AUDIENCE RECEPTION OF ALCOHOL ABUSE MESSAGES AMONG THE VISUALLY IMPAIRED IN NAIROBI, KENYA

BY

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A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF DOCTOR OF PHILOSOPHY IN COMMUNICATION STUDIES, DEPARTMENT OF PUBLISHING, JOURNALISM AND COMMUNICATION STUDIES

SCHOOL OF INFORMATION SCIENCES

MOI UNIVERSITY

2023

DECLARATION

Declaration by the Candidate

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ABSTRACT

In Kenya, the visually impaired report a lack of awareness of where to get reliable information on treatment and prevention of Alcohol Abuse. People with visual impairment are considered most at risk of alcohol and drug abuse, with recent studies showing that 40-50% of people with vision impairments may be categorized as heavy drinkers. Despite this, scarce literature exists on the specific aspects of health information and communication interventions suitable for the visually impaired. Additionally, studies on communication barriers undermining access to healthcare information resources and messages to the visually impaired are also scarce. The gaps identified above constituted the problematic issue that motivated this study which aimed to investigate how the visually impaired in Nairobi access and make sense of alcohol abuse messages in Kenya, with a view to proposing an audience-centred approach to social change communication among this demographic. Specifically, the study sought to answer the following research questions: How do visually impaired people in Nairobi access communication messages against alcohol abuse? What are the experiences of visually impaired people in Nairobi regarding communication against alcohol abuse? And how do visually impaired people in Nairobi make sense of the communication messages against alcohol abuse? The study was guided by the Health Belief Model (HBM) and Transtheoretical Model (TTM). This study adopted a Phenomenological research design. A qualitative research method was used to generate and analyse data. Using a purposive sampling procedure, 25 participants with visual impairment were identified from rehabilitation centres and institutions for people living with disabilities within Nairobi County. Data was generated through in-depth interviews. The interviews were recorded, transcribed, analysed thematically, and presented in narrative form according to the themes. Study findings indicate that many alcohol treatments and prevention messages are available through visual media – newspapers, posters, flyers, and magazines – which are not accessible to the visually impaired. Thus, the visually impaired often rely on intermediaries to interpret the messages communicated through visual media. Additionally, content on mass media rarely paid attention to alcohol addiction issues affecting the visually impaired and thus did not appropriately meet the needs of the visually impaired. Besides, socio-cultural dynamics such as gendered socialization influenced the interpretation and perceived need for information on alcohol. The study further established that health messages would be valuable to the visually impaired if they were communicated in formats accessible to them and had content tailored to their specific needs. The study concludes that current communication interventions on alcohol abuse, including the formats used, do not adequately address the specific needs of the visually impaired, even though this demographic group is disproportionately affected by alcoholism. Consequently, it is recommended that effective audience analysis and inclusive participation of the visually impaired be undertaken before developing appropriate and effective communication interventions for marginalized groups such as the visually impaired.

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DEDICATION

"In the sick room, ten cents worth of human understanding equals ten dollars of medical science."
-Martin H. Fischer

From a broader perspective, this study is dedicated to improving health communication for the well-being of citizens in Kenya, especially those with visual impairment and people with disabilities.

Specifically, I dedicate this study to my third-born brother, Mr Ibrahim Abook, who turned blind in 2010. It was emotionally taxing, and it took him (and our family) years to progressively accept his new condition. As a family, we never really got the chance to understand how to deal with a member who was once very cheerful and normal then, sadly, after health complications, became blind and dependent on the family.

Presently, he is healthy and living happily thanks to a strong family support system.

ACKNOWLEDGEMENT

First and foremost, I am incredibly grateful to my supervisors, Prof. Abraham Kiprop Mulwo and Fr. Dr Fredrick Njoroge, for their invaluable advice, continuous support, and patience during my PhD study. The two supervisors' immense knowledge and ample experience have encouraged me throughout my academic research and daily life. In addition, as my lead supervisor, Prof. Abraham Kiprop Mulwo was influential in shaping my experiment methods and critiquing my results.

Secondly, my sincerest appreciations go to Dr Jared Obuya, the current Head of the Department of Publishing, Journalism and Communication Studies. He assisted me in some of the obligatory departmental administrative procedures during my studies.

I am also grateful to the participants of this study, who devoted their time to share their experiences and insights, and to my fellow PhD students for providing inspiration and encouragement through shared experiences.

I greatly thank my family for their unwavering support and encouragement. I will forever treasure their messages of assurance. In addition, my uncle, Mr Cyprian Wanjir, deserves special mention because he strengthened my determination to continue the journey on many occasions.

Finally, I cannot forget passing my appreciation to many others who contributed to my research journey. I thank them all.

DEFINITION OF KEY TERMS

Accessible formats: Formats that blind and partially sighted persons can read without assistance.

Alcohol Abuse: Unhealthy alcohol drinking habits that cause addiction and dependence and cause the sufferer to inflict a range of damage to their health and lives. The victim cannot stop unhealthy alcohol drinking habits despite the adverse outcomes.

Disability: Any mental or physical impairment hinders or prevents an individual from performing an activity.

Experience of the Visually Impaired: Refers to the knowledge and skills the visually impaired have gained through encountering messages against alcohol abuse, undergoing treatment for alcohol abuse or interacting with healthcare providers over time.

General Population: The population without any form of disability.

Health information: The many different types of information relating to health or healthcare, personal or general.

Making Sense: How the visually impaired understand the meanings of the messages, events, actors, processes, and texts they encounter based on their cultural backgrounds and life experiences.

People with Disabilities: Individuals suffering from impairments — cognitive, developmental, intellectual and sensory, or a combination of these.

Visually Impaired (VI): Those individuals with diminished ability to see beyond the level that is treatable by typical means like the use of eyeglasses or medication. The study also uses it to mean the blind, those who are not visually oriented, and vice versa.

Vulnerable Group: A section of people who require greater protection than normal against potential risks and have higher risks of a negative outcome.

ABBREVIATIONS

ADA: Alcohol and Drug Abuse

DPOs: Disabled Persons Organizations

HBM: Health Belief Model

KDHS: Kenya Demographic and Health Survey

KNBS: Kenya National Bureau of Statistics

KNSPWD: Kenya National Survey for Persons with Disabilities

OHCHR: Office of the United Nations High Commissioner for Human Rights

OHCR: Office of the United Nations High Commissioner for Human Rights

PWDs: Person/People with Disabilities

TTM: Transtheoretical model

VI: Visual impairment or people with visual impairment or not visually oriented

WHO: World Health Organization

CHAPTER ONE: INTRODUCTION

1.1: Overview

In this chapter, I give a background to the study by explaining the academic and social contexts in which the study was conducted. I also state the problem that necessitated this study and give the research questions, scope and rationale for the study.

1.2 Background to the study

Globally, 15% of the world's population experience some form of disability, and disability prevalence is higher in developing countries. PWDs are the world's largest minority, yet they are more likely to experience adverse socioeconomic outcomes than persons without disabilities. 20% of the world's poorest people have some disability and are likely considered the most disadvantaged in their communities, and 80% of PWDs live in developing countries (World Bank, 2023).

In health, many persons with disabilities have additional underlying health needs that make them particularly vulnerable. PWDs are a diverse group, and factors such as sex, age, gender identity, sexual orientation, religion, race, ethnicity and economic situation affect their life experiences and health needs. PWDs die earlier, have poorer health, and experience more limitations in daily functioning than others. Health inequities arise from unfair conditions faced by persons with disabilities, including stigma, discrimination, poverty, exclusion from education and employment, and barriers faced in the health system (World Bank, 2023; World Health Organization, 2023).

Despite significant recent advances in research on people with disabilities in many developed countries, little is known about their counterparts living in the developing world (United Nations Development Programme, 2023).

Studies conducted by Montes and Swindle (2021) established that, in Sub-Saharan Africa, disabilities involving vision, concentration, and mobility are most prevalent. Second, disability rates are higher among those with less education and increase sharply with age. Third, disability affects poor and wealthier households at similar rates. Fourth, women report higher rates of disability, especially conditions related to mobility and vision. Finally, PWDs report low labour force participation rates due to difficulties looking for jobs or finding a suitable employer, both varying degrees due to insufficient accommodations.

Today, in Kenya, alcohol continues to represent the highest proportion of substance abuse disorder among Kenyans. The NACADA Strategic plan for 2019-2022 indicates that 2,807,569 Kenyans, some 10.4% of Kenya's adult population, have been diagnosed with Alcohol Use Disorders.

Alcoholism is a serious problem in Kenya; many adults are addicted to alcohol, and a notable treatment gap persists. Nairobi County has the highest prevalence of alcohol abusers, with a staggering 18.4%. This means that almost a fifth of the population is alcoholic, or one in every five individuals within Nairobi is an alcoholic. The prevalence levels are high despite efforts from the Kenyan government and other key players to manage alcohol and other related problems. Mass media campaigns against alcohol act as sources of information to halt alcohol abuse and its potentially harmful effects. While many anti-alcohol campaigns are held locally in Kenya — especially by government agencies and some private rehabilitation centres — the most common ones are those held by the National Authority for the Campaign Against Alcohol and Drug Abuse (Kathingu, 2015; NACADA, 2017; Patel, 2020;Muthuri, 2021).

Furthermore, there is a general absence of comprehensive data on the extent of drug use among people with disabilities in Kenya (Kathungu et al., 2015). NACADA (2013) lists Nairobi County among the counties with high levels of alcohol and other drug abuse among PWDs in Kenya, with low levels of awareness of communication on treatment against alcohol abuse among PWDs.

Visual impairment, as a disability, is considered a significant issue of public health concern (Bourne et al., 2017). Data from KNSPWD (2007) indicates that, in Kenya, visual disability is highest in Nairobi (2.7%), followed by the Nyanzaregion (1.9%) and Coast region (1.8%). Studies indicate that 40-50% of people with vision impairments may be heavy drinkers. People with visual impairments may resort to alcohol to self-medicate their difficulties and stressors caused by physical disability. Substance abuse and addiction are higher among this category of people because the disabled disproportionately face conditions that encourage illicit drug use. There is also a considerable treatment gap among those who successfully get treatment for addiction and alcoholism versus those who need to receive it (American Addiction Center Resource, 2017; Moore& Li Li, 1998).

Rehabilitation researchers have found that many people with disabilities experience alcohol and drug abuse at rates equal to or above the general population (NAADD, 1999). Disabilities and drug addiction constitute a disastrous combination. For instance, in Kenya, in the general population or persons without disabilities in Kenya, substance abuse prevalence stands at 34%, whereas PWD stands at 40%. Substance abuse preponderance of PWD is higher than that of the general population. Alcoholic drinks are the most abused substance, with 28.2% of PWD abusing it. Furthermore, about 47.4% of PWD also document a lack of awareness of where to get information about treatment and prevention of Alcohol and Drug Abuse (NACADA, 2014; Glazier & Kling, 2013; Kathungu, 2015).

Individuals with visual impairment are part of People with Disability (PWD). PWD is a diverse group of people with an extensive range of needs. Disabilities vary in type and can affect a person's vision, movement, thinking, learning, communication, and hearing — hence, visual impairment is part of disability (CDC, 2022). Global Disability Rights (2018) indicates that, of all the categories of people with disability in Kenya, those with visual impairment are the second largest group, representing approximately 19.09% of the PWD population.

The government has intensified efforts to lower the alcohol prevalence levels, most recently enacting into law the Alcoholic Drinks Control Act, which seeks to regulate the production, sale and consumption of alcohol (Kathingu, 2015).

There have also been a series of campaigns against alcohol addiction conducted by NACADA and other strategic partners. However, while the campaign aimed to facilitate public participation in controlling alcohol and drug abuse and targeted individuals and organizations interested in a society free from alcohol and drug abuse, media platforms and venues do not favour people with visual impairment.

Health messages that are successfully communicated to PWDs are limited. Thus, the chances of PWD struggling with substance abuse are higher compared with that of the general population, making them have low health literacy measures. Moreover, health promotion interventions for visually impaired adults have been limited, and therefore they are more likely to report poor, fair, or worsening health than are adults who are sighted (American Addiction Center Resource, 2017; Zhi-Han et al., 2017; Moore& Li Li, 1998; Capella, 2007).

People with disabilities are affected by the problem of alcohol and drug use, just like the general population. However, they are more vulnerable due to the unique challenges presented by their impairments, which make accessibility to drug information difficult, resulting in low levels of awareness about drugs (Kathungu, 2013).

Cheng et al. (2018) posit that adults with vision impairment may have unique needs when accessing health care to maintain good health. Again, Thurston and Thurston (2010) state that if health information is not in a readable format, blind and partially sighted people may have to ask for help to read it. In general, as Cupples (2012) puts it, when seeking treatment in healthcare centres, people with visual impairment are likely to have limited access to information and healthcare facilities and to receive sub-optimal treatment because staff are unaware of specific needs related to vision; many alcohol treatments and prevention messages are available through visual media – newspapers, posters, flyers, and magazines – which are not accessible to the visually impaired. Hence, the visually impaired hardly access messages in their preferred format.

In making sense of communication messages, the visually impaired are not comfortable with their portrayals in the media. Hardin and Hardin (2004) state that the perceptions portrayed in the media directly influence the way people with disabilities are treated in current society. Images and stories in the media can profoundly influence public opinion and establish societal norms. Persons with disabilities are seldom covered in the media, and when they are featured, they are often negatively stereotyped and not appropriately represented. The media can be vital in raising awareness and countering stigma and misinformation. It can be a powerful force to change societal misconceptions and present persons with disabilities as individuals who are a part of human diversity. Attention should be drawn to the image of disability in the media with a view to an accurate and balanced portrayal of disability as a part of everyday life. The media can play an essential role in presenting disability issues in a way that could dispel negative stereotypes and promote the rights and dignity of persons with disabilities (United Nations, 2023).

Worldwide, the literature on disabled people, disability and their relationship with substance use is limited (Csiernik & Brideau, 2013). It is the same case in studies targeting the visually impaired— notably, there is a shortage of research reflecting people's personal experiences (Galvani et al., 2016).

1.3: Statement of the Problem

The problem that prompted this study is expressed on three levels: social, academic and contextual.

1.3.1: Social Problem

Visual impairment should not create a barrier to effective communication with patients (Osborne, 2020). However, the visually impaired, as PWD, disproportionately face conditions that may encourage illicit drug use; hence, addiction and substance abuse are high when measured against the population without disabilities. The treatment gap between PWD needing treatment and those receiving treatment for alcohol addiction is enormous. They are two and four times more likely to struggle with substance abuse than the general population. Approximately 40-50% of visually impaired people could be classified as heavy drinkers (American Addiction Center Resource, 2017; Moore and Li Li, 1998).

Furthermore, the disabled are an underserved population in drug and alcohol treatment. Therefore, despite the high rates of engaging in risky behaviour, activities for alcohol and or drug abuse prevention and health promotion scarcely ever target PWD. Consequently, they engage in risky behaviours such as alcohol abuse (NACADA, 2013; Glazier & Kling, 2013; Li-Tzy, 2013; Amos Sales, 2000, p. 6).

In Kenya, visual, physical, hearing and mental are the most dominant forms of disabilities. Those with visual comprise 30%, physical 30%, hearing 12% and mental 11% (KNSPWD, 2007). For persons without disabilities in Kenya, the prevalence of substance abuse is 34%, whereas PWD is 40% (Glazier & Kling, 2013). The abuse prevalence of PWD is higher than that of the general population. Alcoholic drinks are the most abused substance, with 28.2%followed by tobacco products at 19.6%, khat (miraa and muguka) at 14.8% and marijuana at 9.2%(Kathungu, 2013; NACADA, 2014).

According to Kentab et al. (2015), the visually impaired have health information needs that if successfully communicated and addressed, would improve their health and lifestyle. Zhi-Han et al. (2017) posit that visually impaired people encounter barriers limiting their access to healthcare information resources and messages. As such, health literacy among them remains low.

Compared to the general population, substance abuse is distinctly prevalent among PWDs. Subsequently, there is a need for tailored messages that are accessible to PWDs and targeted prevention communication and programmes that satisfy the potentially overwhelming demand for accessible substance abuse treatment services and facilities (HSS, 2010; Amos Sales, 2000, p. 6; NACADA, 2013; Kathungu, 2013; Glazier & Kling, 2013; Li-Tzy, 2013).

1.3.2: Academic Problem

Health communication is a rapidly growing interdisciplinary area of study concerned with studying the powerful roles humans perform in mediated communication in healthcare delivery and health promotion. Health communication has developed as an exciting, applied social scientific area of inquiry that uses qualitative and quantitative research to examine how communication influences health, healthcare delivery, and health promotion. Research concerning health communication is often problem-based, focusing on identifying, examining, and solving healthcare and health promotion problems (Kreps, 2014).

The rate at which health communication is recognized as a critical element of public health practice is rising. This helps raise awareness of potential health risks, influences beliefs and attitudes, and encourages individuals to transform from unhealthy behaviours (Williams et al., 2010).

Focusing on health communication that targets people with disabilities creates a unique context. Furthermore, studies on health promotion for PWDs are almost non-existent despite the emergence and development of innovative strategies that uphold health among PWDs (James & Jennifer, 2009).

Williams et al. (2010) add that few health communication messages target PWDs. Thus, the visually impaired have found themselves beyond the reach of healthcare information resources and messages. Health literacy among them remains low (Zhi-Han et al., 2017).

Although research has shown that nearly all categories of people with disabilities experience alcohol and drug abuse at rates equal to or above others within the general population, few existing studies specifically describe the incidence and prevalence of alcohol abuse among visually impaired individuals (Koch et al., 2002; Benjamin et al., 2021). As a result, these individuals require specialized treatment during their adjustment process (Nelipovich& Buss, 1999; Zhi-Han et al., 2017).

These findings are supported by Csiernik and Brideau (2013), who state that the literature on disabled people, disability and their relationship with substance use is limited worldwide. It is the same case in studies targeting the visually impaired; notably, there is a shortage of research reflecting people's personal experiences (Galvani et al., 2016).

The interrelation of substance use with sight loss seems to be a global phenomenon. Given the increase in substance use among adults living with visual impairment, assessing substance use among people with visual impairment is becoming increasingly important (Galvani et al., 2016; Benjamin et al., 2021).

This study adopted the qualitative approach. Busetto (2020) affirms that qualitative research is familiar in other fields but still comparatively underrepresented in research related to health services.

To conclude, much research has been undertaken on communication campaigns; however, there is little focus on people with disabilities, especially the visually impaired. Yet, they compose a significant portion of people suffering from alcohol abuse. Additionally, in adopting a qualitative approach, this study will further enrich the discipline of health communication since qualitative research is familiar in other fields but still comparatively underrepresented in research related to health services. This, therefore, constitutes the problematic issue that motivated this study.

1.3.3 Contextual Problem

This study took place in Nairobi County. KNSPWD (2007) states that visual disability is highest in Nairobi (53%), followed by Coast region in Kenya (35%) and Eastern region in Kenya (30%).

Nairobi County is listed among the counties with high levels of alcohol and other drug abuse among PWDs in Kenya, while there are low levels of awareness among PWD (NACADA, 2013).

1.4 Purpose of the study

This study aimed to investigate how the visually impaired in Nairobi accessed and made sense of alcohol abuse messages in Kenya, with a view to proposing an audience-centred approach to social change communication among this demographic.

1.5 Research Questions

With the background presented earlier, this study sought to answer the following questions:

a) How do visually impaired people in Nairobi access communication messages against alcohol abuse?

b) What are the experiences of visually impaired people in Nairobi regarding communication against alcohol abuse?

c) And how do visually impaired people in Nairobi make sense of the communication messages against alcohol abuse?

1.6 Scope of the Study

In this study, scope implies the boundary line of what was covered. Accordingly, I present three aspects of the scope of this study: academic, methodological and contextual scope.

1.6.1 Academic Scope

This study is in the field of Communication Studies, the discipline of Health Communication and the subject of Promotional Health Information Communication. Under this, the study is focused on the aspects of health communication — such as interpretations of the health messages, tailoring of health communication for the target audience and within particular situations, and the contents and channels of dissemination of health information to influence personal health choices and improve health literacy.

1.6.2 Methodological Scope

This study is positioned in the relativist (interpretivist) paradigm. The research approach in this study is the qualitative approach. The research method used is the Phenomenology Method — under this method, this study used a transcendental approach, also known as eidetic (essence). According to Padilla-Díaz(2015),study samples in the phenomenological research method are generally chosen using purposive sampling.

Therefore, this study used non-probability sampling. Using a purposive sampling procedure, 25 participants with visual impairment were identified from rehabilitation centres and institutions for PWDs within Nairobi County.

Data was generated through in-depth interviews to obtain qualitative data that is vivid, complex, and rich in details. That would help develop a solid understanding of the behaviour patterns of this category of people. Each interview took approximately 70 minutes. Participants were allowed and encouraged, through probing questions, to narrate their experiences regarding alcohol abuse and their access to communication messages regarding alcohol abuse. Data produced from the interviews was recorded, transcribed, then analysed thematically, and presented in narrative form per the themes.

1.6.3 Contextual Scope

In the geographical scope, this study took place in Nairobi County. Nairobi County has a total population of 3,375,000 and an area of 696 km^2 (269 sq. mi.). It is the smallest yet most populated region of the 47 counties in Kenya (KNBS, 2009 and 2019). Besides that, according to KNSPWD (2007), visual disability is highest in Nairobi (53%), followed by Coast Region in Kenya (35%) and Eastern Region in Kenya(30%). In addition, Nairobi is among the counties with high levels of alcohol and substance abuse among PWDs in Kenya, yet there are poor levels of awareness among PWD (NACADA, 2013). When it comes to the distribution of people with a disability by domain in Nairobi County, those with visual impairment take a significant percentage as Table 2.3 on page 39 shows.

1.7 Rationale of the Study

This study is justified because there is a shortage of research targeting visually impaired people's personal experiences and their relationship with substance abuse worldwide (Galvani et al., 2016). Besides, there are few health communication messages targeting PWDs. Thus, the visually impaired have been deprived of reaching healthcare information resources and messages. As a result, health literacy among them remains low (Williams et al., 2010; Zhi-Han et al., 2017).

Reina et al. (2011:244) postulate that visual impairment is one of the most threatening disabilities, predominantly awakening emotional reactions of extreme loss of confidence and independence in individuals confronted with this disability.

Studies indicate that 40-50% of people with vision impairments may be heavy drinkers. Substance abuse and addiction are higher among this category of people because the disabled disproportionately face conditions that encourage illicit drug use. There is also a considerable treatment gap between those who successfully get treatment for addiction and alcoholism versus those who need to receive it (American Addiction Center Resource, 2017; Moore& Li Li, 1998).

The prevalence levels are high despite efforts from the Kenyan government and other key players to manage alcohol and other related problems that have been on the increase (Kathingu, 2015).

People with visual impairment have health information needs that if successfully communicated and addressed would improve their quality of life. In addition, this would assist them in disease management (Kentab et al., 2015). However, studies on health promotion for PWDs are almost non-existent. James and Jennifer (2009) note that studies on health promotion for PWDs are practically non-existent, despite the emergence and development of innovative strategies that uphold health among PWDs.

For the reasons highlighted, this study is critical in enabling us to gain insight into how the visually impaired in Kenya access and make sense of alcohol abuse messages, with a view to proposing an audience-centred approach to social change communication among this demographic.

1.8 Chapter Summary

In this chapter, I have presented the contextual and academic background that underpins this study. The key issues arising from the discussion in this chapter are summarized as follows: first, despite the high rates of alcoholism and substance abuse among the visually impaired as PWDs, alcohol prevention and health promotion activities scarcely target PWDs. Second, individuals with visual impairments have drug and alcohol problems at significantly higher rates than those without disabilities in Kenya. Moreover, 40-50 per cent of PWD who are blind or with visual impairment may be categorized as heavy drinkers. Third, disabled people document a lack of awareness on getting information for treatment and prevention of Alcohol and Drug Abuse. Forth, visual impairment presents unique challenges, making accessibility to alcohol and drug abuse information difficult, resulting in low levels of awareness about alcohol and drug abuse. Lastly, even though much research has been undertaken on communication campaigns, there is little focus on people with disabilities, especially the visually impaired, and their relationship with alcohol and substance use. Yet, the visually impaired compose a significant portion of people suffering from alcohol abuse. This, therefore, constitutes the problematic issue that motivated this study.

In the next chapter, I situate my study within the discipline of development communication studies, particularly health communication, and discuss relevant behaviour change theories and the concept of access to communication messages against alcohol abuse to the visually impaired, including recent research on health communication.

CHAPTER TWO

LITERATURE REVIEW

2.1 Overview

In Chapter One, I discussed the background of the study and presented the social, contextual and academic problem that prompted it. In this chapter, I have discussed the Health Belief Model (HBM) and the Transtheoretical Model (TTM) as theories applied to link parts of the research data and generate relevant findings that fit the overall framework. HBM and TTM are relevant because they fall in the category of theories of communication impact on human behaviour. They enable us to understand communication as an experience of self and others through dialogue — a crucial focus. Additionally, they consider stem points and perceptions of different people in different situations within the given context.

In this study, they offer an understanding of the experiences of the visually impaired when accessing messages against alcohol. They are also critical when establishing the informational requirements for visually impaired individuals. Additionally, I present the status of alcohol abuse among the general population and the visually impaired in Kenya, the policies governing alcohol abuse in Kenya, and the anti-alcohol campaigns in Kenya. Next, I review recent literature based on the thematic questions and discuss the concept of access to health messages by the visually impaired. Finally, I explain the rationale for this study based on the literature review.

2.2: The Theoretical Framework

In this section, I describe the theories that helped explain the relevance of the research problem under study. This study used the Health Belief Model (HBM) and the

Transtheoretical Model (TTM) as theories that offered the conceptual basis for understanding, analysing, and designing ways to examine relationships within various concepts identified in the research problem.

2.2.1: The Health Belief Model (HBM)

HBM is one of the theories of communication impact on human behaviour. It is a psychological model aiming to predict and explain human health behaviours. The model theorizes that individuals must experience threats due to their existing behavioural patterns to succeed in behaviour change. This is also described as "perceived susceptibility and severity". The theory asserts that individuals must believe that there will be valued outcomes resulting from the behaviour change, and that this comes at a modest cost (i.e., perceived benefit). Furthermore, individuals must feel competent to take the required action and defeat the perceived barriers (i.e., self-efficacy). The theory is founded on the assumption that one will undertake an action that is health-related if the individual has the sense that a harmful health condition can be avoided, has an expectation that if they undertake the endorsed actions the outcome will be positive, and considers that they can effectively take the endorsed health action with confidence and comfort (LaMorte,2022;Champion &Skinner, 2008).

HBM focuses on perception and evaluation of behaviour as two aspects that affect a person's healthiness and health behaviour. In this case, threat perception is interpreted as two fundamental beliefs — perceived vulnerability to health-related problems and the anticipated severity of the consequences of illnesses. In addition, behavioural evaluation consists of two separate sets of beliefs —those regarding the efficacy or benefits of the health behaviour that is recommended or approved, and those regarding barriers and costs of implementing the recommended behaviour. The model advances that cue to action (the various trigger factors like social influence, health education campaigns and individual perceptions) can initialize recommended health behaviour (Abraham &Sheeran, 2005).

In summary, this model proposes that a person's belief in a personal threat of sickness or disorder, together with a person's belief in the effectiveness of the recommended health behaviour or action, will predict the likelihood the person will adopt the behaviour (LaMorte, 2018).

2.1.1.1: Constructs of HBM

Champion & Skinner(2008) outlined some primary concepts that the HBM has and uses to predict why people decide to control illness, screen it, or prevent it. They are susceptibility, self-efficacy, seriousness, barriers and advantages to behaviour, and cues to action. In this model, susceptibility or perceived susceptibility are beliefs about the likelihood of encountering a disease or condition. It alludes to the individual's subjective perception or belief about the possibility of getting a disease or experiencing it. This concept is applicable when defining populations at risk, determining their risk levels, personalizing risk based on a person's characteristics or behaviour, and when making a person's perceived susceptibility more consistent with an individual's actual risk (LaMorte, 2022; Champion & Skinner, 2008).

Perceived severity implies an individual's feeling about the gravity of getting a disease or illness or the feeling when leaving it untreated. It is the belief in the level of seriousness and possible consequences. The mixture of severity and susceptibility is identified as a perceived threat. A person's evaluations of the intensity or severity involved with getting an illness or leaving it unattended include assessing consequences from clinical and medical cases —i.e., the amounts of pain, death, or disability caused. Additionally, it consists of evaluating social consequences like the implications on family life, social relations, and the workplace. This concept applies when specifying the consequences of risks and conditions (LaMorte, 2022; Champion & Skinner, 2008).

Perceived benefits include the worthiness or effectiveness of the recommended action to lessen the seriousness and risks of the impacts caused by the illness and the effectiveness of the various available actions for reducing the disease threat. Here, other non-health-related perceptions may also influence behavioural decisions. For instance, the financial savings related to adopting an advised action or an attempt to please a family member. In most cases, a person is expected to evaluate beliefs in perceived susceptibility against perceived benefit. Thus, an individual would agree to a recommended health action if the perception is that the action will be helpful to the individual. This concept is applicable when defining the action to take, as well as to how, where, and when to take it — it helps clarify the positive effects to be expected in a health action (LaMorte, 2022; Champion & Skinner, 2008).

Perceived barriers are the convictions or feelings about the actual and psychological costs of the recommended actions — how the individual feels about the obstacles to performing the desired health action. Feelings vary widely, and hence the aspect of analysis regarding cost-benefit arises. The potentially harmful aspects of health action — in this case, the perceived barriers — act as barriers to pursuing the right behaviours. The negative aspects may include high expenses, unpleasant side effects, and the time-consuming or inconvenient nature of the advised action. This concept applies when identifying perceived barriers to reduce them through reassurance, correction of misinformation, incentives and assistance (LaMorte, 2022; Champion & Skinner, 2008).

The cue-to-action concept incorporates the strategies to activate "readiness" or the strategy to provide the appropriate incitement that prompts decision-making in accepting the desired health action. These cues or indicators to action may be internal (seeking health assistance after experiencing increased pains) or external (for example, getting advice from a professional, a newspaper article or health messages). In addition, this concept is applicable when providing how-to information and messages promoting awareness when using appropriate reminder systems to create an action (LaMorte, 2022; Champion & Skinner, 2008; Abraham & Sheeran, 2005).

The sixth action concept is self-efficacy. It is an individual's confidence regarding the ability to successfully take or perform the required action or engage in the correct behaviour to produce the desired outcomes. This concept is applicable hen providing training in performing recommended actions, using progressive goal setting, giving verbal reinforcement, and demonstrating desired behaviours that could help reduce anxiety (LaMorte, 2022;Champion & Skinner, 2008).

Champion & Skinner(2008) also recognize that other variables predict health behaviour — for instance, a diverse demographic, sociopsychological, and structural variables may all influence perceptions and are thought to directly affect behaviour by impacting the perception or judgment of susceptibility, severity, benefits, and barriers. As a result, they indirectly influence health-related behaviour. An example is the level of educational accomplishment.

Below is a framework illustrating the relationship between modifying factors (variables), individual beliefs (HBM constructs) and actions:

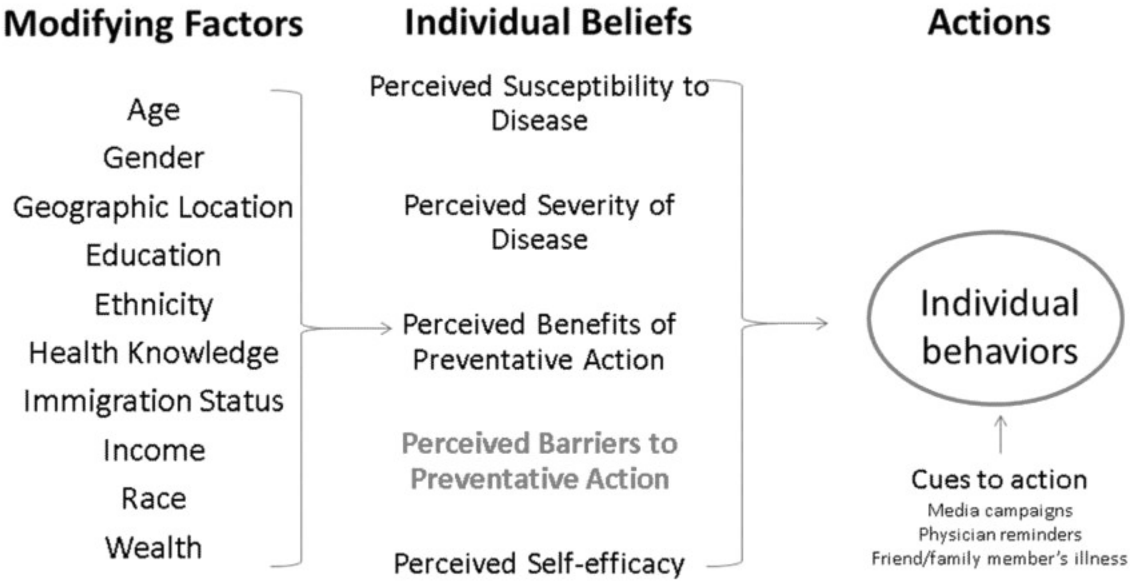

Fig 2.1: Health Belief Model by Fayanju et al. (2014).

2.1.1.2: Application of HBM in this study

As Corcoran(2013) puts it, this model is suitable for small or high-risk populations. In this study, this model plays a significant role in getting information on the beliefs and attitudes of the visually impaired, their perceived threat and net benefits that account for their preparedness to understand and act on communication messages against alcohol abuse.

The concept of perceived barriers provides critical information on visually impaired people’s feelings about the psychological and actual costs of accessing communication messages against alcohol abuse in Nairobi. The concepts of perceived benefits and cues to action provide critical information on how the blind in Nairobi make sense of the communication messages against alcohol abuse.

The concepts of perceived severity and self-efficacy are critical in understanding the experiences of the visually impaired in Nairobi regarding communication against alcohol abuse.

2.1.1.3 Limitations of HBM

This model's limitations are that it considers instances where behaviours are done for reasons that are not health-related — for example, social acceptability reasons.

As well, there are instances where behaviours are habitual and thus may inform decision-making and recommendations for action. Environmental factors outside an affected individual's control could prevent engagement in desired behaviours, such as insecurity. Additionally, the model does not specify how the six constructs interplay (LaMorte, 2018; Carpenter, 2010).

2.2.2 Transtheoretical model (TTM)

Transtheoretical Model (TTM) is one of the theories of communication impact on human behaviour. It is also identified as the Stages of Change Theory and is used by professionals around the globe. This theory's principles are derived from more than 35 years of scientific research. This theory endeavours to give details on someone's readiness or preparedness to alter their behaviour. It illustrates individual behaviour changes like one that transpires in stages. To merge processes and principles of change from other leading theories, TTM utilizes the stage of change (RHI Hub, 2019; Pro-Change, 2017).

Prochaska et al. (1992) observed that other behaviour change models emphasize biological and social influences but, in a contrasting way, TTM integrates the constructs of other theories. It is an integrative biopsychosocial model that conceptualizes change processes in intentional behaviour. Therefore, it merges and includes the constructs of other theories (Pro-Change, 2017).

RCN (2016) stipulates that it is imperative to recognize information on where an individual is coming from, especially regarding making changes related to their lifestyle to promote their health. Consequently, TTM illustrates stages of change to show the different stages we experience when we desire to change some behaviour in our routine lives.

TTM is a model of deliberate change that emphasizes an individual's decision-making; it acknowledges that individuals find it hard to transform their behaviours decisively and quickly. LaMorte (2019) adds that the transformation of habitual behaviour occurs in a continuous cyclical progression.

2.1.2.1 Stages of TTM

According to TTM, people go through six stages to achieve possible change. The stages are: (a) Precontemplation (b) Contemplation (c) Preparation (Determination) (d) Action (e) Maintenance and (f) Termination. Additionally, various intervention strategies are helpful for each stage when shifting an individual to the next stage of health behaviour change (LaMorte, 2019).

An individual may start with the Pre-contemplation stage. Here, an individual is unwilling to change and is unmotivated and resistant. The individual is neither aware of the problems presented by their behaviour, nor the negative consequences and hence does not propose to adapt to measures in the anticipated future, which is approximately six months. Despite emphasizing the disadvantages of changing behaviour, individuals at this stage often undervalue the advantages of behaviour change. Therefore, they have no motivation to take any steps toward changing particular behaviours (RCN, 2016, Pro-Change, 2017, LaMorte, 2019; RHI Hub, 2019).

Prochaska and Velicer (2010) posit that the effective strategies of intervention in this stage are validating the lack of preparedness, seeking clarification on whether the decision made was theirs, encouraging re-evaluation of current behaviour, being mindful and conscious of the advantages of shifting from unhealthy behaviour, encouraging self-exploration, explaining the risks to them, and personalizing the consequences of those risks.

Secondly, we have the contemplation stage. Here, an individual is beginning to think about the behaviour, and thoughts of problems affecting their health have begun to emerge. Intentions of moving to healthier behaviour have emerged in the projected near future. The approximate time is six months. The affected individuals acknowledge that they have problematic behaviours. Because they are aware of the advantages and drawbacks of changing their behaviours, a reasonable contemplation of the positive and negative effects of transforming from harmful behaviours occurs.

Despite this recognition, an individual may feel hesitant about changing behaviour. The ambivalence or reluctance towards transforming from harmful behaviours may obstruct progression into taking action. Here, the individual appreciates the type of person they could become if they embraced behaviour change. They also discover more from those who have adopted healthy ways (Prochaska &Velicer, 2010; RCN, 2016; LaMorte, 2019; RHI Hub, 2019).

The practical techniques used include encouraging those with unhealthy behaviour to put more effort into reducing the disadvantages caused by changing their behaviours. The lack of readiness should be validated, and the individuals should be urged to evaluate the advantages and drawbacks of changing their behaviours. New and positive outcome expectations should be determined and promoted (Prochaska &Velicer, 2010).

Thirdly, we have the preparation stage. Here, an individual is determined and ready to start an action in the subsequent time period, approximately 30 days. Small steps are taken in the route towards changing behaviours. The person believes that behaviour change leads to a healthier life. They have noticed that there needs to be some change in their behaviour. In other cases, they were unaware of the recommended behaviours to be adopted. They may, as well, have an action plan. Small steps towards behaviour change may have been taken. For instance, they seek guidance from friends and relatives on the recommended behaviours or inform them of the intention to change (Prochaska & Velicer, 2010; RCN, 2016; Pro-Change, 2017, LaMorte, 2019; RHI Hub, 2019).

One should verify that the patient has the underlying skills necessary when adapting to change. Apart from encouraging the small steps that have been taken in the initial stages, other effective techniques here could be through identifying and assisting the victim in solving the obstacles faced; the patient should be helped in determining the health and social support systems (Prochaska &Velicer, 2010).

Fourthly, we go to the action stage. In this stage, individuals have just transformed their behaviour. This stage is characterized by the last period of three to six months, and it is the shortest stage. Often, the person plans to sustain the behaviour change. They change their problematic behaviours and acquire new healthy behaviours. The person intends to transform and has examined how to transform and have the appropriate plan they want to actualize. Their actions are observable and have to achieve a sufficient criterion to lessen the risks caused by the disease. However, they are supposed to work hard if they are to sustain the change (Prochaska &Velicer, 2010, Pro-Change, 2017, LaMorte, 2019, RCN, 2016).

According to Prochaska and Velicer (2010), the participants should be trained to strengthen their commitments to transformations and fight any urges to slip back. Training entails teaching them the techniques for sustaining their commitments, like substituting negative health behaviours with positive behaviours. They should be rewarded for the steps taken toward avoiding negative company, tempting situations and embracing behaviour change. The focus should be on social support, restructuring cues, dealing with barriers, and reinforcing self-efficacy. The feeling of loss should be combated, and long-term benefits re-emphasized

Fifth is the maintenance or monitoring stage; recommended behaviours from the participants have been sustained for approximately six months to five years. Besides, they are determined to maintain positive behaviour moving forward. Efforts are made to avoid relapse or going back to negative behaviours. The challenges at this stage are high when compared to the rest. Steps are set to ensure that an individual does not succumb to negative behaviours even though the temptation to relapse is less. As a result, their confidence levels grow, and they are willing to continue with the recommended behaviours (Pro-Change, 2017, LaMorte, 2019, RCN, 2016).

Emphasis is placed on the individual’s situational awareness of aspects that may cause temptation to relapse into unhealthy behaviour, mainly due to stressful situations. At this stage, people seek support from those they trust and pass the time with people with healthy behaviours. To manage stress, they exercise healthy behaviour as a replacement for negative behaviours. There should be mechanisms for follow-up support, managing relapse and supporting internal rewards (Prochaska &Velicer, 2010).

Individuals may quit harmful behaviours only to resume them after a while. Most affected are those in highly addictive behaviours like using alcohol and drugs. This is the stage of relapse or recycling. This stage considers that all humans are subject to temptation — hence, we may have a relapse or resumption of unhealthy behaviours. It is described as a fall from grace. To overcome this, there is a need to obtain support from health facilities and coaches, supportive literature, family members, physicians, or motivational sources. Additionally, there should be an evaluation of relapse trigger factors, a reassessment of barriers and motivation, and a plan to place more demanding coping strategies (Prochaska & Velicer, 2010; RCN, 2016).

LaMorte (2019) and RHI Hub (2019) have divergent views on this argument. They suggest a stage of termination where individuals have no intention of relapsing to the unhealthy behaviours that they previously had. However, this stage is difficult to reach, so participants will likely stay at the maintenance or monitoring stage. Additionally, this stage is hardly considered in programmes for health promotion — it was not a component of the original TTM and is almost inapplicable to the health-related behaviour model.

2.1.2.2 Processes of change in TTM

Cognitive, effective, and evaluative processes are applied for each stage of change development. The processes are used in developing strategies to develop and maintain transformation into the recommended behaviours (Prochaska &Velicer, 2010).

Prochaska and Velicer (2010) and LaMorte (2019) divide the processes into two categories. The five processes that fall under the cognitive and affective category comprise:

a) Consciousness rising — the individual is given facts, and hence their awareness of healthy behaviours is increased;

b) Dramatic relief — where attention is paid to feelings and the focus is on good and harmful emotions aroused by health behaviours;

c) Self re-evaluation — where a new self-image is created as a result of the individual's realization that recommended behaviour is what they desire (self-appraisal);

d) Environmental re-evaluation — where a person becomes aware of the effects of their behaviour on others (social appraisal);

e) Social liberation — where the individual notes public support.

The five that fall in the classification of the behavioural process are:

a) Self-liberation — where one commits to transform his behaviours thanks to the confidence that it is possible to attain positive behaviour;

b) Counter Conditioning — where an individual alternates unhealthy behaviours and destructive thoughts with healthy ones;

c) Helping relationships — where the individual finds relationships that are supportive and promote the preferred change;

d) Reinforcement management — where only the recommended behaviour is rewarded for the purposes of encouraging it;

e) Stimulus Control — where an individual is placed in an environment that is supportive and promotes the required health behaviours without forgetting the elimination of the environment that supports unhealthy behaviours.

TTM offers proposed approaches for interventions that are useful in public health and deal with individuals at different decision-making stages. Interventions can be developed and tailored to be effective. Messages and programmes can be created specifically to suit a target population, fine-tuned to their motivation and knowledge levels.

Through TTM, a participant's stage of change can be assessed, and relapses can be accounted for (LaMorte, 2019).

Below is a framework illustrating the relationship between modifying factors (variables), individual beliefs (HBM constructs) and actions:

Relapse	**STAGE**		**STRATEGY**	**Progress**
↑	**NO**	**PRECONTEMPLATION**	Educate on risks versus benefits & positive outcomes related to change	↓
	MAYBE	**CONTEMPLATION**	Identify barriers & misconceptions; address concerns; identify a support system	
	PREPARE/PLAN	**PREPARATION**	Develop realistic goals & timelines for change; provide positive reinforcement	
	DO	**ACTION**	Provide positive reinforcement	
	KEEP GOING	**MAINTENANCE & RELAPSE PREVENTION**	Provide encouragement & support	

Fig 1.2:Transtheoretical Model by Yunlong et al. (2019).

2.1.2.3 Application of TTM in this study

In this study, this model gives an insight into the readiness or preparedness of the visually impaired who abuse alcohol to alter their harmful behaviour. It helps understanding of how their behaviour changes (as one that transpires in stages), the barriers they encounter, and how to overcome them. It helps explain the experience of the visually impaired who abuse alcohol and their desire to change some behaviour in their routine lives according to the stages of the model.

The pre-contemplation stage was convenient when establishing how the VI in Nairobi access communication messages against alcohol abuse.

Stages of contemplation and preparation provide knowledge on the experiences of the VI in Nairobi regarding communication against alcohol abuse. They also offered information on how the visually impaired who abuse alcohol make sense of the communication messages against alcohol abuse. The stage of action and maintenance helped determine the extent to which they maintain their commitment to recommended health behaviours and abstinence from alcohol.

2.1.2.4 Limitations of TTM

TTM has some limitations. Armitage (2009) and LaMorte (2019) submit that TTM does not consider changes occurring within a social context and ignores aspects such as a person’s social position or social-economic status based on education, income and occupation.

Secondly, the timelines set at each stage may be arbitrary. Hence, it is unclear how long an individual may stay in each stage.

Finally, TTM supposes that people always make sound and rational plans when making decisions in each stage; this may not be the case.

2.2.3: How HBM and TTM complement each other in this study

This study focuses on audience reception of alcohol abuse messages among the visually impaired in Nairobi County. In doing so, HBM and TTM were applied to link the parts of the research data and generate relevant findings that fit the overall framework. As a result, they boosted the impact of the findings, especially in terms of their relevance, rigour and robust nature.

Clemow (2004) posits that both models seek to establish the requirements for individuals to protect themselves from poor health. Glanz et al. (2008) add that they enable predicting and understanding the capability to change. In this study, HBM and TTM provided a more profound understanding, offered predictions, and assisted in establishing what is needed for visually impaired people to access communication messages against alcohol abuse.

In addition to considering the component of self-efficacy, both models emphasize a person's awareness and behaviour, but from different perspectives. For instance, in HBM, behaviour reflects perceived values, but in TTM, behaviour reflects a readiness to respond. HBM, being a cognitively based model, also puts mental processes as a focal point for health behaviour transformations. Furthermore, it concentrates on constructs that support behavioural change, not the emotional component.

TTM focuses on belief and attitude transformations in stages that anticipate achieving change. In TTM, concentration is placed on the behavioural facet (such as individual readiness or attitudinal stages of awareness) of change in health behaviour: it is behaviour-oriented (Glanz et al., 2008; Rossi, 2004). Therefore, the model clarifies the cognitive process of behaviour change among the VI with alcohol abuse problems and their behavioural facet's belief and attitude transformations.

According to Clemow (2004), Glanz et al. (2008) and Rossi (2004), TTM focuses on a participant's readiness to perceive, unlike HBM, which places attention on self-efficacy and risks perceived by the participant. Therefore, in this study, TTM provided knowledge of self-efficacy, risks perceived and the readiness to adopt recommended health behaviour by the VI.

Brug (2004) stipulates that TTM focuses on interventions tailored to fit a targeted individual besides the model being culturally based (social-based). HBM, alternatively, is evidence-based and emphasizes interventions that are generally applied. Here, the theories offered a viewpoint tailored to Communication Messages against Alcohol abuse for the VI versus the typically used interventions.

Glanz et al. (2008) add that TTM, grounded on individual readiness, considers a person's stage of awareness preceding educating, whereas HBM focuses on a person's beliefs and attitudes. While complementing each other in this study, information on the blind person's beliefs, level of awareness, and attitudes was arrived at when establishing their experience, access and how they make sense of the communication messages against alcohol abuse.

Although research has shown that nearly all categories of people with disabilities experience alcohol abuse at rates equal to or above others within the general population, there is a paucity of existing studies explicitly describing the incidence and prevalence of alcohol abuse among individuals who are blind or visually impaired. In addition, few studies have attempted to describe this population (Koch et al. 2002).

About 40 to 50% of people with visual impairment or blindness may experience alcohol abuse, and rates of drug abuse are as high as 35% among some people with a disability. As a consequence of those findings, there is strong reason to believe that individuals with visual impairment are significantly at risk for Alcohol Abuse (Kochet al. 2002).

2.3 An overview of PWDs

People living with disability (PWD) form the world's largest minority; it is estimated that approximately one billion people, or 15% of the world's population, have some degree of disability. The case of substance abuse in PWD is higher in developing countries when compared to developed countries.

According to CDC (2022), a disability is any condition of the mind or body (impairment) that makes it more difficult for the individual with the condition to interact with the world around them (participation restrictions) and do certain activities (activity limitation). Disabilities vary in type and can affect a person's vision, movement, thinking, learning, communicating, hearing, social relations and mental health. People with Disability (PWD) is a diverse group with an extensive range of needs.

Disability is categorized into three dimensions. The first is the impairment which implies an absence of or significant difference in a person's body structure, physical function, or mental functioning. For example, it includes loss of vision, memory, or limb. The second is activity limitation, which entails difficulty walking, hearing, seeing, or problem-solving. The third is the participation restriction in activities that may be considered normal — for example, obtaining preventive and healthcare services and participating in recreational activities (WHO, 2001; U.S. Department of Health and Human Services, 2005).

Statistics estimate that about 80% of the global PWD come from developing countries. In addition, despite 20% of the world's poorest people having some disability, they are likely to be regarded as the most disadvantaged by their communities (Karen Mcveigh, 2011; WHO, 2018; UNICEF, 2017; World Bank, 2018).

Studies have established that PWDs experience high levels of multidimensional poverty, such as malnutrition and lower levels of health, barriers to accessing education and healthcare, and exclusion from gainful employment and social participation (Mitra et al. 2013).

In Kenya, disability is present in society; therefore, support is necessary from all sectors. However, due to their condition, disabled people in Kenya are marginalized. The situation is similar in most developing countries because of poor access to proper healthcare, education, rehabilitation or employment. Nevertheless, the PWD group represents a critical segment in Kenya, with recent findings indicating that about 10% of Kenya's population comprises disabled people. PWD are varied according to their social, physical, mental and disability needs; they are not homogeneous (Global Disability Rights, 2018).

As for levels of education, approximately 19% of the disabled population in Kenya receives a secondary education (0.68 million people). In addition, some 33.3% of the disabled population is employed (1.48 million people), and 67% of the disabled population lives in poverty (2.97 million people) (KNBS, 2009 and 2013, Global Disability Rights, 2018, 2009; Kenya Demographic & Health Survey, 2009; World Bank, 2018).

Findings from the KNSPWD (2007) reveal that visual, physical, hearing and mental are the most dominant forms of disabilities in Kenya. Those with visual impairment comprise 30%, physical 30%, hearing 12% and mental 11%.

Table 2.1: Forms of disabilities as of 2007

Type of Disability	%
Visual	30
Physical	30
Hearing	12
Mental	11

Source: KNSPWD Report (2007)

Visual impairment is considered a significant issue of public health concern. There are rising cases of visual impairment, and the World Health Organization estimates approximately 1 billion people are visually impaired globally (Bourne et al., 2017; WHO, 2022).

What is the definition of visual impairment? Vision impairment can range from no vision (blindness) or very low vision to an inability to see clearly (Raising Children Network, 2022). According to the University of Pittsburgh (2022), vision impairment means that someone's eyesight cannot be corrected to a level considered normal. Globally, at least 2.2 billion people have near or distance vision impairment (WHO, 2021).

Visual impairment is categorized as sixth in the global disease burden of disability-adjusted life-years. Further, it is associated with increased mortality (McCarty, 2001; Chiang et al., 2006; Khanna et al., 2013).

According to Smith (2021), blindness is a term that describes a degree of vision loss. However, vision loss more broadly occurs on a spectrum and can be influenced or caused by a number of factors. Legal blindness is vision loss legally defined to determine eligibility for disability benefits. In the U.S., for example, this means central visual acuity of less than 20/200 in one eye.

Smith (2021) adds that total blindness describes a complete loss of vision. People with total blindness are unable to see at all. On the other side, low vision is used to describe having some vision but difficulty completing tasks due to the degree of impairment. This difficulty can persist even with corrective lenses.

Vision loss is a broad term that describes individuals who have trouble seeing, even with glasses or contact lenses. Visual impairment and blindness can develop due to a genetic condition, occur from birth, injury, macular degeneration or illness (Smith, 2021).

2.3.1 The Visually Impaired in the Kenyan Context

In 2009, the Kenya National Population Census announced that the general disability rate in Kenya was 3.5%. This percentage translated to 1,330,312 million PWDs. Of this, the largest share was taken by those with physical impairment (413,698), followed by visual impairment (331,594). Others are shown in the table below:

Table 2.2: Population by the main type of Disability and Gender as of 2009

Type of Disability	**Male**	**Female**	**Total**
Physical	198,071	215,627	413,698
Visual	153,783	177,811	331,594
Hearing	89.840	97,978	187,818
Speech	86,783	75,020	161,803
Mental	75,139	60,954	136,093
Others	44,073	55,233	99,306
Total	647,689	682,623	1,330,312
% With Disability	**3.4**	**3.5**	**3.5**

Source: OHCHR-National Report (2011:7)

In August 2019, Kenya carried its eighth Population and Housing Census. In the preliminary stages of the 2019 census, the Organization for People with Disability, under the leadership of the United Disabled Persons of Kenya (UDPK), advocated using UN-recommended standards to guide data collection on people with disability. These standards were derived from the Washington Group Questions and were used to identify people with disabilities in the 2019 census in Kenya (Development Initiative, 2020).

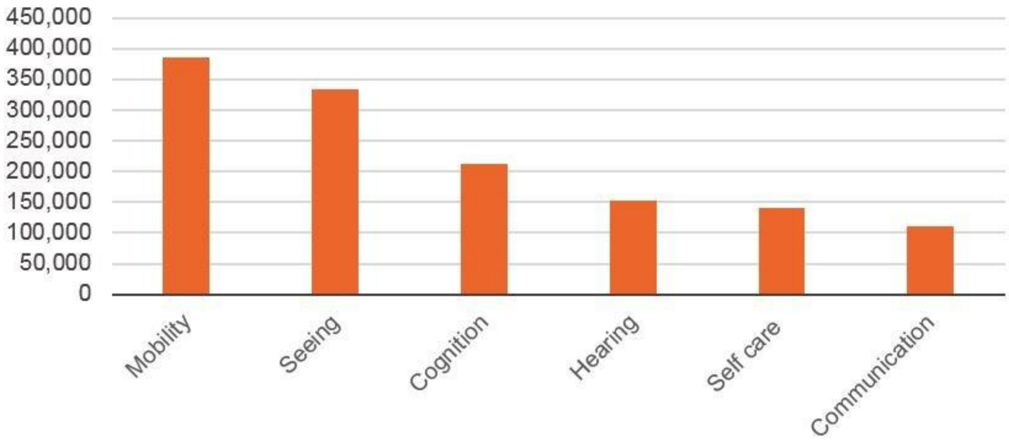

Fig 1.3: Numbers of Kenyan people with disability by domain based on KNBS 2019

Source: Development Initiatives based on KNBS 2019

According to the KNBS 2019 census, about 900,000 Kenyans, or 2.2% of the Kenyan population, live with a disability. Regarding sex, the report indicates that 1.9% of men have a disability compared with 2.5% of women. In an analysis of disability by domain, mobility was the highest. About 0.4 million Kenyans, or about 42% of people with a disability, fell under the category. Visual impairment was the second largest domain, with close to 0.35 million or close to 36% reporting disability in seeing. The other domains of disability –cognition, self-care and communication — made up the rest, with Albinism affecting0.02% of Kenya's population.

Of all the domains of disability, the prevalence rates of people with mobility difficulties are the highest, with prevalence ranging from 2.0% to 0.2%. Visual impairment is the second highest, ranging between 1.7% and 0.1%. Those with cognitive difficulties are third, with prevalence ranging from 1.3% to 0.2% (KNBS, 2019).

These outcomes support the findings by Global Disability Rights (2018), who state that of all the categories of people with disability in Kenya, those with visual impairment are the second largest population, representing approximately 19.09% of the population. The largest are those who are disabled in terms of mobility, with 26.2%. Auditory comes third with 12.4%, followed by Speech with 10.6%, Cognitive with 8.2%, and others share 23.6%

While the above data may represent the status of people with disability in Kenya, reports from the Development Initiative (2020) still suggest that the stigma associated with acknowledging disability might have prevented accurate reporting.

For a long time, Kenya has recognized the challenge of accurately measuring disability demographics. For instance, organisations of people with disabilities (DPOs) noted a case of significant underrepresentation of the number of people with disability in Kenya when the Kenya National Bureau of Statistics (KNBS) 2009 census report placed Kenya's disability prevalence rate at 3.5% (United Disabled Persons of Kenya, 2020).

Generating accurate statistics is a challenge because there is a lack of universally accepted standards for categorizing disabilities and methods for collecting data that navigate the inherent issues of stigma (Development Initiative, 2019).

The Development Initiative Report (2019) further posits that, generally, when generating data for people with disabilities, embracing a universally agreed data collection system allows for an accurate comparison of disability data across locations over time. However, Kenya's past censuses and surveys have utilized varying data collection questions and methodologies.

In another example, the World Health Organization (2018) report placed the global prevalence rate of disability at 15% while Kenya's frequency, quality, quantity and availability of official disability data indicated lower disability prevalence rates.

During the 2019 census, and with the assistance of other strategic research partners, Kenya demonstrated progress toward making disability-inclusive data collection by integrating internationally comparable questions for identifying people with disabilities. Nevertheless, it is still difficult to directly compare disability prevalence in 2009 and 2019 because of the differences in data collection methodologies, ages covered and size of administrative units (Development Initiative, 2019).

Despite the challenges highlighted above, Development Initiative (2020) states that census data is critical in supporting and mapping vulnerable communities and ensuring adequate health facilities, social and economic protections and public safety for people with disabilities. Usually, the data provided is helpful to the government, civil society, and private sector when designing and targeting People with Disability when making disability-inclusive programmes and policies. Therefore, accurate and publicly accessible data is critical in the efforts taken to improve disability inclusion.

2.3.2 Distribution of people with a disability by domain in Nairobi County

The impact of the potentially dramatic underrepresentation of people with disabilities in the official statistics is severe. The statistics are not accurate yet and are broadly accepted. In that case, the focus on disability inclusion hardly receives significant attention and this may also have a damaging impact on the inclusiveness of Kenya’s response to healthcare service provision. To address these concerns, a discussion must be made on what can be done to improve the accuracy of Kenya’s disability data. The leadership of people with disabilities and the organisations that represent them is critical to ensure that Kenya’s statistics on disability leave no one behind (Development Initiative, 2019).

That said, data from the KNBS 2019 census indicates that about 900,000 Kenyans, or 2.2% of the Kenyan population, live with a disability. When it comes to distribution by domain and county of residence, the table below shows the figures in Nairobi County:

Table 2.3: Distribution of people with a disability by domain in Nairobi County

County	Seeing difficulties	Hearing difficulties	Mobility difficulties	Cognition difficulties	Self-care difficulties	Communication difficulties
Nairobi	0.5%	0.1%	0.4%	0.2%	0.1%	0.1%

Source: Development Initiatives based on KNBS

2.4 Status of Alcohol Abuse among the General Population in Kenya

Morriset al. (2020) analysed alcohol abuse among respondents aged 15-65. Their findings showed that the prevalence stood at 12.2% in 2017. Nairobi County was leading in the prevalence of alcohol abuse at 17.5%. Eastern region followed with 14.3% and the Western region with 13.4%. The Western region had recorded a consistent increase in the prevalence of alcohol abuse from 6.8% in 2007, and 13.6% in 2012 to 13.4% in the latest figures. The findings reveal that Nairobi, Eastern, Western, and Rift Valley regions continue to record the highest prevalence of alcohol abuse in Kenya.

In terms of the data according to age categories, 12.2% of respondents between 15-65 years were currently abusing alcohol. Additionally, 15.1% of respondents between 25-35 years were currently using alcohol. 5.6% of respondents aged 15-24 were currently abusing alcohol, and 0.9% of respondents between 10-19 years were abusing alcohol.

According to the study, the burden of alcohol abuse and substance use disorders presents a severe challenge for the country. The study by Morriset al. (2020) emphasizes evidence-based prevention programmes and increasing access to affordable treatment and rehabilitation services in Kenya.

2.4.1 Categories of interactions of Alcohol Abuse with Visual Impairments

Regarding potential interactions of Alcohol Abuse with Visual Impairments, Koch et al. (2002) describe three categories of alcohol abuse based on the onset of visual impairment as a disability. These are categories that the researchers had identified from the Substance Abuse Resources Disability Issues project (SARDI).

In Type One, alcohol abuse precedes visual impairment; in Type Two, visual impairments precede alcohol abuse; and in Type Three, alcohol abuse and other disabilities occur concurrently. The sequence in which disabilities are incurred can affect the adjustments of individuals to their disabilities and the general challenges they must overcome during the rehabilitation process, which, in turn, affects intervention strategies.

i. Type One (pre-existing Alcohol Abuse): For individuals experiencing pre-existing Alcohol Abuse, the consequences of that disability, including lack of emotional balance and exaggerated emotional, social, vocational, and familial problems, are likely to exacerbate the psychosocial consequences of the newly acquired visual impairment or blindness. In addition, by limiting the individual's ability to cope with frustration and significantly impairing their ability to manage their emotions, Alcohol Abuse causes a host of other clinically and socially inappropriate behaviours that impede the rehabilitation process. Other problems arising from Alcohol Abuse may include limited work history, educational difficulties, lack of interpersonal skills, absence of positive social support, and involvement in the legal system. In brief, these individuals may have a long history of impediments that have gone unremediated. The result for the individual is a lack of resources and strengths on which to build while adapting to the onset of visual impairment.

ii. Type Two (Alcohol Abuse following the onset of a primary disability): Individuals whose primary disability precedes Alcohol Abuse face different challenges. They may have adjusted or adapted to their disability and already possess the necessary skills to participate effectively within their family and community systems. However, their abuse of alcohol and drugs may be linked to self-medication and to grief, anger, and frustration. As a result, not only may these individuals begin to experience the direct, harmful effects of Alcohol Abuse, but they may also begin to lose the skills they previously used to adjust to their disability.

iii. Type Three (Alcohol Abuse and primary disability occurring concurrently): Multiple effects may be observed when Alcohol Abuse and visual impairment occur concurrently. The individual may misuse alcohol and drugs as a coping device to deal with the frustrations of the disability and to ease the adjustment. Consequently, individuals who continue to misuse psychoactive substances to cope with stress often develop abuse and dependence problems. This use of psychoactive substances may sabotage the ongoing rehabilitation process.

2.4.2 Alcohol and Substance Abuse among the visually impaired

Some researchers suggest that anywhere from 20 to 50% of people with visual impairment have substance use problems. Due to a lack of research, the cause of this high rate remains unclear (Smith, 2021).

Alcohol and drug abuse significantly affect the lives of the individuals who experience them (Koch et al. 2002). Although the incidence and prevalence of alcohol and drug abuse within the population vary according to demographic characteristics, the abuse affects people of all ethnicities, cultures, ages, genders and with all disabilities (Doweiko, 1999; Benshoff & Janikowski, 2000).

Globally, the estimation of overall substance abuse stands at 34% in the category of persons without disabilities compared to 40% for those with disabilities. Approximately one in seven individuals with disabilities has a problem with drug and alcohol dependency, and this is significantly higher when compared to those without disabilities (Association on Alcohol, Drugs, and Disability, 2013; Glazier & Kling, 2013; Weaver, 2013).

Rehabilitation researchers have found that many people with disabilities experience alcohol and drug abuse at rates equal to or above the general population (NAADD, 1999). Furthermore, when alcohol and drug abuse is left untreated or not identified, these coexisting disabilities may contribute to or exacerbate other disability issues, thereby worsening existing impairments and contributing to potentially fatal secondary consequences (Koch et al., 2002).

Psychoactive substance use to manage the stressors of vision loss is well documented among visually impaired people. Visual impairment can worsen psychological challenges, including isolation, a risk factor for substance abuse. Vision impairment and sight loss are associated with the growing risk of reaching for controlled substances and developing substance use disorder. Furthermore, sight loss among adults is associated with an increased risk of isolation, leading to irregular substance use and depression. In addition, there is a risk that visual impairment coupled with intoxication can lead to injuries and the worsening of existing chronic conditions (Coyle et al., 2017; Jones, 2021; Benjamin et al., 2021).

Substance abuse and addiction can occur in visually impaired people just as often as in anyone else. Understanding the barriers that visually impaired people face, and the available treatment options can help support addiction recovery (Smith, 2021).

Alcohol addiction affects millions of individuals and families globally. According to the journal Disability World (2021), PWDs like the blind or people with visual impairment can be two to four times as likely to develop a substance use disorder.

Substance use disorders can often develop as a coping mechanism, a way to self-medicate stress, physical pain, or emotional pain. They can also be hereditary. People with visual impairments may have difficulty finding and receiving treatment for their substance use disorder (Smith, 2021).

Smith (2021) postulates that understanding the needs and unique issues that the visually impaired face is one step towards addressing them in a way that serves the health and happiness of those affected.

In Kenya, a rapid situation assessment survey on drugs and substance abuse conducted by NACADA in 2017 revealed that the Nairobi region had the highest prevalence of alcohol abusers, with a staggering 18.4%. Furthermore, almost a fifth of the population is alcoholic, suggesting that one in every five individuals within Nairobi is an alcoholic.

There is a general absence of comprehensive data on the extent of drug use among people with disabilities in Kenya (Kathungu et al., 2015). Studies reveal that in the general population or people without disability the prevalence of substance abuse in Kenya is 34%, whereas in the PWD population it is 40%. Therefore, the substance abuse prevalence of PWD is higher than that of the general population. Alcoholic beverages are the most abused substance. Furthermore, about 47.4% of PWD display a lack of awareness about where to get information concerning treatment and prevention of Alcohol and Drug Abuse (NACADA, 2014; Glazier & Kling, 2013; Kathungu, 2013).

The prevalence levels are high despite efforts to manage drug-related problems that have been on the increase. Furthermore, the government's commitment is seen in the enactment into law of the Alcoholic Drinks Control Act which seeks to regulate the production, sale and consumption of alcohol (Kathingu, 2015).

People with disabilities are affected by the problem of alcohol and drug use, just like the general population. However, they are more vulnerable due to the unique challenges presented by their impairments, which make accessibility to drug information difficult, resulting in low levels of awareness about drugs (Kathungu, 2013).

2.4.3 Policies governing the fight against Alcohol Abuse in Kenya

According to Study Mode Research on Drug and Substance Abuse in Kenya (2018), drug and substance abuse is globally recognized as the most significant impediment to the social fabric’s wellbeing and the most significant health risk. It is also representing of the most significant impediments to Kenya's economic growth. With the psychological impacts linked to alcoholism in mind, Kenya resolved to address the issue benevolently. Together with other members of the international community, the first initiative developed was to put in place various conventions to enhance coordination, synergy, and cooperation between member states so that victory against alcohol abuse could be realized within an agreed timeframe.

On its part, Kenya has made significant strides towards achieving this. The parliament has enacted legislation to that effect, and many policies have been crafted to enhance implementation. It is argued that the process of fighting alcoholism and illicit drug use starts with legal frameworks and policies which act as the outline of the whole mission.

These are some of the legislations in place: The Public Health Act (Cap 242); Narcotic Drugs and Psychotropic Substances (Control) Act, 1994; The Compounding of Potable Spirits Act (Cap 123); the Methylated Spirits Act (Cap 129); The Use of Poisonous Substances Act; Liquor Licensing Act (Cap 121); The Standards Act (Cap496); The Industrial Alcohol (Possession) Act (Cap 119); The Chang'aa Prohibition Act (Cap 70); The Chief's Act (Cap 128).

Some laws and policies in Kenya have established specific agencies combating drug and substance abuse. The National Campaign Against Drug Abuse, widely known as NACADA, is one of these institutions.

This agency facilitates coordination between all government institutions and ministries that enforce drug and substance abuse laws. NACADA also ensures the seizure of proceeds achieved due to trading in illicit drugs. In addition, the agency coordinates with other international organizations to share ideas and borrow from practices. Finally, NACADA conducts research, analyses, collates, and collects data generated from conducted research.

In every sense of the statement, NACADA is the lieutenant on the frontline in this battle against drug abuse in Kenya; this is because it has been bestowed with the powers to coordinate all other agencies fighting drug abuse in Kenya, including ministries. Besides, the law requires that the institution empowers other non-governmental organizations and civil society organizations established at the grassroots of society and in touch with the day-to-day experience of the typical Kenyan. NACADA does this by financing these organizations to facilitate their ventures. The maximum that it can pump into such organizations is Kshs. 300,000, and this can only happen if it is convinced that the objectives of that receiving organization align with its blueprint. On top of financing civil society, NACADA also provides grants for institutions or individuals willing to undertake research concerning emergent drug abuse trends.

Another critical role of this institution is to do with enforcement. The new Act also successfully elevated its enforcement powers by allowing it to recruit enforcement staff to help arrest and contain people who flout the policies and regulations in place.

However, taking a pragmatic look at the endeavours of the Kenyan Government in terms of efficacy and results, it is apparent that we are not yet there because of the rise in levels of alcohol abuse. Additionally, the legislations do not adequately address the specific needs of the visually impaired. They fail to consider the use of communication interventions on alcohol abuse that target the visually impaired, including formats used to communicate with them.

2.5 Anti-Alcohol campaigns in Kenya

While many anti-alcohol campaigns are held locally in Kenya — especially by newly-established and private rehabilitation centres — the most common ones are those held by the National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA).

As a result of the revised Executive Order No. 1 of June 2018, NACADA is placed under the Ministry of Interior and Coordination of the National Government in Kenya. NACADA was established under a Gazette Notice dated April 26, 2001 to undertake public education and awareness campaigns against drug abuse, especially among youth in schools and other institutions of higher learning. In May 2006, the President established an Advisory Board and, via the Kenya Gazette Notice No. 3749 of May 19, 2006, appointed the NACADA Chairman. In addition, the Authority's mandate was expanded in 2010 to include implementing the Alcoholic Drinks Control Act 2010.

NACADA carries out public education on alcohol and drug abuse directly and collaborates with other public or private organizations.

Using mass media to create awareness is one of the means NACADA uses to reach the public. Mass-mediated messages benefit from the potential to reach large and hard-to-reach audiences cost-effectively. In addition, they offer educative information about nascent public health issues such as alcohol abuse. They also play a critical role in intensifying awareness and knowledge of a health issue, problem, or solution, influencing perceptions, beliefs, attitudes, and social norms, and enhancing prompt action (Richard Thomas, 2006; Thomas & Chen, 2013; 2014).

In addition, the Authority coordinates and facilitates public participation in the control of alcohol and drug abuse. The Authority works with schools, healthcare centres, workplaces, colleges, universities, technical institutions, ministries, county governments, parastatals, national government administrative offices, CBOs, NGOs, self-help groups, faith-based institutions as well as individuals interested in a society free from alcohol and drug abuse (NACADA, 2021). For example, on 20th February 2016, NACADA, the Catholic University of Eastern Africa (CUEA) and the Teachers Service Commission (TSC) participated in a 5 km walk that aimed at sensitizing people on the effects of Alcohol and Drug Abuse. Over 1200 people took part in the walk, drawn from CUEA staff members and students and staff, teachers and school pupils from TSC.

On January 3, 2018, NACADA held a 10 km campaign walk on the outskirts of Tala town in Matungulu constituency to create awareness among public members about drug abuse.

Similarly, on June 24, 2019, NACADA conducted an Anti-Alcohol and Drug Abuse Campaign walk. The objective was to mobilize support for a nation free from alcohol, drugs and substance abuse — this was part of the annual national campaign conducted by NACADA. Besides long-distance walking, awareness of their campaigns has been promoted via their website, social media platforms (Facebook and Twitter), online platforms of other accredited treatment and rehabilitation centres, blogs, mainstream print, posters, flyers, television and radio.

However, while the campaign aimed to facilitate public participation in controlling alcohol and drug abuse and targeted individuals and organizations interested in a society free from alcohol and drug abuse, media platforms and venues did not favour people with visual impairment.

2.6 Access to messages against Alcohol Abuse among the Visually Impaired

Information is of paramount importance in supporting and improving people's social wellbeing and health, particularly in the information society of the 21st century. However, information is not always accessible or appropriately "packaged" for the visually impaired (Catherine et al., 2011; Darzi, 2008).

The visually impaired, as people with disabilities, are a vulnerable group. They are structurally discriminated against and have traditionally been victims of violations and denied cultural, economic and social entitlements. Alcohol and illicit drug users are hidden, and therefore difficult to locate for giving access to information (Human Rights Centre, 2018; Morgan, 2008).

From the global viewpoint, concerning levels of education, 19% of PWDs receive a secondary education (68 million people). As for employment, approximately 33.3% are employed (which translates to about 1.48 million people), (KNBS, 2009 and 2013, Global Disability Rights, 2018 & 2009, KDHS, 2009; World Bank, 2018).

PWD are diverse in terms of types of disability and hence are not a homogeneous group. For example, visually impaired people are the second-largest in the PWD group; they make up approximately 19.09%. The largest are those who are disabled in terms of mobility, with 26.2%. Auditory comes third with 12.4%, followed by speech with 10.6%, cognitive with 8.2%, and others share 23.6% (Benedicte and Lisbet, 2007 and Global Disability Rights, 2018).

Catherine et al. (2011) and Beverley et al. (2011) add that the visually impaired are a heterogeneous group with different visually related impairments, personal characteristics, and preferences to be met when communicating. They have unique healthcare information needs worthy of exploration in their own right. Thus, understanding the behaviours of the VI and their information needs could help provide interventions that target particular subgroups and individuals, resulting in effective education. It is necessary to treat the visually impaired people as a heterogeneous group and to recognize the value of actively involving them in health-related research as this will improve their participation in health communication. This approach has been successful with other groups.

Harrison and Lazard(2015) support this by stating that the visually impaired — depending on the intensity of impairment — can access, process, and understand their health information in various formats while utilizing a range of accommodations. For example, they can be taught to accommodate their differences by using alternative sensory experiences and interpretations.

People with disabilities disproportionately face conditions that promote the use of illicit drugs. There is a considerable treatment gap between those who receive treatment for alcohol abuse and those that need it. Amongst those with a physical disability, substance addiction and abuse are reported to be even higher. People with disabilities have a likelihood of between 2 and 4 times more than the population without disabilities of struggling with substance abuse. Moreover, 40-50% of PWD who are blind or with VI may be categorized as heavy drinkers. People who have blindness mostly resort to alcohol to self-medicate the stressors and difficulties that emerge and are associated with disabilities (American Addiction Center Resource, 2017; Moore& Li Li, 1998).

HSS (2010) states that PWDs are at considerably more risk of alcohol and substance abuse. The PWDs find themselves in such a situation due to several risk factors —such as, inadequate societal enabling, health problems and medication, deficiency of accessible and appropriate prevention and treatment services, and poor levels of identification of potential problems.

The visually impaired are dependent on acquiring and seeking additional information independently from numerous sources. Besides, information providers do not provide information consistently in the person's preferred format. Information providers or healthcare professionals currently only offer a small portion of social care and healthcare needs that fit the needs of the visually impaired (Beverley et al., 2011).

Harrison et al. (2010), discovered that provider interactions and modes of operation and intervention affected the capacity to establish health literacy among women. For instance, women with VI wanted to be informed about what was being done to them, where they would be going, and how things might feel, and they felt that unless providers were exposed to people with visual impairment they would not know how to act around them.

The visually impaired also have sociocultural influences and a network of support services for health literacy. Some of them are friends, disability activists, family groups and providers. They give bits of advice, interpret healthcare issues and act. Women with VIs observed that the burden of ensuring they acquire, process, and understand health-related knowledge is mainly upon them.

Additionally, when it comes to using the internet and modern technology to access information, people with disabilities access information at levels below that of the population without a disability (Lazar& Jaeger, 2011).

Related to this is the fact that, despite the bulk of information on community services being in temporary formats, other specific health campaigns are circulated through bulletins and brochures in the community health centres. This information, much less its contents, remains unknown to blind people unless it is specifically tailored to suit their attention. A small fraction of alternative formats bearing the information targeting those having visual impairment are available. Medical materials and other reference content are hardly ever obtainable in alternative formats. Documents are available in library collections in large amounts, while others are available on a commercial basis. Very little focus is paid to ensuring that information concerning pharmaceuticals is delivered in formats accessible to the visually impaired. Most medications are packaged in labels that favour individuals having good visual acuity (Blind Citizens of Australia, 2018).

Disability in Kenya demands support from every sector since it intersects all domains of our society. The disabled represent a critical segment in Kenya, with recent statistics indicating that, of the total Kenya population, they comprise approximately 10% (Global Disability Rights, 2018). Furthermore, as in most developing countries, they are marginalized and encounter problems due to their disability. Most lack access to employment, education and healthcare.

Although some data exist on the prevalence of drug abuse among the general Kenyan population, there is a broad deficiency of extensive data on the extent and magnitude of drug abuse among special populations such as persons with disability. For the general population or persons without disability in Kenya, the prevalence of substance abuse is 34%, whereas for PWD it is 40%. Substance abuse prevalence for PWD is higher than that of the general population. Alcoholic beverages are the most abused substance, with 28.2%. About 47.4% of PWD have also indicated that they were unaware of where to get information on treatment and prevention. 31% reported that the biggest challenge was discrimination by society in terms of failure to ensure accessibility to drug information (NACADA, 2014; Glazier & Kling, 2013; Kathungu, 2013).

In Kenya, practices and attitudes rooted in taboos, rites of passage, religion and cultural beliefs produce near-insurmountable barriers that disfavour PWDs and their involvement in sociocultural activities. In addition, health and poverty alleviation programmes commonly fail to identify persons with disabilities as a group of interest; even when identified, such persons still face obstacles (Ingstad & Grut, 2007).

Messages against alcohol abuse for adults with visual impairment have received little attention. They are hardly accessible, yet adults who are visually impaired, as individuals with disabilities, face an increased risk of alcohol and substance abuse and are substantially expected to report poor, fair, or worsening health compared with adults who are sighted (NACADA, 2014;Glazier & Kling, 2013;Kathungu, 2013; Koch et al., 2002).

People with visual impairment have restricted access to healthcare information resources and messages. Health literacy among them remains low (Zhi-Han et al., 2017).

The blind face challenges in obtaining a timely, patient-centred, safe and effective healthcare service. Being aware that people may have problems with vision is an essential prerequisite for good healthcare. Thus, it is crucial to take a moment and consider communicating effectively on matters of diagnosis, available facilities and accessibility, plus making management plans that include VI needs. Communications should be designed to relate to individual needs. Group therapy and counselling sessions comprising the blind are helpful for coping mechanisms and providing life skills. Specially trained healthcare providers are essential to this demographic, especially those qualified to handle co-occurring disorders and conditions unique to the blind. It is important to identify which agency will coordinate comprehensive client care. Having formal mechanisms for shared communication and case management that will enable substance abuse treatment among the visually impaired is necessary. The vocational rehabilitation service providers must know how to manage cases and work together across fields to provide services for their clients. Personal resources should be checked to ensure they are in place and assist in the treatment plan. This will enhance access to good clinical care for the blind (American Addiction Center Resource, 2017; Margaret, 2012; SAMHSA, 2011; O'Day et al., 2004).

2.7: Experiences of the visually impaired when accessing messages against alcohol abuse

If a person cannot access medical and rehabilitation services, they will not benefit from life opportunities like attending school or participating in other social activities. People with disabilities face the challenge of accessing healthcare information and facilities (Shakespeare et al., 2018:3). Communication and other system barriers experienced by the visually impaired make them significantly at risk for Alcohol Abuse (Koch et al., 2008).

SAMHSA (2011) states that the barriers to substance use disorder treatment for the visually impaired are alarmingly numerous. They range from stigma and negative attitudes from healthcare providers (particularly if outcomes are perceived as poor for people with these two co-occurring conditions) and lack of staff training to materials and methods that are not accessible. For example, most of the few available facilities that provide treatment for substance disorders argued that, since they offer ramps to clients, they were handicapped accessible. That implies VI needs are not considered, yet the visually impaired require Braille signs, other navigational features, and alternatives to sight-based counselling treatment activities. For instance, films and booklets should enhance their accessibility to treatment services.

Generally, PWD encounter diverse barriers when accessing communication messages against alcohol abuse. The barriers range from communication, environmental, economic, and social, preventing them from achieving the desired quality of life. Four broad categories classify the barriers: i) basic respect — which involves healthcare providers' belief that PWDs cannot take care of themselves fully; ii) communication barriers — the challenges faced when interacting with healthcare providers; iii) information barriers —the difficulty of obtaining information from written materials in accessible formats (for instance, they are not available in large print, Braille, or on audiotape);iv) physical access — the mobility challenges involved in travelling to and then navigating inside healthcare centres(American Addiction Center Resource, 2017, Benedicte & Lisbet, 2009; O'Day et al., 2004).

According to Beverley et al. (2004:1-24), the visually impaired operate at three levels, depending on their facilitators and barriers. The first level is the individual, which includes the absence of knowledge on health issues, limited understanding of using Braille, and language and cultural barriers associated with ethnicity. The second are the community barriers that include taboos within the society and the short time the visually impaired have to grasp the information they are given. Thirdly, communication of health messages could be done in a range of approaches, such as using friends, relatives and health professionals as information providers and discussion of their health-related matters with other visually impaired people and health professionals.

Thurston and Thurston (2010:6) state that, on average, only 10% of all communications from health services to the visually impaired participants are received in their preferred reading format, even though 96% of blind respondents prefer accessing communication messages in reading format(Braille and large print formats).

In Kenya, 47.4% of PWD report a lack of awareness of where to get information on Alcohol Abuse treatment and prevention. 31% report that the biggest challenge was discrimination by society in terms of restricted accessibility to drug information. Studies recommend translating drug information to modes accessible to all PWD, such as Braille print and audio materials for the visually impaired. The different disability types vary regarding the kind of impairment, hence the need to make their needs unique concerning drug-related interventions (NACADA, 2014).

Visually impaired people encounter formidable barriers when seeking information and substance use disorder treatment. Besides that, many treatment facilities are not fully reachable by PWDs. In addition, they experience various obstacles, such as harmful attitudes and biases about people with substance and drug abuse, lack of staff training, and inaccessible methods and information in communication materials (SAMHSA, 2011).

Salminen and Karhula (2014) argue that the young with visual impairment encounter obstacles to participation — most recurrently concerning mobility, interpersonal interaction, creating relationships, handling domestic life, and leisure activities. Furthermore, their immediate environment is fundamental in enabling or being a barrier to participation.

Despite the blind having a right to receive healthcare information, they cannot access it in their preferred format. Most of them do not think the medical staff know how to provide information in their preferred format. Most of them also believe that medical staff do not realize that they require an alternative format, and they think that there is too short notice to receive information in a preferred format. They are also unaware that they are entitled to ask for healthcare information in a format they deem favourable (Thurston & Thurston, 2010:12)

Apart from experiencing difficulties in accessing healthcare services, the blind feel that, due to their disability, they are denied treatment. However, they expressed satisfaction with the information given by their family doctor. They were unlikely to feel that their doctor was oversensitive or insensitive to their disability (Veltman et al., 2001).

As for means of mass communication, there are limited sources of information for the visually impaired. Notwithstanding that situation, community radio was a helpful means of acquiring information. In addition, television was identified as a resource since blind people absorb the contents of the messages even though they cannot see the images (Pagliuca et al., 2009; Medeossi, 2014).

The experience of VI is not any better when discussing access to health messages in cyberspace. At present, most resort to the web to acquire health-related information. Thus, this influences how people treat an illness, the questions doctors ask, and how they care for themselves. On this note, VI individuals access the internet through automated screen readers as the standard method. However, among the blind, the degree of access to health information from the internet, which is conveyed via automated screen readers, is low (Davis, 2010).

Furthermore, Davis (2010) posits that the visually impaired experience challenges accessing health communication in cyberspace. They access the internet through automated screen readers as standard. However, due to the scarcity of automated screen readers, their access to health information from the internet is low.

Jonathan and Paul (2011) posit that, in accessing messages on the internet, PWDs experience challenges. The visually impaired, for instance, encounter challenges when the web content and screen readers are incompatible and when software for computer-synthesized speech output is unavailable. In addition, when designers do not place suitable text tags on tables, links, forms and graphics, problems are usually encountered by screen-readers. To make health communication messages more accessible, identifying an agency that will coordinate comprehensive client care is critical. This will cater to the needs of the visually impaired within a proper timeframe.

Despite the mentioned barriers, the internet is thought to have tremendous potential to advance social inclusion for PWDs. To make it more accessible to visually impaired people, non-visual equivalents should be appropriately coded for the blind. Currently, computer interfaces largely favour those with normal vision (Jonathan & Paul, 2011).

Davis (2010) states that suggested coding changes and designs should be implemented to improve the accessibility of online content. Making health information available in multiple formats is imperative. It should also be tailored for those with varying degrees of visual impairment by providing care lines and patient information leaflets in clear print and Braille labelling. Other formats like Braille, computer disks, talking newspapers, the internet, television, audiotapes and large prints were also suggested, plus verbal information and support (Beverley et al., 2004:1-24).

Formal mechanisms for shared communication are required. Case management will also enable vocational rehabilitation personnel and healthcare providers to know how to manage cases of substance use disorder and work together across fields to provide services for the patients (SAMHSA, 2011).

Sabatello et al. (2019) argue that those developing health communication materials have little knowledge of the challenges faced by people with VI. Thus, understanding barriers to the inclusion of the visually impaired is necessary to make their participation easier. Additionally, including the blind in research dealing with precision medicine is vital for enabling them to attain social justice, enhancing their knowledge of health matters and improving diversity.

Visual impairment has a significant impact on an individual's quality of life. Moreover, it seems to affect the general health-related quality of life more adversely compared with other chronic conditions. Information is not always provided in an appropriate format, at the required time, or in sufficient detail. Besides, empirical studies that examine the health information needs of the visually impaired are surprisingly few(Beverley et al., 2004; Maaike et al., 2009:119-126).

2.8: Making sense of messages against alcohol abuse among the visually impaired

Visual impairment is a decrease in the ability to see to the degree that causes problems not fixable by visual means, such as glasses. Over the world, the estimated population of the blind was approximately 36 million in 2015; studies project the numbers to reach 115 million by the year 2050. Those with visual impairment that could be classified as moderate or severe amounted to some 216.6 million people (WHO, 2018; Bourne et al., 2017).

Veltman et al. (2001) presuppose that PWDs embody approximately 10% of the total population in the world. They are, nonetheless, an underserved group. Consequently, they lack opportunities to participate in preventive healthcare activities, apart from not having adequate access to messages on primary healthcare, hospital care, and long-term healthcare services.

Visual impairment affects an individual's independence and mobility (Vu et al., 2005; Welp et al., 2016), plus their ability to carry out activities of daily living (Pardhan et al., 2015; Welp et al., 2016). As a result, people with visual impairment have a poor quality of life (Jones et al., 2019).

Most visually impaired people have, at some time, used alcohol excessively as a form of drug abuse (Veltman et al., 2001). Furthermore, Pagliuca et al. (2009: 404-411) state that blind people acknowledge the drug problem as a public health problem because it affects society and the life of users and yet they know little regarding the consequences and characteristics of substances and drugs. In addition, influence from media, friends, and other family members may succeed or not succeed in persuading them to quit the abuse. This suggests that unwanted drug use is real among the PWD and that they are not excluded from the risks that come with it.

In addition, most visually disabled patients consider that family doctors who attend to them lack knowledge and education about disabilities and the precise services available for PWDs. Because of that, they feel that their primary healthcare needs are unmet (Veltman et al., 2001).

The portrayal of blindness has essentially constituted stereotypical representations, branding blind people as either unfortunate, mysterious, deprived or disabled (Barasch, 2001).

This finding is supported by Strechay (2012), who states that PWDs are valued members of society. Yet, for decades, television and movies have depicted different portrayals of PWDs in roles that do not focus uniquely on the nature of the disability. As a result, we rarely see them represented on television in roles that hold respect.

Strechay (2012) adds that just as positive portrayals of individuals with disabilities can help overcome stereotypical and misguided public perceptions, many depictions in the media produce and disseminate limiting assumptions about what PWDs can achieve, particularly concerning vision loss.

Shared misconceptions about people with disabilities are reinforced by the media's negative and inaccurate portrayals of the visually impaired. However, content from television can desensitize and educate the public, especially when content targeting people with disabilities is appropriately created(Strechay, 2012).

When visiting rehabs and health centres, the visually impaired have concerns such as information being communicated in inaccessible formats, difficulties communicating with practitioners, and needing assistance getting around healthcare facilities. Physical access limitations to healthcare facilities, providers, and health information hamper safe medical treatment. Additionally, the VI have difficulties reading medication information and thus may take the wrong medication or incorrect doses of medication, resulting in severe consequences, including overdose or inadequate treatment of health problems. As a result, in order for healthcare information about medical conditions, treatments and medications to be helpful, communication messages on the expected outcomes should not be only tailored to the requirements of the VI but also delivered in a format that is accessible to them (Kentab et al., 2015; Koo et al., 2016).

Communication is also a challenge when providing healthcare to the blind. Their knowledge levels of medication are, therefore, lower than those in the normal population. As a result of challenges in communication with those giving healthcare, PWDs were approximately four times more likely to report difficulty managing their medicines than the normal population. For instance, the most common challenges for patients with visual disabilities were identifying proper medication, being unable to read prescription labels, recognizing medicine dosages, not knowing how to store their medicines appropriately, and identifying expiry dates. As a result, most manage their self-medication and distinguish between medicines and dosages solely by memory (Killick et al. 2018).

Much of the information that is communicated on in-patient, out-patient, and community and preventive health programmes is generated by healthcare institutions. Nevertheless, little attention is paid to making this information accessible to the visually impaired. Most encounter difficulties identifying medications while at home and getting messages about the required dosage. They use their improvised methods like storing different medicines in different kinds of containers or different locations to aid them in distinguishing medications and dosages. Lack of proper access to medical information endangers the health and lives of the blind and PWDs (HeeLee & Jeonglee, 2018; BCA, 2018).

For many of them, since their childhood, particularly during open family dialogues, opinions on drugs will have been oriented towards use prevention. The focus ranges from personal experience to the different modes of information, such as lectures, the media, and classes. As a result, several aspects of creative and interesting opinions regarding prevention strategies for alcohol and drugs are given. This illustrates the potential of the visually impaired in finding their own solutions to the healthcare challenges they are facing (Pagliuca et al., 2009).

In one sense, the behaviour and perception of blind people regarding health problems is no different from that of sighted people. Consequently, health services have to offer a health education process incorporating concepts of special education and materials and methods using special technology. For example, it is not enough for blind people to listen to the message on television. Audio materials must be followed by tactile means such as Braille texts(Pagliuca et al., 2009).

The ability to see influences how humans perceive and interpret the world around them. Normal eyesight is part of regular communication, social activities, personal health maintenance, independence, education, mobility and professional pursuits, and the care of others. In addition, normal vision reduces an adult's risk of chronic health, social isolation, depression, and other psychological problems (Vu et al., 2005).

Much information about healthcare concerning community resources and specific campaign messages is disseminated via bulletins and brochures in health centres. However, this information remains unknown to blind people unless they are specifically made aware of it. Only a negligible portion of medication information exists via alternative formats that boost accessibility to the blind as a group experiencing print disabilities. Those with visual impairment require special services for the disabled during rehabilitation and further explanation of the medicine's use, including drug labelling,to aid self-medication (BCA, 2018).

Communication with the visually impaired is enhanced by using medicine labels in a more explicit prescription, more prominent writings, texts in Braille, and more straightforward language by healthcare staff (Killick et al.,2018). Furthermore, rather than blaming the visually impaired for not integrating with the general population, society should ensure they integrate with other members of society. In addition, awareness of their communication needs as consumers of the messages is supposed to be created, making a more inclusive and accessible environment (Jones, 2021).

2.9: Rationale for the study based on Literature Review

The literature reveals that messages against alcohol abuse for the visually impaired have received little attention and are in sufficiently accessible to the visually impaired. Yet, visually impaired adults experience a substantial risk of alcohol and substance abuse.

The visually impaired with alcohol addiction repeatedly struggle with how people will comprehend their addiction treatment needs. Further, stigma may be even greater, and individuals may struggle to find trained professionals who understand and are empathetic. In media platforms, the portrayal of blindness has essentially constituted stereotypical representations, branding blind people as either unfortunate, mysterious, deprived or disabled. Positive portrayals of individuals with disabilities can overcome stereotypical and misguided public perceptions.

While many anti-alcohol campaigns are held locally in Kenya, especially by new and private rehabilitation centres, the most common ones are those held by the National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA). However, while the campaign aims to facilitate public participation in the control of alcohol and drug abuse and targets individuals and organizations interested in a society free from alcohol and drug abuse, the choice of media platforms and venues does not favour the people with visual impairment. Many drug and alcohol treatments and prevention services are available through visual media: newspapers, posters, flyers, and magazines.

Unfortunately, these platforms are not easily accessible to individuals with visual disabilities, yet they have the right to participate in all aspects.

Besides the general absence of comprehensive data on the extent and magnitude of drug abuse among special populations, such as PWDs, little consideration has been made towards making this type of information accessible to the visually impaired. Furthermore, not much has been identified regarding obstacles to the inclusion of the visually impaired; thus, understanding barriers to inclusion of this community is necessary to facilitate their participation and production and dissemination of various health messages.

2.10: Chapter Summary

In this Chapter, I have reviewed literature relating to the policies governing the fight against alcohol abuse and anti-alcohol campaigns in Kenya, the access and experience of the visually impaired when accessing anti-alcohol messages and how they make sense of them. I have also highlighted the Health Belief Model (HBM) and Transtheoretical model (TTM) and their relevance to this study.

The key issues arising from this chapter are summarized as follows: first, in Kenya, disability is present in society; the PWDs represent a critical segment, with recent findings indicating they account for about 10% of the population. Of all the domains of disabilities, the prevalence rates of people with Visual impairment is the second highest, ranging between 1.7% and 0.1%. Second, a rapid situation assessment survey on drugs and substance abuse conducted by NACADA in 2017 revealed that the Nairobi region had the highest prevalence of alcohol abusers, with a staggering 18.4%. Furthermore, almost a fifth of the population is alcoholic, suggesting that one in every five individuals within Nairobi is an alcoholic. Third, PWDs are affected by the problem of alcohol and drug use, just like the general population. However, they are more vulnerable due to the unique challenges presented by their impairments, which make accessibility to drug information difficult, resulting in low levels of awareness about drugs despite the anti-alcohol campaigns conducted in Kenya led by NACADA. Lastly, researchers suggest that anywhere from 20 to 50 per cent of people with visual impairment have substance use problems. However, due to a lack of research, the cause of this high rate is unclear.

In the next chapter, I discuss the methodological issues underpinning this study.

CHAPTER THREE: METHODOLOGY

3.1 Overview

In this chapter, I present the philosophical paradigm that guided my study and linked it to the qualitative approach. Additionally, I have explained the research design, the preference for purposive sampling as a sampling technique, and the use of in-depth interviews for data generation. Further, I have explained how I analysed the data and discussed the trustworthiness and the ethical considerations I made.

3.2: Philosophical Paradigm

Philosophical paradigms influence what should be examined and the interpretation of the results. Paradigms are thus important because they dictate and provide beliefs which, for scholars in a particular discipline, influence what should be studied, how it should be studied, and how the results of the study should be interpreted (Kivunja &Kuyini, 2017). With that understanding, this study is positioned in the relativist or interpretivist paradigm.

Kivunja and Kiyuni (2017) propose that the significant endeavour of this type of paradigm is to understand the subjective world of human experiences. The relativist paradigm uses exploration as a way of arriving at knowledge. This approach tries to get into the head of the subjects being studied and to understand and interpret what the subject is thinking or the meaning he or she is making of the context. It acknowledges that individuals actively construct their subjective representations. These representations originate from objective reality; thus, prior knowledge is linked to the newly discovered information. Under this paradigm, constructivists believe we do not have a single reality or truth but that reality needs to be interpreted —therefore, we have a high chance of getting multiple realities when using a qualitative approach. Additionally, qualitative research is essentially descriptive and inferential in character (Ong'ondo & Jwan, 2011; Patel, 2015).

The reason for choosing the relativist paradigm is that it allows for flexible approaches towards the search for knowledge. It believes that knowledge is contextual and makes an effort to 'get into the head of the subjects being studied' and to understand and interpret what the subjects are thinking or the meanings they are making of a particular context. Thus, the researcher utilises data gathered through interviews, discourses, text messages and reflective sessions (Kivunja, 2017).

In this study, it was helpful when understanding the experiences of the visually impaired.

3.3: Research Design

In this study, a research design is considered as the plan of the proposed research work. It is the arrangement of conditions for the collection and analysis of data in a way that aims to merge relevance to the research purpose and procedure. It is the glue that embraces all the research project elements together (Akhtar, 2016).

According to Yin (2003), research design enhances the trustworthiness of a study. The research design ensures that the evidence obtained enables a researcher to address the research problem effectively, logically and unambiguously. In social sciences research, getting information relevant to the research problem generally entails specifying the evidence required to accurately describe and assess meanings related to an observable phenomenon (Vogt, 2012; De Vaus, 2001; Gorard,2013; Leedy & Ormrod, 2013; Creswell, 2018).

This study adopted the phenomenological research design. Creswell (1998, 2013) speculates that, when a research problem necessitates what he describes as a “profound understanding of human experiences common to a group of people”, it is suitable to utilize the phenomenology method. Phenomenology is also identified as an educational research design (Creswell, 2013; Ponce, 2014; Marshall & Rossman, 2010).

Under phenomenological design, this study used the phenomenology method.

3.4: Research Approach

This study took the qualitative approach. A qualitative approach to research is the systematic inquiry into social phenomena in natural settings. These phenomena include but are not limited to how people experience aspects of their lives, how individuals and groups behave and how interactions shape relationships (Arianne, 2015).

I have used the qualitative approach because qualitative research records attitudes, behaviours and feelings. Information is provided in detail and depth and is more extensive than analysing ranks. It creates openness, thus encouraging the expansion of responses that could lead to new topics that were not considered initially. It revitalizes individual experiences from people and provides detailed pictures of why individuals’ actions are the way they are and how they feel about their actions. The approach attempts to avoid pre-judgments since it is not concerned with universalities. Researchers in this approach focus on the meaning of people’s life experiences and world structures. Researchers focus on process and meaning; pictures and words develop an understanding (Atieno, 2009;Ong’ondo&Jwan, 2011).

According to Siegle (2017), human behaviour is significantly influenced by the setting in which it occurs; thus, the qualitative approach is suitable because it enables one to study human behaviour under given situations.

In this study, this approach assisted in understanding and recording the visually impaired sample population's experiences, what they feel, and their behaviours, thus enabling a detailed picture to be constructed on why they are acting that way toward messages against alcohol abuse.

3.5 Research Method

This study used the phenomenology method. Phenomenological methods are particularly effective at bringing to the fore the experiences and perceptions of individuals from their perspectives and, therefore, challenging structural or normative assumptions (Lester, 1999).

Phenomenology aims to describe an experience that has been lived rather than explain or quantify it. Phenomenology is solely interested in studying the experience from the participant's perspective. It uses various methods, including interviews, conversations, participant observation, action research, focus meetings, and analysis of diaries and other personal texts. Predominantly, the methodology is designed to be less structured and more open-ended to encourage the participant to share details regarding their experience. In other words, phenomenology emphasizes subjectivity. Phenomenological research methods maximize the depth of the information collected; therefore, less structured interviews are the most effective (Giorgi, 2012; Padilla-Díaz, 2015; CIRT, 2017).

Under the phenomenology method, this study used transcendental or psychological phenomenology. This is because this criterion of phenomenology is critical when analysing the essences perceived via consciousness in connection with individual experiences (Padilla-Díaz, 2015). Furthermore, in transcendental phenomenology, the researcher seeks to obtain an unbiased description of the raw data in which the researcher exempts their personal bias (Patton, 2014).

According to Narayana Rao (2019), transcendent alphenomenology is focused less on the researcher's interpretations and more on a description of the participant's experiences. He further adds Clark Moustakas' (1994) theoretical underpinnings of phenomenology that emphasize Husserl's epoche (or bracketing) concept. Here, the investigator sets aside his experience as much as possible and has to take a fresh perspective on the phenomenon under examination based on the description of the lived experience presented by the participant in the research project. The term "transcendental" means "in which everything is perceived freshly, as if for the first time".

3.6: Study Population

According to the University of Pittsburgh (2022), vision impairment means that someone's eyesight cannot be corrected to a level considered as normal. Therefore, visual impairment is considered a significant issue of public health concern. There are rising cases of visual impairment and the World Health Organization estimates that approximately 1 billion people are visually impaired globally. It is categorized as sixth in the global disease burden of disability-adjusted life-years. Further, it is associated with increased mortality (McCarty, 2001; Chiang et al., 2006; Khanna et al., 2013; Bourne et al., 2017).

Kenya's population includes disabled people. However, PWDs vary according to their social, physical, mental and disability needs; hence, they are not homogeneous (Global Disability Rights, 2018).

According to the KNBS 2019 census, about 900,000 Kenyans, or 2.2% of the Kenyan population, live with a disability. Regarding gender, the report indicates that 1.9% of men have a disability compared with 2.5% of women. In an analysis of disability by domain, visual impairment was the second largest domain, with close to 0.35 million or close to 36% of the PWD respondents reporting disability in seeing. Furthermore, the highest prevalence rates of disability were recorded in central parts of Kenya.

Morriset al. (2020) analysed alcohol abuse among adult respondents in Kenya. Their findings showed that the prevalence stood at 12.2% in 2017. Nairobi county was leading in the prevalence of alcohol abuse at 17.5%. When it comes to the distribution of people with a disability by domain in Nairobi County, those with visual impairment take a significant percentage as Table 2.3 on page 37 shows.

However, the visually impaired, as PWD, disproportionately face conditions that may encourage illicit drug use; hence addiction and substance abuse are high when measured against the population without disabilities. The treatment gap between PWD needing treatment and those receiving treatment for alcohol addiction is enormous. The VIare two to four times more likely to struggle with substance abuse than the general population. Approximately 40-50 per cent of visually impaired people could be classified as heavy drinkers (American Addiction Center Resource, 2017; Moore& Li Li, 1998; Smith, 2021).

In Kenya, according to the NACADA website in Nairobi County, as of October 2023, there were 15 NACADA-accredited alcohol, drug or substance abuse rehabilitation centres.

PWDs, specifically those with visual impairment, are considered vulnerable groups. They are structurally discriminated against as members of a population and have traditionally been victims of violations and denial of cultural, economic, and social entitlements. Alcohol and illicit drug users are hidden, and find it difficult to locate and access information (Human Rights Centre, 2018; Morgan, 2008).

In this study, visually impaired people recovering from alcohol addiction were identified from institutions for the PWDs and rehabilitation centres catering to the PWDs in Nairobi.

3.6 Sampling Techniques

Sampling is the selection of a subset of the population of interest in a research study. The participation of an entire population of interest is not possible in the vast majority of research endeavours; hence a smaller sample group is relied upon for data collection. Furthermore, sampling from a small population is more reliable and cost-effective (Turner, 2020).

This study used non-probability sampling because this sampling type represents a valuable group of sampling techniques that can be used in qualitative research. Under non-probability, this study used purposive sampling. In general, phenomenological research samples are selected according to purposive sampling (Padilla-Díaz, 2015). Purposive sampling offers a valuable perspective on the examined phenomenon (Larkin & Thompson, 2012).

Purposive sampling incorporates specific criteria that the participants have met during the selection. This study applied extreme case (deviant case) purposive sampling. Deviant case derives samples from cases that are perceived as unusual or rare. It makes it possible to learn highly unusual manifestations (yet placed within a researcher's phenomenon of interest), notable failures, and crises or outstanding success. It reflects the purest form of insight into the studied phenomenon (Lund Research, 2012; Siegle, 2017).

The recommended number of participants for an appropriate sample size in phenomenological research is 5 to 25. This range of sample size makes it feasible to attain the desired saturation (Creswell, 1998).

When collecting data, I had attained saturation on the 20th participant. This was evident when, while interviewing, I noticed the same themes coming out from the data. Thus, enough data had been collected to draw the necessary conclusions. However, I chose to go out of my way to seek additional participants that stretch data diversity as far as possible to ensure that saturation is based on the broadest possible range of data, hence stopping at the 25th respondent. At that point, I became empirically confident that the data collected was rich. Any further data collection would not produce value-added insights in this study.

In this study, 25 visually impaired people were identified from institutions for the PWDs plus rehabilitation centres that cater to the PWDs in Nairobi. The nature of my study population dictated the sample size and sampling technique. PWDs, specifically those with visual impairment, are considered a vulnerable group. They are structurally discriminated against as members of a population and have traditionally been victims of violations and denial of cultural, economic, and social entitlements. Alcohol and illicit drug users are hidden, and difficult to locate (Human Rights Centre, 2018; Morgan, 2008).

3.7 Data Generation Techniques

The data generation technique used was in-depth interviews. Byrne (2012) states that in-depth interviews bring rich insights into people's opinions, feelings, emotions, and experiences told with their own words and language. In in-depth interviews, the objective is to obtain a highly detailed, rich understanding of the topic of interest. In in-depth interviews, the participant's experience, behaviour, feelings, and attitudes may be probed deeply to identify underlying concepts that the researcher analyses to generate a theory surrounding the research topic. (Crinson & Leontowitsch 2006; Morgan 2016). According to Scârneci-Domnișoru (2013), they generate qualitative data that is vivid, complex, rich in details, genuine, and not influenced by the researcher's intervention.

In-depth interviews are more structured as the topic discussed is directed by the researcher. In-depth interviews allow the participant to communicate much more freely and provide more detailed descriptions when compared to semi-structured interviews (Crinson & Leontowitsch 2006; Morgan 2016).

Moreover, Finlay (2014) affirms that in-depth interviews are suitable among the various data collecting methods available in the phenomenology method. The chosen sample size of participants for the interviews was 25, since the recommended number of participants in the phenomenological method ranges from 5 to 25 (Creswell, 1998).

In this study, 25 visually impaired participants were identified, and each respondent was interviewed individually on different days. The interview exercise lasted for approximately one month. A schedule was developed for face-to-face meetings. The interviewer notified each participant in advance of the interview time.

I introduced myself to the respondent in each interview and established a good rapport, thus putting the respondent at ease. As an in-depth interviewer, I tried to be interactive and sensitive to the language and concepts used by the interviewee while keeping the agenda flexible. During the exercise, I improved the quality of my in-depth interview experience by active listening, allowing the respondent to speak freely while guiding the conversation to cover important issues, and gently re-focusing the conversation if it wandered off track. I always kept in mind that in-depth interview questions are like invitations to share a story.

Generative questions were asked to motivate the participants to speak and to lead the respondent toward generating a story of interest. While playing the role of a facilitator during this period, I asked clarification questions and interest questions consequent to the main topics. In addition, I approached other emerging topics of interest as they surfaced. Finally, I ensured flexibility during the interview sessions by being open to slight deviations from the main topic that required rearranging or reordering the questions or coming up with new relevant questions. I took notes as well as audio-recorded each in-depth interview. Questions about unmentioned topics were asked after collecting relevant data.

While conducting the in-depth interview, participants were allowed to narrate their experiences. Greater freedom was given to the narrators to let them express themselves. There was considerable restraint of control on the participants by the researcher. Each interview took approximately 70 minutes. The sample group comprised 25 visually impaired individuals. Analysing each narrative interview took approximately 72 hours. A period of approximately ten months was needed to complete the exercise.

When conducting in-depth interviews, there were instances where the respondents were uncomfortable using the English language. In that case, I considered using Swahili and Sheng during the interviews. Beck(2015) defines Sheng as Swahili and English-based cant, perhaps a mixed language originating among the urban youth of Nairobi.

I followed Shi's (2011) guide, which states that when respondents could not articulate their feelings and thoughts regarding the experience being investigated due to language barriers, a researcher should ask the participants what language they felt comfortable with — for instance, if they are more comfortable being interviewed in their first language rather than their second language.

Credibility was established by reviewing key concepts, providing evidence, and member checking for trustworthiness. Transferability was established by illustrating how this study's findings can be applied in various similar contexts, circumstances, and situations. Dependability was established by ensuring sufficient detail and clarity was provided to explain the conceptualization and execution of this study to any other researcher.

There was confirmability by putting all biases in the open since, in a qualitative approach, one cannot extricate oneself from the study. Other researchers and readers will get to know the extent to which this study was free from external and internal influences.

For ethical concerns, there was honesty through adherence to integrity to avoid unintentional errors and data falsification that may weaken or invalidate the findings. There was informed consent by ensuring that the purpose and methods intended for use in this study, as well as the risks likely to be encountered, were well understood by the participants. Each participant was empowered to make a free choice devoid of forceful intervention, deceit, duress, fraud, or any other type of coercion.

Privacy was respected and individuals were able to control the distribution of personal information. In addition, participants were protected from harm that could be caused by humiliation (personal embarrassment) and psychological stress or any other adverse effects.

To ensure integrity, research permits from relevant authorities were sought from Kenya’s National Commission for Science, Technology, and Innovation (NACOSTI) after submitting appropriate documentation on the research protocols and the strategies put in place to ensure ethical conduct of the study. Additionally, a research permit was obtained from the Department of Education, Social Services and Gender in Nairobi City County.

3.7.1 Pilot Study

The pilot study is the final preparation for data collection (Yin, 2003). A pilot study is necessary because, among other reasons, it helps to develop and test the adequacy of research instruments. Furthermore, it helps to assess the feasibility of the full-scale study, the likely success of the selection approaches, and to establish whether the sampling frame is effective. It also provides opportunity to assess the data analysis techniques to uncover potential problems as well as identifying logistical issues that may occur using the proposed methods and determining the estimated costs needed for the study. In addition, pilot studies can reveal potential problems (for example, arising from local politics) affecting the research process (Edwin, 2001).

I obtained my research permit from NACOSTI on March 23rd, 2020,and proceeded with the piloting exercise. I involved two visually impaired respondents involved in an alcohol detox and rehabilitation programme. The two were from Thika town (Kiambu County).

The choice of Thika town was guided by the fact that Thika is considered one of the Kiambu County Regions that fall in the Nairobi Metropolitan Area. Kiambu County is adjacent to the northern border of Nairobi County.

To start with, I created a rapport. Then, over two months, from June to July 2020, I built a relationship with the respondents built on mutual interest, support, and understanding. Developing rapport motivated the respondents to make accurate statements and complete the interview freely.

Data was generated through in-depth interviews. Four steps were involved in conducting the interviews. First, I developed a sampling strategy — in this case, purposive sampling. As a researcher, I leveraged respondents who could be identified and approached with as little effort as possible and at a minimum cost in terms of resources yet deliver reliable data for analysis. Secondly, I developed an in-depth interview guide and conducted the interviews before analysing the data generated.

Each respondent was interviewed separately on different dates. I conducted intensive interviews with the two respondents to explore their feelings or beliefs about messages against alcohol abuse in Kenya. I aimed to gain rich insights from their opinions, feelings, emotions, and experiences told in their own words and language. I noted positive reactions because the respondents were empathetic, provided information and compliments, and were sometimes humorous. However, they also shared negative views on the topic of discussion and, in other cases, appeared to share too much personal information.

The participants were allowed to narrate their experiences and express themselves freely. Each interview took approximately 3 hours. Data generated from the interviews was recorded, transcribed, and analysed thematically.

Transcription was done in three stages. First, I read the transcripts to familiarize myself with the data and then coded them to identify emerging themes based on the research questions. Secondly, I regrouped sections as per the themes identified. Thirdly, I merged some themes to develop the main issues for the study and the emerging issues from the literature review. It took me approximately one month to analyse my findings and the gaps identified by the piloting exercise.

The pilot study was successful because I learned critical lessons, and I made the following decisions to improve my study:

a) To reduce my interview time frame from three hours to 70 minutes. This was possible by focusing on the main questions that reduced the chances of the respondents giving too much personal information, which was detrimental and irrelevant to the study. Therefore, I reduced the questions from twenty to six.

b) That being the case, I revised the interview guidelines to fit the shorter time, which would enhance the focus on the main interview questions as well as the proper utilization of resources. It also made it possible to get appropriate responses from the sample group because the time was well within their concentration span.

c) To achieve maximum involvement, it was essential to conduct the in-depth interview in more of a conversational session than a strict interview session.

d) I needed to buy a modern voice recording device with a noise-cancelling ability, a low charging time and a higher-powered retention ability. I also needed to upgrade the memory card to continuously record interviews from a larger group of respondents without deleting the data.

e) In terms of transcribing, I realized that it was much more reliable and cost-effective to procure real-time transcription software that could also assist in categorizing the transcripts into themes. Thus, I bought NVivo (Release 1.0), the latest software version at that time. NVivo is computer software for qualitative data analysis developed by QSR International.

f) The data generation phase came at a point when Kenya was experiencing a surge in COVID-19 infections bearing in mind that on 13 March 2020 the first case of COVID-19 was confirmed in Kenya. At that time, Nairobi was the epicentre of the epidemic, and government control measures such as school closures, mandatory quarantines, countrywide night curfew, closure of non-essential businesses, suspension of international flights, and partial lockdowns were in place. Such conditions made it even more complicated to reach the respondents. Nonetheless, the COVID protocol was observed in every meeting during the interviews.

3.8: Data Analysis

Transcription: The first step was to transcribe the recorded interviews. The data format was in the form of audio files, and all the 25 recorded interviews were transcribed using NVivo (Release 1.0), at that time the latest version of the software. NVivo is computer software for qualitative data analysis developed by QSR International, an Australian-based qualitative research software development organization. It is used across varied fields such as psychology, health, forensics, sociology, communication and other social sciences (McNiff, 2017).

I uploaded the audio formats of the recorded interviews in NVivo and conducted the automated and verbatim transcription. NVivo's intuitive editor allowed me to make changes whenever necessary, tag the speakers, annotate and format the transcripts. Additionally, paralinguistic features like voice tones and pauses were transcribed to extract findings from the content and its rhetorical form. Even though the software was expensive, it was cost-effective in terms of time saved.

Familiarizing with the data: After transcribing the data, I read through it in its entirety (data corpus) to code and search for meanings and patterns. Finally, I read through all the data to reflect on the content and compare the transcriptions with the recorded interviews to further edit.

Generating initial codes: Gibbs (2007) describes coding as a way of categorizing or indexing texts to develop a framework of thematic ideas. In this study, comments obtained were rearranged to answer each interview protocol question. For each question, the main ideas in the responses were noted. Main ideas were reviewed to identify repeated statements and fundamental ideas that occur in answers to multiple questions. In this study, I used data-driven coding; in this case, I looked for ideas and concepts in the text without preceding conceptualization. I initially read through the data and indicated the noticeable patterns or themes. I also identified several passages or brief remarks with similar codes or expressed a shared concept. Meanings of the codes were documented in a separate file, and short descriptions noting the meaning of each code were made.

During the coding stage, all themes from the document of the combined participant's themes were divided into a selected number that comprised the final presentation. This stage involved winnowing the data and reducing it to a small, manageable set of themes to write into the final narrative. Winnowing is essential since it helps to eliminate irrelevant and redundant data, improving the results' accuracy. Later on, themes were created.

Generation of themes: This stage was conducted in three steps. First was searching for themes, the second was reviewing themes, third was defining and naming themes. In searching for themes, the target was to collect themes and sub-themes. I had prepared a long list of codes and focused on broader levels of themes. I later sorted the various codes into possible themes. The themes generated resulted from the subset of the codes; thus, some codes were used to create main themes and sub-themes. Other codes were kept as outliers, whereas others were discarded.

Themes were identified from main recurring ideas. Non-verbal cues and quotations that illustrate each theme were identified and explained. The second stage of reviewing the themes mainly involved refining. Some were merged, whereas others were used as sub-themes and sub-sub themes. I re-read my data extracts (coded data) to ensure that the data formed a coherent pattern. Afterwards, I reviewed the level of the themes and considered each theme with my entire data (data corpus). While arranging the themes, I ensured that the relationship between the themes reflected the meanings of my data as a whole. In the third stage, I defined and named the themes. I captured the essence of each theme and the aspect of data it captures. I created an overall narrative with all my data and analysed each theme with its individual narrative. I identified the sub-themes and sub-sub themes and named them using working titles.

Producing the report: I focused on my final analysis and write-up report at this stage. Braun and Clarke (2006) insist that the thematic analysis write-up should be logical, concise, coherent, non-repetitive and offer an interesting data account across the themes. The findings were written in an engaging narrative to describe the themes, quotations, and descriptions. I used direct quotes from the participants. Braun and Clarke (2006) and King (2004) state that quotes and extracts from raw data need to be inserted within the analytic narrative to illustrate the story and emphasise specific points. I referred to the literature review while explaining the findings, how and why themes are similar or different from others and compared related studies. Aronson (1994) states that when a researcher interweaves literature with the findings, the story constructed stands with merit.

In the report, symbols were used to indicate respondents. For instance, R2 represents the quotes for respondent number two during the second interview.

3.9: Trustworthiness in the study

Shenton (2004) reckons that positivists regularly question the trustworthiness of qualitative research. She adds that it happens possibly because the concepts of validity and reliability are not addressed in the same way in naturalistic work. However, research methods from various qualitative researchers have demonstrated ways in which qualitative research can incorporate measures that deal with these issues and investigators. For instance, Lincoln and Guba (1985) relied on four general criteria in their approach to trustworthiness. These are credibility, transferability, dependability, and confirmability. Guba's constructs correspond to the measures employed by the positivist investigator in which credibility is used in preference to internal validity, transferability is used in preference to external validity or generalisability, dependability is used in preference to reliability, and confirmability in preference to objectivity. Furthermore, Ong'ondo and Jwan (2011:137-142) posit that in qualitative research, trustworthiness ensures that the process is truthful, careful and rigorous enough to make claims.

Considering that my respondents were laden with a double tragedy of vision impairment and alcohol abuse, I ensured the following so as not hamper me as a phenomenological researcher:

3.9.1 Credibility

Credibility implies the confidence level of the qualitative researcher in the truth of the research study's findings, which is achieved through triangulation (Statistics Solution, 2022). Denzin (2006) highlighted four basic types of triangulation: i) data triangulation, which involves time, space, and persons; ii) investigator triangulation which involves multiple researchers in an investigation; iii) theory triangulation, which involves using more than one theoretical scheme in the interpretation of the phenomenon; and iv)methodological triangulation, which encompasses using more than one method to gather data, such as interviews, observations, questionnaires, and documents.

I used investigator triangulation in this study by involving two PhD research students from the University of Nairobi, ensuring member checking. Additionally, I confirmed credibility by reviewing key concepts and providing evidence. I also ensured credibility through theory triangulation by using two theories, the Health Belief Model and the Transtheoretical Model, in interpreting the phenomenon that was identified when analysing data.

3.9.2 Transferability

Transferability refers to the degree to which the results of qualitative research can be transferred or generalized to other similar settings or contexts. A researcher can boost transferability by describing the research context in detail and clarifying the assumptions central to the research (William, 2022).

In this study, I ensured transferability by describing the research context and assumptions incorporated, plus illustrating how this study's outcomes can be applied in similar contexts, circumstances, and situations.

3.9.3 Dependability

William (2022) states that dependability is based on the assumption of repeatability or replicability. A qualitative researcher can use an inquiry audit to achieve dependability. In addition, one can involve an outside person to examine and review the research process and the data analysis to certify that the findings are consistent and can be repeated (Statistics Solution, 2022).

I ensured dependability by clarifying my findings, hence elaborately exposing this study's conceptualization and execution. I did this to give the reader or any other researcher a complete understanding of my study and the confidence to depend on it to conduct similar studies.

3.9.4 Confirmability

Confirmability can be described as the degree of neutrality in the research study's findings (Statistics Solution, 2022) and, thus, the degree to which the results could be confirmed or corroborated by others (William, 2022).

In this study, I was open to my biases to enhance confirmability since, in a qualitative approach, one cannot extricate oneself from the study. Thus, other researchers and readers will know the extent to which this study is free from external and internal influences.

3.10: Limitations of the Study

Having conducted this study, I must acknowledge that a few issues may be considered limitations of the study, which I explain below.

The difficulty of selecting my research respondents was a potential limitation in this study. PWDs, specifically those with visual impairment, are considered vulnerable groups. They are structurally discriminated against as members of a population and have traditionally been victims of violations and denial of cultural, economic, and social entitlements (Human Rights Centre, 2018); hence, the visually impaired with alcohol addiction are not easily accessible.

Faced with this situation, I used the extreme (deviant) purposive sampling technique. Deviant case derives samples from cases that are perceived as unusual or rare. It makes it possible to learn highly unusual manifestations yet placed within a researcher's phenomenon of interest, notable failures and crises or outstanding success. It is thought to reflect the purest form of insight into the phenomenon being studied (Lund Research, 2012; Siegle, 2017).

However, Varnica (2017) reckons that purposive samples can be highly prone to researcher bias since they are primarily created based on the researcher's judgement, regardless of the type of purposive sampling used. Purposive sampling reflects a group of sampling techniques that rely on the researcher's judgement when selecting the units. For that reason, it may also be known as judgmental, selective or subjective sampling (Varnica Nigam, 2017).

On this matter, William (2022) notes that a researcher can overcome bias by documenting the procedures for checking and rechecking the data all over the study, or engage other researchers who will take a "devil's advocate" role regarding the results, which can be documented. For example, the invited researchers may actively search for and describe negative instances that contradict prior observations. Alternatively, a researcher may conduct a data audit examining the data collection and analysis procedures and judge the potential for bias or distortion. Varnica (2017) adds that this judgmental subjective component of purpose sampling is only a key shortcoming when such judgements are ill-conceived or poorly considered. It occurs when judgements have not been based on clear criteria, whether expert elicitation, a theoretical framework, or accepted criteria.

To alleviate possible researcher biases, I ensured there was confirmability. Confirmability can be described as the degree of neutrality in the research study's findings (Statistics Solution, 2022) and, thus, the degree to which the results can be confirmed or corroborated by others (William, 2022).

I appreciated that, in a qualitative approach, one cannot extricate oneself from the study. Hence, I documented the procedures for checking and rechecking the data throughout the study. I had the assistance of my supervisors, who acted in the "devil's advocate" role with respect to my results. They actively described the negative instances that contradicted prior observations. I also conducted a data audit to examine data collection and analysis procedures and make judgements about the potential for bias or distortion. Furthermore, I illustrated clear criteria for how my theoretical framework would help me analyse my data.

I also made use of expert elicitation. In this case, I engaged the services of other peer reviewers both in Kenya and outside. They reviewed and offered their recommendations for incorporation. As a result, based on each research question, I had three journal papers revised and published in different reputable peer-reviewed journals. The published research journal papers are titled *Communication Dynamics in Campaigning Against Alcohol Abuse among the Visually Impaired in Kenya* published in the Journal for Africa Interdisciplinary Studies (Kenya); *Audience Reception of Alcohol Abuse Messages Among the Visually Impaired in Kenya* published in the European Journal of Special Education Research (Europe)*;* and *Audience Reception of Alcohol Abuse Messages Among the Visually Impaired in Kenya* published in the Journal of Drug Abuse (United Kingdom).

To this extent, I believe I made other researchers and readers aware of the extent to which this study is free from external and internal influences.

3.11 Ethical Issues

The ethical dimension of a research study must be considered when generating data from human participants. It is essential to pay attention to ethics in qualitative research to ensure there is no coercion, respect for truth and persons, and strike a balance between the demands placed on researchers as professionals and the rights and values of their participants. Additionally, paying attention to ethics is critical as researchers must maintain good manners since they invade participants' privacy (Ong’ondo&Jwan, 2011).

In this study, there was honesty through adherence to integrity to avoid unintentional errors and data falsification that may weaken or invalidate the findings. There was informed consent by ensuring that the participants fully understand the study's demands, its purpose, the methods intended to be used and any risks likely to be encountered. Finally, there was voluntary consent by ensuring that each participant was empowered to make a free choice devoid of forceful intervention, deceit, duress, fraud, or other coercion types.

I ensured respect for privacy by respecting the right of an individual to control the distribution of personal information and minimally invading participants' privacy. Furthermore, there was the protection of the participants from harm that could be caused by humiliation (personal embarrassment) and psychological stress or any other influences likely to cause, in a significant way, adverse effects.

To ensure integrity, a research license was obtained from Kenya’s National Commission for Science, Technology and Innovation(NACOSTI) after submitting relevant documentation on the research protocols and the strategies put in place to ensure the ethical conduct of the study.

Additionally, a research permit was obtained from the Department of Education, Social Services and Gender in Nairobi City County.

3.12 Chapter Summary

In this chapter, I have highlighted the philosophical paradigm that guided my study. I have also discussed how I sampled the participants and generated and analysed the data. I have also shown how I ensured trustworthiness in my study and how I observed ethical considerations.

The key issues arising from this chapter are summarized as follows: first, this study is positioned in the relativist or interpretivist paradigm. The significant endeavour of this type of paradigm is to understand the subjective world of human experiences. Second, this study adopted a qualitative approach. The approach revitalizes individual experiences of people and provides detailed pictures of why individuals' actions are the way they are and how they feel about their actions and avoids pre-judgments since it is not concerned with universalities. Third, through purposive sampling, twenty-five (25) visually impaired people were identified from institutions for the PWDs and rehabilitation centres catering to the PWDs in Nairobi. Purposive sampling was preferred because, as people with disabilities, the visually impaired people are considered a vulnerable group. Furthermore, alcohol and illicit drug users are hidden and difficult to locate. Fourth, during the study, I ensured that ethical issues such as informed consent, confidentiality, privacy and anonymity were considered. Forth, for trustworthiness in the study, I ensured credibility through data triangulation, transferability by describing the research context, dependability by clarifying my findings, and confirmability by being open about all my biases. Lastly, data produced from the interviews was recorded, transcribed, then analysed thematically, and presented in narrative form per the themes.

In the following three chapters (Chapters Four, Five and Six), I present my findings based on the research questions.

CHAPTER FOUR

CHALLENGES IN ACCESSING COMMUNICATION MESSAGES AGAINST ALCOHOL ABUSE AMONG THE VISUALLY IMPAIRED IN NAIROBI COUNTY

4.1: Overview

In this chapter, I will present the study findings related to the first research question — How do visually impaired people in Nairobi access communication messages against alcohol abuse? - under the theme of challenges in accessing communication messages against alcohol abuse among the visually impaired. Data was acquired through in-depth interviewing. It was informed by the literature review, theoretical considerations and phenomenology method as the research method used in this study. The verbal quotes used are those that I considered relevant and concise.

Findings revealed that some key challenges were inadequately trained healthcare professionals, inappropriate communication media, expensive equipment and inadequate assistive technologies, inaccessible venues and information sources and socio-cultural dynamics. This chapter discusses the findings.

4.2 Inadequately trained healthcare professionals

Participants revealed that they faced communication barriers with healthcare professionals when accessing communication messages against alcohol abuse and medication-related information. Furthermore, the participants indicated that it was necessary to have the messages in a format accessible to them, such as in audio, Braille translation, large print and screen readers. They also noted that the healthcare staff did not know how to communicate in their preferred format, and others never knew that the visually impaired required an alternative communication format.

Challenges faced included difficulties interacting with caregivers and other officers within the health facilities and rehabilitation centres. Almost no healthcare professionals within the area of study were able to use Braille or present healthcare messages via Braille. Additionally, there were scarce messages against alcohol abuse available in large print and on audiotape within the health facilities and rehabilitation centres, limiting access of the visually impaired to messages that improve alcohol addiction management. Additionally, participants indicated that while communicating about alcohol abuse, professionals and caregivers inappropriately focused on their disability rather than the health matters. They felt that the healthcare workers perceived them as unable to properly manage their health and medication independently unless with the assistance of a closely related person. As a result, they felt that their desires and potential to control life decisions were underestimated.

> 08:11: We have healthcare workers who are supposed to offer their services to all, but they only know how to serve well those without disabilities. Mostly, I think those people (the healthcare workers) should have at least some knowledge on special needs education, so that they know how to handle this person with visual impairment…We need somebody who, maybe, has some full knowledge of special needs, education. Or at least some knowledge (April 2021, R5).

Respondent R5 explains that healthcare workers cannot offer good healthcare services to visually impaired patients because they lack the skills to handle them. The respondent further adds that the visually impaired feel that the healthcare workers perceive them as unable to properly manage their health and medication independently unless with the assistance of a closely related person.

4.3: Inaccessible formats for self-treatment methods

Study findings also show that the information and messages on dosage in the medicines given to the visually impaired were not tailored for their disability. For example, very few had touchable differentiated packaging and tactile markings, making it challenging to self-medicate. Besides that, communication techniques are not individualized to obtain reliable primary care and basic preventive messages on alcohol abuse. As a result, as illustrated by respondents 19 and 14 in their statements below, most of the visually impaired with alcohol addiction found it challenging to access medication that could assist in overcoming their addiction:

> Personally, I get confused with the type of medicine to take because they are not marked and I cannot see. That is a challenge because I am forced to somehow improvise ways of managing (April 2019, R19).
>
> Some of them that have been taken to rehab …. have ended up dying because of stress. They come back and they don't switch off from Alcohol. Caregivers do not understand us so it [rehab] is not that helpful to them. It is not easy to take medicine. It's only one or two people that I've seen that have changed after rehabilitation (April 2021, R14).

The respondents noted that most caregivers did not have specialized training, adequate education, or knowledge of the visually disabled and their precise communication needs. In addition, most caregivers lacked the knowledge and skill of Braille language interpretation. For instance, respondents 5 and 27 expressed the need to have adequately trained caregivers and healthcare professionals who sufficiently understand their communication needs, especially alcohol rehabilitation programmes.

> Mostly, I think those people should have at least some knowledge on special needs education at least, so that they know how to handle this person with visual impairment, because sometimes giving a person who has actually general psychological awareness or maybe education may not fit a totally blind person or a visually impaired person. We need somebody who maybe has some full knowledge of special needs education. At least (April 2021, R5).

> 10:05: We are faced with lack of trained healthcare workers and facilities we can easily access. They (healthcare centres) should make alcohol addiction treatment information in formats available to the visually impaired …they should also increase the number of trained counsellors since I believe most of the visually impaired get back to alcoholism due to discrimination from the society and feeling left out in the society (April 2021, R 27).

The participants noted that messages are primarily available through visual media: newspapers, posters, flyers, bulletins, brochures, and magazines were not accessible to the visually impaired because of the size of the texts used. Low-vision individuals have to use a high-powered magnifying glass to access the messages conveyed through the print media. However, this would only benefit the low-vision individuals and cut out their blind counterparts. The low-vision individuals felt they preferred messages shared in large print and increased contrast. If they were available in soft-copy, larger monitors with screen-magnification programmes would be helpful. Another disadvantage of visual media was that such platforms never delivered the audio bit of the message, thus preventing the visually impaired from being able to access the message.

Respondent 4 illustrates that she is a low-vision individual and prefers messages in large texts, with increased contrast, larger monitors and accompanying audio to enhance access to messages.

> We all know that print media is one of the most used platforms when sending messages against alcohol abuse in Kenya. But newspapers, magazines and posters have small font sizes. I always have to use screen-magnification devices. There are no newspapers in Braille you know. They also do not come with audio assistance. I wonder how those who are totally blind can access the messages. It is a big challenge for us (April 2021, R 4)

4.4 Expensive equipment and Inadequate Assistive Technologies

Study participants reported facing the challenge of expensive equipment and inadequate assistive technologies while accessing communication messages against alcohol abuse. The cost of acquiring essential communication equipment for the visually impaired, such as Braille writers and materials, is very high. They also face shortages of equipment such as Braille-print embosser, CCTV, and telescopes for the VI. One informant said:

> I have heard of alcohol addiction prevention workshops and even sensitization seminars. They are an important source of information, and most of those attending usually take notes and participate. However, for us who are visually impaired, if I need to attend, participate and take notes, it comes with a huge cost. It is a challenge for us…But compared to the lifestyle of a normal person and a disability person, those are two different worlds. I always call them two different worlds, because for you (without disability), having a pen and a book will cost only like 150 shillings, sometimes it is freely given in the workshops, but for me, I need to buy a Brailler to help me take notes. I'll have to have eighty thousand and to buy fresh papers I need to have like five thousand. So that is expensive to me. Such a huge cost makes it difficult for me to attend and participate in such forums for getting information (April 2021, R27).

Respondents stated that they encounter challenges in accessing communication messages in cyberspace despite the progress made in ICT in Kenya. They are faced with this barrier because information materials are not readily available to the visually impaired, thanks to the inherent unfriendly nature of web-based content. Some of the obstacles faced when using technology to access online information comprise messages in inaccessible formats, unclear images, complex images, inadequately described videos, and videos presented without audio or text. In addition, readable online material is scarcely available in formats that suit the visually impaired. Besides the existence of communication-aiding software such as Talkback software, Non-visual Desktop Access (NVDA), and Siri, they are expensive to obtain. These challenges mean that the visually impaired face restrictions on what health education materials are available and accessible to them. R4 and R11 mentioned the scarcity of communication-aiding software that is also expensive to obtain:

> .…for instance, the Foundation of Hope Rehab and treatment centre in Nairobi which is approved by NHIF, NACADA and KMPDU. They claim to offer world-class treatment and support services for families and people suffering from alcohol addiction, but when you want to get more information on their website,

> you will realize that it is not accessible to the visually impaired. Sometimes when they communicate with written materials, you will find that the VIs don't benefit a lot because they cannot read those materials. There are scarce communication materials…mostly, they will tend to go for these people who are sighted [rather] than the VI (April 2021, R4).

> It is true that messages on alcohol addiction treatment are easily available online. But they are not accessible to us. To help myself, I use alternatives. Well, I follow most of this information…on WhatsApp messaging platform with aid of a software. The aiding softwares…like Siri… are limited to specific expensive phones (April 2021, R11).

Respondent 11 explained the scarcity of communication-aiding software such as Siri and that it is expensive to obtain.

In addition, respondents revealed that few visually-impaired people could afford the modern electronic Braille note takers. These modern Braillers are small, easily portable and store information via typewriter keyboards. Besides that, they are reliable because the user can retrieve the stored messages via a built-in speech synthesizer and a Braille display. However, they are expensive and hardly ever available on the market. For that reason, many visually impaired people resort to using the mechanical Braille typewriter, which is weighty, large in size, and generates a lot of noise.

Moreover, it produces bulky Braille books because of the minimum size requirement per Braille cell. Furthermore, the visually impaired have to overcome the challenge of carrying the bulky Braille books to take notes in the workshops. Faced with such challenges, the visually impaired often feel discouraged from attending and participating in *alcohol and substance abuse workshops and seminars. Respondent 27 said:*

> Even when I am invited to the seminars, I find it difficult to participate not only due to mobility challenges but also use of the Braille I have…for example, the Brailler, I can't go carrying whenever I go because it's like a big radio. I'll call it a radio because it makes noise when typing. This ordinary Braille machine is heavy and for you to take notes, you also need fresh Braille papers and Braille books which are bulky. So yes, that's what creates an impediment… So, it is

> discouraging when you feel others are writing yet you can't, since you don't have your materials to write as well (April 2021, R27).

Additionally, Respondent 27said:

> So that is what discouraged me, especially in that seminar, because, yes, for example, all youths when they are going for seminars, they carry books. But for a visually impaired who has learnt to Braille will carry a Brailler to the seminar and a fresh paper. (April 2021, R27).

Again, when accessing information sources, the interviewees stated that the formats used to convey messages were unfavourable. The visually impaired also use social media as one of the platforms to access information. Nevertheless, messages passed through social media platforms like YouTube, Facebook, and Twitter are ineffective. They are only accessible with the aid of screen readers as assistive technology. Screen readers read aloud the contents on the screen using synthetic speech. For instance, Window Eyes and JAWS for Windows and Voice-over for Mac computers are available as screen reading software.

Respondent 14 highlighted the challenges faced by the visually impaired when accessing information through social media platforms.

> I am shaping my life towards looking into a healthy future and not dwelling on alcohol. I access information through different media personalities, social media platforms, and groups advising against it on social media. But I think that messages passed through social media platforms like YouTube, Facebook, and Twitter are challenging to access without the help of screen readers as assistive technology like Window Eyes and JAWS for Windows and Voice Over for Mac computers are available to screen reading software (April 2021, R 14).

4.5 Challenges in accessing meeting venues

Respondents mentioned that local community halls used for drug and alcohol prevention campaigns — for instance, the Shauri Moyo YMCA and the Kibera Soweto East Resource Centre, among others — were inaccessible because they did not have ramps, had non-functional or non-existent elevators and were mostly overcrowded during the events. Furthermore, there were no audio descriptions to give direction services, and they were located in distant places. The respondents had similar experiences when visiting some rehabilitation centres and clinics that offered specialized care.

These challenges have hindered them from obtaining reliable primary care and essential preventive messages on alcohol abuse.

Respondent 9 highlighted the challenge encountered when attending the initiatives organized by the local authorities and conducted within a local public social hall:

> I just heard that he [the area chief] called the meeting and talked to people about this thing to do with Alcohol. So, you see, most of us are disadvantaged because we can't access the places that those people are being called at. So, they just talk to the other people. We are sort of left out (April 2021, R9).

4.6 Socio-cultural dynamics

Socio-cultural dynamics, such as gendered socialization, affected the perceived need for information on alcohol. Both male and female respondents thought alcohol addiction was more rampant among the male visually impaired than their female counterparts.

Men often felt that it would portray a sign of weakness and unmanliness. Furthermore, men believed they needed to be stoical, invulnerable, free-spirited, and self-sufficient. Consequently, the alcohol-addicted were reluctant to come forward and felt disgraced, sometimes combative when asked to seek medical assistance for the addiction. On the other hand, women dependent on alcohol felt they were not playing the expected role of a woman. Other respondents thought that the messages against alcohol should be tailored to suit the male visually impaired. Therefore, they needed more support on the issue of alcohol addiction compared to females.

> Alcohol addiction…mostly it affects the men, not the ladies. Messages should go to them (the males) …Oh yeah. In fact, I've never heard of a lady taking alcohol who is visually impaired. Most of them are engaged in church activities, such things. You never know whether it's keeping you from stress or is what they want. Yes, that is for the ladies now (April 2021, R14).
>
> For us (male), we feel that when we drink too much alcohol, it is a sign of wealth, independence, strength and entertainment…African man must survive…hospital is for the weak (April 2021, R5).

4.7 Discussions

This study confirms that healthcare professionals are inadequately trained to communicate with the visually impaired. This was illustrated when the communication techniques used by the healthcare professionals and caregivers were not individualized to suit the needs of the visually impaired. In addition, most professionals did not have specialized training on handling the visually disabled and their precise communication needs, and they lacked the knowledge and skill of Braille language interpretation.

These findings accord with Amie Reilly (2017), who states that healthcare staff may be unaware of the barriers people with visual impairment face in accessing primary care services. This perception inhibits the need to act and make positive changes to improve accessibility.

Furthermore, Cupples (2012) states that people with visual impairment are likely to have limited access to information and healthcare facilities and receive sub-optimal treatment because staff are unaware of specific needs related to vision. Therefore, she recommends that communicating effectively about access, facilities, diagnosis, and management plans is necessary and that communications should be tailored to individuals' needs in visual or audio format.

The visually impaired with alcohol addiction do not fit into a single, specialized service delivery system. Healthcare workers and counsellors are usually unfamiliar with visual impairments and lack the skills and knowledge to provide reliable services. Likewise, strong evidence exists that assigning counsellors with little or no substance abuse training or experience to serve consumers with substance abuse disorders may deny them services because of misconceptions about the disorders and ignorance of their impact on consumer perceptions and behaviour (Koch et al., 2002). Consequently, lack of cross-training and formal education about each disability and the effects of coexisting disabilities results in consumers failing to benefit from interaction with either system. Professionals who are unprepared to deal with substance abuse fail to assess and intervene with alcohol abuse disorders (Koch et al., 2002).

Doweiko (2002) states that although alcohol abuse may be the most common disease in patients seeking medical treatment, medical doctors are often unaware of alcohol abuse disorders. Amodeo (2000) also found that social workers who lacked specific training in substance abuse issues were less likely to assess and intervene with substance abuse. Harley, Greer, and Hackerman (1997) and West and Miller (1999) reported a dearth of rehabilitation professionals with the training to respond to alcohol abuse as a coexisting disability and noted that rehabilitation counsellors who are unprepared to serve the population are themselves barriers to adequate services for this population.

Persons with disabilities go through significant barriers to accessing healthcare. Among others, the barriers include lack of communication and accommodation in healthcare settings, untrained personnel, negative attitudes from healthcare providers, and physically inaccessible medical clinics and hospitals (United Nations, 2020).

SAMHSA (2011) states that barriers to substance use disorder treatment for the visually impaired are alarming. They include stigma and negative attitudes from healthcare providers, lack of staff training, materials, and methods that are not accessible. For example, the few available facilities that provide treatment for substance disorders believe that they are accessible to the disabled because they offer ramps. That implies that VI needs are not included — yet the visually impaired require Braille signs, other navigational features, and alternatives to access counselling treatment activities. Ramps are of little benefit to the VI.

The new dimension that this study adds to what these scholars have said is that the visually impaired felt that the healthcare workers perceived them as unable to properly manage their health and medication independently without the assistance of a closely related person. As a result, the respondents felt that their desires and potential to control life decisions were underestimated.

Therefore, healthcare centres should provide communication access plans for visually impaired patients (Centers for Medicare & Medicaid Services, 2021).

Findings indicate inappropriate communication media available for the visually impaired. For instance, very few medication documents had touchable differentiated packaging and tactile markings, making it challenging to self-medicate and forcing the visually impaired to improvise alternatives.

Many drug and alcohol treatments and prevention services are available through visual media: newspapers, posters, flyers, and magazines. Thus, they are not easily accessible to individuals with visual disabilities (Amos Sales, 2000:6).

According to Blind Citizens of Australia (2018), a small fraction of alternative formats bearing information targeting print disabilities are available to visually impaired people. Medical material and other reference content is hardly ever obtainable in alternative formats. Very little focus is paid to ensuring that information concerning pharmaceuticals is delivered in formats accessible to the visually impaired. Most medications are packaged in labels that commonly favour individuals having good visual acuity.

Lishner et al. (1996) note that disabled people may rely heavily on alternative models of care due to the absence of specialized expertise, facilities, and primary care providers explicitly trained to care for them.

PWDs are willing to participate in precision medicine research. However, they still encounter barriers to achieving their participation. The barriers to disability inclusion need to be removed. The visually impaired are disproportionately affected by the barriers (Sabatello et al., 2019).

Sabatello et al. (2019) further add that including the blind in research dealing with precision medicine is important to enable them to attain social justice, enhance their knowledge of population health, and increase their diversity. Therefore, healthcare providers should provide suitable accommodation with good access for all persons with disabilities, including those with vision loss, to ensure full participation (Withers & Speight, 2017; Sabatello et al., 2019).

In Kenya, 20% of PWDs suggest the need for strategies to accommodate persons with various forms of disabilities in broadcasting information (NACADA, 2014). In addition, Withers and Speight (2017) suggest that each individual with a disability presents different and unique needs. The preferable communication aids and services used in healthcare settings for the visually impaired include qualified readers, audio recordings, Braille materials, high contrast, Braille signage and displays, large print materials, magnifiers and video magnification systems, accessible electronic information and assistive listening aids. Notably, the patient is the best source to identify the most effective supplementary aids and services to facilitate communication and participation.

The visually impaired have the right to participate in all aspects of society, yet visual impairment is associated with important limitations in functioning. Activities-and-participation categories that are limited or restricted for the visually impaired are, for instance, communicating with written messages, receiving written messages, writing messages, watching, reading, communicating with nonverbal messages and receiving nonverbal messages. In addition, reading is also used as a measure of functioning and quality of life (Withers & Speight, 2017; Leissner et al., 2014).

From the findings, the visually impaired in Nairobi face the challenge of unfriendly online platforms and the need for expensive and scarce equipment and assistive technologies to enhance access to messages.

The findings are affirmed by Lazar and Jaeger (2011). They state that, in terms of utilizing the internet and modern technology to access information, people with disabilities access information at levels clearly below those without a disability. Moreover, the inherent unfriendly nature of the internet acts as a barrier. For instance, they face difficulties using incompatible screen readers and web content.

In the case of assistive technologies, Seyoum Teshome (2017) states that, despite the staggering advances in information and communication technology (ICT), the visually impaired healthcare information needs are not being met. Additionally, Adetoro (2009) affirms that converting information materials into alternative formats is time-consuming and expensive. As a consequence, few materials ever get converted into alternative formats.

Davis (2010) posits that the visually impaired experience challenges accessing health communication in cyberspace. They access the internet through automated screen readers as the standard method. However, due to the scarcity of automated screen readers, their access to health information from the internet is low. Jonathan and Paul (2011) add that the visually impaired encounter challenges when the web content and screen readers are incompatible and when software for computer-synthesised speech output is unavailable.

The inherent unfriendly nature of the internet acts as a barrier — particularly when it comes to its use by those with various forms of disabilities — not forgetting that obstacles to access and use range according to the kind and degree of disability. For instance, the visually impaired face difficulties when using incompatible screen readers with web content. These consist of computer-synthesized software that provides speech output from what the screen displays and text equivalent to the back-end code of the computer. Furthermore, challenges are also encountered when appropriate text tags are not placed on graphics, forms, tables, and links. The consequence is that, in the information society, the PWDs become, in effect, second-class citizens. The VI face the challenge of accessing health messages since very few media platforms consider the communication needs of PWDs when disseminating health-related information (Kathungu, 2013; NACADA 2007, 2013, 2014).

This implies that, due to the inherently unfriendly nature of internet-related technologies and the scarcity of messages available in alternative formats, the visually impaired are left out when accessing messages against alcohol abuse, especially when visiting online healthcare resources and during online campaigns against alcohol abuse.

Nevertheless, SeyoumTeshome (2017) suggests that the digital divide caused by visual impairment can be alleviated by incorporating intelligent design and realizing information systems intended to fulfil healthcare information needs.

Thus, there should be policies on Alcohol and Drug Abuse (ADA) prevention and treatment programmes tailored for the visually impaired as PWD.

Study findings also reveal that inaccessible venues and physical environments are barriers, thus presenting mobility challenges. For example, there were mobility challenges besides many health information materials being communicated on visual media. The mobility challenges were caused by public health centre buildings and community halls not having ramps or non-functional or non-existent elevators. In addition, most venues were overcrowded, especially during alcohol prevention communication campaigns.

The findings are supported by Sutton (2002), who states that several formats of a text have to be provided, thus promoting access to the blind; alternate formats include the use of Braille. Texts could be made on large print or electronic files, and there should be an audiotape for the VI to listen to. Owing to the absence of these adjustments, blind people are likely to suffer limited access to healthcare facilities and information related to healthcare, besides receiving sub-optimal treatment because staff are unaware of special needs related to those with blindness. In addition, the visually impaired with alcohol addiction repeatedly struggle with how people will comprehend their addiction treatment needs. Further, individuals may struggle to find trained professionals who understand and are empathetic (Margaret, 2012; American Addiction Center Resource, 2017).

SAMHSA (2011) maintains that, for the blind, barriers to treatment for substance use disorder are alarming.

The findings of this study corroborate findings from Blind Citizens of Australia (2018:7). Their results reveal that modern hospitals are increasingly large and complex organizations, yet little attention appears to be paid to finding a way for the visually impaired in these complex environments. As a result, most would find it impossible to negotiate independently. The study adds that nearly all information in the health setting is provided only in print, including admissions procedures, preadmission information, general information about hospital services and personnel, information about medications, and related public health information. The lack of independent unassisted access to this information creates unnecessary dependence on others, compromises privacy and dignity, and jeopardises the health of visually impaired people.

Inhibiting factors such as unsuitable physical access, lack of relevant education materials available in Braille or alternative communication formats, the absence of interpreters and culturally sensitive service providers contribute to depriving the blind of their access to treatment services. As part of PWD, individuals with visual impairment experience these as some of the obstacles inhibiting them from seeking and receiving substance abuse treatment (HSS, 2010).

Accommodations for the visually impaired may not be familiar to general health practitioners, and there is a need to improve the mode of providing health information so that it is done via multiple means(Withers & Speight, 2017; Harrison et al., 2010).

Alkawai and Alowayyed (2017) add that poorly designed buildings can create significant barriers for people with disabilities. As a result, they act as a barrier to accessing alcohol prevention communication campaigns.

Rehabilitation centres should focus on improving the accessibility for the visually impaired to enhance healthcare services; this will aid in goal setting and rehabilitation referral, ultimately leading to more successful transitions, better participation, and improved quality of life (Elsman et al., 2017).

Lastly, socio-cultural dynamics such as gendered socialization affected the perceived need for information on alcohol. For instance, alcohol addiction was more rampant in visually impaired males than their female counterparts because society had normalized it, and excessive drinking was perceived as a sign of manhood.

Obot’s (2005) findings support this by stating that men are more likely to drink, consume more alcohol, and cause more problems than women worldwide. Some of the gender differences in drinking, and much of the variation in such gender differences, are cultural. Societies have long used alcohol consumption and its effects as important ways to differentiate, symbolize, and regulate gender roles — for example, by making drinking behaviour a demonstration of masculinity. Evans et al. (2011) add that holding traditional beliefs about masculinity is the strongest predictor of individual risk behaviour throughout life.

Similarly, Mankowski and Maton (2010) have posited consistent evidence suggesting that men have a poorer overall quality of life in terms of physical and mental health, safety, and education than women.

Somewhat differently, McKenzie et al. (2018) suggest that patterns of social connectedness among men are diverse. They add that not all men are less able and interested in seeking support and assistance. Whereas some may crave independence by rejecting social support, others may actively seek help.

In Kenya, practices and attitudes rooted in taboos, passage rites, religion, and cultural beliefs produce near-insurmountable barriers that disfavour the PWDs and their involvement in socio-cultural activities. In addition, health and poverty alleviation programmes typically fail to identify persons with disabilities as a group of interest and, even when identified, such persons still face obstacles (Benedicte &Lisbet, 2007).

Harmful practices, particularly concerning persons with disabilities, impede their access to healthcare (United Nations, 2020).

The new dimension that this study brings in and adds to what these scholars have said is the fact that the visually impaired men under alcohol addiction often felt that it would portray a sign of weakness and unmanliness to seek healthcare or any form of support, and thus shied away from support or accessing information against alcohol abuse.

4.8 Key aspects of TTM and HBM in interpretation of data

The philosophical foundations of this study and the nature of the research questions drove the choice of the Transtheoretical Model (TTM) and the Health Belief Model (HBM). Furthermore, with the use of in-depth interviews, information obtained from the visually impaired participants constituted a valuable source of knowledge that, together with the scientific knowledge in the literature, has helped to guide analysis of the data in this chapter.

The TTM describes how an individual integrates new behaviours, goals, and programmes at various levels. Different intervention strategies will assist individuals to progress to the next stage via the model in each stage. As a result, individuals within a population will likely vary in their readiness to change. In addition, it is essential to understand that movement via this model is cyclical — it is possible for individuals to regress to a previous stage or progress to the next stage (Boston University School of Public Health, 2022; The Rural Health Information Hub, 2023).

On the other hand, the HBM defines the key factors that influence health behaviours as an individual's perceived risk of sickness or disease (perceived susceptibility), the belief of consequence (perceived severity), potential positive benefits of action (perceived benefits), perceived barriers to action, exposure to factors that prompt action (cues to action), and confidence in the ability to succeed (self-efficacy) (Boston University School of Public Health, 2022; The Rural Health Information Hub, 2023).

In interpreting data in this chapter, this study utilized two of the five key action-related components of the HBM identified by the Rural Health Information Hub (2023) that are used in designing long- and short-term health communication interventions. These action-related components helped in understanding the respondents’ influence on health behaviours.

First, HBM underpins the need for conducting a health needs assessment to determine the population at risk that should be targeted. In this case, the population at risk was the visually impaired — specifically, those with alcohol addiction problems. Literature indicates that 40-50% of people with vision impairments may be categorized as heavy drinkers (American Addiction Center Resource, 2017; Moore& Li Li, 1998).

Secondly, HBM emphasizes conveying the consequences of the health issues associated with risk behaviours in an unambiguous fashion to promote understanding of the perceived severity. In this study, this knowledge made it possible to determine whether the visually impaired could access the messages against alcohol without any challenges. From the analysis of their statements, they faced the challenge of inaccessible formats for self-treatment methods, inadequately trained healthcare professionals and socio-cultural dynamics that portray society's inadequate understanding of the perceived susceptibility and severity of excessive alcohol drinking.

Additionally, according to the Boston University School of Public Health (2022), TTM encourages an assessment of an individual's current stage of change and accounts for relapse in people's decision-making process. In this case, it made it possible to bring out the component of socio-cultural dynamics. Chances of relapse among the visually impaired were high due to gendered socialization affecting the perceived need for information on alcohol. Findings revealed that both male and female visually impaired respondents thought alcohol addiction was more rampant among the male visually impaired than their female counterparts.

4.9 Chapter Summary

In this chapter, I have presented the study findings related to the first research question —How do visually impaired people in Nairobi access communication messages against alcohol abuse? — under the theme ‘Challenges in accessing communication messages against alcohol abuse among the visually impaired’.

The key issues from this chapter are summarized as follows: the visually impaired encounter diverse barriers when accessing communication messages against alcohol abuse. The barriers encountered include prejudices, unfavourable socio-cultural tendencies and attitudes from healthcare providers, particularly if health outcomes are perceived as poor. Again, the healthcare workers also had limited knowledge of communicating with the visually impaired and using Braillers. Furthermore, many drug and alcohol treatments and prevention services are available through visual media: newspapers, posters, flyers, and magazines. Thus, they are not easily accessible by individuals with visual disabilities. The VI face the challenge of unfriendly online platforms, as well as the expense and lack of equipment and assistive technologies that enhance access to messages. In addition, socio-cultural dynamics such as gendered socialization affected the perceived need for information on Alcohol.

In the next chapter, I present the experiences of the visually impaired people in Nairobi regarding communication against alcohol abuse.

CHAPTER FIVE

EXPERIENCES OF THE VISUALLY IMPAIRED PEOPLE REGARDING COMMUNICATION AGAINST ALCOHOL ABUSE IN NAIROBI COUNTY

5.1 Overview

In this chapter, I present the findings of the second research question of this study: What are the experiences of visually impaired people in Nairobi regarding communication against alcohol abuse? The findings are presented under the theme Experiences of the Visually Impaired People Regarding Communication Against Alcohol Abuse in Nairobi County. Analysis is drawn from data acquired through in-depth interviewing and informed by the literature review. The verbal quotes used are ones I considered most relevant and concise.

Findings revealed that respondents experienced a lack of privacy, autonomy, stereotyping, and discrimination. This chapter discusses the findings.

5.2 Lack of privacy

Respondents indicated that they lacked privacy when accessing alcohol abuse prevention healthcare. Alcohol abuse prevention and healthcare messages were inadequately available in a format they (the visually impaired) could read. Additionally, healthcare workers did not know how to communicate with the visually impaired, especially through Braille.

While accessing healthcare services, respondents' confidentiality was breached due to reliance on relatives and friends having to read and interpret their medical appointment letters and other medical documents on their behalf. Sometimes, when the healthcare personnel had difficulties communicating with the visually impaired patient, they sought assistance from their caregivers, making them (the visually impaired) uncomfortable.

Due to the lack of accessible messages and the fear of exposing their health information to other parties, the visually impaired risked missing alcohol abuse treatment and rehabilitation. In addition, they experienced low self-esteem as one of the impacts of losing patient confidentiality.

> It is difficult to communicate my problem. I feel bad. The medical staff are not facilitated. Since when I come to you (who can see) to tell things that are personal you discriminate, you don't understand what I'm going through since you are not disabled…We should not pass through the same problems of discrimination by the society. Medical professionals and society should learn how to support our needs without interfering with our privacy (April 2021, R 27).

5.3 Lack of Autonomy

Participants reported that they felt they lacked the independence to freely make choices in their personal and social lives without seeking assistance. The loss of autonomy contributed to a negative feeling when accessing healthcare messages.

When disseminating information against alcohol abuse, unsuitable communication formats — such as newspapers, posters, flyers, bulletins, brochures and magazines - make the visually impaired feel left out. During the interviews, they stated that health messages were primarily available through print media — hence not accessible to the visually impaired.

In such circumstances, they felt abandoned by the system and compelled to rely on the general population to access and interpret the messages for them because they could not independently read printed newspapers and magazines.

For instance, on November 17th, 2019, the National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA) conducted an Anti-Alcohol and Drug Abuse

Campaign walk. The objective of the concept was to mobilize nationwide support for a nation free from alcohol, drugs and substance abuse. This was part of the annual nationwide campaigns conducted by NACADA. However, these campaigns are hardly accessible to the visually impaired because they are often publicized via print media and websites and are rarely available in Braille format.

Not being able to access health information without seeking assistance leads to a negative psychological impact on the visually impaired because they lack independence in conducting their personal and social lives.

> We feel left out. It is not good. We hear about these activities and campaigns from friends. Nowadays, we take our own initiative to distribute our own information, but not through those common initiatives like the newspapers, radio and television... And so maybe you talk to a friend going through alcohol abuse and advise him in a friendly way. The authority should consider the blind people in such initiatives (April 2021, R 14).
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> This Anti-drug something…I don't know what you call it and the drugs something. NACADA...and yeah, yeah, yeah. It's not very active (NACADA), so I don't know what's happening nowadays. We also have few registered Visually Impaired so I think the records do not really have a true representation of our numbers. We have been left out in these campaigns against alcohol. It is a challenge because we mostly rely on those we trust for information (April 2021, R 4).

5.4 Stereotyping

The respondents felt that the general population often pictured them as lonely, nervous, fearful, and weak. Furthermore, the visually impaired felt that the general population believed that those who were visually impaired could not have access to alcohol, and it was not possible to have a visually impaired person suffering from alcohol addiction.

When accessing healthcare, the respondents reported that most healthcare professionals had unjustified fears and shared beliefs that the visually impaired cannot perform tasks independently. During their communications, the visually impaired were presumed unable to make independent and correct decisions. Some were assumed to be having other disabilities, like intellectual disability. Others were perceived as mentally challenged, experienced unhealthy curiosity (for example, being tested to see whether they could perform specific general tasks) or encountered what they felt was deliberate malice. Most of the alcoholics who were visually impaired thought that medical staff did not know that they required communication about medication and rehabilitation provided via an alternative format.

For example, R9 reveals that she has never encountered any alcohol abuse prevention messages targeting the visually impaired. But, again, she believes that the general population has a shared belief that the visually impaired cannot consume alcohol or suffer from alcohol addiction. Thus, there is a need to develop tailored messages that communicate directly with the visually impaired.

> You know, I've never heard someone talking about us (the visually impaired) when it comes to treatment and prevention of alcohol addiction. It is because we have been forgotten. Many people think that people with visual impairment cannot take alcohol? They think we are abnormal and disability is inability to do anything. Same case to many healthcare workers — they can hardly communicate to us properly (April 2021, R9).

5.5 Discrimination

When accessing messages against alcohol abuse and seeking alcoholism treatment and management, the interviewees also noted they were treated less favourably than the general population in similar circumstances. Discrimination was experienced when interacting with caregivers and other officers in health facilities and rehabilitation centres. Almost no healthcare professionals can use Braille or present healthcare messages via Braille to visually impaired patients. Furthermore, while the general population have easy access to premises, the visually impaired encountered mobility challenges because the buildings housing the public healthcare centres and social venues (like churches and public social halls) did not have ramps, had non-functional or non-existent elevators, and most public venues were overcrowded. One participant described the experience as follows:

> *So, you see, most of us are disadvantaged because we can't access the places where those people are being called. Because of that, we are neglected. So, they just talk to other people. We are left out. (April 2021, R9).*

Another participant adds that, besides the healthcare attendants not having the skills to communicate with the VI patients appropriately, they were at times hostile. Such treatment made some visually impaired patients feel they were not worthy enough to make requests, share their addiction problems or complain about the unfriendly health service.

> *They criticize us a lot rather than…rather than advising. They are almost criticizing us, like scolding us against alcohol. It is not a good thing, but we just endure* (April 2021, R14).

During the interviews, most of them admitted that they got the majority of information on alcohol abuse from media such as the radio, television, social media, and print. However, whereas mass media sources such as radio and television were preferred, the respondents revealed that tailored messages were severely limited and so they felt discriminated against.

For instance, on television, they depended on the sighted people to properly understand facial expressions and explain the environment and atmosphere of the characters portrayed. As for the radio, a detailed description of topics was expected. The media never had programmes focusing on the visually impaired and their needs. The respondents could identify the alcohol brand advertisement that placed age restrictions on alcohol consumption and warnings against drinking and driving. The visually impaired cannot drive; hence they felt it was meant for the general population. Generally, the visually impaired did not perceive that any of the alcohol-related messages conveyed via radio and television stations was targeted at them, thus discriminating against them. This was elaborated on by R27 and R9, as shown below:

> I hear that no alcohol should be sold to anyone below 18, which is good. But it's discouraging because they never show any programmes that feature the visually impaired. We feel like the society at large, most of the society at large, doesn't recognize the disabled people living in society. So even in mass media, I don't hear about disabled persons. So that discourages me since I feel that most of the community at large does not recognize us (April 2021, R27).
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> I liked the fact that they talked to people about alcohol and the harmful effects that they have shown on young. Moreover, I dislike that they forget about the Visually Impaired. They tend to forget about us, you know. For example, we cannot drive, but they warn people against drinking and driving (April 2021, R9).

In addition, those disseminating messages were from the general population; hence, they felt discriminated against by not being included. The respondents noted that the visually impaired were not included in developing content for dissemination. In that regard, they feel it would create a significant impact if there were blind persons involved in developing, tailoring, and disseminating messages against alcohol abuse instead of having them play the passive role of only being recipients. R5 explained that:

> The visually impaired always play the recipient's role when it comes to communication. We are hardly consulted when the messages are developed. We feel that we should be part of it. VI should not always be perceived as the recipient. They should be part of it, from developing to disseminating that information. So, they should be there in all the stages (April 2021, R5).

During alcohol abuse prevention seminars and workshops, the demonstrations made by those giving speeches targeted the general population. For example, as R27 explained, the presenters used untailored content like images and photos to create illustrations. Even during group discussions, the visually impaired were hardly involved because of the perception that they were unable to perform some tasks. R27 explained:

> Ok, for example, for the seminar I went to in my local church, they didn't know I was disabled, so they thought that the entire population was just the general population. So, they did not recognize me in that sense. Since some of the people

> see me and don't see the disability in my eyes, so they didn't recognize me in their seminar section. They made their presentation using visual formats only. So, I felt they were addressing the general population (April 2021, R27).

Some participants explained that owing to perceived discrimination and rejection, they felt desperate, leading to excessive alcoholism and drug abuse amongst some of the visually impaired.

> I believe most of the visually impaired enter into alcoholism due to discrimination of the society and feeling left out in society (April 2021, R27).
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> For the men. Yeah, mostly you can understand even from the background without asking them, you are able to understand these people are doing this because of … segregation in society. (April 2021, R14).

5.5.1 Condescension

Social stigma is also identified in the form of condescension. Some respondents stated that they experienced a patronizing attitude from some healthcare workers and friends without disabilities when seeking health services or assistance. They felt that the tones used during communication depicted an arrogance and high-handedness bordering on dictatorial towards them. In most cases, the condescending language derailed their conversations, made them have low self-esteem and feel degraded when accessing information. Some visually impaired respondents felt that the general population was superior to them.

Respondent 5, for instance, described how experiencing condescension acts as a barrier to accessing medical care and any information that could help against alcohol abuse.

> Sometimes, we are not treated like normal human beings when seeking medical assistance. They don’t talk to us well. Like, they talk down on us. It feels like we are only supposed to be recipients of the orders to avoid alcohol addiction. Yet, we should be part of the development up to disseminating that information. They hardly do so, and it is discouraging and demoralizing to us. Most of society doesn't recognize the disabled people living in the society (April 2021, R5).

5.5.2 Internalization

Some participants stated that discrimination made them harbour negative emotions or feelings towards themselves. In this case, the visually impaired adopted negative beliefs and perceptions about their blindness as a form of disability. The negative perceptions made them feel embarrassed and ashamed about their disability and hindered them from accessing messages against alcohol abuse. As a result, they felt safer keeping to themselves or sharing their addiction problems with fellow visually impaired people rather than with members of the general population.

For example, R11 describes that he felt more comfortable relying on his memory and personal viewpoint to interpret messages against alcohol and access alcohol treatments and prevention services.

> I never want to look like a beggar. But, unfortunately, that is how they will see me when seeking health assistance, so when I have a problem, I am open to my friends with whom we share similar experiences or keep to myself. So, yes. As I said, I also prefer being personal and operating at a personal level. And I don't know of any mass-media initiative that addresses the matter (April 2021, R11).

5.6 Discussions

The results confirm a scarcity of tailored messages that suit the needs of the Visually Impaired. The available messages on alcohol abuse were accessed via media such as the radio, television, social media and print. Whilst the visually impaired acknowledge the essential roles that the various media platforms play, most platforms are not tailored to suit their needs and lack adequate content tailored to improve their everyday social lives.

These findings corroborate those of Thurston and Thurston (2010:6) who found that only 10% of all communications from health services to visually impaired participants are received in their preferred reading format, even though 96% of blind respondents prefer accessing communication messages in their preferred reading format. Additionally, the

VI face the challenge of losing autonomy and privacy regarding their experience accessing healthcare information and frequently have to rely on others to help them access healthcare information. However, caregivers and relatives have to varying degrees cushioned some of the effects of not receiving information about good health practices via the preferred reading format.

Despite the blind having a right to receive healthcare information, they cannot access it in their preferred format. Most of them do not think the medical staff know how to provide information in their preferred format. Most of them also believe that medical staff do not realize they require an alternative format. They are also unaware that they are entitled to seek healthcare information in a favourable format (Thurston & Thurston, 2010:12).

In her studies, Jones (2019) noted low awareness about the option to request alternative formats among visually impaired patients, mainly due to the reference to "other formats" being poorly flagged on healthcare documents. Additionally, the healthcare workers did not tell the visually impaired patients to request information through alternative formats. Other visually impaired patients were informed that they could cope without an accessible format and felt unable to request their needs. Consequently, she adds that patient confidentiality is breached due to individuals having to rely on carers, relatives or friends to interpret information on their behalf.

Data suggests that the visually impaired experience loss of autonomy in making healthcare choices because they hardly receive health information in a preferred format. However, carers and relatives primarily buffered the effects of not receiving health information in a preferred reading format. This meant they had a mutual negative feeling due to a lack of privacy.

Another place mentioned for greater access to information is school. Educational events and talks with teachers increase their knowledge, confirming that school is the place to approach ADA-related issues (Pagliuca et al., 2009).

Beverley et al. (2004:1-24) state that the visually impaired operate at three levels, depending on their facilitators and barriers. The first level is the individual, which includes the absence of knowledge on health issues, limited knowledge of using Braille, and language and cultural barriers associated with ethnicity. The second is the community barriers that include taboos within the society and deficient time for the visually impaired to grasp the information they are given. Thirdly, communication of health messages could be done through various approaches such as friends, relatives, and health professionals as information providers, discussing their health-related matters with other visually impaired people and health professionals.

As mentioned earlier, the respondents disclosed that they face the challenge of losing autonomy and privacy concerning their experience accessing healthcare information and frequently rely on others to help them access healthcare information. However, some of the effects of not receiving information about good health practices via the preferred reading format could have been largely cushioned by caregivers and relatives — but frequently relying on others to help them access healthcare information exposes them to loss of autonomy and privacy regarding their experience of accessing healthcare information.

These findings concur with Thurston and Thurston (2010), who revealed that if health information is not in a readable format, blind and partially sighted people may have to ask for help to read it. Client confidentiality could thus be compromised. The inability to access health information had a negative psychological impact. Loss of autonomy was the most common negative feeling. The respondents adopted a variety of coping strategies to access health information and services. Some participants relied solely on family support.

While investigating the risks to client confidentiality when communicating health information to the blind, Thurston and Thurston (2010) note that loss of autonomy was the most commonly reported psychological side effect of the problem, because relying on others led to both lack of independence and compromised privacy. Most visually impaired employ coping strategies to mitigate the effects of receiving information in inaccessible formats. Most use a combination of low vision aids or assisted technology and help from family, friends, or caregivers.

Findings revealed that the visually impaired experienced stereotyping when accessing messages against alcohol abuse or any form of medication against alcohol addiction. Stereotyping is characterized by derogatory generalizations about a group of people to the extent that they are essentially, though not entirely, immune to counterevidence, thereby homogenizing a particular group of people. Stereotypes shape the perceptions of the stereotyped groups to the general public (Lawrence, 2004).

Weigl (2000) states that stereotypes may occur in two dimensions. The first depends on transforming a particular occurrence into a stereotypical situation. This case involves linking specific categories and attributes with already existing stereotypes. For example, in this study, the respondents reported that most healthcare professionals had unjustified fears and shared beliefs that the visually impaired cannot perform tasks independently. The second dimension occurs when individuals create a new stereotype — in this case, the cognitive representation of social groups or, rarely, individuals. This study's findings showed that when the respondents, during their communications, were presumed to be unable to make independent and correct decisions, some were assumed to be having other disabilities like intellectual disability.

Emilia (2017) states that stigmatizing and stereotyping are very productive categories nowadays when describing adverse social facts concerning different communities, including the PWDs. Nevertheless, concerning blind people, the aspects of stigma and stigmatizing are rarely used. She adds that, both in the theoretical studies concerning the element of stigma and in the empirical ones, disabled people are practically always mentioned as subordinate to this aspect.

A stereotype could also be illustrated when the visually impaired people are denied rights accessible to the non-disabled (Życzyńska-Ciołek, 2008). Blind people indicate that some attitudes and general incomprehension of the sighted presented towards them result from ignorance or a lack of imagination arising from the belief that a blind person can do very little on their own and need assistance. The sighted people may also treat the visually impaired as immature or mentally challenged people. In addition, there are cases of thoughtlessness expressed when using visual materials during training. A stereotype may also be illustrated through unhealthy curiosity, where visually impaired people are tested to see whether they can manage a given task (Emilia, 2017).

Individuals with disabilities may use alcohol and drugs as a strategy for gaining social acceptance and as a means for easing the social discomfort resulting from their disabilities. This behaviour may be supported by professional and public beliefs that people with disabilities may be justified in using alcohol and other drugs to cope with their disabilities. Due to this stereotype, their misuse and abuse of substances may be overlooked or ignored (Benshoff & Janikowski, 2000). For those reasons, whereas societal institutions may discourage the immoderate use of alcohol and drugs, they may accept and tolerate substance misuse and abuse by people with visual impairments (Koch, 2000).

Professionals who work with the visually impaired are likely to encounter individuals with coexisting alcohol abuse disabilities who may experience a complex array of adverse psychosocial effects directly related to the effects of alcohol abuse. This could also come with secondary effects caused by the preponderance of negative public and professional attitudes toward these disability groups. Therefore, if counsellors working with the visually impaired are to achieve successful outcomes, they need to identify these complications and respond to them with effective strategies (Kosch, 2002).

The analysis indicated that the visually impaired confront stereotyping and discrimination as forms of social stigma, which are barriers to accessing messages against alcohol abuse. Similar findings were realized in studies conducted by the University of Washington (2016). They state that, throughout history, people with disabilities have been stigmatized. The study adds that disability is associated with dependence, disease, helplessness, and curses in many cultures. Further, the study states that disability stigma plays out in several ways, including social avoidance, stereotyping, and discrimination.

Apart from experiencing difficulties accessing healthcare services, the blind feel that due to their disability, they are denied treatment (Veltman et al., 2001).

Disability discrimination is when you are treated less well or put at a disadvantage for the reason that relates to your disability (Equality and Human Rights Commission, 2022).

Discrimination by society is the biggest challenge to the visually impaired when accessing health communication messages. Approximately 31% of the visually impaired in Kenya report that the biggest challenge was discrimination by society to ensure accessibility to drug information. Furthermore, the accessible drug information and strategies do not accommodate persons with various disabilities in disseminating information (Kathungu, 2013;Glazier & Kling, 2013; NACADA, 2007, 2013 and 2014).

Negative cultural practices and attitudes towards disability are a challenge. People with disabilities are still discriminated against within communities and many other spheres of life. As a result, they miss out on many opportunities for self-improvement and live destitute lives (OHCR, 2015).

Beverley et al. (2004) reveal that access to and provision of information is key to reducing health inequalities. But information is not always accessible and does not always meet the needs of the visually impaired. In supporting this, Baloch and Ashfaq (2017) state that, when it comes to the needs of blind people, producing any tailored content can help them. Yet, media owners and programme producers ignore the vast population of the visually impaired. Regarding tailored content for the visually impaired, it is not possible to comment on the quality of such content as there is no content.

Visually impaired people encounter formidable barriers when seeking information and substance use disorder treatment. Besides that, many treatment facilities are not fully accessible to PWDs. In addition, they experience various obstacles such as harmful attitudes and bias about people with substance and drug abuse, lack of staff training, and inaccessible methods and information in communication materials (SAMHSA, 2011). NACADA (2014), Glazier and Kling (2013) and Kathungu (2013) support this by stating that PWDs report that their biggest challenge was discrimination by society in terms of ensuring accessibility to drug information.

Chifamba et al. (2011) add that the print and electronic media have been immensely absorbed in, and consumed by, a one-dimensional and limited focus on the able-bodied audience. When it comes to disseminating health messages, the mass media seem to have done this with some measurable degree of distinction; however, the picture is dramatically different when the blind audience is included.

In a nutshell, many visually impaired, like other people with disability, experience disability-related discrimination, which has a negative effect on their life satisfaction. However, this is mitigated by a sense of belonging to the community. For example, studies indicate that people with disability, particularly the youth, do not report lower life satisfaction when a high sense of belonging is present, even if they experience discrimination (Daley et al., 2018).

The analysis reveals that the visually impaired experienced a patronizing attitude from some healthcare workers and friends without disabilities while communicating with healthcare workers, some family members and friends. They felt that the tones used during communication depicted arrogance and high-handedness and were dictatorial towards them.

Condescension is associated with a patronizing attitude and other negative words such as divisive, heartless, arrogant, high-handed, and dictatorial. Condescension is bad behaviour and takes the form of insulting patients. The use of condescending language derails conversations and disrupts healthy communities over time. The people who make condescending comments may not realize that a listener interprets their underlying tone as humiliating. It is an agonizing experience and contributes to an atmosphere of destructive conflict during communication (Keogh, 2005; Wang, 2019).

It is common for people to be condescending without realizing it (Wong et al., 2014). Some doctors have trouble recognizing how their condescending behaviour can damage their ability to work with and relate to others (Keogh, 2005).

While surveying disruptive behaviours in doctors, Keogh (2005) found that condescension during communication is a disruptive behaviour and an issue that healthcare leaders must address. Most healthcare workers need the training to empower them with knowledge, skills and attitudes that will enable them to communicate effectively and empower people with disabilities in education or counselling environments.

From the findings, the visually impaired reported that discrimination made them harbour negative emotions or feelings towards themselves. Consequently, they adopted negative beliefs and perceptions about their blindness as a form of disability. As a result, some developed depression and resorted to alcohol, whereas others felt more comfortable keeping to themselves.

Generally, blind people may resort to alcohol to self-medicate stress and difficulties brought about by blindness as a physical disability (American Addiction Center Resource, 2017; Moore& Li Li, 1998).

While assessing the risks to client confidentiality when communicating health information to the blind, Thurston and Thurston (2013) discovered that, despite experiencing difficulty accessing health information and health services, very few of the visually impaired participants reported that they had complained. The most common reason given was that they thought it would be a waste of time. Some participants also reported that they lacked the emotional strength needed to complain. This highlights the important role that individual representatives, researchers and organizations have in representing the views and needs of blind and partially sighted people.

Access to messages on alcohol abuse creates awareness and makes it easy for the visually impaired addict to actively participate in healthy behaviours. Since the World Health

Organization (WHO)'s International Classification of Functioning, Disability, and Health (ICF) — a framework for measuring health and disability — the idea of participation has become essential. Thus, participation needs to be a central concern when developing rehabilitation interventions that promote the participation of the blind (Alma et al., 2012).

Alma et al. (2012) reveal the existence of a dynamic relation between participation, health conditions, and contextual factors (such as personal and environmental factors). Involvement of the visually impaired in their life situations can be referred to as participation. Participation improves an individual's quality of life, also described as someone's perception of their state of life in their cultural context and value system. Individuals engage in these perceptions in connection to their concerns, goals, expectations and standards (ICF, 2001).

Other solutions that enable proper communication of health messages to the blind are extra explanations by healthcare providers during drug dispensing, Braille alphabet labelling, touchable-differentiating marks on drug packages, information pamphlets on drug abuse that have texts in the Braille alphabet, a telephone helpline and the availability of messages in audio format (Kentab et al., 2015).

Healthcare centres may require resources such as hardware (e.g., Braille printers) and software to ensure information is sent in an accessible format. Additionally, education and training may be necessary for healthcare professionals. This would include raising staff awareness of supporting the needs of blind and partially sighted persons physically and emotionally (Thurston &Thurston, 2013).

5.7 Key aspects of TTM and HBM in the interpretation of data

This study used the Transtheoretical Model (TTM) and Health Belief Model (HBM) to help design the research question, guide the selection of relevant data, interpret the data, and propose explanations of the underlying causes or influences of observed phenomena.

According to BMJ (2008), theories provide complex and comprehensive conceptual understandings of how societies work, how organizations operate, and why people interact in specific ways. Theories give different lenses through which a researcher looks at complex problems and social issues, focusing their attention on different aspects of the data and providing a framework in which to conduct their analysis. In this study, for instance, theories played a critical role in understanding how society lives with the visually impaired and the experiences of the visually impaired seeking medical treatment for alcohol addiction and why they interact in specific ways —in particular, the feeling of lack of autonomy due to compromised client confidentiality.

TTM acts as a central guideline for positive health-behaviour changes, indicating that individuals attempting to change their health behaviour might experience a series of stages of readiness for change (Liu et al., 2018). The model posits that health behaviour change involves progress through six stages: pre-contemplation, contemplation, preparation, action, maintenance, and termination. Ten change processes have been identified for producing progress along with decisional balance, self-efficacy, and temptations. Basic research has generated a rule of thumb for at-risk populations: 40% in pre-contemplation, 40% in contemplation, and 20% in preparation (Prochaska &Velicer, 2016).

The TTM has been widely used to describe and understand exercise behaviour (Han et al., 2017). TTM suggests strategies for interventions to address people at various stages of the decision-making process, thus making it possible to develop tailored messages that suit each stage's needs. Through the stages, and while analysing data in this chapter, it was possible to realize individuals' first behaviour change process. In this case, it was consciousness-raising. The respondents showed consciousness and desire for healthy behaviours. However, they felt discriminated against because most health messages are in formats not accessible to visually impaired people. Consequently, they experience a loss of autonomy and privacy while accessing healthcare information because they frequently have to rely on others to help them access that information. Additionally, they felt this compromised client confidentiality. The inability to access health information had a negative psychological impact on them.

TTM notes dramatic relief, whether negative or positive, as the second process. In this study, there was emotional arousal about alcohol addiction; however, the discrimination of the visually impaired derailed their crossing over to the contemplation and preparation stages.

Boskey (2022) states that the HBM model focuses on one's beliefs about health and health conditions. The model emphasizes the critical role that individual beliefs play in determining health-related behaviours. Two key factors (identified in the model) that affect someone's approach to health include any barriers that an individual thinks might be standing in their way and exposure to information that prompts an individual to take action. In addition, these factors may affect an individual's confidence in their ability to adopt healthy behaviours. From the respondents in this study, it was possible to identify their loss of autonomy and privacy while accessing healthcare information because they frequently rely on others to help them access healthcare information. Additionally, they suffered compromised client confidentiality which had a negative psychological impact. The negative impact may affect their confidence in adopting healthy behaviours.

5.8 Chapter Summary

In this chapter, I have presented the study findings related to the second research question - What are the experiences of the visually impaired people in Nairobi regarding communication against alcohol abuse? —under the theme Experiences of The Visually Impaired People Regarding Communication Against Alcohol Abuse in Nairobi County.

The key issues from this chapter are summarized as follows: respondents reported that alcohol abuse prevention and healthcare messages were rarely available in a format they could read independently. Most messages against alcohol abuse were available in unsuitable communication formats — such as newspapers, posters, flyers, bulletins, brochures and magazines — making them feel left out. Secondly, since most health messages are in formats not accessible to visually impaired people, they experience a loss of autonomy and privacy while accessing healthcare information because they frequently rely on others to help them access that information. Consequently, client confidentiality was compromised. Thirdly, the visually impaired desire to access communication messages in their preferred reading format. In addition, the inability to access health information had a negative psychological impact on them. Lastly, the visually impaired confront stereotyping and discrimination as forms of social stigma, which are barriers to accessing messages against alcohol abuse. In most cases, disability is associated with dependence, disease, helplessness, and curses in many cultures.

In the next chapter, I present findings on how visually impaired people in Nairobi make sense of the communication messages against alcohol abuse.

CHAPTER SIX

HOW THE VISUALLY IMPAIRED MAKE SENSE OF COMMUNICATION MESSAGES AGAINST ALCOHOL ABUSE IN NAIROBI COUNTY

6.1 Overview

This chapter answers the third research question: How do the visually impaired people in Nairobi make sense of the communication messages against alcohol abuse? Analysis was undertaken on data acquired through in-depth interviewing. It was informed by the literature review, theoretical considerations and phenomenology method (as the research method used in this study). The verbal quotes used are those that I considered most relevant and concise.

Findings revealed a perceived stereotypical portrayal of the visually impaired in the media. In addition, there were moralistic discourses about alcohol abuse in the media, reliance on intermediaries to interpret messages, and the influence of celebrities and appeals and non-verbal cues in interpreting messages. This chapter discusses the findings.

6.2 Stereotypical portrayal of the visually impaired in the media

Findings showed the visually impaired do not conform with the way the media consistently portrays them as needing assistance and sympathy. The respondents noted that their portrayal and messages about them were stereotypical as they primarily depicted people with disability as needy and objects of charity. To respondents, it was humiliating for the disabled to be projected as individuals in a state of self-pity who struggle to get basic needs and whose lives depend on others. They felt that, due to the low profile of the visually impaired, society had been encouraged to pity them and not recognize them as ordinary beings, hindering normal communication. In the respondents' view, depictions in the media reinforced the over-generalized beliefs that PWDs cannot make independent and informed decisions. The respondents felt they were often pictured as lonely, nervous, fearful, and weak. Some were assumed to have other disabilities, like intellectual disability. The general population had unjustified fears and shared beliefs that the visually impaired cannot perform tasks independently.

R27, for example, explained how demoralizing it is not to be recognized as normal beings and to be neglected when conveying messages against alcohol abuse.

> The messages against alcohol do not target us. But it's discouraging because the society at large doesn't recognize the disabled people living in society. They mostly portray us as needy and weak. So even in mass media, I don't hear about the disability persons being independent. So that discourages me since I feel that the community, most of the community at large, does not recognize us. (April 2021, R27).

There was also the belief that the visually impaired could not consume alcohol or suffer from alcohol addiction. As a result, their needs were hardly considered when messages were developed. For example, R9 reveals that she has never encountered any messages against alcohol targeted at the visually impaired. But, again, she believes that the general population has a shared belief that the visually impaired cannot consume alcohol or suffer from alcohol addiction.

> No. I've never heard someone talking about us because we have been forgotten. So they think people with visually impaired impairment cannot take alcohol? (April 2021, R9).
>
> I like that adverts talk to people about alcohol and its harmful effects on the youth. But what I dislike is just that they forget about VIs. They tend to forget about us, you know. (April 2021, R9).

The stereotypic representation also reinforced the perception that the visually impaired cannot make good life choices — for example, appropriately managing their health and medication independently without the assistance of a closely related person. On the contrary, they have autonomy like the general public and are capable of making independent choices. Such a demonstration of stereotypical images develops a false impression of the visually impaired and influences the mentality of the public and attitude towards them.

The respondents also felt it would be impactful if the messages gave prominence to their fellow visually impaired who had endured similar alcohol addiction behaviours that were health threatening but had survived and adopted the required attitude. R9 and R10 spoke about this:

> The images do not give a true picture of us. The visually impaired are not abnormal. They are just like any other person. I want someone with a visual impairment to talk to us about alcohol abuse because, with them, at least they understand how we understand things better and at least someone who has gone through these so that they can share similar experiences with us. Yeah. (April 2021, R9).

> I want somebody to come in and tell us how they have gone through the addiction situation and how it affected them so that we cannot be involved in alcohol abuse.(April 2021, R10).

6.3 Moralistic discourses

The respondents stated that the Visually Impaired preferred objective messages. Moral messages condemning individuals with alcohol addiction only succeeded in pushing them away and in dismissing them, since most of them reacted defensively. Additionally, the respondents preferred that messages that condemn harmful drinking behaviours be supported with scientific justification. In doing so, messages would be unbiased, enabling them to make impartial choices. The visually impaired were more comfortable with messages that endeavour to educate them about what alcohol addiction control is, the actions to be undertaken or avoided, and would be more likely to lead them to act. It would be more tolerable when tailored that way than the current messages that seem to criticize. R14 and R26elaborated on this:

> Most messages keep demonizing alcohol. They criticize those under addiction rather than advising them. They are attacking them…like scolding them against alcohol (April 2021, R14).

> I think that they should not be harsh to those addicted to alcohol. Instead, they should be free with us…to enable the visually impaired not to abuse alcohol (April 2021, R26).

As R26 explains, she is agreeable when the messages are tailored and objective and focus on both the good and the bad aspects of consuming alcohol. She herself had stopped excessive alcohol consumption because after being informed that it would result in liver cirrhosis.

> I like when messages are balanced and open to us. Alcohol is not bad. In fact, during parties, alcohol must be there. And some people, such as these companies that there are those around us that are making that are brewing the alcohol — they are using it as a source of economy. So, to me… I like it. It's not a bad thing. However, we are informed excess consumption leads to liver cirrhosis. That is what made me change my drinking habits (April 2021, R26).

In addition, the respondents felt that the messages should not only be focused on the age restrictions for alcohol consumption. Instead, there should be additional information on healthcare and rehabilitation centres that can assist when they encounter an addiction. Additionally, there should be information on the types of disease caused by alcohol addiction, the appropriate treatment, the availability of treatment services, and the treatment centre's details. That way, messages would be more effective. As illustrated below, R9 expressed her dissatisfaction with the present messages against drinking alcohol that give importance to the age limit and leave out other essential factors:

> The campaigns don't elaborate on where to get healthcare and what diseases excess alcohol can cause. Mostly they are just about restrictions for people under 18 (April 2021, R9).

6.4 Influence of celebrities and appeals in interpreting messages

The respondents acknowledged that using celebrities makes the messages more effective depending on the credibility of the celebrity or endorser. Endorsers, in this case, could be celebrities, well-known persons, or typical persons. In most cases, messages are perceived as credible when the character is viewed as trustworthy, and the audience can relate to the message conveyed. Therefore, famous and likeable celebrities made the messages friendly. In this context, R14 identified the use of Chipukizi, a Kenyan celebrity, and R9 identified Mututho, the former Naivasha Constituency member of parliament and the immediate former Chairman of the National Authority for Campaign against Alcohol and Drug Abuse Board:

> I like it when a celeb is involved. In one of the campaigns against alcohol, Chipukizi was involved. I just heard it—the comedian who was appointed the other day. Chipukizi talked about going to the ghettos and educating people on drug abuse and alcohol use (April 2021, R14).
> Campaigns against alcohol were also active when Mututho was involved. He is famous. Since his exit, they (campaigns) are not as functional (April 2021, R9).

However, some respondents noted that they had seen no messages using fellow visually impaired as endorsers. Their exclusion made them perceive that messages were only targeted at the general population and thus were not effective for them. The visually impaired felt it would be much easier to relate to the message if the endorser also had visual impairment. R4, R26 and R22 explained:

> Yes. More speakers, more people and especially the visually impaired (VI) themselves are supposed to make some initiative groups, moving around and educating the VI on the issue of alcohol (April 2021, R4).
> If a disabled person, or visually impaired maybe, comes and starts discouraging me from excessive consumption of alcohol, I will feel free to share my experiences and quickly transform (April 2021, R26).
> The effects of alcohol are significant and do not divide the disabled and those without disabilities. So, people with disabilities must be fully involved in the campaigns. And not only the blind or visually impaired but also the physically impaired (April 2021, R22).

6.5 Non-verbal cues in interpreting messages

The participants stated that they missed out on some aspects of communication, especially non-verbal communication. However, to cope with that, they indicated that they relied on paralanguage or vocalics to understand the meaning of messages during a conversation, or to form perceptions. Participants revealed they could interpret the vocalics as a component of meta-communication, especially those who accessed the alcohol messages via radio, friends, healthcare workers, or listened to presenters during the alcohol and drug abuse workshops and seminars.

The respondents identified pitch, volume, and intonation as some of the components they used to give meaning to statements or understand the presenter's emotions when communicating to them. However, they also highlighted that they missed out on vital messages transmitted through facial expressions, postures, eye contact (patterns of fixation, frequency of glances, pupil dilation), gestures, and body language due to their visual impairment. In addition, they missed out on the messages transmitted through visual media.

Respondent 27 explained that she is more receptive to messages communicated in a friendly tone than a harsh tone:

> When listening to the radio or communicating with someone, the variation of tones helps me know how to measure the message's importance. When the tone is soft and kind, it is friendly and easy to understand the message passed, especially by friends, healthcare workers, and family members. On the other hand, harsh tones make me feel like I am being forced to do something that I am not ready to do and will make me not disclose my problems…but you know I cannot see other non-verbal cues like postures, facial expressions and eye contact. So, I rely on verbal communication (April 2021, R27)

The participants also valued haptic communication, using the sense of touch to interact with and pass messages during conversations, especially with their close friends and family members. For example, friendly hugs from an immediate family member gave them psychological comfort during the moments when they were undergoing challenges in changing to healthy lifestyles during the detoxification programmes.

Respondent 5 explained that haptic communication had been significant when her mother consoled her during the detoxification programme:

> *When I go through difficulties, my mother hugs me. It is encouraging and makes me feel wanted, valued and loved. However, the journey to stop alcohol addiction is difficult (April 2021, R5).*

6.6 Reliance on intermediaries to interpret messages

The interviewees stated that the type of media used to communicate often forced them to rely on intermediaries. According to the respondents, the visually impaired have highly individual needs, yet the choice of media and, therefore, the design of messages failed to recognize that. Thus, they needed intermediaries. They preferred religious leaders, local authorities, teachers, friends, and close family members to assist when they faced difficulty interpreting messages. Moreover, they felt comfortable confiding with them as their intermediaries.

The intermediaries assisted them in assessing the social consequences and implications that alcohol abuse may have on their family life, social relations, and the workplace. They informed them of the perceived benefits and the efficacy, worthiness or effectiveness of the recommended action to lessen the seriousness of the addiction. They played a critical role in elaborating the strategies to provide the appropriate encouragement that prompted decision-making to accept the desired health action. Intermediaries also played the role of offering respondents reassurance and correcting misinformation. They also boosted confidence by guiding respondents to successfully take the necessary action and engage in the correct behaviour to produce the desired outcomes.

R27, for instance, drew her knowledge of alcohol abuse from the church:

> I know about alcohol from my church. I am a Catholic, so I always attend seminars. They always conduct seminars every December when all of us are at home. So, I get to learn how to handle alcohol in a balanced way in my life…My feelings toward alcohol are in two different ways. There's a positive and a negative; the positive is taking alcohol is not bad if it's taken in the right amount but taking excessive alcohol and not able to be assertive. But so that is the discouraging part because you get addicted to it. So, I don't think alcohol is bad

> since even Jesus created alcohol in the wedding… with a purpose. So, in celebration, it's not a crime, but you should consume it properly (April *2021*, R27).

The respondents also pointed out that education from school promoted their knowledge, attitude and proper practices concerning the consumption of alcohol. Respondents who had attended school were more knowledgeable about coping with alcohol addiction and improving their health status, as R4 explained:

> Those in the schools or learning institutions are advantaged because the teachers are guiding them. They are being guided by those people who come to talk. We have foreign speakers who come around and talk to the students. So, they get more knowledge on the disadvantages of excess consumption of alcohol. So, we have people, and schools have made peer groups that guide students on that. And also have a committee for guidance and counselling, which advises students not to take those drugs (April 2021, R4).

In some instances, the local authorities created awareness of alcohol abuse, which prompted decision-making to accept the desired health action. R4 also illustrated the role of local authorities:

> We have awareness from the Sub-Chief, and Chief Barraza and people have made groups that educate the youth in the local areas about drugs and alcohol and the disadvantages of taking those drugs and alcohol. They also guided us to the local dispensaries where we could get help (April 2021, R4).

6.6.1 The clergy as a source of messages against alcohol addiction

The interviews revealed that the clergy remained a popular source of advice and assistance for the visually impaired dealing with alcohol abuse. So, the impact of religion and religious groups on the drinking patterns of the visually impaired was a reality. During the interviews, the respondents stated that religious factors were associated with alcohol prevention. The church, its leaders, and the clergy were identified as sources of messages against alcohol abuse.

Furthermore, alcohol drinking habits were associated with religious perceptions throughout the various religious affiliations. Different religions encouraged diverse views on the proper use of alcohol. However, it was effective when the clergy used health interventions contextualized with cultural and spiritual references

For example, R27 consumed alcohol responsibly because of the interpretation of alcohol use in the Bible — specifically drawing reference to Jesus' first miracle where he changed water into wine— and alluded to what her priest preached in the church:

> Our priest taught us many things…My feelings toward alcohol are in two different ways. There's a positive and a negative; the positive is taking alcohol is not bad if it's taken in the right amount but taking excessive alcohol and not able to be assertive. But so that is the discouraging part because you get addicted to it. So, I don't think alcohol is bad since even Jesus created Alcohol in the wedding… with a purpose. So, in celebration, it's not a crime, but you should consume it properly (April 2021, R27).

In some cases, religious involvement resulted in low levels of alcohol use. The relationship with clergy and church leaders influenced their perception of what is morally acceptable. Their interrelation indicated observance of Biblical doctrines on alcohol. That being the situation, if their religion or religious leaders promote abstinence, the visually impaired religious follower is less likely to be a drinker. An individual's commitment to teachings against alcohol by the clergy is linked to a reduced likelihood of drinking alcohol. Belief in teachings against alcohol abuse by the clergy is related to lower alcohol use. This was captured during the interview with R10:

> Our church leader. I like how he told us we should not be involved in those things (drinking alcohol), which is OK. He always tries to tell us how harmful alcohol is and links it to Bible verses and real-life experiences out there. For instance, Ephesians 5:18 states, "Do not get drunk on wine, which leads to debauchery. Instead, be filled with the Spirit."(April 2021, R 27).

The church was also identified as a venue for access to messages against alcohol abuse. In addition, the interviews revealed that messages on good health reached the visually impaired through church-based health promotion interventions, thus enhancing awareness of managing alcohol addiction.

This aspect is illustrated by statements from R14 and R27:

> The church plays a major role in shaping my beliefs about alcohol. And in fact, during that time when seminars were being held in our churches, it was for the youth against alcohol abuse. In addition, most of the worshipers were involved in advising their fellow people about the benefits of avoiding over drinking (April 2021, R14).
>
> For me, I know about my church, I am a Catholic, so I always go to seminars. They always conduct seminars (on alcohol abuse) at every December when all of us are at home…And so, I trust Catholic teachings…I attend seminars in my local parish church (April 2021, R27).

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6.6.2 Education centres as sources of messages against alcohol addiction

Education centres such as schools were identified places that provide an atmosphere for participating in activities that promote awareness of alcohol and drug abuse effects. Additionally, the level of education played a role in enhancing access to messages against alcohol abuse and understanding them. The school also offered an opportunity to interact with counsellors and other professionals. While at school and other higher learning institutions, respondents noted that they got information on reliable primary care and essential preventive messages on alcohol abuse through counselling sessions and meeting with medical professionals. Education from school promoted their knowledge, attitude and proper practices concerning the consumption of alcohol. Respondents who had attended school appeared to be more knowledgeable on coping with alcohol addiction and improving their health status.

For instance, R26 provided an account of how a school visit by an invited health professional and counsellors in one of their student counselling sessions made her know more about the controlled consumption of alcohol and the adverse effects that alcohol addiction brings to an individual's body:

> Education centres like schools expose us to messages against alcohol. We get to talk to counsellors. What I liked about them was that they were open to us. They told us, yes, it is good to drink responsibly. They told us when using alcohol responsibly, it's not bad. In fact, during parties alcohol must be there. And some people, such as these companies that there are those around us that are making that are brewing the alcohol, they are using it as a source of economy. So, to me, I liked it. It's not a bad thing. It is not bad to use it responsibly, it only becomes bad when you abuse it (April 2021, R27).

In another case, one of the respondents, R4, who happens to be a professional high school tutor and a visually impaired respondent, expressed the importance of being educated and the role that schools play as a venue for accessing reliable messages about public health and awareness of the problems linked to alcohol abuse. He acknowledged that those who never attended school or had no formal education faced the risk of being excluded from accessing reliable messages against alcohol abuse. He said:

> We offer teachings on good life morals like responsible drinking in schools. We have even people and schools that have made some peer groups which guide students on that. And also, we have a committee for guidance and counselling, which also advises students not to take alcohol or any other harmful drugs (April 2021, R4).
>
> As a visually impaired and professional teacher, I try to move around the like in schools, trying to talk to the visually impaired students and, and then at home there, we should have also a group and that group should be involving some visually impaired people so that they can even be visiting some of those visually impaired people who are in their own homes or in the local initiatives to go and talk about them (April 2021, R4).

Additionally, R4 showed, from his statements, that barriers were reduced with increased education:

> We have speakers who come around and talk to the students in schools. So, it is the students, the visually impaired students, who benefit from such talks. Unfortunately, those visually impaired who do not have an opportunity to go to

> school miss out on the opportunities to get this essential information. Also, the level of engagement with the counsellors varies depending on the level of education. The uneducated miss out on so much (April 2021, R4).

As much as the schools were identified as one of the venues for accessing messages, the respondents pointed out that they preferred visually impaired counsellors. Similarly, they felt a need to have courses on alcohol use and abuse incorporated as part of the Kenyan education system. R27 explained:

> We need illustrations from people with similar experiences as us. They should choose a subject where they should put the lesson to be learned, and also, they should be counsellors. Also, they should contact a counsellor with a disability who should be used to pass[ing] messages of encouragement to other people with disabilities…I think they should put, in our education system, courses that create more awareness of alcohol abuse (April 2021, R27).

6.7 Discussions

Findings established that there was a stereotypical portrayal of the visually impaired in the media. The media depicts an inaccurate understanding of what it means to be visually impaired and therefore does the opposite of promoting awareness (Royal National Institute of Blind People [RNIB], 2017). Furthermore, the media are less successful in playing a role in providing information about disability to the community. Yet, delivering good information about PWD can create positive awareness about the group(Hazlin Falina, 2017).

Whether in art, literature, or other media, blind people have been consistently represented as unfortunate, disabled, and deprived, or as exotic, mysterious, and in touch with the supernatural. This depiction of the blind person as the "abnormal other" is the symptom and, at the same time, partial cause for prejudicial attitudes and practices held by non-blind, especially non-disabled people (Brylla, 2022).

PWDs are often objectified and excluded from many aspects of life and stereotyped as dependent and incompetent (Dunn, 2014; Nario-Redmond, 2010). Many depictions in the media generate and perpetuate limiting assumptions about what people with disabilities can accomplish, particularly concerning vision. These inaccurate characterizations generate false ideas in the public about those who are blind and visually impaired (American Foundations for the Blind, 2012).

Baloch and Ashfaq (2017) found that mass media does not correctly gratify the needs of the visually impaired, entrenching the stereotypical portrayal of the visually impaired. This is experienced mainly in mainstream media, such as television channels that hardly pay any attention to the issues and events affecting the visually impaired. As a result, the blind community is marginalized and annoyed by the behaviour of sighted society, feeling depressed due to its stereotypical portrayal in mass media.

Although PWDs comprise a heterogeneous social group, cross-impairment cultural stereotypes reflect consistent beliefs that characterize this population as dependent, incompetent, and asexual (Nario-Redmond, 2010).

Studies conducted by the University of Washington (2016) bear similar findings. They state that, throughout history, people with disabilities have been stigmatized. The study adds that disability is associated with dependence, disease, helplessness, and curses in many cultures. Further, the study states that disability stigma play out in several ways, including social avoidance, stereotyping, discrimination, condescension, blaming, internalization, hate crimes, and violence. Similarly, Śmiechowska-Petrovskij(2017), while drawing reference from Ostrowska (1994), states that concerning the blind, there is a stereotype picturing them as weak, fearful, nervous, and lonely people. They are also seen as withdrawn, insecure, unhappy, and needy.

Reinforcing stereotypes and false beliefs concerning visually impaired people is done on several levels through mass media broadcasts. The researchers working on analyses of the image of the blind presented in the media underline two tendencies. The first is depicting a disabled person as depending on others, needing assistance and evoking mercy; the second is representing a person with disabilities as a hero overcoming every restraint and achieving impressive goals when undertaking complex tasks (Barnes 1997).

Additionally, the stereotype of a blind person constructed in literature includes such additional features as helplessness, dependence on others, submission, and melancholy. Quite commonly the visually impaired are also viewed as immersed in their own thoughts, mysteriousness, passive, having self-esteem, and possessing a particular sensitivity and ability to foresee future events (Sadowska, 2005; Czerwińska 2009, 2011).

Proper and effective reporting on disability issues is vital for including disability in the development agenda within society. Unfortunately, although Kenyan journalists seldom report on disability-related matters, they have hardly any training on how to do it in a manner that is humanizing and non-stigmatizing. For instance, the most widely read paper in Kenya, Daily Nation, had only 0.003 per cent gender and disability stories during the study and only allocated 0.24 per cent of space for reporting on gender and disability. Instead, these stories are used as fillers, given their poor weighting as news. (Aghan, 2007: 4;Njogu, 2009).

Ayesha Ashfaq (2017) also discovered that almost every visually impaired participant in her study strongly condemned the sympathetic approach of society towards them. The visually impaired are unwilling to accept this stereotypical behaviour of sighted society and consider it inhumane and humiliating. Blindness is a physical phenomenon, but the general population often treats it as a social phenomenon, which is incorrect and creates many obstacles to the progress of blind individuals. Participants believed that mass media also follows this absurd notion of society and continuously portrays blind people in a state of self-pity.

Acritical factor in building the social image of the blind lies in the visual materials created by institutions working to aid disabled people and organizing various social campaigns. Unfortunately, it turns out that, in practice, while having the best interests of the blind in mind while fighting for their positive image, the truth about their actual abilities is falsified (Czerwińska 2007;Śmiechowska-Petrovskij, 2017).

Participants revealed that moral messages condemning individuals with alcohol addiction only pushed them away and succeeded in dismissing them since most reacted defensively. Instead, they preferred messages with scientific justification.

These findings concur with findings from Rozin and Singh(1999:321). First, they describe moralization as converting a preference into a value within a culture and individual life. Their findings predict that liking for and disliking a substance or activity will be more extreme if it (substance or activity) is moralized or treated as a value. They further postulated that values are more likely to produce internalization than instrumental concerns such as health risks because of associated moral meanings.

Studies by Benoit et al. (2015) submit that those abusing alcohol and other substances are habitually regarded as engaging in behaviour that violates social norms and arouses negative social reactions. Breaching the moral code by engaging in substance abuse was often more prominent than evidence of harm by substance use alone.

Benoit et al. (2015) add that those who consume substances are frequently viewed as out-of-control addicts, criminals, or deviants. They further disclose that addiction is sometimes framed through the narrow lens of gendered responsibilization. For example, they established that the use of substances by women, and specifically pregnant women, was viewed as morally wrong by health and social care providers. Furthermore, the magnitude of guilt aligned more closely with the perceived stigma of substance use than with actual evidence of risk to themselves. The normative rhetoric around abstinence is moral, with motherhood framed as a corruptible bastion of purity and selflessness (Bell et al., 2009; Lupton, 2012).

By and large, moralization need not always associate behaviours or preferences with negative moral meanings. In most cases, though, when a situation is moralized, it takes on a negative moral meaning. Moralization often involves a shift in focus to the individual as the problem, not the phenomenon itself or the social context (Frank & Nagel, 2017).

Frank and Nagel (2017) further state that evidence suggests that medical language used in addiction does not necessarily offer liberation from moralized language. Instead, the moralization of addiction invokes shame, blame, and rejection of addicts as those with profound character flaws, often overlooking addiction's social and biological context.

However, Watz (2019) differs from the scholars mentioned. His findings state that morality on alcohol use does not seem to affect how an individual would act morally. An individual remains the same with their interpretation of ideas and values of the world.

In this study, the respondents acknowledged that using celebrities would make the messages more effective depending on the credibility of the celebrity or endorser. Celebrities are critical in passing messages.

Findings from Blakeman (2007:194 and 2015) show that testimonials are most effective when the person used in the testimonial is credible, and the audience can relate to the message. From the data in this study, information about alcohol was mainly endorsed by local celebrities. However, the visually impaired noted no fellow visually impaired endorsers. Besides the use of appeals, the visually impaired felt that messages from television and radio were one-sided and targeted the general audience, especially those warning against drinking and driving since the visually impaired cannot drive.

While researching celebrity-based appeals in health and risk messaging, Myrick (2017) defined celebrities as famous individuals well-known by many public members who frequently appear in media content. She adds that it becomes a celebrity appeal when a celebrity appears alongside another cause — for instance, promoting public health. Thus, celebrity appeals are messages a celebrity advocates for or are implicitly associated with a target behaviour. In health and risk-related messages, celebrity appeals can take the form of public service announcements, advertisements for health and risk-related products, or news coverage of a celebrity's struggles with a health issue or risky behaviour.

In her findings, Myrick (2017) states that celebrity endorsements demonstrate celebrities' ability to draw the audience's attention to an idea or product. Furthermore, celebrity disclosures of illnesses in awareness campaigns can elicit emotions in audiences and motivate behaviour change. Nevertheless, she notes that there are factors that moderate how persuasive a celebrity-based appeal can get — for instance, the credibility of the celebrity, gender, familiarity and involvement with the cause being advanced.

Many celebrities have relied on their prominent social standing to endorse health products or propose medical advice. Celebrity advocacy can lead to the adoption of certain health prevention behaviours. Thus, the use of celebrity appeals is a trend that is expected to increase. Celebrities may alter the public's health-related knowledge by changing the public's understanding of a particular disease's aetiology, risk, diagnosis, and treatment. In addition, they may change the public's health-related attitudes and behaviours and health status outcomes, such as the incidence and prognosis of preventable disease (Hoffman et al., 2017).

Even though the use of celebrity endorsement is increasing, not all instances lead to positive outcomes. In some cases, celebrities have been used to present biased health information that arouses irrational fear and persuades audiences to behave in a particular way rather than educating patients (Larson et al., 2005). In addition, Caulfied (2015) and Sabel and Cin (2016) argue that the power of celebrities to influence public opinion can be a cause for concern.

Myrick (2017) also supports this by noting that media coverage of celebrities has also been associated with harmful effects on lay individuals' well-being. She suggests the need for caveats for message designers who depend on celebrities to get attention for a cause or to motivate individuals to change their health and risk-related behaviours.

The participants in this study stated that they missed out on some aspects of communication, especially non-verbal communication. However, to cope with that, they relied on paralanguage or vocalics to understand the meaning of messages during a conversation.

Nonverbal signals are so established that people almost always unconsciously make decisions based on nonverbal signals. Furthermore, the interpretations of these cues are generally automatic and happen within milliseconds (Weisbuch & Ambady, 2009; Ambady & Gray, 2002).

Visual impairment fundamentally means missing out on a large portion of communication that those with sight take entirely for granted, hence the disconnect between what the visually impaired and the sighted people perceive in communication (Kyle, 2018).

Gestures and facial expressions work together to establish and maintain attentive focus, enable conversational regulation, and send relational messages. Moderately frequent gestures help the communicator be perceived as credible, likeable, and engaging, whereas a lack of gesture is linked to the opposite response (Sharkey et al., 2000).

Vernon (2015) states that visually impaired individuals often depend on other senses like smell, temperature differences, and sound, and must use adaptive techniques to minimize conversational stress. Therefore, people with visual impairment must learn to communicate without receiving the elusive nuances and complementary data provided by visual and nonverbal signals that once made up a significant part of their communication repertoire. Furthermore, such partial messages often interrupt interpersonal communication, creating uncertainty between the interlocutors.

In a sighted culture, nonverbal cues are a valuable part of the message, and are usually unconsciously decoded as part of the message (Ambady & Gray, 2002; Weisbuch & Ambady, 2009). Thus, the visually impaired are constantly left out when communicating.

Vernon (2015) admits that it is not easy to understand a visually impaired person's perception from a sighted person's standpoint. He further acknowledges that communication is more than words. Communication is a tapestry consisting of verbal and nonverbal symbols, creating a complete message.

For some researchers, it is impossible to detach verbal and nonverbal messages in communication (Knapp & Hall, 2006). However, other studies differ from this. Vernon (2015), for instance, notes that separating verbal and nonverbal messages was possible when communicating with people with visual impairment. Therefore, it is necessary to find communication methods without visual and nonverbal cues when communicating with people with visual impairment.

Despite having no visual reference frame for gestures, persons with vision impairments instinctively use gestures while speaking. Nevertheless, they tend to differ from sighted gestures in type and frequency. Despite their difficulty in transmitting appropriate gestural messages to sighted partners, studies indicate that the visually impaired are entirely capable of discerning emotive subtext through vocal means of nonverbal communication (Kyle, 2018).

The problem visually impaired people encounter when communicating with their sighted counterparts involves changing the common practice of depending on nonverbal visual cues as part of the message. Descriptive language provided by the sighted individual takes the place of nonverbal cues, usually providing the rich peripheral information required to complete the message. Moreover, a blind person can understand a kiss as a coded interpersonal nonverbal message. Unfortunately, often, these interactions create a social dependency for the visually impaired individual, reinforcing the socially constructed stigma of reliance and further affecting their self-image and identity (Vernon, 2015).

Kyle(2018) asserts that the obligation for adaptation has traditionally rested on the visually impaired individual who must remodel their behaviour to the majority's social norms. However, she suggests that the sighted community is also responsible for improving communication climates, even though many visually impaired people can be trained to use normative gestural communication in their interactions with sighted partners. The visually impaired are completely capable of understanding and learning to employ gestures and other non-vocal cues considered socially acceptable by the sighted community, although they are significantly disadvantaged in both usage and comprehension of certain aspects of nonverbal communication.

Findings revealed that the visually impaired relied on intermediaries to interpret messages. The visually impaired are compelled to rely on intermediaries to interpret some messages because they have highly individual needs. Yet, the choice of media and, therefore, the design of messages failed to recognize that. Williamson and Schauder(2000) reveal that, traditionally, access to printed material for the blind or sight-impaired has been mediated through others, such as a family member, a helper, or an organization.

The visually impaired audience has been increasingly eliminated from accessing health messages and making informed decisions. This is apparent because the print and electronic media have been immensely absorbed in and consumed by a one-dimensional and limited focus on the able-bodied audience. When it comes to disseminating health messages, the mass media seem to have done this with some measurable degree of distinction; however, the same cannot be said for the blind audience (Chifamba et al., 2011).

Studies conducted by the University of Surrey (2009) postulate that although sighted people read letters and documents to them, the visually impaired would like to do this privately rather than through an intermediary. An essential need for many people with visual impairment was equipment that could read letters and documents to them. The visually impaired prefer to interpret messages independently. Those attending healthcare risked missing appointments due to the delay of having someone available to interpret messages for them.

Equally, education enhances the chances of adequately understanding messages against alcohol abuse. On this, Vergunst et al. (2017) confirm that barriers increase with disability severity and are reduced with an increasing level of education. Furthermore, religion, the clergy, and places of worship are vital sources of interpreting messages. Campbell et al. (2007) support this by stating that Church-based health promotion (CBHP) interventions have great potential for reducing health disparities because they can reach broad populations. In addition, churches and other religious organizations can influence members' behaviours at multiple change levels from a socioecological perspective.

Reports by NACAD (2014) show that, in Kenya, 42% of people with a disability indicate that workshops and seminars would be the best strategy to increase access to drug-related information and 20% support the use of churches for disseminating Alcohol and Drug Abuse Information.

6.8 Key aspects of TTM and HBM in the interpretation of data

At the most basic level, the HBM is a value-expectancy theory that acknowledges that behaviour depends on the subjective value placed on the outcome and the expectation that an action will lead to that outcome. HBM is a widely used cognitive model of health behaviour developed to explain the lack of participation in Public Health Service programmes, responses to experienced symptoms, and medical compliance (Thompson, 2012).

The HBM has provided a valuable framework for investigating health behaviours and identifying fundamental health beliefs, has been widely used, and has met with moderate success in predicting and changing a range of health behaviours (Norman & Conner, 2017).

HBM is suitable for small or high-risk populations; in this study, it was the suitable choice because of the respondents — visually impaired people who face the challenge of alcohol addiction. This model played a significant role in getting information on the beliefs and attitudes of the visually impaired, their perceived risk and net benefits that account for their preparedness to understand and act on communication messages against alcohol abuse.

The concept of perceived barriers provided critical information on the visually impaired people's feelings about the psychological and actual costs of accessing communication messages against alcohol abuse in Nairobi. The concepts of perceived benefits and cues to action provided critical information on how the blind in Nairobi make sense of the communication messages against alcohol abuse. Finally, the concepts of perceived severity and self-efficacy were critical in understanding the experiences of visually impaired people in Nairobi regarding communication against alcohol abuse.

In the analysis of the findings in this chapter, three of the five key action-related components that influence health behaviours were used. They were (1) communicating with the target population; (2) reducing barriers to action; and (3) demonstrating actions through skill development activities. When it came to communicating to the target population the steps involved in taking the recommended action and highlighting the benefits of action, it was realized that the visually impaired relied on intermediaries to interpret messages. Consequently, celebrities, clergy and education centres were some of their preferred sources of information. However, the messages would have been more impactful if the celebrities had been visually impaired themselves.

On the second component, the visually impaired experience barriers when accessing messages against alcohol abuse, hence the need to eliminate them by developing content tailored to their needs. On this matter, the analysis indicated that mass media did not correctly match the needs of the visually impaired, and instead entrenching astereotypical portrayal of the visually impaired. This was experienced mainly in the mainstream media like television channels that very rarely pay any attention to the issues and events affecting the visually impaired. This being the case, it was challenging to realize component three, which involves demonstrating actions through skill development activities and providing support that enhances self-efficacy and the likelihood of successful behaviour changes.

Regarding TTM, Kliegman (2020) posits that it is a dynamic theory of change based on the assumption that a common set of change processes can be applied across a broad range of health behaviours. TTM conceptualizes behaviour change as a process involving a series of six distinct stages: pre-contemplation, contemplation, preparation, action, maintenance and termination. These stages are transtheoretical and integrate principles of change from across a variety of theories of intervention. In the early stages of change, individuals apply cognitive, affective, and evaluation processes to progress forward; the later stages involve commitments, conditioning, contingencies, environmental controls and support to move toward maintenance and termination (Procheska et al., 2002).

With the above in mind, the Transtheoretical Model was critical in giving an insight into the readiness or preparedness of the visually impaired who abuse alcohol to alter their harmful behaviour. It helped me understand how their behaviour changes (as one that transpires in stages), the barriers they encounter, and how to overcome them. It helped explain the experience of the visually impaired who abuse alcohol and their desire to change some behaviour in their routine lives according to the stages of the model.

The pre-contemplation stage was convenient when establishing how the visually impaired in Nairobi access communication messages against alcohol abuse. Stages of contemplation and preparation provided knowledge about the experiences of the VI in

Nairobi regarding communication against alcohol abuse. These stages also offered information on how the visually impaired who abuse alcohol make sense of the communication messages against alcohol abuse. Finally, the stage of action and maintenance helped determine the extent to which the visually impaired maintain their commitment to recommended health behaviours — that is, abstinence from alcohol addiction.

In this chapter, it was noted that mass media does not accurately reflect the needs of the visually impaired. Instead, it further entrenches the stereotypical portrayal of the visually impaired and consequently depicts an inaccurate understanding of what it means to be visually impaired and therefore does the opposite of promoting awareness. Their negative portrayal impeded establishing a positive relationship with the general population. Establishing healthy relationships is one of the stages of change since, through it, it is possible to find supportive relationships that encourage the desired change. It also made it a challenge to realize environmental re-evaluation —in this case, a social appraisal of how their unhealthy behaviours affected others.

6.9 Chapter Summary

In this chapter, I have presented the study findings related to the third research question: How do visually impaired people in Nairobi make sense of the communication messages against alcohol abuse?

The key issues from this chapter are summarized as follows: first, when it comes to disseminating health messages, the mass media seem to have done all this with some measurable degree of distinction; however, this is not the case when the blind audience is included. Mass media does not correctly reflect the needs of the visually impaired, entrenching the stereotypical portrayal of the visually impaired and consequently depicting an inaccurate understanding of what it means to be visually impaired and therefore does the opposite of promoting awareness. Second, even though delivering good information about PWD can create positive awareness about the group, the media are less successful in playing a role in providing information about disability to the community. This is experienced mainly in mainstream media like television channels that pay hardly any attention to the issues and events affecting the visually impaired. As a result, the blind community is marginalized. Furthermore, print and electronic media have been immensely absorbed in, and consumed by, a one-dimensional and limited focus on the able-bodied audience.

Lastly, reinforcing stereotypes and false beliefs concerning visually impaired people is done on several levels through mass media broadcasts. The visually impaired are unwilling to accept this stereotypical behaviour of sighted society and consider it inhumane and humiliating.

CHAPTER SEVEN

SUMMARY OF KEY FINDINGS&CONCLUSIONS

7.1 Overview

In this chapter, I present a summary of key findings and a discussion with reference to the literature presented in Chapter Two. Additionally, I present an overview of my thesis, identify the study contributions and then present the implications for policy practice. I also give suggestions for further related research and reflect on what I have gained from the research process.

7.2 Summary of key findings

7.2.1 Communication Dynamics in Campaigning Against Alcohol Abuse among the Visually Impaired

In relation to research question one —How do visually impaired people in Nairobi access communication messages against alcohol abuse? —findings established that the visually impaired in Nairobi generally encounter diverse barriers when accessing communication messages against alcohol abuse. For example, healthcare facilities are critical in delivering messages against alcohol abuse. However, healthcare professionals have inadequate skills in handling the communication needs of the visually impaired. Similarly, the healthcare venues have inadequate facilities, and this results in the visually impaired encountering mobility challenges.

The interviewees stated that the formats used to convey messages were unfavourable when it came to accessing sources of information. Messages are primarily available through visual media — newspapers, posters, flyers, bulletins, brochures, and magazines— and these were not accessible to the visually impaired because of the size of the texts used and the absence of audio assistance.

In addition, expensive equipment and inadequate assistive technologies make it difficult for the visually impaired to access messages. This is compounded by online messages not being available in formats accessible to the visually impaired.

Socio-cultural dynamics such as gendered socialization affected the perceived need for information on alcohol. In gender, for instance, males have been socialized to believe they are self-sufficient; hence, alcohol-addicted visually impaired males shy away from accessing messages against alcohol abuse.

In a nutshell, the visually impaired encounter multiple barriers when accessing health messages. The barriers encountered range from prejudices, unfavourable socio-cultural tendencies and attitudes from healthcare providers, particularly if health outcomes are perceived as poor. Healthcare workers also had limited knowledge of communicating with the visually impaired and of using Braille. Furthermore, many drug and alcohol treatment and prevention services are available through visual media: newspapers, posters, flyers, and magazines. Thus, they are not easily accessible to individuals with visual disabilities.

7.2.2 Experiences of Visually Impaired People Regarding Communication Against Alcohol Abuse

In relation to research question two - What are the experiences of visually impaired people in Nairobi regarding communication against alcohol abuse?-the findings revealed that the visually impaired experienced lack of privacy when accessing healthcare against alcohol abuse. Respondents reported that alcohol abuse prevention and healthcare messages were rarely available in a format they could read independently. Most messages against alcohol abuse were available in unsuitable communication formats — such as newsprint, posters, flyers, bulletins, brochures and magazines — making them feel left out. In most cases, they had to rely on friends and healthcare service providers to assist in interpreting messages on visual media. Consequently, they lacked privacy when accessing healthcare against alcohol abuse.

Lack of privacy or confidentiality was experienced when, while accessing healthcare services, they had to rely on relatives and friends to read and interpret their medical appointment letters and other medical documents on their behalf. Sometimes, when the healthcare personnel had difficulties communicating with the visually impaired patient, they sought assistance from their caregivers, making them (the visually impaired) uncomfortable. They felt they lacked the independence to freely make choices in their personal and social lives without seeking assistance. The loss of autonomy contributed to a negative feeling when accessing healthcare messages.

The visually impaired addicts also experienced discrimination. Discrimination occurred when they were treated less favourably than the general population in similar circumstances while seeking healthcare and rehabilitation centres. Most healthcare professionals had unjustified fears and shared beliefs that the visually impaired cannot perform tasks independently. Therefore, during their communications, the visually impaired were presumed unable to make independent and correct decisions. In addition, some were assumed to have other disabilities, like intellectual disabilities.

They felt desperate due to perceived discrimination and rejection, leading to excessive alcoholism and drug abuse amongst some visually impaired.

To summarize, since most health messages are in formats not accessible to visually impaired people, the visually impaired experience a loss of autonomy and privacy while accessing healthcare information because they frequently have to rely on others to help them. Consequently, client confidentiality is compromised. The visually impaired desire to access communication messages in their preferred reading format.

In addition, the inability to access health information has a negative psychological impact on them. The visually impaired confront stereotyping and discrimination as forms of social stigma, which are barriers to accessing messages against alcohol abuse. In most cases, disability is associated with dependence, disease, helplessness, and curses in many cultures.

7.2.3 Audience Reception of Alcohol Abuse Messages Among the Visually Impaired

In relation to research question three-How do the visually impaired people in Nairobi make sense of the communication messages against alcohol abuse?-findings pointed out that the visually impaired did not conform with the stereotypical way they are portrayed in the media —needing assistance, eliciting sympathy, and becoming objects of charity.

The visually impaired preferred objective messages. Moral messages condemning individuals with alcohol addiction only succeeded in pushing them away and making them react defensively. Additionally, the respondents preferred that messages that condemn harmful drinking behaviours be supported with scientific justification.

The use of celebrities makes the messages more effective but this is dependent on the credibility of the celebrity or endorser. Endorsers, in this case, could be celebrities, well-known persons or typical persons. In most cases, messages are perceived as credible when the character is viewed as trustworthy, and the audience can relate to the message conveyed.

During conversations or listening to audio sources, the visually impaired use paralanguage or vocalics to understand the meaning of messages during a conversation or to make perceptions. Participants revealed they could interpret the vocalics. Furthermore, the respondents identified pitch, volume, and intonations as some of the components they used to give meaning to statements or understand the presenter's emotions when communicating with them.

In Kenya, the media seldom report on disability-related issues and are less successful in playing a role in providing information about disability to the community. Yet, delivering good information about PWD can create positive awareness about the group. Moreover, celebrities are critical in passing messages. To the visually impaired, testimonials are most effective when the person used in the testimonial is credible and the audience can relate to the message. However, there is never a fellow visually impaired endorser in the testimonials, which presents a challenge when connecting with the message conveyed.

Medical material and other reference content are hardly ever obtainable in alternative, accessible formats. Additionally, the visually impaired experience incompatibility challenges when accessing health communication in cyberspace. Those who are able to access messages on the internet through automated screen readers as the standard method. However, due to the scarcity of automated screen readers, VIaccess to health information from the internet is low.

The visually impaired have highly individual needs, yet the choice of media and, therefore, the design of messages fails to recognize that, with the result that they have recourse to intermediaries. In this study, interviewees said they preferred religious leaders, local authorities, teachers, friends, and close family members to assist when they faced difficulty interpreting messages. Moreover, they felt comfortable confiding with them as their intermediaries.

As far as the needs of visually impaired people are concerned, producing any tailored content can support them. The lack of such tailored content means that blind and VI people are significantly at risk for alcohol and drug abuse.

7.3 Overview of my thesis

In this study, I investigated the audience reception of alcohol abuse messages among the visually impaired in Nairobi County. I conducted this study at a time when Kenya is being plagued by alcohol addiction, and alcohol continues to bear the highest burden of substance abuse disorder among Kenyans. Many adults are addicted to alcohol, and a notable treatment gap persists. Besides, Nairobi County has the highest prevalence of alcohol abusers. Nairobi County also has high levels of alcohol and other drug abuse among PWDs in Kenya. (NACADA, 2017 and 2022; Patel, 2020).

Alcohol abuse prevalence levels are high despite efforts from the Kenyan government and other key players to manage alcohol and other related problems. Mass media campaigns against alcohol act as sources of information to halt alcohol abuse and its potentially harmful effects. However, while the campaign is supposed to facilitate public participation in controlling alcohol and drug abuse, the media platforms and venues do not favour people with visual impairment. Yet, visual impairment is the second highest of all the domains of disabilities.

The substance abuse prevalence of PWD is significantly higher than that of the general population. The treatment gap between PWD needing treatment and those receiving treatment for alcohol addiction is enormous. Hence, they have higher chances of struggling with substance abuse when compared with the general population. Despite the high rates of alcoholism and substance abuse, alcohol prevention and health promotion activities rarely target PWDs (American Addiction Center Resource, 2017; Moore& Li Li, 1998). In Nairobi, there are low levels of awareness of communication on treatment against alcohol abuse among PWD (Kathingu, 2015; NACADA, 2017 and 2022; Patel, 2020; Muthuri, 2021).

This study was prompted by the desire to generate empirical data that could advance an audience-centred approach to social change communication among the visually impaired. Findings will be critical in the ongoing reforms in developing health campaigns by the Ministry of Health, specifically messages targeting the visually impaired as PWDs. In addition, they will enhance the provision of timely information that is person-centred, especially when disseminating messages to the visually impaired.

In terms of literature, the study fits within the current understanding of communication studies on promotional health information communication. When it comes to access to health messages against alcohol abuse among the visually impaired, scholars argue that information is not always accessible or appropriately packaged, yet healthcare information is significant in supporting and improving the social care and health status of the visually impaired (Catherine et al., 2011; Darzi, 2008). Visually impaired people encounter diverse barriers in light of accessing communication messages against alcohol abuse. The obstacles range from communication, information, environmental, economic, and social, preventing them from achieving the desired quality of life (American Addiction Center Resource, 2017, Davis, 2010; Benedicte & Lisbet, 2009; O'Day et al., 2004). When it comes to making sense of it all, the visually impaired face difficulties satisfying their information needs through media content that focuses more on visuals and less on audio description. Their exclusion leads them to perceive that messages are only targeted at the general population.

Nevertheless, they seek assistance from intermediaries such as religious leaders, local authorities, teachers, friends, and close family members when they face difficulty interpreting messages. Intermediaries largely buffered their challenges in interpreting messages. Additionally, celebrities are critical in helping to promote healthcare messages.

In this study, the research design adopted was Phenomenological research design. Qualitative research method was used to generate and analyse data. Using a purposive sampling procedure, 25 participants with visual impairment were identified from rehabilitation centres and institutions for the PWDs within Nairobi County. Data was generated through in-depth interviews. The interviews were recorded, transcribed, analysed thematically, and presented in narrative form according to the themes.

Generally, the study showed that many alcohol treatments and prevention messages are available through visual media — newspapers, posters, flyers, and magazines — which are not accessible to the visually impaired. Thus, the VI often relied on intermediaries to interpret the messages communicated through visual media. Yet, content on the mass media rarely paid attention to alcohol addiction issues affecting the visually impaired and, thus, did not appropriately cater to the needs of the visually impaired. Additionally, socio-cultural dynamics such as gendered socialization influenced the interpretation and perceived need for information on alcohol. The study concludes that current communication interventions on alcohol abuse, including formats used to communicate them, do not adequately address the specific needs of the visually impaired. And yet this is the very group that is disproportionately affected by alcoholism. The study further notes that health messages would be of more value to the visually impaired if they were communicated in formats accessible to them and had content tailored to their specific needs. This study has identified what I consider several main contributions to knowledge, which I will highlight in the next section.

7.4: Contribution of the Study

Based on my knowledge of the context of the study, the literature review I carried out and the data analysis, I would say that my research makes significant contributions to knowledge, especially in the field of development communication.

In the Kenyan context, I hardly came across any study that specifically focused on the audience's reception of health communication among the disabled, let alone the visually impaired. Kathungu (2015) acknowledges a general absence of comprehensive data on the extent of drug use among people with disabilities in Kenya. This study sought to contribute to that area of study. The study makes an essential contribution to the literature on disabled people, specifically the visually impaired, considering that, as Csiernik and Brideau (2013) uphold, studies on disability and their relationship with substance use are limited worldwide. Additionally, in adopting a qualitative approach, this study further enriches the discipline of health communication since qualitative research is familiar in other fields but still comparatively underrepresented in research related to health services (Busetto, 2020).

In terms of substantive findings, this study determined that current communication interventions on alcohol abuse, including formats used to communicate them, do not adequately address the specific needs of the visually impaired. Yet, this group is disproportionately affected by alcoholism. Many alcohol treatments and prevention messages are available through visual media — newspapers, posters, flyers, and magazines — which are not accessible to the visually impaired. Thus, to overcome this, the visually impaired often relied on intermediaries to interpret the messages communicated through visual media, which meant they lost their privacy and autonomy. Hence, this study recommends that more appropriate formats and aids are used for the visually impaired — for instance, Braille and assistive devices.

Additionally, content on the mass media rarely pays attention to alcohol addiction issues affecting the visually impaired and, thus, does not appropriately cater for the needs of the visually impaired. The study further noted that health messages would be more valuable to the visually impaired if they were communicated in formats accessible to them and had content tailored to favour their specific needs. Besides, socio-cultural dynamics such as gendered socialization influenced the interpretation and perceived need for information on alcohol. Hence, this study recommends an effective audience analysis (involving inclusive participation of the visually impaired) before developing appropriate and effective communication interventions for marginalized groups such as the visually impaired.

In healthcare facilities, healthcare professionals were inadequately trained to communicate with the visually impaired. This was illustrated when the communication techniques used by healthcare professionals and caregivers were not individualized to suit the needs of the visually impaired. In addition, most healthcare professionals did not have specialized training in handling the visually disabled and their precise communication needs, and they lacked knowledge of and skill with Braille. Hence, this study recommends developing policies that enhance healthcare professionals' training to enable them to communicate appropriately with the visually impaired.

7.5 Implications for policy and practice

These implications arise from my analysis of the issues identified in the discussion as possible constraints to enhancing access to messages against alcohol abuse to the visually impaired; hence, what may need to be done to improve their experience. The major implications are outlined below:

7.5.1 Effective audience analysis for proper portrayal of PWD in the media

The media depicts an inaccurate understanding of what it means to be visually impaired and therefore does the opposite of promoting awareness. As discussed earlier in this study, findings pointed out that the visually impaired were not conformable with how media consistently portrays them as needing assistance, sympathy and charity. The respondents felt that due to the low projection of the visually impaired, society had been encouraged to pity them and not recognize them as ordinary beings, thus hindering normal communication. Therefore, they face difficulties satisfying their information needs through the media.

PWDs are often objectified and excluded from many aspects of life and stereotyped as dependent and incompetent. Many depictions in the media generate and perpetuate limiting assumptions about what people with disabilities can accomplish, particularly concerning vision. These unrealistic characterizations generate false ideas in the general population about those who are blind and visually impaired. In addition, these unrealistic portrayals can spur the public to behave inappropriately around people with visual impairments and exclude them from certain opportunities.

Negative and inaccurate portrayals reinforce common misconceptions held by the public; therefore, it is essential to conduct proper audience analysis to satisfy the information needs of the visually impaired as part of the heterogeneous social group of PWDs.

Audience analysis encompasses identifying the audience and adapting a message to their interests, level of understanding, attitudes, and beliefs. An audience-centred approach is critical because communication will be more effective if the presentation is created and delivered appropriately. However, sometimes identifying the audience through extensive research is challenging, so adaptation often relies on the healthy use of imagination.

When conducting audience analysis, the media must know more about the visually impaireds' wants, needs, and values, making it possible to develop effective messages. Success will depend on how well they can tailor the messages to their audience.

Ashman (2018) states that it is important to reflect the needs of the primary audience, which are the intended audience and the people they have in mind when deciding to communicate something. However, when analysing them, the communicator must also beware of the secondary audience. These are other people they could reasonably expect to come in contact with the message. She adds that beyond these two audiences, the communicator must also consider the hidden audience, people with whom they may not have intended to come in contact with the audience (or message).

Content should target five main audiences with different aims for social impact. According to Brylla (2022), the audience analysis strategy has been implemented through a range of partnerships with organizations and individuals:

Visually impaired groups: In this case, the health message should target the visually impaired as the key audience. The messages should be simple, clear and descriptive enough, and with media being aware of stigmatizing media representations and the risk of stereotyping. Preferably, there should be more demonstrations made using fellow visually impaired. In addition, the media should take the opportunity to identify opportunities for promoting well-being, awareness, and empathy.

Clinical groups: These comprise clinicians, therapists, and rehabilitation workers. They can be categorized as the secondary audience since they fall in the category of other people who could reasonably be expected to come in contact with the message.

Research groups: These comprise researchers in visual impairment and disability contexts (cultural studies, media studies, anthropology, psychology, art therapy, and medicine). The messages should be clear to enable them to identify underrepresented areas for further research and to encourage knowledge exchange with stakeholders outside academia.

Media groups: These could comprise the commissioning editors, producers, writers, and film directors. The messages should enable them to acquire critical media literacy to understand the mechanisms of media stereotyping of the visually impaired. Messages should encourage them to use media to break stigmatizing stereotypes.

General public: Messages broadcast must aim to adjust prejudice and behaviour towards blind people, reconfigure stereotypes, and reduce overall public stigma.

When done well, media can desensitize and educate the public and accurately portray people with disabilities (American Foundations for the Blind, 2022). Proper and effective reporting on disability issues is vital for the inclusion of disability in the development agenda and within society. Unfortunately, Kenyan journalists have hardly any training on how to do it in a manner that is humanizing and non-stigmatizing and seldom report on disability-related matters. Thus, journalists must undergo proper training on how to report disability-related issues.

7.5.2 Training healthcare personnel to communicate with VIs and making healthcare facilities accessible

There is a need to have trained healthcare personnel with the skills to communicate with the visually impaired. Plus, healthcare centres in Kenya should provide communication access plans for visually impaired patients.

People with disabilities go through significant barriers to accessing healthcare. Among others, the barriers include lack of communication and accommodation in healthcare settings, untrained personnel, negative attitudes from healthcare providers, and physically inaccessible medical clinics and hospitals. This study revealed that visually impaired participants faced communication barriers with healthcare professionals when accessing communication messages against alcohol abuse and medication-related information.

Visual impairment should not create a barrier to effective communication with any patient. With that in mind, this study suggests strategies that Osborne (2020) supports to improve communication with visually impaired patients. Below are the strategies:

Providing reasonable accommodations: Healthcare facilities must make reasonable accommodations for the visually impaired. Accommodations mean providing information in large print, audiotape, or Braille formats and having a person available to read information aloud. Further, it is essential to inquire whether the visually impaired want assistance**.**

Providing clear directions for access: The visually impaired desire to be as independent as possible when moving around the healthcare centre. Detailed directions that make use of available landmarks should be provided. Offering guidance should be from the visually impaired person's perspective. And, lastly, it is essential to use both print and Braille for signs.

The visually impaired rely on verbalized instructions or directions for effective communication at different points of a patient visit. Below are the options that, when implemented, will facilitate communication. They are in line with proposals from the Centers for Medicare & Medicaid Services (2021). They are:

Assisting patients with written documents or paperwork. Healthcare staff may read aloud written materials, such as checking paperwork. However, when aiding a patient with sensitive paperwork or written documents, it is vital to maintain the patient's privacy.

Developing a communication access plan is essential since the plan can describe how providers and staff verbally identify themselves when entering a room. For instance, during most healthcare visits, patients interact with multiple providers, including medical assistants, nurses, and doctors. Therefore, identifying oneself verbally according to the guidelines of the access plan upon entering a room is important.

While communicating, providing other auditory cues as needed is essential, as this will facilitate effective communication for the visually impaired.

Communicating with the visually impaired requires several competencies, such as the ability to listen, which is a valuable instrument in developing a relationship of help. To reach satisfactory and humanized communication, healthcare workers must involve themselves and believe that their presence is significant as performers of technical procedures.

Studies by Macêdo-Costa et al. (2014) confirm that the Model of Verbal Communication with a blind patient is effective. Thus, its use is recommended when taking care of blind patients. When communicating with the visually impaired patient, it is up to the healthcare worker to verbally describe the procedure in detail and clearly before intervention. Describing in detail implies mentioning their name as healthcare workers, their function, the procedure to be performed, how the procedure will be done, who will do it and the purpose of the procedure. This provides security, tranquillity and familiarity to the patient. Besides that, they should have empathy when communicating with visually impaired patients.

Generally, technical knowledge does not always work so well in stressful conditions. In such a case, the effectiveness of the communication is supported by the empathy and respect established (Ferreira, 2006). Standing alongside the patient to listen to them is a therapy action which should be recognized (Pontes, 2008).

7.5.3 Operationalization of policies that enhance access to health messages, uniformity and capacity building of PWDs

The Persons with Disability Act was implemented in 2004. Later, the Act created the National Council for Persons with Disabilities (NCPWD) — a semi-autonomous government agency with broad mandates for persons with disabilities. Furthermore, all sections of the Act were gazetted in January 2010.

The Act provides equal opportunities and the right to health, education, employment, and access to buildings, information and services. It also recognizes that persons with disabilities face discrimination in various forms and that the government shall act to the maximum of its resources to realize the rights of persons with disabilities as set out in the Act. The Disability Act provides for the rights, rehabilitation and equalization of opportunities for persons with disabilities (NACC, 2021).

However, while the Act provides equal opportunities and the right to health for PWDs, studies have indicated that Kenya has not equalized opportunities for PWDs. For instance, discrimination is still the biggest challenge in ensuring accessibility to drug information (Addiction Center, 2022; NACADA, 2014; Kathungu, 2013). Currently, there is a considerable treatment gap between those who receive treatment for alcohol abuse and those who need it. Moreover, among those with a physical disability, substance addiction and abuse are even higher (NACADA, 2014; Glazier & Kling, 2013; Kathungu, 2013; Koch et al., 2002).

While Disabled Persons Organizations (DPOs) endeavour to realize disability mainstreaming in matters affecting them, like access to appropriate healthcare, three significant challenges have been highlighted by OHCR (2015). First is their disjointed approach, where each or some operate independently and not within a recognizable network. Secondly, there are inadequate funds for disability mainstreaming programmes conducted by the DPOs. Most of those organizations have capacity challenges, mainly financial, which inhibit their lobbying ability at national, regional, and international levels. The funds obtained from the exchequer or government are insufficient to meet the demands for support expressed by PWDs and their organizations. Thirdly, there is the challenge of inadequate human resource capacity and low organizational and management capacity for DPOs, which inhibits their ability to articulate issues in the sector. As a result, many cannot generally implement projects. Consequently, they require a high investment in financial resources and time to ensure the required capacity is in position before funding can be undertaken.

Nonetheless, there is still a very high expectation from PWDs. Therefore, it is essential for the government to adequately fund and strengthen the capacity of representative organizations of PWDs to facilitate their participation in legislative, policy and other decision-making processes. Furthermore, having the required finances will enhance their ability to lobby for access to better healthcare amongst the demographic in Kenya. Policies that ensure harmony and coordination in their operations are vital to avoid the current disjointed approach, where each or some operate independently and not within a recognizable network.

7.5.4: Developing access to healthcare programmes that are disability-inclusive

There is a need for programmes that plan for disability inclusion. Such programmes will ensure barriers are identified and removed and disability-specific processes are in place. Inclusive programmes also ensure that the visually impaired can access more expansive opportunities.

In Kenya, as in other parts of the world, negative cultural practices and attitudes toward disability present a challenge. Like persons with other disabilities, the visually impaired are still discriminated against within communities and many other spheres of life. Consequently, they miss out on many opportunities for self-improvement and live impoverished lives.

An environment that is disability-inclusive enhances access to healthcare information and awareness. In addition, disability-inclusive development encourages awareness of and active participation by people with disability. The development approach should emulate the CBM Report of Inclusion Made Easy in Eye Health Programmes (2020).

Disability-inclusive development sets out to achieve equality of human rights and full participation in and access to all aspects of society. Thus, the development approach made should respect the diversity in the contribution made by people with disability and appreciate that disability is an everyday part of the human experience.

Disability-inclusive health programmes should be designed to welcome and support all community members regardless of their disability and whether disabled or not.

Disability-inclusive programmes should also be created in a way that they can respond to attitudinal, physical, communication and policy-related barriers.

The following points exemplify what a disability inclusion programme for the visually impaired should entail:

a) A disability inclusion committee that is made up of staff with knowledge of access strategies for people with a visual impairment and a wide range of disabilities, including knowledge of particular access requirements for women and girls with disability.
b) The presence of large contrasting signage, availability of messages translated in Braille and other assistive devices for people with visual impairment.
c) Staff who are welcoming and with positive perceptions about people with disability and inclusive attitudes.
d) Availability of staff trained in communication skills for people with visual impairment in healthcare facilities.
e) A focal person responsible for gender-sensitive disability inclusion.
f) Financial support to ensure people in poverty with a disability can access treatment.
g) Networks, linkages, referrals and access to a low-vision unit.
h) A disability policy and a committee to oversee its implementation.

7.7 Suggestions for future research

Alcohol addiction can occur in visually impaired people just as often as in anyone else. Understanding the communication barriers people with visual impairments face and their available communication options can help support addiction recovery. That said, a number of issues have been featured in this study that would require further empirical investigation. For a start, I propose replicating this study in other contexts — for instance, conducting a similar study in another country. In the context of gender, this study offers an opportunity to investigate the variations in interpreting messages against alcohol abuse among males and females in Kenya.

Lastly, during this study, some unique issues arose for which I had insufficient resources to be able to draw conclusions. For instance, the literature in this study submits that the media are less successful in playing a role in providing reliable information about disability and alcohol and drug abuse to the community. Yet, delivering good information about PWD can create positive awareness about the group. Effective and proper reporting on disability issues is critical for including disability in the development agenda and within society. Unfortunately, Kenyan journalists seldom report disability-related matters and have hardly any training about reporting on issues affecting the disabled in a humanizing and non-stigmatizing way. Consequently, I propose a study on media coverage and creating awareness of healthcare for persons with disabilities undergoing substance abuse in Kenya, specifically the visually impaired.

7.8 My reflection as a PhD scholar

Looking back, I have learnt that a PhD is not just about my chosen field of specialization but also about how I develop as a researcher. I agree with the view of Kamler and Thomson (2006) that doctoral thesis writing is an interplay between research activity and writing. From the rigorous nature of this research, I appreciated the recursive, non-linear and reiterative process of thesis writing that continually kept me reflecting on my position concerning my research.

On a personal level, I have a visually impaired brother who is undergoing rehabilitation. Therefore, the motivation to choose the research topic naturally stemmed from a concoction of my personal experience and feelings besides the gaps I had identified in the relevant literature. In addition, I reckoned that my knowledge of development communication (acquired from my master's studies and invigorated by my PhD coursework) presented the perfect foundation to build on. Therefore, I was reasonably confident I could conduct my study once I started reading the literature.

Concerning data analysis, I became progressively conscious (through constant deliberations with my supervisors and reading literature sources) that the foundation of a desired analysis is a robust methodology and a sensible analytical framework. That said, perhaps one of the greatest gifts I got from this study was how to apply qualitative research. With the guidance of my supervisors, I appreciated the realization of the several strands of philosophical thoughts that inform qualitative research; plus, the fact that it examines aspects that I never imagined would be explored, such as morality, imagination, expressions and beliefs.

Thanks to the expressions of the visually impaired people as the key respondents, I want to highlight that this study lays bare the gaps present when developing health messages to the public, particularly the disabled. For instance, this is evident when looking at the challenges affecting the visually impaired when accessing healthcare-related messages in Kenya. On this, I endeavour to continue seeking dependable answers and engaging more experts in furthering contributions to the knowledge available.

Ultimately, I would like to recap by stating, like Mark Nartey (2021), that my involvement with the doctoral thesis (in my quest to earn a PhD) was intellectually exhausting, physically strenuous and emotionally draining. At some point, this long journey mirrored the confession of Afful (2008) that PhD thesis writing can be "messy". Nevertheless, the experience formed a vital part of the entire process. The success of this study is a manifestation of my long journey to achieve an eventual sense of victory and fulfilment.

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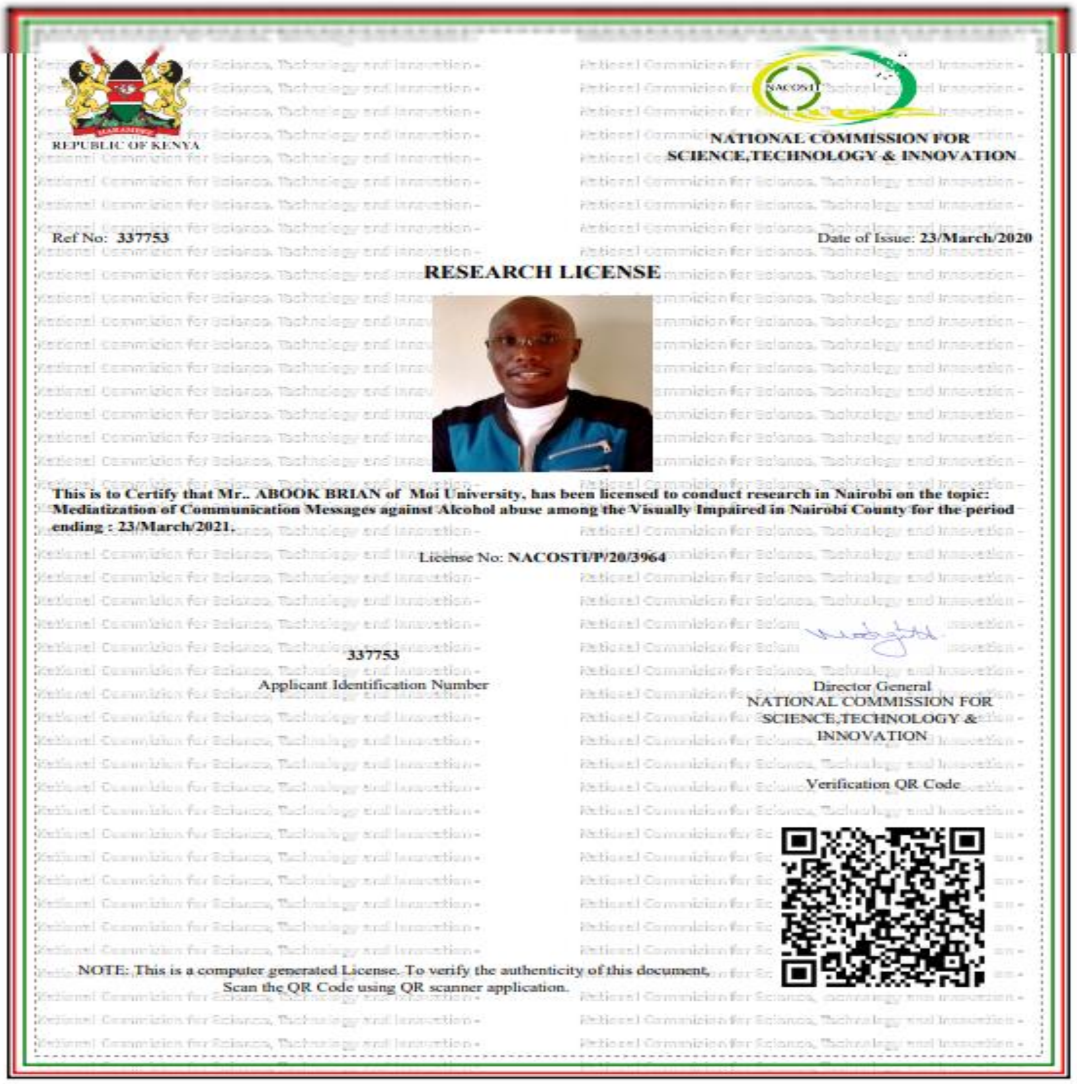
APPENDICES

Appendix I: Copy of NACOSTI Research Permit



REPUBLIC OF KENYA

NATIONAL COMMISSION FOR
SCIENCE,TECHNOLOGY & INNOVATION

Ref No: 337753

Date of Issue: 23/March/2020

RESEARCH LICENSE

This is to Certify that Mr.. ABOOK BRIAN of Moi University, has been licensed to conduct research in Nairobi on the topic: Mediatization of Communication Messages against Alcohol abuse among the Visually Impaired in Nairobi County for the period ending : 23/March/2021.

License No: **NACOSTI/P/20/3964**

337753
Applicant Identification Number

Director General
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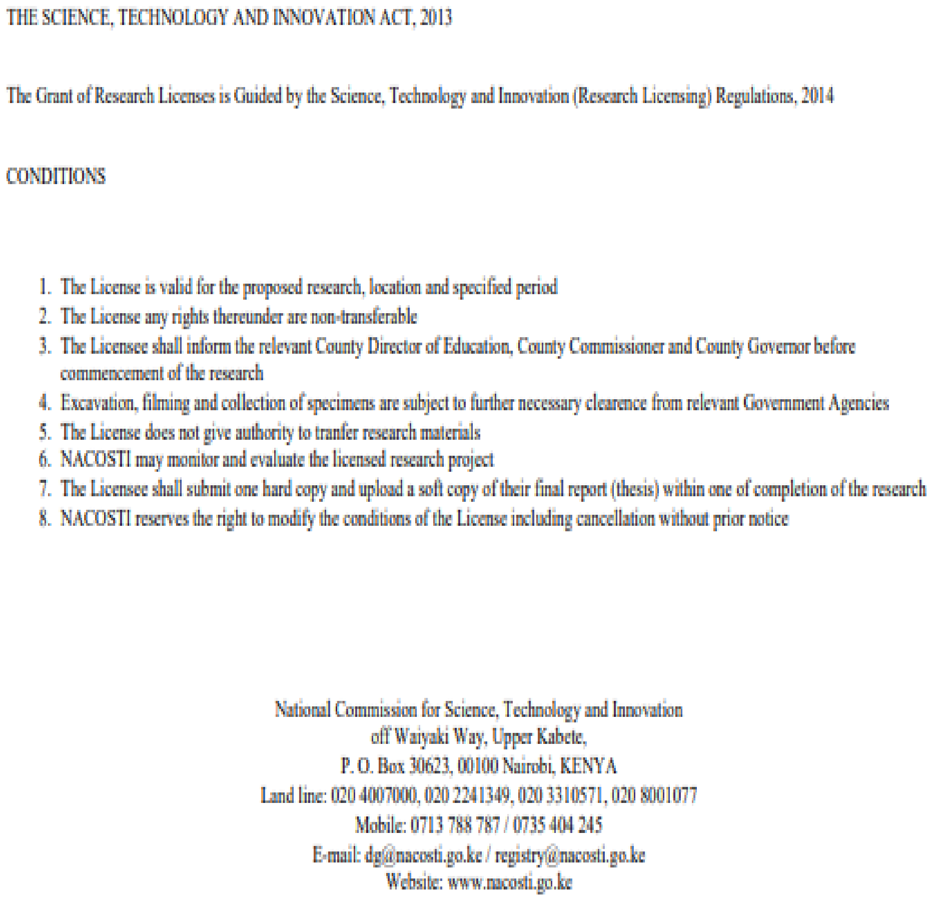

THE SCIENCE, TECHNOLOGY AND INNOVATION ACT, 2013

The Grant of Research Licenses is Guided by the Science, Technology and Innovation (Research Licensing) Regulations, 2014

CONDITIONS

1. The License is valid for the proposed research, location and specified period
2. The License any rights thereunder are non-transferable
3. The Licensee shall inform the relevant County Director of Education, County Commissioner and County Governor before commencement of the research
4. Excavation, filming and collection of specimens are subject to further necessary clearence from relevant Government Agencies
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6. NACOSTI may monitor and evaluate the licensed research project
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National Commission for Science, Technology and Innovation
off Waiyaki Way, Upper Kabete,
P. O. Box 30623, 00100 Nairobi, KENYA
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Mobile: 0713 788 787 / 0735 404 245
E-mail: dg@nacosti.go.ke / registry@nacosti.go.ke
Website: www.nacosti.go.ke

Appendix II: copy of Research Permit from Nairobi County

NAIROBI CITY COUNTY

Telegraphic Address
Email: info@nairobi.go.ke
Web: nairobi.go.ke

CITY HALL ANNEXE:
P .O. BOX 30298 GPO – 00100.
NAIROBI, KENYA

EDUCATION, SOCIAL SERVICES AND GENDER

Our Ref: GL/NC/141 VOL. VI/347

19th February, 2021

Abook Brian
Moi University
P.O. Box 3900 30100
NAIROBI

RE: RESEARCH AUTHORIZATION

Following your application to carry out Research and Subsequent approval by National Commission for Science, Technology and Innovation vide letter Ref: **NACOSTI/P/20/3964** dated **23rd** March, 2020;

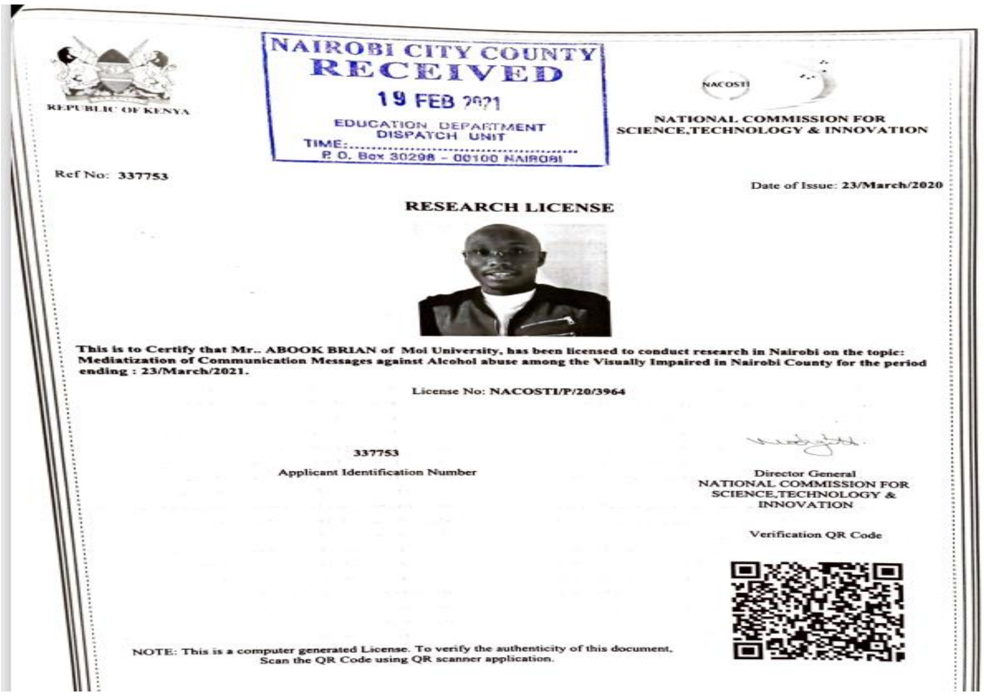
I am pleased to inform you that authority has been granted to you to carry out research on *"Mediatization of Communication Messages against Alcohol abuse among the Visually Impaired in Nairobi County"*.

On conclusion of the study, you are expected to submit a copy of the research findings to the undersigned:

RAPHAEL K. KINYUNGU
DEPUTY DIRECTOR EDUCATION – PROJECTS, PARTNERSHIP, POLICY & PLANNING

Copy to: Chief Officer – Education, Social Services & Gender
Director City Education

"The City of Choice to Invest, Work and Live in"



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Appendix III: Sample Informed Consent Form

Title of study: Audience Reception of Alcohol Abuse Messages Among the Visually impaired in Nairobi County
Investigator: Abook Brian
Institution: Department of Communication Studies, Moi University

Introduction:
I am Abook Brian, a Doctor of Philosophy student from the Department of Communication Studies of Moi University. I am researching Audience Reception of Alcohol Abuse Messages Among the Visually impaired in Nairobi County.

Purpose of this research study
This study intends to find out how the visually impaired in Kenya accessed and made sense of alcohol abuse messages in Kenya; with a view of proposing an audience-centred approach to social change communication among this demographic.

Procedures
I am inviting you to take part in this research project. If you accept, you will be asked to participate in an interview with me. This will take between 1 hour to 1 hour and 10 minutes of your time. During the interview, I will sit down with you at the rehab center or any other area of your choice. If you do not wish to answer any questions during the interview, you may say so, and I will move on to the next question. It will be as interactive as possible. So, feel free. No one else except myself will be present unless you want someone else to be there.

The recorded information is confidential, and no one else will access the information documented during your interview.

Possible risks or benefits
There is no risk involved in this study except your valuable time. Therefore, there is no direct benefit to you also. However, the study's results may help improve the development of health messages targeting PWDs, with a particular focus on the visually impaired.

Right of refusal to participate and withdrawal
You are free to choose to participate in the study or not. You may also withdraw at any time from the study.

Confidentiality
The information provided by you will remain confidential. Nobody else except myself will have access to it. Your name and identity will also not be disclosed at any time. However, the data may be seen by an Ethical review committee and published in a journal and elsewhere without giving your name or disclosing your identity.

Available Sources of Information
If you have any further questions, you may contact me on 0718023933.

AUTHORIZATION:
I have read and understood this consent form and volunteered to participate in this research study. I understand that I will receive a copy of this form. Furthermore, I voluntarily choose to participate, but I understand that my consent does not take away any legal rights in the case of negligence or other legal faults of anyone involved in this study. Furthermore, I understand that this consent form does not replace applicable state or local laws.

Participant’s Name:
Signature :
Date :

Investigator’s Name :
Signature :
Date :

Appendix IV: Sample Interview Introduction & Guide for The Visually Impaired Respondents

Introduction (Part 1)

In Kenya, the visually impaired report a lack of awareness of where to get reliable information on treatment and prevention of Alcohol Abuse. People with visual impairment are considered most at risk of Alcohol and drug abuse, with recent studies showing that 40-50% of people with vision impairments may be categorized as heavy drinkers. Despite this, scarce literature exists on the specific aspects of health information and communication interventions suitable for the visually impaired. Additionally, studies on communication barriers undermining access to healthcare information resources and messages to the visually impaired are scarce. The gaps identified above constituted the problematic issue that motivated this study.

This study intends to find out how the visually impaired in Kenya access and make sense of alcohol abuse messages in Kenya; with a view of proposing an audience-centred approach to social change communication among this demographic. Specifically, the study seeks to answer the following research questions: How do the visually impaired people in Kenya access communication messages against alcohol abuse? What are the experiences of the visually impaired people in Kenya regarding communication against alcohol abuse? And how do the visually impaired people in Kenya make sense of the communication messages against alcohol abuse?

To arrive at that, I shall engage you in a friendly interview session and ask you the following guiding questions:

Field Research Questions (Part 2)

1. What kind of information regarding alcohol do you have access to?
2. Tell me about any local initiatives that educate people on alcohol abuse?
3. Describe the features that you like/dislike about them?
4. How often are you involved in developing and distributing in formation regarding alcohol abuse?
5. Tell me about any mass media campaign against alcohol abuse and how it changed your feelings towards alcohol.
6. What impact does a mass media campaign against alcohol abuse have in your life?

APPENDIX V: SAMPLE OF INTERVIEW TRANSCRIPT

Transcript for Respondent 14: Joshua P1, P4, P3 & P2 **Date:** 12th March 2021

00:00 SPEAKER1: Your name please.
00:01 SPEAKER2: Joshua Mwonga.
00:04 SPEAKER1: Your persons with disability number is one three five zero six-1.3.3.5.0.6 (reading from the PWD card given to me by the respondent)
00:09 SPEAKER2: Yeah.
00:11 SPEAKER1: Welcome to the discussions today. Jushua, what kind of information regarding alcohol do you have access to? What do you know about alcohol and from which source of information?
00:27 SPEAKER2: It's a form of entertainment and relaxing for many people. But at some point, it's been not assumed, but of I used therefore leading to social vices in the society; like addiction.
00:52 SPEAKER1: From which source did you get this information?
01:00 SPEAKER2: Most probably, we've seen it with our relatives. Not from hearing from someone. We've seen it being done by our relatives and so forth and friends.

01:19 SPEAKER1: Tell me about any local initiatives that educate people on alcohol abuse, any local, like say the chief in that area has been doing to prevent alcohol abuse?
01:30 SPEAKER2: The Chiefs only arrest people who bring chaos due to alcohol influence. Most likely the clergy people preach against alcohol. Yeah.
01:46 SPEAKER1: Have you ever participated in them (the local initiatives)?
01:53 SPEAKER2: Not that active that, let's say passive. I was not active, but I was a member in initiating that.
02:07 SPEAKER1: So, what did you like or dislike more about these local initiatives?
02:15 SPEAKER2: That is, first of all, it changed one of my best friends, one of our neighbors at our place from taking alcohol and also Bhang. Yeah, he stopped doing that. And we also had to take him to rehabilitation. Yes.
02:40 SPEAKER1: What did you dislike about them?
02:43 SPEAKER2: They criticize them a lot rather than me, rather than advising them. They are almost criticizing them, like scolding them against alcohol.
02:56 SPEAKER1: Now, were these initiatives conducted by the general population, people who are normal or the VIs?
03:08 SPEAKER2: I guess I was the only VI in my place. Yes.

03:15 SPEAKER1: All right, and the communication messages, the messages developed to prevent alcohol abuse, were they meant for the eyes or were they just for the general population?
03:29 SPEAKER2: The general population. Because there are not many cases of VIs in that area. So most probably it was for the general population, maybe they meet a VI, its okay they will try and tell him the disadvantages of using alcohol and why they should leave it.
03:57 SPEAKER1: OK, how often have you been involved in the development of communication messages against alcohol abuse? Have you ever been involved in developing such messages?
04:11 SPEAKER2: No.
04:11 SPEAKER1: OK and distribution of such information regarding alcohol abuse? Have you ever participated in the distribution? Sharing of information, for example?
04:25 SPEAKER2: Nowadays we take our own initiative to distribute our own information, but not through those initiatives, because at some point most of the people will not cooperate. And so maybe you talk to a friend who is that who does alcohol abuse and advise him in a friendly way, but not through the initiatives. And in fact, during that time when it was being held in our churches, it was it was for the youth. They were are the ones who are involved in trying to advise their fellow people in that state.
05:15 SPEAKER1: So, the type of information was for which group of people? Is it the VIs or the general population?

05:24 SPEAKER2: The general population. Yes, I say general, because it did not distinguish whether it should be VI or any type of disability. It is anyone who gets a of alcohol.
05:38 SPEAKER1: So, tell me about any mass media campaign against alcohol abuse that you know. Any mass media campaign against alcohol abuse that, you know.
05:49 SPEAKER2: NACADA. Where do we place NACADA?
05:53 SPEAKER1: NACADA is an authority. Has it ever conducted such campaigns? Have you heard of them?

06:02 SPEAKER2: They do that.
06:03 SPEAKER1: OK. You have any more information that you would like to share?
06:08 SPEAKER2: I just heard it through someone. The comedian who was appointed the other day, Chipukizi. Yes. Was talking of going to the ghettos and educating people on the drug abuse and alcohol use. Over drinking.
06:30 SPEAKER1: From which platform did you hear that?
06:32 SPEAKER2: From the television and also from YouTube.
06:43 SPEAKER1: And how did it change your feeling towards alcohol?
06:48 SPEAKER2: It did not change my feeling. I had the same feeling about alcohol.
06:55 SPEAKER1: So, what are your perceptions towards alcohol?

07:00 SPEAKER2: The most funny thing is that a good many friends who take and I don't criticize them. I stopped and now don't take alcohol and the reasons for not taking alcohol could be because of the behavior that I've seen in society. People may be engaging in abusive language. You get to being involved, may be family. Family or they call them? family wrangles or social violence.
07:48 SPEAKER1: All right, so what impact does mass media campaign on alcohol abuse have in your life?
08:01 SPEAKER2: It has mentored me in shaping my life towards looking into the future and not dwelling on alcohol. Through different media personalities and also the social media platforms, through groups that are advising against it,
08:27 SPEAKER1: Given an opportunity. What do you propose should be done to improve the communication messages that are targeting the visually impaired? The communication messages against alcohol abuse, targeting the visually impaired. What do you think should be done to improve?
08:49 SPEAKER2: What is there for us so that we can improve?
08:54 SPEAKER1: Is there anything that you know that is done?
08:57 SPEAKER2: I've never seen anything against talking on VI on drug and alcohol use. Yes, they should start by maybe starting by campaigning on the use of alcohol and getting the particular group of people (VIs). But and it has never been there, even from the National Council for People with Disabilities (NCPWD). It has never been there. Whatever I saw was only on the HIV and AIDS in campus. That was the campaign that I was seeing.
09:40 SPEAKER1: And it targeted the VIs?
09:41 SPEAKER2: Yes, that one targeted the VIs but the rest, story of alcohol, No.
09:51 SPEAKER1: All right. Thank you for that very informative session.

PART 4

00:00 SPEAKER1: You say that visually impaired, those that are heavy drinkers find their way through the clubs in the city, especially Moi Avenue, and they maneuver to these clubs. How do they get their way to these clubs? How do they maneuver through the city, the big city of Nairobi?
00:19 SPEAKER2: They have their own guides and they also take motorbikes to specific designations or tuktuks. Yeah. And how do they, act after drinking alcohol? How safe are they getting back to their homes or whatever place?
00:45 SPEAKER2: I've experienced most of them complaining of being robbed like maybe their phones, which are very expensive. There was my friend who was robbed an I-Pad along Park Road in Ngara. He was blind. But he was apparently, I guess, together with the guide that he was with they were too drunk.
01:26 SPEAKER1: Is it them who prefer the guides that drink alcohol?

01:34 SPEAKER2: They assume that you cannot go with someone who does not take alcohol to clubs. That is the assumption, so most of their guides are also alcohol takers.
01:47 SPEAKER1: So, they prefer guides that consume alcohol?
01:52 SPEAKER2: You cannot say...I don't want to put the word prefer. Yes, that is what they find themselves in.
02:07 SPEAKER1: And who 02:14 SPEAKER2: There is no regulation, it's your money that determines what you're going to take and most of them know. Some of them that I know come from very well-established families. Others have got good jobs, though they come from a poor background. But I've got good jobs. Others participate in. like there is a friend of mine is about to participates in sports activities for the disability. Like one time he went to Brazil, Rio de Janeiro, the Olympics, 2016. He was given close to one point five million as an official of Kenya National Paralympics Committee. Yeah, but when he came back, every day he used to hire an Uber, coming to KU to get you to drink with his friends. Maybe going to a new stadium, there was the sports activities that we were going during that time, attending during that time of the Paralympics and meetings. So after the meetings, you'll find out, he would hire ask an Uber

from Nyayo stadium to maybe town, a place where you can walk, a place that we used to walk, especially with him. But because of money and what, now goes to every club trying to buy alcohol for everyone. And the ones that don't take alcohol are given maybe like 1K. But now I can tell you by December, not even December. From August to November. By November mid. He was borrowing money from us and we were students, be that time. Well, you see, alcohol has made him go back to zero. He has not done anything at this place, not even built a house. He's just there. OK.

04:34 SPEAKER1: So, do they do they have families?

04:42 SPEAKER2: They've got families, others not yet married. Yes.

04:49 SPEAKER1: OK.

04:50 SPEAKER2: But very young families, maybe one or two years or three years, not more than five, the ones that I know. They have recently married.

05:09 SPEAKER1: OK.

PART 3

00:00 SPEAKER1: Visually impaired, taking alcohol, you say which gender is mostly affected?

00:05 SPEAKER2: Mostly it affects the men, not the ladies. Message should go to them

00:10 SPEAKER1: Oh yeah.

00:12 SPEAKER2: In fact, I've never heard of a lady taking alcohol who is visually impaired. Most of them are engaged in church activities, such things. You never know whether it's keeping you from stress or is what they want. Yes, that is for the ladies now. For the men. Yeah, mostly you can understand even from the background without asking them, you are able to understand these people are doing this because of this and that or maybe even segregation in the society. Something that may make them engage in alcohol abuse.

Others, maybe they were expecting to have their sight back, especially the ones who've lost their sight recently. But now they come to a point where the site is irreversible. It cannot be corrected. So what next? Stress comes up and they only find the solution to relax their minds. It's by taking alcohol.

01:33 SPEAKER1: So, do the rehabs really know how to go about this issue? The caregivers, do they help them in this situation?

01:44 SPEAKER2: They've got a challenging because some of them that have been taken to rehab say. Have ended up dying because of stress. You don't know they come back and they don't switch off from alcohol. Care givers do not understand us so. They go back again. So it is not that helpful to them. It is not easy to take medicine and recover. It's only one or two people that I've seen that have changed after rehabilitation.

02:17 SPEAKER1: What of the health care givers in the rehab are they well placed? Do they have the required skills? What's your view on this?

02:25 SPEAKER2: They've got a challenge because, for example, you see when you take alcohol, if you're going for medical checkup, yes, the eyes are affected by alcohol a lot. I don't know whether you have that information, especially if you have undergone a surgery, don't make the mistake of drinking. Others drink occasionally, but to see the effect in sight continues having problem. So that poses a challenge to the doctor taking care of the person in terms of correcting the vision. Yeah, alcohol is one of the main causes of blindness, especially people with a visual impairment, if you are able to see a little bit at some point decide to go on reducing, reducing, reducing, for the more you take alcohol, the severity may increase. Most of them advise against it. And you see also, even generally, in one’s body alcohol reduces immune system immunity, it reduces immunity. And this poses a challenge of maybe infections, maybe the eye. You see.

In the hospitals there are no specialized care and equipment

03:52 SPEAKER3: Thank you.

PART 2

00:00 SPEAKER1: So, studies indicate that 40 to 50 percent of children are categorized as heavy drinkers, kindly expound on this aspect.

00:12 SPEAKER2: Most of the people who are visually impaired who are around me are heavy drinkers and also addicted to marijuana.

00:25 SPEAKER1: When they say, at what age does this come?

00:29 SPEAKER2: When the most probably when they get into universities, others began even after completing their KCSE. We never know whether they had begun it before.

00:41 SPEAKER1: And you also talked about when they become adults, then get the visual impairment. That's when they get into alcoholism.

00:50 SPEAKER2: Yes, when are, the most of them that are in this situation. Yes. Those that have lost their sight may be when they are old enough like me. Maybe in high school, then they have to revert back to. Let's say they were in high school and have to revert for maybe like four, three years; trying to be rehabilitated to brail and also being able to read using in their hands, most of them are psychologically affected. And because of that stress. Yeah, that may be the cause of them being addicted to alcohol as a solution to relax their minds. Often when they take alcohol, they are too talkative, relaxed and happy.

So you never know. Maybe they are taking out their stress, especially the ones that have lost their sights when they are old enough, not when they are when they are children. The ones that are born with a condition, we got a good number that are heavy drinkers. Others, they drink occasionally and then. Most probably because of the clique they getting into that category of heavy drinking after some time because their friends are now taking alcohol every now and then.

02:29 SPEAKER1: Thank you. OK.

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00:00 SPEAKER1: Your name, please.

00:01 SPEAKER2: Agneta,

00:03 SPEAKER1: your people with disabilities number?

00:06 SPEAKER2: No, I don't have it.

00:08 SPEAKER1: OK, so what kind of information regarding alcohol do you have access to? What kind of information?

00:17 SPEAKER2: The information I have access to is ....

00:20 SPEAKER1: What they know about alcohol abuse?

00:22 SPEAKER2: It's just not it's not a good substance.

00:27 SPEAKER1: Yes

00:30 SPEAKER2: It really makes people go through a lot. Like let me talk about people like me that people with visual impairment, if you dare take up all you are in very big problems because you see the junk food for most of the investigation, you can't be stable. And with us, most of us do not have that balance. So you find someone with a visual impairment that is drunk. We are exposed to many, many accidents. And it's not just safe.

01:07 SPEAKER1: From which kind of media platforms have you have you ever gotten any information regarding alcohol abuse and where they present messages against alcohol abuse?

01:23 SPEAKER2: I've heard it most of the time from the radio. Yeah, but most of the time when they talk about it, they just talk about the advantages of it, the lowering of the price. Most of the time I've not heard them talking about much. They only say it ones that don't drink and drive. So that is the only thing they advise people against.

01:48 SPEAKER1: And do they address the visually impaired?

01:51 SPEAKER2: No. You know, I've never heard someone talking about us because we have forgotten. They think that people with visually impaired impairment cannot take alcohol?

02:05 SPEAKER1: So tell me about any local initiatives that educate people on alcohol abuse.

02:11 SPEAKER2: I've heard of the chief from our area. OK, but I wasn't there. No, I just heard that he called the meeting and talked to people about this thing to do with alcohol. So you see, most of us are disadvantaged because we can't access the places that those people are being called at. So they just talk to. We are sort of left out.

02:33 SPEAKER1: Describe any features that you liked or disliked about them?

02:41 SPEAKER2: The features that I disliked, are just they praise alcohol and it's not a good substance. I insist. But they keep on praising it. Talking of the lowering of the price, they are giving people the urge of taking the alcohol. And the thing that I like about it.At least the the mind of other people, like talking to the drivers not to drink well and then drive at the same time.

03:07 SPEAKER1: What of the local initiatives, anything that you liked or disliked about?

03:13 SPEAKER2: I liked the I liked the fact that they talk to people about alcohol and the harmful effects that they have shown on young. And what I dislike is just that they forget about VIs. They tend to forget about us, you know. Messages are not in braille

03:29 SPEAKER1: Huh. Have you ever been involved in the development of information regarding alcohol abuse?

03:39 SPEAKER2: Seldom. It's not that easy.

03:40 SPEAKER1: OK, which is this experience that you have when you say don't know me at least once?

03:48 SPEAKER2: Yeah, I had it once. OK, yeah. Well that was when I was in primary school. Yeah. OK, I was involved because it was a teacher and he was going through depression just as an friend said the mother died and then the only thing that he thought that could at least bring him back to normal was turning to alcohol. So I just took this courage and talked to him. At least he had me thanks to God.

04:19 SPEAKER1: And distribution of information regarding alcohol abuse? Have you ever been involved in sharing information to maybe of your fellow colleagues? The VIs.

04:31 SPEAKER2: It's the same case. And I've also talked about it with some of my friends. So it's like telling people what alcohol can do because I saw the things that they chose going through. I can they can talk from experience.

04:44 SPEAKER1: And now this is this was out of your own initiative, not with the not with a team or an organization that came up with this.

04:53 SPEAKER2: No.

04:54 SPEAKER1: OK, so tell me about any mass media campaign against alcohol abuse. That you know of, and how it has changed your feelings towards alcohol.

05:06 SPEAKER2: And it's only the radio. Yeah, yeah. And it has made me know that.

05:13 SPEAKER1: Which is this, if you don't remember that type of campaign and how has it changed our your feeling towards alcohol? Can you remember the campaign that you had from the radio?

05:23 SPEAKER2: The campaign was just about youth not drinking alcohol, people under the age of 18.

05:29 SPEAKER1: How did it change your feeling towards alcohol?

05:32 SPEAKER2: It changed my feeling towards alcohol that alcohol is not a good thing. Though we take it, it's not it's a good thing is in the young ones could have not being taught not to take it, but since that they are telling people to take some people to some group of people to take and others not to take meaning, it's not a good thing and it cannot be sustained in the body for that long without hurting. So I just believe that alcohol is not a good thing all around.

06:04 SPEAKER1: What impact does a mass media campaign against alcohol abuse have in your life? What impact does such a campaign have in your life.

06:14 SPEAKER2: I'll keep on repeating myself? according to me, if I if it could have been in my power, alcohol could have been ruled out. And that is what I just believe, because it kills it makes many people become blind. You see, I don't like just my good.

06:43 SPEAKER1: So if if you're given an opportunity to propose what you feel should be done with reference to development of and the distribution of the communication messages that are against alcohol abuse to the visually impaired, what would you suggest to be done?

07:08 SPEAKER2: I would like someone with a visual impairment to be talking to us because with them at least they understand how we understand things better and at least someone who has gone through these so that they can share with us similar experiences. Yeah.

07:28 SPEAKER1: Thank you very much. Thank you