a healthy life and check one another." Participant 10 had to explain, "Thank God I did not have much to do during the pandemic and I was the only one in my house." and, "I am a pastor; this means I must attend prayers and tend to my pastoring in my church on Sundays and Wednesdays in the evening time. Because I was sick, I thought my church members were safe without me attending these services." and, "As I regained, we conducted prayers every evening to the sick or to the family members who were affected by COVID-19." and, "Some people went through traumatic experiences, Violence

against women increased tenfold. Substance abuse among young people has left many families financially and emotionally affected." and, "As a community, we did start a weekend program for prayers and counseling young ladies who were unable to complete school because they became pregnant and stopped schooling altogether." and, "There is also another program we started in our local church to improve the housing conditions among the community members. Families live nearby and social distancing was impossible leading to high infection of COVID-19 around the community."

These are statements by the participants about daily living experiences on medication to cure their health problems, they also believe in God to have saved them from the pandemic, the fact that they are using other traditional herbs to fight the COVID-19 pandemic and other issues that affected them in the community during the Covid-19 pandemic like abuses, violence against women and the fact that students were idle in the community and the teen pregnancies led to the theme of the Role of Religion and Culture.

Discrepant Cases

Most of the participants during the interview process expressed the role of herbs in curing the disease. Some participants also expressed other medications like Panadol and aspirin to alleviate their symptoms. The COVID-19 disease no doubt created confusion and a lack of understanding of what medication to take to cure the disease. Therefore, the statement on herbs and other remedies makes it hard to confirm their role in curing the COVID-19 pandemic. Figure 3 and Table 3 contain the themes and subthemes found in the study.

Figure 3

Four Themes That Emerged During the Study

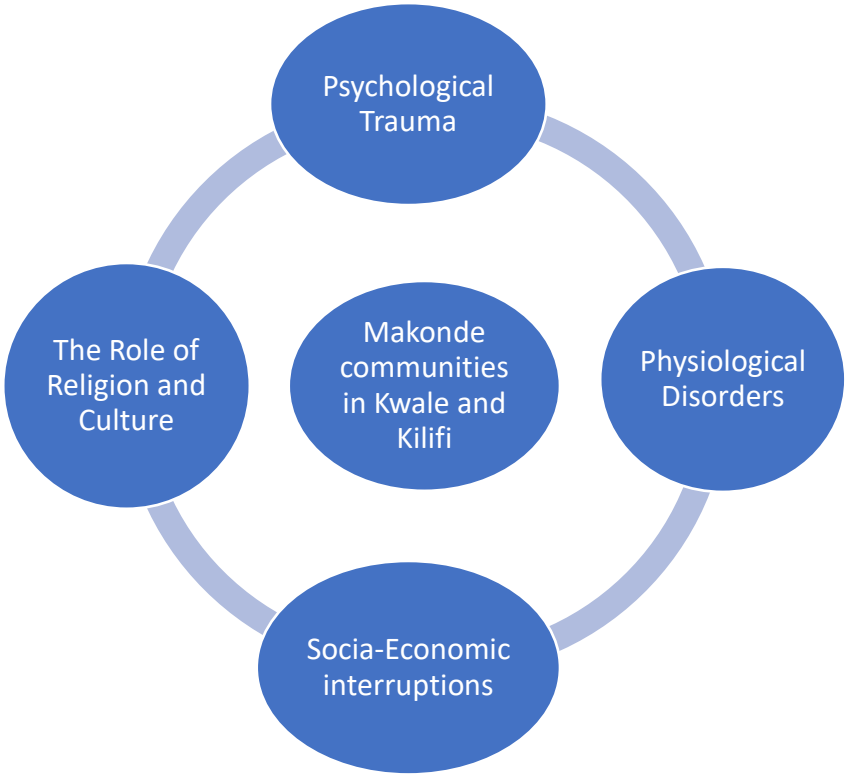


Table 3

Themes and Subthemes

Theme	Subtheme
Psychological trauma	Anxiety
	Fear of death, fear of suffering
	Sadness
	Loneliness
	Depression
	Insomnia
	Sickness
Physiological disorders	Fatigue
	Weakness
	Headaches
	Pain
	Muscle joint pain
	Insomnia
Social-economic interruptions	Lockdown
	Social isolation
	Social distancing
	Unavailability of internet
	Lack of masks
	No money during covid
	Shortages of food
	Unemployment
	Poverty
	Unavailability of medication
	Lack of medical coverage
	Lack of support from the government
Role of religion and culture	Changes in daily routine and lifestyle
	Loss of life
	Farming
	Traditional alternative remedies to COVID-19
	Faith in God
	Social issues during the COVID-19 pandemic

Evidence of Trustworthiness

Credibility

Attaining credibility in qualitative research involves that the results are believable from the perspectives of the research participants (Patton 2015). In the process of establishing credibility in this study, I used triangulation. Triangulation included analyzing the consistency of the 10 different participants' data and using the same interview method. Thematic saturation was achieved with a total of ten participants who were selected and interviewed in this study (Creswell& Creswell, 2018). During the analysis of the data, I sent all the recordings, transcriptions, and the process of analysis to my chair a doctoral-prepared researcher for reviewing and feedback. Merging and reviewing these multiple data sources provide multiple knowledge and perspectives to give the needed validity to the study (Ellis, 2019).

The second way used in this study to establish credibility was to participate in member checking. Participants were called once again to the place of interviews to check the transcripts and review the transcripts to ensure the validity of their statements (Hui et al.,2021). The findings in qualitative research must represent the participant's perspectives and are credible in representing their lived experiences during and after the COVID-19 pandemic (Hui et al.,2021). During the member checking, nine participants participated in person and the tenth participants participated by phone. The ten participants responded that the transcripts and recordings were accurate.

The third method I used to establish credibility in this study was reflexivity. This method describes the contextual relationship between the participants and the researcher

increasing the credibility of the findings in this study by creating a mutual understanding of the research ((Fusc et al.,2018). Reflective journaling helped me examine my assumptions, beliefs, and judgment by thinking critically about how this influenced the study of the lived experiences of Makonde immigrants during and after COVID-19.

Transferability

Transferability is considered when the results of the study can be generalized or transferred to other settings while maintaining the original context and details (Creswell& Cresswell, 2018). In obtaining transferability in this study, I engaged in intensive and extensive details and thick descriptions by reporting the study's location using maps, and pictures, their demographics, and climate, observing the participant's culture, atmosphere, participants reactions, and daily life and my feelings as a researcher of this study. It is imperative to provide readers with the evidence that this study's findings could apply to other settings, contexts, situations, times, and populations (Ellis, 2019).

Dependability

Dependability in qualitative research is used to measure or demonstrate the consistency and reliability of the study's results. This means that if another researcher performs a similar study, the researcher will be able to get similar results (Tuval-Mashiach, 2021). Dependability also refers to whether the evaluation of the findings, the interpretations, and the recommendations of the study are supported by the data collected from the participants from the Makonde community. First, I performed an inquiry audit by having my dissertation chair all the data including, the recordings from the participants, the transcripts, the initial analysis, the analysis using Excel, and transcripts

from NVivo software to examine the process of data analysis and confirmation. I also used triangulation to establish and validate the data collected from the participants.

Confirmability

Confirmability refers to the extent to which the result of the study can be confirmed or corroborated by other researchers (Ellis, 2019). To attain the process of confirmability, reflective journaling, and an audit trail were created from the beginning of the research through data collection and the process of analyzing the data. This includes ensuring the details of each step of data analysis demonstrating that the findings are not the researcher's imagination and bias but accurately demonstrate the participant's responses. As the main researcher, my objective was to ensure a rigorous process prevails in this study.

Results

I sought to understand the lived experience with the quality of life among Makonde immigrants in Kenya during and after COVID-19. Ten participants were interviewed and five questions were employed to answer the following question: What are the lived experiences of Makonde immigrants living in Kenya regarding their health and quality of life during and after the COVID-19 pandemic? The themes I developed to answer the research question were identified from a thorough review, along with a manual coding, of written transcripts. The themes that emerged from the data analysis include Vicarious Traumatization, Physiological disorders caused by the COVID-19 Pandemic, Impaired Social Networks, Financial Disruption and Lack of Resources to Combat COVID-19, and Religion/ Culture/ social issues during the COVID-19

pandemic. Additionally, transcripts, recordings, journals, excel spreadsheets coding processes, and themes were sent to the chair for feedback.

Theme 1: Psychological Trauma

The theme emerged from the participants exploring their lived experiences feelings and how they struggled with covid-19. All the selected participants in this study shared their individual experiences about their experiences during and after COVID-19. the theme of psychological trauma arrived at as participants experienced Anxiety, Fear of death, fear of suffering, Sadness, Loneliness, Depression, Insomnia, and sickness. According to Hogg et al. (2023), one factor that has been implicated in the onset and maintenance of a range of mental problems is psychological trauma. Psychological trauma can be defined as a person experiencing events or circumstances that are physically or emotionally harmful or life-threatening, and which have a lasting adverse reaction on their daily functioning and mental, physical, social, emotional, and spiritual well-being, and can include experiences of physical, psychological emotions or sexual abuse, or the presence of any traumatic life events like diseases, accidents, and loss of loved ones.

The theme of psychological trauma for example is shared by Participant One expressing anxiety, depression, and fear by stating, “My kids stayed home and I told them to stay away from me and I was worried that the children and my husband were going to be infected, I would not go out of my room to do anything.” Participant 2 shared, “The disease made me ashamed because not even my family members wanted to get near me because of fear of contracting the disease. I become distressed with my sickness to the

point of no return." and, "I become distressed with my sickness to the point of no return." Participant 3 also expressed psychological worry and loneliness by stating, "I was always worried about my situation. I thought I was going to die because I never had such weakness before in my life." and, "I never even attended church, I found myself stranded at home and in my room by myself." Participant 4 also shared, "I went through periods of tension, anxiety, terror, melancholy, loneliness, and insomnia throughout the COVID-19 pandemic." Participant 5 expressed despair and worries stating, "I was never sure I was to see the next day. I was sweating and always living with headaches. I felt sorry for myself and the situation I was in." and, "I would not travel anywhere after testing positive for fear of giving it to someone else." Participant 6 expressed the effects of loneliness and that sleeping was hard while sick with COVID-19 by stating, I stayed in my room all the time and avoided contacting anyone."

Participant 7 expressed anxiety and depression by stating, "I was so worried because there were updates all the time from the radio and many people were becoming sick and others lost their lives." Participant 8 also expressed the traits of anxiety, despair, insomnia, and depression during the time of sickness by stating, "Most of my friends became infected and I was worried because the information was scanty on the disease." and, "We were told that the disease did not have any medicine and I was anxious about what would happen to me and some of my friends who contracted the disease." and. "I would not sleep well because wondered what would happen next." and, "Then three of my friends lost their lives and I thought I was going to be next. I become helpless." Participant 9 retorted about his situation when he was sick by stating, "The disease causes

caused me to lose hope of ever being well." and, "Many thoughts were running in my mind, and depression eventually caught with me." Participant 10 expressed, "I isolated myself from my loved ones and those close to me." and, "I would not interact with people." These quotes reflect the understanding of participants who experience some form of stress, depression, loss of hope, despair, sadness, and insomnia thus demonstrating multiple perspectives of psychological trauma.

Theme 2: Physiological Disorders

Graziella et al. (2021) explained physiological symptoms and disorders that affected patients who contracted COVID-19 and how they affected their quality of life. The main symptoms associated with COVID-19 were headache, fatigue, muscle aches, articular pains, cognitive impairment, loss of concentration, and loss of smell. The COVID-19 pandemic has had a significant impact on patients, families, healthcare workers, the healthcare system, and communities around the globe. Patients diagnosed with COVID-19 have a broad range of presentations from symptoms to those with severe critical illness with pneumonia, acute respiratory distress syndrome, and multiorgan failure (Mayer et al.,2020) Physiological disorders caused by COVID-19 pandemic are symptoms described by the participants of the COVID-19 sickness that affected their quality of life. For example, participant 1 shared their experience stating, "I felt I was losing the will to breathe." And, "I stopped tending to my crops because the disease made me weak, I coughed and developed chest pain." and "I sweat a lot followed by coldness all over my body." and, "I had pain all over my body, I developed muscle spasms and pain." Participant 2 shared their physiological state, "I had a lot of pain, especially in the

legs and hands." and, "I needed a cane to walk, I had fever and chills that caused fatigue to the point that I needed a cane to walk." and, "I did not have the energy to do anything. Breathing became a problem." and, "I could not stand without feeling dizzy or the feeling that I was losing the will to breathe."

Participant 3 shared his physical status while sick from COVID-19 by stating, **"**When I was sick, I was very weak, I felt fatigued, I did not have the energy to move from one place to another and I felt fatigued all the time." And, "I thought I was going to die because I never had such weakness before in my life." and, "I felt dry and constipated. I was coughing a lot. The cough was dry and I felt like my lungs were too dry." Participant 4 states, "Consequently, I developed symptoms such as dry cough, pyrexia, pharyngitis, rhinorrhoea, watery diarrhea, and severe dyspnoea." and, "Additional symptoms included weakness, exhaustion, loose stools, vomiting, and changes in taste and smell." Participant 5 also shared about his physical well-being by stating, "I was sweating and always living with headaches, I had to force air into my lungs." and, "Opening my eyes was a problem, and grasping things in my hands was a problem and I felt my hands were numb." and, "My feet did not have much energy to help me stand." The physical statement from Participant 1, and Participant 3, aligns with Participant 6, "I started with a headache, sometimes I felt hot and cold and I started coughing and I thought it was a common cold, Sooner the cough becomes worse." and, "I started feeling dizzy and I believed I would not be able to breathe well." and, "I am sometimes tired and I never felt like that before COVID-19." and, "I used to wake up

early in the morning but since the pandemic, I feel like I must force myself off the bed every morning."

The statements from Participant 1, participant 2, and Participant 3 align with Participant 7, "I was feeling aches all over my body, especially in the joints." and, "In the evenings, I never would get out of bed because I had chills all over, then I was sweating." and, "I lacked the energy to stand for a whole week." and "Very severe headaches that made me shake with pain when standing up. I felt like my heart was racing. I had diarrhea once and then stopped." Participant 8 shared their individual physical experience which also aligns with a statement from Participant 4 by stating, "When I contracted the disease, I became physically weak I would not sleep well because wondered what would happen next, I lost the sense of smell and every food was tasteless." Statement of Participants 1, 4, 5, and 6 aligns with Participant 9, "Physiologically the effects of the disease were a slide fever which would result in mild migraine and a little bit of coughing." Participant 10 shared their sufferance; I lost a lot of energy because I lost my appetite to eat." and "I remember not being able to eat at all. Everything was tasteless in my mouth. The disease causes caused me to lose hope of ever being well. I felt like lost the energy to breathe." The participants' perspectives above demonstrated an increase in physiological weakness and exhaustion with risks associated with physiological disorders caused by the COVID-19 pandemic.

Theme 3: Social-Economic Interruptions

Shah et al. (2022) explained that the COVID-19 pandemic affected many lives across the globe with severe and short-term consequences for an economically

disadvantaged population. The Pandemic has taught us that these are the most affected groups of society with the disturbed ecosystem. COVID-19 not only affected the healthcare structure but also affected the livelihood of the social-economically backward individuals. Various schemes and initiatives started to address the needs of the community at a larger scale including food security, health service coverage, and generating awareness about the disease and prevention of its spread. With countries imposing national lockdowns, it was obvious to face disturbance in the food supply system, unemployment increased poverty levels among lower income earners.

The Theme of socioeconomic interruption emerged with participants sharing their lived experiences of unemployment, poverty level increasing during the COVID-19 pandemic, isolation from friends and family members due to sickness, and frustrations over the lockdown by the Government. Some participants expressed their inability to buy medication and lack of masks. Participants who were small-scale farmers would not attend to their daily lives of working and selling their produce. For example, participant 1 shared their daily lived experiences stating, “Because I did not have the energy to work.” and, “I would not be able to conduct my daily work as a small farmer. I felt weakened.” and, “From my farming, I can pay fees for my two daughters who have resumed their high school education.” Participant 2 expresses the lived experiences during covid-19 pandemic and how isolated they were, “The county was locked down therefore, even if I was well, there was no place for us to go. So, I stayed home in isolation to avoid spreading the disease.” “I am happy and no longer isolated, I visit my friends and family members without restrictions.” participant 3 stated, “I wish the Government would give

us more help during the Covid-19. The Government promised to give us medicine." And, "We did not get the medicine, we did not have masks." and, "We did not have the means to get the masks because we were unable to go to the shop." and, "Most hospitals were closed and many people in my community did not have money to pay to get treatment." and, "Only people who can gain employment from the Government can have medical coverage."

Participant 4 expressed their financial situation stating, "The policies implemented in response to the pandemic appeared to have two distinct and opposing effects on household finances: while they made it possible for households to reduce their spending, they also had an impact on employment and incomes." and "Since the pandemic started, many people have been seeking unemployment benefits, and these individuals are surely more likely to be experiencing financial difficulties." and, "This comprises those who have lost their jobs and are either in receipt of Job Seekers Allowance." Participant 6 lamented, "I stayed at home since the country was closed and many people were instructed to keep social distance. So, I stopped going about my job and took time off, besides, I was sick." and, "Though I work, many businesses closed and many people lost their employment and do not have money and the ability to buy and sell. Financially, I believe I am not the only one struggling. The county depends on tourism since the country was shut down due to COVID-19, the financial situation worsened." Participant 7 explained the lack of resources and the government's inability to provide resources by stating, "I stayed in my room all the time and avoided contacting anyone." and, "What I am talking about is advanced ICU medicine and care. If we lacked

masks, would the hospital afford medication and machines that help people with breathing?"

Participant 8 shared, "I hope that in the continent of Africa, we can manage resources. Foreign governments donated many resources including money to help the continent with the pandemic." and, "The resources I believe never reached the people in the countryside. Even in this county, we lacked the basic needs to manage the disease, vaccinations came way later." Participant 8 expressed hopelessness with their lived experiences in the countryside and their challenges with financial situation and inability to access medical facilities, stating, "Many people in this community do not have access to medical care because they do not have medical coverage." and, "Many people in this community are poor and medical expenses are very expensive." Participant 9 expressed the changes in social changes and the financial decline with the COVID-19 pandemic, stating, "It affected us because it was a surprise so were worried and we were forced to adopt the changes to fight the virus." and, "It also affected our businesses. most businesses closed." And, "We were allocated time to open the business and when to open." and, "We closed business earlier than usual." Participant 10 shared**, "**Many people lost employment and source is income and the ability to earn a living." and, "Some people who were affected severely are still struggling with medical bills." Theme 3 identifies the participants' lived experience with the effects of social isolation and the impact of financial downtown during and after the COVID-19 pandemic.

Theme 4: Role of Religion and Culture

The culture of a group or class is the peculiar and distinctive way of life of the group or class, the meanings, values, and ideas embodied, in institutions, social relations, the system of belief, mores, and customs, in the uses of objectives and material life (O'Hagan, 1999). Culture is a distinctive shape in which this material and social organization of life express itself. Culture includes the mapping of meanings that make things intelligible to its members, and yet culture is also a way the social relations of a group are structured and shaped. It is also a way those shapes are experienced, understood, and interpreted (O'Hagan, 1999)

Culture is a set of practices and behaviors defined by shared customs, habits, language, and geography by individuals. The concept of culture and its influence on individuals is dynamic, therefore, when individuals and society change, the relevant aspects change subsequently. Culture can be considered an effective factor in life and health due to its effects on the way by which people deal with problems and solve them (O'Hagan, 1999).

According to Mohseni et al. (2020), Culture cannot only assist in the prevention of epidemic diseases like the COVID-19 pandemic but can also be effective in treatment and recovery if the context is set for cultural influence and individual growth. Cultural guidelines provide a framework for the group's social behavior, which is essential, especially in a communicable disease context.

Cultural influence impacts the degree to which individuals may follow hygienic recommendations like personal hygiene and quarantine more and help each other

(Mohseni et al., 2020). Participants express their lived experiences and how they isolated themselves to prevent those who tested negative and other family members from contracting the disease. They also explain part of their culture in treating the pandemic using alternative remedies like traditional herbs and the use of honey and lemonade. Participants also express in their own way the influence of religion and their faith in God. Participants also proved their resilience against social issues during the COVID-19 pandemic in their community. For example, participant 1 stated, “My kids tested negative and I isolated myself to prevent infecting them. My husband was negative too.” and, “The soup is made of onion, tomatoes, and meat bones.” and. “This soup is believed to provide high calories that provide energy, especially for sick people.” and, “I have a cow that needs to be fed every day and milked twice daily.” and, “As a mother of two daughters, I feel sorry for some of my church members who tell me their life experiences during the Covid-19 pandemic.” And, “Many young ladies and young men were out of school and engaged in negative behavior, alcoholism increased in this village, I have also been told of young women who lost their employment and engaged in prostitution., there was also an increase in stealing activities.”

Participant 2 stated, “Thank God. I am no longer angry at the disease for disrupting my life and causing so much pain and suffering for so many people.” Participant 3 expressed how grateful they are and how life has changed now that COVID-19 is no longer a threat to the community and stated, “The situation is getting better, I now attend to my roles in my house and my cows, goats, and chickens.” and, “I am now attending church services every Sunday.” Participant 4 stated, “To help ease a cough, I

would try to have a teaspoon of honey." "Participant 5 also accepted the use of alternative traditional remedies while sick with COVID-!9 by stating, "I took herbs that my father gave me every morning. A glassful and I believe it helped with aching though I caused stomach upset and nausea." Participant 6 also expressed their acceptance of a culture of isolation stating, I stayed in my room all the time and avoided contacting anyone." and, "I started drinking boiled water mixed with citrus fruits and slowly started improving my breathing." and, "I attend church service because I believe God saved me from the disease. I lost friends to the disease and I am thankful to God that I am still alive. I attend our go-around meetings and contribute to the organization."

Participant 7 expressed their appreciation to God and faith and marriage thus stating, "I guess the porridge kept me hydrated." and, "My family suggested me to use some herbs, but I do not know any herbs and I do not know if the herbs work and how would I get it." and, "The pandemic taught me a lesson that I should not wait to do certain things now and I am thankful that though I was sick, God helped me to heal fully from the disease. and, ". I have since found a girlfriend, and I would like to marry and raise a family. The statement from Participant 6 aligns with Participant 8 who stated, "We were told to eat fruits and drink water to stay hydrated." Participant 9 demonstrated a culture of isolation and their trust in African traditional remedies to help cure COVID-19 by stating, "I isolated myself from my loved ones and those close to me. I also used home remedies like lemon and honey to boost my immunity." and, "I also sanitized myself. I kept my distance and wore masks." Participant 10 stated, "Thank God I did not have

much to do during the pandemic and I was the only one in my house, I stayed at home and isolated myself."

Participants expressed their lived experiences on matters of faith, their daily experiences with COVID-19, the traditional remedies like herbs they used as alternative remedies to cure the disease, and social issues they experienced during the COVID-19 pandemic led to the theme of The Role of Religion, and Culture.

Summary

The research question guiding my study was What are the lived experiences of Makonde immigrants living in Kenya regarding their health and quality of life during and after the COVID-19 pandemic? Ten participants in the interview helped answer the question by sharing their unreserved experiences, resulting in four key themes. Many challenges emerged during the COVID-19 pandemic including sickness, mental, financial, physiological, and social issues in many communities around the globe. The data from the participants' interviews illustrate that many underserved communities needed assistance to combat the COVID-19 pandemic.

In this chapter, I detailed the setting of the study, the demographic of the participants, data collection, and analysis process for my study. Additionally, I provided evidence of trustworthiness by demonstrating credibility, transferability, dependability, and comfortability. Thereafter, I provided the research question and the result of the findings utilizing direct quotes from the participants. Chapter 5 will discuss my interpretation of the findings, detailing the limitations of the study, and providing a

discussion on the recommendations and implications for future research and nursing practice and how these findings may facilitate social change.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this qualitative study was to understand the lived experiences of Makonde immigrants in Kwale and Kilifi counties in Kenya during and after the COVID-19 pandemic and how these experiences impacted their daily lives and quality of life. In addressing the lived experiences of Makonde immigrants' quality of life during and after the COVID-19 pandemic, I conducted a descriptive phenomenological study using semi structured, individual interviews with 10 participants in Kilifi and Kwale counties in Kenya who had been sick or hospitalized due to the COVID-19 virus.

A descriptive phenomenological approach aligned with the problem of wanting to understand the lived experiences of Makonde immigrants during and after the COVID-19 pandemic because this approach provided a deeper understanding of what Makonde immigrants experienced during the pandemic and how these experiences impacted them and similar ethnic groups around the world. Findings from this study may be used to understand the impact of the COVID-19 pandemic or a future pandemic on ethnic groups such as Makonde immigrant communities around the world to identify strategies preventing adverse outcomes including loss of life, social-economic interruptions, sickness, and other social issues that are caused due to such pandemics. This may lead to positive change by providing insight into strategies leading to a better supply of resources, medicine, treatment, lockdown, and spread of the disease among people of ethnic groups and their communities, thereby improving safety and creating effective plans for future large-scale pandemics.

I conducted 10 semi structured interviews with participants who had been sick or hospitalized due to the COVID-19 pandemic. At the time of the sickness, all the participants were in Kilifi and Kwale counties in Kenya. Data collected during the interviews were analyzed. Key findings included four major themes describing the participants' lived experiences with quality of life during and after the COVID-19 pandemic: (a) psychological trauma, (b) physiological disorders, (c), social-economic interruptions, and (d) the role of religion and culture.

Interpretation of the Findings

I conducted the descriptive phenomenological study using Wilson and Cleary's (1995) model that described physiological factors such as symptoms, body functions, general body health perceptions, and overall health quality of life. This model allowed me to explore the lived experience of the 10 participants who had been sick or hospitalized due to COVID-19. The participants were open and frank when describing their lived experiences during and after the COVID-19 pandemic.

The major findings of this study align with the previous research published about the lived experiences of immigrants and other ethnic people around the world. Makonde immigrants' experiences confirm what was previously known about immigrants and challenges to better health care due to lack of medical coverage and challenges with psychological and socioeconomic issues in respective host countries. Antar et al. (2024) explained that following a COVID-19 infection, an individual may experience persistent or new symptoms for weeks or months. Long COVID-19 is a complex syndrome that can include a wide range of symptoms. To date, around 200 different symptoms have been

associated with long-term COVID-19 (Antar et al.,2024). These symptoms can affect the function of different organ systems including neurological and psychological complaints. Physical complaints include fatigue, myalgia, persistent shortness of breath, loss of smell and taste, insomnia, chest pain, muscle pain, cough, and diarrhea.

Physically, the patients will have dyspnea, fatigue, myalgia, no appetite, loss of smell, chest pain, headaches, carditis, and heart failure. The mental health of patients will show symptoms of brain fog, depression, post-traumatic stress disorder, dizziness, anxiety, insomnia, and emotional exhaustion. Regarding social relations, patients with COVID-19 will show symptoms of isolation, difficulty reconnecting with others, fear, anxiety about social gatherings, and loss of social skills. Problems with the environment will be experienced, and some of these signs will be changes in the work environment, descriptions of routine and daily routine and daily life, economic change, job loss, and disruption in learning (Antar et al., 2021). These symptoms experienced by patients with COVID-19 sickness affect the quality of life.

Consistent with other studies, preexisting conditions, and COVID-19 infections in the domain of physical health, mental health, social relationships, diabetes, lung disease, cardiovascular disease, diabetes, lung disease, or anxiety disorders increase people's risk of developing persistent symptoms associated with a reduced quality of life (Antar et al., 2024). COVID-19 causes pathological processes in the respiratory, cardiovascular, and musculoskeletal systems because of systematic inflammation, leading to impaired function and decreased exercise capacity. However, exercise capacity will return to normal as the disease inflammation lessens over time (Satar et al., 2023). More than 3

years after the outbreak of coronavirus, disease reports showed that up to 90% of patients hospitalized for COVID-19 experienced a wide range of physical, cognitive, and mental health symptoms up to 1 year. These symptoms could impact patients' participation in society, including a return to work (Bek et al., 2023).

The participants in the current study confirmed to me that although the COVID-19 pandemic has ended, they have persistent symptoms from the illness. Participants lamented the time when they went without medication, the lockdown, the lack of masks, and the period of depression sickness, and anxiety. All these symptoms affected their functions, their health perception, and their physiological functioning and caused social-economic decline.

Wilson and Cleary's (1995) model served as a valuable framework for understanding the lived experiences of Makonde immigrants and other ethnic groups around the world during the COVID-19 pandemic. COVID-19 led to a lockdown and employment was shut down causing social and financial turmoil to many immigrants in their host countries. COVID-19 and its implications led to many people being psychologically and physically sick leading to insomnia, depression, and a low quality of life (Antar et al., 2024).

Current participants stated that they were stressed and went through psychological trauma without medication and a lack of resources such as masks to prevent the spread of the disease to other family members, thereby leading to their isolation from the members of the family. Participants also expressed how anxiety led to insomnia, anxiety, and physiological symptoms such as fatigue, muscle aches, and inability to taste food. Nehme

et al. (2023) explained that the lockdowns of countries, the banning of social gatherings, and social distancing were encouraged to prevent the spread of the disease. People were obliged to wear masks in public. All these measures forced millions of people to rapidly change their lifestyles and habits, which resulted in severe psychological effects in both infected and noninfected people. High levels of anxiety, stress, and depression were described, leading to poor quality of life. The confusion on medication treating COVID-19 symptoms led some of the current participants to use traditional herbs and other remedies such as honey, citrus fruits, and lemon juice to treat themselves. Additionally, participants stated that the lockdown and isolation made them stay away from each other, causing loneliness among friends and family members. The lockdown had also financial implications. Participants shared their lived experiences of financial challenges. They could not go to work and earn income. Their counties of Kwale and Kilifi, which depend on tourism, were locked down leading to financial decline because tourism promoted the economy.

Based on the data from current participants and previously published studies about immigrants and the COVID-19 pandemic, documented immigrants and immigrants who have settled in their host countries faced the same challenges. Immigrants who have settled in their host countries and undocumented immigrants' responses were related to their challenging experiences during and after the COVID-19 pandemic. They all reported psychological, physiological, social, and economic hardships that were caused by COVID-19 spreading around the world. In addition, the participants reported that contracting COVID-19 affected their health conditions and their well-being, causing a

feeling of uncertainty, anxiety, depression, insomnia, and fatigue that affected their general perception of life and lowered their quality of life.

Limitations

In qualitative research, there exists a certain level of bias (Creswell & Creswell, 2018). I have worked as a nurse in the emergency room and in COVID-19 units. My experience with patients with this disease may have created a bias during the process of data collection and analysis in this study. To ensure bias did not influence this study, I was the main researcher collecting the data and putting the data through several different methods of data collection. I executed reflection by recording memos and notes, examining each recording, and acknowledging assumptions and preconceptions that may have shaped the outcome of this study. To avoid researcher bias, I recruited participants from different professional backgrounds. Although I used the media to advertise the study, I visited the counties of Kilifi and Kwale personally and screened the participants face-to-face. I also used different methods to create transcripts and analyze the data.

Recommendations

This study adds to the existing literature on the lived experiences of immigrants with health quality of life during and after the COVID-19 pandemic. There was considerable published literature on immigrants and their lived experiences with their health and quality of life during the COVID-19 pandemic in Europe, Asia, and the United States of America, but I did not find studies on Makonde immigrants in Kwale and Kilifi counties in Kenya. My study adds to the existing literature by highlighting settled immigrants and their lived experiences during and after the COVID-19 pandemic.

Suggestions for future research include exploring the experiences of settled and undocumented immigrants in urban centers to gain insight into how different settings influenced immigrants' lived experiences during and after the COVID-19 pandemic.

The COVID-19 pandemic placed immigrants under unprecedented challenges that impacted their mental, physical, and socioeconomic well-being. In this study, Makonde immigrants in Kilifi and Kwale counties in Kenya described several challenges such as sickness, depression, fatigue, and lack of resources to manage the disease. Baron et al. (2023) found similar findings in immigrants experiencing inequalities in the distribution of COVID-19 infection-related morbidity and mortality by race, ethnicity, and socioeconomic status. Also important to understand were the desperate effects of the pandemic, including social sequelae in the loss of earnings for many low-income workers and their families especially immigrants and others who were excluded from unemployment compensation, stimulus payments, and other health and social assistance programs (Baron et al., 2023).

Sayad et al. (2023) found that socialization restrictions were important in preventing the spread of COVID-19, especially for older adults; however, socialization restrictions could have negative consequences for cognitive and mental health. These restrictions limited the time spent with family and caregivers and reduced opportunities to engage in social and community activities, all of which can exacerbate cognitive deterioration. Quarantine measures such as social distancing can lead to social isolation and loneliness, which increases the risk of developing depression and anxiety. Previous studies showed that older adults in U.S. immigrant communities were more likely to be

disproportionately affected by the COVID-19 pandemic due to limited access to health care, living in poverty, and fear of legal consequences (Sayad et al.,2023).

Yang et al. (2020) observed that people who have an illness caused by COVID-19 have different degrees of psychological pain such as anxiety, depression, and insomnia, which may be related to their prognosis and require psychological interventions at a personal level. The supply of resources such as personal protective equipment and effective government health policies could aid in the improvement of health quality of life during pandemics such as COVID-19. In addition, Kimani-Murege et al. (2022) found that the primary COVID-19 response measures from the government in partnership with nongovernmental organizations, faith-based organizations, private stakeholders, and well-wishers were put in place to promote compliance with preventive measures and to mitigate the unintended consequences of the restrictive measures. The programs were economic relief, provision of cash transfers, food aid, the revival of neighborhood watch committees, strengthening social safety nets, and the establishment of economic empowerment initiatives such as a youth program called Kazi Mtaani, which provided cleaning jobs for jobless youths, provision of personal protective equipment, and COVID-19 sensitization efforts (Kimani-Murege et al., 2022).

The COVID-19 pandemic is declining with the introduction of vaccinations around the globe and introduction of the medication that helps with COVID-19 symptoms. Participants in this study expressed problems with fear, depression, depression, and hopelessness caused by the COVID-19 pandemic. Wilson and Cleary's (1995) model introduces biological and physiological factors, functioning, general health

perception, and overall quality of life. Participants expressed symptoms that have been described within this model and how these symptoms affect quality of life. Participants also expressed that they still have symptoms like depression, fear of lack of testing, and smell still lingering with themselves. Measures such as the implementation of community workshops from health services and counseling will be needed to help people affected by the disease reduce stress and anxiety. Chronic stress and anxiety lead to poor quality of life. The Government and other non-government organizations would inject financial assistance to people who have lost employment due to the COVID-19 pandemic. Future research should also be conducted to determine how adapting to a challenging environment caused by a pandemic like COVID-19 influences body function and how people can deal with stress levels. Future studies should be conducted to understand the full impact of an immigrant's environment. This will assist policymakers and healthcare organizations in developing policies that support immigrants during and after major health crises like COVID-19.

From this study, there is common knowledge that there exists a widening disparity including removing access barriers to COVID-19 treatment, vaccination, and general health care and increasing programs and support for immigrants' businesses, immigrant-serving organizations, and immigrant communities. Future studies should include putting efforts into providing resources and testing sites for pandemics like COVID-19 to be accessible for example mobile clinics. Efforts to provide community health workers who can assist with language access and be able to integrate culture into health services for the people. Future studies should include how to establish government

health centers that support linguistically and culturally preventive health and clinic centers and funding to serve immigrants. Establish policies that expand insurance coverage and access for immigrant families.

Implications

The results from this study are supported by literature that explored the lived experiences of Makonde immigrants in Kwale and Kilifi counties with their quality of life during and after the COVID-19 pandemic and how the experiences affected them in their daily lives. Participants expressed their psychological trauma, physiological disorders, socioeconomic disruptions, and the role of culture and religion during and after the pandemic. In this study, participants expressed symptoms that affected their normal functioning in their communities. The symptoms caused by COVID-19 also affected them socially and led to financial decline causing unprecedented suffering. The implication of positive changes brings forth awareness of symptoms such as fatigue, depression, hopelessness, and insomnia. These symptoms once well understood to be affecting health and quality of life would be relied on by policymakers, non-government organizations, and the government of the day to make policies that will enhance resources and serve the community thus improving healthy quality of life.

To enhance positive changes, Government agencies like the Department of Health will provide counseling sessions for people who have been affected by stressors caused by the COVID-19 pandemic. Additionally, state, local public health, and non-governmental organizations should create emergency cash assistance funds to support immigrant-owned businesses and immigrant workers. Immigrants should be a priority in

the public health response because they are not well represented and are more likely to lose employment during outbreaks of pandemics like COVID-19. If these programs are put in place, they are likely to instill positive social changes among immigrants and other ethnic people under the same circumstances.

Ahmed and Rasmussen (2020) noted that social inequalities are behind many risk factors associated with mental and physical health problems. Social status hierarchies categorize individual and group characteristics such as gender and race into organizational structures of resources and power that engender durable patterns of disparity. Relative position, or ranking, within social hierarchies, affects individuals' patterns of emotional, behavioral, and physiological reactivity to and recovery from stressors, subsequently impacting risk. Specifically, individuals of lower social status experience more risk factors associated with negative mental and physical health outcomes. Epidemiological surveys across several countries have repeatedly shown the progressive impact of social status on the well-being of individuals within societies. Social status research with nonimmigrant populations suggests that differences in educational attainment, occupation, gender, and other demographic variables are associated with individuals' standings in their society's social hierarchy (Ahmed & Rasmussen, 2020).

Positive social changes are attainable at the community and county level by creating an environment that promotes solidarity, diversity, and openness is essential for settlement to grow sustainability. The arrival of refugees can trigger positive social and economic changes, transform civic culture and local institutions, and promote social

cohesion, particularly when communities are engaged in welcoming them (UNHCR, 2024). This can be done by ensuring that resettled refugees can access the resources they require for their integration and participation in the communities and institutions of the receiving society. The community should ensure opportunities for the newcomers' voices and meaningful participation in the community. There should be in place a fostering climate of understanding and acceptance of the people from the refugee background, enhancing possibilities for meaningful connection with individuals and institutions in the receiving society. This will create positive changes (UNHCR, 2024).

This study was vital to understanding the lived experiences of Makonde immigrants in Kwale and Kilifi counties with their quality of life during and after COVID-19 to find strategies and policies that promote healthcare and resource delivery to people who need it most during large-scale pandemic outbreaks like COVID-19 pandemic leading to positive changes.

In this study, participants shared their struggles with the COVID-19 pandemic and what it caused in their communities. Loss of earnings was potentially significant for many low-income workers and their families, especially immigrants and others who were excluded from unemployment compensation, stimulus payments, and other health and social assistance programs. Understanding these factors can contribute to better public health planning consistent with public health leaders’ calls for a new Public Health 3.0 model that more rigorously and effectively monitors and intervenes in upstream social and economic factors linked to health inequities leading to positive changes among

immigrants and other ethnic groups like Makonde community in Kwale and Kilifi counties (Baron et al.,2023).

The COVID-19 pandemic opened a new awareness of healthcare inequalities among immigrants. Programs focusing on the psychological, physiological, and functional for this population are essential to thriving. The implication for social change for the individuals and family members and the community at large brings awareness of functional symptoms that correlate to well-being and the ability to function in society by providing resources and other supportive services to help settled immigrants and non-documented immigrants attain a high level of quality of life.

My study used descriptive research to understand the lived experiences of Makonde immigrants in Kwale and Kilifi Counties and their quality of life during and after the COVID-19 pandemic. The descriptive phenomenological research method was chosen because it is an ideal method for studying the lived experiences of a phenomenon (Creswell& Creswell, 2018). Additionally, this method requires setting aside the researcher's prejudices, personal feelings, and priori assumptions and focusing on the immediate live experiences of the participants.

A descriptive phenomenology study also requires the researcher to first hand describe the lived experiences objectively and then reflect on the description with references to the existing theories about the phenomena. The descriptive phenomenological research design is the only design that fits the study to uncover the lived experiences of Makonde immigrants and their health and quality of life during and after the COVID-19 pandemic to gain a deeper understanding of the phenomena.

Empirical implications in using phenomenological research were used on observations and measuring phenomena delivering knowledge from participants' actual lived experiences (Creswell& Creswell, 2018).

The theoretical basis of this study includes Shye's (1989) theory of systematic quality of life will be used to provide ideas on how to approach participants. The theory of systematic quality of life and Wilson and Cleary's (1995) conceptual mode of health quality of life influenced the clinical decision-making based on the outcome regarding the health quality of life during the COVID-19 pandemic among Makonde immigrants in Kenya. According to Shye (1989), the theory of systematic quality of life model measures the quality of life in its broad and extensive sense including the cultural, social, physical, and mental well-being of individuals.

Both models support my study and provide structure for my research by guiding me in developing the research questions and seeking the participants' lived experiences, participant selection criteria, and the design of qualitative analysis. Both theories' positions and empirical findings provide many of eh principles currently used in the health quality of life and are the common scientific basis for research, theory, and practice (Kaman et al., 2023). Understanding the multi-resource of psychological, physiological, and functional. Perception and health quality of life due to COVID-19 pandemic patients may help health organizations, and government agencies in developing that will enable access to supportive services and programs to enable better health quality of life thus positive social change.

Conclusions

In this study, I examined the lived experiences of Makonde immigrants with their health and quality of life during and after COVID-19. The results have shown that Makonde immigrants experienced severe physical, psychological, and financial constraints caused by sickness and the COVID-19 environment that caused lockdown, social isolation, and unemployment. Participants who participated in this study reported that they continued having symptoms of COVID-19 long after they had been treated and tested negative. Participants also expressed a lack of supportive social, medical, and financial services. Participants in this study also expressed a lack of preparedness from the Department of Health and the Government to combat COVID-19.

This study found that programs should be developed and administered to support the participants experiencing distress caused by COVID-19 and ensure current and future safeguards are in place to protect settled immigrants, non-documented immigrants, and other ethnic groups and safeguard their well-being by providing access to medical care, counseling services and provide financial incentives for those who have lost their jobs and business due to covid-19 and future large scale illness caused by another pandemic.

During COVID-19, the participants experience physical and psychological stress because of the effects and consequences of the disease. There is a need to focus on the mental well-being of the people who have been affected directly and indirectly by the COVID-19 pandemic. Community-based initiatives are needed to find innovative ways to provide psychosocial support, including technology that can reach remote areas to

provide guidance, tools, and recourses to help community health workers health planners, and the public on how deal with health problems caused by a pandemic like COVID-19.

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Appendix A: Screening Questionnaire

1. Do you belong to the Makonde immigrant community?
2. Do you belong to the Makonde immigrant community in Kwale or Kilifi?
3. Are you 18 years of age?
4. Do you speak English?
5. Were you sick from COVID-19 infection?
6. Did you test positive or were hospitalized because of Covid-19 infection?
7. What is your occupation?

Appendix B: Flyer

Walden University Minneapolis, USA
Volunteers are needed for Research on Makonde Immigrant Health and Quality of life during and after Covid-19 Pandemic.

Introduction

If you are from the Makonde immigrant community and over 18 years old, this study may be for you. Study for Health quality of life of Makonde immigrants during and after Covid-19. Many people were impacted by the Covid-19 pandemic worldwide. Many people fall sick or died due to sickness that nobody knew to prevent or treat. The health and quality of life of many individuals were affected.

Potential benefit: Improving health and quality of life during the Pandemic crisis

Location

- Sessions and appointments in Kilifi County
- Sessions and appointments in Kwale county

Are you eligible?

- 18 years or older
- You were sick from Covid-19 illness
- From the Makonde immigrant community
- Hospitalized due to Covid-19 illness

Participants will receive:

- Snacks and refreshments
- 5 Doller gift card

If you are eligible or you have a question call or email:

Shem kenyanya
Tel 281-902-7661
Shem.kenyanva@waldenu.edu

Appendix C: Interview Guide

Introduction to Interview Guide

Hello, my name is Shem Migosi kenyanya. The purpose of this interview is to learn about your experiences with Covid-19. During this interview, you will be given a code number that will be used to refer to you throughout this study to ensure your confidentiality. Only I and the chair of my doctoral committee from Walden University will have access to the data collected.

This interview will approximately take 45-60 minutes. It will consist of questions. I will be taking notes and audio recording the interview. you are not obliged to complete the interview and can opt out of the interview as you wish.

Do you have any questions before we begin?

Questions

1. How did Covid-19 affect your physiological, mental social and biological function during the pandemic? Probe: To effective organization, metabolism, responsiveness, movement, and production
2. Tell me, how did you manage the symptoms of Covid-19 during the sickness? Probe: lived experiences before the Covid-19 pandemic, expectations of daily life and goals in daily life, and function during the pandemic such as weakness, difficulty walking, talking, and breathing.
3. How would you describe the experience with natural functions status during the Covid-19 pandemic? Probe: functional status, the ability to stay healthy,

positions in society, and adaptation to changes during and after the pandemic. Fulfilling roles and maintaining health and well-being.

4. How would you describe the overall quality of life now after the Covid-19 pandemic? Probe: Overall perception of life, healthy, financial situation, social lifestyle, culture, religion, and beliefs.
5. Is there anything you have not described related to your experiences during and after Covid-19? Probe: Financial situation, goals in life, social life, culture, and traditions