

Lived experiences of young Black women with physical disabilities in Lesotho

By

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DECLARATION

I, Seithati Rafoneke, declare that the research dissertation that I herewith submit for the degree of Master's of Social Sciences (Sociology) at the University of the Free State is my independent work, and that I have not previously submitted it for a qualification at another institution of higher education. I declare that I am aware that the copyright is vested in the University of the Free State. I furthermore declare that all royalties as regards intellectual property that was developed during the course of and/or in connection with the study at the University of the Free State, will accrue to the University.

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I would also like to thank Mrs Ackermann, for translating the summary into Afrikaans.

DEDICATION

I dedicate this dissertation to my father **Thabang Simon Rafoneke**: Ntate Rafoneke thank you for always being there for me and pushing me to achieve more than what I ever thought I could [**KEA LEBOHA MOKHATLA**].

SUMMARY

This research study aims to improve our understanding of the intersectionality between disability, race/ethnicity, identity, religion, social class and gender and the ways in which these impact on how women with physical disabilities perceive and make meaning of their everyday life experiences and how they think society perceives them. The study therefore aims to understand the world from the point of view of young African women with physical disabilities in Lesotho. Different theoretical lenses that will assist us in making sense of the research participants' lifeworlds are used.

Phenomenology, together with its specific concepts—lifeworld and intersubjectivity—are discussed. This research study also pays attention to existential sociology as the study of human existence. It discusses how emotions impact on the lives of women with physical disabilities and how they influence social relations and human activity. The existential self is discussed as one of the main concepts of existential sociology. Furthermore, the research turns to the issue of the social construction of reality which provides us with a basis for the identification of the body, gender and disability construction. It also focuses on the feminist disability theory, with specific attention on the importance of integrating disability into feminist conceptions of intersectionality.

This qualitative study made use of purposive and snowball sampling. Semi-structured in-depth interviews are utilized to elicit data on participants' personal life histories, experiences and perceptions. The research schedule is used as an important tool to guide the interviews. The collected data is transcribed into Sesotho, translated into English and then analysed thematically.

Overall, the narratives of eight research participants aged between 21 and 35 generated five themes encompassing gender and femininity; the impact of the disabled body on claiming identity; religion; acceptance of disability; and the challenges faced by young women with physical disabilities in Lesotho. The principal theme is gender and femininity which plays an important part in constructing a disabled identity.

The study concludes that women with physical disabilities are isolated, stigmatised and discriminated against as a result of their disabilities. The responses of the research participants to situations of oppressive behaviour reflect their status as an oppressed group. Women with physical disabilities experience oppressive behaviour such as physical, emotional and sexual abuse from able-bodied individuals. This oppressive behaviour leads to women with physical disabilities being treated as unable and unfit to perform many gendered roles that are believed to be culturally and socially acceptable. They experience a limitation of rights, including the right to employment, to bear children, to live independently, to have an intimate partner and to get married.

African women with physical disabilities remain one of the most vulnerable and marginalized groups and attention is given to how they experience disability. Within this study, an effort is made to enhance our understanding of the everyday life experiences of young African women with physical disabilities in order to fill the gap in previous literature.

OPSOMMING

Die doel van die studie is om ons begrip van die verband tussen gestremdheid, ras/etnisiteit, identiteit, godsdiens, sosiale klas en geslagtelikheid (gender) te verbeter, asook hoe vrouens met fisiese gestremdhede sin maak van hulle alledaagse ervaring en hoe hulle dink die samelewing hulle beskou. Die studie poog om die wêreld vanuit die oogpunt van jong Swart, fisies gestremde vrouens wat in Lesotho woonagtig is, te verstaan. Verskillende teoretiese lense word benut om sin te maak van die navorsings deelnemers se lewensbeskouings en lewenservarings.

Fenomenologie, tesame met konsepte eie aan die benadering – leefwêreld en intersubjektiviteit – word aangespreek. Die navorsingsprojek skenk ook aandag aan eksistensiële sosiologie as studie van die menslike bestaan. Dit bespreek hoe emosies op die lewens van vrouens met gestremdhede impakteer en ook hoe dit sosiale verhoudings en menslike aktiwiteite beïnvloed. Die eksistensiële self word aangeraak as een van die hoofkonsepte van eksistensiële sosiologie. Die studie spreek ook die sosiale konstruksie van die werklikheid aan, wat aan ons 'n grondslag verskaf oor hoe identiteit, die liggaam en gestremdheid sosiaal gekonstrueer is. Die navorsingsprojek gee ook aandag aan feministiese gestremdheid (feminist disability) teorie, waar die belangrikheid om gestremdheid in ag te neem in feministiese konsepsies van interseksionaliteit beklemtoon word.

Hierdie is 'n kwalitatiewe studie wat gebruik gemaak het van doelbewuste en sneeubal steekproeftrekking. Semi-gestruktureerde in-diepte onderhoude is met die deelnemers gehou, wat aan hulle die geleentheid gegee het om hulle ervaringe te verbaliseer. 'n Navorsingskedisple was benut om die onderhoude te rig. Die data wat

versamel is, is in Sesotho getranskribeer en dan na Engels vertaal. Dit is dan tematiese geanaliseer.

Die narratiewe van hierdie agt deelnemers (wat tussen die ouderdomme van 21 to 35 is) het vyf temas gegenereer: Geslagtelikheid (gender) en vroulikheid; die impak van die gestremde liggaam op identiteit; godsdiens; aanvaarding van gestemdheid; die uitdagings wat gestremde vrouens in Lesotho konfronteer. Die hooftema is geslagtelikheid (gender) en vroulikeheid. Hierdie tema speel 'n belangrike rol in die konstruksie van die gestremde identiteit.

Die studie wys dat vrouens met fisiese gestremdhede, geïsoleer, gestigmatiseer en teen gediskrimineer word as gevolg van hulle gestemdheid. Die response van die deelnemers teenoor situasies van 'n onderdrukkende aard reflekteer hulle status as 'n minderheidsgroep. Vrouens met gestremdhede ervaar onderdrukking deur mense wat nie gestremd is nie. Hierdie onderdrukking neem die vorm van fisiese, emosionele en seksuele misbruik aan. Die vrouens word behandel asof hulle nie instaat (of goed genoeg) is om sekere aanvaarbare sosiale en kulturele geslagsrolle uit te voer nie. Hulle ervaar ook dat van hulle regte ingeperk word, wat insluit die reg tot indiensneming, om kinders te baar, om onafhanklik te lewe en om 'n intieme verhoudingsmaat te hê en om te trou.

Swart vrouens met fisiese gestremdhede, bly een van die mees gemarginaliseerde en kwesbare groepe in die samelewing en aandag word aan hulle gegee om uit die vind hoe hulle hul gestemdheid ervaar. Hierdie studie poog om ons begrip te verbeter oor die alledaagse ervarings van jong Swart vrouens met fisiese gestremdhede, en om sodoende 'n gaping in die literatuur aan te spreek.

KEY WORDS

Medical model

Social model

Phenomenology

Narrative inquiry

Women

Disability

Identity

Everyday life

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INTRODUCTION

This qualitative study examines the aspects of the lived experiences of young African women with physical disabilities in Lesotho. It explores issues such as gender, ethnicity/race, religion, social class and disability. An understanding is sought of how individuals with disabilities experience embodiment in relation to identity in a predominantly able-bodied society. This phenomenological study attempts to enhance an understanding of how women with physical disabilities construct meaning of their everyday lives in relation to their cultural and societal influences. The research questions therefore include:

- How do women living with physical disabilities narrate their everyday lived experiences?
- How do women with physical disabilities constitute their identity and how do they relate to femininity and disability?
- How do women with physical disabilities experience intersectional identity (gender, race/ethnicity and disability) and how are the experiences reflected in their narratives?
- What is the interplay between the women's experiences of embodiment and their lifeworlds?
- What impact does the social meaning of the body have on women with physical disabilities and what are their intersubjective relations within society?

The dissertation is divided into five chapters.

Chapter one: This chapter provides an overview of the theoretical framework. This study aims at understanding the experiences of women with physical disabilities. Therefore, a number of theoretical perspectives—such as phenomenology, existential sociology, social construction of reality, intersectionality and feminist disability theory—are seen to be relevant for the purpose of this research. Chapter two: In order to understand disability, the foundation, the construction and the intersection of concepts such as race/ethnicity, gender, disability, religion, social class and identity are discussed. This chapter highlights disability in the global context, the meaning of disability and its causes. The two models to the study of disability—medical and social model of disability—are discussed to further our understanding of the different attitudes that society holds towards disability.

Chapter three: This chapter provides an overview of methodology used in this research study. It focuses on all the methodological steps taken to conduct the study. The aim for utilizing qualitative research is underlined and the process of how data were collected and analysed are discussed in detail. The study also includes applied ethical procedures and the techniques used to ensure accuracy of the study findings.

Chapters four and five: These chapters focus on the presentation of findings as presented by eight women interviewed for this study. The findings represent the narratives of young women with physical disabilities that are analysed in terms of the selected theoretical basis. In order to present to the reader the narratives of the participants, direct quotes are used to confirm the trustworthiness of the findings. Finally, the dissertation ends with the concluding remarks.

CHAPTER 1: THEORETICAL FRAMEWORK

1.1. Introduction

In this chapter the research draws on several theories that will provide me with an insight into the research participants' lifeworlds: phenomenology, existential sociology, social construction of reality, intersectionality and feminist disability theory.

The research is largely conducted within the context of the social construction of reality. Briefly, social construction of reality focuses on the subjective understanding of personal experiences that lead to shared meanings of women with physical disabilities. The goal of the present study is to assess how physically disabled young African women in Lesotho view their situations and how each individual understands and perceives her reality (Creswell, 2013:24-25). Peter Berger and Thomas Luckmann (1966:27) suggest that it is important to understand how each participant understands her lifeworld and creates her own knowledge through her everyday social interactions. These social interactions enable participants to narrate the knowledge of how they perceive and understand their own meaning of disability.

Within the context of the social construction of reality, a phenomenological perspective guides the research. Following a phenomenological perspective, all human beings constitute meaning and researchers are urged to make sense of people's lifeworlds. The research attempts to establish how young research participants experience the interrelationship between disability, race/ethnicity, religion, social class and gender (Inglis and Thorpe, 2012:90). For the purpose of this study, the interplay between gender and disability is a particular case in point.

According to one of the authors who are working on the feminist disability theory, Rosemarie Garland-Thomson (2002:6), the importance of gender issues among people with disabilities should be taken into consideration. The feminine and the disabled bodies are mostly perceived as weak (Howson, 2013:52). Thus, women with disabilities are at a higher risk of experiencing multiple forms of oppression not only because they are disabled but also because they are women (McDonald, Keys and Balcazar, 2007:147). The study attempts to enhance the understanding of how women with disabilities make meaning of their lives in relation to the cultural and societal impositions associated with femininity.

From the perspective of Garland-Thomson (2002:2), disability studies and feminist theory complement each other. Both frameworks maintain that the body is socially constructed. Furthermore, both the feminist disability theory and disability studies seek to create positive identities for women with physical disabilities and recognise the interrelationship between femininity and disability (Garland-Thomson, 2002:2).

1.2. Phenomenology

Phenomenology with its emphasis on the importance of subjective experiences is an appropriate theoretical framework for understanding the lived experiences of young African women with physical disabilities in Lesotho. The term phenomenology is described by the father of modern phenomenology, Alfred Schutz (1970:13), as the reality which is embodied in the process of an individual's subjective experiences. The focus of phenomenological inquiry is to understand the nature of everyday lived experiences. Phenomenological research explores the "...humanness of being in the world" (Bergum, 1991:55). It focuses on the "...practical acting of everyday life and leads to a practical knowledge of thoughtful action" (Bergum, 1991:55). John

Creswell (2013:7) observes that phenomenologists such as Schutz are interested in understanding and interpreting the nature of everyday lived experiences. The purpose of phenomenology is to go beyond the aspects of the taken-for-granted life and "...to uncover the meanings in everyday practice in such a way that they are not destroyed, distorted, decontextualized, trivialized or sentimentalized" (Benner, 1985:6). Phenomenology allows an insight into an individual's world exactly as it is experienced (Van Manen, 1990:30). In this sense, an individual's world is produced and experienced by her in the environment in which she lives. Therefore, the experiences of women with physical disabilities are their experiences in their world. The specific purpose of this study is to identify how a woman with a physical disability uniquely experiences and perceives her disability. Christopher Smith (1998:75) substantiates that phenomenology is a methodology to investigate "...being in the world."

David Inglis and Christopher Thorpe (2012:86) present phenomenology as an event exactly as it appears to "...human consciousness". Phenomenologists are interested in how people experience and understand their consciousness as opposed to what is apart from perception. The focus in the present study is on how women with physical disabilities experience their own feelings and emotions and how they make sense of their experiences. As the experiences of living with a physical disability are highly charged with emotional and personal meanings, phenomenology is necessary to illuminate these perceptions to gain a deeper understanding of how women with physical disabilities construct their own meaning ascribed to their lived experiences (Inglis and Thorpe, 2012:86).

1.2.1. Lifeworld

According to the phenomenological conception, the lifeworld is the umbrella within which all other worlds exist: the worlds of scientific and perceptual objectivity as well the world of pre-scientific interests (Overgaard and Zahavi, 2009:97). It is assumed that these worlds constitute a sphere of social and cultural practices. Robert Sokolowski (2000) points out that perceptual meaning result from each individual's unique practical interests and activities. At any moment of her practical life, a woman with a disability may find herself in certain situations which may contain specific limitations and conditions. These situations are the everyday lifeworld "...which seems self-evident" to her (Zaner and Engelhardt, 1973:3). The content and the sequence of limitations and conditions that women with physical disabilities experience in their everyday lives are unique to them. Each individual finds herself in a present situation which is rooted in her past and which constitutes her unique experiences (Sokolowski, 2000).

To be precise the lifeworld focuses on the "...cultural, taken-for-granted frameworks of social life" and how they impact on the thoughts and actions of women with physical disabilities (Ritzer, 1983:198). By this taken-for-granted reality, an individual simply takes the social world given to her for granted in the attitude of common sense. An individual always finds herself in a world which is for her a taken-for-granted reality and with it the interpretations of life situations and social relationships are experienced. These interpretations are the world in which action and communication are rooted (Ritzer, 1983:200).

The lifeworld is based mainly on the stock of knowledge obtained from experiences (Ritzer, 1983:199). Therefore, I aim to understand disabled women's past

experiences and their ability to act upon the world. George Ritzer (1983:199) makes the point that people orient themselves in certain life situations through their stock of knowledge that includes meanings and constructs. Without their stock of knowledge, women with physical disabilities cannot create their own experiences and they cannot make meaning of their life situations. According to phenomenological theory, no individual can have a similar stock of knowledge to the other because the stock of knowledge is unique to each individual (Ritzer, 1983:199). Hence, no individual can understand the intended meaning of the other in the same way as she would. As this study focuses on women with physical disabilities, their stock of knowledge will revolve around how they perceive and understand their disability. In order to understand the participants' life experiences of disability, the focus is on their constructs, meanings and motives.

Phenomenologists, such as Simone de Beauvoir (1974) and Maurice Merleau-Ponty (1945), claim that there is a relationship between the human body and the human lifeworld. Merleau-Ponty (1945) draws on the importance of the lived body in order to determine its perceptual meaning. The lived body experiences an interrelation with other individuals and things, and this is essential for the constitution of the human lifeworld (Merleau-Ponty, 1945). The lived body refers to the phenomenological fact that to be a human being is to always be bodily in the world and to understand the world through the body (Merleau-Ponty, 1945). Therefore, it is fundamental to explore how women with physical disabilities experience their bodies in relation to their physical disabilities.

Lifeworld constitutes a crucial role in this study because the study assumes that it articulates the experiences that influence how women with physical disabilities

perceive their disability, identity, femininity as well as support structure and how the way they interact with others in their communities influences their experiences of their day-to-day lives. Furthermore, the study assumed that an understanding of how women with physical disabilities construct their own meaning from social and cultural coverage of their own lifeworld would be gained. Experiences of disability are examined in relation to an individual's sense of identity to her lifeworld.

1.2.2. Intersubjectivity

Intersubjectivity derives from the lived world as the interrelationship between the self and others. It can be defined as "...the intersection of two or more subjectivities" (Schulte, 2000:531). It emphasizes an intersectionality of self and the world of things and that of others (Schulte, 2000:531).

Intersubjectivity is seen as "...a world which we share with others of whom we have original knowledge of being in the world in the same way as we are" (Schulte, 2000:531). Therefore, it is important to point out that intersubjectivity refers to how people share similar views. It can be recognized through understanding an individual's position in relation to herself as being in the same world as others. Thus, the focus of this study is on how an individual with a disability finds herself among others in her community (Schulte, 2000:531).

According to Emmanuel Olanrewaju (2012:18), an intersubjective world is not a private world. It is the world in which people share common experiences and how they understand each other. In addition, Intersubjectivity is concerned with how women with physical disabilities understand their self with others and how they see themselves as belonging with others (Scott and Laura, 2012:520).

Appelrouth Scott and Edles Laura (2012:520) refer to intersubjectivity as “...not so much to the fact that we share the same empirical or material world as others, but that we share the same consciousness.” Through consciousness, women with physical disabilities become aware of their surroundings. Hence an individual identifies herself as belonging within a shared world with others (Scott and Laura, 2012:520). Intersubjectivity then can be applied to how women with physical disabilities shape their own experiences as affected by the communities to which they belong.

Alessandro Duranti (2010:6) perceives intersubjectivity as “...the assumption that the world, as it presents itself to me, is the same world as it presents itself to you, not because you can ‘read my mind’ but because I assume that if you were in my place you would see it the way I see it.” There is no doubt then that if an individual understands disability, he/she may be able to walk a mile in the shoes of a disabled person, imagine herself in her situation and understand her experiences.

The rationale for choosing intersubjectivity as a core phenomenological concept is to understand the shared experiences of women with physical disabilities. They may share their different experiences of disability, how it impacts on their everyday lives and the coping mechanisms that they employ in order to come to terms with the various challenges of their disabilities.

1.3. Existential sociology

Joseph Kotarba defines existential sociology (2009:139) as “...the study of human experience-in-the-world (or existence) in all its forms.” In addition, Kotarba (2009:140) insists that existential sociology is a “...sensibility, a way of life, a passion for living, an orientation to the flux and emergence of actual lived experience.” Existentialists are interested in the impact of emotions on people with physical disabilities, how they experience their social world and how they create their own meaning with regard to their everyday lived experiences. Emotional experience is one of the important features of existential sociology (Kotarba, 2009:139).

Feelings and emotions are therefore important concepts that play a vital role in the everyday social life of women with physical disabilities. Feelings and emotions such as “...love and hate, ecstasy and agony, pleasure and pain, lust and satiety, hope and despair, sympathy and spite, full and hungry, tasty and foul, comfort and discomfort” are central to all individuals (Kotarba, 2009:144). Therefore, emotions and feelings complement each other. By paying attention to feelings and emotions the study gains an understanding of how women with physical disabilities adapt to emotional changes as part of their everyday lives (Kotarba, 2009:139).

Emotions are described as “...the darker side of human experience, powerful forces overwhelming reason and impelling action, but at the same time more authentic and more important than reason” (Kotarba and Johnson, 2002:158). For women with physical disabilities, emotions such as denial and anger may precede acceptance. However, they are normal and they form part of the process of adapting to disability (Kotarba, 2009:144). “Emotions such as gratitude, liking, love, obligation, respect, concern and sympathy” are perceived as positive emotions that may promote a

bond. Furthermore, "...emotions such as greed, envy, pride, power, lust, shame, anger, enmity and hate" are regarded as the negative emotions that may bring confusion and destruction to women with physical disabilities (Kotarba, 2009:144). Emotions may impact differently on women with physical disabilities. For example, some women are born with disabilities while others acquire disabilities at some point in their lives. Unlike a woman who was born with a disability, a woman who acquired a disability at a later stage in her life may experience challenges which may impact on her physical, emotional and psychological wellbeing. In this study, existential sociology is implemented to determine how women with physical disabilities perceive and construct meaning with respect to the changes and challenges that they come across.

The self is regarded as a fundamental concept to understanding an individual's experiences. According to Kotarba and Fontana (1987:11) "...the self is considered to be embodied, becoming, situational and reflexive." The self is embodied because it receives its stimulation to act from feelings and emotions arising from the body (Kotarba and Fontana, 1987:11). Thus, the body is important in determining the everyday lived experiences. "The self is becoming because it is always unfolding, changing, and developing in response to its changing perceptions of the world around it" (Kortaba and Fontana, 1987:11). The concept of self focuses on how women with physical disabilities cope with certain challenges of their everyday lives (Kortaba and Fontana, 1987:11).

Furthermore, the self is reflexive because "...it is aware of itself; it is the focal point for the social, biological, cognitive, affective, and interpretive dimensions of being" (Kotarba and Fontana, 1987:11). Existential self is also described as "...an incarnate

self, filled with rational thoughts, sudden emotions, deeply felt anxieties, biological urges, and cultural elements” (Kotarba and Fontana, 1987:11). The self is in society because “...it is studied in its natural settings, in its interacting stance, and in its experiential confrontation with society” (Kotarba and Fontana, 1987:11).

The existential self and disability may define the process of becoming, as experienced by women with physical disabilities, and the importance of thoughts and emotions and how they impact on self. I implement the existential approach in this study to examine what happens to different areas, such as social life and leisure time, of the life of women with physical disabilities.

1.4. Social construction of reality

Thomas Schwandt (2008:93) argues that “...social constructionism—a notion originating in sociology—is the view that the meaning of the state of things (e.g., childhood, family), practices (marriage), conditions (disability), behaviour (shoplifting), and so on is always interpreted or constructed in specific linguistic (discursive), social, historical, and material contexts.” Berger and Luckmann (1966) are concerned with how knowledge is constructed, how it emerges and how it significantly influences social reality. They believe that knowledge is influenced by how people interact within society. Because social order as a product of human activity is an ongoing human process that makes interaction and action possible (Inglis and Thorpe, 2012:94). Knowledge is concerned with what individuals know as reality in their everyday lives (Berger and Luckmann, 1966:27). Women with physical disabilities are able to create meaning to their experiences through knowledge.

Berger and Luckmann (1966) indicate that society exists both as objective and subjective reality. Subjective reality may be described in terms of conversations

between individuals. In addition, subjective reality is identified by concepts that can be shared with others. Therefore, how people interact with others shapes their social reality. To support this statement, Schutz (2004:215) reveals that unlike the world of nature "...social reality—has a specific meaning and relevance structure for the human beings living, acting and thinking within it. It is these thought objects of theirs which determine their behaviour by motivating it."

Social constructivism which maintains that reality is constructed through human activity, accentuates the importance of culture in the understanding of what occurs in society and how knowledge is constructed based on what an individual understands (Berger and Luckmann, 1966:27). The key issue in social constructivism is that it enables an understanding of how women with physical disabilities create and understand their own reality. The meaning of disability will be understood from the participants' perspective of what and how they constructed it as meaning through language and actions. Through language, thoughts and feelings are shared (Inglis and Thorpe, 2012:95). Language is crucial within this research because an individual may be able to voice her opinions and experiences of disability by narrating her own story.

It is through narratives of discomfort and pain that individuals with disabilities may understand and create meaning of their disability and how their experiences affect their body, self and being in the world (Williams and Bendelow, 1999:156). Through language, the meaning of what was experienced and understood by women with disabilities may be conveyed. In this research study I explore language as a meaning-making resource which enables women with physical disabilities to communicate with others and maintain their social relationships. In my opinion, the

use of language to narrate the experiences of disability may act as a therapeutic process. Talking about problems may allow an individual a better understanding of her experiences as well as an opportunity to voice her concerns.

The study may gain an understanding of how society influences the everyday experiences of women with physical disabilities and how this impacts on their own understanding of identity, gender and femininity. Because social constructivism is closely related to culture, an understanding of how norms, values and beliefs may impact on the experiences of women with physical disabilities is gained. I find out if the participants experience some form of labelling and discrimination in relation to their disabilities.

1.4.1. Social construction of the body

In order to understand disability, it is important to take into consideration the common understanding of the body. According to Holmes (2010:110), the social construction of the body takes place globally. Throughout history, the world has always been interested in the appearance of the body in everyday life. The social theory of the body offers an understanding of the body as experienced in specific social contexts (Holmes, 2010:102).

It is the opinion of Mary Holmes (2010:102) that embodiment is an important concept in social theory and it is understood as the result of social forces. Social constructivism questions the medical ideas about bodies and disagrees that biological reality (mainly genetic constitution) determines people's actions. Holmes (2010:111) emphasises that the body can be a biological reality and a socially constructed entity. This means that the body is physical and symbolic at one and the same time. Within the modern world, individuals are expected to be responsible for

how their bodies look. Thus, the body is seen as an important form of capital which women (particularly), are expected to make attractive (Holmes, 2010:111). Carrie Sandahl (2002:24) indicates that disability can "...radically refigure" how people look at and how they organize their bodies in the twenty-first century.

In medical science, the body is considered as an object to be examined. The medicalization of the body, cosmetic surgery, beauty and body work coincide with the classification of bodies, among others as feminine and masculine (Holmes, 2010:105). From a phenomenological point of view, the body can be perceived as an object. It is also a subject. In this sense and from one perspective, the body is an object (physical body), as perceived by others from the outside but from the other perspective the lived body is subjective (phenomenal body), as experienced from the inside by the subject (Merleau-Ponty, 1945).

Drawing on the perspective of Iris Marion Young (2005:16), the lived body is described as "...a unified idea of physical body acting and experiencing in a specific sociocultural context; it is body-in-situation." The body offers valuable ways to theorize disability and an understanding of the experiences of oppression among young African women with disabilities (Loja, Costa, Hughes and Menezes, 2012:191). In the opinion of Garland-Thomson (2002:5), the body does not lead to oppression. Dominant social practices favour able-bodied individuals and ostracise women with physical disabilities. This happens when the body is attached with negative subjective meanings that are socially and culturally constructed (Holmes, 2010:106).

The study gains an understanding of how women with physical disabilities experience embodiment in relation to identity (Loja et al. 2012:192). Because the

subjective meaning of the body is culturally and socially constructed, the study attempts to enhance an understanding of how women with disabilities make sense of their experiences based on the cultural and societal impositions in relation to their bodies (Hacking, 1999:228). Moreover, an analysis is made of how women talk about their bodies.

1.4.2. Social construction of gender

Gender is a continuous part of our everyday life that determines who an individual is and how she is treated by others. Individuals' bodies, their personalities and the way they think are all gendered (Lorber, 2008:531). Therefore, gender is not sex but rather an organised principle of social order that divides people into either male or female (Lorber, 2008:531). Individuals are categorised as men and women and women are expected to be different. This is why they are often treated in ways that make them look inferior and controlled by men (Lorber, 2008:531). In the transformation of physical bodies to fit the ideals of culture and feminine beauty, gender is perceived as one of the major reasons (Garland-Thomson, 2002:5).

It is often believed that women with physical disabilities do not fit into the societal norms for ideal feminine beauty. As a result, they have often been unable to achieve certain gender roles (Hanna and Rogovsky, 2006:44). Gender roles are defined as "...the attitudes, behaviours, and activities that are socially defined as appropriate for each sex and that are learned and reinforced through the socialization process" (Kendall, 2011:137). Thus, the norms and values of culture require all individuals to perform their gender roles because not doing so may lead to them being ostracised by society (Lorber, 2008:532). Performing gender roles determines the construction of behaviour and identities of people (Lorber, 2008:532). The principle of social

construction is based on the fact that individuals are responsible for the creation of their own social realities and identities. They are therefore expected to take gender into account through their everyday social interaction with others (Lorber, 2008:532).

Simone de Beauvoir (1974) has created a better theory to help us understand the sexually differentiated body of a human being. The ideas of de Beauvoir's female body revolve around Merleau-Ponty's phenomenology which says that the biological and reproductive features of a female body place it in the world in a specific way. It creates particular situations and challenges that women with physical disabilities are expected to relate to. This is why the female body is both subjected to the gaze of others and exposed to oppression (Stuart, 2006:295).

African women with disabilities are subjected to simultaneous oppression of class, gender and race. Simultaneous oppression results from the isolation of African disabled women from their societies, leaving them without a social role or image (Stuart, 2006:296). Although both women and men with disabilities experience discrimination at a certain level, women are more likely to experience double oppression due to the fact that they are women and they are disabled (Stuart, 2006:296). However, when a woman with a disability tries to engage in a normal life and interacts with others, she tends to experience barriers imposed by the society (Shakespeare, 2006:197).

As this research focuses on women with physical disabilities, it is important to understand how each individual creates and understands her own gender. The study is intended to find out how women with physical disabilities perform their gendered roles and how they relate to identity, femininity and disability. Specifically, it is intended to identify how women perceive, understand and experience their disability,

based on the view that they are women and that they are disabled. It examines how physical disability can influence the lived body in women's lifeworlds.

1.4.3. Social construction of disability

Disability, just as is the case with gender, is socially constructed (Hirschmann, 2012:396). For example, children are taught about disabled individuals from the early process of development. As they grow up, children start to classify individuals into disabled and non-disabled people, showing a preference for able-bodied individuals over people with disabilities (Krahe and Altwasser, 2006:60) "...because of the ways that social relations, the built environment, laws, customs, and practices are structured and organized, certain bodies are disabled, and other bodies are facilitated" (Hirschmann, 2012:396). Disability studies argue that, what makes an individual disabled is the social context in which she exists rather than the bodily differences (Hirschmann, 2012:397). The structure of the society prevents disabled people from participating in many mainstream activities of the society (Anastasiou and Kauffman, 2011:371).

In terms of disability studies, disability has a social history and it is understood through perceptions such as "...the normal, the abnormal, the natural, the unnatural, ability, and disability" (Shogan, 1998:269). The social practices and assumptions about female bodies disable women with physical disabilities just as a wheelchair may disable the user from entering a building (Hirschmann, 2012:399). Disability studies explore how disability interconnects with other categories such as gender, social class, identity, religion and race/ethnicity. Further, the social construction of disability distinguishes between disability and impairments, claiming that

impairments are physical dysfunctions while disability is socially constituted (Anastasiou and Kauffman, 2011:371).

How disabilities have been understood shifted over time but women with disabilities have always been a social concern (Shogan, 1998:270). Fear and illness have always been a reflection of the way in which society responds to women with physical disabilities. For instance, fear is used as a protective response against individuals with disabilities. When disability is viewed in this way, the result is discrimination (Barnes and Mercer, 2005:7). Disability has also been perceived as illness which is expressed as weakness and dependency (Garland-Thomson, 2002:8). This way of looking at disability creates a meaning to disability that encourages pity and shame (Stone, 2005:216). This study helps us to understand how women perceive their disability and how they understand their disability from their own point of view, as opposed to the way in which the society perceives and understands the meaning of disability.

1.5. Intersectionality

To examine the role of social and cultural categories such as gender, disability, social class, religion and race/ethnicity, the study of intersections between the forms of systems of oppression and discrimination which is bound with the concept of identity is discussed. According to Erik Erickson's identity theory, identity can be described as the image of self, where individuals integrate their ideas of who they are and what they want (Schultz and Schultz, 2009:215). This may also include the idea of what other people think of them. Personal identity is a construct of self through knowledge. How an individual integrates with the world affects the meaning of self and the growth of her personal identity (Schultz and Schultz, 2009:217).

Intersectionality is an “...analysis claiming that systems of race, social class, gender, sexuality, ethnicity, religion and age form mutually constructing features of social organisation, which shape black women’s experiences and in turn are shaped by black women” (Collins, 2000:299). African women do not only experience oppression independently but as an intersection of numerous social classifications (Barnes, 2013:94). Patricia Collins’ idea of intersectionality questions an assumption of what it means to be a mother in an African community. Furthermore, “...Intersectionality explains black and minority ethnic (BME) women’s experiences of discrimination in relation to the law” (Woodin, 2014:88). Collins (2000:299) is of the opinion that African women are situated at a point where race and gender come together as two powerful systems of oppression.

Joanne Conaghan (2007:321) points out, that intersectionality provides empowerment for people with disabilities who are unable to speak out against oppression. The application of intersectionality in this study helps one to understand African women’s experiences of gender. This framework further helps one to understand how the cultural patterns of oppression impact on the day-to-day experiences of women with physical disabilities; an understanding of how race/ethnicity, identity, gender and disability intersect to shape specific experiences is gained.

1.6. Feminist disability theory

For Susan Wendell (1996:243), disability theory should be feminist—because more than half of disabled people are women. Femininity is understood by Kristen Myers (2004:11) as a socially constructed process. According to Garland-Thomson (2002:7), women with disabilities are commonly undermined and assigned as the

'other'. The concept of the 'other' as developed in feminist theory is fruitful for understanding the social position of women with physical disabilities. When a woman is portrayed as the other, people group them as objects rather than as subjects. To non-disabled individuals, women with disabilities are regarded as imperfect and weak (Wendell 1996:64). For women whose disabilities are readily apparent, every appearance in the public eye means risking insult and potential embarrassment (Wendell, 1996:64). As a result of being subjected to forms of abuse, women with disabilities may experience both negative self-esteem and negative sexual identity. Feminist thinkers perceive the attitudinal barriers towards the body that lead to women's oppression as a crucial issue in understanding femininity (Wendell, 1996:243).

Moreover, Garland-Thomson (2002:6) "...denaturalizes disability by removing the dominant assumption of the medical model that disability is something that is wrong with an individual." By this statement, feminist disability theory claims that women with disabilities experience discrimination on grounds of gender, disability and race/ethnicity (Garland-Thomson, 2002:6).

Feminist disability theory centres on four domains of Garland-Thomson's theory: representation, the body, identity and activism. However, the study focuses on two domains: body and identity. The first domain entails that "...representations portray subjugated bodies not only as inadequate or unrestrainable but at the same time as redundant and expendable" (Garland-Thomson, 2002:9). Feminist disability theory illuminates how women with disabilities are perceived. It also focuses on the societal norms and practices that give rise to representations (Garland-Thomson, 2002:9).

The focal point of the second domain, the body, is concerned with how politics and identities impact on the lived experiences of the female body. It further emphasizes that cultural practices modify the body's appearance through medicalization and consumerism. Furthermore, the female body interacts with its surroundings, leading to experiences and expectations different from those of men (Garland-Thomson, 2002:6). Moreover, physical disability can lead to particular changes in the body. As a result, a woman's experiences of disability may have negative consequences when her body is changed in relation to both functional abilities and appearance (Garland-Thomson, 2002:12). The body may lose its normal ability to function, causing changes such as those pertaining to body language, personal style, appearance and gestures (Garland-Thomson, 2002:21).

The third domain, namely identity, focuses on the various interrelationships of the identities of women, such as race/ethnicity, gender and disability. This domain aids the exploration of the gendered identities of women that are shaped by social beliefs related to disability. The last domain, activism, focuses on the protests on behalf of people with disabilities who experience oppression (Garland-Thomson, 2002:9). Representation and activism argue for acceptance of women with physical disabilities in their societies (Garland-Thomson, 2002:9). Activists can promote representation of women with disabilities in a manner that they are not perceived as deserving pity (Garland-Thomson, 2002:9). For instance, activism through the media representations can adopt images that normalize the unique experiences of women with physical disabilities.

Following the feminist disability approach, this study focuses on the cultural history of the body and its lived experiences in relation to identity (Garland-Thomson, 2002:4).

I implement a feminist disability theory in order to understand how experiences of disability interrelate with identity, race/ethnicity and gender. By using feminist theory in this study the researcher may be able to engage in the point of view of the participants. It is important in this research because it may enable an examination of knowledge as gendered rather than as being neutral.

1.7. Conclusion

Phenomenological approaches, social construction of reality, existential sociology, intersectionality and feminist theories are employed to add value to this study by aiming at providing a context for the lifeworlds of young African women with physical disabilities in Lesotho and by contributing to understanding their narratives.

Phenomenology focuses on investigating the lived experiences and intersubjectivity that interconnects an individual with her society. The important aspect of phenomenology is that the everyday life should not be taken-for-granted. The body has served an important role in how women with physical disabilities experience their lifeworld. Existential sociology is more focused on an individual's emotions and feelings. People react to challenges and changes in different ways: therefore, they experience different emotions and feelings. When individuals are faced with certain challenges they use different methods of coping.

The social construction of reality is used to indicate how a person attaches meaning to her experiences. Societal norms and practices are attached by the society. As a result, reality is culturally and socially constructed. Social participation of women with physical disabilities demonstrates that the barriers which they experience are often embedded in the structures of the society. Intersectionality focuses on the subjective experiences of women and their lifeworlds. Furthermore, intersectionality focuses on

how the attitude imposed towards forms of intersectionality, namely identity, gender and race/ethnicity—may impact on the position of women with physical disabilities in Lesotho.

Femininity as a concept refers to ways in which women experience their social world. A feminist theoretical lens is therefore utilized in this study because the participants of this study are all women. Feminist disability theorists such as Garland-Thomson (2002) argue that able-bodied individuals should not dominate the representations of disabled women.

In the next chapter I present the literature review which is necessary to understand the previous perspectives on experiencing physical disability. The two models to the study of disability—medical and social models of disability—are also discussed to determine how society understands and responds to disability.

CHAPTER 2: LITERATURE REVIEW

2.1. Disability in the global context

Physical disability is perceived as a complex human condition. The World Health Organization (WHO 2011:261) interprets disability in its widest sense when it makes the statement that “...almost everyone will be temporarily or permanently impaired at some point in life, and those who survive to old age will experience increasing difficulties in functioning. Disability is complex and the interventions required to overcome disability disadvantage are multiple, systemic, and will vary depending on context.” It is suggested that disability can strike anyone, in spite of his/her social rank or status (Stone, 2005:1).

The focus of this research is on permanent disability and particularly on this kind in as far as young African women are concerned. Although having a disability is not a reason to exclude women with physical disabilities from participating in the mainstream activities such as attending school, finding a job, being a mother and a wife, the World Health Organization (WHO) emphasizes that women with disabilities are often marginalized and their lives are described in terms of social isolation, poverty and discrimination. Globally individuals with disabilities often experience poor health, low education, and higher rates of poverty and are less engaged in economic activities than able-bodied individuals (WHO, 2011:1). Women with disabilities have ordinary needs: the need for health and well-being, for economic and social security, to learn and develop skills, and the right to participate in mainstream social and cultural activities (WHO, 2011:264).

The research conducted by the WHO (2011:261) signals that women make up more than half of the people with disabilities throughout the world. In order to contextualise

my research, the world statistics relating to disability will be introduced. According to the WHO (2011:261), studies indicate that more than a billion people in the world live with disabilities and this figure accounts for 15% of the world's population, making people with disabilities the world's largest single minority. At least 785 million of this population are children and women. Moreover, studies speculate that a larger part of this significant part of the world's population comprises women. As a result, they are likely to be deprived of proper education, to be unemployed and to have low income jobs if they are employed (WHO, 2011:262).

People with disabilities experience physical and social barriers such as limited built environment and the modes of transport that are not designed to accommodate their needs (Shakespeare, 2006:201). Negative attitudes also leave women with disabilities isolated from the mainstream social and cultural opportunities (Barnes and Mercer, 2005:7). This is because they are perceived as helpless, incapable and weak (Garland-Thomson 2002:8). To be disabled is to be presented with problems, to be unable to compete with others and to be disadvantaged in earning a decent living (Garland-Thomson 2002:8).

Even though disability has been part of humanity since its inception, knowledge of how women with physical disabilities experience their everyday life remains limited. The issue of disability has often been ignored within mainstream sociological practice and the sociology of the body has contributed little to the study of disability (Turner, 1992:252). Lula Beatty (2003:227) enunciates that there is little research on gender and ethnicity among African women and because of that, there is often little understanding towards disability and the lived experiences of African women with physical disabilities. The experiences of living with a physical disability have been

neglected by both disability and feminist studies. The previous research that has been done on women with physical disabilities mainly focuses on the psychological, economic and social issues that impact on women with disabilities and ignore the experiences of their everyday reality (Shakespeare, 2006:197). The voices of women with physical disabilities have therefore almost entirely been omitted in research.

The main value of this study is to enhance our level of understanding of the everyday life experiences of women with physical disabilities within a predominantly able-bodied society and to increase our knowledge on how women with physical disabilities view their disabilities. In order to do this, the study looks at the lifeworlds of women with physical disabilities at the intersection of gender, race/ethnicity, religion and social class. The information produced in this study attempts to contribute to the strengthening of the social model of disability as the one that should be used regarding people with disabilities.

2.2. Defining disability

To quote Michael Oliver (1993:62): "Disability is the loss or reduction of functional ability." WHO (1980:28) points out that "...disability is concerned with compound or integrated activities expected of the person or the body as a whole, such as are represented by tasks, skills, and behaviours." A disability is a disadvantage for a given individual. It limits or prevents the fulfilment of a role that is regarded as normal. This definition is further understood through the statement that to say that someone has a disability is to preserve neutrality, with nuances of interpretation with regards to his or her potential still being possible. Disability itself might best be described as an inability to perform the activities, share in the relationships and fulfil the same roles which are expected of individuals of the same age and sex in society

(Bickenbach, Chatterji, Badley and Ustun, 1999:1176). When disability is viewed in this way, it impacts on the well-being of individuals who experience it, their social relations with others as well as their psychological conditions (Hosain, Atkinson and Underwood, 2002:297).

Disability can be seen as an umbrella term for impairment. According to Bickenbach et al. (1999:1177), impairments are limitations experienced by individuals because of their physical dysfunctions. Therefore, while disability describes the nature of the loss of an individual, impairment refers to a physical condition (Oliver, 1983:38). For that reason, "...disability and impairments are both always about bodies in social situations and thus always about the material and social conditions of not just one's body and its abilities but also of one's environment" (Schriempf, 2001:70). Bodies are often classified in a social context as able-bodies and disabled bodies. When the body is impaired also as a result of societal classification of certain bodies then impairment becomes disabling because of the lack of social and physical access for those who are disabled (Sawadsri, 2011:54). Disability and impairment underlie a description of the body that is based on the idea that the body is culturally and materially shaped (Hughes and Paterson, 2006:91). Therefore, disability and impairments are about the body and the inability of an individual to perform the activities of the everyday life (Schriempf, 2001:70). In the opinion of Bickenbach et al. (1999:1176): "Impairments and disabilities may disadvantage an individual by limiting or preventing the fulfilment of six important survival roles: orientation, physical independence, mobility, occupation, social integration and economic self-sufficiency." An inability to perform these roles may negatively impact on individuals and in this respect women with physical disabilities often feel isolated as a result of being limited in terms of performing certain roles. When women with disabilities are

isolated, their rights often become further infringed and this situation makes them even more vulnerable (Sawadsri, 2011:54).

Understanding disability broadens our understanding of how people relate with others, what it means to be human and the lived experiences associated with disability (Hall, 2011:17). It expands on an understanding of physical appearance and gendered embodiment. To further understand disability, it is important to take into consideration the distinction between acquired and developmental disabilities.

2.3. Developmental and acquired disabilities

Some people are born with disabilities while others acquire disabilities at some point in their life. Disabilities that occur from the time of birth are known as developmental disabilities but disabilities that occur later in life, as a result of injuries, accidents and illness/diseases, are referred to as acquired disabilities (Stone, 2005:216). Some people with acquired disabilities believe that their disabilities are a result of a kind of punishment (Shakespeare, 2006:197). That is why they are likely to suffer from shame, denial, helplessness and depression. Others with developmental disabilities believe that their disabilities are a result of bad luck or misfortune (Stone, 2005:123). However, whether acquired or developmental, disability is often associated with shame and pity (Stone, 2005:216). People who have been disabled from the early years of their lives may have been able to adapt to the social systems in which they exist, but people with acquired disabilities may have their lives shaped by their disabilities because they may find it hard to adapt to their social systems (Power and Dell Orto, 2004:33). Individuals who acquire disabilities at a later stage in their lives often incur more negative life experiences than those who were born with disabilities. For instance, they may struggle with chronic sorrow, anger and anxiety over

perceived losses (Stone, 2005:123). Consequently, these individuals often experience recurrent adaptation and specific emotions that may recur at regularly. Recurrent adaptation may be influenced by individuals' awareness of their personal resources to deal with challenges associated with treatment and their responsibility of the everyday life (Goodley and Lawthom, 2006:960).

A woman who acquired a disability at a later stage in her life may also struggle with trying to create meaning of what happened to her personally as a result of her disability. Trying to create meaning may be stressful and confusing for a woman with a physical disability. When this happens she may experience shifting of emotions from self-acceptance to self-rejection (Power and Dell Orto 2004:56-57). People with disabilities do not only have to learn to accept and adapt to the new changes and limitations but they also have to learn to understand themselves and focus on their capabilities as well as how to achieve emotional support (Nosek, 2006:997).

2.4. Causes of disability

Throughout the world physical disability has been a major public health concern. It has long been portrayed as a result of impairment, characterized by many causes (Abberley, 2006:31). Nowadays, the most known causes of physical disabilities in Africa are associated with spinal cord injuries, back pain, arthritis, mental disorders, mental retardation, orthopaedic malfunction and even asthma (WHO, 2011:33).

Activists such as Garland-Thomson (2002) believe that disability is a social construct and social conditions—such as the society's failure to overcome sickness and injury—are some of the roots for disability. Medical care plays a vital role in either preventing or creating disabilities (Abberley, 2006:31). For example, insufficient medical care may create disabilities when there is lack of good prenatal care

practices. The inability to cure impairments to the body also leads to severe body damage that can cause permanent disabilities (Wendell, 1996:59). In addition, the violence of wars and terrorism may create more disabilities. Crimes such as beatings, rape and shootings are also regarded as some of the causes of disability.

According to WHO (2011:34): “Road traffic injury, occupational injury, violence, and humanitarian crises have long been recognized as contributors to disability.” Cultural practices such as female genital mutilation are likely to cause impairments. Additionally, natural disasters such as earthquakes and floods sometimes also play a role in causing impairments that may later lead to disabilities (WHO, 2011:37). Furthermore, infectious diseases such as “...lymphatic filariasis, tuberculosis, HIV/AIDS, and other sexually transmitted diseases also lead to impairments” (WHO, 2011:32).

Disability is often regarded as the source of poverty (Emmett and Alant, 2007:452). Poor people with disabilities normally experience poverty because of their social class which gives rise to poor conditions that limit them in terms of their socio-economic status—leading to social exclusion. In this way people with disabilities may be financially disadvantaged and denied autonomy. Studies indicate that “...environmental factors such as low birth weight and a lack of essential dietary nutrients, such as iodine or folic acid, impact on the incidence and prevalence of health conditions associated with disability” (WHO 2011:37).

2.5. Approaches to disability

Two models to the study of disability are identified in this research study in order to understand the different perceptions on disability and the different attitudes of society towards disability. In this discussion, both the medical and the social model of disability will be examined. Briefly, the medical model of disability perceives disability as a personal tragedy that needs to be treated (Cameron, 2014:99). Whereas the social model sees disability as a social construct and people with disabilities are regarded as normal members of the society (Cameron, 2014:137).

2.5.1. Medical model

With the rise of the impact of the medical profession, the medical model took a dominant stance in people's views on disability in the late 19th and early 20th century (Sullivan, 2011:3). Within the medical model of the study of disability, disability is seen as a personal problem rising from the impairment of an individual's physical condition (Cameron, 2014:137). Because the medical model regards disability as a problem within an individual that should be fixed, certain means are taken into consideration by the medical professionals in order to fix disability to allow an individual's participation within her society (Cameron, 2014:137).

The medical model defines disability as "...loss, abnormality, restriction or lack of ability that is heavily laden with cultural meaning and indicates a perception of impairment and disability as characteristics of individual deficit or personal tragedy" (Cameron, 2014:137). When disability is viewed as an individual problem it impacts negatively on people who experience it (Cameron, 2014:137). Because they are viewed as weak and dependent, people with disabilities may experience restrictions from gaining access to services as well as restrictions of life opportunities and

experiences. Within this model, it is argued that people with disabilities feel isolated from the rest of the society (Sawadsri, 2011:54).

Medical professionals believe that disabilities should be cured (Wendell, 1996: 83). This way of looking at disability often places women with physical disabilities in conflict with their identity and self-respect (Wendell, 1996:83). Medical professionals are interested in curing disabilities to such an extent that they place little emphasis on the lived experiences of disabilities. The medical model is therefore not seen as an appropriate model of disability. Nevertheless, Katherine Sullivan (2011:4) says that when a disability involves chronic pain, it may be necessary to seek medical aid in order to find treatment. Some women with physical disabilities may redefine the self through acceptance of medical treatment and many may gain a new perspective on living. Susan Wendell (1996:82) is of the opinion that individuals with disabilities require medical attention because they sometimes experience pain. This way of understanding disability implies that even if social and environmental barriers are removed, an individual may still experience emotional and physical symptoms of disability such as pain, depression and fatigue (Shakespeare, 2006:200). Although individuals with disabilities may have medical needs, the medical model of disability is discouraged as the one that should be used to deal with and understand disability.

2.5.2. Social model of disability

During the 1970's, people with disabilities started to gain equal rights and a social approach to disability was adopted. The social model to the study of disability originates from the struggles of people with disabilities within society. The social model takes a different approach towards disability and rejects the idea of the medical model which indicates that disability is a medical condition. In this model

individuals are, in principle perceived as full members of the society (Siebers, 2006:173).

The social model of disability perceives disability as the product of an unfriendly environment towards people with disabilities. Disability is a term that refers to what society and the built environment have produced. For example, the stairs that may disable a wheelchair user to move around freely (Siebers, 2006:173). The social model of disability removes the problem of disability from a person towards environmental attitudes and barriers that are believed to institutionalise the disablement of an individual (Siebers, 2006:173). Lennard Davis (2006:199) agrees that the social model of disability strives to remove and identify the barriers that prevent individuals with disabilities from full participation in the societal activities. The social model illustrates that people experience disability because of social oppression and it therefore indicates that it is the society's responsibility to remove the barriers that lead to the disablement of people. In this way, the social model empowers people with disabilities and it suggests that the challenges that they face are the results of the environment that does not accommodate for them (Shakespeare, 2006:199). By identifying and attempting for the social barriers of disability to be removed, the social model of disability has been regarded as a fundamental way to look at people with disabilities (Shakespeare, 2006:203).

Unlike the medical model of disability, the social model has been useful in improving the self-esteem of women with disabilities and in building a positive sense of identity (Shakespeare, 2006:200). The social model suggests that disability is socially constructed and it is not the attribute of an individual (Shakespeare, 2006:214). In

this way, the social model of disability resonates with this study which is premised on the ideas of social constructivism.

The social model of disability separates disability from impairment. Oliver (1996:33) describes disability as "...all the things that impose restrictions on disabled people; ranging from individual prejudice to institutional discrimination, from inaccessible public buildings to unusable transport systems, from segregated education to excluding work arrangements." According to Carol Thomas (1999:22), disability does not occur as a result of impairment but rather as a result of the interaction between the social environment and the impairment. Moreover, Harlan Hahn (1986:128) points out that "...disability is the failure of a structured social environment to adjust to the needs and aspirations of citizens with disabilities rather than from the inability of the disabled individual to adapt to the demands of society." Disability is not an individual problem but rather society's ignorance to meet the needs of disabled people (Oliver, 1996:33). When society fails to meet the needs of the disabled, the society itself becomes a disabling factor to people with disabilities. In accordance with the social model of disability, individuals with disabilities are likely to become the victims of oppression and of the negative attitudes within their societies (Shakespeare, 2006:199).

Instead of coming up with traditional medical ways to cure disabilities, the social model proposes that the society should be fixed in order to allow for access of services and elimination of negative attitudes towards people with disabilities. A belief that society is the foundation of disability enables a rejection of the idea of disability as a personal problem (Shakespeare, 2006:199).

According to Oliver (1996:48): “The social model is not about the personal experience of impairment but the collective experience of disablement.” Even though the social model of disability helps us to understand the social construction of disability, it pays less attention to the importance of how impairment can impact on the experiences of individuals with disabilities (Oliver, 1996:48). The social model is interested in removing all the social barriers that restrict people with disabilities from gaining full participation in societies. Moreover, Oliver (1996:48) points out that the social model rejects the idea of individualism as a way of understanding disability.

In the perspective of Shakespeare (2006:203) the medicalization of disability is an improper approach to address disability while the social model is regarded as one of the available options for theorizing disability. One of the strengths of the social model is that disability is not an individual problem that only affects those with disabilities but also the society at large (Garland-Thomson, 2002:5). The social model of disability will be utilized to examine how well disability is understood and expressed in everyday reality.

Unlike the medical model that is more focused on individualism, the social model emphasizes that disability is a social issue (Davis, 2006:198). Hence, the social model of disability believes that disability is socially constructed while the medical model views disability as a problem of an individual (Davis, 2006:198). Disability research has, therefore, reinforced the social model of disability as the one that should be used, seeing that individuals with disabilities are oppressed by non-disabled individuals. The social model of disability enables individuals with disabilities to better describe their experiences of living with a disability (Davis, 2006:198). In addition, the social model of disability allows an insight into the way

women with disabilities make sense of, cope with, and manage their disability (Goodley and Lawthom, 2006:96). The social model encourages that individuals with disabilities, like the able-bodied individuals, should be treated in a non-discriminatory way (Oliver, 1996:37).

2.6. Qualitative research on disability

This research study focuses on the concepts that are important in understanding the experiences of disability. This is why a variety of concepts such as gender, identity construction, religion, race/ethnicity and social class are discussed here through a comparison of the literature on previous research disability studies (Barnes, 2013:94).

2.6.1. Disability and gender

Research that focuses on the experiences of people with physical disabilities indicates that there is an intersection between disability and gender (McDonald et al. 2007:147). Gender itself is defined as “...the socially learned expectations and behaviours associated with members of each sex” (Andersen and Taylor, 2013:253). The society perceives women and men in different ways. While men are associated with masculinity, women are described in terms of femininity. Women are expected to conform to the norms of femininity such as being a mother, a wife, a sexual partner as well as being physically attractive (Hanna and Rogovsky, 2006:44).

Women with disabilities may experience more difficulties conforming to the ideal of motherhood than their able-bodied counterparts because they are perceived as incapable of the role of being a mother. For instance, in a study done by William Hanna and Betsy Rogovsky (2006:44), there was little research done in terms of

special education for the role of a mother with physical disabilities. With this noted, it is clear that many people do not accept the notion that women with physical disabilities should have children because they are perceived as unsuited for this role (Hanna and Rogovsky, 2006:44). It is therefore not surprising that parenting by women with physical disabilities is often seen as a negative experience rather than a positive one.

It may be hard for some women with physical disabilities to meet the expectations of the role of a wife. Among many other roles, being a wife is seen by Hanna and Rogovsky (2006:44) as being a provider, a sexual partner and a domestic worker. The point here is that some women with physical disabilities may not be able to perform the above mentioned roles, depending on the severity of their disability. They experience double disadvantages, based on gender and disability: they may be less likely to marry (Hanna and Rogovsky (2006:44). This might be the case where a woman with a disability is seen as being unable to perform basic activities of daily living that are necessary for physical well-being. These include household chores, cooking and individual appearance. When women are not able to do a lot of things on their own, they are forced to be dependent on others. However, some women with disabilities are totally independent yet they may be unlikely to marry because they are portrayed as unfit and incapable of the role of a wife (Hanna and Rogovsky (2006:44).

Women with physical disabilities may feel inadequate and vulnerable as sexual partners. This is because they are often denied sexual rights (Hanna and Rogovsky, 2006:45). People assume that women with disabilities cannot have a healthy sex life. The reality is that most women with physical disabilities find it hard to meet men

and be in serious relationships because society believes that they are not worthy of love (Tilley, 1996:140). It is the opinion of Hanna and Rogovsky (2006: 45) that even if a woman was sexually active before impairment, her sexuality is thought to be lost after impairment.

According to Hanna and Rogovsky (2006:45): “Physical attractiveness is the most visible and most easily accessible trait of a person. Physical attractiveness is also a constantly and frequently used informational cue...Generally, the more physically attractive an individual is, the more positivity the person is perceived, the more favourably the person is responded to, and the more successful is the person’s personal and professional life.” However, this may be different for women with physical disabilities. While women may be expected to be attractive, women with disabilities are often perceived as being unattractive and unpleasant. When they are perceived in this way they may experience a negative body image. Women with disabilities are uncomfortable in their societies because they have to deal not only with the male gaze but also with the ideals of what constitutes feminine beauty.

Within the African context, women are often perceived as members of a minority and cannot do anything without the permission of men (Holmes, 2010:107). For instance, women cannot buy or sell property without the consent of their husbands because they are perceived as being inferior. Women with disabilities are often denied autonomy in many ways. They are denied the right to make their own free choices and they are forced to be dependent on others (WHO, 2011:9).

2.6.2. Disability and identity construction

Disability can be an important characteristic of self-identity. It is a powerful identity which affects people of all classes, ages, gender and culture (Davis, 2006:233).

Individuals with disabilities may face challenges in developing a positive sense of identity as a result of discrimination, stereotyping and oppression. Moreover, people with physical disabilities often struggle to develop positive self-perceptions of their physical and social abilities (Davis, 2006:233). Because of failing to develop positive self-perceptions, disabled individuals may experience negative perceptions of the self which may prevent them from participating in societal activities leading to social exclusion, limited opportunities and labelling (Blinde and McClung, 1997:327).

Additionally, studies reveal that society plays an active role in determining the negative self-perception of people with disabilities. The everyday lived experiences and day to day interaction within the society can reinforce the negative perception of self for the physically disabled (Blinde and McClung, 1997:328). This suggests that the self-image of women with disabilities may be subjected to the reactions, such as being feared or avoided, of others. Hanna and Rogovsky (2006:46) claim that some women with disabilities accept the image given to them by the rest of the society. For instance, they may accept that they are weak, incapable and in need of help. People with physical disabilities normally face the problem of having to deal with the curiosity of others with regard to their disability (Goodley and Lawthom, 2006:99). For example, a woman with one arm may come across questions such as: What happened to your leg?

Identity describes belonging. It refers to what people have in common and how they are different from each other (Davis, 2006:233). At its most basic function, identity provides an individual with a sense of individual location. Nicholas Watson (2002: 519) comments that there is no one single meaning of disability because it is defined differently across many cultures. Thus, it is impossible to coin a concept of identity

for individuals with disabilities. Rather, disability as an identity, can be seen as an individual construction in attempting to make self-meaning.

Individuals with disabilities can achieve their self-identity through a reconstruction of what is viewed as normalcy. In this way, an individual with a disability may challenge the notion of social construction of what is perceived as a normal body and create her own understanding with regard to what is normal to her (Watson, 2002:519). The construction of self-identity for people with disabilities is important because it may enable them to construct self-identities that are removed from the medical model of disability that, itself, defines disability as a personal tragedy (Watson, 2002: 521). Disability-identity is referred to as that part of the self-concept that develops from how women with physical disabilities define themselves in relation to their disability (Watson, 2002:513).

2.6.3. Disability and religion

Physical disability may be a threat to the independence of many women who experience it. When they are not able to care for their physical needs, women with disabilities may experience distress and suffering. Linda Treloar (2008:9) is of the opinion that depending on other people may impact on an individual's self-esteem and sense of purpose in life. As a result, such a woman may experience depression and other negative emotions such as feelings of disempowerment and vulnerability. In some cases, disability sets a stage for questions that include self and God, especially when an individual with a disability perceives her physical wellbeing to be different from that of other individuals.

Treloar (2008:10) concludes that: "In the mist of theological confusion and public attitudes surrounding the meaning of disability, people with disabilities may

internalize negative messages and the outcome may be rejection of God and spiritual belief that could be helpful.” Religious believes may present a structure through which people with disabilities create their own meaning of disability. Some individuals with disabilities may reject God because they believe that their disability is a kind of punishment for something they did wrong. That is why negative religious emotions such as ‘God was punishing me’ and ‘why me?’ may be experienced (Blanks and Smith, 2009:301).

Religion is important to many people globally. However, studies indicate that there has been a lack of attention to the spirituality of women with disabilities (Blanks and Smith, 2009:295). Spiritual beliefs may influence how women with disabilities perceive themselves and others around them. In addition, spiritual involvement may help women with physical disabilities to live a better and positive life; it may help them to remove the negative psychological consequences associated with disabilities. Thus, religious individuals with disabilities may have greater hope and motivation for recovery. Furthermore, some individuals increase their personal religious involvement as a means to cope with challenges of disabilities (Treloar, 2008:5).

What an individual beliefs affects how she responds to everyday lived experiences. She may accept her disability and choose to live a positive life. This reflects on an individual’s believe in God who helps her to create a positive meaning of everyday live by creating acceptance. Individuals exercise their spiritual beliefs in order to experience less stressful situations, lower levels of loneliness and to gain more self-confidence (Hill, 2003:66). In addition, women who have a connection to God may experience health related benefits such as less depression and high degrees of self-

esteem. The negative outcomes of religion may involve negative mood and depression. In relation to physical health, the negative side of religion may involve a decline in speedy recovery. With respect to positive outcomes, individuals may grow spiritually. Furthermore, the kind of support that individuals receive from members of their congregation may benefit their health (Hill, 2003:68).

An individual's disability and her spirituality may impact on her personal identity. Treloar (2008:5) claims that there is a relationship between the spiritual meaning of disability and the physical and cultural features of what individuals with physical disabilities experience. How an individual identifies with her disability may be influenced by her spiritual beliefs. "Religion may modify one's primary appraisal of negative life events such as pain, causing one to reassess the meaning of potentially stressful situations and to see them as opportunities for spiritual growth or learning or as part of a broader divine plan, rather than as a threat to personal identity" (Koenig, King and Carson 2012:517). Women with physical disabilities may use prayer as a means of coping in order to overcome difficulties. In addition, spirituality may impact on an individual's ability to accept pain and disease. Research indicates that just like any other means of coping, religion and spirituality may be an important source of an improved self-esteem and a positive personal identity (Lysne and Wachholtz, 2010:1).

Religion may promote acceptance and provide a way for women with disabilities to give meaning to their disability (Cook, Powell and Sims, 2009:129). Even though religious participation plays a vital role in creating meaning for people with disabilities, some people with disabilities do not always have positive experiences. In some cases, individuals with disabilities may not be involved in faith communities

and these may lead to negative experiences of disability (Cook et al. 2009:129). How women with disabilities cope may be affected by various factors such as the cause and nature of their disability.

2.6.4. Intersectionality

Intersectionality as a concept was introduced to feminist theory in order to deal with the various forms of interrelated classes such as disability, race/ethnicity, religion, gender and social class (Shaw, Chan and McMahon, 2012:83). Furthermore, intersectionality was defined by Kimberle Crenshaw (1999) in trying to understand the various oppressions of race/ethnicity, gender and social class as experienced by African women. Wendell (1996:70) is of the opinion that living with a disability is not the same for all individuals with disabilities because disabilities are differently experienced. Thus, living with a similar disability is different for women from different races/ethnicities, social class and age groups. Wendell (1996:71) writes that disability usually gives people with disabilities experiences of the world different from that of non-disabled people. And that "...these differences in experiences create the possibility of different perspectives which have an epistemic advantage with respect to certain issues" (Wendell, 1996:71). Even though sometimes women with disabilities may experience the same bodily struggles, their social experiences may differ (Wendell, 1996:71).

Intersectionality deals with the effects of discrimination on different sectors of the society. Following the research of Shaw et al. (2012:84), women with physical disabilities are perceived as members of society who are in the most inferior position, compared to other members of the society. Shaw et al. (2012:88) state that the interrelationship of the forms of oppression indicates that some women are at a

higher risk of experiencing harassment and oppression, based on the notion that they are women, they are disabled and they are members of the minority racial group. Such women who also happen to be members of minority groups have experienced injustice, have been discriminated against and isolated, in many cases from their families, employment and educational institutions (Shaw et al. 2012:88). For convenience and simplicity, each form of oppression is dealt with separately and in isolation in order to increase our understanding of Intersectionality (Mollow, 2006:284).

2.6.4.1. Race/ethnicity

It is important to point out that to be an African disabled woman is to experience a double oppression. Women with disabilities are expected to contend to the norms of the society yet when they do, they are discriminated against and stereotyped. Authors such as Stuart (2006:295) argue that racism within disability is part of oppression which many women with disabilities experience. African women with disabilities experience oppression not only from the able-bodied individuals but also from disability communities themselves. With this in mind, it should be noted that African disabled women are assumed to be outsiders as a result their rights to access services and resources are compromised (Stuart, 2006:295).

According to Mitch Berbrier (2008:569), differences in race are expressed in culture and reproduced in educational institutions; above all, such differences are reproduced in family life. Race is about power while ethnicity is about history, politics and culture. Ethnicity is "...the broader category, differentiating peoples primarily along cultural lines, and race is but one form of ethnic distinction, the one that

emphasizes both physical and cultural characteristics even though it is recognized as the form most strongly correlated with hierarchy” (Berbrier, 2008:569-570).

McDonald et al. (2007:147) use the term race to refer to an individual’s physical characteristics such as the colour of her skin and eyes and the texture of her hair. African women with disabilities often experience restrictions from access to resources and are likely to be cut off from their communities as a result of their disability. In her comment, Angela Harries (1990:589) says that “...black women will never be anything more than crossroads between two kinds of domination or at the bottom of a hierarchy of oppressions.” Therefore, African women with disabilities experience additional discrimination based on their race/ethnicity, and as a result, they may find it hard to deal with negative stereotypes.

2.6.4.2. Social class

Social class is “...a nexus of unequal lived relationships arising from the social organisation of production, distribution, exchange and consumption” (Bradley, 1996:46). Class and financial concerns are related to disability, especially when women with disabilities experience low-class income or are unemployed (McDonald et al. 2007:148). More people with disabilities may experience poverty as a result of lower levels of income leading to the impact on their day-to-day reality. Some people with disabilities are likely to be marginalised because they live in poverty (McDonald et al. 2007:148), possibly because some individuals with disabilities that experience lower levels of income have limited economic and social resources (McDonald et al. 2007:148).

2.7. Qualitative research on the lived body

Disability and impairment are experienced in, out and through the body in terms of cultural and personal narratives that allow an individual to construct her own meaning of disability as part of her lifeworld (Papadimitriou, 2008: 694). The body is central to the experiences of everyday life. How people interact in everyday life emphasises the importance of embodied experience (McMahon and Huntly, 2013:31). Embodiment is viewed as highlighting the physical and emotional framing of our bodies in everyday encounters (McMahon and Huntly, 2013:31). In this study, disability is understood from the point of embodied experience of action and meaning. The lived body is an impaired body. Moreover, it is linked to the experiences such as past actions, thoughts and beliefs that women with physical disabilities have encountered in their lives while the living body experiences the current thoughts, beliefs and actions (McMahon and Huntly, 2013:31).

By focusing on the narratives, an understanding will be gained of how the lived body represents subjective experiences that entail or are connected to the concept of embodiment. From the perspective of Bill Hughes and Kevin Paterson (2006:101) “...the impaired body is not just experienced: it is also the very basic experience.” The body is our point of view on the world. That is why it is important to consider the meaning of the lived body in order to understand disability while the meaning of disability is also important to help to recall the concept of the lived body (Hughes and Paterson, 2006:101). It is not surprising then that disability is experienced from the angle of impairment. For instance, when an individual loses her mobility, her subjective experiences becomes linked to the capacity of her body as well as her surroundings. For example, an individual on a wheelchair may not be able to reach

for a pocket of sugar in a store because the shelves are high. Therefore, she may have to find someone to take the sugar off the shelves for her.

The body is described by Hughes and Paterson (2006:101) as “...an experiencing agent, itself a subject and therefore a site of meaning and source of knowledge about the world.” Hughes and Paterson (2006:102) further consider the importance of physical, emotional and cultural factors in determining women with physical disability’s embodied experiences. Peters, Gabel and Symeonidou (2009:548) claim that “...the body becomes a metaphor for culture, where culture is created from whole body experiences and the disabled body is the interactive force for cultural identity and change.” This means that physically an impaired body cannot escape cultural meanings. When women with physical disabilities cannot meet the cultural expectations of the normal body, they may perceive their bodies as a source of pain and embarrassment.

Identifying women with disabilities in terms of their body limitations implies stigma. Stigma originates from the cultural expectations about an individual. When a woman is unable to meet the cultural expectations of a feminine body, the body is stigmatised leading to negative reactions which may lead to making attempts such as surgery to avoid the basis of stigmatisation (Holmes, 2010:110). Furthermore, women with physical disabilities may experience isolation because they are viewed as members of a stigmatized group by the non-disabled society (Wendell, 1996:25).

2.8. Feminist disability research

Feminist disability researchers such as Garland-Thomson (2002) have taken into consideration the importance of gender issues among people with disabilities. Gender is defined as “...established psychological, social and representational

differences between men and women, which are socially determined and culturally variable” (Howson, 2013:51). Gender determines categories of the body as either male or female and the lived experiences of a gendered embodiment (Howson, 2013:52). The feminine and disabled bodies are perceived by society as weak and inferior (Howson, 2013:52). Thus, women with disabilities are at a higher risk of experiencing a double oppression, based on the notion that they are women and they are disabled (McDonald at el. 2007:147). Turning the spotlight on oppression, how non-disabled people behave towards women with disabilities has become a social problem (Morris 2006:291). According to Hall (2011:4), an understanding of the relationship between gender and disability points towards a continuing relationship between forms of oppression. Social oppression negatively impacts on women with disabilities. Thus, to understand the oppression that women with disabilities come across, their everyday lived experiences should be taken into consideration (Goodley and Lawthom, 2006:95).

The feminist disability approach offers an understanding of the cultural history of the meaning of the body. Garland-Thomson (2002:4) is of the opinion that: “Feminist disability theory addresses such broad feminist concerns as the unity of the category woman , the status of the lived body, the politics of appearance, the medicalization of the body, the privilege of normalcy, multiculturalism, sexuality, the social construction of identity, and the commitment to integration.” Normalcy is related to the control over bodies of women with physical disabilities. Hall (2011:4) sustains that disciplined bodies are also properly gendered bodies. This means that people behave and act in a way that is related to sex and gender. Moreover, Deborah Lupton (2012:39) claims that “...a body that does not function normally or appear normal or that is confined to a wheelchair or bed is both visually and conceptually out

of place, as evidenced by lack of public facilities for people with disabilities.” Normal is understood by Hall (2011:3) as an identity constructed by able-bodied individuals on how an individual’s body should look. Disability is seen as part of human experience that is also defined in terms of non-disabled people (Morris, 2006:284). According to Garland-Thomson (2002:11): “Normal has inflected beautiful in modernity.” In other words, what is believed to be a normal body should undergo surgery to remove blemishes, scars and impairments (Holmes, 2010:110). This way of looking at disability may make women with disabilities more conscious of their bodies and this can leave them feeling worthless and ashamed (Goodley and Lawthom, 2006: 95). This specific aspect of disability is highly influenced by cultural representations and disabling images (Holmes, 2010:107).

Women with physical disabilities are hardly ever seen on televisions and films and, when they are part of the story-line, the focus is not on their experiences but on their impairments. “All these discriminatory practices are legitimated by systems of representation, collective cultural stories that shape the material world, underwrite exclusionary attitudes, inform human relations, and mould our senses of who we are” (Garland-Thomson, 2002:9). These negative cultural practices do not only affect how women with disabilities perceive themselves but also how the society at large perceives them (Goodley and Lawthom, 2006:95).

The female body is perceived as being naturally different from the male body hence it is believed to be weaker and inferior to the male body (Howson, 2013: 52). According Holland, Blair and Shelton (1995:263), “...the relation of the two sexes is not quite like that of the two electrical poles for man represents both the positive and the neutral whereas woman represents only the negative, defined by limiting criteria,

without reciprocity.” Unlike men, women with disabilities are at a higher risk of experiencing negative attitudes than disabled men. Such attitudes include isolation from their own society and elimination from performing certain roles of femininity such as, motherhood and sexuality (McDonald et al. 2007:147).

The society’s construction of the female body has led to the distance between women with disabilities and able-bodied women. Society divides individuals of the same race against each other (Morris, 2006:292). When this distance occurs, women with physical disabilities may incur fear of being further discredited within their societies. As a result, they may struggle to create intimate relationships because they fear rejection as their bodies are usually undermined. For this reason, women with physical disabilities also face difficulties in describing their everyday lived experiences because they are usually judged based on their capacities and personalities.

2.9. The disabling barriers and implications of everyday life

Women with physical disabilities face multiple barriers in their everyday lives. These barriers may vary from interaction of health conditions to personal and environmental factors. WHO (2011:6) describes barriers as: “Factors in a person’s environment that, through their absence or presence, limits functioning and creates disability. These include aspects such as a physical environment that is not accessible, lack of relevant assistive technology (assistive, adaptive, and rehabilitative devices), negative attitudes of people towards disability, services, systems and policies that are either non-existent or that hinder the involvement of all people with a health condition in all areas of life.” For the sake of this study the attitudinal, physical and social barriers are discussed.

2.9.1. Attitudinal barriers

Of all the barriers that people with disabilities face, attitudes of others are the most difficult to eradicate. How an individual feels about herself is often affected by the attitudes of others. The negative attitudes may result in discrimination, stigma and stereotyping that may impact on women with disabilities, resulting in poor self-care and low self-esteem while positive attitudes may promote acceptance and a sense of self-worth (Power and Dell Orto, 2004:31).

The negative attitudes of non-disabled people toward women with disabilities result from the way in which society constructs built environment which socially marginalise people with disabilities (Sawadsri, 2011:53). How able-bodied individuals react towards disabled individuals evokes negative reactions such as gazing and staring, fear, hostility and anxiety (Sawadsri, 2011:61). Negative attitudes towards individuals with disabilities result in negative treatment of women with disabilities such as being patronised by strangers (WHO, 2011:6). People with negative attitudes towards the disabled usually fail to distinguish between disability and impairments. Therefore they are unable to understand how the environment barriers impact on the lived experiences of disabled individuals (Sawadsri, 2011:54). Furthermore, disabling environment is understood as "...the phenomenal form of sub-structural processes which devalue physically impaired bodies" (Sawadsri, 2011:53). This is why the construction of physical barriers by the society limits the ability for people with disabilities to participate freely in community activities (Wendell, 1996:25).

Many laws maintain that women with disabilities should be treated just like any able-bodied individual (Woodin, 2014:88). Nevertheless, individuals with disabilities still experience discomfort and fear during interaction with others in communities. Within

the society, the negative attitudes towards people with disabilities stem from an assumption that disability is an individual problem that needs medical attention (Cameron, 2014:137). The prejudice and myths about disability constitutes barriers when people with disabilities are avoided or neglected (Goodley and Lawthom, 2006:98).

2.9.2. Physical barriers

Physical barriers are described by WHO (2011:263) as the manmade environments that limit people with disabilities from moving freely from one place to another, thereby blocking their mobility. Built environments, transportation and information systems are often inaccessible for people with physical disabilities (WHO, 2011:263). Physical barriers imposed by the society hinder disabled people from access to public buildings (Sawadsri, 2011:53). Such environments can limit choices and opportunities for individuals with disabilities where obstacles such as uneven ground and sidewalks, inaccessible public bathrooms, narrow doorways and ramps limit wheelchair users.

Studies indicate that public transport has been a problem for individuals with disabilities over the years. Barriers in transportation may involve lack of wheelchair anchoring in buses and inaccessible bus or train stations. Additionally there has been discrimination of individuals with disabilities by unfriendly taxi operators (WHO, 2011:178). Due to limited special transport services and inaccessible taxis, women with physical disabilities may be unable to access public transport on their own.

2.9.3. Social barriers

Social barriers consist of conditions such as where an individual was born, where she grew up, where she lives and where she works. Social barriers may be emotionally and physically challenging for women with disabilities because living with a physical disability affects an individual's sense of independence, sense of worth and her social value (Mumma, 2000:19). People with disabilities experience lower job opportunities. When they are employed, they are likely to earn smaller salaries than able-bodied individuals. Hence, most people with disabilities experience higher rates of poverty than non-disabled individuals and they are likely to have poorer living conditions than their able-bodied counterparts (WHO, 2011: 263).

2.10. Conclusion

The 21st century world is often more interested in the normality of the body and how the female body should look (Holmes, 2010:110). "Feminist representations of the body have attested to the necessity of the rational disembodiment of the person, rejecting the notion of the relation of sex (as given fact) to gender (as cultural artifact)" (Lupton, 2012:25).

From the literature review of disability, the purpose of this study now moves to develop an understanding of what it entails to live a life with a physical disability in Lesotho from the perspective of young African women. The notion of individuals' experiences as experts in their experiences helps us to gain a richer understanding of the lives of women with physical disabilities.

The nature of previous research on disability points out much of how society perceives and understands disability and how it ignores the experiences of women

with physical disabilities. With reference to the models of disability, it is important to develop an insight into how women with disabilities construct meaning and how they understand their disability (Goodley and Lawthom, 2006:96). Hence, particular models of disability are applied in this research study. The main point uncovered by the social model of disability is the freedom for people with disabilities to engage fully in the society as members. Nevertheless, models of disability give very little attention to the needs and emotional impact of disability on people with disabilities.

The selected methods and how the study was conducted in order to understand the experiences of young African women with physical disabilities in Lesotho are discussed in the next chapter.

CHAPTER 3: METHODOLOGY

3.1. Introduction

This chapter focuses on the methods that are used to identify how young African women with physical disabilities in Lesotho experience their everyday lives. The main reason for choosing a qualitative approach to conduct this study is discussed. The research design, sampling methods, interviews and the process of collecting and analysing collected data are applied with care to address the ethical procedures. The techniques taken to ensure accuracy of the study findings are also discussed.

3.2. Research design: qualitative approach

Research design is referred to by Kevin Durrheim (2006:34) as “...a strategic framework for action that serves as a bridge between research questions and the execution or implementation of the research.” The essential step in constructing a good research design calls for a researcher to answer several important research questions before undertaking a study (Bless, Higson-smith and Kagee, 2006:71). Research design relates directly to the phenomena under scrutiny and can be understood as detailed guidelines on how researchers plan to conduct their study (Durrheim, 2006:34). Researchers make use of a research design when there is a need to explore any topic of the social world such as experiencing disability (Bless et. 2006: 72). In order to draw a detailed guideline on how to conduct this study the researcher had to answer the initial questions before formulating the actual research questions. For instance, the initial questions such as *how* can research be conducted with women with physical disabilities? What right does a researcher have to undertake this study? Who is this study for and what responsibilities come with it? (Nind, 2008:5). The initial premise is to know the everyday lived experiences of

women with physical disabilities. Therefore, the important question is not if women with physical disabilities should be included in the study but *how*. To answer these questions the researcher carefully identified the research problem, reviewed the previous literature associated with physical disabilities, formulated the research questions central to the research problem, planned how data would be collected and the methods that would be used to analyse collected data (Bless et al. 2006:73).

Qualitative research is at the heart of this study. Norman Denzin and Yvonna Lincoln's (2011:3) definition of qualitative research is utilized. Qualitative research "...consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings, and memos to the self." Hence an alternative set of methods such as individual interviews, conversations, field notes, memos and recording of interviews are used in this study to discover participants' perceptions of physical disabilities (Creswell, 2013:43-44). According to Sally Hartley and Mohammad Muhit (2003:103), qualitative research holds the views that as far as individuals' perceptions are concerned; there is no one single truth.

Qualitative researchers study things in their natural settings, in an attempt to make sense of or to interpret a phenomenon in terms of the meanings that people bring to it (Creswell, 2013:44). The premise for choosing qualitative research for this study is to explore how women with physical disabilities interpret their subjective experiences of femininity and gender. Creswell (2013:48) proposes that in qualitative research, research participants construct reality as forms of lived experiences and this reality is understood when participants communicate their different perspectives. Moreover,

qualitative research is used as an effective tool in identifying intangible issues, such as social norms, gender roles, race/ethnicity, disability and religion whose roles in research are not readily apparent (Creswell, 2013: 48). Thus, this research study deserves a qualitative approach because there has been little known about this field and because women with physical disabilities are a vulnerable group (Hartley and Muhit, 2003:108).

One of the common theoretical approaches to qualitative research is phenomenology (Creswell, 2013:76). A phenomenological approach attempts to describe the participants' lived world in a way that increases the understanding of human beings through human experience (Norlyk, Martinsen and Kjaer-Petersen, 2013:2). According to Greenfield and Jensen (2010:1185), "...a phenomenological approach provides a more contextual approach to ethical decision making through probing, uncovering, and interpreting the meaning of stories of patients." It is through phenomenological conversations that the everyday lived experiences of women with physical disabilities are understood from their own point of view.

3.3. Narrative inquiry

The experiences of participants were elicited through narrative interviews. A narrative is defined by Robert Atkinson (2002:123) as a "...method of looking at life as a whole, and as a way of carrying out an in-depth study of individual lives...It has become a central element of the burgeoning subfield of the **narrative study of lives**, for its interdisciplinary applications in understanding single lives in detail and how the individual plays various roles in society." Narrative inquiry is based on the notion that people organise and tell stories as a way of making sense of their lived experiences. It is crucial to note that in this research project, stories are referred to as meanings of

the lived experiences as assigned by women with physical disabilities. Narrative inquiry provides an individual with an opportunity to tell her story the way she knows it (Webster and Mertova, 2007:15). Therefore, narrative inquiry acts as a therapeutic process which allows women with physical disabilities to voice the meanings and constructs of their lived experiences (Webster and Mertova, 2007:15). Narratives refer to the lived experiences of people with disabilities as means to point out the ways in which they are culturally or socially marginalised. For Margaret Somers (1994:606) people understand and make sense of their social world through narratives and it is through narratives that they constitute their social identity. Narrative inquiry is necessary because listening to the stories of women with physical disabilities reflects on an intersection between their personal beliefs and their cultural influences.

Given that through communication the meaning of what was experienced is conveyed, the narrative approach plays a fundamental role in this study. The narrative approach is a method of data collection which enables an insight into the physical, social and psychological situations of women with physical disabilities and how this impacts on their lives. By implementing the narrative inquiry, the researcher engages in conversations with research participants on a personal level in order to understand their experiences of disability. The researcher listens carefully to the stories of individuals the way they know it (Titchkosky and Michalko, 2014:101). Accordingly: "The meaning of disability is given whenever we speak of it, act upon it, or even think of it. To say anything about disability is to tell something of the life of disability and to tell is the Latin root-meaning of narrative. Disability, then, always has a narrative form; insofar as we say, do, or imagine something about disability, it is a storied life" (Titchkosky and Michalko, 2014:101). Therefore, narrative inquiry

focuses on the stories that women with physical disabilities communicate when they are asked to narrate their experiences (Titchkosky and Michalko, 2014:102). By encouraging women with disabilities to share their personal narratives, the researcher can also contribute to changing how society perceives and understands disability.

3.4. Collecting the narratives

In this section the steps taken to collect data and the ethical considerations necessary for research are discussed.

3.4.1. Sampling

Sampling helps researchers to select research participants from a larger population. The premise of sampling is to enable researchers to make decisions about the research population, research settings, events and social processes for observation (Terre Blanche, Durrheim and Kelly, 2006:323). Creswell (2013:155) maintains that purposive sampling is one of the non-probability sampling methods where researchers locate participants for in-depth interviews. The premise of purposive sampling is that a deeper understanding of a particular field of study is gained and the participants do not represent a larger group (Creswell, 2013:155). This method of sampling selects women with physical disabilities who share particular knowledge on disability (Creswell, 2013:155).

Purposive sampling as the chosen sampling method for this study was used to select one individual with a physical disability who was willing to take part in the study. Due to the sensitivity of the study, the participant who was willing to take part was requested to help the researcher to identify other individuals with physical disabilities that were also willing to take part in the study. The new participants were not forced

to take part in the study. The process continued until sufficient individuals who qualified as research participants were identified. Thus the sample group appeared like a rolling snowball, the form of sampling also known as network or referral sampling (Neuman 2012:149).

3.4.2. Target population

Disability was conducted examining eight study participants, all of whom are African women from Lesotho. Their everyday, taken-for-granted world is identified through expression of their thoughts, language, perceptions and the body (Merleau-Ponty, 1945). Furthermore, young African women with physical disabilities are involved in this study in order to research disability as an intersection of gender, ethnicity/race, religion and social class. The study is done on young women because they are a more vulnerable group that experiences a double discrimination based on their disability and gender. Since the researcher is aware that young women who have been living with physical disabilities for large parts of their lives are sensitive to embarrassment, special care was taken to be discreet and understanding. As indicated in the participant information sheet and in the informed consent form, the interests of participants are protected.

At the time of the interviews, two participants were married, two were in intimate relationships and one of them was a single mother while three other women were single. All the participants lived, for most of their life, in rural areas but at the time of the interviews they were studying at the vocational school of the physically disabled in the capital city of Lesotho, Maseru. Their socio-economic levels and the information on their educational level did not play a role in their recruitment. The aim was to select participants that best match the specifics and experiences linked to the

research questions. The eight participants for this study were selected according to the dissertation's definition of physical disability.

Five participants use mobility aids. For example, three women are wheelchair-dependent. One uses walking sticks while one uses mobility aid shoes. Three other women do not need mobility aid as they have full use of both legs. Participants' ages range between 21-35 years.

Following the ethical approval for the study project (discussed later in the study) the potential participants were recruited. The following section is based on the necessary measures taken to recruit the research participants.

3.4.3. Gaining access and recruitment of research participants

One participant was recruited through Tsepo Counselling Services.¹ The researcher contacted Mr Mosa² from Tsepo Counselling Services. After explaining the research study and aims to Mr Mosa, a potential participant was introduced by him to the researcher. Mr Mosa had no further involvement in the participant invitation process. This participant then contacted the researcher directly by e-mail. Taking the sensitivity of the study into account, the participant who was willing to take part in the study was requested to help the researcher to identify other individuals with physical disabilities that were also willing to take part.

The researcher was then referred to Bophelo Vocational School of the Physically Disabled by the potential participant. The researcher made personal contact with the principal of the school to facilitate access to the school. Melanie Nind (2008:9) is of

¹ Tsepo Counselling Services is a pseudonym for one of the organisations involved in the recruitment of research participants. All names given to organizations are pseudonyms to protect the organisations from being identified.

² Mr Mosa is a pseudonym for one of the people who took part in the recruitment of research participants. The real names of all people involved in research participants' recruitment are not identifiable.

the opinion that “...gaining access to participants in order to collect data almost always involves going through gatekeepers or facilitators, and even through a hierarchy of gatekeepers or ties of management.” Before being granted access to the school the researcher provided the principal of the school with a copy of the approved ethical clearance. The researcher explained the purpose of the study to the principal who, in turn, was later asked to suggest members of the school community who fulfilled the criteria for the physically disabled women. The principal approached the potential participants and distributed the participant information sheets to them in order to determine their interests. Special care was taken to emphasize that participation in the research was voluntary. The process continued until sufficient participants had been identified. The principal had a good relationship with the potential participants and this added to the advantage of the researcher because she was accepted and trusted by the participants. In order to avoid any possible embarrassment or leaving participants feeling pressured to take part in the study, none of them were known to the researcher before the interviews.

3.4.4. Research setting

It is the responsibility of the researcher to foresee and identify any possible physical safety risks before conducting interviews (Neuman, 2012:56). Because the participants are people with physical disabilities, qualitative research stresses the importance of conducting research at a place convenient to the research participants. In-depth interviews were conducted with women with physical disabilities residing at the vocational school of the physically disabled in Lesotho. In an occasion where danger could arise during the interviews, the interviews would be suspended and if necessary, participation would be terminated.

3.4.5. Ethical boundaries and risk mitigation

Qualitative research methods are utilised in this study to discover the participants' feelings, emotions and the construction of meanings (Hennink, Hutter and Bailey, 2011:63). This is a highly sensitive study that demands the researcher to apply for an ethical clearance. After applying for ethical clearance from the Faculty of Humanities' Ethics Committee at the University of the Free State, permission was granted to conduct the research. The ethical clearance number is: (UFS-HSD2015/0615, 09-Nov-2015).

The interviews in this study carry a potential to cause subjective distress in women with physical disabilities (Terre Blanche, Durrheim and Kelly, 2006:72). Therefore, it is the responsibility of the researcher to identify the kind of risk factors that could be foreseen for general participant involvement (Neuman, 2012:58). Because this study deals with sensitive issues, an effort was made to avoid/minimise any harm to participants, whether physical, psychological or legal (Neuman, 2012:58).

In this section the ethical procedures as required by the Ethics Committee of the Faculty of Humanities at the University of the Free State are discussed.

3.4.5.1. Consent

The standard components of a valid consent are "...provision of appropriate information, participants' competence and understanding, voluntariness in participating and freedom to decline or withdraw after the study has started, and formalization of the consent, usually in writing" (Terre Blanche et al. 2006:72). With this in mind the researcher provided the potential participants with a valid written informed consent form, with clear detailed information about the study. This is a highly sensitive study and the risks of harm were high. It was, therefore essential to

obtain a signed consent from each participant. The consent clearly highlights the assurance of confidentiality and anonymity. Attention was brought to the participants that the study was voluntary and that they had a right to withdraw from it at any time if they felt any form of discomfort. An effort was made to avoid deception as this might have increased mistrust and might have led to disrespect.

3.4.5.2. Emotional distress

Neuman (2012:58) makes a strong point that some studies can generate anxiety which may produce personal discomfort for research participants. An effort was made to ensure that participants were protected from emotional harm. Where sensitive information was addressed, participants were made aware that painful experiences might be uncovered and there might be a possibility of emotional experiences. In order to manage this risk factor, the researcher made participants aware that they were not forced to answer any questions which might make them feel uncomfortable. The participants were also reassured that they had a right to change the topic or any other issue that might upset them. They were made aware that the interviews would be stopped immediately and counselling services would be provided if they were upset during the interviews.

3.4.5.3. Confidentiality

Confidentiality is an essential issue to the study participants. However, any participation in research carries the risk of loss of confidentiality (Neuman, 2012:62). In order to minimize this risk factor, the study records (including audio and electronic data files) were kept as anonymous as possible and passwords were protected. Any information on hardcopies was scanned into PDF documents and the scanned

documents were stored electronically. The original documents of the hard copies were destroyed after being scanned.

For the sake of privacy, an effort was made to prevent data from being published in a manner that links the participants to the study. Some participants wished for their personal identification to be disclosed in order to maintain ownership of data (Neuman, 2012:62). However, the researcher made them aware of the shortcomings of disclosing identity. Anonymous information is used here to prevent it from being associated with the participants. To prevent participants from being identified, their lifestyle details are not mentioned in data transcriptions. The researcher also de-identified participants by using pseudonyms.

3.4.5.4. Cultural embarrassment

The interviews took place in the community where participants are well known. There was a possibility that participants would experience some discomfort. To minimize this potential risk, the participants were visited at an organization for the physically disabled individuals. The reason for the visits remained confidential between the researcher and the participants. The researcher made it clear that should the participants wish to withdraw from the study they were free to do so without incurring any negative effect.

3.4.5.5. Token of appreciation

Neal Dickert, Ezekiel Emanuel and Christine Grady (2002:368) indicate that “...money may induce subjects to participate in research by compromising the voluntary nature of their decisions or their willingness to explore the risks and benefits of the study.” Hence, the participants received a R100 gift voucher from the researcher as a token of appreciation. To minimise the risk of participants’

volunteering for payment, the participants were not informed of this token beforehand. The token of appreciation served as the researcher's acknowledgement of the contribution made by the research participants.

3.5. Data collection process

In this section the semi-structured-in-depth interviews, the pilot study and observation are discussed as methods of collecting data.

3.5.1. Semi-structured in-depth interviews

In a semi-structured interview, the researcher and the research participant engage in a formal interview. After the design and research methods had been selected the researcher designed an interview schedule ahead of the actual interviews (Creswell, 2013:164). The interview schedule consisted of open-ended questions related to the phenomenon under study in order to obtain information relevant to the experiences of physical disabilities (Silverman, 2013:199). The premise for open-ended questions is to allow the participants an opportunity to answer questions on their own (Silverman, 2013:199). During the interviews the researcher used appropriate verbal and non-verbal feedback to indicate that she was paying attention to the purpose of the interview (Creswell, 2013:164). Face-to-face interviews allows the researcher an opportunity to use prompts and probes to clarify concepts and extend the narrative in order to yield rich data.

By conducting an in-depth interview, the real stories of women with physical disabilities are uncovered (Atkinson, 2002:126). A starting point to conduct in-depth interviews was introducing the research topic to the potential participants. The participants were then provided with informed consent forms which they were asked to read, understand and sign. Before signing the informed consent form, participants

were given a chance to ask the researcher any questions concerning the study and to seek clarity on the participant information sheet. An agreement was obtained from the participants to audio-record the interviews so that later the interviews were translated and transcribed. No participant raised questions about the consent form and the recording of the interviews. When all the participants had read, understood and signed the informed consent forms, the in-depth interviews started. The research interviews started with what seemed like a simple question: "Please tell me a bit about yourself. Anything." The participants started by introducing themselves. They also talked about their families and their experiences. These included their feelings, emotions, knowledge and reactions.

Using in-depth interviews as a method of data collection is important in this study because an understanding of the narratives of young African women with physical disabilities in Lesotho was obtained. The primary aim for in-depth interviews is to generate data which give an authentic insight into the experiences of living with a physical disability (Silverman, 1993:91). In this sense, authenticity is described as how participants perceive and understand their experiences of disability (Miller and Glassner, 1997:99). The interviews lasted between 50 minutes and 2 hours. All the interviews were performed individually. Rest breaks were provided as needed in the course of conducting the interviews to allow for participants' maximum comfort. This was necessary because people with physical disabilities often get tired easily.

3.5.2. Pilot study

A pilot study is described as the "...smaller version of a proposed study conducted to refine the methodology" (Burns and Grove, 2001:49). Before the actual interviews were conducted, a pilot study was conducted to test the research design and

methods (Burns and Grove, 2001:49). The interview schedule was discussed with the researcher's supervisor before conducting the pilot study. The research questions were tested in order to find out whether the participants would understand the questions and provide rich data. The pilot study participants reported that the questions were clear and easy to answer. Therefore, the questions did not need to be refined. However one participant suggested that the researcher should use the phrase "bokooa ba masapo" to refer to physical disability as opposed to "bokooa ba hao" which also means physical disability but with a different connotation. The two phrases are homonyms but hold different meanings when translated into Sesotho. At the end of the interviews the participants indicated that they felt happy after talking about their experiences. The pilot study was conducted with two women with physical disabilities from the researcher's community.

3.5.3. Observation

Observation is referred to as "...what can be seen through the eyes of the researcher" (LeCompte and Schensul, 1999:95). In this study the researcher first familiarised herself with the research setting and the research participants. Observation is also used as a method of collecting data during individual interviews in order to interpret behaviour and people's subjective meanings. During the interviews the researcher observed that research participants also expressed themselves through non-verbal language, body language and facial expressions.

3.6. Data analysis

According to Neuman (2012:353), data analysis is a process of evaluating data. The researcher carefully examines each component of data provided to reach a conclusion. In qualitative research, researchers collect a large amount of data,

describe the data and then document how they collected it, transcribed and translated it (Neuman, 2012:353). The process of data analysis for this study is discussed in the following sub-sections.

3.6.1. Collecting data

Face-to-face interviews were conducted with each participant using the semi-structured open-ended interviews. In order to maintain high quality recordings and to prevent difficulties later in the research process, a digital recorder was used to record the interviews. The interviews were conducted in the participants' first language, Sesotho. They were transcribed and later translated into English.

3.6.2. Memo

Memoing is described as "...an indispensable strategy in other forms of qualitative research where the focus may be description, interpretation or critique, rather than theory" (Birks, Chapman and Francis, 2008:72). Memos can clarify the research topic, provide assumptions and perspectives about the research setting, and simplify the development of the study design (Birks et al. 2008:70). This is why the researcher drew up a memo to map the steps taken in conducting this research study (Birks et al. 2008:70).

Researchers write memos to ensure the retention of ideas that may be lost. Therefore, the memo was extracted during and after the interviews. The researcher made notes on any nonverbal language cues such as facial expressions that participants did not express through words during the interviews. The thoughts and theoretical insights that occurred in the literature related to the present study were also recorded in the researcher's notes.

3.6.3. Data transcription

A computer assisted qualitative data transcription software package (Philips SpeechExec Transcribe) was used to transcribe data. The non-spoken language data collected in the memo was also entered in data transcripts to enhance confirmability. It is the opinion of Creswell (2013:183) that following the transcription of data, researchers read and re-read the transcripts several times in order to elicit important details while trying to get a sense of the interview as a whole before breaking it into parts. The researcher carefully listened to the audio tapes while reading the transcriptions to ensure accuracy during interpretation (Silverman, 2013:208). The main focus was what participants said about experiencing disability. The transcripts allowed the researcher to focus on the participants' most important information without misinterpreting it (Silverman, 2013:208).

3.6.4. Coding

After data transcription, the researcher worked carefully through the transcripts to identify themes in relation to the research question (Creswell, 2013:183). By reflecting on the larger thoughts presented by women with physical disabilities in the transcripts, the major organizing ideas were identified and then assigned to initial categories and codes (Terre Blanche et al. 2006:321). The categories that had similar themes were highlighted with a highlighter pen and then grouped together with care to identify subthemes. Some themes recurred more regularly than others. The researcher then considered which of these themes would be more useful.

According to Terre Blanche et al. (2006:323), themes "...arise naturally from the data but at the same time they should also have a bearing on your research question." As such, themes emerged from organized information in the telling and recording of the

stories of the young African women with physical disabilities, describing their life stories and experiences of living with disabilities. Themes provide insights into how women with physical disabilities interpret events and situations in their everyday life. Each theme is then linked with the literature and theory that explains the challenges that young women with physical disabilities experience in their everyday lives (Creswell, 2013:183).

3.7. Trustworthiness

Ensuring trustworthiness of the findings is an essential issue. The term trustworthiness is applied in this study to ensure that research findings were truly representative of the participants' and researcher's experiences of the investigated phenomena. The three measures of trustworthiness used in this qualitative research as proposed by Lincoln and Guba (1985) are:

Credibility (in preference for internal validity)

Transferability (in preference to external validity/generalisability)

Dependability (in preference to reliability)

3.7.1. Credibility

According to Janice Morse (1994:105): "Credibility refers to the truth, value or believability of the findings that have been established by the researcher through prolonged observations, engagements, or participation with informants or the situation in which cumulative knowing is believable or the lived-through experiences of those studied." Credibility can also be described as "...the truth as known, experienced or deeply felt by the people being studied" (Morse, 1994:105). The

issues of credibility and trustworthiness highlight the relationship between researcher and participants within a qualitative research interview (Morse, 1994:105). As has been mentioned in the recruitment of research participants (section 3.4.3), the principal of Bophelo Vocational School of the Physically Disabled suggested the potential research participants for this study. The principal had a good relationship with the potential participants and this was an advantage to the researcher because she was accepted and trusted by the participants. In order to gain more trust the researcher ensured the participants' confidentiality and anonymity. Participants were assured that special attention would be paid by carefully listening to them during the interviews without any bias (Hassanein, 2015:87). They were guaranteed that pseudonyms would be used to protect their identity. Another way to ensure credibility is through triangulation. The following sub-themes deal with triangulation.

3.7.1.1. Triangulation

Triangulation is used in this study as a credibility measure for qualitative research. It is defined as "...a process of verification that increases validity by incorporating several viewpoints and methods. In the social sciences, it refers to the combination of two or more theories, data sources, methods or investigators in one study of a single phenomenon to converge on a single construct" (Yeasmin and Rahman, 2012:154). The four types of triangulation, namely data, methods, theory triangulations and peer debriefing, as originally identified by Norman Denzin (1970) are discussed below.

3.7.1.2. Data triangulation

Data triangulation is described as “...the use of a variety of data sources, including time, space and persons, in a study. Findings can be corroborated and any weaknesses in the data can be compensated for by the strengths of other data, thereby increasing the validity and reliability of the results” (Rugg, 2010:14). To maintain trustworthiness of the findings, eight women with physical disabilities were asked similar research questions relating to their experiences. The researcher engaged fully with the participants to ensure clarification on each participant’s responses to increase the validity of research. All of them were recruited from different districts by the two relevant organisations (Bophelo Vocational School of the Physically Disabled and the Tsepo Counselling Services). Although the participants had different backgrounds, all the interviews were conducted at Bophelo Vocational School of the Physically Disabled. Here the focus was on the various experiences from a range of research participants from different communities. The initial premise was that the viewpoints and experiences of women with physical disabilities would be verified against others and, ultimately, a rich picture of their experiences was constructed based on the contributions of a range of women under scrutiny (Rugg, 2010:14). The relationship between the connections among the participants’ experiences of physical disabilities enhances validity. Participants were interviewed at different times and days within a period of two weeks.

3.7.1.3. Methods triangulation

Methods triangulation is described as “...the use of multiple methods to study a situation or phenomenon. The intention is to decrease the deficiencies and biases that come from any single method” (Rugg, 2010:14). Interviews were conducted with

participants and in a natural setting in an attempt to make sense of and interpret their experiences (Creswell, 2013:44). Therefore, the researcher's own presence at the research setting ensured validity. The researcher ensured that the study design, methods and procedures used to conduct the study were sufficiently apparent. Moreover, in order to triangulate the findings, several methods of data collection were utilised. The researcher made use of individual interviews, observations and field notes to ensure credibility of the study. Data were documented by audio recording the participants' interviews. Validation of data was ensured through review of all the participants' transcripts. In addition, verbatim quotes were utilised in order to highlight very important information as described by women with physical disabilities. Moreover, the participants were ensured that participation in the study was voluntary and that they had a right to withdraw from the study at any time without any negative consequences. Voluntary participation enhances credibility because participants who are genuinely willing to take part in the study are honest and give rich data freely (Shenton, 2004:66). The researcher used probes to elicit detailed data and iterative questioning during the interviews.

3.7.1.4 Theory triangulation

Theory triangulation is "...the use of multiple theories or hypotheses when examining a situation or phenomenon. The idea is to look at a situation/phenomenon from different perspectives, through different lenses, with different questions in mind" (Rugg, 2010:15). As it is seen in chapter one (section 1.1), I am moving between a number of relevant theoretical perspectives such as phenomenology, existential sociology, social construction of reality, intersectionality and feminist disability theory. A comparison is made between the study findings and the reports of previous

disability studies and more attention is paid to reflecting on theory and the literature review in analysing the data

3.7.2. Peer debriefing

Peer debriefing is described as the process of "...allowing a peer who is a professional outside the context and who has some general understanding of the study to analyse, test working hypotheses and emerging designs, and listen to the researcher's ideas and concerns" (Erlandson, Harris, Skipper and Allen, 1993:140). In this study the researcher's supervisor served as a peer who challenged the researcher's thoughts and experiences about the study where necessary. The supervisor also examines and gives feedback on the final report. To enhance credibility, the supervisor provided feedback to the researcher after examining the general methodology and transcripts.

3.7.3. Dependability

According to Andrew Shenton (2004:71): "In addressing the issue of reliability, certain techniques are employed to show that, if the work were repeated, in the same context, with the same methods and with the same participants, similar results would be obtained." A clear and detailed description of the purpose of the study, research design, sampling methods, recruitment of research participants, research collection methods and the process of data analysis are provided to enhance dependability. Moreover, the study is examined by the researcher's supervisor to ensure a logical research design and study findings. In this research project, dependability is used to determine the consistency of research findings that emerged from the answers provided by women with physical disabilities during the interviews. Probing, in particular, is used to ensure reliability of the data as it enhances

clarification to relevant issues raised by participants. The study findings will be continually compared with available information, including reports, in the literature. When this dissertation is completed, it will be examined by its readers and any comments and suggestions in relation to this study will be considered.

3.7.4. Transferability

According to Shenton (2004:69), transferability is the “...extent to which the findings of one study can be applied to other situations.” Transferability in qualitative research requires researchers to describe research so that the findings can be transferred accurately. It is important that the final research project provides a rich description of the context of the study to determine whether the study findings can be generalised (Shenton, 2004:70). The researcher provides the descriptions about context, selection of study participants, processes of data collection and the process of analysing data. In the present study, the researcher applied phenomenology. Phenomenology allows insight into the participants’ perspectives on experiences of physical disabilities. It is through phenomenological conversations that the everyday lived experiences of women with physical disabilities are understood from their own point of view (Greenfield and Jensen, 2010:1185). This can allow the reader to easily gain a deeper understanding of the experiences of women with physical disabilities thereafter enabling them to compare the instances of the phenomenon described to determine whether the findings are transferable to other contexts or not. Moreover, the use of field notes, observation, recording and similar interviews with different participants ensure that this study can be replicated by other researchers. Transferability is also confirmed by quoting the participants’ narratives to highlight crucial information, as described by women with physical disabilities.

3.8. Conclusion

As the aim of this research study is to examine the aspects of the lived experiences of young African women with physical disabilities in Lesotho, a qualitative study approach is utilized to enhance an understanding of the narratives of these young women. This is a phenomenological study that aims at generating an understanding of how women with disabilities make meaning of their everyday lives. Several methods of collecting data and the process of data analysis have been discussed. Ethical considerations are also outlined and trustworthiness is discussed in detail to ensure accuracy of the study findings.

People's needs and emotions can only be heard when they are given a chance to tell their own stories. This is the focal point in the data analysis section of this dissertation.

CHAPTER 4: LIVING WITH DISABILITY

4.1. Introduction

This chapter focuses on the presentation of the findings from the interviews and notes recorded in the memo when exploring the experiences of young African women with physical disabilities. Identity formation is at the heart of this chapter. The initial questions focus on the experiences of intersectional identity and how these experiences are reflected in individuals' self-narratives. Attention is on how gender and femininity are relevant to disability identity. Identity will be rephrased by using words such as self-concept, self-perception, self-esteem and self-image interchangeably to refer to how women with physical disabilities perceive and construct the meanings ascribed to their own lived experiences (Darling, 2013:6).

4.2. Relevant themes

The following themes are connected to theories of gender and femininity and to constructs of disability that emerge from the data analysis. Each theme is further analysed by means of subthemes:

- Gender and femininity
- The impact of the disabled body on claiming identity
- Religion
- Acceptance of disability
- The challenges faced by young women with physical disabilities in Lesotho.

The first four themes are covered in this chapter (Chapter Four) and the last theme is covered in chapter five. Before all the themes are presented, I draw on Botle³ to provide an insightful standpoint from which to hear the stories of all the participants. Botle is the most articulate participant in as far as experiencing physical disability is concerned and most of her narratives have been used to illustrate the various themes. This does not mean that the above mentioned themes do not represent other participants' experiences of physical disability. All the themes are constructed from the common experiences of women who are interviewed for this research study. This is how Botle presents her introductory standpoint:

Let me start off by saying it is very difficult to find a job especially when you are a women with a disability. What happened is I first started off as a volunteer at the IEC [Independent Electoral Commission] during the elections. My friends and other people told me that I should apply to volunteer because I had experience. While I was a volunteer at the IEC I also applied to study part time at NTTC [National Teachers Training College] and I was admitted. There was a lot of discrimination against individuals with disabilities at this institution [NTTC]. We were given special care and we were welcomed in different ways from the able-bodied individuals...This made me feel different from others. I was not alone...there were many of us [disabled people]...From women and men, young and old alike. When I got to this institution I realized that there are so many people with disabilities...That I was not alone. When I realized that there were many people with disabilities, I started

³ Botle is the pseudonym for one of the research participants in this research project. All names given to research participants are pseudonyms in order to protect their identities: see section 3.4.5.3 (methodological chapter)

growing emotionally and spiritually. We were allocated rooms downstairs because all the other rooms were upstairs. In most cases, the rooms downstairs had single rooms. However, we were first asked if we preferred to stay in single rooms or sharing. They gave us options...sometimes you would like to stay with other people...Roommates...We were asked first, they did not want to force us to stay in single rooms. When it was time to eat, we were given first preference, we were told not to queue for food... (Bottle)

Telling from Bottle's perspective, it is evident that people with disabilities are still often perceived as different from able-bodied people and are regularly attributed stereotypes such as being incapable, helpless and dependent. It is clear that people with disabilities at this institution were treated differently and that their agency might have been undermined in the process (Garland-Thomson, 2002:6). Bottle feels that she was often perceived in a negative light, as an individual with a problem and this inadvertently led to a cycle of dependency and exclusion, both of which turn negative perceptions into a self-fulfilling prophecy. This way of society looking at disability may lead to people with disabilities to being in conflict with their identity (Wendell, 1996:83).

In the following section I present and interpret each theme in accordance with participants' narratives. Participants' narratives are presented as quotations in order to highlight their own words and the important information as narrated by them.

4.3. Gender and femininity

4.3.1. Gender

Women with physical disabilities are social beings affected by the experiences of living with physical disabilities. This theme which permeates all of the narratives refers to how the participants' gender plays a significant role in constructing an identity as being disabled. The participants are often stereotyped as unsuitable for the role of a suitable partner/wife and motherhood (Hanna and Rogovsky, 2006:44). The focus here is to examine how participants' disabilities affect the way in which they perceive, understand and claim identity as mothers, wives or partners.

4.3.1.1. Motherhood and the disabled body

Identifying self in relation to motherhood is an important issue to women. The research participants discuss in detail the experiences of motherhood. An interesting point is made by Botle who, when introducing herself, says:

My name is Botle Sello from Malibamatso. I got married in Pitseng. I have a house in Tsikoane...I am 35 years old. I have two daughters and my husband is non-disabled. (Botle)

Similarly, Nthati says:

My name is Nthati Pheko, I am 30 years old...From St Michaels but I was born in Quthing. I have a daughter and I live with her. (Nthati)

From the narratives of Botle and Nthati, it is clear that being a mother is an important identity that they have constructed for themselves. Constructing an identity as a mother plays an important role in the sense of self of these participants. In the same

way, Botle and Nthati emphasise that they are capable of the role of child-bearing and child-rearing.

According to Garland-Thomson (2002:17): “Women with disabilities often must struggle to have their sexuality and rights to bear children recognized.” This is borne out by some of the participants who report that their right to reproduction was violated by nurses at the clinics. They seem to have experienced discrimination during pregnancy. For example, Nthati was told that she would not be able to give birth naturally because she had polio. She was also told to stop falling pregnant. This is how she expresses her story:

I remember on the day I was going to give birth...the nurses told me that I had to give birth by caesarean section. They told me that I could not give birth naturally due to my disability. They told me that because I had polio I would not give birth naturally. They also told me that I should never get pregnant again...But I do not know, I think that I will still have more babies. I do not know. The nurses told me that because I had a disability I would never give birth to a healthy baby...But I gave birth naturally. I did not have to go through any surgical procedures. My baby was healthy. Nothing went wrong. (Nthati)

Iponeng shares a similar story:

...They told me that I could not give birth to healthy babies because of my disability...

Botle shares a poignant story which takes place at a clinic at the time she was going to give birth:

...Even at clinics and hospitals the female nurses ignore us. They do not take care of people with disabilities. For example, when I was pregnant I went to a hospital. When I got there, the nurses ran some tests and everything was fine. When it was time for me to give birth, I asked one lady to take me to the hospital and we got there on time. When we got there, we went to one nurse's office and she told me to go to the labour ward and wait for her there. What astonished me was that there was one nurse with a physical disability in that office...They were sleeping. I went to the labour ward as directed. The other nurse who asked me to wait for her in the labour ward came but she had to go back because she had forgotten to bring gloves. Immediately when the nurse turned to get the gloves, I gave birth. When she came back the baby was born and I did not know what to do. I was so scared because the bed was too small and when the baby came I had to grab her because I was too scared that she was going to fall. However, the baby did not fall and I realized that the reason the baby did not fall was because she was connected to the umbilical cord...So the umbilical cord was around the baby's neck and I was scared that it would strangle her. But when I looked closer I realized that it did not do any harm to the baby. When the nurse arrived, she found that the baby was born. She did not even apologise. That is how much non-disabled women care about disabled women! They ignore us... (Botle)

Later in the interview Botle emphasises that she did not encounter any problem when giving birth. Like Nthati, she also gave birth naturally to her two children:

...Luckily both my children were born healthy...God's plan is that a woman should carry a baby for nine months and that is exactly what happened with

me...The time that God had planned...I got married on the 23rd of December...and I started having sex. I missed my periods the following month [January]...I was pregnant. (Nthati)

One factor which seems to fuel the attitude from nurses is reflected in negative perceptions of disability which suggest that women with disabilities are not capable of giving birth and when they do, they will not give birth to normal babies. Viewed from Botle and Nthati's perspectives, being physically disabled does not mean one is incapable of giving birth to normal babies. These participants have challenged ideas about the normalization of bodies in relation to the held assumptions about reproductive issues (Garland-Thomson, 2002:15).

It is not surprising that motherhood by individuals with disabilities is seen as a negative experience (Hanna and Rogovsky, 2006:44). When motherhood is viewed negatively, the attempts of women with disabilities to construct a positive sense of self is often interrupted. Nevertheless, it is evident that Nthati and Botle verify their identity claims as disabled and at the same time claim an ability to fulfil their role as mothers. Botle and Nthati love being mothers. They both make a strong point when saying that it is not easy to be a mother but they enjoy doing it because their children are important to them.

Depending on the nature of her disability, Botle seems to need additional support with the physical demands of raising a baby:

...But because my husband is so supportive sometimes he would carry the kids when together we walk to the clinic. When my husband was away...Like when he had gone to work, I had to find someone to help me with the kids and then pay her. Life is really hard for women with physical disabilities. (Botle)

Botle talks about how she has to depend on others to help her get children to the clinic. By relying on others she further identifies herself as being disabled. However, she demonstrates that being disabled and reliant on others does not contradict an individual's claim as a mother. It is clear that, with necessary support, women with physical disabilities can be successful mothers.

While disability might have enabled some mothers to perform ideal motherhood in a way that put them at an advantaged position, compared to able-bodied women, some mothers describe the hardships of being a disabled mother:

I am 30 years old. I work very hard...When you are a woman with a disability you have to work very hard. It is very hard raising a child alone. Being a single mother is really hard. Because you are not married...You also have to work in the garden on a wheelchair. When people see you do all this they get shocked. You have to clean the house and do all other things. But even so life moves on. I am still raising my daughter. (Nthati)

Nthati further explains that as a single mother she has to work very hard, just to show the world that she may be disabled but she has an ability to perform many gender - assigned roles:

Iyoh...I love cleaning with all my heart. I do it really well, even outside. I also like gardening and I master raising a child. When my baby was still young I made sure that she wore clean clothes and she looked clean all the time...So much that when people saw me with her they would ask: "Is she really your daughter?" Because people assume that disabled women cannot do anything. That is why we work very hard to show the world that we can do things and we are capable in our disabilities. (Nthati)

For Nthathi, the point here is not only about female roles or disabled roles. The two are merged. It is more about showing the world of what women with disabilities are capable (Hanna and Rogovsky, 2006:48). Her opinion fits with the normative feminine role of being a mother and a hard worker.

The findings indicate that many able-bodied individuals do not accept the notion that women with disabilities should have children because they are perceived as unworthy for that role. However, it also seems that mothering is at the heart of these women's lives. It incorporates positive social recognition and it is one of the few roles available to young women with physical disabilities (Hanna and Rogovsky, 2006:44).

4.3.1.2. Marriage and the disabled body

The right to marry seems to be an important issue to the research participants, a right that many people take for granted (Pfeiffer, 2006:74). Many participants experience negative reactions to marriage from their immediate families and from the public in general. These reactions include non-acceptance of disabled women as wives because they are perceived as unfit for this role. Being a wife is normally seen as a helping role such as being able to provide for and to take care of a husband (Hanna and Rogovsky, 2006:44). Married women interviewed for this study do speak about being depended on their husbands. They explain how they rely on their husbands for support with many activities.

Botle indicates that her husband is able-bodied and she speaks passionately about her marriage. She mentions that she is dependent on her husband because she cannot do many things on her own. She further articulates that she has not experienced any serious challenges in her marriage. This is what she has to say:

I have not experienced any challenges in my marriage thus far. I was expecting many challenges because I had seen so many things happen to other married couples. I did not experience the biggest challenges that I thought Basotho, or rather other black people, experience in their marriages. I swear to the living God that I have not experienced any challenges at all as was expected. The only challenges that I have experienced are disagreements...We sometimes disagree on how to raise our children and sometimes on the kind of clothes I should and should not wear. Those are the only challenges that I have experienced. But on top of everything else, I do not ask my husband to do things for me. He knows what I am able to do and he knows what I am not able to do. He does most of the things for me. (Botle)

Iponeng, whose husband is also able-bodied, shares a comparable story. She had been married for four years at the time of the interview and she never faced any challenges in her marriage:

No challenges whatsoever... The only problem is that he did not want me to come back to school this year... He says I have been away for too long...He always wants me around. (Iponeng)

Both Botle and Iponeng emphasize that they are unable to do many things that able-bodied individuals can do. But they are worthy of being loved and taken care of. They both make it clear that their husbands made a choice to marry them regardless of the social stigma against women with physical disabilities. Most importantly, these research participants report that they have not been abandoned by their partners. Viewed from the feminist perspective, these participants have constructed an identity as wives despite having to depend on their partners. However, Nthati reveals that,

based on the level of dependency, women with disabilities may experience negative reactions when they are supported by their husbands:

When you are married and your husband does things for you like getting water from the community tap, people start talking. They say: "Wow, he has eaten it!" [Love potion]. Sometimes they will say: "Look at how he is struggling. Why did he marry someone with a disability?" (Nthati)

For some participants who are not married, it seems like the problem of marriage is further complicated by the able-bodied individuals who talk able-bodied men out of marrying women with physical disabilities. The remarks made by Nthati, illustrate this point:

...The other thing that made me sad was when one guy asked me to marry him...when I was doing my grade eight. I asked him why he wanted to marry me and he told me, it is because his parents told him to marry since he was old enough. Again he told me that, he told his parents about me and they had a problem with him marrying someone with a physical disability. His parents were worried if I would be able to perform the roles of a wife. For example, they were worried if I could take care of their son, do his laundry, cook for him and many other things. When he told me this, I was very sad... (Nthati)

From Nthati's story, the parents of her former boyfriend were concerned about how she would perform the role of a provider. Putting disability in the spotlight, Nthati has experienced negative perceptions, which suggest that women with physical disabilities are not capable of performing the traditional gendered role of being ideal wives (Hanna and Rogovsky, 2006:44). Moreover, this way of looking at disability presents "...a system for interpreting and disciplining bodily variations and provides a

set of practices that produce both able-bodied and the disabled” (Garland-Thomson, 2002:5). The research finds that participants are doubly disadvantaged due to gender discrimination and their impairment. The narratives of participants therefore prove that feminine positions such as motherhood and wife are often aligned with negative attitudes where disabled women are concerned (Garland-Thomson, 2002:7).

4.3.1.3. Relationships: trust and insecurities

The participants seem to find it harder to experience everyday intimacies which non-disabled people take for granted, possibly because many people fail to consider women with physical disabilities as desirable potential and romantic partners (Hanna and Rogovsky, 2006:44). This way of defining women with physical disabilities seems to have impacted negatively on many participants because they might have accepted the image given to them by able-bodied individuals, that they are unworthy of love (Hanna and Rogovsky, 2006:44). Many participants experience insecurities and fear of being rejected by men. While a few participants define themselves in terms of being partners some define themselves in terms of not being able to establish intimate relationships.

Palesa reveals that she finds it hard to establish romantic relationships because she is insecure and she has fear of being rejected by men. Her negative attitude towards relationships and intimacy seems to hinder her from being with a partner just like everyone else. This insecurity, as a result, leaves her isolated. She says:

I am scared that they will not love me. I wonder if they will love me the way I am. Maybe it is because I am self-doubting. I am scared. I think they will only take advantage of me because I am disabled. (Palesa)

Palesa's fear of being taken advantage of probably stems from a previous relationship. She says that she broke up with her boyfriend because she was assuming that he only wanted to have sex with her:

The relationship was good...but the problem was sex...I think about so many negative things that persuade me to break up with men. (Palesa)

Lisebo tells a similar story when she narrates:

The things he used to do...He did not want to see me have a bright future because, he wanted to have sex with me. When I refused to have sex with him, he got angry. I had to let him go because every time I was with him, he wanted nothing but sex. The problem is that I do not do such things. I told him that love is not about sex; it is rather about building a future together. I think he did not understand so I decided to leave him. At the moment I am single...I do not have a boyfriend. I will wait for God's gift. He is the one who will provide me with a good boyfriend. (Lisebo)

Nthathi shares with the researcher the difficulty of getting into a relationship. She explains the distrust that she experiences towards able-bodied males. She also believes that she does not deserve to be loved by any man because of her disability:

Haii...I think non-disabled guys feel sorry for us. When you are in a relationship with them and you have a disagreement...They give you that look, like they feel sorry for you. I do not believe that a non-disabled man would love me. They just feel sorry for me. I am scared that I might fall in love with him and the next thing, he regrets being in a relationship with a disabled woman while there are so many able-bodied women out there. (Nthathi)

Like Palesa, Nthati's fear of rejection stems from previous relationships. She makes a comment that able-bodied men whom she dated in the past seem to be in a relationship with her because they pity her, not necessarily because they love her. The pity has impacted so negatively on Nthati that she believes all able-bodied males are the same and they will never love her because of her disability.

Lillo is a 23 year old who has never been in a relationship. When she was probed to share whether she would choose to be in a relationship and to move in with someone or have children in the future, she answered: "Yes". However, Lillo fears the worst. This is what she says:

I think maybe...My husband...The one that I will be staying with...He is going to turn his back on me. He is going to cheat on me. I think he will not take care of the children...I am going to have to raise children on my own. He will cheat on me because I am disabled. (Lillo)

Some participants who do not have partners seem to believe that they will be abandoned by their future partners. These negative attitudes have led them to distance themselves from possible relationships through the use of the assumption that no man will love a woman with a physical disability.

Failure to get marriage partners is also mentioned among the participants. For example, Konesoang illustrates this point well when she says that she was in a relationship with a guy who loved her dearly. However, she highlights that the parents of her partner did not approve of his plan to marry her because she has a disability:

...He loved me a lot and he wanted to marry me but the problem was his parents. They said he could not marry a woman with a disability. I was disappointed and angry. (Konesoang)

Despite the difficulties presented by the negative reactions of others, Konesoang moved on fearlessly into another relationship. When she was probed to tell the researcher a bit about her new relationship, she laughed and said:

...He knows that I have a disability. At the beginning I was scared to date because of my disability. But he was so supportive and he understood my disability so much that I ended up being comfortable around him...With myself and I learned to accept that I have a disability. (Konesoang)

Konesoang told the researcher that she has been in a relationship with her partner for six years. She emphasises that her partner works in South Africa but he goes to Lesotho often just to be with her. She makes an interesting point that she is happy because she believes her partner loves her and that she has never experienced any challenges in her relationship. In this sense, she has constructed a self-identity (amongst others of being a partner) that has challenged the notion that women with physical disabilities are unworthy of love. She has also constructed a positive self-identity that is removed from the medical point of view and that defines disability as an individual problem (Watson, 2002:521).

4.3.2. Femininity

The participants' narratives also address perceptions and understanding of the body, its appearance, its lived experiences and its relation to subjectivity and construction of identity. The informing premise of femininity is that ...“Disability, like femaleness, is not a natural state of corporeal inferiority, inadequacy, excess, or a stroke of misfortune. Rather, disability is a culturally fabricated narrative of the body, similar to what we understand as the fictions of race and gender” (Garland-Thomson, 2002:5). The participants highlight their own perceptions of the appearance of their bodies in relation to their disabilities. They describe their feelings about their body-image and how they experience the subject of women's beauty ideals. The findings reveal how identity impacts on the body and the lived experiences of women with physical disabilities.

4.3.2.1 Perceptions of beauty

Women with physical disabilities are usually stereotyped and seen as unsuitable to achieve female beauty ideals. However, after I dealt with all the things that make a woman beautiful—such as make-up, clothes and hairstyles—the research participants were asked whether they would be happier should they perform these tasks. Some participants give a startling answer. They say:

[Laughs]...I like doing these things so that I can also look beautiful like other people. I should not look ugly just because I have a disability. I do not want to be ugly just because I am disabled...No...I have to look beautiful, really. A woman should look stunning all the time, whether she is disabled or not.
(Khauhelo)

These duties are not a waste of time because one has to look and dress appropriately—so that one looks beautiful. The hair must be nice...Even if it is short, it must always be clean. The clothes should always look nice and one should dress for her body just like other women do... Yes. (Botle)

I like them. A woman has to look beautiful...I like being pretty and presentable. I do not want to look like I come from the farms. I have to look pretty all the time. Even when I am at home...People should think that I just came back from somewhere. (Iponeng)

We have to look beautiful. (Lisebo)

Several participants believe that their physical attractiveness is important. They seem to believe that being disabled does not mean that one has to look ugly. However Botle, Iponeng and Lisebo do not use make-up nor do they follow fashion. They are also less concerned about changing their hair styles. They specify that they prefer natural looks. When asked why they do not use make-up, some participants had the following to say:

I look stupid with make-up on. (Lillo)

Eh...In most cases...It depends on whether you like something or not. I am not used to makeup...My friends...My friend uses make-up. Sometimes I use her make-up...It makes me feel uncomfortable. Yes...Maybe because I always use Ponds [face cream]. I do not use make-up. (Lisebo)

For Lisebo, using make-up, following fashion and changing hairstyles are the least of her concerns because she feels somewhat less attractive:

I am....ehh...I am not a beautiful person...Yes ma'am...I am not a beautiful person. (Lisebo)

The interpretation of Lisebo's narratives is that she might have been subjected to the comments and behaviours of others that have damaged her self-image and that women with disabilities are unattractive and unable to take care of themselves. Feeling unattractive and undesirable, however, was not common among the participants. Many women are less pre-occupied with enhancing their beauty because they believe that they are naturally beautiful. Nonetheless, the majority of research participants concentrate on their physical appearance and spend more time preparing to look attractive. These participants seem to believe that having their hair styles, wearing make-up and dressing well make them more feminine. This is probably because "...the beauty system's mandated standard of the female body has become a goal to be achieved through self-regulation and consumerism" (Garland-Thomson, 2002:10). For example, when probed further to explore why she uses make-up, Konesoang laughs and says:

The thing is, I like it. It makes my skin look flawless. (Konesoang)

Nthati uses make-up because she wants to look beautiful for a certain reason. This is what she says:

Didn't I tell you that I want a man [laughs]? I have to look beautiful not just like a typical Mosotho lady...Men should notice me. (Nthati)

Later in the interview, Konesoang was further asked whether applying make-up changes the way she feels about herself. She responded:

No, it does not change the way I feel about myself. I feel the same. It is just that my skin glows. It makes me look beautiful. (Konesoang)

4.3.2.2. Perceptions of the body

Experiencing physical disability often leads to an individual rethinking her self-concept. This is the case because this experience alters one's perceptions of the body. Hanna and Rogovsky (2006:44) indicate that the more physically attractive an individual is, the more positively she feels about her body. This may be different for some women with physical disabilities but it is true for most participants interviewed for this study. In order to understand how women with physical disabilities perceive and understand their disabled bodies, all participants were asked: "How do you feel in your body?" This is how women express their reflections in their narratives:

I love my body. I feel good in it. There is nothing wrong with my body. (Lillo)

I like my body...It is beautiful...I am satisfied with my body...I am not sick. My body does not give me any problems. I am not thin...I have never lost weight...I am fine like this. They told me that I had a big body when I was little... But I do not remember that. I have always been like this. My body is beautiful. I do not want to gain weight... (Iponeng)

Hm...I love my body so much. I love myself and I am very comfortable in my body, I do not like it when I gain weight, I wish there were some activities that I could do to keep healthy and I wish I had enough information on what to do to keep healthy so that I do not gain weight... (Bottle)

I do not want to gain weight. Instead of gaining weight, I would rather lose a bit of it. I do not like a big body. A big body puts you at a risk for diseases, such as sugar diabetes. I like my body as it is. I feel healthy. (Lisebo)

It seems that these four research participants have come to a point of being comfortable with their bodies and accepting their disability as part of their bodies. Body image is related to physical characteristics such as weight. With this notion in mind, Lisebo and Iponeng seem to be comfortable with their bodies and they do not want to gain weight; they believe their bodies are beautiful the way they are. Botle seems to be concerned with her physical fitness and would like to incorporate exercise in her lifestyle. To her, exercising would reduce the negative body—related self-perceptions that she harbours. This indicates that for Botle, body image is clearly important and that a more acceptable image can be achieved through exercising.

Botle further says that looking at her body in the mirror reveals a lot of issues about her body and body acceptance:

When you are standing in front of the mirror and you are looking at your naked body, when you really love yourself and your body... it will affect you emotionally. It will teach you how to love yourself, respect your body and dress in a way that will cover it. Your body does not look attractive in other people's eyes. To me, my body does not look attractive, so I have to make sure that I cover it so that other people do not see it. Sometimes at funerals...especially family funerals, we sleep in the same room...Me and other people. When it is time to bathe I undress and bathe in the presence of my relatives. I do not care whether they look at me or not. Disability is not a

secret. They learn how people like me look like. I do not care if they look at me. I bathe and then dress. At the workshops and conferences, I undress and bathe in the presence of the others. For me it's a normal way for people to see me and learn how people like me look like. Yes, true enough, we do not look attractive at all...Of course we do not look attractive, that is why in most cases you discover that men will be attracted to you but do not want to move in with you because they do not want to see you naked...Because your body does not look attractive. That is why a man should have unconditional love.
(Bottle)

Bottle's perception of her body implies that she has accepted and appreciated her feminine features although she is not confident over her physical appearance.

For Palesa, getting comfortable in her body means being confident in what she is wearing. She believes that when she looks good she also feels good. She makes a strong point that one gets comfortable with one's body when she knows her body:

...I am my body. You just know when you look good. I mean, the way you dress. The way you dress identifies your body. You know you will look good when you dress nicely. You feel good in your body when you know your body. I know what kind of clothes look good on my body and I know what to wear if I want to feel good. (Palesa)

Konesoang speaks positively about her body:

My body...I do not concentrate too much on my body because; this is who I am. I am like this and I have to accept my body as it is because I will never be

able to change my appearance. I have accepted that I have a physical disability. (Konesoang)

Konesoang has accepted her body. Her appearance may not match that of an ideal body but she has learned to be proud of the body that she possesses. Although most research participants express positive attitudes towards their bodies, Nthati expresses a negative attitude towards her body. These negative attitudes are related to her disability:

...My body...Sometimes....I do not like my body because I feel too fat. I have gained a lot of weight and my body becomes heavy on my wheelchair. I am not happy about my body. (Nthati)

Nthati has defined her image of her own body as unsatisfactory and this indicates a negative body perception. How people view their bodies is important in establishing their identity and self-esteem. For this reason, body image plays a vital role in the lives of women who participated in this study. It is evident from the narratives that not all women with physical disabilities suffer from negative images concerning their bodies. Self-esteem appears to be higher among those women who have accepted their bodies and who express positive attitudes toward their body images but it appears to be especially low for those who experience a negative body image (Hanna and Rogovsky, 2006: 46).

4.4. The impact of the disabled body on claiming identity

The medical model of disability views disability as a problem arising from an individual's physical condition (Cameron, 2014:137). When disability is viewed in this way, it negatively impacts on the identity construction of those who experience

disability (Wendell, 1996: 83). Most women who participate in this study confirm that disability has a major impact on their everyday lived experiences. In order to understand how the participants' disabled bodies impact on their identity construction, all participants were asked: "Does disability affect the way in which you experience embodiment (such as the ability to lift, carry or move ordinary objects.)"

While many participants talk about the difficulties that they face in performing the basic activities necessary for physical well-being, the majority of these participants ascribe these difficulties to their disabilities. Puseletso demonstrates this point by saying:

I cannot do some things which able-bodied people can do...like carrying something from outside into the house...I cannot do them because of my hand. For example, I cannot lift up that thing [pointing at the printer] because I cannot use both hands...I can only use one hand. (Puseletso)

Similarly, Lillo blames her difficulty to carry a bucket of water on her hand:

Oh...I am not able to... I can do laundry...I can also wash dishes...I can bathe but I am not able to carry a bucket using this hand [left hand]...A 10 litre bucket of water...When I carry it...Put it on a table...I must use the other hand [the right hand] for support. When I want to throw water outside after bathing...I must use this hand [the right hand] for support. That is the only problem. (Lillo)

Furthermore, Lisebo identifies her foot as the most difficult part to clean the cupboards. She says:

It has affected me. Sometimes I want to stand on the chair...true I can...but it is not easy...I can do everything. I...but sometimes when I want to clean the cupboards and cannot reach up there I need to climb on a chair. I am able to climb on a chair but it is difficult. I don't know how I can explain it. But I can do everything. My body allows me to do things. It is just that I cannot do things like able-bodied people... at the time that I want to do them. Yes. (Lisebo)

Iponeng talks about how she finds it difficult to carry a bucket of water from the community water tap to her house. She complains that she is unable to carry heavy objects. She blames her difficulty on her disability, away from the environmental barriers:

Yes, because I cannot carry a bucket of water outside of the house...I cannot carry a bucket of water from the tap to the house. It has affected me...When I sweep...I am not able to move heavy objects like chairs...a table...furniture. Sometimes I want to shift...Move a bed from here to there...I cannot move it...I have to find someone to help me move heavy objects... (Iponeng)

Konesoang uses a wheelchair to move around but she faces a major difficulty getting herself onto the bed:

It has affected my body because I cannot stand. When I want to sleep I have to plan first...how I am going to climb on to the bed without having to stand up...because I cannot stand. I have to move myself from the wheelchair on to the bed. (Konesoang)

Similarly, Palesa ascribes her difficulty to carry a bucket of water and cooking to her disability. She says that sometimes she finds it very difficult to cook because the stove is too high:

...I think...let me make an example...here, there are some things...Like...I am not able to carry a bucket of water. This is one of the things that I cannot do...Sometimes cooking...When the stove is too high I am not able to cook because I cannot reach for the pots. (Palesa)

Palesa continues her narratives and this time she talks about how she is unable to give her boyfriend a hug because she cannot stand up from her wheelchair:

When it comes to relationships...sometimes I have a boyfriend and I want to give him a hug...I cannot...I cannot give him the best hug...I don't get satisfied by giving him a hug when I am on a wheelchair. (Palesa)

Botle elaborates that due to the changes in her body, her health and the impaired body are weakening, leading to reduced abilities:

Hmm, eish...It has affected me because even when I want to do some things, like laundry, I easily get tired, my feet get tired easily. Then my whole body becomes weak and I have to rest. Sometimes I ask my children to help me by passing certain things to me. Like when I want to wash dishes I sit down and ask them to pass me a big basin filled with water. Then I can wash the dishes. After washing the dishes I then give it back so they can put it away. Sometimes when my feet get weak, my body, hands and mind are still very active. The problem is my bones. They are painful; this irritates me. (Botle)

Although most participants report an inability to perform certain activities as a result of their disabilities, they show more confidence in their physical strength. They describe the things that they are able to do on their own and in this sense they display self-understanding of their bodies. Nthati makes this clear when she says that she takes pride in her disability because she is still able to work hard, especially in as far as doing housework, raising a child and working in the garden:

Iyoh... I love cleaning with all my heart. I do it really well. Even outside. I also like gardening and I master raising a child. (Nthati)

However, Nthati's body needs more time to be able to perform some of the everyday activities. She says that the only way to speed up her body would be to exercise but she is unable to exercise because her body restricts her:

I want to exercise...My body... But I do not know how to do it. I really want to exercise because I want my body to be flexible. But now the problem is that when I work hard my body becomes painful...I cannot exercise but I want to. (Nthati)

Some participants report that with the assistance from others they are able to perform some of their daily activities. An example of this is Palesa's narrative:

I can do a lot of things on my own. I make my bed, sweep and mop the floor and cook. The only thing that people help me with is getting water from the tap.I ask people to help me with a lot of things. Especially at home, lots of things are outside. You get water from outside...You have to throw water outside...If I want to do laundry I have to ask someone to bring a basin with

water and laundry to me so that I can wash then she can go and hang laundry on the line outside. Yeah. That is what I do. (Palesa)

It is apparent from this narrative that disabled people experience their bodies as dependent on significant others in terms of needed help. When the participants experience their bodies in this way they face limited flexibility and autonomy. Depending on others seem to be emotionally and physically challenging for many participants because it affects their sense of independence, their sense of worth and their social value (Mumma, 2000: 19).

Interestingly, most of the participants have accepted an identity of being disabled, based on the characteristics that identify an individual as disabled from the medical point of view. It therefore seems that many participants live with an identity attributed to them by themselves, that they are incapable and dependent. However, they confirm that they are aware of their bodies and of their abilities and disabilities.

4.4.1. Understanding disability

Participants often hold different beliefs about what it means to have a physical disability. They direct their perceptions about what it means to be physically disabled to the medical model's point of view that defines disability as being abnormal, experiencing limited functioning and being dependent on others. But a few of them make comments about being sick and being different from others (Garland-Thomson, 2002:7). When asked "What does having a physical disability mean to you?" Botle says it means that she cannot do a lot of things on her own:

To have a physical disability for me means a change from normal life to a life that restricts me from doing many things that I was able to do before I was

physically disabled. I say this because; I cannot do a lot of things on my own. I have to rely on other people to help me. (Botle)

Similarly, for Nthati having a physical disability means that her life has changed. When probed to further illustrate why she says her life has changed she says:

I will never be able to do a lot of things that I used to do before I was disabled. (Nthati)

Nthati further adds that, having a physical disability for her means that she needs assistance, because she uses a wheelchair and sometimes crutches to get around. She confesses that she occasionally feels useless and helpless because she has to rely on others for help:

Sometimes I feel useless and helpless. (Nthati)

From the participants' narratives it is clear that they often understand their disability from the medical point of view which is feeling useless and helpless, being dependent and in need of guidance (Garland-Thomson 2002:8).

4.4.2. Disabled bodies in everyday encounters

Some participants experience oppression and negative attitudes within their societies. They are often made to feel different because they are devalued individuals who are perceived as unable to conform, as expected, to the norms of the society. In the light of this, Konesoang narrates poignantly about how she was made to starve because of her disability:

...Sometimes they forced me to cook...I was unable to do anything...I was not able to cook. I was not allowed to eat because I was unable to cook. I swept

the floor on my knees because I had to crawl. When I cooked I had to do it outside with a malikotoana [a little black, three legged pot] because I could not walk. I had to carry the pot with my teeth. I was crawling. I could not carry the pot with my hands. I had to take it by with teeth to cook outside. And when I was supposed to go to the toilet...They dug a pit on the route to the toilet. The only route they knew very well that I used to go to the toilet. I fell into that pit and this leg was broken [pointing at the left leg]. Can you see that this leg looks different from this one [Pointing at the right leg]. (Konesoang)

Botle also shares a heart-breaking story about how she was almost raped by a man whom she knows from childhood:

...There was no one in the street. As I was walking by, I saw one guy approaching me. I knew this guy. We attended the same primary school. He asked me if I still refused to marry him and I said: "Eh eh...no...I will not marry you! I do not like you!" Then he said: "You know what; I will marry you by force." Then I told him: "You won't do it. You will never do it. You will never...I only remember that he slapped me here [pointing at the neck]. Then my neck started swelling. Then he dragged me into the bush. He dragged me into the nearest bush and he tried to rape me. (Botle)

Similarly, Lisebo, who was a student at a vocational school at the time of the interviews, presents a disconsolate story about her boss whom she worked for before she registered to study. She used to work as a domestic worker. With a shaking voice and tears in her eyes she relates:

...He started undressing himself. While he was undressing, I was screaming at the top of my voice. I wanted to get out through the window but the window

was too small. I wanted to break the window. I had to use the window to get out. He had the key with him. I ran to the door. It was locked. I asked him to open the door but he refused. "Please open the door. You won't do anything to me!" He refused to open the door. He asked me to undress but I told him: "Never! You would rather kill me!" He started being aggressive. "I am not playing games with you," he said. "You have to start undressing now!" I told him I would never do that...and he said: "You are so stubborn, you will give me what I want and you will give it to me today!" (Lisebo)

For Lisebo, it was as if a miracle happened: just when her boss was about to force himself on her, the neighbour knocked because she had heard someone screaming.

...Luckily someone knocked at the door. It was the neighbour..."What is happening in there?" she asked...I shouted: "It is Mr Paki! Please talk to him. I do not know what to do. My life is in danger! He is naked!" She asked me what was going on and I shouted again: "It is Mr Paki! I am still dressed but he is naked; he is forcing me to sleep with him. I do not want to sleep with him!" The neighbour asked Mr Paki to open the door or she was going to call the police. When he heard the word police he quickly grabbed a blanket and wrapped it around his waist and went to open the door... (Lisebo)

Lillo also shares a story of how she was almost raped. She says that when the guy who attempted to rape her found out that she was having her periods he was so furious that he strangled her:

Yes... it happened...in 2010...It was a guy who wanted to rape me. But his plan failed...I was on my periods. He strangled me...I went to report him at the police station...He was arrested. Yes. (Lillo)

From these narratives it appears that some participants have been subjected to gender based violence, making them recipients of offensive reactions by able-bodied individuals. From the participants' narratives it seems that women with disabilities are not only abused in their homes and in intimate situations but also in public. The participants also experience negative reactions such as gazing and staring from able-bodied individuals. These negative attitudes lead to negative treatment of women with physical disabilities. In this regard, Konesoang relays a distressing experience of being patronised by strangers at her brother's initiation ceremony:

...I remember when I was at home this past December holidays...It was my brother's initiation ceremony. I went there to celebrate with my brother and I was singing praises. Everyone was staring at me. Like they had never heard a young woman sings before. I noticed that they were talking about me but I did not pay attention to what they were saying. The most hurting...It was when people started singing about my disability as if I was not even there. They came up with songs...They sang about my disability and my wheelchair...I was so hurt. (Konesoang)

It is clear from the interviews that women with physical disabilities are often harassed when they appear in public. They also experience being called all sorts of names such as cripple and limp. These terms impact negatively on women with disabilities leaving them with experiences of being stereotyped and oppressed (Garland-Thomson, 2002:22). Botle illustrates this point:

....They have called me names: Lenyoka [limp]. As I have indicated before, I was a teacher at a combined school for both able-bodied and disabled children. When I did well at work my colleagues used to say: "Ke heno

bokooeng” [disability is your field]. Young people with severe physical disabilities were always referred to me when they had problems. “Take her there!” Meaning where...These children were referred to me because, like them, I had a disability...I was a teacher with a disability. (Botle)

Iponeng points out that able-bodied individuals also call her names:

They call me names like sekooa sena [cripple]. (Iponeng)

Nthati reveals that she also experienced name calling:

They used to call me sehlotsa sane sa nyeo mane [limp]. *They used to call me that especially when I had been seated for a very long time....When I stood up I would limp and they would start calling me...”Sehlotsa sane”* [limp]. *They also called me names like malikela* [another variation of limp]. *People called me by these names since I was young...* (Nthati)

When identity is defined by significant others and when it mostly happens in a negative way, it becomes difficult for people with disabilities to maintain a positive sense of self and to establish and maintain positive relationships (Blinde and McClung 1997:327). Nthati illustrates this when she was probed to share how she feels about the way non-disabled individuals treat women with disabilities. She breathed heavily and paused for a moment. Then she said:

...This makes me hate them. Sometimes I hate non-disabled people. When they approach me I feel angry because already when I look at them, I wonder what they are going to say or do. This makes me hate them...Yes. (Nthati)

Lisebo indicates that as a child she often felt like she was better off dead than alive and treated horribly:

I was always sad. I remember when I was in grade 5...Because they always harassed me...I was scared go to school. I went to school because of my parents. They gave me hope. I was really afraid to go to school. They used to say the most horrible things about me. They treated me differently. I used to feel that death was far better than life. (Lisebo)

Botle, Iponeng and Nthati have been directly identified and classified as disabled by able-bodied individuals. For them, the way they are interacting with significant others in public signifies that they are perceived as disabled because they are treated differently and called names related to their disabilities. When identity is assigned by able-bodied individuals, it limits the opportunity for self-discovery of identity by women with disabilities (Blinde and McClung, 1997:328). Garland-Thomson (2002:22) is of the opinion that some individuals with disabilities refuse to accept identity as disabled. For example, Iponeng rejects an identity as being disabled by rejecting terms such as being crippled and by directly shifting the accusation of disability to those who call her a cripple. She illustrates this statement by saying:

They call me names like sekowa sena [cripple]. When they call me this I always tell them: "I am not disabled because my disability is visible to everyone, you're the one who is disabled because your disability is invisible!"...When I tell them this they never talk to me ever again. Yes. (Iponeng)

4.4.3. Meeting the world

A clear source of frustration for participants interviewed for this study is receiving definitions of themselves in the course of interacting with others within their communities. These definitions impact on identity and self-perceptions of women (Blinde and McClung, 1997:327). In the extract below Puseletso illustrates how she experiences “meeting the world.” She comments on the challenges of having to deal with the curiosity of others flowing from her impairment and how this impacts on her self-perception.

I was afraid to walk with them because I was scared that they would call me names: “Her hand is twisted and short. Look at how she walks!” I was always afraid. I did not want people to see my hand. (Puseletso)

Palesa enunciates that the negative reactions of others towards her disability often force her to avoid contact with the world. It is apparent that she is afraid to meet the world because she is worried that people will look down on her, tease her or even ostracise her:

It was very difficult. I am shy...I am still scared to meet people. When you are on a wheelchair people stare. I want to learn to ignore people who stare at me. If I can be able to do that, I will be happy. (Palesa)

For Palesa, experiencing gazing and staring not only forces her to exclude herself from the public but also forces her to accept a negative identity as disabled. She demonstrates this point when she says that she wants to be confident and to accept that she is disabled:

I would like to be able to go out there and meet new people and learn about their experiences of living with disabilities. I am scared of meeting people. I cannot even go to town. I find it really hard to meet new people. I wish I could be more confident and accept that I am disabled, maybe then I can be able to go out and meet new people. (Palesa)

Palesa stays at the school hostel and the only time she leaves school is when she goes home during the holidays. Her negative self-perception about her disability affects her interaction with other individuals. She mentions that when she goes home, she calls a meter taxi that picks her up from the school yard and takes her straight home so that she does not have to meet other people:

When I need to go somewhere far I use a meter taxi...I do use public transport. (Palesa)

The participants who report that they are afraid to meet the world indicate that they are trying to avoid the identity which might have been given to them by others. This in turn affects the way they perceive and construct their own identity.

4.5. Religion

Religion turns out to be an important phenomenon in this research study which explores the relationship of participants' religious beliefs, how they respond to their disability and the way in which their religious organizations impact on their everyday lived experiences. Some participants report that the challenges that they experience contribute to emphasising their dependence on God and that these challenges strengthen their faith. Palesa is one of the more articulate participants in as far as the role of religion is concerned:

I believe that...I think....I do not want to say it is a blessing...I think it is God's way of doing things. I think if I were not on a wheelchair I would not have known God at all. Maybe I would focus on myself and forget about God. But now I know that I have to thank God even though I am on a wheelchair. I believe that when Jesus comes, I will be able to walk again. (Palesa)

For Palesa religious beliefs provide meaning to her disability. She uses religious beliefs as a means of coping and of deriving motivation to live her lifeworld. She has constructed a positive self-image and self-concept through faith. In a similar way, the narratives of Nthathi indicate the advantages of faith experiences. She signifies that her faith in God has grown stronger and she believes that one day she will be able to walk again:

My spiritual belief motivates me so much because in the Bible there is a verse that says: One day all these things will come to an end. And eventually I will walk again. This keeps me motivated. I know that it is a matter of a time. One day I will be able to walk again. (Nthathi)

Puseletso also speaks about the importance of having faith. She points out that faith grants her strength and helps her to construct meaning of the events in her life. She seems to believe that feeling a sense of connection with God has helped her to sustain problems related to her disability. She strongly trusts that God made it possible for her to earn her disability grant:

I have not been earning a disability grant since I was born... They always told me that my name did not reflect on their systems. It was always very sad for me to see other people earn their disability grants. But in February...I forgot the exact date, but my mother called me and told me that finally I qualified for

a grant. I was happy because I applied in 2005. It was not easy getting this grant but since I have been going to church everything worked out perfectly. There has been a change since I started praying...God helped me.
(Puseletso)

When attending church, it is clear that some research participants experience support from other members of their church and this plays a big role in helping them accept their disabilities and gaining hope. Lisebo verifies this point by saying:

I rely on my spiritual belief. It has helped me a lot. Even in the most difficult times. When I get back from church I come back feeling better. They give me scriptures... Which ones to read...These verses give me hope. They take my pain away. I feel better...People from church support me and give me hope.
Yes. (Lisebo)

Nthathi talks about using prayer as a way to communicate with God. She speaks about how communicating with God allows her to tell Him about all her problems and grants her a chance to ask for what she needs:

Yes...It helps me a lot because: when I am facing challenges, I have to pray to my Lord. Praying is one of the most helpful coping mechanisms that I use. I tell God everything. I tell God that I need a husband. That I am raising a baby alone and it is not an easy task. I also tell Him that I need a job...Yes...All these things. (Nthathi)

Similarly Botle uses prayer to communicate with God and she believes that prayer improves her emotional wellbeing:

My spirituality teaches me that: when there are challenges in my life I should pray. When I need something I should pray. What can I say? When I do not feel happy about something...In life there are some things that I cannot share with other people. When that happens, I lock myself up in my house and pray about it. I talk to Jehovah and tell Him everything. I feel much better when I communicate with Jehovah. Therefore, I tell Him things that I cannot tell anyone else. I do not tell people, I talk to God. (Botle)

Botle further reveals that God is present and is able to help her with challenges connected to her disability. Her viewpoint emphasises the positive purposes of religiousness. She believes that God provides assistance when life brings challenges:

He is able to save you from being raped and from people knocking at your door. All these worries come to an end. There is God, mme [lady]...God is alive. It is true that people with disabilities get raped and murdered, all these bad things. But God is there and He is above everything. (Botle)

Botle also describes her disability as a blessing. She believes that her disability is God's way of preparing a better life for her. She also expresses the viewpoint that perhaps, if she was able-bodied, she would not have been half the person that she currently is:

I have explained from the beginning that disability has done many big things for me. First of all...It has taught me not to be selfish and not to think less of others. I have also learned that adultery is a sin...I have learned not to judge other people and not to attend parties and many more. I am sure that some things will never affect me. I am proud of my God because some of these

things will never harm me. I am blessed. Therefore, I believe that my disability has saved me. It has prevented me from many bad things. For me this is a blessing. I can make a typical example: I am more blessed than my peers. I am the only one who is blessed in terms of education in my family. (Botle)

Iponeng believes that everything happens for a reason. Similar to Botle, she describes her disability as a blessing:

...I think my disability is a blessing from God. I do not take it as a curse...it is not a curse because I do not know why God wanted me to have a disability. God has His own reasons for my disability. (Iponeng)

Each research participant uses her personal relationship with God to provide a view that helps her to give purpose and meaning to her disability and her everyday lived experiences. Many participants claim that their close relationships with God motivate them to believe more. The motivation to serve God often provides women with disabilities with a way to obtain meaning in their everyday lives despite all the challenges and limitations.

4.6. Acceptance of disability

Most research participants confirm that they have accepted their disability and they use the word “accept” when telling their narratives. According to Hanna and Rogovsky (2006:48), acceptance of adversity may be more common among women with disabilities. This may be because many of these women do not want to let their disabilities get the better of them. The following narratives from the participants illustrate aspects of acceptance as stated by women in this study:

I was in denial for a very long time but my parents gave me so much hope. In the end I had to get used to the fact that I have a physical disability. These days I do not care what people say about me. I do not pay attention at all. I have accepted that I have a disability. (Lisebo)

It was very hard for me to accept that I have a physical disability... I was not able to accept... For a very long time...Especially when I saw other children happy...Playing. They did not look at me in a good way....I hated the way they looked at me. I was not happy about the way they looked at me. Only my relatives treated me well...The other children did not...My relatives treated me well...They treated me just like any other girl of my age. I accepted that I had a disability when I was 17 years old...I did not care then...I accepted...I was able to go for check-ups at the hospital alone...until I got married...I had made a promise that I would never get married...I did not want to get married. (Iponeng)

Iponeng and Lisebo struggled to come to terms with their disabilities. The difficulty in accepting their disabilities may have been related to the perceptions of the able-bodied about the impaired body, that people with disabilities are less useful, weak and helpless (Garland-Thomson, 2002:8). When they were treated differently by people around them, they felt left out. As a result, they had to reconstruct their self-identities and they actively worked towards acceptance.

Botle illustrates her experiences with a perturbing story that leads her to challenge and to accept her disability:

...I failed to understand why I had to be like this, but then again I told myself that at least now I am able to walk unlike in the past two years when I was

crawling. Then I told myself that my body has changed but at least I can still walk. It was very painful when other kids of my age stared at me...They always looked shocked and surprised by the way I walked. There are many trees behind our house and some kids would pass by there. When they saw me outside the house, they would stop by the trees and watch me walk while they laughed...At that time I was still learning to walk. Sometimes I would walk against the wall...For support, so that I did not fall. When they saw this, they would shout: "Come see how Botle is walking!" And when they saw me...Some...They would get shocked and some would be scared. This made me upset. One day my mother made an example of one woman in the same village that got ill and afterwards she was also physically disabled. Unlike me, she was still able to walk even though she was physically disabled. The only problem was that when she came across people she sat down because she did not want people to notice her disability. Therefore, as a result, this woman ended up avoiding contact with people and she decided to stay in her house all the time. Eventually she could not walk at all. Then my mother told me to walk, regardless of who is watching and who is laughing because at the end they would get used to the way I walked and in turn I would accept my disability. "Just the fact that they come here and hide by the trees to look at you means that already they can see how you walk. One day they will get used to it and you will be fine." Eventually I accepted that I had a physical disability and life moved on. (Botle)

Botle's story illustrates changing self-identity. Firstly, she experienced the loss of the self before her physical disability and then, with the help of her mother she focused on reconstructing a new and stronger self. Botle's narrative emphasises self-

acceptance and appreciation of who she really is. From this, it seems that women who have accepted their disabilities see disability as a challenge and having been able to overcome that challenge provided them with a sense of confidence and self-satisfaction (Hanna and Rogovsky, 2006:48).

Participants were also asked whether there is any day when they forget that they are disabled. This question was asked in order to further explore the extent to which they have accepted their disabilities. It is clear that most participants accept their disability to a point where they sometimes forget that they are disabled. Nthathi is one participant who said that she sometimes forgets that she has a disability. Her discussion begins to focus on what happens at the time when she forgets that she has a disability:

Yes...I experience that sometimes. When I am with my daughter sometimes...I hardly think about my disability. I forget about it totally. Sometimes I only remember when I have to do something and I cannot do it: "Iyoh, I am disabled!"...Yes. (Nthathi)

The same is the case for Botle who also claims that sometimes she totally forgets about her disability but only remembers when others start talking about the way she walks. She expresses it in this way:

Tuu [totally]...Sometimes I totally forget and I only remember when people walking behind me start talking about how I walk. (Botle)

Similarly Palesa also sometimes forgets that she is physically disabled. She says this happens when she is engaging in deep conversations with others:

Yes...Sometimes when we are in a deep conversation I tend to forget that I am in a wheelchair. (Palesa)

It is possible that Nthathi and Botle sometimes forget about their disabilities because they have become familiar with their impaired bodies and have developed a positive sense of self. However, forgetting about her disability does not mean that Palesa has accepted her disability. Instead, it makes her question herself in as far as the future is concerned:

It is very sad because after the conversation, I remember that I am still on a wheelchair. Sometimes I just close my eyes and assume that I am not on a wheelchair and then I see the future. But then I ask myself...Is there a future for me...On a wheelchair? And then reality hits me...That I am on a wheelchair. (Palesa)

It is clear that Palesa is struggling to accept her disability:

I wish I would be more confident and accept that I am disabled. Maybe then I can be able to go out and meet new people. (Palesa)

Palesa asserts that she finds it hard to accept that she has a physical disability because she was not born disabled:

Maybe the problem is that I was not born with a disability and I do not understand it. (Palesa)

Palesa acquired impairment⁴ when she was 23 years old. It started as cramps in her feet and then she was dizzy. She was taken to the hospital where she was admitted

⁴ Acquired disability is discussed in more detail in section 2.3 (literature review)

and discharged after four days. When she got home, she was told that her mother had gone to work in Bloemfontein. Therefore, she had to stay with her grandmother. She indicates that after a couple of days the cramps got worse and she was taken back to the hospital where she spent seven months. For Palesa it is even more challenging to accept her disability because she does not know what really caused it. As a result she is struggling to construct meaning of what happened to her. This is what she had to say:

...The doctors could not figure out why the cramps caused the pulling of muscles. (Palesa)

It appears that participants who were born with disabilities and those who acquired it at a younger stage seem to have higher levels of acceptance of disability. Their acceptance of disability allows them social confidence to integrate into the society. However, unlike most participants who have accepted their disabilities, Palesa exhibits negativity in her life experiences because she is struggling to accept her disability. As such, she is experiencing cyclical emotions that hinder her from being able to deal with the challenges related to her disability. It is clear that Palesa experiences lower levels of self-esteem and perceptions of self-satisfaction. Her experience of negative emotions and lower levels of self often drive her from self-acceptance to self-rejection. Experiencing self-rejection often leads to Palesa avoiding interaction with other people.

4.7. Conclusion

Most of the research participants in this study constructed self-identities that are directed towards the medical model of disability that defines disability as a personal tragedy (Watson, 2002:521). They have mostly claimed an identity as disabled and their bodies as weak and themselves as helpless and dependent. Furthermore, their identities are made up of all the names that are given to them and that they have taken on from the able-bodied people around them. Identity is constructed according to their subjective and unique social encounters. Moreover, they seem to have accepted their disability and to have chosen to live a positive life. This often relates to their faith that is used as a means to construct a positive meaning of life and understanding of disability. As a means of coping, religion improves participants' self-esteem and provides them with a positive personal identity.

CHAPTER 5: DISABILITY AND EXISTENTIAL EXPERIENCES

5.1. The challenges faced by women with physical disabilities in Lesotho

Disability is a limitation upon the freedom which existentialism⁵ perceives as a characteristic of existence (Couser, 2006:399). In this second part of the analysis attention is focused on the existential experiences, which are expressed in research participants' responses to the limitations and exclusions which are part of their existence. Many research participants report facing multiple barriers in their everyday lives. These barriers vary from interaction with non-disabled individuals to personal and environmental factors. They talk about their experiences of the physical, attitudinal and social barriers and how these impact on their disabilities and their construction of identity.

5.1.1. Experiencing physical barriers

Physical barriers are described as the manmade environments that hinder individuals with physical disabilities from moving around freely (WHO, 2011:263). For the women who were interviewed in this study, physical barriers act as a powerful obstacle to their exclusion from their communities. When they are not able to access facilities like everyone else in the community, their independence and quality of life are challenged (WHO, 2011:263).

Firstly, most participants narrate their experiences of physical barriers outside of their homes. These physical barriers include uneven terrain, staircases, limited special transportation services and un-accessible taxis. Oliver (1996:33) views

⁵ Existential sociology is discussed in more detail in section 1.4 (theory chapter)

disability as society's ignorance to meet the needs of disabled people. Botle is the most vocal advocate of this opinion:

The Lesotho government does not do anything about the situation of people with disabilities. Therefore, according to the government I must walk up the stairs and I will. It is very difficult...In this country. I use a car to get from one place to other. Where I come from there were no built roads but lately the roads are fixed. Before then, sometimes I would use a horse to get from one place to another. (Botle)

Later in the interview Botle also talks about how the uneven ground as well as the steep and rocky road restricted her from going to school. She points out that if the roads were fixed she would have been able to attend school just like other children of her age:

...Finally after two years of crawling, I was able to walk again even though it was not easy because I could only walk shorter distances. Because the school was far from home I had to stay home because I was unable to walk long distances. Besides the fact that I could not walk long distances, the road from home to school was very bad; it was steep and rocky. This then also contributed to preventing me from going to school. (Botle)

Similarly, Iponeng who uses crutches complains about the rocky road in her area:

When I get home...I cannot walk...The roads are rocky...I cannot walk. I asked one of the ladies from the council: "Is there any way in which you can help me? I do not like this place...This place is not nice... It is dangerous.

Please fix the road so that it is easy for me to get home.” There are no proper roads there. I cannot get home... It is terrible. (Iponeng)

Later in the interview Iponeng illustrates some of the most difficult moments in her life that resulted from being excluded:

At home...It is very tough especially when I am at home alone. It is even more difficult when I do not have airtime to call people when I need help...They stay far from my place...It is very far. I moved from where I used to stay. I wanted to be closer to the services...but it is worse...I did not buy the land. The chief allocated me that land for free. But it is very bad there. If I had money I would move. This impacts on me negatively because I am excluded from the rest of the community. When I need water...Sometimes I cannot get to the shops...They are very far. Sometimes I sleep without airtime. (Iponeng)

Nthathi describes the difficulty and frustration of shopping alone. She says that whenever she needs to go shopping, she has to find someone to push her around in her wheelchair. She describes shopping alone as difficult. She can access the buildings but once she is inside, she encounters further barriers such as stairs that hinder people with disabilities from gaining access to the interior of many buildings:

Iyoh, shopping is the most difficult one. Sometimes doing shopping means I have to go up the stairs. Sometimes I just look at something that I want to buy but I cannot reach for it. I have to find someone to go shopping with me; someone who will push me around and help me pick up what I want. Sometimes I have to ask someone to go shopping on my behalf and they bring me things that I did not ask for. Shopping is not easy...And I get emotional when I cannot do shopping on my own. (Nthathi)

5.1.2. Experiencing barriers in transportation

Limited transportation acts as a barrier in the everyday lives of most participants interviewed for this study (WHO, 2011:263). For Konesoang, inaccessible public transport leaves her reliant on the taxi system. She points out that she does not only experience limited transportation services and inaccessible taxis but she also experiences discrimination by taxi operators:

I move around in my wheelchair to perform everyday activities. But the problem is public transport. These people say nasty things about us, painful words. Due to this intolerance, I took the initiative to report to the taxi drivers and inspectors. They treated me badly. (Konesoang)

Konesoang further describes using public transport as a painful and sad experience:

Whenever I travel from Maseru to Buthe-Buthe I have to use public transport. When I get into the taxi I have to ask someone to fold my wheelchair and put it in the taxi...I feel more comfortable sitting in front but they force me to sit at the back. Then no one holds my wheelchair. I will have to hold it myself. It is very heavy. Every one ignores me, even a kontae [taxi operator]. This is a very sad and painful experience. (Konesoang)

For some participants, using public transport means that in one way or another they have to interact with other people. Nthathi discusses the kind of challenges that she experiences when having to negotiate with able-bodied individuals who become intolerant with her disability:

Whenever I use public transport...People do not even bother to help me. They just take me and put me in the taxi without asking how exactly they can help.

The proper way is for them to at least ask nicely: “How can I help you?”

(Nthathi)

All research participants who were interviewed for this study use public transport. However, most of them complain about how they are treated by unfriendly taxi operators. This is not the only reported problem. Research participants also report that non-disabled individuals are a serious issue in public transport. It is clear that many individuals with disabilities are at risk of discrimination at the hands of taxi operators and other non-disabled passengers. Clearly, lack of availability of transport for people with disabilities is more complex in the rural communities. From the perspective of the research participants, it is evident that the medicalisation of disability is not about medication or individual impairments but to socially exclude people with disabilities from societies, forcing them to experience the same world but in a different way (Cameron, 2014:137).

5.1.3. Experiencing discrimination: the attitudes of others

Of all the barriers that people with disabilities face, attitudes of others are seen as the most difficult to eliminate. How an individual feels about herself is often affected by the attitudes of others. It is evident from the narratives that the negative attitudes of non-disabled individuals towards the participants bring stigma that impact on them resulting in low self-esteem and discrimination. To be stigmatized is to be deprived of normal access to everything offered by society (Katz, 1981:4).

The majority of participants report experiencing negative reactions not only from the society at large but from their families as well. In support of this statement, Lisebo presents her narrative of family rejection, explaining her brother's actions, which within the context of disability were clearly the acts of discrimination.

...Maybe the fact that people think we have disabilities...they take us for granted. My worst moment was...my brother...I don't know, maybe it was a mission. These people came to me, there were three of them. My brother was the one who sent them...But he did not come with them. I heard afterwards that he was the one who sent the people. My brother send people...It was a forced marriage. He wanted me to get married. He was worried...He wanted me to get married. He said that all girls my age were married and they had families of their own. He asked me why I was still staying in our parents' house. You know...I am not an obstacle...I am not preventing him from doing anything. I am not in his way. He said he was not happy that I wasn't married. So, he sent these men to take me. Luckily their mission failed. God protected me. The day they planned to drag me away I did not get out of the house. That is the reason why I am here today. (Lisebo)

It is evident that women with disabilities are socially marginalised because of discriminatory practices performed by able-bodied individuals (Davis, 2006:198). Nthati uses the word “discrimination” to explain how her own parents violated her right to education as a result of her disability:

...I am the eldest child at home but I was denied the right to education...They said that since I had a disability I should stay at home and give my able-bodied siblings an opportunity to study. They said that they would help me with other things. I feel that I was discriminated against, compared to others. They always said that they had plans for me. (Nthati)

Nthati makes it clear that her family did not fully care for her and they did not support her. This left her to experience isolation and oppression. Konesoang further

highlights this point by describing her experiences. She also used the word “discrimination” to explain how she was emotionally abused during her childhood:

I was always discriminated against by other kids. They also told me that I had a disability and I am HIV positive. When I played with other kids...At that time I was not using a wheelchair but I could not stand on my own...I needed someone to hold me for support. Then when somebody's child tried to help me she told me that I am a crawling cow! (Konesoang)

Similarly Botle shares a story about how she was discriminated against, as a child, due to her disability:

I was also discriminated against when I was at primary school. When the other learners were sent to fetch wood from the bushes, my class teacher would ask me to stay behind because I could not walk properly. Then this other teacher would go like: “Oho [hey you], go sweep in one of the class rooms instead of just sitting around doing nothing!” Then my teacher would ask me: “Where are you going? I said you must rest.” Then I would tell her that one teacher said I should go and sweep in one of the class rooms because I did not go to fetch wood with other learners. The teacher said I should not just sit around, that I should also do something because the others have gone to fetch the wood. This is one of the most painful experiences of my life. But from that time I don't think I have experienced discrimination. (Botle)

5.1.4. Experiencing discrimination in employment

Women with disabilities need meaningful job opportunities not only for their own financial security but most importantly also for their physical health, personal wellbeing and sense of identity (WHO, 2011:6). Many people with disabilities experience lower job opportunities. In addition they are sometimes even asked to leave their jobs (WHO, 2011:263). Stereotypes against women with disabilities influence the attitudes of employers to such a point that such attitudes can impact on the ability of women with physical disabilities to do their jobs efficiently. Lisebo narrates to the researcher about her employer's attitude that affected her sense of independence, her sense of worth and her sense of social value at the workplace:

...I decided to work in the clothing factories. It was very tough at home...I went to work in the factories. I experienced so many challenges at work because of my disability...Because people with disabilities are treated differently. I did not enjoy working there because they always teased and called me names. This made me feel very insecure...I even started becoming doubtful of myself and my abilities. They made me feel different from other people but even so I stayed on. I continued working there until they fired me. The supervisor fired me...She said she was not totally satisfied with me and my work. Then I stopped going to work. (Lisebo)

From Lisebo's perspective, it is clear that she strongly feels discriminated against. She was treated as if she was incapable of doing her job, because of her disability. Botle makes a comment that clarifies why women with physical disabilities are often perceived as unfit and undeserving of employment:

Let me start by saying it is very difficult to get a job firstly because you are physically disabled and secondly because you are a woman. (Botle)

Other participants also report restricted access to meaningful employment which forces them to lose hope. This point was confirmed by Lillo who believes that she will never be employed because of her disability. However, she indicates a lasting desire for earning her own money:

I want to...to...Have my own business. (Lillo)

Puseletso also points out that her dream is to own a business:

I would like to try making cakes...I want to have a business of my own...Catering. (Puseletso)

Although disabled, some of the research participants attempt to be independent in the future. For many participants, lack of job opportunities is a major issue preventing them from living full lives. Hence some research participants express the desire to want to run their own businesses.

5.2. Conclusion

Women with disabilities experience various barriers in different sectors of their communities. These barriers exclude them from society and leave them unable to access the mainstream institutions of society. Individuals reported inaccessibility to meaningful employment, public buildings and shopping centres, means of transport and, most importantly, to independence. Experiences of such barriers are important implications for constructing an identity as a disabled person (WHO, 2011:263).

6. CONCLUDING REMARKS

The objective of this study was to explore the lived experiences of young African women with physical disabilities in Lesotho. In trying to understand how these young women construct a meaning to disability, the social model of disability is used in this study to enable them to describe their experiences of living with physical disabilities. The social model of disability provides a way in which to understand disability holistically. "An adequate social theory of disability would include all dimensions of disabled people's experiences: bodily, psychological, cultural, social, political, rather than claiming that disability is either medical or social" (Shakespeare and Watson, 2001:20). Physical disability is understood from the everyday lived experiences of women with disabilities in Lesotho in the context of their lives. The participants share similar views on experiencing physical disabilities, including the barriers that vary from personal and environmental factors.

The perception of femininity is strongly associated with looking attractive. As such, many women believe that using make-up as well as following fashion and changing hairstyles make them feminine. However, not all participants are interested in modifying their beauty. The need to conform to the high standards of ideal beauty and body perfect is uncommon among them. Feeling comfortable in their bodies also seems to be an important part of femininity. Many of them identify their bodies as strong and able to perform many activities.

Women experience difficulty with performing some of the gender role expectations as a result of limited mobility, leaving them claiming an identity as disabled. Even though they regard themselves as disabled, many recognise their abilities to perform some of the daily activities necessary for their well-being. Research participants also

express negative experiences of disability where they describe their bodies as weak and painful. In this sense, the word disability has a negative connotation.

Participants' lack of social inclusion is the most frequently raised issue. Many participants seem to be excluded from participation in the mainstream society due to society imposing barriers that hinder them from full participation. It is evident from the interviews that many people with physical disabilities in Lesotho experience unfriendly environment such as lack of access to public buildings that do not have ramps and wheelchair accessibility. They also report steep rocky roads as a barrier. As such, the physically disabled are given little or no opportunity to take part in the mainstream life of their communities. Furthermore, they experience frustrations in accessing public transport where they sometimes experience discrimination at the hands of taxi operators and other able-bodied individuals who are impatient with them.

The study reveals that many women with physical disabilities in Lesotho experience discrimination in their communities. Negative attitudes that people impose on women with physical disabilities are seen as a huge problem that sometimes forces people with disabilities out of the public eye. These negative attitudes seem to be some of the reasons why people with physical disabilities avoid contact with able-bodied individuals (Blinde and McClung, 1997:328). This is because when women appear in public they experience identities, as defined by others, that they are incapable of doing anything. They are therefore perceived as inferior (Garland-Thomson, 2002:79). When women with physical disabilities are treated in this way they develop a negative self-concept.

In addition, people with disabilities experience the highest rate of unemployment because they are perceived as useless and incapable of completing the same tasks as everybody else. This situation leaves them unfairly misinterpreted. Many research participants report that they have accepted their disabilities because they have come to a point of accepting disability as part of their body image. The relationship between religious believers and disability is seen as a successful coping mechanism for women with disabilities. Faith has also helped women with disabilities to construct a positive sense of self and by so doing they experience greater hope for the future.

Drawing on experiences of women with physical disabilities in this research study, it seems that in Lesotho, mainstreaming of women with physical disabilities is a serious matter. In order to overcome this challenge, it is essential to change the attitudinal, social and environmental barriers and in order to do this the social model is perceived as being the necessary model to look at people with disabilities in Lesotho. The social model of the study of disability rejects the idea of the medical model and perceives disability as a result of the unfriendly environment (Siebers, 2006:173). The problem of disability is removed from an individual to environmental attitudes and barriers that hinder an individual from participating in mainstream society (Siebers, 2006:173).

In conclusion, it is clear that women with physical disabilities are responsible mothers and loving partners. They are capable of achieving feminine beauty standards. Pfeiffer (2006:86) is of the opinion that "...if people with disabilities have the right to exist in this society, then they have the right to ways to make that existence meaningful and effective." Through the use of the social model of disability, this end can be achieved. The social model of disability is believed to be

useful in empowering and improving the self-esteem of individuals with disabilities and in building their positive sense of identity (Shakespeare, 2006:200).

LIST OF REFERENCES

Abberley, P. 2006. The concepts of oppression. In L. Barton (ed). *Overcoming disabling barriers: 18 years of disability and society*. New York: Routledge.

Anastasiou, D. and Kauffman, J.M. 2011. A social constructionist approach to disability: Implications for special education. *Council for Exceptional Children*, vol. 77, no. 3, 367-384.

Andersen, M. L. and Taylor, H .F. 2013. *Sociology: The essentials*. 7thed. Boston: Wadsworth Cengage.

Atkinson, R. 2002. The life story interview. In J. F. Gubrium and J. A. Holstein (eds). *Handbook of interview research: Context & method*. London: Sage Publications.

Barnes, C. 2013. The social model of disability: A sociological phenomenon ignored by sociologists. In T. Shakespeare (ed). *The disability studies reader*. London: Cassell.

Barnes, C. and Mercer, G. 2005. The social model of disability: A sociological phenomenon ignored by sociologists. In T. Shakespeare (ed). *The disability studies reader*. London: Cassell.

Beatty, L. A. 2003. Substance abuse, disabilities, and black women: An issue worth exploring. *Women & Therapy*, vol. 26, no. 3, 223-236.

Benner, P. 1985. Quality of life: A phenomenological perspective on explanation, prediction and understanding in nursing science. *Advances in Nursing Science*, vol. 8, no. 1, 1-14.

Berbrier, M. 2008. The diverse construction of race and ethnicity. In J.A. Holstein and J.F. Gubrium (eds). *Handbook of constructionist research*. New York: Guilford.

Berger, P. L. and Luckmann, T. 1966. *The social construction of reality: A treatise in the sociology of knowledge*. New York: Penguin.

Bergum, V. 1991. Being a phenomenological researcher. In M. Morse (ed). *Qualitative nursing research: A contemporary dialogue*. London: Sage publications.

Bickenbach, J. E., Chatterji, S., Badley, E. M. and Ustun, T. B. 1999. Models of disablement, universalism and the international classification of impairments, disabilities and handicaps. *Journal of Social Science and Medicine*, vol. 48, no. 2, 1173-1187.

Birks, M., Chapman, Y. and Francis, K. 2008. Memoing in qualitative research: Probing and processes. *Journal of Research in Nursing*, vol. 26, no. 13, 68–75.

Blanks, B. and Smith, J. D. 2009. Multiculturalism, religion, and disability: Implications of special education practitioners. *Education and Training in Development Disabilities*, vol. 44, no. 3, 295–303.

Bless, C., Higson-Smith, C. and Kagee, A. 2006. *Fundamentals of research methods. An African perspective*. 4th ed. Cape Town: Juta and Co. Ltd.

Blinde, E. M. and McClung, L. R. 1997. Enhancing the physical and social self through recreational activity: Accounts of individuals with physical disabilities. *Journal of Sport Behavior*, vol .14, 327-344.

Bradley, H. 1996. *Fractured identities: Changing patterns of inequality*. Cambridge: Open University Press.

Burns, N. and Grove, S. K. 2001. *The practice of nursing research: Conduct, critique and utilization*. New York: W.B Saunders Company.

Cameron, C. 2014. *Disability studies: A student's guide*. London: Sage Publications.

Collins, P. H. 2000. *Black feminist thought: Knowledge, consciousness, and the politics of empowerment*. 2nd ed. New York: Routledge.

Conaghan, J. 2007. Intersectionality and UK equality initiatives. *South African Journal of Human Rights*, vol. 23, no. 2, 317–334.

Cook, C., Powell, A. and Sims, A. 2009. *Spirituality and psychiatry*. London: RCPsych Publications.

Couser, G. T. 2006. Disability, life narrative, and representation. In L. J. Davis (ed) *The disability studies reader*. New York: Routledge.

Crenshaw, K. W. 1999. Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, vol. 43, no. 6, 1241-1299.

Creswell, J. W. 2013. *Qualitative inquiry and research design: Choosing among five approaches*. 3rd ed. London: Sage Publications.

Darling, R. B. 2013. *Disability and identity: Negotiating self in a changing society*. Boulder, Col: Lynne Rienne Publishers.

Davis, L. J. 2006. The end of identity politics and the beginning of dismodernism: On disability as an unstable category. In L. J. Davis (ed). *The disability studies reader*. New York: Routledge.

Denzin, N. K. and Lincoln, Y. S. 2011. *Introduction: The sage handbook of qualitative research*. 4th ed. Thousand Oaks, CA: Sage Publications.

Dickert, N., Emanuel, E. and Grady, C. 2002. Paying research subjects: An analysis of current policies. *Annals of Health and Medicine*, vol. 136, no. 5, 368-373.

Duranti, A. 2010. *Husserl, intersubjectivity and anthropology*. Los Angeles: University of California.

Durrheim, K. 2006. Research design. In M. Terre Blanche., K. Durrheim and D. Painter (eds). *Research in practice: Applied methods in the social sciences*. 2nd ed. Cape Town: University of Cape Town Press.

Emmett, T. and Alant, E. 2007. Women and disability: Exploring the interface of multiple disadvantage. *Journal of Women and Disability*, vol. 23, no. 4, 445-460

Erlandson, D. A., Harris, E. L., Skipper, B. L. and Allen, S. D. 1993. *Doing naturalistic inquiry: A guide to methods*. London: Sage Publications.

Garland-Thomson, R. 2002. Integrating disability, transforming feminist theory: Feminist disability studies. *NWSA Journal*, vol. 14, no. 3, 1-32.

Goodley, D. and Lawthom, R. 2006. *Disability & psychology: Critical introductions & reflections*. New York: Palgrave Macmillan.

Greenfield, B. H. and Jensen, G. M. 2010. The lived experiences of patients: Application of a phenomenological approach to ethics. *Physical Therapy*, vol. 90, no. 8, 1185-1197.

Hacking, I. 1999. *The social construction of what?* Cambridge, MA: Harvard University Press.

Hahn, H. 1986. "Public support for rehabilitation in programs: The analysis of US disability policy" *Disability, Handicap & Society*, vol. 1, no. 2, 121-138.

Hall, K. Q. 2011. *Feminist disability studies*. Indianapolis: Indiana University Press.

Hanna, W. J. and Rogovsky, B. 2006. Women with disabilities: Two handicaps plus. In L. Barton (ed). *Overcoming disabling barriers: 18 years of disability and society*. New York: Routledge.

Harries, A. P. 1990. "Race and essentialism in feminist legal theory." *Stanford Law Review*, vol. 42, no. 3, 581-616.

Hartley, S. and Muhit, M. 2003. Using qualitative research methods for disability research in majority world countries. *Asia Pacific Disability Rehabilitation Journal*, vol. 14, no. 2, 103-114.

Hassanein, E. E. A. 2015. *Studies in inclusive education: Inclusion, disability and culture*. Rotterdam: Sense Publishers.

Hennink, M., Hutter, I. and Bailey, A. 2011. *Qualitative research methods*. London: Sage Publications.

Hill, P. C. 2003. Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. *American Psychological Association*, vol. 58, no. 1, 64-74.

Hirschmann, N. J. 2012. Disability as a new frontier for feminist intersectionality research. *Politics and Gender*, vol. 8, no. 3, 396-405.

Holland, J., Blair, M. and Shelton, S. 1995. *Debates and issues in feminist research and pedagogy: A reader*. Clevedon: Open University.

Holmes, M. 2010. Social theory of the body. In A. Elliott (ed). *The Routledge companion to social theory*. London: Routledge.

Hosain, G. M., Atkinson, D. and Underwood, P. 2002. Impact of disability on quality of life of rural disabled people in Bangladesh. *Journal of Health Population Nutrition*, vol. 20, no. 4, 297-305.

Howson, A. 2013. *The body in society: An introduction*. 2nd ed. Cambridge: Polity Press.

Hughes, B. and Paterson, K. 2006. The social model of disability. In L. Barton (ed). *Overcoming disabling barriers: 18 years of disability and society*. New York: Routledge.

Inglis, D. and Thorpe, C. 2012. *An invitation to social theory: Phenomenological paradigms*. Cambridge: Polity Press.

Katz, I. 1981. *Stigma: A social psychological analysis*. New Jersey: Lawrence Erlbaum Associates.

Kendall, D. 2011. *Sociology in our times: The essentials*. California: Wadsworth.

Koenig, H.G., King, D.E. and Carson, V.B. 2012. *Handbook of religion and health*. 2nd ed. New York: Oxford University Press.

Kotarba, J. A. 2009. Existential sociology: The self-confronts society. In M. H. Jacobsen (ed). *Encountering the everyday: An introduction to the sociologies of the unnoticed*. New York: Palgrave Macmillan.

Kotarba, J. A. and Fontana, A. 1987. *The existential self in society*. Chicago: University of Chicago Press.

Kotarba, J. A. and Johnson, J. 2002. *Postmodern existential sociology*. Lanham: Rowman and Littlefield Publishers, INC.

Krahe, B. and Altwasser, C. 2006. Changing negative attitudes towards persons with physical disabilities: An experimental intervention. *Journal of Community & Applied Social Psychology*, vol. 16, 59-69.

LeCompte, M. D. and Schensul, J. J. 1999. *Designing and conducting ethnographic research*. London: Altamira.

Loja, E., Costa, M. E., Hughes, B. and Menezes, I. 2012. Disability, embodiment and ableism: Stories of resistance. *Disability & Society*, vol. 28, no. 2, 190-203.

Lorber, J. 2008. Constructing gender: The dancer and the dance. In J. A. Holstein and J. F. Gubrium (eds). *Handbook of constructionist research*. London: Guilford Press.

Lupton, D. 2012. *Medicine as culture: Illness, disease and the body*. 3rd ed. London: Sage Publication.

Lysne, C. J. and Wachholtz, A. B. 2010. Pain, spirituality, and meaning making: What Can we learn from the literature? *Religions*, vol. 2, 1-16.

McDonald, K. E., Keys, C. B. and Balcazar, F. F. 2007. Disability, race/ethnicity and gender: Themes of cultural oppression, acts of individual resistance. *American Journal of Community Psychology*, vol. 39, 145-161.

McMahon, J. A., and Huntly, H. E. 2013. The Lived and living bodies of two health and physical education tertiary educators: How embodied consciousness highlighted the importance of their bodies in their teaching practice in HPE. *Australian Journal of Teacher Education*, vol. 38, no. 4, 31-49.

Merleau-Ponty, M. 1945. *Phenomenology of perception*. London: Routledge.

Miller, J. and Glassner, B. 1997. The “inside” and the “outside”: Finding realities in interviews, in D. Silverman (ed). *Qualitative research: Theory, method and practice*. London: Sage Publications.

Mollow, A. 2006. The Politics of race, gender, and emotional distress in Meri Nana-Amadanquah’s willow weep for me. In L. J. Davis (ed). *The disability studies reader*. New York: Routledge.

Morris, J. 2006. Personal and political: A feminist perspective on researching physical disability. In L. Barton (ed). *Overcoming disabling barriers. 18 years of disability and society*. New York: Routledge.

Morse, J. M. 1994. *Critical issues in qualitative research methods*. Thousand Oaks, CA: Sage Publications.

Mumma, C. M. 2000. Perceived losses following stroke. *Rehabilitation Nursing*, vol. 25, no. 5, 192–195.

Myers, K. 2004. "Ladies first: Race, class and the contradictions of a powerful femininity." *Sociological Spectrum*, vol. 24, no. 1, 11-41.

Neuman, W. L. 2012. *Basics of social research: Quantitative and qualitative approaches*. 3rd ed. New Jersey: Pearson Education, Inc.

Nind, M. 2008. *Conducting qualitative research with people with learning, communication and other disabilities: Methodological challenges*. Manchester: University of Southampton.

Norlyk, A., Martinsen, B. and Kjaer-Petersen, K. 2013. Living with clipped wings: Patients' experiences of losing a leg. *Journal of Qualitative Studies on Health and Wellbeing*, vol. 8, no. 21891, 1-9.

Nosek. M, A. 2006. The changing face of women with disabilities: Are we ready? *Journal of Women's Health*, vol. 15, no. 9, 996-999.

Olanrewaju, A. E. 2012. Social phenomenology of Alfred Schutz and the development of African sociology. *British Journal of Arts and Social Sciences*, vol. 4, no.1, 12-25.

Oliver, M. 1966. *Understanding disability: From theory to practice*. London: Macmillan.

Overgaard, S. and Zahavi, D. 2009. Phenomenological sociology: The subjectivity of everyday life. In M. H Jacobsen (ed). *Encountering the everyday: An introduction to the sociologies of the unnoticed*. Houdnmills, Basingstoke, UK: Palgrave MacMillan.

Papadimitriou, C. 2008. Becoming en-wheeled: The situated accomplishment of re-embodiment as a wheelchair user after spinal cord injury. *Disability and Society*, vol. 23, no.7, 691-704.

Peters, S., Gabel, S. and Symeonidou, S. 2009. 'Resistance, transformation and the politics of hope: Imagining a way forward for the disabled people's movement.' *Disability & Society*, vol. 24, no. 5, 543-556.

Pfeiffer, D. 2006. Eugenics and disability discrimination. In L. Barton (ed). *Overcoming disabling barriers: 18 years of disability and society*. New York: Routledge.

Power, P. W. and Dell Orto, A. E. 2004. *Families living with chronic illness and disability: Interventions, challenges and opportunities*. New York: Springer Publishing Company.

Ritzer, G. 1983. *Contemporary sociological theory*. New York: Alfred A. Knopf.

Rugg, D. 2010. *An Introduction to triangulation*. Geneva: UNAIDS Monitoring and Evaluation Fundamentals.

Sandahl, C. 2002. Considering disability: Disability phenomenology's role in revolutionizing theatrical space. *Journal of Dramatic Theory and Criticism*, vol.16, no. 2, 17-32.

Sawadsri, A. 2011. Embodiment in the disabling built-environment: An experience of daily life. *Forum Ejournal*, vol. 53, no. 66, 53-66.

Schriempf, A. 2001. An interactions' bridge for feminism and disability. *Feminism and Disability*, vol. 16, no. 4, 53-79.

Schriempf, A. 2001. An interactions' bridge for feminism and disability. *Feminism and Disability*, vol. 16, no. 4, 53-79.

Schulte, P. 2000. Holding in mind: Intersubjectivity, subject relations and the group. *Group Analysis*, vol. 33, no. 4, 531-544.

Schultz, D. P. and Schultz, S. E. 2009. *Theories of personality*. 9th ed. Belmont, CA: Wadsworth.

Schutz, A. 1970. *Alfred Schutz on phenomenology and social relations*. Chicago: University of Chicago Press.

Schutz, A. 2004. Concept and theory formation in the social sciences. In C. Seale (ed). *Social research methods: A reader*. London: Routledge.

Schwandt, T. A. 2008. Handbook of constructionist research. *Journal of Multidisciplinary Evaluation*, vol. 5, no. 10, 93-94.

Scott, A. and Laura, E. D. 2012. *Classical and contemporary sociological theory: Text and readings*. Los Angeles, CA: Sage Publications.

Shakespeare, T. 2006. The social model of disability. In L. J. Davis (ed). *The disability studies reader*. New York: Routledge.

Shakespeare, T. and Watson, N. 2001. The social model of disability: An outdated ideology? In S. N. Barnatt and B. M. Altman (eds). *Research in social science and disability*. London: Elsevier Science Ltd.

Shaw, L. R., Chan, F., and McMahon, B. T. 2012. Intersctionality and disability harassment: The interactive effects of disability, race, age, and gender. *Rehabilitation Counselling Bulletin*, vol. 55, no. 2, 82-91.

Shenton, A. K. 2004. Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, vol. 22, no. 2, 63-75.

Shogan, D. 1998. The social construction of disability: The impact of statistics and technology. *Adapted Physical Activity Quarterly*, vol. 15, no. 3, 269-277.

Siebers, T. 2006. Disability in theory: From social constructionism to the new realism of the body. In L. M. Davis (ed). *The disability studies reader*. New York: Routledge.

Silverman, D. 1993. *Interpreting qualitative data: Methods for analysing talk, text and interaction*. London: Sage Publications.

Silverman, D. 2013. *Doing qualitative research*. 4th ed. Thousand Oaks: Sage Publications.

Simone de Beauvoir. 1974. *The second sex*. New York: Vintage Books.

Smith, C. P. 1998. *The hermeneutics of original argument: Demonstration, dialectic, and rhetoric*. Evanston: North-Western University Press.

Sokolowski, R. 2000. *Introduction to phenomenology*. New York: Cambridge University Press.

Somers, M. R. 1994. "The narrative constitution of identity: A relational and network approach." *Theory and Society*, vol. 23, no. 5, 605-649.

Stone, J. H. 2005. *Culture and disability: Providing culturally competent services*. London: Sage Publications.

Stuart, O. W. 2006. Race and disability: Just a double oppression. In L. Barton (ed). *Overcoming disabling barriers: 18 years of disability and society*. New York: Routledge.

Sullivan, K. 2011. The prevalence of medical model of disability in society. *AHS Capstone Projects*, vol. 4, no. 1, 1-18.

Terre Blanche, M., Durrheim, K. and Kelly, K. 2006. First steps in qualitative data analysis. In M. Terre Blanche, K. Durrheim and R. Painter (eds). *Research in practice: Applied methods for the social sciences*. Cape Town: University of Cape Town Press.

Thomas, C. 1999. *Female forms: Experiencing and understanding disability*. Buckingham: Open University Press.

Tilley, C.M. 1996. Sexuality in women with physical disabilities: A social justice or a health issue? *Sexuality and Disability*, vol. 14, no. 2, 139–151.

Titchkosky, T. and Michalko, R. 2014. Narrative. In C. Cameron (ed). *Disability studies: A student's guide*. London: Sage Publications.

Treloar, L. L. 2008. Spiritual beliefs, response to disability, and the church—Part 1. *Journal of Religion, Disability & Health*, vol. 3, no. 4, 5-32.

Turner, S. S. 1992. *Disability and the sociology of the body*. London: Routledge.

Van Manen, M. 1990. *Researching lived experience: Human science for an action sensitive pedagogy*. Albany, New York: State University of New York Press.

Watson, N. 2002. Well, I know this is going to sound very strange to you, but I don't see myself as a disabled person: Identity and disability. *Disability & Society*, vol. 17, no. 5, 509-527.

Webster, L. and Mertova, P. 2007. *Using narrative inquiry as a research method: An introduction to using critical event narrative analysis in research on learning and teaching*. New York: Routledge.

Wendell, S. 1996. *The social construction of disability: The rejected body*. New York: Routledge.

Williams, S. J. and Bendelow, G. A. 1999. *The lived body: Sociological themes and embodied issues*. London: Routledge.

Woodin, S. 2014. Intersectionality. In C. Cameroon (ed). *Disability studies*. London: Sage Publications.

World Health Organisation. 1980. *International classification of impairments: Disabilities and handicaps*. Geneva: WHO Press.

World Health Organisation. 2011. *Community based rehabilitation as we have experienced it: Voices of persons with disability*. Geneva: WHO Press.

Yeasmin, S. and Rahman, K. F. 2012. 'Triangulation' research method as the tool of social science research. *BUP Journal*, vol. 1, no. 1, 2219-4851.

Young, I. M. 2005. *On female body experience "Throwing like a girl" and other essays*. New York: Oxford University Press.

Zaner, R. and Engelhardt, H. 1973. *Alfred Schutz and Thomas Luckmann: The structures of the life-world. Volume 1*. Evanston: Northwestern University Press.

APPENDIX A: APPROVAL LETTER



Faculty of the Humanities

09-Nov-2015

Dear Ms Rafoneke

Ethics Clearance: Experiencing disability: Narratives of black young women with physical disabilities in Lesotho

Principal Investigator: Ms Seithati Rafoneke

Department: Sociology (Bloemfontein Campus)

APPLICATION APPROVED

With reference to your application for ethical clearance with the Faculty of the Humanities. I am pleased to inform you on behalf of the Research Ethics Committee of the faculty that you have been granted ethical clearance for your research.

Your ethical clearance number, to be used in all correspondence is: **UFS-HSD2015/0615**

This ethical clearance number is valid for research conducted for one year from issuance. Should you require more time to complete this research, please apply for an extension.

We request that any changes that may take place during the course of your research project be submitted to the ethics office to ensure we are kept up to date with your progress and any ethical implications that may arise.

Thank you for submitting this proposal for ethical clearance and we wish you every success with your research.

Yours Sincerely

Prof. Stephen Walker
Chairperson: Research Ethics Committee
Faculty of the Humanities

Office of the Dean/Kantoor van die Dekaan/Ofisa ya Dine
T: +27 (0)51 401 2240 | F: +27 (0)51 401 7363 | E: benkeshu@ufs.ac.za
P.O. Box/Posbus 339 | Bloemfontein 9300 | South Africa/Suid-Afrika | www.ufs.ac.za



APPENDIX B: PARTICIPANT INFORMATION SHEETS (ENGLISH AND SESOTHO VERSION)

Dear Participant,

My name is Seithati Rafoneke, I am registered for a Master's degree in Sociology (**The Narrative Study of Lives**) at the University of the Free State. I would like to invite you to participate in this project, which is concerned with "Lived experiences of young Black women with physical disabilities in Lesotho." The study is aimed at getting a deeper understanding of the challenges faced by women living with physical disabilities.

During the first meeting, you will have a chance to ask questions about the study. Afterwards, I will ask you to sign the informed consent form, both to participate in the study and to give permission for **audio-recording** of the interview.

Participation is voluntary and the interviews can be conducted at any place convenient for you, including your home. I would like to be able to visit you a number of times in order to observe some of your daily activities and some of the difficulties you encounter.

All the interviews will be **audio-recorded** so that the researcher can listen to them at a later stage and have the interviews written down from what was recorded. To ensure confidentiality your identity will be protected and **pseudonyms** will be assigned. You have a right to withdraw from the interview at any time if you feel any form of discomfort and you have a right to answer only specific questions.

There will be a probability of emotional experience during the interview due to some of the sensitive questions that will be asked by the researcher in trying to get a better

understanding of your everyday experiences. As a result you are allowed to stop the interview at any time you wish to. In addition, counselling services will be provided by Mr Seturumane Moeketsi. Further referrals will be made to Sesiouna Counselling Services SDA.

If you have any questions please do not hesitate to contact any of the following:

Ms Seithati Rafoneke

Institution: University of the Free State

Position: Master's student

Email: sechabarafoneke@gmail.com

Telephone: 0789935399

Professor. J.K. Coetzee (Supervisor)

Institution: University of the Free State

Position: Senior Professor

Email: coetzeejk@ufs.az.za

Telephone: 0514012881

Sesiouna Counseling Services SDA

Email: scs@hotmail.co.ls

Telephone: (+266) 22312661

Cell: (+266) 6270000

Mr Seturumane Moeketsi

Email: seturumanemx@gmail.com

Cell: (+266) 63986423

Kindest regards

.....

Seithati Rafoneke.

PARTICIPANT INFORMATION SHEET

Thlakisetso ea ho nka karolo

Ho uena ea tlang ho nka karolo,

Lebitso laka ke Seithati Rafoneke. Ke ntse ke ntsetsa lithuto tsa ka pele sekolong se phahameng sa University of the Free state lefapheng la Sociology (**The Narrative Study of Lives**) boemong ba Masters. Ke kopa o nke karolo ho projeke ena e ipapisitseng le “Lived experiences of young Black women with physical disabilities in Lesotho.” Ka ho etsa lipatlisiso ntlheng ena maikemisetso aka ke ho utluisisa hore na ke a feng a mang a mathata ao batho ba phelang le bokooa ba masapo ba kopanang le ona maphelong a bona a letsatsi le letsatsi.

Kopanong ea rona ea pele o tla fumana monyetla oa ho botsa lipotso mme ha morao ke tla kopa hore o tekene lengolo le bontsang hore o lumela ho nka karolo ka hona o lumela le hore puisane ea rona etla hatisoa **[audio-recording]**.

O ke ke oa qobelloa ho nka karolo puisanong ena haeba o sa thabele ho etsa joalo mme haeba o lumela, puisano ena etla nka sebaka moo oena oka thabelang joalo ka lapeng moo o lulang teng. Nka thabela ho tla moo o phelang teng ho tla bona a mang a mathata ao o kopanang le ona letsatsi le letsatsi.

Lipuisano tsohle tsa rona litla hatisoa **[audio-recorded]** ele ho lumella mofuputsi hore ha morao atle a ngole fatse mme a fetolele ho senyesemane. Ho etsa bonnete ba hore puisano ea rona ha e na tsejoang ke mang kapa mang, mabitso a hao a nnete a ke ke a sebelisoa. ho o sireletsa, retla sebelisa mabitso a boiqapelo**[pseudonyms]**. Ona le tokelo ea ho ikhula hoba karolo ea projeke ena ka nako eohle hao utloa o se osa thabele ho ba karolo ea eona.

Ho ka etsahala hore puisanong ena e o ame maikutlong mme o qetelle o ikutloa o sena khotso lebaka ele hobane otl'a botsoa lipotso tse amanang le maikutlo a hao. Ha sena seka etsahala, puisano etla emisoa hang hang mme hao o hloka motho eo oka buisanang le ena sebakeng sa ho o thoba maikutlo, mongahali Seturumane Moeketsi eo e leng mo conselara otl'a buisana le oena. Haeba ehlile o amahele maikutlo haholo o hloka thuso e ngoe otl'a fitisetsoa ho ba Sesiouna Counselling Services SDA ho fumana thuso.

Haeba ona le lipotso oka sebelisa linomoro tse lateng:

Ms Seithati Rafoneke

Sebaka sa tsebetso: University of the Free State

Boemo: Master's student

Email: sechabarafoneke@gmail.com

Telephone: 0789935399

Prof. J.K. Coetzee (Supervisor)

Sebaka sa tsebetso: University of the Free State

Boemo: Senior Professor

Email: coetzeejk@ufs.az.za

Telephone: 0514012881

Sesiouna counseling services SDA

Email: scs@hotmail.co.ls

Telephone: (+266) 22312661

Cell: (+266) 6270000

Mr Seturumane Moeketsi

Email: seturumanemx@gmail.com

Cell: (+266) 63986423

Ka boikokobetso

.....

Seithati Rafoneke.

APPENDIX C: INFORMED CONSENT FORMS (ENGLISH AND SESOTHO VERSION)

I have been given the information sheet on the research project entitled “Lived experiences of young Black women with physical disabilities in Lesotho.” I have read and understood the information sheet and the researcher has answered all my questions.

I agree to participate in this research project and I understand that participation is voluntary and I can terminate my participation at any time without any negative consequences. I also understand that I do not have to answer any questions that I am not comfortable with.

I grant the researcher permission to **audio-record** the interview and I understand that to ensure confidentiality, **pseudonyms** will be used to protect my personal identity. I also understand that the study will not reveal any information that may identify me. If I am not happy with the way the researcher is conducting the study I can contact Mrs Charné Vercueil of the Research Ethics Committee, University of the Free State on (+277) 0514017083 (vercueilcc@ufs.ac.za) or the research’s supervisor Professor Jan K. Coetzee on (+277) 0514012881 (coetzeejk@ufs.ac.za).

.....

.....

.....

Name of participant

Signature

Date

.....

.....

.....

Name of researcher

Signature

Date

INFORMED CONSENT FORM

Lengolo le kopang hore o nke karolo

Ke amohetse lengolo laho nka karolo projekeng e buoang ka “Lived experiences of young Black women with physical disabilities in Lesotho.” Ke balile mme ka utluisisa litaba tse hlahang lengolong lena mme mofuputsi oa litaba tsena o nhlaloselitse tsohle tseo ke neng ke hloka holi utluisisa mme a araba le likarabo tsohle tseo ke neng ke ena le tsona.

Ke lumela ho nka karolo projekeng ena mme kea utluisisa hore nke ke ka tlangoa hoba karolo ea projeke ena empa ke tla etsa joalo ka boithatelo le boithaopo baka. Ke utluisisa hape hore ha kea tlameha ho araba lipotso tseo ke utloang eka e tla ba bothata ho nna empa hape nka emisa hoba karolo ea projeke ena ka nako eohle hake utloa ke se kesa khotsofalla ho tsoela pele ka eona.

Ke fa mofuputsi tumello ea hore a hatise kopano ea rona **[audio-record]** mme ke utluisisa hape hore ele ho netefatsa hore litaba tsa kopano ena litla fella lipakeng tsa rona re le babeli, mofuputsi a ke ke a sebelisa mabitso a ka a nnete ho nsireletsa mme le mabitso ohle aka nkamahanyang le litaba tsena a keke a sebelisoa. ke utluisisa hore bakeng sa ho nsireletsa, mofuputsi otlalelela sebisa mabitso a boiqapelo **[pseudonyms]**. Ke amohetse linomoro tsa mohala tseo nka li sebelisang ho tlaleha haeba mofuputsi a etsa lipatlisiso ka mokhoa oo kesa o utluisising mme nka mo tlaleha ho Mrs Charné Vercueil Research Ethics Committee, University of the Free State nomorong ena (+277) 0514017083 (vercueilcc@ufs.ac.za) kapa ea ikarabellang ho projeke ena eleng Professor Jan K. Coetzee ho (+277) 0514012881 (coetzeejk@ufs.ac.za).

Tekena.....letsatsi.....
.....

Tekena.....letsatsi.....
.....

APPENDIX D: INTERVIEW SCHEDULES (ENGLISH AND SESOTHO VERSION)

Biographical information

1. Please tell me a bit about yourself. Anything.
2. Can you tell me something about your family?
3. Do you any have children?

If yes, can you please tell me about your experiences of being a mother?

4. If you have a partner: how was it when you started the relationship you are having today? Have you experienced any challenges in your relationship/previous relationships?

If you are single: can you choose to be in a relationship?

Can you choose to have children? Yes/no and Why?

What Challenges do you think you can come across?

5. Tell me a bit about your work life?

Hobby

1. What are the things that you do really well? Exemplify.
2. How do you spend your free time?
3. Which places do you like going to? Such as church, parks, mall etc. Why?
4. What would you like to try in the future?

Understanding the body

1. Let's assume that I do not know you and therefore I have never seen you at all; would you describe your physical appearance to me?
2. What words or images first come to mind when you hear the word 'body'?
Why these thoughts?
3. Do you feel that you had a good childhood? Can you exemplify this with a story? *Because*.....
4. Can you tell me a bit about how you lost ability?

[Depending on the previous answer] How old were you?

5. [Depending on the previous answer] How did you feel when meeting "the world"—your relatives and others when your appearance has changed?
6. What does having a physical disability mean to you?
7. How did your loss of ability affect the way you saw yourself among others?
8. Tell me about your best moment.

Tell me about your worst moment?

9. Tell me about being healthy?

What do you do to keep healthy or avoid being healthy?

10. How do you feel in your body? For example, are there times when you feel particularly good in your body and are there times when you do not feel good in it?

Please tell me more?

Experiencing the female body: femininity

1. Do you use make-up? Why and when?

Does applying make-up change the way you feel about yourself?

If yes, how?

2. Tell me about your hair style?

Would you say that there is a particular hair style that suits you the best?

If yes, which one is that?

Do you often do your hair at the hair dresser or do you prefer doing it at home?

3. Do you follow fashion?

If yes, what kind of fashion attracts you the most?

4. Do you in any way compare your appearance with that of other women?

If yes, when and why?

Because.....

[Depending on previous answer] Does comparing yourself to other women change the way you feel about yourself?

5. Is there anything about your look that you are particularly happy or unhappy about?

What's your most beautiful body part?

What's your list favourite body part?

6. Do you take into consideration other people's opinions about you?

If yes, whose opinions and why?

7. How do you feel about workouts/exercises?

[Depending on the previous answer] How often do you work out?

How do work outs make you feel?

8. After we talked about all the things that make a women beautiful—fashion, make-up and hairstyles—would you be happier should you perform these tasks?

Experiencing the disabled body.

1. Does disability affect the way in which you experience embodiment? (Such as the ability to lift, carry or move ordinary objects.)

How does this make you feel?

2. It can be difficult for a person with a physical disability to move from one place to another; what do you use to get around? i.e wheelchair, crutches

3. What aspects of disability has been the most difficult for you?

4. [Depending on previous answers] Can you do a lot of things on your own or do you have to rely on others for help? Exemplify

How does this make you feel?

5. Are there any ways in which able-bodied people interact with you that you particularly dislike? It can be the way they look at you, or the way they talk to you.

Please tell me about it?

How does this make you feel?

6. If you get an impression that people see you as different, how do you pick it up from their behaviour? If at all.
7. Are there any moments when you forget that you are disabled? Can you tell me about it

How did you feel?

8. Would you say that disabled women are ignored by the abled society?

If yes, how?

9. Have you ever been hid, isolated or abused in any way?

If yes, what happened?

How did you feel?

10. Have you ever been teased or called names?

If yes, what happened?

How did you feel?

11. Would you say that you have faced gender discrimination?

If yes, what happened?

How did this make you feel?

12. How do you think disability affects you as a woman?

Spirituality

1. Tell me about your spiritual beliefs?
2. Please tell me about how your spirituality impacts the way you think and feel about disability?

Such as, experience of discrimination/disabling barriers

God's presence

Overcoming difficulties

3. [Depending on the previous answers] What is the role of religious beliefs in helping you cope with disability

Support

1. Are you a member of any support group?

If yes, how often do you play a part in these groups?

2. Do you find these groups supportive?

If yes, in what way?

❖ Is there anything else you would like to tell me before we end the interview?

❖ Any other views and experiences that you would like to discuss?

INTERVIEW SCHEDULE

Biographical information

1. Ka kōpo na u ka mpoella hanyenyane ka uena? Ntho efe kapa efe?
2. Na u ka mpoella ho hong ka lelapa la hao?
3. Na u nale bana?

Haeba ho joalo, ke se feng seo u ka mpoellang sona mabapi le boiphihlelo ba hao ba ho ba 'mè?

4. Haeba u na le molekane kapa motho utloananag le ena likamano pakeng tsa lona li ne li le joang qalong ho fihlela ha joale? likamano tsa nako e fetileng tsona li ne li le joang? Na le phela 'moho? Nqoqele hanyane ka ena. Mathata ao u kopanang le 'ona ke afe?

Haeba ha ona molekane kapa motho o utloanang le ena: Na u ka khetha ho ba le likamano / ho lula le motho e mong / ho ba le bana? E kapa Che / Hobane'ng? U nahana u ka thulana le mathata a feng?

5. Aku nkamele hanyenyane ka tsa mosebetsi oo u o sebetsang?

Hobby

1. Ke lintho life tse u ka reng u ipabola haholo ho tsona? Hlalosa.
2. U sebelisa nako ea hao ea mahala joang?
3. Ke libaka life tseo u ratang ho ea ho tsona/ho li etela? Mohlala: kereke, lirapeng tsa boikhathollo, mabenkeleng Hobane'ng?

4. Ke eng eo u ka ratang ho e leka nakong e tlang? E fapaneng le tse u seng u li tseba?

Understanding the body

1. Ha re nke hore ha ke o tsebe ebile ha ke so o bone ho hang? Na oka nthusa hore ke utluisese na o shebahala joang?
2. Ha u utloa lentsoe 'mele' ke eng ya pele e tlang kelellong ea hao?

Ke hobane'ng ha unahana joalo?

3. Na u nahana hore u bile le kholo e ntle ho tloha bonyaneng ba hau? Hobaneng u cho joalo? Na u ka 'manollela pale eo?

Hobane

4. Na u ka hlalosa hanyane tsela eo/mokhoa oo u ileng oa lahlehela ke bokhoni bahau/oa holofala ka teng?

[Ho latela likarabo tse fitileng] u ne u le lilemo li kae ha seo se etsahala?

5. *[Ho latela likarabo tse fitileng]* u ile wa ikutloa joang hao qeta ho hlokomela hore o se ona le bokooa/disability haholo ha o kopana le batho ba bang?
6. Hoba le bokooa ba masepo ho bolela eng ho oena?
7. Hoba le bokooa ba masapo bo o amme joang haholo ha o ipapisa le batho ba bang?
8. Mpollele ka se kileng sa o thabisa haholo bophelong ba hao?

Mpolelle ka se kileng sa o kwatisa haholo bophelong ba hao?

9. Mpoelle ka tsa bophelo bobotle

u etsa eng hore 'mele oa hao o lule o phetse hantle/ ke eng se u se etsang ho qoba ho lula u phetse hantle?

10. O ikutloa joang ka mmele wa hao? Na hona le nako eo o utloe osa thabele mmel oa hao- mme na hona le nako eo o utlui o thabela

Ee kapa Che? Hlalosa.

Experiencing the female body: Femininity

1. Na u sebelisa make-up? Hobaneng? Neng?

Na ho sebelisa make-up ho fetola tsela eo u ikutloang ka eona? Joang?

2. Ntjoetse ka hairstyle ea hau?

U kare hona le hairstyle e u ts'oanelang ho feta tse ling?

Haeba ho joalo, ke e feng eo?

Hangata u isa moriri saloneng kapa u thabela ho lokisetsa hae?

3. Na u latela feshene,?

Haeba ho joalo, ke fashion ea mofuta o feng eo oe ratang haholo?

4. Na ka tsela e feng kapa e feng uke o bapisi tsela eo u shebahalang ka eona le ka moo basali ba bang ba shebahalang ka teng?

Hobane.....

[Ho latela karabo e fitileng] na ho ipapisa le basali ho fetola tsela eo o ikutloang ka eona?

5. Ke eng eo o e ratang ka tsela eo o shebahalang ka eona?

Ke eng eo o sa e rateng?

Hobaneng?

Ke karong e feng ya mmele wa hao eo o e ratang haholo?

Ke karolo e feng eo o sa e rateng eona ke e feng? Hobaneng?

6. Na o nkela hlohong maikutlo a batho ba bang ka oena?

Haeba ho joalo, a mang mme hobaneng?

7. Maikutlo a hau ke a feng mabapi le ho koetlisa 'mele?

[Ho latela karabo e fitileng] Na u oa ikoetlisa?

u ikoetlisa hangata hole ho kae?

Ho ikoetlisa ho etsa hore u ikutloe joang?

Hona le phethoho eo u e bonang 'meleng oa hau esale u qala ho ikoetlisa? Ke e feng?

8. Ka morao hore re bue ka lintho tsohle tse etsang hore motho oa mosali abe motle (ho lukisa moriri, make-up le fashion) o bona ele lintho tseo o ka thabelang holi etsa kapa tseo o kekeng oa thabela ho li etsa?

Mohlala, o bona ele tsenyo ya nako ho wena kapa ke lintho tseo o ka thabelang ho li etsa?

Experiencing the disabled body.

1. Ho holofala ho amme 'mele oa hao joang?

Mohlala (bokhoni ba ho phahamisa lintho, kapa mabaka amang a tloaelehileng a letsatsi)

Se se etsa hore u ikutloe joang?

2. Ho kaba thata ho motho ya nang le bokooa ba masapo ho tloha sebakeng se seng ho ya ho se seng? Ebe o sebelisa eng hore otle o khone ho phetha mabaka a hao a letsatsi le letsatsi? Mohlala; wheelchair kappa melamu
3. ke nako e feng eo o ko utlui o thatafalletsoe ho feta nako tsohle ka lebaka la boko aba masapo?

Mohlala, mosebetsing, sekolong, hae. Nqoqele

4. *[Ho latela likarabo tse fitileng]* Na o khona ho iketsetsa lintho tse ngata ka bo wena kapa o kopa ba bang bao thuse? Mohlala, hoya toilet, ho pheha? Nqoqele .

See se etsa hore o ikutloe joang?

5. Na hona le lintho tseo o sa li rateng tseo batho ba se nang bokooa ba li etsang ha batla ba lebane le oena? Ekaba tsela eo ba o shebang ka eona kapa tsela eo ba buoang le oena ka eona.

Ke kopa o nqoqele?

Se se etsa o ikutloe joang?

6. Haeba hon a le nako eo o ke o bone eka batho ba bang ba o bona e ka o fapane le bona, o ba bona haba etsang?

7. Na o ke o fihleloe ke nako eo ka eona o lebalang hore o na le bokooa?

Ako ntjoetse ka nako eo

Ha nako eo e fihla o e o ikutloe joang?

8. Na o kare batho ba iphapanyetsa batho ba nang le bokooa haholo ele basali ? Mphetele na hobaneng o cho joalo

9. Na o kile wa hlekefetsoa ka tsela e feng kapa e feng? Mohlala, ho otloa kapa ho khesoa?

Haeba ho joang, ho ne ho etsahala eng?

Se se ile sa etsa hore o ikutloa joang?

10. Na u kile oa phephetsoa kapa hona ho bitsoa ka mabitso a hobosang?

Haeba ho joalo, hone ho etsahala joang?

Se se ile sa etsa hore o ikutloe joang?

11. Na u kile oa tobana le khethollo/ho khesoa ka lebaka la hobane o le motho oa mosali?

Haeba ho joalo, ho ne ho etsahala eng?

Se se ile sa etsa hore o ikutloe joang?

12. O nahana hore bokooa ba masapo bo o ama joang joalo ka motho oa mosali?

Na o nahana hore mokhooa oo o etsang lintho ka ona o ka be o tsoana le hae e ne eka eaba ha ona bokooa?

Haeba eea kappa che, hobaneng?

Spirituality

1. Ke kopa u ntjoetse ka tumelo ea hau?
2. Ke kopa u mpoelle hore na tumelo ea hau e etsa u ikutloe joang kapa u nahane joang ka ho holofala hoa hau? Haeba ho e ho be joalo.

Mohlala; khahlano le ho khetholloa/kappa ho fe hone ho fihlella lintho tse ling

Boteng ba Molimo

Ho hlola mathata

3. [Ho latela karabo e fitileng] Tumelo ea hao e o thusa joang hore o utloe o hlotse mathata a hao? Mohlala; na e o thusa hore o ikutloe o boetse bo weneng hape/ kapa ona le tsepo ? Hlalosa.

Support

1. Na u setho sa support group efe kapa efe?

Haeba ho joalo ke ha ngata ha kae utsamaeang support group ee?

Na li support group tse lia o thusa?

Joang?

2. Na hona le li care centre sebakeng se?

haeba ho joalo na u setho ho care centre efe kapa e feng?

E bohlokoa ho wena joang, liphethoho

Hlalosa

- ❖ Na hona le se seng seo u ka ratang ho bua ka sona pele re qetella puisano ea rona
- ❖ Mohlomong lietsahala kapa maiphihlelo ao oka ratang ho ntjoetsa ona. Ho hong fela?

APPENDIX E: CONFIRMATION LETTER

The National University of Lesotho

Department of English

Prof. Francina L.
Moloi



cell: +2665846013749 (w)

+266 22315 894 (h)

30 January 2017

Professor Jan K. Coetzee
Department of Sociology
University of the Free State
Bloemfontein
RSA

Dear Sir,

Re: Editing of Seithati Rafoneke's Thesis

I hereby confirm that I have edited Seithati Rafoneke's Thesis.

Sincerely,

Francina L. Moloi (Professor)

APPENDIX F: RESEARCH PARTICIPANTS' PROFILE SUMMARIES

Botle: Has an impairment in both her legs - sustained as a result of illness when she was 16 years old. She walks with a moderately severe limp and she uses mobility aid shoes. She is married to a non-disabled man and they have two children together. At the time of the interview she was 35 years old and working as a principal at a vocational school for the physically disabled people.

Nthati: Has poliomyelitis that she acquired when she was three years old. She is a wheelchair user. She is a single mother. She was 30 years old at the time of the interview and she was a student at a vocational school for the physically disabled.

Iponeng: Has had a hip fracture when she was six years old. She uses crutches. She is married to a non-disabled man but they do not have children because their twins passed away at birth. She was 30 years at the time of the interview and she was a student at a vocational school for the physically disabled people.

Palesa: Acquired an impairment that was sustained as a result of illness when she was 23 years old. She is a wheelchair user. She is a single lady who feels that her impairment hinders opportunity for intimate relationship. She was 28 years at the time of the interview and she was a student at a vocational school for the physically disabled people.

Konesoang: Was born with an impairment and she was told that her impairment was sustained as a result of witchcraft. She is a wheelchair user. She was 22 years at the time of the interview, she was in an intimate relationship and she was a student at a vocational school for the physically disabled people.

Puseletso: Has congenital deformed right forearm. She was 21 years old at the time of the interview, she was single, and she was a student at a vocational school for the physically disabled.

Lillo: Has congenital deformed right forearm. She believes that her deformity was a result of witchcraft. She was 23 years old at the time of the interview, she has never been in any intimate relationship. She was a student at a school for the physically disabled.

Lisebo: Has congenital deformed left forearm. She was 28 years old at the time of the interview, she was single and she was studying at a school for the physically disabled people.