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Walden University

College of Social and Behavioral Sciences

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Grace Faraja Nkundabantu

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Walden University
2020

Abstract

Experiences of Refugee Women With Different Physical Abilities in Kenya

by

Grace Faraja Nkundabantu

MA, Ashford University, 2014

BS, Daystar University, 2007

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human and Social Services

Walden University

February 2020

Abstract

Refugee populations worldwide increase every day as a result of social and political wars. Women and children, particularly those with different physical abilities, are the most vulnerable populations affected by atrocities in their home countries and in their countries of refuge. In Africa, it is believed that women with different abilities bring shame to their families. The purpose of this descriptive phenomenological study was to explore the lived experiences of refugee women with different physical abilities, specifically regarding challenges related to accessing services in Kenya. The research question that guided this study focused on the lived experiences of refugee women with different physical abilities in Kenya seeking social services. Wendell's feminist theory was the conceptual framework for this study. Data collected from face-to-face interviews with a sample of 10 women in an urban center in Kenya revealed the lived experiences of refugee women with different abilities seeking services. Open coding was used to extract emergent themes from the interview data. Five themes emerged: (a) fleeing traumatic violence in the country of origin; (b) gratitude for supportive social networks; (c) the hardship of inadequate support for basic needs; (d) the anxiety, frustration, and shame of dependence; and (e) the distress of living with unmet needs. Social change implications include the ability of scholars and service providers to share information with those who assist refugee women with different physical abilities to help them better meet this population's needs. The study findings may also help people in African communities to view those with different physical abilities in a more positive manner.

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Dedication

This dissertation is dedicated to my loving husband, Denis Horaho, my cousin, Angel M. Nsengiyumva, and my daughters—Deborah Horaho, Elsa Horaho, and Neza Horaho—who have been very supportive during my education journey. I dedicate this study to my father, Bishop Simon Nkundabantu, and my mother, Domitila Nagaju, for your unceasing prayer over my life and my education success, my cousin Dr. Thomas Kigabo, and to my parents-in-law, Dr. Norbert Runyambo and Maman Laurence Mukabatsinda, for all of your encouragement throughout my education. Finally, I dedicate this study to all African girls who cannot access education. I would like to give you hope. Walden University is a great university with a powerful social change mission. I have learned so much, and my prayer is that through my foundation—the African Girls Hope Foundation—God will help me to provide resources for many of you to have an education.

Acknowledgments

The completion of this doctoral study would not have been possible if not first with God's help and with the day-to-day support of my loving husband, Denis Horaho. Thank you so much for honing my passion for education and the time spent with me as I worked on my assignments and research; thank you for taking care of our children and all other household responsibilities. Also my cousin, Angel Nsengiyumva, who was God-sent to me during my education journey. Angel, thank you for taking care of your little sisters. I would like to acknowledge my father, Bishop Simon Nkundabantu, my mother, Domitila Nagaju, my siblings, Jean Paul Shaka, Furaha Francine, Benjamin Karomo, Celina Bukuru, and Guillaume Muco, my cousin Dr. Thomas Kigabo, my father-in-law, Dr. Norbert Runyambo, and my mother-in-law, Laurence Mukabatsinda. Your love, encouragement, and moral support during my study was very vital to my standing strong to the end of this journey. I am very thankful for every contribution of your support toward my education.

I want to acknowledge my dissertation chair, Dr. Barbara Benoliel, for your time, guidance, and support in preparing me to become a scholar. I will always cherish all your advice, your guidance, and time spent investing in me. And also, all of my dissertation team, Dr. Avon Marie Hart-Johnson, Dr. Kelly Chermack, Sonia Castleberry, and Dr. Jesse Lutabingwa. All of you participated in one way or another, your advice, your time spent reading my materials, and your encouragement throughout this study. I thank you very much for all of your support.

To Walden University, thank you for the great definition of positive social change that has really impacted me and made me stay strong to complete my study! I will always stand with your mission of social change.

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Chapter 1: Introduction to the Study

The United Nations has estimated that more than 65,600,000 people worldwide live as refugees (United Nations High Commissioner for Refugees Kenya [UNHCRK], 2018). These refugees were forcibly displaced due to war, conflict, persecution, and other forms of civil violence and have fled to neighboring countries (Silove, Ventevogel, & Ress, 2017). Some have resettled in Europe and the United States (Langlois, Haines, Tomson, & Ghaffar, 2017). Women and children are the majority of the refugee population and the ones most affected by the social atrocities that caused them to flee (Silove et al., 2017).

Kenya, the present study's setting, has an estimated 486,460 refugees (UNHCRK, 2018). Nearly 80% of the refugee population in Kenya are women and children (Lischer, 2017). Some of these refugees are women with different physical abilities, who have been noted to be more vulnerable to conditions of refugee status than males (Silove et al., 2017; World Health Organization [WHO], 2018). Although this population is known to be vulnerable, and protections have been put in place that prioritize security of the vulnerable, it is not known whether other barriers keep refugee women with different physical abilities from accessing services (WHO, 2018).

Different abilities is a socially constructed concept and a culturally created phenomenon (Wendell, 1996). It is also a human rights issue (WHO, 2018). The WHO deals with different ability issues on an international level and has established the International Classification of Functioning, Disability and Health (ICF) as a universal framework for describing and organizing information on functioning and disability so

that statistics gathered on people who are differently abled properly represent the sample populations. Furthermore, the WHO recognizes the United Nations Convention on the Rights of Persons with Disabilities as the authoritative document for all matters pertaining to the civil, cultural, political, social, and economic rights of people with different abilities (WHO, 2018).

The global increase of refugees has created the need for long-term planning to protect those who are vulnerable (Wenzel, Völkl-Kernstock, Wittek, & Baron, 2019). Environmental factors have been identified as essential to the well-being of people with different abilities, as outlined in the ICF (WHO, 2018). Refugees may face environmental factors (e.g., social stability, cultural norms, and economic resources) that lead to greater difficulty in accessing services. These factors are especially troublesome for individuals with different physical abilities, who may face many barriers to social services that put their well-being at risk (WHO, 2018), including refugee women with different physical abilities.

Chapter 1 includes a brief discussion of current research on refugee women with different physical abilities and an explanation of the gap in the knowledge that was addressed in this study. The problem statement, study purpose, and the theoretical and conceptual frameworks are then presented, followed by sections on the nature of the study, definitions, assumptions, scope, and delimitations. A statement of significance and a summary conclude the chapter.

Background

In recent research on refugee populations, researchers have focused on the rights of refugees (Skarstad, 2018), the perceptions of humanitarian institutions toward persons with different abilities (Bucher, 2018), the role of women with different abilities in humanitarian institutions (Women's Refugee Commission, 2018), and sexual- and gender-based violence (J. Marshall & Barrett, 2017). Refugees with communication-based different abilities are at a greater risk for sexual- and gender-based violence, but little research has been conducted in this specific area (J. Marshall & Barrett, 2017). There have been calls to establish the means to protect these highly vulnerable refugees and for more research on refugee health care, experiences of refugee discrimination, and cultural stigmas regarding people with different abilities (Mirza, 2015; Woodgate et al., 2017). In prior research, lack of familiarity with health care systems and social and language barriers are prevalent themes (Woodgate et al., 2017).

Researchers have also reported on misconceptions regarding the sexual reproductive health of women with different abilities (Tanabe, Nagujjah, Rimal, Bukania, & Krause, 2015). The perception is that women with different abilities are not able to participate during sexual activities and therefore cannot give birth. Tanabe et al. (2015) called for an awareness of sexual reproductive health rights for refugee women who face challenges in the understanding of their rights.

In the African cultural perception, women in general are discriminated against and face challenges simply because of their gender (Naami, 2015). Those with different abilities face double vulnerabilities. The cultural perception of people with different

abilities in Africa is that they are cursed and bring shame to the family (Bunning, Gona, Newton, & Hartley, 2017).

The United Nations enacted the Convention on the Rights of Persons with Disabilities in 2008. Although there has been improvement regarding the realization of rights, much discrimination still exists (Njelesani, Siegel, & Ullrich, 2018). Little is known about the lived experiences of refugee women with different abilities in Kenya, especially regarding seeking access to social services.

Problem Statement

Access to social services is a core factor that influences refugees in their countries of refuge (Crock, Smith-Khan, McCallum, & Saul, 2017; Pearce, 2015; Woodgate et al., 2017). This access is critical for maintaining day-to-day life as refugees, people who cannot return back to their country of origin. Furthermore, many refugees experience different ability stigmas in their countries of origin and continue to experience these issues in their countries of refuge (King, Edwards, Correa-Velez, Hair, & Fordyce, 2015). Among refugee populations, those with different abilities are the most hidden, neglected, and socially excluded (Crock et al., 2017).

The problem is that individuals with different physical abilities face barriers to social services and are at risk (WHO, 2018). According to the WHO, there is a gap in the knowledge about which environmental factors are barriers for refugees. By studying this gap and focusing further on the experiences of refugee women with different physical abilities, results from this study could be shared with organizations providing social services.

Social stigmas also may be environmental barriers. Even though there may be a blend of cultures in the refugee enclaves, one factor remains constant: Those with different abilities are a social disgrace (Pearce, 2015). This is because many African families view people with different abilities as taboo (Bunning et al., 2017; Naami, 2015). It is believed that women with different abilities bring shame to their families (Bunning et al., 2017; Naami, 2015). In many of these communities, women face discrimination, and women with different physical abilities face double challenges in both gender-based discrimination and different-ability-based discrimination (Naami, 2015). These women may be pushed away from their own family and communities (Bunning et al., 2017). Refugee women in Kenya with different abilities face different challenges that make life more difficult due to their refugee status and that impact their access to social services (Pearce, 2015).

Although this discussion provides valuable insights into the situation of refugee women with different physical abilities, I did not find any studies about refugee women with different physical abilities in Kenya. With increased understanding and knowledge, there may be an opportunity to inform those who wish to provide appropriate interventions to assist this population in Kenya. Furthermore, the WHO (2018) stated that a gap in knowledge exists in the area of environmental factors that may be barriers to social services for refugees.

Purpose of the Study

The purpose of this descriptive phenomenological study was to explore the lived experiences of refugee women with different physical abilities, specifically regarding

challenges related to accessing services in Kenya. My goals for this study were (a) to provide in-depth understanding of the challenges of these women due to lack of citizenry status as displaced people and their double vulnerability as women and people with different physical abilities, and (b) to inform those who want to address the challenges faced by refugee women with different physical abilities in Kenya as displaced people who cannot return to their countries of origin.

Research Question

The research question that guided this study was, What are the lived experiences of refugee women with different physical abilities in Kenya seeking social services?

Conceptual Framework

According to Wendell (1996), the feminist theory of disabilities is that disability is a socially constructed concept and a culturally created phenomenon. Disability is not the same as impairment, which refers to a biological condition (Wendell, 1996). Disability refers to people's abilities to function in the given framework of their societies. All impairments can be understood to be disabilities if the impairment has deviated too far from the general norm. However, not all disabilities are also impairments (Wendell, 1996).

In this study, I explored what Wendell (1996) calls the *negative body.* The *positive body* is made of those who are healthy, those who have not become aged or weak, and those who represent the typical (Wendell, 1996). Women with different abilities, as described by Wendell, exist in the negative body of their societies because their experience of reality is not that of the standard experienced by most others. This

negative space is one that has no voice in the public, positive space (Wendell, 1996). Therefore, according to Wendell's theory, women with different abilities lack a representative voice in the public, male-dominated social space (Wendell, 1996). Women in Africa who are physically able experience discrimination from equal opportunities, but those with different abilities face double inequality due to views among Africans that people with different abilities bring curses to their families (Naami, 2015). This concept was used in this study as a means to approach the issue of women with different abilities in a refugee situation.

According to Wendell (1997), women are oppressed in their own cultural beliefs, communities, and nations. The concept of this theory assists with better understanding the experiences of women and girls who are differently abled, physically facing double discrimination in the employment sector, education inaccessibility, and unequal human rights (Wendell, 1989). Wendell (1989) stated that 16% of women are differently abled. The lens of the feminist theory of differently abled in this study helps to demonstrate experiences and challenges faced by refugee women with different abilities. The theory also furthers the understanding of the discriminations and double vulnerabilities of refugee women who are differently abled physically, emotionally, and mentally as well as experience inaccessibility of social services. Wendell's theory is discussed in more detail in Chapter 2.

Nature of the Study

A descriptive phenomenological approach was used to address the lived experiences of refugee women with different physical abilities in Nairobi, Kenya, in

keeping with Giorgi's (2009) phenomenological method. A descriptive phenomenological approach was used because it brings a deeper understanding of the lived experiences of the phenomena as described by the study participants (Moustakas, 1994). Participants in this study were a criteria-based group of refugee women with different physical abilities in Nairobi, Kenya.

The goal of phenomenological research is to describe participants' experiences in a specific context and to understand a phenomenon (Moustakas, 1994). This approach involves collecting the lived experiences of individuals. If these experiences are unique and largely unstudied, then a phenomenological study can generate thick descriptions of great value for understanding a problem that has not been well studied (Moustakas, 1994; Sloan & Bowe, 2014), and the findings are largely not generalizable beyond the sample (Sloan & Bowe, 2014).

Semistructured in-depth interviews of refugee women with different abilities living in Nairobi, Kenya, were the data source for this study. In-depth interviews were relevant for this study because they help to clarify study participants' experiences and perspectives (see Oltmann, 2016; Sutton & Austin, 2015).

Implications for Social Change

Wendell's (1989) theory of disability calls for a greater awareness of the limitations inherent in any social or cultural structure. Society members who fit these structures typically experience fewer difficulties in completing daily tasks such as eating, sleeping, cleaning, and working. Others, however, may experience greater difficulties

completing these daily tasks. For these people, due to social structures, their experience is one of greater difficulty (Wendell, 1989).

Through discourse with marginalized members of a social or cultural group, one may attempt to understand whether people with different abilities are less able than people without any different abilities to perform the necessary daily tasks requisite for survival, as well as to maintain membership within that sociocultural sphere. The goal of social services agencies is to provide the basic necessities of survival for these differently abled people (Barker & Wilson, 2019). If there are refugees who continue to have great difficulty in obtaining and maintaining the basic needs for survival, this is a situation that calls for social change. It is only through an all-inclusive humanitarian and social services approach that services and assistance are available and accessible for all people.

Definition of Terms

Accessibility: One's ability to understand, reach, or approach someone or something (WHO, 2018).

Activity limitations: Problems with executing daily activities, as in using the restroom (WHO, 2018).

Differently abled: People who are conventionally categorized as disabled but who are able to perform some activities (WHO, 2018). In this study, the terms differing abilities, different abilities, or differently abled decreased the reality of the disability stigma; people with differing abilities are capable to perform some activities.

Disability: The combination of health conditions with environmental factors. (WHO, 2018). Disability also refers to people incapable of performing work. In the

African context, people with disabilities are stigmatized as those who are meaningless in the community, incapable of ever doing anything functional, and are pushed away.

Impairments: Problems in body function or alterations in body structure or functioning, such as being born with one leg (an ICF component), and alterations in bodily functions and structures that can been associated with a health condition (WHO, 2018).

Participation restrictions: Social exclusion in any area of life, as in discrimination (WHO, 2018).

Public accommodations: Buildings open to and provided for the public and public roads (WHO, 2018).

Social services: Services such as health insurance, transportation service, access to employment, education, and others provided to people with different abilities (Rios, Magasi, Novak, & Harniss, 2016).

Assumptions

In this study, I assumed that the participants would be honest in their answers to the interview questions. This was necessary for gathering reliable data. Also, I assumed that I would be able to adequately interpret the meaning behind any contextual aspects of participants' responses.

Scope and Delimitations

The geographical scope of this study was the refugee neighborhood area in Nairobi, Kenya. Study participants were adult women (18 years of age or older) who are physically differently abled and have refugee identification status accorded to them by

the UNHCR due to their state of displacement. There were 10 participants, which aligned with Giorgi's (2009) and Moustakas's (1994) recommendations for minimum sample sizes for qualitative research. Interviews were conducted in the homes of the study participants in order to easily access them.

Limitations

Because of the nature of the participant population, verbatim translations of their interview responses was identified as a potential limitation. Because this population is stigmatized by society, easily accessing them was another potential limitation. Another limitation was that individuals with different abilities may have refused to participate due to previous interactions with nongovernmental organizations and unmet promises. Some potential participants might have refused to be interviewed if they were not given financial incentives. Language barriers might have been another study limitation if potential participants used languages other than the ones I speak. Participant honesty in their responses to the interview questions was another area in which data may incorrectly reflect their experiences. These assumptions, limitations, scope, and delimitations were considered to provide a better understanding of my intentionality as the researcher and are further discussed in Chapter 5.

Significance

The results of this study provided much needed insights into the issues refugee women with different physical abilities face daily due to lack of support systems, including issues previously noted by Ganle et al. (2016) such as access to skilled care and gaining access to unfriendly physical health infrastructures. Study findings may also be

useful to the officials and site workers at the UNHCRK and other international organizations in bringing the awareness of the challenges refugee women with different abilities face as displaced people in Kenya. The findings may also help African communities to view people with different physical abilities with more positive perceptions.

Summary

In this chapter, I discussed the background of the refugee situation in Kenya, the problem that was addressed in this study, the purpose of the study, the research question, theoretical and conceptual frameworks, definitions, assumptions, scope and delimitations, limitations, and the study significance.

I sought to reveal the deep lived experiences of refugee women with different physical abilities in Nairobi, Kenya, because there is a lack of information about the conditions of this highly vulnerable population. A qualitative approach—specifically, phenomenology—was used to conduct this study. The conceptual lens of Wendell's theory of disability was the theoretical framework for this study. Potential limitations and assumptions were as discussed in this chapter.

Chapter 2 is a review of the literature on refugee women with different physical abilities in Kenya and around the world. In this chapter, I review the professional and academic literature and further detail this study's theoretical framework. The chapter ends with a summary.

Chapter 2: Literature Review

The WHO (2018) has estimated that 15% of the world's population has some form of different abilities, with 2.2% of people ages 15 years and older having difficulties in functioning. The rates of persons with different ability have been increasing due to aging and chronic health conditions (WHO, 2018). Among the 15% of persons with different abilities, 300,000,000 are women with mental and physical disabilities (WHO, 2018).

The purpose of this phenomenological study was to explore the lived experiences of refugee women with different physical abilities and the challenges they face accessing services in Kenya. Despite efforts to provide equal access to such services, discrimination still exists (Njelesani et al., 2018). Refugees experience stigma in their home countries and the countries in which they arrive (King et al., 2015) and often are victimized by violence (J. Marshall & Barrett, 2017). Despite these traumas, they lack access to services that might help them (Woodgate et al., 2017). Little is known about the barriers that prevent these individuals from receiving needed services (WHO, 2018). As such, there is a gap in the literature regarding these barriers. Stigma has been suggested as one form of environmental barrier, with some cultures stigmatizing specific different abilities (Bunning et al., 2017; Naami, 2015). This stigma may play a role in influencing whether women receive services, but if this is actually the case, it remains unconfirmed.

The United Nations estimated that more than 65,600,000 people worldwide live as refugees (UNHCRK, 2018). These refugees were forcibly displaced due to war,

conflict, persecution, and other forms of civil violence (Silove et al., 2017). As a result, these refugees have fled to neighboring countries (Silove et al., 2017).

Chapter 2 is organized as follows. First, the literature search strategy is presented. Second, a review of the theoretical framework is provided. Next is a review of the literature, followed by a conclusion. In this chapter, I review literature related to the study's key concepts; namely, the issue of refugee women in Kenya with different abilities. I examine how researchers have approached this study's key concepts: women with different abilities, refugee women, and refugees with different abilities. I then assess the strengths and weakness in these studies. The review of the literature in this chapter is organized by keywords, as detailed in the Literature Search Strategy section, and reflects the following subtopics: (a) study methodology and design; (b) bioethics, intersectionality, society, culture and ability; (c) the refugee condition; (d) accessibility of health care for refugees; and (e) nongovernmental organizations and refugees.

Literature Search Strategy

Walden University library's databases were used to locate literature relevant to this study. These databases included Communication & Mass Media Complete, Academic Search Premier, PsycARTICLES, PsycINFO, PsycCRITIQUES, PsycEXTRA, ERIC, Centers for Disease Control, and SAGE Journals. Google Scholar was also used. The search focused on peer-reviewed articles from 2015 to 2019 on topics pertinent to refugee women with different abilities in Kenya.

The following key search terms and phrases were used to guide the research: *ableism and refugees with different abilities*, *ableism and refugee camps*, *ableism and*

women with different abilities or disabilities, *ableism in society*, *descriptive phenomenology*, *disabilities and refugees*, *disabilities and women and refugees*, *disabilities and women and refugees in Africa*, *disabilities and women and Kenya*, *disabilities and women and Nairobi*, *existential phenomenology*, *Giorgi and phenomenology*, *Husserl and phenomenology*, *Heidegger and phenomenology*, *impairment and refugee women*, *impairment and refugee women in Africa*, *impairment and refugee women in Kenya*, *impaired refugee women in Kenya*, *impaired refugee women in Kenyan refugee camps*, *impaired refugee women in Nairobi*, *interpretive phenomenology*, *people with disabilities*, *phenomenology*, *phenomenology and social sciences*, *phenomenology and humanities*, *phenomenology and qualitative research design*, *refugees and health care*, *refugees in Africa and health care*, *refugees in Kenya and health care*, *refugee women and health care*, *refugee women in Africa and health care*, *refugee women in Kenya and health care*, *status of refugees*, *status of refugees with different abilities or disabilities*, *Susan Wendell*, *Wendell and disability*, *Wendell and society*, *women refugees with disabilities in Kenya*, and *women refugees with disabilities in Nairobi.*

Conceptual Framework: Feminist Theory of Different Abilities

To frame the following literature review, I first discuss how different abilities are viewed and have been defined by society. According to Wendell (1996), the term different abilities is a socially constructed concept and a culturally created phenomenon. Different ability is not the same as impairment, which refers to a biological condition (Wendell, 1996). Different ability refers to the ability to function in the given framework

of one's society. All impairments can be understood to be different abilities if the impairment has deviated too far from the general norm. However, not all different abilities are impairments (Wendell, 1996).

Wendell (1996) distinguished between what she termed the negative body and the positive body. The positive body reflects those who are healthy, those who have not become aged or weak, and those who represent the typical (Wendell, 1996). Women with different abilities, as described by Wendell, exist in the negative body of their societies because their experience of reality is not that of the standard experienced by the majority (Wendell, 1996). This negative space is one that has no voice in the public, positive space (Wendell, 1996). Therefore, according to Wendell's theory, women with different abilities lack a representative voice in the public, male-dominated social space (Wendell, 1996).

Women in Africa who are physically able also experience discrimination regarding equal opportunities (Naami, 2015). Those with different abilities face double inequality due to the negative views of Africans that people with different abilities will bring a curse to their families (Naami, 2015). According to Wendell (1997), individuals of the female gender are the most oppressed people in their own cultural beliefs, communities, and nations. Wendell's theory helps to better understand the experiences of women and girls who are physically differently abled and who face double discrimination in the employment sectors, education inaccessibility, and human rights (Wendell, 1989).

The right to equality of opportunity in society for people with different abilities has been fought for many years in the United States, with some positive results. The most

prominent legal effort at protecting individuals has been the Americans with Disabilities Act (Department of Labor, 2019), which prohibits discrimination against those with disabilities in several respects throughout society, ranging from transportation to access to government programs and services. Despite attempts at promoting equity, people with different abilities continue to struggle in society. Because of a lack of appropriate services and support, they face challenges to succeed at similar levels to their nondisabled peers.

Social and Medical Lenses of Different Ability

Governmental definitions of different ability encompass limitations across physical conditions, such as vision and movement, but also mental health and social relationships (Centers for Disease Control and Prevention, 2017). These limitations impact the many aspects of differently abled people's lives both in public and private. However, governmental definitions have to be balanced against the contextual aspects of impairment, as indicated by Bickenbach, Cieza, and Sabariego (2016), which include the differently abled population's own insistence that they are not impaired. In practice, researchers and theorists use two main approaches when studying the concept of different abilities: social and medical. The social lens holds that all humans are physically different, and it is only in social settings that these similarities and differences between people become apparent (Silvers, 2009). Those who are less similar and more different than most of the group may then be considered to have different abilities than most of that group. The medical lens holds that the root of different abilities is not a social or cultural construct, but is instead biological and understood through medicine (Silvers,

2009). As opposite as these views may be, they do account for the primary assumptions seen in many studies on the topic of different abilities.

Wendell (1996) elaborated on the social lens and indicated that differing abilities are a socially constructed concept and a culturally created phenomenon. Different ability is not the same as impairment, which refers to a biological condition (Wendell, 1996). Different ability refers to the ability to function in the given framework of one's society. All impairments can be understood to be different abilities if the impairment has deviated too far from the general norm. However, not all different abilities are impairments. Wendell suggested that there are negative and positive body perceptions, with the positive body characterized as those who have not become aged or weak, and those who represent the typical. Women with different abilities exist in the negative body of their societies because their experience of reality is not that of the standard experienced by the majority (Wendell, 1996).

The social lens has been used to study disability in various contexts, including among ethnic minorities. M. Bailey and Mobley (2018) indicated that using an intersectional framework was necessary to explore the experience of being Black, feminist, and disabled. This approach could address how different abilities, race, and gender impacted individuals and society. Similarly, Bickenbach et al. (2016) did not propose a framework for understanding disabilities but did indicate that disability was often contextual. Both M. Bailey and Mobley and Bickenbach et al. emphasized the importance of integrating social factors into disability research. Bickenbach et al. further

stated that disabilities are difficult to conceptualize given that there is no single accepted definition, even between medical professionals and those with specific conditions.

In practice, few researchers use both the social and medical models in their work. Egner (2019) examined a situation in which the social model was used to critique the medical model by exploring neuroqueer, a collaboration of activists, academics and bloggers focused on online community building. Egner found that group members supported disidentification from the social conditioning understood to be generated out of the medical theory of a cure. Neither model of disability may be wholly appropriate for the study of disabilities. The social model of disability fails to account for the medical model of disability (Silvers, 2009).

In summary, the medical approach holds disability to be a problem that can be solved through medical interventions. The social model holds that disability is a political problem, one to be solved by activists and policy makers (Silvers, 2009). As such, using integrated approaches to studying disability may be beneficial and produce more meaningful results than using either model alone (Silvers, 2009).

Stigmas Regarding Individuals With Different Abilities

People living with disease and different abilities must negotiate not only their own physical conditions but also the public response to these ailments. Koschorke et al. (2017) noted that stigma and discrimination often arise in response to such conditions. Increasing attempts to improve treatment of the disabled has successfully improved the general well-being of such people, but stigmatization has continued to limit the progress of people who are differently abled. Social reactions toward those with different abilities

can often be as harmful as the conditions themselves (Koschorke et al., 2017). Stigmatization impacts individuals as well as families. As such, the impact of stigma may be widespread (Koschorke et al., 2017). Stigma can impact people with various physical disabilities, those who carry diseases such as HIV and cancer, or even impact people with different abilities. Because of this, different ability can impact a wide part of the population (Koschorke et al., 2017).

Disability stigmas have also been studied in developing countries. Although she did not specifically address cultural norms, Rohwerder (2018) noted that disability stigmas differed depending on country, community, and family. Societies in more rural regions are more likely to generate stigmas toward those who are differently abled, resulting in harmful practices directed toward those individuals (Rohwerder, 2018). Rohwerder noted that cultural and religious beliefs may impact awareness of disability causes, resulting in the creation of stigma toward these disbeliefs. Traditional beliefs that frame disabilities negatively often lead to the marginalization of people with different abilities, who often find themselves with fewer rights and a diminished role in their community. For example, religious beliefs that frame different abilities as a punishment often result in harmful practices toward the disabled (Rohwerder, 2018).

In most African countries, cultural beliefs and religion play significant roles in the stigmatization of people with different abilities. These beliefs have worsened the well-being of people with different abilities in their communities (Etieyibo & Omiegbe, 2016; Ndlovu, 2016). Etieyibo and Omiegbe (2016) stated that Christians believe evil spirits to be the cause of different abilities. As a result, people with different abilities originate

from a sinful act committed against traditions in the past by a member of the family or parents. Etieyibo and Omiegbe (2016) further stated that appropriate measurement and education is required in African society to bring awareness of discrimination against people with different abilities and to combat the stereotypes, prejudices, and harmful practices relating to person with different abilities.

Between 2015 and 2016, more than 2% of the Kenyan population was living with different abilities (Kabia et al., 2018). Because of their physical limitations, women with different abilities live a life of poor self-esteem, are unrecognized and excluded from community activities, and are pushed away by those who assume that they are incapable of sexual activity and reproduction (Tanabe et al., 2015). Kabia et al. (2018) suggested health care service availability as the most challenging and most needed service in Kenya and that government leadership should take these needs into consideration. Similar concerns were noted by Rugoho and Maphosa (2017) in Zimbabwe, who also posited that women with different abilities face sexual and reproductive health challenges. Rugoho and Maphosa stated that women with different physical abilities are viewed as people who are not able to participate in sexual and reproductive activities. They further noted that not only in the country of Zimbabwe, but in most other African countries with strong cultural beliefs, women face challenges in accessing the normal routine of a man pursuing a woman with different abilities. The beliefs are that women with physical different abilities cannot give birth or they are not healthy, and, therefore, the children will have the same physical deformities (Rugoho & Maphosa, 2017). Rugoho and

Maphosa called for governments and other stakeholders to address the challenges women with different physical abilities face in accessing sexual and reproductive health services.

Society, Culture, and Ability

Societies tend to function along divisionary lines, with people considered members more accepted while those considered nonmembers given less consideration. In the populace of any society are members who embody the public representation of that society and those who are kept in private (Wendell, 1989). People of different abilities are one of the largest minority groups and are often misrepresented. Kearney, Brittain, and Kipnis (2019) indicated that misrepresentation can lead to differentiated treatment of people and mistreatment of those who are misrepresented. Any civil society must examine which types of human beings it will value and which it will devalue. However, societies are impacted by different structures that characterize them. Goodley (2016) examined people of different abilities in the context of neoliberal capitalism and found that these individuals fit into the greater picture of activism, community, and politics, suggesting that a neoliberal context was a relatively positive one for the disabled. Still, there are negatives to this form of economic structure, and different people are unequally impacted by disparities in how they were treated. Those who are the most disadvantaged are also the most likely to suffer from this unequal treatment (Goodley, 2016).

People with different abilities may wield an influence on a nation’s economy. According to Nordenfelt (2009), this population poses an economic problem for society. Nordenfelt’s statement was made less about medically impaired people and more about employees who have become disabled because of their work or social environment and

can no longer function at a competitive level with their fellow employees. Nordenfelt noted that the equivalent of $17,000,000,000 was paid due to employee ability issues and sick leave compensation in 2003. Capri (2019), who also discussed relationships between the differently abled and society, indicated that society impacted the disabled and more efforts, including new policies. This was similar to statements by Shauri and Bonventure (2019), who indicated that many institutions now understand that they need to provide additional aid to help the disabled achieve equitable outcomes to their nondisabled peers. Such changes were documented in educational institutions, which have reorganized over the last half century to better support the disabled. However, help for the disabled was contingent on the existing environment, including the political environment, which influenced the ability for organization to support the disabled (Capri, 2019). Capri called for impaired individuals to be treated as experts for future policies and concluded with a call to action for researchers and policy makers to ask the opinions of these experts and no longer exclude their voices. Similar suggestions were made by Gona, Newton, Harley, and Bunning (2018) in a study on using personal narratives to affect community attitudes in rural Kenya. Gona et al. concluded that exposing community groups to experts-by-experience (their term) gave these groups opportunities to examine and adjust their views on disability.

Motherhood and different abilities may come together to make child raising more difficult for some. Daniels's (2019) study of motherhood, different abilities, and society indicated that some societies have outlawed motherhood for women with different abilities and enforced these laws through mandated sterilization. Other societies have

mandated that any children of mothers with different abilities must be given up for adoption. Daniels also noted that some societies refuse access to basic child-rearing needs for mothers with different abilities. This form of discrimination could potentially be reduced by highlighting it in the media and governmental policies.

Students often struggle to be understood when they present with different abilities. Different abilities are understood in an administrative framework (Hollar, 2019). This can be at once both liberating and stifling to the individual students as they grow, learn, develop, and change throughout the years. Alternative physical education options were noted as a means of improving understanding of organizational leadership and its effects on nontypical students (Hollar, 2019).

Even medical settings can disadvantage specific parts of the population. R. Bailey, Lowton, and Scambler (2019) used a qualitative approach to study how people with different abilities overcome obstacles to health care in hospital settings. They noted that in some cases, the obstacles to health care in hospital settings can be threatening to the well-being of individuals with intellectual impairment. These individuals must do anything possible in order to maintain protection over their notion of the embodied self. R. Bailey et al. suggested removal of these obstacles to health care but noted that such actions could only be achieved once policy makers have both empathetic and sympathetic understanding of people with intellectual impairments.

Intersectionality

Individuals are influenced by more than one factor. Researchers have noted that intersectionality is an important factor in research and have examined how different

demographic factors shape the experiences of people with different abilities (Naples, Mauldin, & Dillaway, 2018). Kulesza et al. (2016) addressed this junction of demographic factors in a study on disability and race, ethnicity, and gender. The researchers included 899 individuals in a study designed to better understand stigma toward substance use disorders. These individuals were not persons who used drugs. Rather, they were individuals of multiple ethnicities and included both men and women whose perspectives toward drug users was gauged using the Implicit Association Test. Following data collection, Kulesza et al. concluded that individuals judged people who used drugs to be worthy of judgment. This effect was particularly strong toward Latinos and Latinas, indicating that stigma may be directed more strongly toward people of certain ethnicities. Judgment was harsher toward Latinos and Latinas versus their White counterparts (Kulesza et al., 2016).

Intersectionality has also been studied from the perspective of the intersection of different abilities. An example of stigmas studied at the intersection of multiple disabilities is a study of HIV/AIDS, mental illnesses, and physical different abilities among individuals conducted by Jackson-Best and Edwards (2018), who found that previous researchers had not sufficiently reviewed stigma as it impacted different types of disease. This examination of different ability and disease was conducted using a systematic review of the literature to identify studies that included these three forms of different ability. Stigma surrounding HIV/AIDS, mental illnesses, and physical disabilities needed to be studied in order for studies to be included in the review (Jackson-Best & Edwards, 2018).

Jackson-Best and Edwards (2018) included 98 studies in their research and found that in most studies, the researchers investigated only health conditions. Only three studies focused on physical disability. Most interventions developed to address stigmas were behavioral in nature rather than structural (Jackson-Best & Edwards, 2018). A full review of these studies indicated that there was little comparison of stigmas surrounding HIV/AIDS, physical disabilities, and mental illnesses. Jackson-Best and Edwards suggested that more cross-comparative analysis of the intersectionality of stigma between multiple factors was necessary. However, the commonality in stigma interventions across all three forms of disability was that interventions did not address structural issues but instead targeted behavioral roots of stigmatization.

The intersectionality of disease was also studied in the context of understanding internalized HIV and substance use stigma. Earnshaw, Smith, Cunningham, and Copenhaver (2015) studied 85 people living with HIV and a history of substance abuse to determine if there was an intersection between HIV and substance use stigma. Following data analysis and review, Earnshaw et al. concluded that depressive symptoms increased when there was an intersection of internalized HIV and substance use stigma. As such, the intersection of disease and stigma may result in developing mental health symptoms.

The Refugee Condition

With an increase in refugees comes an increase in the need for social services. Critical challenges occur when individuals become refugees (Wenzel et al., 2019), including trauma from war, death threats, torture, and sexual violence (Regev & Slonim-Nevo, 2019). These traumas leave individuals open to depression and anxiety (Regev &

Slonim-Nevo, 2019). Wendell (1996) also noted that stress and trauma impacted refugees. Mental health challenges leave individuals more vulnerable to exploitation (Regev & Slonim-Nevo, 2019). Although there is a need to address the challenges presented by mental health issues, certain protocols should be followed when providing mental health services (Weissbecker, Hanna, El Shazly, Gao, & Ventevogel, 2019). Weissbecker et al. (2019) indicated that health care providers must understand the psychological aid being provided and what interventions are to be used. Also important is that health care services include appropriate assessments of individuals and deliver coordinated service (Weissbecker et al., 2019). The need for health care was highlighted by Khamis (2019), who noted that posttraumatic stress disorder (PTSD) was higher in refugee children in Lebanon than in Jordan but decreased significantly with the passage of time in the host country. This is one example of the role of violence in promoting mental health maladaptation. However, cognitive-behavioral coping interventions have been suggested as a means of addressing posttraumatic environments. Study findings therefore indicated the need for appropriate mental health care assessments (Weissbecker et al., 2019) followed by appropriate therapeutic interventions (Khamis, 2019).

Social stigma differentially impacts women from case to case in ways that go beyond physical or mental health. In a study on disability experiences and the negotiation of disability identity among physically impaired women in Pakistan, Akbar (2018) highlighted the social stigmas and norms that hold women to be a burden and different ability meaning that one is nonfunctioning. Akbar found that these women upheld positive perceptions of impairments. They also viewed themselves as being able to

partake in the female roles of their society. In contrast, Syrian refugees in a Canadian population reported inaccessible health care aid in a study by Oda et al. (2017). In a follow-up study, Tuck et al. (2019) found that health care needs for these refugees were still unmet, with 42.6% of participants reporting difficulties accessing services to meet their needs. Many participants experienced postmigration socioeconomic hardships (Tuck et al., 2019). The authors concluded that services for refugees needed better coordination. The contrast between Akbar and Oda et al. suggests that even when women felt they could participate in society, they were limited in their ability to access services.

Social stigmas and norms can even affect such basics of life as cooking among refugees. Kaburu, Rosemary, and Mortimer (2019) conducted a cross-sectional study of the social influences that affect the use of solar cooking in Kakuma Refugee Camp in Kenya and found that the refugees tended to not use solar cooking due to social stigmas and social norms. Other factors included education level and family size. Higher education levels correlated with higher chances of using solar cooking. Bigger families also correlated with lower chances of using solar cooking (Kaburu, 2019).

Health Care Accessibility for Refugees

Health care issues have accompanied the growing numbers of refugees worldwide. Many refugees have reported difficulty gaining access to health care resources in their host countries (Schouler-Ocak et al., 2019), and infectious diseases among refugees mirror that of the diseases in their countries of origin (Abbas et al., 2018). Despite the health care needs of refugees, there is often a lack of needed care. Parajuli and Horey (2019) identified several barriers to refugees receiving the care they

need. One is the refugee's individual characteristics, sociocultural factors, and previous life experiences. A second barrier is the quality of available health care, including the experience and skill levels of the health care professionals providing this care. Finally, refugees often encounter problems related to their new living environment, including sociocultural mores and availability of basic living needs plus existing attitudes toward health care and health care professionals (Parajuli & Horey, 2019).

Another problem that arises is the lack of care-seeking behavior among refugees. After resettlement, many refugees exhibit poor health; however, these refugees rarely seek health care services, which researchers have attributed partly to cultural differences between refugees and doctors (Parajuli & Horey, 2019). Trust building needs to be addressed to improve accessibility of health care for refugees. There are respectful means of addressing refugees' needs. Culturally sensitive care should be implemented in these types of situations (Parajuli & Horey, 2019).

Refugees struggle when they have settled in their host countries. Hynie (2018) stated that it is not easy for refugees to integrate into new countries and communities. Settlement and immigration policies at multiple levels can affect how refugees integrate by being less welcoming and limiting refugees' access to different opportunities (Hynie, 2018). Refugees typically experience culture shock and stigmas caused by how communities in the host countries perceive refugees in general and people in the host countries trying to change refugees' beliefs regarding various aspects of health care; for example, beliefs that a man cannot treat a woman. At the same time, how people in developed host countries perceive people with different abilities can result in more

positive services for members of this population. Refugees with different abilities are at high risk of challenges due to cultural perceptions of their different abilities (Hynie, 2018). Not understanding their rights in the host country has also made it more difficult for refugees with different abilities to integrate (Hynie, 2018).

Perceptions of Causes of Refugees With Different Abilities

Refugees are people who have been forced to flee from their countries due to different social and political issues (WHO, 2018). Elder (2015) stated that every day around the world, people are displaced from their country of birth, are labeled as refugees, and are relocated to refugee camps. Since 2010, the numbers of refugee who were forcibly displaced from their homes due to war has substantially increased. These numbers include refugees from Syria, Iraq, Afghanistan, sub-Saharan Africa, Southeast Asia, and the Ukraine (Elder, 2015).

Perceptions of people with different abilities vary among countries (Elder, 2015). Elder (2015) posited that in developed countries, people with different abilities are viewed to have rights equal to people without different abilities as a way to celebrate human diversity. This contrasts with less-developed countries where the disabled are not given equal opportunities or are not perceived as deserving of such opportunities. As one example, Naami (2015) indicated that people with different abilities in African cultures have been viewed as individuals who are cursed and cannot function. African women with different abilities are particularly challenged, given their inability to get an education and the stigma surrounding their sexual and health needs. Besides the inherent cultural issues surrounding disabilities, Elder (2015) noted that the refugee label itself

caused different perceptions and challenges in refugees' host countries, with people of different abilities being perceived incorrectly. Elder (2015) suggested that refugees with different abilities need more opportunities to share their stories, which may help to change perceptions of them and improve perceptions of disability. The recommendation to educate the public was consistent with Naami, who recommended educating the public about the capabilities of those with disabilities as a possible way to bring about greater public awareness of what these women truly are and can do.

Challenges of Refugees in the Host Country

Various researchers have found that PTSD is a major challenge faced by refugees in their host countries. Bryant et al. (2018) posited that children and adolescents are the most affected by PTSD. Results from Bryant et al.'s study showed that postmigration difficulties were factors associated with PTSD and that harsh resettlement conditions also contributed to PTSD in refugee children and adolescents. Bryant et al. suggested programs to enhance refugee children's mental health to account for PTSD in parents and caregivers and enhance the parenting behaviors that these children are exposed to.

In a cross-sectional examination of Saudi Arabian newspaper articles, McCrae, Sharif, and Norman (2019) found that careless reporting of information and opinions on mental health reinforced negative social stigma. The researchers used descriptive and thematic analysis and found that the themes of the recurrence of treatment and recovery and blame cast a negative light on mental health. Being possessed by spirits was a recurring theme (McCrae et al., 2019). Suicide was also a prevalent issue in refugee populations (McCrae et al., 2019). McCrae et al.'s findings mirror those of Akotia,

Knizek, Hjelmeland, Kinyanda, and Osafo (2019), who noted existential and supernatural reasons for suicide as complex and not easy to understand as a humanitarian. Sociocultural implications are deeply woven into the lives of refugees (Akotia et al., 2019). McCrae et al. also noted that as a result of the stigma surrounding mental health, Ghanaians attempted suicide because of five reasons: lack of appropriate support, feelings of abandonment, feelings of shame, existential struggles, and attribution to supernatural causes.

The most common issues refugees fac are war trauma, national trauma, and lack of family communication, which can all lead to PTSD, psychological distress, and depression (Dalgaard, Diab, Montgomery, Qouta, & Punamäki, 2019). Dalgaard et al. (2019) identified these as constant factors in the lives of refugees that impacted their mental health. Refugee access to social services is also challenging. Dalgaard et al. (2019) further noted that language barriers and lack of understanding of refugee culture have played key roles in the social well-being of refugees with different abilities. Any attempt to approach the situation of refugees will at the same time be an approach to understanding a different culture (Dalgaard et al., 2019). Social services must, therefore, be informed by the cultural values of those in refugee status (Dalgaard et al., 2019).

Nongovernmental Organizations and Refugees

There has been a paradigm shift in how the disabled are supported. Bucher (2018) and Skarstad (2018) stated that refugees with disabilities have been overlooked, neglected, and marginalized in humanitarian responses. Humanitarian institutions have viewed people with different abilities as persons with needs and people who need to

receive aid rather than persons with abilities who can contribute to society (Bucher, 2018; Skarstad, 2018). Greenaway et al. (2018) posed some concerns regarding the health of those providing aid to refugees. To maintain health for caregivers during prearrival screening and during postarrival health care delivery, Greenaway et al. suggested screening for tuberculosis, chronic hepatitis B and C, HIV, strongyloidiasis, schistosomiasis, and Chagas disease and to provide vaccines to all caregivers. Greenaway et al. also noted that care must be taken to protect caregivers against common tropical infections. This call for international humanitarian nongovernmental institutions to address the issue of refugee with disabilities warrants further discussion (Bucher, 2018; Women's Refugee Commission, 2018). Skarstad posited that all people should be treated with same dignity and respect, including people with different abilities. Researchers have noted the importance for humanitarian organizations to provide not only aid but other social services as well as opportunities for inclusion and participation in the community and professional activities (Bucher, 2018; Skarstad, 2018).

Summary and Conclusion

This chapter was a review of the literature on refugee women, women with different abilities, and refugees with different abilities. First, Wendell's theory of disability was presented as a means to approach abilities as a social construct. Then, various theoretical and conceptual approaches to the issue of humanitarian aid for refugees were covered. The theoretical and conceptual approaches are numerous; however, ableism is of note as a functional conceptual framework when dealing with the issue of different abilities. The concepts of society and culture in light of ability were

then discussed. This included the living conditions and sociopolitical environments in which many refugees live. Obstacles refugees face in accessing health care in their host countries were briefly covered. Many refugees need health care services available in their host countries, yet they experience great difficulties accessing the care that is available.

Overall, the situation of female refugees with different abilities has yet to receive serious research attention. The topics surrounding and relating to female refugees with different physical abilities have been well studied, yet no researchers have directly studied the women themselves. It is for this reason that a gap exists in the current literature about refugee women with different physical abilities.

Chapter 3: Research Method

The purpose of this descriptive phenomenological study was to explore the lived experiences of refugee women with different abilities. The focus was on gaining a better understanding of the lived experiences of refugee women in Kenya with different abilities and the challenges they face daily due to lack of citizenry status as displaced people and their double vulnerability as differently abled females. The goal was to inform those who want to address the challenges of refugee women with different abilities in Kenya as displaced people who cannot return to their original countries.

In this chapter, I present the research design and rationale for the present study, followed by a discussion of my role as the researcher. I then detail the study methodology, including participant selection, instrumentation, recruitment procedures, participation, data collection, data analysis, issues of trustworthiness, and ethical issues and how they were addressed.

Research Design and Rationale

I sought to understand the lived experiences of a select group of refugee women with different physical abilities and value their experiences as valid interpretations of reality. For this reason, Colaizzi's descriptive phenomenological method (Morrow, Rodriguez, & King, 2015; Moustakas, 1994) was the most appropriate research approach to describe the experiences of refugee women with different abilities in Kenya. In qualitative research methodology, the researcher is considered the primary research instrument throughout the entire research process (Sutton & Austin, 2016). Sutton and Austin (2015) indicated that a qualitative method is appropriate for describing particular

situations and experiences of participants. Also, qualitative research is the most appropriate method for understanding the in-depth lived experiences of participants where they willingly discuss these experiences at a deeper level without restrictions that would accompany using a quantitative survey method (Moustakas, 1994; Sutton & Austin, 2015).

Researchers have used many approaches to understanding trauma and disability. Many researchers have focused on social and cultural aspects of refugees and the disabled, with a heavy emphasis on qualitative investigation of the experiences of these populations. Social lens explorations of the disadvantaged and disabled have revealed many qualitative approaches to exploring various forms of disadvantage, including engrained research in the community (Antunes & Dhoest, 2019), mixed methods approaches used to draw quantitative data contextualized by qualitative responses (Miles, 2018), and interviews to create the narratives of those disadvantaged in a community (Akbar, 2018). Heavy emphasis on qualitative investigation has limited the overall generalizability of many findings, although such research also provided the groundwork for understanding the perspectives of those who are disadvantaged. Statistical data have also been collected regarding the specific disadvantages of those in various communities, as exemplified in Tuck et al.'s (2019) study of Syrian refugees' health care needs and whether these needs were being met. The body of literature that quantitative data have yielded contains important information regarding statistical associations between various states of disadvantage and lack of various needs being met (Tuck et al., 2019). A review of this literature also suggested that quantitative approaches to exploring disadvantage

can be used to best understand what various groups lack regarding having their needs met (Tuck et al., 2019). However, qualitative research is useful in novel explorations of groups that had previously not been researched in depth. Such approaches are valuable not only for contextualizing quantitative data, but also for identifying unique phenomena in such groups that could then later be converted to quantifiable variables that might be explored in statistical research (Tuck et al., 2019).

Disability as a concept has been well researched, and this research has extended into various communities around the world. However, given the lack of research on the disabled in Kenya, a qualitative approach was deemed most appropriate because, like previous studies in which the experiences of those who are disadvantaged was explored, there was a lack of concrete variables from which a quantitative study might be created.

A descriptive phenomenological approach assumes that reality is not static but experienced over time and is understood differently by each person and each community (Englander, 2016). A descriptive phenomenological approach was therefore the best approach for the present study. Taking this approach facilitated gathering the information necessary to help me understand the life experiences of refugee women with different abilities in Nairobi, Kenya.

Role of the Researcher

Researchers play a critical role in the qualitative research process. According to Sutton and Austin (2016), the role that the researcher plays in a qualitative study increases the study credibility. I identified the target population in specific geographical areas, chose the appropriate participants, conducted interviews with participants, and

analyzed and interpreted the data collected, in accordance with guidance in Rahman (2017) and van Manen (1990). Another role of the researcher is to ensure data accuracy by preparing how it will be collected (Sutton & Austin, 2016). Interviews with study participants were the primary data source for the present study. Having been a refugee at a young age in the mid-1990s, it was important that I maintained the highest ethical standards throughout this study. I avoided comparing my previous situation with the participants' experiences. I also avoided judging participants' feelings so as to minimize bias during the interviews.

Methodology

Participant Selection

The target population for this study was refugee women with different physical abilities living in Nairobi, Kenya. Moustakas (1994) posited that study participants should have sufficient knowledge of the research topic to be able to answer interview questions so that researchers can collect meaningful data. Consequently, the criteria for participant selection for this study were female refugees with different physical abilities who were a minimum of 18 years of age at the time of the study and who had lived as refugees in Nairobi for at least 1 year. Participants could use their native languages, such as Swahili, Kinyarwanda, and French, which are three languages I also use. The participants had to have at least one verifiable different physical ability and must have been able to take part in an interview. These criteria had to be met for consideration as a study participant. I posted flyers in local public shops, grocery stores, open market

bulletin boards, and public bulletin boards near churches to recruit participants. See Appendix A for an example of the flyers.

Population and Sampling

Purposive criterion sampling (e.g., Gentles, Charles, Ploeg, & McKibbon, 2015; Sutton & Austin, 2015) was used to select study participants. This sampling method helped to determine the adequacy of the sample size and ensure that the sample represents the target population (see Gentles et al., 2015). I posted flyers on public bulletin boards to recruit study participants. Snowball sampling (e.g., Waters, 2015) was also used to identify participants. Through this approach, the initial group of participants was asked to identify others they knew with different physical abilities.

The goal was to select 10 participants. However, to insulate the study against natural attrition and sample mortality, I oversampled with the hope that there would be 12 women willing and interested in being part of the study or that I would reach saturation; that is, where no new information is revealed in additional interviews, in keeping with guidance by Moustakas (1994). Once the initial group of 12 participants was achieved, I stopped accepting additional potential participants.

Instrumentation

In qualitative research, the researcher is the primary instrument and may use face-to-face interviews, direct observation, emails (a newer interview approach), the phone, and document review to collect data (C. Marshall & Rossman, 2016; Sutton & Austin, 2016). For the present study, I used semistructured interviews, which are a highly functional type of instrumentation for collecting qualitative data and have been used

extensively by researchers and professionals (see Sutton & Austin, 2016). In-depth interviews were relevant for the present study because they help to make clear the participants' experiences and perspectives (see Oltmann, 2016; Sutton & Austin, 2015). I also used artifacts, such as documents, and keen observations of the physical environments of the participants' homes and their neighborhoods.

Recruitment, Participation, and Data Collection Procedures

After Walden University institutional review board approval was received (10-31-19-0665827), I began participant recruitment in the Nairobi refugee areas. I shared my phone number on the flyer and posted it on public announcement locations such as groceries and open market communication boards. Individuals who were willing to be interviewed were asked to call me to confirm their willingness to participate. During the confirmation call, I explained the study purpose and the voluntary nature of their participation. I also explained that there would be no financial benefit from study participation. Once participants consented to being part of the study, interviews were scheduled at times convenient to them. The interviews were conducted in the participants' homes. Conducting the interviews in the participants' homes was preferred as they are physically differently abled, and in-home interviews were more convenient for them. More importantly, participants in the comfort of their own homes were able to respond to questions more freely and with no fear.

At the appointed dates and times, I traveled to the participants' homes to conduct face-to-face interviews. Before commencing each interview, I clarified informed consent with the participant. The participant was then asked to sign the consent form. Participants

were then reminded that their participation in the study was voluntary and that they had the right to withdraw at any moment, choose not to answer a question, or stop the interview for any reason without need for disclosure. They were informed that their identities would remain confidential. They were again informed that there would be no benefits to participating in the study aside from knowing that the information obtained may lead to a better understanding of their lived experiences as refugee women with different physical abilities. I explained that the interview would take between 45 min to 1 hr and that short breaks of 5 min would be scheduled to provide both the participants and me time to rest or use the bathroom.

Each participant was also informed that the interview would be audio recorded in order to capture all information during the session. I then asked each participant if she agreed to be recorded. After confirmation, I set up the recording instrument.

As noted, the participants' spoken responses, which were audio recorded, were the primary data source. I used semistructured face-to-face interviews to gather data from the study participants. See Appendix B for examples of these questions in English and Swahili. I also took notes and made keen observations of the physical environments of the participants' homes and their neighborhoods. This reflected efforts to triangulate information and data (see Maguire & Delahunt, 2017). My observations of participants' environments helped to shed more light on their vulnerability levels and generate a deeper understand of the conditions in which they live.

Data were collected over 1 month, with at least three interviews planned per week. I debriefed each participant after the interview and informed them that follow-up

interviews may be conducted if there was a need for more data or to clarify information already collected. After the interview was over, I gave the participant the opportunity to add any additional information or ask any questions about the study.

Paper files will be stored for 5 years, then shredded. Audio files were transferred to my computer and deleted from the audio recording device at the closure of each interview. Electronic data files will also be stored for 5 years and then deleted.

Data Analysis Plan

Data analysis is a major process that highlights the credibility of qualitative research (Sutton & Austin, 2015). The ability to collect data, understand it, describe the information collected, and interpret participant experiences is what makes qualitative research credible (Loubere, 2017).

As suggested by Sutton and Austin (2015) and Maguire and Delahunt (2017), I manually transcribed the audio recordings after each participant's interview. It is important for participants to use the language of their choice so that they are more open in detailing their information (Loubere, 2017). As further suggested by Sutton and Austin, participants were only identified by pseudonyms in the transcripts. Once transcribed, I used thematic analysis to generate themes from the interview data. This process brings to light key themes of the lived experiences of study participants (see Maguire & Delahunt, 2017).

Data analysis begins with verbatim transcriptions of the interviews (Austin & Sutton, 2015; Maguire & Delahunt, 2017). The perspective of daily life is the essence of the matter and should be the focus of the interview (Loubere, 2017). I used the written

descriptions in their original and unadulterated forms to analyze the data collected. I read every word of the transcribed interviews or written descriptions to gain a general understanding of the participants' situations. I also employed member checking by providing the written transcript of each participant's interview to the participant to ensure the transcript accuracy. Member checking is very important for ensuring that all transcripts are correct (Gunawan, 2015). Because participants were advised of the possibility of follow-up calls in case I had any questions, member checking was done during the data collection time frame when participants were still available.

Once all transcript information was thoroughly reviewed, the data coding process commenced. Saldaña (2016) stated that "coding is just one of the way of analyzing qualitative data, not *the* way" (p. 3). Coding then refers to identifying topics, issues, similarities, and differences that are revealed through participant narratives and interpreted by the researcher. I used the qualitative analysis program NVivo to manage participant transcripts and for data tracking and coding. I used open coding and coded in cycles. Open coding involves codes that are derived from text (Saldaña, 2016). This means analyzing the text, which results in finding answers and emergent codes. Coding in cycles can help researchers develop deeper understandings of the data's meaning. Saldaña stated that coding is not just labeling, it is linking data to ideas and back to other data. This process involves comparing data codes and categories in and across transcripts and across variables deemed important to the study (Maguire & Delahunt, 2017; Sutton & Austin, 2015).

Issues of Trustworthiness

Qualitative research has been constantly critiqued, if not disparaged, by a lack of consensus on how to assess its quality and robustness (Leung, 2015). It is therefore imperative to understand the issues of trustworthiness. Researchers must demonstrate that their findings are credible, transferable, dependable, and confirmable.

Credibility

In the present study, credibility was established through triangulation of the data received through the interview process. This is to insure whether the data collected are clear and make sense (Gunawan, 2015). To ensure credibility, I employed member checking by having the study participants review the interview transcripts. Gunawan (2015) described member checking as either going back to participants or peer checking by using panel experts or experienced colleagues to analyze some of data. This is a vital step in qualitative research to ensure the quality and credibility of information collected. My observations of the physical environments of the participants' homes and neighborhoods were also used as additional data and information.

Transferability

Study transferability is when researchers demonstrate that study findings are applicable to other contexts, circumstances, and situations through thick descriptions of data collected (Gunawan, 2015; Nowell, Norris, White, & Moules, 2017). I used in-depth interviews and audio recorded each participant to capture all detailed information and provide thick and rich descriptions of the participants' experiences. Audio recording interviews with participants helps researchers to remember all important information and

can strengthen study findings (Nowell et al., 2017). As researchers cannot themselves prove the applicability of study findings, transferability of this study's findings are at the discretion of future researchers and will reflect their judgment of transferability.

Dependability

In qualitative research, researchers can use inquiry audits to establish dependability, which refers to whether findings from inquiry can be consistently replicated with the same subject or in a similar context (Gunawan, 2015). This includes detailing how the data are collected to ensure that the findings are consistent and could be repeated (Nowell et al., 2017). I established an audit trail, as described next, to detail how the data were collected.

Confirmability

Confirmability of research is based on participants' responses and not any potential bias or personal motivations of the researcher (Nowell et al., 2017). The interpretation and findings of the research must be clear, and all information must originate from the data collected (Nowell et al., 2017). According to Nowell et al., (2017), confirmability is established when credibility, transferability, and dependability are all achieved. It is important to establish confirmability of the study such as providing an audit trail. I established confirmability by using an audit trail to record and detail every data analysis step.

Ethical Procedures

Before each interview, I had the participants review and sign the informed consent forms. I suggested that a family member, relative, or caregiver be nearby in case

the participants needed help. The audio recordings will be filed for 5 years and deleted thereafter. All paper documents will also be kept for 5 years and deleted thereafter.

Summary

In Chapter 3, I covered the methodological procedures and data collection method that were used in this phenomenological study. Semistructured face-to-face interviews were conducted with study participants. Triangulation established dependability. Sensitive documents and files will be destroyed. Anonymity was maintained for the participants. Heidegger (2008) noted that a phenomenon is that which shows itself in itself. The descriptive phenomenological study discussed in this chapter may help to explain the phenomenon of refugee women in Kenya with different abilities.

Chapter 4: Results

The purpose of this descriptive phenomenological study was to explore the lived experiences of refugee women with different abilities. The focus was on gaining a better understanding of the lived experiences of refugee women in Kenya with different abilities and the challenges they face daily due to lack of citizenry status as displaced people and their additional vulnerability as differently abled women. The research question used to guide the study was, What are the lived experiences of refugee women with different physical abilities in Kenya seeking social services?

Chapter 4 includes a description of the data collection setting, followed by a presentation of relevant demographic characteristics of the study participants. Next is a description of the implementation of the data collection and data analysis procedures described in Chapter 3, followed by a discussion of the evidence of the trustworthiness of the findings. then present the study results. A summary concludes the chapter.

Study Setting

One-on-one, face-to-face interviews were conducted in participants’ homes at a time of each participant’s choice. Before I began each interview, I reviewed the terms of informed consent, including the right to withdraw and the assurance that all reasonable precautions would be taken to ensure confidentiality. Conducting the interviews in participants’ homes and reviewing and discussing their rights prior to beginning the interviews was intended in part to help the participants feel as comfortable as possible, to protect them from any distress, and to facilitate rich and candid responses to the interview questions. Conducting the interviews at a time of each participant’s choice allowed them

to provide full responses without feeling pressured to attend to other obligations. No adverse conditions arose during data collection, and there were no conditions that might have influenced the interpretation of the results.

Demographics

The study sample was 10 female refugees with different physical abilities who were a minimum of 18 years of age and who had lived as refugees in Nairobi, Kenya, for at least 1 year at the time of the study. Unless otherwise noted, all different abilities among the study participants were acquired rather than congenital. Table 1 shows the participants' relevant demographic characteristics.

Table 1

*Participant Demographics (*N = *10)*

Country of origin	# of participants	Age range (in years)	Nature of disability	Education
Burundi	3 (Participants 8, 9 & 10)	19 to 32	1 with sensitivity to sunlight; cannot go outside without severe sunburn. 2 lost legs during the war.	All completed high school.
Democratic Republic of Congo	5 (Participants 2, 4, 5, & 7)	18–65	All 5 lost legs.	2 completed high school; 3 never attended school.
Rwanda	2 (Participants 3 and 6)	22–35	1 with paralyzed leg, 1 with impaired vision.	All completed high school.

Data Collection

Interviews were conducted with the 10 participants. They were interviewed face-to-face in their homes. Interview duration was approximately 50 min. All interviews were

audio recorded with a digital recorder. There were no variations from the data collection plan described in Chapter 3, and no unexpected or unusual circumstances were encountered.

Data Analysis

After each interview, I transcribed the audio recording verbatim into a Word document. I then asked each participant to review her transcript to ensure accuracy, as discussed in greater detail in the Evidence of Trustworthiness section of this chapter. Next, I translated the transcripts into English and uploaded them into NVivo 12 software. I read and reread the transcripts in NVivo to gain familiarity with the data and then began the initial open coding cycle by identifying topics, issues, similarities, and differences revealed through the participants' narratives (see Saldaña, 2016). I placed transcript excerpts that expressed similar themes and ideas into child nodes in NVivo, which I labeled descriptively. The child nodes represented codes. I continually reviewed and refined the codes as additional data clarified the emerging patterns.

Next, I grouped similar codes into themes. This process involved grouping NVivo child nodes that expressed similar perceptions and experiences under a parent node, which represented a theme. The theming process involved further cycles of reviewing and refining the data, as I continually compared data within and across themes to ensure that transcript excerpts were appropriately categorized and emerging themes accurately represented the participants' experiences and perceptions. Lastly, I named and defined the emergent themes to clarify their relevance to the research question, and I created the presentation of results that is included in this chapter. Table 2 indicates the codes that

emerged during open coding and their frequencies (i.e., the number of times the perception or experience represented by each code was mentioned across all participants). Table 3 shows how the open codes were grouped into emergent themes.

Table 2

Open Code Frequencies and Sample Participant Quotes

Open code	*n*	Sample quote
Challenge of meeting daily needs	15	Due to my physical limitation, I depend mostly on other people helping me . . . It is a daily struggle for me, as a young girl under 30 years old, not being able to provide for myself. (Participant 4)
Connecting with other refugees	5	Some people who lived with us back in DRC and who went through the same [displacement] were already in Kenya. They really helped me to get settled. (Participant 1)
Different ability regarded as a burden on others	9	Some people think that we are useless in this world, we cannot do anything, and we are a burden to the family and others. (Participant 1)
Experiencing different abilities	9	My daily experience is a struggle, knowing that I have become so limited and can no longer even provide meals for my children. (Participant 7)
Family and friends can only help so much	4	Sometimes church friends help with food, sugar, or vegetables, but other times we don't have anything for the day. (Participant 3)
Initial temporary assistance not enough	1	[My church] helped me with rent for 2 months. After that, life has been very hard. (Participant 1)
Joining a church community	7	Integrating with other Kenyan communities came after I learned basic things from other refugees who I met [in my church]. (Participant 2)
Lack of healthcare coverage is a major challenge	9	Here in Kenya, the health department does not recognize us, and the UNHCR does not cover all health needs. I am very scared for the life of my child. (Participant 10)
Lack of transportation as the biggest challenge	10	Transportation to go to church or even to clinics is a challenge. For me to get someone to provide transportation, I have to wait a long time, for whenever someone is available. (Participant 8)
Language barrier increases reliance on other refugees	6	We met with other refugees from Burundi. I was glad to see them and speak the same language. (Participant 9)

(table continues)

Open code	*n*	Sample quote
Living in overcrowded housing	2	It has been a painful life of living in a single bedroom with seven children. Still, we cannot afford this single bedroom. (Participant 7)
NGOs and church have a lot of refugees to help	6	Although the church has helped me [with my rent], they cannot do so every month, because they have many other refugees that they help. (Participant 10)
No consistent or permanent support	2	There is no consistent or permanent support that I receive, only one-time supports. (Participant 4)
Traumatic violence in country of origin	10	I left Rwanda during the genocide . . . I lost part of my leg, and my husband was killed. (Participant 6)
Unable to afford children's schooling	2	I cannot provide school fees for my children. Seeing my children not going to school like other children has been a daily challenge and painful to see. (Participant 4)
Unmet need for assistance equipment	5	For me to move from one place to another, I have to crawl. I wish I could have a wheelchair. (Participant 5)
Unmet need for education	4	My biggest need is to have access to education. (Participant 5)
Unmet need for mental health counseling	2	Sometimes my kids have bad dreams and scream at night. There is a huge need for counseling facilities. (Participant 6)
Working is a challenge	6	I am not able to do any work due to my condition. So it has been very hard to depend on one person’s income. (Participant 6)

Note. DRC = Democratic Republic of Congo; UNHCR = United Nations High Commissioner for Refugees; NGOs = nongovernmental organizations.

Table 3

Grouping of Codes Into Emergent Themes

Emergent theme	Open codes grouped into theme
Fleeing traumatic violence in the country of origin	Traumatic violence in country of origin
Gratitude for supportive social networks	Connecting with other refugees
	Joining a church community
	Language barrier increases reliance on other refugees
The hardship of inadequate support for basic needs	Family and friends can only help so much
	Initial temporary assistance not enough
	NGOs and church have a lot of refugees to help
	No consistent or permanent support
The anxiety, frustration, and shame of dependence	Challenge of meeting daily needs
	Experiencing different ability
	Different ability regarded as a burden on others
	Unable to afford children's schooling
	Living in overcrowded housing
	Working
The distress of living with unmet needs	Unmet need for mental health counseling
	Unmet need for language instruction, education, training
	Lack of transportation as the biggest challenge
	Unmet need for assistance equipment

Note. NGOs = nongovernmental organizations.

Evidence of Trustworthiness

Procedures were used to enhance each of the elements of trustworthiness identified by Lincoln and Guba (1985). The elements of trustworthiness are credibility, transferability, dependability, and confirmability. These components are analogous to the quantitative constructs of internal validity, external validity, reliability, and objectivity, respectively.

Credibility

Qualitative findings are credible to the extent that they accurately represent the reality they are intended to describe (Gunawan, 2015; Lincoln & Guba, 1985). The credibility of the results in this study was strengthened through the audio recording of interviews and member checking of transcripts. After I transcribed the audio-recorded interviews verbatim, I provided each participant with a printed copy of her transcript in her native language and asked her to read it and either confirm its accuracy or indicate corrections. In the case of Participant 3, whose vision is impaired, I read the transcript aloud to her in her home. All participants confirmed the accuracy of their transcripts. Member checking was conducted because the accuracy of results can be damaged by errors in transcription.

The credibility of results can also be weakened if participants intentionally or unintentionally provide inaccurate data. To encourage the participants to answer honestly, I assured them their identities would be kept confidential. Member checking allowed the participants to confirm that their responses were not inadvertently inaccurate by giving them an opportunity to review their responses at a later time, without the pressure that

might be associated with answering questions extemporaneously during an audio-recorded interview.

Transferability

Qualitative results are transferable to the extent they hold true for other populations and samples (Gunawan, 2015; Lincoln & Guba, 1985). To assist future researchers in assessing transferability, I provided detailed descriptions of the study population and sample. I also included many direct quotes in the presentation of results as examples of the rich descriptions found in them and to report the participants' experiences in their own words.

Dependability

Qualitative results are dependable to the extent that they would be replicated if the study were repeated at another time in the same research context (Gunawan, 2015; Lincoln & Guba, 1985). To enhance the dependability of the results in this study, I conducted member checking of transcripts. I also created an audit trail detailing the decisions I made during the study, and I provided detailed descriptions of the study procedures, as recommended by Nowell et al. (2017).

Confirmability

Qualitative results are confirmable to the extent that they represent the perceptions and opinions of the study participants rather than the researcher's biases (Lincoln & Guba, 1985; Nowell et al., 2017). Nowell et al. (2017) stated that confirmability is established when credibility, transferability, and dependability are

achieved. Thus, the procedures used to strengthen the other three elements of trustworthiness also contributed to the confirmability of the results in this study.

Study Results

The research question that guided this study was, What are the lived experiences of refugee women with different physical abilities in Kenya seeking social services? The following presentation of results is organized by theme. Five themes emerged during data analysis to answer the research question: (a) fleeing traumatic violence in the country of origin; (b) gratitude for supportive social networks; (c) the hardship of inadequate support for basic needs; (d) the anxiety, frustration, and shame of dependence; and (e) the distress of living with unmet needs. The ordering of the themes in this presentation is intended to approximate the chronological ordering of the experiences they are used to describe. Table 4 shows the frequencies of the emergent themes.

Table 4

Emergent Themes and Frequencies

Emergent theme	*n*
Fleeing traumatic violence in the country of origin	10
Gratitude for supportive social networks	18
The hardship of inadequate support for basic needs	13
The anxiety, frustration, and shame of dependence	43
The distress of living with unmet needs	30

Theme 1: Fleeing Traumatic Violence in the Country of Origin

All participants sought refugee status in Kenya because they were fleeing violence associated with ethnic conflicts in their home countries of the Democratic Republic of Congo (which some participants referred to by the acronym DRC), Rwanda, or Burundi. Eight participants became differently abled when they were victimized by ethnic violence, and most participants also reported that members of their immediate families had been murdered. Participant 1, for example, stated, “I arrived in Nairobi [in] 2016 from the Democratic Republic of Congo. I left my country due to war in which I lost my family members and both of my legs.” Participant 4 provided a similar account:

> I am from the DRC. I left my country due to civil war, and that was when I lost my left leg, due to rebels shooting in the village where I was living. I had four siblings, but one died, and currently we are three remaining.

Participant 3 reported similar experiences of victimization in ethnic violence, but she did not report murders of relatives.

> I was born in DRC and lived there until the ethnic war in the village started and I lost my left leg, completely cut off to knee level. I fled to Kenya with my seven siblings: two girls and five boys.

Participant 7 stated, “I am from Congo and fled my country due to war. I came with my husband and seven children.” Participant 6, who left Rwanda during the genocide, said she lost part of one leg and her husband as a result of ethnic violence in her country of origin. Participant 2 had fled the same wars as Participants 1 and 4. Participant 4 stated, “I am from the Democratic Republic of Congo. I live here in Nairobi

and I am a refugee by status due to war in my country." Participant 10 immigrated with her family to escape violence and said, "I came from Burundi with my family and children. We fled Burundi due to ethnic fights that have been going on for years now. My left leg was cut short, and that was how I became handicapped." Participant 8 also fled from violence in Burundi and the ethnic conflicts that have continued there for many years.

Two participants are not differently abled because of victimization in ethnic violence. However, both are also refugees who had fled traumatic violence in their countries of origin, so their experiences supported Theme 1. Participant 2, whose different ability is associated with her sensitivity to sunlight, detailed her reason for seeking refugee status in Kenya: "I left my country Congo because of war and now I live in Nairobi." Participant 9 said, "I was born with a disability. My legs cannot function at all. My way of walking is by crawling." Participant 9 said of attaining refugee status in Kenya after fleeing violence in Burundi, "I was happy, because I had peace of mind in knowing that I will not be afraid to sleep at night."

Theme 2: Gratitude for Supportive Social Networks

All 10 participants reported that they had relied on at least one social network to help them partially integrate into Kenyan society. These social networks included churches participants joined after arriving in Nairobi, family members who were already living in Kenya as refugees, and networks of refugees from the participants' home villages or regions. Five participants networked with other refugees for help with basic needs and integration, including family and friends from their country of origin.

Participant 1 received assistance in learning rudimentary language skills through acquaintances from her country of origin.

> Some people who lived with us back in DRC and who went through the same [displacement] were already in Kenya. They really helped me to get settled, and they taught me basic [language skills] such as how to ask for things or help.

Participant 4 reported being welcomed by other refugees. “On our arrival, we were welcomed by other refugees who had arrived in Kenya before us. These friends helped us on our arrival and took us to the UNHCR to be registered for refugee status.” Participant 6 received temporary accommodations for her family from a friend of fellow refugees. “Some friends connected me with their friend in Kenya, who accepted to host me for few weeks with my kids and brother.” Participant 10 networked through her brother, who was already in Kenya. “My brother fled before us. He was already in Kenya, and he is the one who helped me to integrate into the community and helped me with all basics needs.” Participant 8 networked through her mother, who joined a church on the recommendation of a fellow refugee, and said, “My mom was connected with another refugee, who connected her with a church where my mom started attending and she was welcomed.”

Seven participants received support from their churches during their integration. Unlike individual refugees, churches are well resourced and can provide tangible assistance with necessities such as rent and food. Participant 1 received assistance from her church with integration and other basic needs. She said, “I joined [my church], which

played a big role in supporting me with basics on my arrival such as food, 2 months' rent, and clothing." Participant 2, who attended the same church as Participant 1, stated,

> My first week, I attended [my church], where we met other refugees like us. [My church] is located near the refugee community, closer to where many of the Congo refugees in Nairobi live. We then met many refugees with whom we had suffered together. I was happy that I met people that I knew before, and I trusted that they could also help. It was then easier for me to stay connected with the church members in case I need help. Integrating with other Kenyan communities came after I learned basic things from other refugees, who I met [in my church]. [Church] was very helpful for me.

Participant 3's brother visited several churches in Nairobi before selecting the one their family joined. She said,

> I live with my younger brother and my mother. We survived the genocide [in Rwanda]. My younger brother was the first who started looking for other people like us, refugees, and visiting different churches near where we live. He eventually met someone who directed him to a community church, and we started attending the church. From that time, the church people welcomed us.

Participant 5 attended the same refugee church as Participants 1 and 2. She reported that the church had helped her integrate into refugee and native social networks and that it assisted her family with practical necessities. In addition, her membership in the congregation was a vital source of emotional support during her integration process.

> A refugee church welcomed us, and we found some other friends from our village in that church. The church helped us with food, rent for 2 months, so we [were able to settle in Nairobi]. [The church] helped us a lot on our arrival and paved a warm welcome for us. I was impressed with the love, and after a few weeks, I realized this church has been the major support in welcoming refugees from different places. It is a refugee place, where every refugee around the community can run for emergency help. The church also helped to connect us with other Kenyan communities.

Participant 9 said of her membership in her refugee church that it was a relief to be able to communicate fluently, in her native language, with other members of the congregation: “Within 2 weeks of our arrival, my brother took me to church, and we met with other refugees from Burundi. I was glad to see them and speak the same language.”

As Participant 9’s experience suggested, some participants (five out of 10) found their lack of proficiency in Nairobi’s dialect of Swahili to be a barrier to their integration. Networking with other refugees gave them opportunities to communicate in their native language and helped them acquire needed language skills. Participant 3 stated that language had been a barrier to her integration. “It was very hard to integrate into the Kenyan community. . . . The Kenyan Swahili is different from the Swahili I spoke in Rwanda, [so] I was only able to communicate a little bit.” Participant 5 also identified language as the hardest challenge in her integration process. Participant 8’s experiences were similar. She said, “When we arrived in Kenya, it wasn’t easy for me because of the limitation of the language. I did not know how to ask for help.” The language barrier

increased participants' dependence on networks of fellow refugees and the churches that serve refugees because they needed assistance in meeting basic needs and acquiring language skills. As Participant 1 stated of her fellow refugees in Nairobi, "They taught me basic [language skills], such as how to ask for things or help."

Theme 3: The Hardship of Inadequate Support for Basic Needs

As discussed in relation to previous themes, all of the participants reported that they and their families received assistance in meeting their basic needs from fellow refugees and from churches that serve refugees. All 10 participants also reported, however, that because of the large number of refugees in Nairobi and the resulting high demand for assistance and services, their own needs were only met temporarily or occasionally. All the participants lived with family members, but the family members were often unable to meet the participants' basic needs because they were away at work or are also differently abled. Participant 1 stated that she received only temporary assistance and that her family had to struggle when formal supports ended.

> I received help when I arrived. The first 3 months, old friends from DRC that arrived in Kenya before were able to help me with kitchen stuff, clothing. [My church] helped me with rent for 2 months. After that, life has been very hard. My younger brother who we live with in the same, single room, he tries to sell African women [fabric] so we can have food that day. I also live with my mother, who was born handicapped and cannot do anything either. Sometimes we have one meal per day, and at other times we get a friend who feels sorry for us and brings milk for the children.

Participant 10 also relied on a brother for support, but his other obligations prevented him from providing all the supports she needed. The rent assistance Participant 10 received from her church was temporary because of high demand. She said, “It has been very hard to get someone to help with rent. Although the church has helped me, they cannot do so every month, because they have many other refugees that they help.” Participant 2 also received assistance, but it did not meet all her basic needs. She said,

> It is not easy to get help from other people . . . The church sometimes collects donations from different people and other churches to support vulnerable people. The pastor then distributes food one time, or clothing, or whatever donations the church received. But it does not cover daily needs, such as meals for lunch and dinner, or transportation when it is needed to go to UNHCR or look for other organizations to ask for help.

Participant 3 reported that her family was unable to obtain a sufficient amount of food. “Sometimes church friends help with food, sugar, or vegetables, but other times we don’t have anything for the day.” Participant 4 described social supports as temporary and inconsistent, resulting in unmet needs for basic supports. “Some of the needs that I have received [assistance with] are women’s dresses that the church received from different people who donate . . . There is no consistent or permanent support that I receive, only one-time supports.”

Theme 4: The Anxiety, Frustration, and Shame of Dependence

In addition to citing the temporary or inconsistent nature of social supports for refugees, all study participants reported frustration that their different abilities prevented

them from being self-supporting. The primary way in which participants' different abilities precluded independence was by limiting their employment opportunities. For example, Participant 4 said,

> Maisha siyo raisi, san asana kwa watu wanao kuwa na ulemavu na hawawezi ku fanya kazi yoyote yaku leta chakula, kulipa nyumba and kununuwa nguwo. Kwaajili ya ulemavu wangu, uwa nangoja usaidizi kutoka watu mbalimbali, kama watu wa kanisa. Ni shida kabisa ya kila siku kuwa mu sichina mudogo kama mimi wa miya 30 na siwe kujisaidiya.
>
> [Life is not easy, especially with my physical needs that prevent me from performing work that can help with my daily basic needs, such as food, rental, and clothing. Due to my physical limitation, I depend mostly on other people helping me, especially members of the local church I attend. It is a daily struggle for me, as a young girl under 30 years old, not being able to provide for myself.]

Participant 5 expressed a desire to leave Kenya because she perceived employment opportunities for persons with different abilities as unfairly restricted there.

> Maisha yangu yakila siku yana tegemeya kwa wa dada na kaka zangu. [My daily life depends on my siblings.] If God blesses them with some food, then they bring it home. But if they don't receive any support, then they have to run to church ask for help, and if the church does not support us, we have a day without food. It is challenging to depend on others, especially when those people have other issues and commitments. The only way I manage these challenges is by trusting God that it is only [temporary], and one day I will leave Kenya and resettle in a

developed country, where people with disabilities have the same opportunities as others.

Participant 7 expressed the anxiety she felt in being unable to provide for her children as a result of her different ability: “Uwa sijuwe njisi kesho yaweza kuwa” [I am living a life of uncertainty]. She continued,

> I don’t know what tomorrow will look like. My daily experience is a struggle, knowing that I have become so limited and can no longer even provide meals for my children . . . I do really experience hardship every single day . . . I always call for church friends to help, and sometimes I have one or two who come, but sometimes I don’t get anyone because they are also busy. I always wish there was a service to help people like me with our basic needs.

Participant 9 reported a similar experience of the anxiety of forced dependence on inconsistent supports.

> My day-to-day challenge is that I do not have assurances of what tomorrow looks like for me. Especially with my basic needs such as food, rent, and transportation, I depend on asking and asking . . . The only way I manage my challenges is by praying to God to touch someone to help me.

Participant 1 experienced her different ability and resulting dependence as a state of perpetually waiting for charity.

> Maisha yangu ni maisha yaku ngoja usaidizi wamaitaji yangu kutoka kwa watu. [I live a life of waiting for someone to provide for my needs.] Hata usaidizi wa gari yaku nifikisha kanisa. [This includes even transportation to go to church.] As a

> Christian believer, it has been very hard for me to know that my choices are very limited. Hata nguwo ya kuva, lazima nikubali ile ambayo napokeya. [Even for what to wear, I have to accept what is available.]

Participant 4 also described the experience of waiting for charity, and she described her frustration in being unable to function as she had before her victimization in ethnic violence.

> Kuwa nilizaliwa muzima bila ulemavu, kisha badaadaye sasa naitwa kilema na sijiwezi. Imekuwa ngumu kwangu sana kwasababu ya kukosa kujiweza kwa mamambo mengi nilikuwa niki wezakufanya na sasa siwezi. Imekuwa piya uzinu kwakuwa hata watu waliyo nijuwa mbeleni kwa mambo nilifnya lakini sasa wa nisogeleye. [Having been born normal, with all parts of my body, and now being called handicapped and disabled—it has been very difficult for me, especially because of the limitations of many things that I used to do. Now I cannot do them. It has been hard to believe that even people who knew my capability of doing different activities now cannot approach me for anything.] Najiisi kuwa mimi siyo wa maana! [I feel useless!] Siwezi kufanya kitu kama wengine, lakini nangoja tu usaidizi kila siku! [I cannot contribute, but rather have to wait for help every single day!]

Participant 9 perceived herself as dependent on the forbearance of anyone who might want to harm or exploit her and as living in fear because she could not defend herself.

> I have experienced thieves coming into the house and taking small things I had. I live a life of fear every single day, especially fearing to be raped. A refugee lady who is also disabled was raped recently, and when I heard that, I was very much afraid. I am now in daily fear for my life, because I know if someone comes to me with the purpose of raping me, they will [succeed], because I am disabled.

Because of her dependence on her younger brother as their household's sole provider, Participant 7 experienced the challenge of living as one of seven people in a single room.

> We are seven people in this single bedroom. Three of the kids are under 18 years old, and two of my own are 2 years old, they are twins. This single bedroom is very small for seven people, and sometimes my brother is not able to pay full rent, because he is the only provider.

The anxiety and frustration of dependence were exacerbated for participants by prejudices against them. Participants reported that discriminatory attitudes toward the differently abled included the belief that they were useless and a burden, and some participants struggled with internalizations of these beliefs. Participant 5 described how discrimination limited her opportunities to become less dependent.

> I have asked for training in tailoring, so I'll be able to make African women dresses to sell and help my siblings with house expenses. It is painful to know that I am capable of doing some things, or contributing, or even getting an education, but our society does not provide it, they shut down our lives because of our disability. I can use my hands and work, I can read and help with some things, I

> also have some ideas to contribute in projects as I used to participate in school. Having once been proactively involved in many different activities, it has been painful that now no one sees me or approaches to ask what I can do.

She added, “Maisha yaweza kuwa na mpaka.” [Life can be very limited.]

Like Participant 5, Participant 8 stated that being regarded as a burden is painful and limiting.

> Usaidizi wote watoka kwa jamii langu, hata kwenda kwa choo and napiya kuoshwa. [I depend on family support, even going to the restroom or taking a shower.] Uwa naisi kama, mimi ni mzigo kwajamii langu piya naisi kama mimi si kitu duniani. [I always feel I am a burden to my family, and I am meaningless to the world. Sometimes I feel no sense of living.] Wakati natoka inje, watu wananiangaliya sana kwa ulemavu wangu, nan a jisikiya vibaya sana. [When I get help to go outside, people stare at me, and I feel very bad] . . . The challenge I experience every day is my self-esteem. I feel very useless and cannot help my mom. I feel that people look down on me as a burden.

Participant 1 explained how cultural factors contributed to the discrimination she and other differently abled persons experience: “Kuwa kilema nikama kitusu.” [Being handicapped is a huge challenge in our African beliefs.] “Some people think that we are useless in this world, we cannot do anything, and we are a burden to the family and others.” Participant 3 experienced being differently abled as “like an insult” in African culture. “Being handicapped in Africa is like an insult. People are disgraced, not given

opportunity to perform like others, and we are pushed away. My hope is that one day we will have a voice and live like others."

Theme 5: The Distress of Living With Unmet Needs

As a result of the dependence resulting from their different abilities and of the necessity of relying on temporary or inconsistent supports for assistance in meeting basic needs, all 10 participants reported that their experiences include living with unmet needs. Eight participants reported that they experienced an unmet need for health care coverage and that this unmet need caused them significant distress because they could not obtain adequate medical care without better coverage than they currently have. Participant 1 stated, "Although the UNHCR provides some portion of health insurance, it does not cover everything. "Mara nakuwa mugojwa, lakini siwezi tutzwa kwa shida zote kwa sababu UNHCRK halipi malipo ya magojwa yote." [It is very challenging to me when I get sick and I cannot get a complete treatment because of the limitation in the UNHCRK coverage.] Participant 10 reported that her unmet need for healthcare coverage caused her significant fear for the sake of her sick child.

> My kid has epilepsy. He needs to be on medication all the time. Here in Kenya, the health department does not recognize us, and the UNHCR does not cover all health needs. I am very scared for the life of my child.

Participant 2 had an urgent need for health care coverage that would facilitate treatment of her sunlight sensitivity, but she could not meet it, with the result that she was confined to her house. She said, "The UNHCR cannot provide insurance for my condition. It has been a very difficult life of staying in the house with no hope of any help

. . . I have become unable to function or do many things." Participant 6 could not obtain treatment for her pain because her insurance did not cover it, and stated, "Kuna siku nakuwa na maumivi mingi kwa muguu wangu na nivigumu kutibiwa kwa sababu, hospitali haiwezi nitibu mpka niwe na pesa mukononi." [Some days I have pain in my leg, and it is difficult because the hospital will not help unless I have money or insurance. And yet the UNHCR insurance for refugees does not cover my condition.]

Participant 7 had a progressive infection in her injured leg at the time of her interview, and she was unable to obtain treatment without better health insurance. She said, "Mimi itaji langu kubwa ni kupewa matibabu kwa muguu wangu, kwasababu muguu una oza na sijuwe nita fanya nini." [The most urgent need that I have currently is health insurance, so that I get full treatment for my leg. I have an infection now, and it is becoming worse, and I don't know what will happen.] Participant 6 also described coverage and provision of trauma-focused counseling for atrocity survivors as an urgent and unmet health care need.

> We witnessed rebels killing our family members and also shooting me. My children have been affected especially by watching me being raped during the war. I wish we could have service counseling and a trauma program to help our children not to live in fear all their lives . . . Sometimes my kids have bad dreams and scream at night. There is a huge need for counseling facilities.

Seven participants regarded inadequate access to transportation as a distressing unmet need because it prevents them from traveling to churches and nongovernmental organizations to seek assistance with their basic needs. Participant 2 stated that relying on

volunteers to help her travel to assistance sources resulted in long delays. “Traveling to reach out to other organizations is very difficult due to my condition. And to get someone to take me, I have to wait for weeks.” Participant 8 also experienced distressing delays caused by having to wait for someone to assist her with transportation. “Transportation to go to church or even to clinics is a challenge. For me to get someone to provide transportation, I have to wait for a long time, for whenever someone is available.”

Participant 4 described her unmet need for transportation as the greatest challenge she experienced as a differently abled refugee in Nairobi: “Kwenda maali nivigumu sana, hata kutoka fasi moja na nyingine. Na nivigumu hata kufikiya marafiki wenye wangeliweza kunisaidiya.” [Transportation has been the most challenging (unmet need), even to move from one location to another. Very limiting, even to reach out to friends who can help]. It is very hard to manage.” Because she lacks transportation, Participant 7 said she missed appointments in which she hoped to receive assistance. “Sina rafiki ama sijuwe mtu mwenye ana gari kwa kunisaidiya and siwezi tumiya gari za wana inchi wote kwaajili ya mguu wangu vile ulivyo.” [I have been having many appointments, but I miss them because of the transportation issue. No friends or people I know have a car, and I cannot use public transportation due to my leg.]

Four participants reported distress because their unmet needs for assistance equipment increased their dependence on others. For Participant 1, not having a wheelchair reduces her to crawling. “For me to move from one place to another, I have to crawl. I wish I could have a wheelchair, that’s the only way I would be able to move from one place to another.” Participant 4 experienced her unmet need for crutches as a cause of

distress. “One of my biggest needs is that I tried to ask for handicap equipment such as handgrips and elbow crutches, but I did not receive these, and it has been very challenging and made life more difficult.” Participant 5 associated her unmet need for hand crutches with her inadequate healthcare coverage. “These hand crutches are weak now and cannot last for long. I have tried to request a replacement for a long time, but I have not been approved. The health insurance we were given does not cover handicap equipment.”

Three participants reported distress resulting from their unmet need for education and training. Participant 3 described her unmet need for education as a factor contributing to her dependence and the distress she associated with it, as discussed in relation to Theme 4:

> I fully believe that if I can have an opportunity to learn and help my mother to make women dresses, we will have enough to live . . . I am still young, and I know I can learn other skills, but I don’t have any access to basic education.

Participant 5 also identified having access to education as her biggest need, and said, “Maitaji yangu kubwa ni kuwa na namna ya kwenda shule.” [My biggest need is to have access to education.] As with other unmet needs, participants perceived their unmet needs for education as perpetuating their inability to meet their own needs and as contributing to the anxiety, frustration, and shame their dependence causes them to feel.

Summary

One research question guided this study, What are the lived experiences of refugee women with different physical abilities in Kenya seeking social services? Five

major themes emerged during data analysis to describe the lived experiences of differently abled women refugees in Nairobi: (a) fleeing traumatic violence in the country of origin; (b) gratitude for supportive social networks; (c) the hardship of inadequate support for basic needs; (d) the anxiety, frustration, and shame of dependence, and (e) the distress of living with unmet needs. In Chapter 5, I discuss and interpret these results. I also offer implications suggested by them and suggestions for further research.

Chapter 5: Discussion

The purpose of this phenomenological study was to explore the lived experiences of refugee women with different physical abilities, specifically regarding challenges related to accessing services in Kenya. The problem I sought to address is the gap in what is known pertaining to the environmental factors that are barriers for refugees seeking social services. To address this gap, I employed a descriptive phenomenological approach to gather qualitative data through semistructured interviews with 10 refugee women with different abilities living in Nairobi, Kenya. Wendell's (1996) feminist theory of disabilities and the negative body was employed to help answer this study's research question, What are the lived experiences of refugee women with different physical abilities in Kenya seeking social services? In this chapter, I review the study findings and analyze them in order to gain a deeper understanding of the lived experiences of these women.

Emergent Themes

I identified five emergent themes that contribute to fostering the understanding sought in this study: (a) fleeing traumatic violence in the country of origin; (b) gratitude for supportive social networks; (c) the hardship of inadequate support for basic needs; (d) the anxiety, frustration, and shame of dependence; and (e) the distress of living with unmet needs. The study participants were living as refugees with barriers to accessing social services, and even their basic needs were sometimes not met. Other findings were that the participants were unable to provide for children, had mental health problems, and lived under fear of dependence on others and discrimination from others. Through

analysis of these themes, I concluded that serious social change is needed to improve the lived experience of refugee women living with different abilities in Nairobi, Kenya.

Interpretation of the Findings

Five emergent themes were identified as a result of the data analysis conducted for this study. In the following sections, I discuss each theme and analyze them to extend the current understanding of the lived experience of refugee women living with different physical abilities in Nairobi, Kenya. I employed Wendell's (1996) feminist theory of disabilities as the lens for this analysis.

Theme 1: Fleeing Traumatic Violence in the Country of Origin

All study participants were placed under refugee status after fleeing their home nations of the Democratic Republic of Congo, Rwanda, or Burundi, with eight of the participants becoming disabled as a result of ethnic violence in their home nation. Participants also reported familial deaths and murders as a result of the ethnic violence. These results shed light on the likelihood that the participants are at significant risk of suffering mental health challenges from the trauma and stress of violent displacement. This finding relates to the work conducted by Wendell (1996) in that the impact of stress and trauma is a normalized lived experience for refugee women with different physical abilities, leaving them at risk of depression and anxiety and open to exploitation (Regev & Slonim-Nevo, 2019). This finding also reflects research by Dalgaard et al. (2019) and McCrae et al. (2019), who stated that the most common issues that refugee women face are war trauma and national trauma, which contribute to comorbidities of physical disabilities and mental health conditions. However, Participant 9 also indicated a sense of

happiness once her refugee status was obtained, suggesting that the relief of becoming a refugee may alleviate some risk of PTSD and other mental health conditions frequently identified within refugee populations. Participant 9 did not become differently abled as a result of the violence in her home nation or through the process of fleeing, which suggests a possible reason for her experience being different from the others. None of the other participants discussed any sense of happiness after obtaining refugee status except for Participant 2, who was also differently abled prior to fleeing her home nation.

Addressing the specific mental health issues described by the study participants is one area for further research identified by this study. Future researchers should seek to address the gap in understanding whether there is a difference in the lived experiences of refugees who are victims of violence that renders one differently physically abled compared to those with preexisting conditions.

The literature reviewed for this study did not specifically address the perceptions or stigmas of refugee women with different physical abilities, nor is this reflected in Theme 1, but the findings suggest that these women are also at risk of the double stigma of having different physical abilities and being refugees. As the participants were located in Nairobi, Kenya, an African country, the results relate to the findings of the study conducted by Naami (2015)—that refugee women with different physical abilities are cursed individuals who cannot function. Under the consideration that cultural beliefs and religion often play a role in African countries, the trauma and stress resulting from these elements cannot be ignored (Etieyibo & Omiegbe, 2016; Ndlovu, 2016). Furthermore, Elder (2015) argued that the refugee label caused different perceptions and challenges of

host countries. Although the present study's findings do not directly further this area of understanding, Theme 1 suggests that the study participants are likely living with the double stigma of being differently abled and a refugee, which may be why there are so few appropriate social services to support the needs of these women and others like them (discussed further in Theme 5). Further research reflecting Theme 1 should focus on gathering data on perceptions of refugee women with different physical abilities among populations in the host countries to discern whether double stigmas exist.

Theme 2: Gratitude for Supportive Social Networks

The prevalence of social networks as a key positive in the lived experiences and support provided to the study participants suggests that strong social supports mediate the refugee experience. Herein lies the argument that these women do not suffer from the intersectionality of double stigmas related to disabilities and refugee status; however, this argument is settled when discussed in relation to Themes 4 and 5 in that refugee women with different physical abilities feel a personal sense of self-stigma (i.e., anxiety, frustration, and shame of dependence) as a result of their lived experiences. Overall, the core conclusion that can be drawn from Theme 2 is that host countries should seek to instigate interventions to decrease stigma and work to bridge the gap between communities of refugees and citizens alike.

All 10 participants reported that they had relied on at least one social network to help them integrate into their new Kenyan society. This finding is significant as it suggests that in order to bridge barriers and further their understanding of refugee culture, refugee women with different physical abilities can increase their social well-being

through introductions to social networks of similar demographics that may have already integrated into their host society. This builds on the research conducted by Dalgaard et al. (2019) in finding a proposed solution to the issue of access to social services. Dalgaard et al. argued that social services must be informed by the cultural values of those in refugee status.

As every participant stated that she had received support from someone, with a majority accessing support from their religious groups at church, it could be hypothesized that religious institutions may be able to foster a system that bridges the social divides new refugees experience in their home nations. Further research should focus on ascertaining if church groups can appropriately facilitate cultural understandings that increase access to appropriate social services for refugee women with different physical abilities. Any such study would also benefit from the finding that many of the present study's participants were welcomed to Nairobi by individuals from their home nations who were also refugees, as this implies that refugees are more likely to have a positive lived experience when integrating into a new society when they are surrounded by people like them.

The extent to which the participants each noted the importance of their social networks implies that the lived experiences of refugee women with different physical abilities are improved when they feel a sense of community and share lived experiences with those around them. This finding also relates to Dalgaard et al.'s (2019) finding that social services must be informed by the cultural values of those in refugee status in order for those being served to have positive lived experiences. Tanabe et al. (2015) argued

that, due to their physical limitations, refugee women with different physical abilities are excluded from community activities. Theme 2 disconfirmed this finding, as participants repeatedly reported being welcomed into refugee churches.

It could be that, as stated by Goodley (2016), the neoliberal approach to capitalism in developing nations is fostering a positive sense of community and placement for people with different abilities. Neoliberalist capitalist agendas often lead to results including large scale economic, political, and social dislocations unless culturally responsive agendas are formed (Abel & Kunz, 2018). Future researchers should seek to discern if this is the case.

Theme 3: The Hardship of Inadequate Support for Basic Needs

Despite the positive findings pertaining to the Theme 2 discussion in the previous section, Theme 3 was identified as a result of the participants being in a high-density area for refugees, which often led to inadequate support for their basic needs. The social services that were initially available, often coming through church, friendship, or familial groups, did not last longer than the first few months for the study participants. This suggests a particularly negative lived experience for refugee women with different physical abilities, particularly those who also live with other differently abled individuals. Basic needs like rent and food often went unmet, but other basic needs such as transportation, clothing, and work were also scarce for the participants.

Whether or not the participants were treated differently from other refugees could not be discerned in the findings related to this theme; as such, their experiences cannot be compared or discussed in conjunction with Goodley's (2016) research. However, the

finding that these women often could not work or support themselves relates to the finding from Nordenfelt (2009) that differently physically abled individuals pose an economic problem for society. Participant 4's statement that she only received intermittent one-time support suggested that her church did not consistently help her as it would be required to. This aspect of the lived experience for refugee women with different physical abilities should be further explored to better understand why these individuals are often so disadvantaged.

Theme 3 relates to the research conducted by Gona et al. (2018), who explored the use of personal narratives to affect community attitudes in rural Kenya. The personal narratives and lived experiences portrayed in Theme 3 could be used to evolve attitudes toward and treatment of refugee women with different physical abilities in urban Kenya too. Key stakeholders from international nonprofit and aid groups could use the results from this study to develop programs to help mitigate any potential for discrimination.

Finally, the results in Theme 3 confirm Oda et al.'s (2017) research on Syrian refugees' reportage of inaccessibility to health care and Tuck et al.'s (2019) finding that refugees experience postmigration socioeconomic hardships as well as the conclusion both authors drew: services for refugees need better coordination. Theme 3 further confirms findings from Akbar (2018) and Oda et al. in that even when the women felt they could participate in society, they were limited in their ability to access services. This suggests that the present study's participants, were they provided appropriate services, might be better able to partake in normalized society, likely far improving their lived experiences and quality of life.

Theme 4: The Anxiety, Frustration, and Shame of Dependence

Theme 4 continued from the findings for Theme 3 as the inability to support themselves further compounded the negative lived experiences for refugee women with different physical abilities. Building on research by Naples et al. (2016), this finding confirmed that the participants were influenced by more than one factor in their lived experience of refugee status. Various factors, including work (Participants 4 and 5), inability to provide for children (Participant 7), the mental health detriment caused by inconsistent support (Participants 1, 4, and 9) compounding fears that stem from being almost exclusively dependent on others who could easily cause them harm (Participant 9), decreased lifestyle quality due to displacement (Participants 1 and 7), and experiences of discrimination and being treated like a burden (Participants 5 and 8), all combined to shed light on the negative lived experiences of refugee women with different physical abilities.

These findings confirm the research and theory put forth by Wendell (1996) that women with different abilities experience the negative body of their societies. The present study's participants explicitly stated that their lived experiences were less than women who are healthy (experiencing the positive body) and that they are unable to realize a successful life in their host nations as a result of the stigmas placed upon them and the inconsistent nature of the help they are provided. Furthermore, Naami's (2015) finding that women in Africa who are physically abled experience discrimination and that women with different physical abilities face a double inequality due to the consistent

stigmas held against disabled individuals in African nations can be confirmed as a result of Theme 4.

Theme 4 also confirms and extends the argument put forth by Wendell (1996) that differing abilities are socially constructed concepts and culturally repeated phenomena. The present study's participants explicitly stated that they could work but that finding consistent work was difficult as a result of the stigmas held against them. In this way, the social constructs of refugee women with different physical abilities hinder their ability to experience a normal life like their contemporaries who are not differently abled. The disabilities these women have are contextual and likely would not hinder them from living a full life in their home nations had they not come under a conflict, building on research by Bickenbach et al. (2016). Solving for this macrolevel and inherent social issue and addressing the stigmas held by many in African nations against refugee women with different physical abilities will need to reflect both medical and social approaches, confirming the work of Silvers (2009).

Theme 5: The Distress of Living With Unmet Needs

Theme 5 is arguably the most related to this study's theoretical framework, as all participants reported having unmet needs as a result of their dependence on others, caused by their disabilities. Wendell (1996) argued that disabilities and different abilities are not the same as impairments. In keeping with Wendell's argument, all of the present study's participants should be able to support themselves if they were granted access to work and social services to mitigate the limitations posed by their different abilities. These women, however, are discriminated against as a result of their different abilities.

They lack adequate access to work, and various other aspects of their human rights are also impacted. Therefore, they experience unequal opportunities.

For example, Participant 10's description of accessing appropriate medication for her epileptic son appears to reflect both political and medical barriers. She was able to get her son's medication while in her home nation, but upon fleeing to Kenya, her status for medical assistance was no longer recognized, leading to an inability to access essential medical supplies. In addition, the UNHCR did not cover all of her needs, implying a potential political barrier to care caused by the international organization. By failing to fulfill its purpose of helping refugees, the UNHCR significantly contributes to the experiences of the negative body and lived experiences of refugee women with different physical abilities. There is also a potential that the UNHCR's inability to adequately support these women contributes to the perpetuation of social stigmas against them.

The intersectionality of barriers to care is rampant and often compound into a wholly negative lived experience and experience of the negative body. Social stigmas were not explicitly identified as an environmental barrier to social services in the present study, but there was significant evidence suggesting that the support networks designed to work with refugees are often inconsistent and may favor supporting those without different abilities. Further research is needed to confirm this finding, but this study's results imply this to be the case.

Summary of the Findings

This study's findings confirm the general stigmas experienced by the participants as refugees living in a foreign country. As the participants fled traumatic violence in their

country of origin, they had to live with the double stigma of being labeled as being differently abled in addition to being refugees. There is no official system for refugees in Kenya to access social services; community churches represented an unofficial system for the study participants as they all joined churches so they could access some help. There were also a number of barriers such as cultural customs and values limiting their access. Their negative lived experiences included the inability to provide for their children, mental health issues resulting from inadequate support, and other sources of fear including the need to be exclusively dependent on others in addition to other harmful and discriminatory propositions they were presented with. For example, Participant 1 stated that her landlord sometimes disconnected water and electricity to her home.

Limitations of the Study

None of the initial limitations considered in Chapter 1 were identified or occurred throughout the course of this study. Although further research is needed to confirm the study results, due to the qualitative nature of the data collection, these results are significant and were not affected by any of the identified limitations. It was initially hypothesized that translating participant interviews may be difficult given the language barriers, but this was not the case. Access to the target population was also considered to be potentially difficult, but enough participants were recruited to make the results of this study significant enough to contribute to policy. The trustworthiness of these results is therefore high and should be considered concrete enough for informing future studies on the more niche areas uncovered in this investigation.

Recommendations

Many areas for further research were identified as a result of this study's findings. The first is the need to address specific mental health issues experienced by refugee women with different physical abilities in order to adequately develop services for these women, furthering the work of Dalgaar et al. (2019) and McCrae et al. (2019). Research is also needed to discern whether there are specific differences between the lived experience of refugees who are victims of violence that render them differently abled and refugees and those who are differently abled prior to becoming refugees, as this could not be discerned in this study. Overall, Theme 1 contributed significantly to understanding the lived experiences of refugee women with different physical abilities, but future research is needed to discern the specific stigmas experienced by these individuals per their perception.

The major finding from Theme 2 was the dependence on church groups for support upon arrival in host nations. Further research is essential to discern why these supports are inconsistent after initial arrival and to establish practical means of extending the support potential presented by these groups. Further research in this area may also help to fill the gap in understanding whether refugee women with different physical abilities are treated differently by church groups. In addition, exploring this theme will contribute to the work of Goodley (2016) and possibly confirm the argument that neoliberalism is a positive thing for refugee women with different physical abilities. Themes 3, 4, and 5 all reflect further evidence of the intersectionality of stigmas experienced by refugee women with different physical abilities. Overall, the

recommendations from this research are to focus on (a) discerning the prevalence, nature, and intersectionality of stigmas experienced by refugee women with different physical abilities, (b) extending the understanding of churches as communities and sources of support for these individuals, which may allow them to evolve from the negative to the positive body in their host nations, and (c) mitigating the plethora of sources of stigma in a country-wide perspective.

Implications

The potential positive social impacts that can be developed from this study relate to the finding that church groups are often sources of immense and positive social support for refugee women with different physical abilities but that this support typically wanes after a short time. Exploring why this support wanes may help religious and nonprofit groups and other key stakeholders extend their services in such a way that they allow refugee women with different physical abilities to find adequate work so they can become self-sufficient. For many individuals, churches are considered their families and the individual level of one's lived experience. However, in the present study's context, churches are technically the organizational level of society and therefore can be influenced and supported by a multitude of stakeholders, including external religious leaders (e.g., Catholic leadership in Rome), affiliated nonprofits, and various policy makers. Those looking to directly support refugee women with different physical abilities should seek to work with religious organizations.

The study results also shed light on the relevance and use of Wendell's (1996) feminist theory of disabilities; specifically, that one's experience of the negative body has

the potential to evolve into the positive body should the appropriate social supports exist. The participants in this study implied that their lived experiences with different abilities did not hinder them from having a full life in their home nations, prior to the start of the conflict, and therefore gaining this same lifestyle should be possible in their new home. The use of qualitative data in discerning these results was significant. Furthermore, this study's qualitative nature allowed for gathering primary data that nonprofits and other organizations can use for educational material with the purpose of evolving social constructs and understandings of refugee women with different physical abilities, as described in the research conducted by Gona et al. (2018). Future practice should focus on confirming the exact nature of the stigmas, their intersections, and how they impact attribution of care.

Conclusion

The core conclusion drawn from this qualitative phenomenological study is that refugee women with different physical abilities face a plethora of negative, painful, and detrimental lived experiences from the moment their home nations fall into conflict. They are an inherently understudied population, and one that requires increasing intervention in order to increase their quality of life and allow them to flourish despite their refugee status. Refugee women with different physical abilities are able to take care of themselves and their family members when the appropriate social services are rendered and community support exists (e.g., church, family, and friendship groups), which allows them to increase their lived experiences. It is likely due to external factors that refugee women with different physical abilities experience the negative body, and when awarded

the autonomy of self-support and community support, there is potential for evolving the lived experience of these individuals to the positive body. Future research should focus on dispelling social stigmas, increasing care provided by church groups, and evolving the agency and autonomy of this severely at-risk population.

It is hoped that this study's results lend to creating all-inclusive humanitarian and social services to improve the lived experiences of refugee women with different physical abilities and further research into the best means of tackling the identified themes. These much-needed insights into refugee women with different physical abilities are of value to officials and site workers at UNHCRK and other international organizations that seek to bring awareness to the challenges these women face. The results are also applicable to African communities and to evolving their perceptions of refugee women with different physical abilities.

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Appendix A: Recruitment Flyer

❖ There are more than 469,000 refugees and asylum-seekers in Kenya. Nearly 80% of the refugee population in Kenya are women and children.

❖ If you are **a refugee woman aged 18 years old and above** with **physical disabilities** living in Nairobi Kenya and would like to participate in a research study and share your story,
Please **contact me on the contact information written below**.

Contact Info;
Call/Text/Whatsapp : [redacted]
Call/Text : [redacted]

Grace Nkundabantu

Appendix B: Interview Questions on Access to Social Services (in English and Swahili)

1. What country did you come from? What caused you to leave?
2. How did you travel to Kenya? What was your experience of the journey?
3. What is your daily experience like, here in Nairobi?
4. Can you talk about times when you felt unsafe?
5. Do people help you with your daily needs? What are those needs? How do they help?
6. Can you describe other needs that you do and do not receive? If you have some needs, please explain.
7. What challenges do you experience in your day-to-day life?
8. How do you manage these challenges?

1. Ulitoka nchi gani?
2. Waweza kuzungumzia kuhusu wakati ulipo wasili Kenya na namna gani uliweza kujizoweza na wakaaji piya maisha ya Kenya?
3. Na hapa Nairobi, maisha yako ya kila siku yako vipi?
4. Kuna watu wanakusaidia na mahitaji yako ya kila siku? Mahitaji hayo ni gani? Wanasaidiaje?
5. Unaweza kuelezea mahitaji mengine ambayo unayo unasaidiwa hama husaidiwe? Ikiwa unayo mahitaji kadhaa, tafadhali fafanua.
6. Ni shida gani hama changamoto gani ambozo unapata kwa maisha yakila siku? Wa weza eleza namna gani washugulikiya izo changamoto moto hama shida za kila siku?