EVALUATING ACCESS AND USE OF INFORMATION SERVICES BY PATIENTS OF ALCOHOL AND DRUG ABUSE IN NAIROBI COUNTY: A CASE STUDY OF ASUMBI TREATMENT CENTRE

BY

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A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF SCIENCE IN LIBRARY AND INFORMATION STUDIES, DEPARTMENT OF LIBRARY, RECORDS MANAGEMENT AND INFORMATION STUDIES, SCHOOL OF INFORMATION SCIENCES

MOI UNIVERSITY
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2018
DECLARATION

DECLARATION BY THE CANDIDATE:

This research is my original work and has not been presented for a degree or for any other purpose to any other institution.

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DEDICATION

This research is dedicated to my loving parents, Mr. Dominic Kalangi and Mrs. Dolphine Kalangi, my siblings Lina, Pat, Lucy, Fred and Paul, who have supported and encouraged me, and to my daughter Angel for her patience.
Information plays a key role in helping the recovery of patients of alcohol and drug abuse (ADA). In the rehabilitation centres, ADA patients are engaged in a treatment programme and are expected to integrate back to the society and become productive people. Alongside other medical procedures, information plays an important role in helping in the recovery of patients of alcohol and drug abuse. However, no studies have been undertaken to evaluate access and use of information services to ADA patients in Nairobi County, Kenya. This study aims to evaluate the access and use of information services by patients of alcohol and drug abuse in Nairobi County, a case study of Asumbi Treatment Centre and to suggest ways in which they can be enhanced. The objectives of this study were to: determine the information needs ADA patients in the rehabilitation centre; establish information seeking habits of ADA patients; assess the existing information services available to ADA patients; find out how ADA patients use information; find out the challenges faced by ADA patients in accessing and using information, and suggest ways of enhancing provision of information services to ADA patients in rehabilitation centres. This study was based on the Wilson’s Theory of Human Behavior and Niedzwiedzka model of information behaviour. This research adopted a case study design and the approach qualitative. The study population consisted of ADA patients and an administrative staff from the rehabilitation centre. The sample size consisted of 30 patients and an administrative staff drawn from the rehabilitation centre. A census inquiry was adopted as the population consisted of a small number of people. Data was collected through face to face semi-structured interviews for both the ADA patients and administrative staff. The interview schedule was pretested to determine the validity and reliability. Data was presented in tables and analyzed using content analysis. The major findings revealed that ADA patients have their unique information needs that included information on: career choice, business, sign language, current affairs, coping after rehabilitation and behavior change. They experienced challenges of accessing and using information which included; inadequate information, no library, no internet access limited ways to seek information, lack of information searching skills, and few television channels to watch. The short term recommendations were that ADA rehabilitation centres should carry out information needs analysis for ADA patients, offer bibliotherapy services, provide forums for motivational speakers, permit more visiting days and assign tasks and assignments for ADA patients. The long term recommendations included setting up of a library and a computer laboratory equipped with internet facilities all for the benefit of ADA patients.
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LIST OF ABBREVIATIONS AND ACRONYMS

ADA        Alcohol and Drug Abuse
ALA        American Library Association
CBOs       Community Based Organizations
EU         European Union
HIV/AIDS   Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
ICTs       Information and Communication Technologies
IFLA       International Federation of Library Associations
NACADA     National Authority for the Campaign against Alcohol and Drug Abuse
NASCOP     National Aids and STI Control Programme
NGOs       Non-Governmental organizations
TC         Therapeutic Community
UNODC      United Nation Office of Drugs and Crime
WHO        World Health Organization
ACKNOWLEDGEMENT

I would like to acknowledge my supervisors, Dr. Andrew Chege and Dr. Emily Kogos who have given me guidance and advice to enable me write this proposal. I would also like to acknowledge the staff and clients (patients) of Asumbi Treatment Centre for the support they accorded me. I would also like to acknowledge my colleagues for their support.
CHAPTER ONE: INTRODUCTION

1.1 Introduction
Alcohol and drug abuse cause major physical and psychological problems to the affected individuals. This chapter presents the background to the study. It defines alcohol, drugs and describes alcohol and drug abuse (ADA) in Kenya, highlighting its impacts and interventions from stakeholders like NACADA and related NGOs. These stakeholders are of great help to the affected individuals in their recovery process. NACADA provides a framework within which rehabilitation facilities are established and ensure quality services are provided to the patients. According to IFLA, help groups like Alcoholics Anonymous all tackle the problem at the psychological level. With awareness of the causes of alcohol and other substance abuse, how addiction develops and the consequences of abuse and addiction, families and communities can fight to prevent addiction and organize treatment. Therefore there is a need for good information for addicts and their families. This chapter also details the statement of the problem, which highlights the various challenges that the study seeks to address with a view of coming up with concrete proposals that will alleviate the challenges. The aim of study, objectives of the study, the research questions, scope of study, limitations of study, significance of the study and finally the definition of terms used in the study have been also highlighted.

1.2 Background of the Study

1.2.1 Alcohol and Drug Abuse in Kenya

1.2.1.1 Alcohol Abuse
Alcohol is of course the most commonly used and widely abused commodity in the world. In many cultures, alcohol is used on many important occasions and religious
ceremonies (Lily and Harmon, 2012). The various kinds of alcohol include beer, wine, and spirits. Treating addiction is to stop abusing the drugs or alcohol. In Kenya, people abuse alcohol so much that they do not see it as a problem in over consumption of it. People spend so much time in bars and drinking dens consuming both licensed and illicit alcohol. You will find that these people spend most of their days drinking and less time on work to earn a living for themselves and their families. These habits not only affect the person abusing alcohol, but anyone closely involved with them

1.2.1.2 Drug Abuse

Drug abuse is an intense desire to obtain increasing amounts of a particular substance or substances to the exclusion of all other activities. Drug dependence is the body's physical need, or addiction, to a specific agent. The impacts of drug use include intoxication (including intoxication related risky behaviours), withdrawal, drug dependence, the development or exacerbating mental illness, the development or exacerbating physical illness, such as HIV, NASCOP (2013).

In Kenya, drug abuse is prevalent among the youth. The Kenya Vision 2030 identifies drug and substance abuse as one of the major challenges facing the youth and as one of the strategies for youth empowerment and reduction of crime. This has mainly been attributed to inadequate social skills, unemployment, limited resources and opportunities, increasing social decay and permissiveness towards alcohol and drug consumption. During the 2nd national conference on alcohol and drug abuse in Kenya (2013), research presentations at the conference showed high rates of alcohol and drug abuse were witnessed in several secondary schools. Cigarettes stood at 77 per cent followed by bhang at 68 per cent. Khat (Miraa) was third at 61 per cent while
alcohol was fourth with 58 per cent according to the report. Also during the conference NACADA director George Achola pointed out that alcohol consumption accounted for 4 million users, tobacco 2.7 million while more than 700,000 people abused drugs. Most of these drugs are abused because they are readily available.

1.2.2 Impacts of Alcohol and Drug Abuse

The effects of any particular drug depend on a number of factors. These depend on the type of drug taken, how much of the drug is taken and how often, how the drug is taken, how the drug is taken, physical characteristics, mood and environment of the user and what other drugs are used, (Australian Drug Foundation 2005).

1.2.3 Impact of ADA on the Individual

Alcohol and drug abuse impact on the individual in various ways. For example, the physical health of an individual is affected. Chesang (2013) states that the abuse of alcohol and other drugs lead to acute effect on the body. It alters judgment, vision, coordination and speech and also leads to risk taking behaviour. Drug use increases the likelihood of being involved in traffic accidents which may lead to death or injury. Other psychological effects of substance abuse are directly linked to the biological impact of psychoactive substances such as anxiety and irritability stemming from withdrawal and the behaviors that result from dependence on drugs and alcohol such as craving and preoccupation with obtaining desired substances Ammerman, (Ott and Tarter 1999). Chesang (2013) points out that drugs erode self discipline and motivation necessary for learning. Substance abuse inhibits a student from the ability to have a logical thinking and have rational approach to solve problems. Absenteeism in class, engaging in fights and so on can result in the individual being suspended or expelled from the learning institution. The same situation can happen at the workplace
and experts have warned that the constant abuse of drugs and alcohol can slow down development.

1.2.4 Impact of ADA on the Family

The constant abuse of alcohol and drugs by the individual affects the family. The abuser can be a child in the family, a spouse or both parents. According to Lameman (2015) in Chicago Tribune, addiction often creates interpersonal problems among family members. These include;

i) Jealousy: You can grow jealous of your friends, your partner, other family members and other people in your life. Your partner may also be jealous and resentful of you.

ii) Conflict with Partner: You may have arguments, get/give the "silent treatment" or grow apart by putting your addiction first.

iii) Conflict with Children: You may argue with your children and they may disregard your authority or be afraid of you.

iv) Conflict over Money: You may struggle economically because of losing your job, taking time off from your job, making poor financial choices or simply pouring your money into your addiction.

v) Emotional Trauma: You may create emotional hardships for your partner and/or your children by yelling, talking down, insulting or manipulating.

vi) Violence: You may become violent or your family members may become violent with you, including slapping, hitting or smashing or throwing objects.

vii) Cheating: You may become distant from your partner and seek satisfaction through pornography, Internet sex, prostitution or someone else in your life.
viii) Separation: Your behavior due to addiction may cause separation, divorce, and/or isolation from other family members, particularly children, either because they've been taken from you or because they don't want to be around you.

ix) Patterns: Your life example will influence your partner, your children and other family members. There is a high likelihood that your children will become addicted to drugs or alcohol.

x) Health Risks: Drinking while pregnant can cause damage to the baby's brain. Smoking in the household can cause health problems for family members from secondhand smoke, including lung cancer.

1.2.5 Impact of ADA on the Community

Alcohol and drug abuse affect the society in many ways. The individuals who abuse drugs create an avenue for illicit drug trade. In Kenya there is the issue of insecurity which can be attributed to the abuse of alcohol and drugs. You find that youth constantly need money to purchase these drugs and alcohol and most of the time they lack the money to spend. They therefore resolve to burglary organized crime to obtain money. Drug related crime can destabilize the community. Young children are recruited to help the older ones to be on the lookout for police or security personnel when committing the crimes. Children whose parents cannot afford to take them to school or pay for their higher education end up being recruited to gangs that abuse alcohol and drugs. The community is equally affected as it mainly depends on agricultural produce, like milk and maize, whose prices keep on fluctuating. Due to these harsh conditions, there’s a possibility that the affected are stressed and are forced to indulge in alcohol so as to reduce stress, (Birech …et al 2013). Therefore a community cannot develop when most of the youth engage in alcohol and drug abuse.
1.2.6 Impact of ADA on the National Economy

Chesang (2013) states that sophistication in the mode of transportation and packaging makes the work of the Drug control organisation increasingly difficult. Customs immigration and provincial administration and anti-narcotics personnel are all caught in this web. Therefore, the economy of a country is greatly affected when there are abusers of alcohol and drugs. Here in Kenya, the government is constantly engaged in activates and policy formulation that can help in economic growth. However, the presence of alcohol and drug abuse often drags down the efforts of any government. With the increased crime rated and the trafficking of illicit drugs, the Kenyan government is spending a lot of money in addressing insecurity and in drug related litigations. In the workforce, drug and alcohol users skip work on various occasions which in turn affect productivity.

1.3 Interventions from Stakeholders

Substance abuse is an illness that can be eliminated through treatment. So many addicts have been able to recover through treatment methods. Various sectors are currently involved in the rehabilitation and treatment of ADA patients. According to a report by NACADA, individuals, NGOs and Faith Based Organisations are the major stakeholders involved in the fight against alcohol and drug abuse.

1.3.1 International Advocacy and Campaigns

1.3.1.1 United Nations Office on Drugs and Crimes (UNODC)

UNODC was established in 1997 through a merger between the United Nations Drug Control Programme and the Centre for International Crime Prevention. UNODC has a network of field offices in all areas of the world. UNODC gets its funds from voluntary contributions and it is mandated to assist Member States in their struggle against illicit drugs, crime and terrorism.
The three pillars of the UNODC work programme are:

Field-based technical cooperation projects to enhance the capacity of Member States to counteract illicit drugs, crime and terrorism

i) Research and analytical work to increase knowledge and understanding of drugs and crime issues and expand the evidence base for policy and operational decisions

ii) Normative work to assist States in the ratification and implementation of the relevant international treaties, the development of domestic legislation on drugs, crime and terrorism, and the provision of secretariat and substantive services to the treaty-based and governing bodies

1.3.1.2 International Day Against Drug Abuse and Illicit Trafficking

This day is marked on 26th June as a result of resolution 42/112 of 7 December 1987 of the UN General Assembly. The UN General Assembly in April 2016 held a special session that marked an important milestone in achieving the goals set in the policy document of 2009 – ‘Political Declaration and Plan of Action on International Cooperation towards an Integrated and balanced Strategy to Counter the World Drug Problem,’ – which defined action to be taken by Member States as well as goals to be achieved by 2019.

On 26th June, 2016, Kenya joined other nations in marking the International Day Against Drug Abuse and Illicit Trafficking. Among the key stakeholders present on this day was NACADA Chairman. The chairman Mr. John Mututho had this to say ‘the facilitation and support of the various players must be recognized. Our own Ministry of interior and other Public Sector institutions, Civil Society organizations, the Private Sector and Development Partners are truly appreciated. We recognize and
applaud all those individuals and institutions who have worked tirelessly to interdict the illicit trade, but brewers of counterfeit and illicit alcohol out of business, carried out preventive education and advocacy, and provided treatment and rehabilitation services. Your tremendous tasks undertaken are not in vain.” (Source: Daily Nation, 26th June, 2016).

On a similar note, NACADA Chief Executive Officer Dr. William N. Okedi highlighted the responsibility of NACADA Act of 2012, citing that the Act provides that NACADA coordinates both supply suppression and demand reduction policies, strategies and interventions. He further pointed out that the Authority carries out preventive education and advocacy against consumption of intoxicating substances, as well as promoting uptake of treatment and rehabilitation for those affected by drug addiction.

1.3.1.3 The ‘Listen First’ Initiative

“Listen First” Initiative was the 2016 theme of the International Day Against Drug Abuse and Illicit Trafficking. ‘Listen First’ is an initiative to increase support for prevention of drug use that is based on science and is thus an effective investment in the well-being of children and youth, their families and their communities. Listen First slogan thus reads ‘Listening to children and youth is the first step to help them grow healthy and safe.’

The previous years also had their observance themes. These included;

2015    Let’s Develop – Our Lives – Our Communities – Our Identities – Without Drugs

2014    A message of hope: Drug use disorders are preventable and treatable

2013    Make health your ‘new high’ in life, not drugs
2012  Global Action for Healthy Communities without Drugs
2011  Say No!
2010  Think health – not drugs
2009  Do drugs control your life? Your life. Your community. No place for drugs
2008  Do drugs control your life? Your life. Your community. No place for drugs
2007  Do drugs control your life? Your life. Your community. No place for drugs
2006  Value yourself…make healthy choices
2005  Drugs is not child’s play
2004  Drugs: treatment works
2003  Let’s talk about drugs
2002  Substance abuse and HIV/AIDS
2001  Sports against drugs
2000  Facing reality: denial, corruption and violence

(Source: Daily Nation, 26th June, 2016)

1.3.2  Government Agencies

1.3.2.1 Ministry of Interior and Co-ordination of National Government

This Ministry of Interior and Co-ordination of National Government, among other responsibilities, is charged with the responsibility of championing campaign against drug and substance abuse. The ministry has also been keen on pushing for policy and legislation against licit and illicit substances and has made use of its administrative structure to fight drug cartels from the grassroots level. NACADA falls under one of the five departments of the ministry.
1.3.2.2 National Authority for the Campaign against Alcohol and Drug Abuse

The government of Kenya established the National Authority for the Campaign against Alcohol and Drug Abuse (NACADA) through an act of parliament in July 2012 mainly to coordinate and facilitate an all-inclusive effort towards prevention, control and mitigation of alcohol and drug abuse in Kenya.

NACADA has established partnerships with public, private as well as international organizations and institutions in furtherance of its mandate. On the issue of rehabilitation centres especially in the rural areas, NACADA is committed to:

i) Partner with County governments to set up 10 public rehabilitation centres in various parts of the country

ii) Offer free counseling and referral services through the Helpline 1192

iii) Develop and implement national standards for treatment and rehabilitation services

iv) Undertake certification of addiction practitioners and professionals

v) Maintain a register of certified licensed addiction practitioners.

Other responsibilities of NACADA include:

i) Licensing and regulating operations of rehabilitation facilities;

ii) Facilitating the development and operation of rehabilitation facilities, and ensure that quality services are provided to persons suffering from substance use disorders; Preparing, publishing and submitting an alcohol and drug abuse control status report bi-annually to both Houses of Parliament through the Cabinet Secretary.

iii) Assisting and support County Governments in developing and implementing policies, laws and plans of action on control of drug abuse.
According to NACADA, the drugs that are commonly abused in Kenya include alcohol, tobacco, bhang, heroin, miraa, muguka and glue. NACADA classifies drugs under narcotics, hallucinogens, depressants, stimulants and volatile solvents. The biological names of different drugs include:

i) Cannabis sativa – bhang

ii) Catha edulis

iii) Papaver – poppy (opium, heroin)

iv) Erythroxylon coca-coca (cocaine)

v) Nicotina-tobacco (nicotine)

NACADA has a Toll-Free Helpline which is 1192, for those who need help with alcohol and drug abuse or those who need someone to talk to about the problem of alcohol and drug abuse. *(Source: www.nacada.go.ke)*

**1.3.2.3 The Alcoholic Drinks Control (Amendments) Bill, 2014**

This is an amendment of the Alcoholic Drinks Control Act, 2010. According to Kenya gazette supplement of 1st April, 2014, this Act was enacted by parliament to provide for the regulation of the production, sale and consumption of alcoholic drinks, to repeal the Chang‘aa Prohibition Act, the Liquor Licensing Act and for connected purposes.

The Alcoholic Drinks Control (amendments) Bill, 2014 proposes for some of the following:

i) Alcohol tests on pedestrians suspected by police of engaging in disorderly conduct.

ii) Motorists convicted of the offence of drink-driving three times within a year lose their right to drive.
iii) Members of Parliament and members of the disciplined forces would also be stripped of the privilege of accessing duty-free alcohol.

The principle object of this Bill is to amend the Alcoholic Drinks Control Act, 2010 so as to provide an additional function to the relevant agency NACADA, namely the provision of support and assistance in the establishment of treatment and rehabilitation programmes.

1.4 ADA Rehabilitation Organizations

1.4.1 Rehabilitation Centres

There are many alcohol and drug rehabilitation centres in Kenya today that have been accredited by NACADA. Refer to appendix V for a list of ADA rehabilitation centres in Nairobi region. This has attracted many players including individuals, NGOs, Faith Based Organisations, civil society, public and private institutions to play a role in providing rehabilitation services. As a result, NACADA has developed standards that have to be observed by every rehabilitation centres in Kenya for both residential and non-residential treatment ‘to address one of the most pressing socio-economic and health problems in Kenya, that of treating those presenting with Substance Use Disorders (SUDs). These standards are for the regulation, supervision, guidance and monitoring of residential and nonresidential treatment and rehabilitation facilities and programs for persons with SUDs in Kenya.

The rehab centre has personnel who include a team of doctors and other health workers who provide treatment counseling to individuals who are addicted to substance abuse. They educate the patients about alcohol and drug addiction. According to NACADA standards, an alcohol and drug rehabilitation centre should provide the following:
i) Thorough and adequate client assessment  
ii) Individualized treatment planning  
iii) Pharmacotherapy and medical care  
iv) Structured treatment programmes and daily activities  
v) Criteria for discharge, readmission and continuing care

Treatment in the rehabilitation centre may include detoxification, substitution or maintenance therapy and/or psychosocial therapies and counseling. It is important to note that:

i) No single treatment is appropriate for all individuals  
ii) Effective treatment attends to multiple needs of the individual, not just his/her drug use  
iii) Treatment must address medical, psychological, social, vocational, and legal problems (Source: www.nacada.go.ke)

1.4.2 Healthcare Facilities

The specific healthcare facilities in Kenya that are involved in the treatment and rehabilitation of ADA patients are referral hospitals where ADA patients are directed to get the required treatment. According to Drug news Africa newsletter (2011), NACADA, UNODC and civil society organizations initiated emergency services at the Coast Provincial General Hospital and eleven surrounding primary health care facilities in order to respond to the crisis. The Mathari drug abuse prevention and treatment Centre was established in May 2003 through a collaborative effort of the Ministry of Medical Services and the United Nation Office of Drugs and Crime (UNODC), with a bed capacity of 15 patients for males, in response to rising demand for drug use treatment and rehabilitation services. This hospital admitted the worst
cases of ADA patients who were severely intoxicated and affected mentally, exhibiting withdrawal disorders ranging from depression, anxiety, and mood swings. According to the Drug news Africa (2011), the treatment of ADA patients involves detoxification, rehabilitation and treatment of co-morbid psychiatric disorders with a well-refined referral system to those who are physically sick or those who need specialized treatment to include surgery and gynecological treatment. It is a 90-days program based on the matrix model and recently the rehabilitation center has incorporated some of the concepts of the Therapeutic Community (TC) Model. The TC model uses the approach of Community as a method, where members interact in a structured and unstructured ways to influence attitudes, perceptions and behavior associated with drug use.

Other healthcare facilities that offer treatment to ADA patients include Kenyatta National Hospital patient support centre at the Kenyatta National Hospital and Port Ritz District Hospital. It has been observed that many patients are not aware of the government facilities that offer treatment and rehabilitation of ADA patients. Most rehabilitation facilities available are privately owned thus making it expensive and inaccessible to most ADA patients, (Drug news Africa 2011).

1.4.3 Non-Governmental Organizations (NGOs)

NGOs, fall under the umbrella of the National Council of NGOs. Encyclopædia Britannica(2015) defines NGOs as voluntary group of individuals or organizations, usually not affiliated with any government that is formed to provide services or to advocate a public policy. NGOs are also development partners in health care provision in Kenya. As implementation partners, they assist in coordinating delivery of services especially at the community level. In the fight against alcohol and drug
abuse, NGOs have demonstrated their commitment by carrying out field studies, in advising and working with the national government and enabling those affected to receive the support and treatment they deserve.

The NGOs are equally involved in drug prevention and in educating the communities on the effects of alcohol and drug abuse. They share evidence based information on the strategies of preventing drug and alcohol abuse. Here in Kenya, NACADA funds the NGOs that fight against alcohol and drug abuse. Wamuswa (2015) reports that the National Aids and STI Control Programme (NASCOP), has prioritized IDUs in its national strategic plan and policy documents and has intervened to address the high rate of HIV spread among IDUs. According to Nascop, some of the programmes to stem HIV spread among IDUs include use of condoms, provision of needles and syringes, HIV testing and drug rehabilitation/treatment.

1.4.4 Faith-Based ORGANIZATIONS (FBOs)

Faith-based organizations are defined as faith-influenced non-governmental organizations. They are often structured around development and/or relief service delivery programmes and are sometimes run simultaneously at the national, regional and international levels, UNAIDS (2009).

They mainly provide healthcare to individuals who cannot afford healthcare. Other activities of these FBOs include supporting communities in sustainable development. For example, the mission of Anglican Church of Kenya (ACK), a faith based organization in Kenya, is to improve the quality of life for the needy in the communities through participatory and sustainable approaches for a better society. According to capacity project In Kenya, the faith-based organizations Kenya Episcopal Conference (KEC) and Christian Health Association of Kenya (CHAK)
provide more than 40% of the country’s health services.

Currently, scarce human resources are the biggest challenge facing these organizations in their efforts to serve the poorest citizens in the most remote locations. These faith based organizations therefore equally participate in treating ADA patients, rehabilitating them and also involving them in sustainable development activities.

1.4.5 Community-Based Organizations

Community Based Organizations (CBOs) fall under the umbrella body of The National Council of community-based Organizations. CBOs like all other non-governmental intermediaries have generally broad-based membership, built from grassroots. Their beneficiaries are their own members and “owners” or founding members, Kameri-Mbote, (2000). Community-based organisations (CBOs) play an important and relevant role in providing services at the local level. They work in a variety of different fields, such as education, health, the rights of the disabled, gender issues, and so on. Wise management of the organisation can contribute significantly to ensuring the effectiveness of the work that it does, (Chechetto-Salles... et al (2006).

ADA patients can be involved with CBOs to assist them in their recovery. CBOs can assist them in their recovery by providing counseling and healthcare. The recovering patients can get involved in income generating projects to assist them integrate back to the society.

1.4.6 County Government Initiatives

In the recent months, the county governments have taken the initiative to fight alcohol and drug abuse menace. In 2013, at least 12 governors from Rift Valley had enlisted the support of the National Authority for the Campaign Against Drug Abuse (NACADA) in policy formulation and capacity building (Chesereck 2013). Mbae,
(2015) in an article noted that Interior Cabinet Secretary Joseph Nkaissery who was speaking on at the National Conference on Alcohol and Drug Abuse at the Bomas of Kenya said it is the responsibility of county leaders to crack the whip on the menace. He called on the elected leaders to establish drug abuse control initiatives in the regions saying no leader can be a leader to unproductive people.

During the same conference, NACADA chairman John Mututho said they have already established branches in ten counties to help fight drugs at the grassroots. “County governments need to be involved in supporting rehabilitation centres and conducting sensitization forums,” he said. The two have also suggested the establishment of special courts that will be in charge of prosecuting cases related to drugs.

The Alcoholic Drinks and Licensing Bill was established to address all aspects of alcoholic drinks selection, preparation, storage, distribution, sale and consumption within counties. The Bill comes in the wake of hundreds of deaths due to consumption of illicit brews, which prompted the National Authority for Campaigns Against Alcohol and Drug Abuse (NACADA) to direct county governments to fast track implementation of the Bill to curb the vice, (Muthoni… et al 2014). County governments have also set up rehabilitation centres within the counties to help addicts overcome their addiction and recovery. Examples are Nairobi, Kiambu, Mombasa counties among others.

The Nairobi City County Alcoholic Drinks Control and Licensing Act, 2014, is an Act of the Nairobi City County Assembly meant to provide for the implementation of the national government policy on alcoholic drinks and for the control, licensing, regulation and general administration of the manufacture, advertisement, sale and
consumption of alcoholic drinks in the country and for connected purposes.

1.4.7 Profile of Asumbi Treatment Centre

Asumbi Treatment Centre is a Faith-Based organization which was started way back in 1978 by Turbeg brothers in Asumbi-Homabay. Other Asumbi Treatment Centres were opened in Nairobi-Karen in May 2005 and Ridgeways in December 2006.

1.4.7.1 Vision and Mission of Asumbi Treatment Centre

The vision is to realize self-fulfillment and social harmony for all the community members through sharing and caring for each other. Its mission is to continue reaching out to the substance users, to create awareness, treatment and rehabilitation, where need be reintegrate them to their communities for healthy nation.

1.4.7.2 Organizational Structure

Asumbi treatment Centres are managed by the Catholic Diocese of Homabay. Asumbi Treatment Centre in Homabay caters for both male and female clients, while the ones in Nairobi cater for male clients only. The focus is on social learning, personal growth, lifestyle change and concepts such as peer pressure, role modeling, self-help, personal responsibility, reality confrontation.

1.4.7.3 Services Provided

Asumbi Treatment Centre offers residential drug-free treatment. The rehabilitation centre uses group and individual counseling and family therapy. The residential drug-free treatment is based on the 12 steps of Alcoholic Anonymous and Narcotics Anonymous programmes, which has been successfully used as a treatment method and fellowship for alcoholics/drug addicts. The 12 steps of Alcoholic Anonymous are as follows:
i) We admitted we were powerless over alcohol—that our lives had become unmanageable.

ii) Came to believe that a Power greater than ourselves could restore us to sanity.

iii) Made a decision to turn our will and our lives over to the care of God as we understood Him

iv) Made a searching and fearless moral inventory of ourselves.

v) Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

vi) Were entirely ready to have God remove all these defects of character.

vii) Humbly asked Him to remove our shortcomings.

viii) Made a list of all persons we had harmed, and became willing to make amends to them all.

ix) Made direct amends to such people wherever possible, except when to do so would injure them or others.

x) Continued to take personal inventory and when we were wrong promptly admitted it.

xi) Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His Will for us and the power to carry that out.

xii) Having had a spiritual awakening as the results of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.
The information resources include television, videos, radio and newspapers. Other facilities available include indoor games and boarding facilities.

1.5 Statement of the Problem

Kenya has had increased cases of alcohol and drug abuse. Most of these cases are referred to rehabilitation centres. Rehabilitation centres are available to help ADA patients recover from their addiction. In most cases, treatment and recovery of ADA patients mostly focuses on the 12 steps of treatment as prescribed by Alcoholic/Narcotics Anonymous and Asumbi treatment centre is one such example. Access and use of information by ADA patients, if well executed, could address information needs and complement treatment and recovery process of patients at Asumbi Treatment Centre, which formed the basis of this study.

Access and use of information at Asumbi Treatment Centre has a number of challenges as experienced by the patients' information needs. Information services provided to the ADA patients is not adequate. The inclusion of information provision to ADA patients has not been sufficiently prioritized. For this to be well achieved, ADA rehabilitation centres, should understand the information needs of the patients, their information seeking behaviour and enhance provision of information resources and services. In addition the ADA rehabilitation centres should consult or partner with the various stakeholders or government agencies concerned in order to implement some of the information services.

1.6 Aim of Study

The aim of this study was to evaluate access and use of information services by patients of alcohol and drug abuse in Nairobi County and to suggest ways in which these can be enhanced.
1.7 **Objectives of Study**

The objectives of the study were to:

i. Determine the information needs ADA patients in the rehabilitation centre

ii. Establish information seeking habits of ADA patients

iii. Establish the information resources and services available in ADA rehabilitation centres

iv. Find out how ADA patients use information resources and services available in ADA rehabilitation centres

v. Find out the challenges faced by ADA patients in accessing and using information

vi. Suggest ways of enhancing provision of information services to ADA patients

1.8 **Assumptions of the Study**

i. Information resources and services available at ADA rehabilitation centres are inadequate to meet patients’ information needs

ii. Evaluating information needs of ADA patients at the rehabilitation centres will contribute towards enhancing access and use of information at the ADA rehabilitation centres

1.9 **Research Questions**

The study was guided by the following questions:

i. What are the information needs of ADA patients?

ii. How do ADA patients seek information?

iii. What are the information resources and services available in ADA in rehabilitation centres?
iv. How do ADA patients use information resources and services available in ADA rehabilitation centres?

v. What are the preferred information formats by ADA patients?

vi. What challenges do the ADA patients face in accessing and using information?

vii. How can rehabilitation centres enhance provision of information services to ADA patients?

1.10 Scope and Limitations of Study

1.10.1 Scope of Study
The study focused on access and use of information services to ADA patients in Nairobi County, a case study of Asumbi treatment Centre. Respondents included the patients and staff of Asumbi Treatment Centre.

1.10.2 Limitations of Study
Some patients were uncooperative during collection of data; therefore only willing patients were interviewed. Those who declined were eight in number, whose information could have contributed significantly to the findings of this research.

1.11 Significance of Study

1.11.1 Theoretical Significance
The study has contributed to new knowledge in terms of provision of information to patients in ADA rehabilitation centres.

1.11.2 Practical Significance
This study has provided practical solutions to provision of information to ADA patients in rehabilitation centres.
1.11.3 Policy-Related Significance

It is expected that the findings of this study would provide a framework for policy formulation regarding access and use of information to ADA patients.

1.12 Chapter Summary

This chapter defined drug abuse, alcohol abuse and described the various categories of drugs that are abused. Impacts of ADA have been highlighted. Different players who intervene against alcohol and drug abuse come into play, some being government initiatives while others non-governmental initiatives. This chapter highlighted the statement of the problem with regards to the research, the aim and objectives of the study and significance of the study. Finally all the terms used in the proposal have been defined.
1.13 Operational Definition of Terms

Alcohol: a drug, classed as a depressant, meaning that it slows down vital functions—resulting in slurred speech, unsteady movement, disturbed perceptions and an inability to react quickly.

Alcohol abuse: a pattern of drinking that results in harm to one’s health, interpersonal relationships, or ability to work.

Alcoholics anonymous: a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism.

Alcoholic: a person suffering from alcoholism

Alcoholism: an addiction to the consumption of alcoholic liquor or the mental illness and compulsive behavior resulting from alcohol dependency.

Bibliotherapy: the use of selected reading materials as therapeutic adjuvant in medicine and psychiatry; also guidance in the solution of personal problems through directed reading.

Catharsis: the cleansing of emotions brought about by expressing oneself through some form of art, such as music, movement, painting or writing.

Drug: a substance which may have medicinal, intoxicating, performance enhancing or other effects when taken or put into a human body or the body of another animal and is not considered a food or exclusively a food.

Drug abuse: an intense desire to obtain increasing amounts of a particular substance or substances to the exclusion of all other activities.

Information access: the ability to find information regardless of format, channel, or location.
**Information need:** a recognition that your knowledge is inadequate to satisfy a goal that you have.

**Information seeking:** a conscious effort to acquire information in response to a need or gap” in knowledge.

**Information use:** involves interacting with information when you read, view, touch, and then extract relevant information for the task at hand.

**Rehabilitation:** the process by which a person presenting with a substance related problem achieves an optimal state of health psychological functioning and social well being devoid of substance abuse.

**Rehabilitation centre:** a facility that seeks to help individuals recover from a variety of ailments, some physical and others caused by substance abuse or mental illness. Some centers offer residential areas, where those being treated will stay overnight.

**Substance abuse:** the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.
CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

Literature review helps to sharpen and define understanding of existing knowledge in the problem area, provides a background for a research project and makes the reader aware of the current status of the issue (Mutai, 2000). This chapter reviews the study and related literature that has been made by various scholars and stakeholders concerning or in relation to provision of information services to patients of Alcohol and Drug abuse. Although there is no such study that has been made in Kenya, there are studies that have been made on patients with other ailments either in a hospital set up or rehabilitation centres. The various themes reviewed in this chapter include; Information as a concept; Information needs of ADA patients; Provision of health information services; Standards on health information service provision; Bibliotherapy services and Use of ICT in provision of health information.

2.2 Theoretical Framework

A number of models on information behavior have been developed by different scholars over the years. In this study the researcher has mainly applied the theory of information behaviour as advocated by Wilson’s model of information behaviour (1996) and the new model of information behaviour as designed by Niedźwiedzka (2003). The models outline players in information needs and communication of feedback.

2.2.1 Wilson’s Model of Human Behaviour (1996)

Wilson’s model of human behaviour (1996) is a variation of Wilson's original model of 1981. Wilson’s models have been extensively used in research that
concerns information seeking, use and users. According to this model as shown in Figure 2.1, the person seeking information remains the center of attention of the information needs, identifies a need and begins to seek for information. In the process, the person may encounter intervening variables which may be psychological, environmental or source characteristics. The seeking process may drive the person to use different sources of information or do what is required to attain the need. Certain behaviour is exhibited in all these processes and this ascertains whether the person has succeeded in the search, if not, the search process begins afresh.

**Figure 2.1: Wilson's general model (1996)**

According to Wilson (1997), the human behavior model focuses on three theories in the information search process namely:

i) Stress/coping theory: Wilson explains that some needs may not prompt someone to seek information, thus the person has to sift through the needs to identify the most important ones in order to conduct a search.

ii) Risk/reward theory: this theory explains why some information sources may
be consulted by the user more than others

iii) Social learning theory or the self-efficacy theory is the estimation of whether a person can successfully accomplish the information seeking behavior. This influences the individual’s decision to perform the necessary information seeking activities and determines whether the person will cope with the situation or not.

Within the information behavior, Wilson identifies passive attention, passive search, active search and ongoing search. Passive attention refers to when an individual pays attention and absorbs information from the surrounding for example a television set. Passive search refers to when an individual acquires relevant information after exhibiting certain behaviours. Active search is when an individual seeks information for update or to expand their scope of knowledge.

This model is quite applicable to this study as ADA patients seek information as a result of a need. The patients’ information needs were varied depending on different factors. During the information seeking process, the patients exhibited a behavior. From the model, during the information seeking process an individual may consult various information sources or services, which may result in success or failure to find relevant information. If the search is successful, the individual will then makes use of the information found. If not successful the information seeking process will have to start again. The unsuccessful information seeking is as a result of intervening variables. In this study, patients experienced intervening variables to information seeking mostly due to their restricted environment within the rehabilitation centre.

2.2.2 Barbara Niedzwiedzka Model of Information Behaviour (2003)

This model was based on Wilson’s theoretical model. According to
Niedzwiedzka (2003) the proposed new model encompasses the main concepts of Wilson's model, such as: person-in-context, three categories of intervening variables (individual, social and environmental), activating mechanisms, cyclic character of information behaviours, and the adoption of a multidisciplinary approach to explain them. However, the new model introduces several changes. They include:

i) Identification of 'context' with the intervening variables

ii) Immersion of the chain of information behaviour in the 'context', to indicate that the context variables influence behaviour at all stages of the process (identification of needs, looking for information, processing and using it)

iii) Stress is put on the fact that the activating mechanisms also can occur at all stages of the information acquisition process

iv) Introduction of two basic strategies of looking for information: personally and/or using various intermediaries.

The model shows two strategies that a user can apply when seeking information. These are:

- A user seeks information personally or
- a user uses the help or services of other people

According to the model, a user can apply either of the strategies or both. Depending on their own knowledge, a user can seek information and consult available sources and interact with search systems and information services independently. Tools that may be applied include databases, catalogues, archives, search engines and so on. The user also selects and processes the acquired information personally.

On the other hand, users can rely on intermediaries such as information specialists, co-workers or subordinates and their services to seek and acquire information. Such a
user is termed as a semi-independent user. A user can also depend almost entirely on intermediaries to seek and acquire information, and only acts independently at the stage of processing the acquired information. It is said almost entirely because a user can rely on other information sources available without consulting an intermediary.

In light of Niedzwiedzka’s model, it can be said that ADA patients are both dependent and independent information seekers. There are those patients who depend entirely on intermediaries to seek information while there are those who independent, who are aware of what information they are seeking and where to seek it.

According to Niedzwiedzka (2003), the model applies to a wider range of information users. However, the model does not present all aspects of information behavior, for example it does not reflect the fact that from the birth of a need (problematic situation) through the following stages of decision-making and information acquisition, the process is not separated from other needs, and often several sequences of information seeking are performed simultaneously using various strategies.

In this study, the primary goal was to establish information needs, behavior, preferences and limitations for ADA patients in rehabilitation centres. The Niedzwiedzka (2003) model was used in this study because it represents information seeking that is either user dependent or independent. ADA patients identify their needs within an intervening variable, and they may use intermediaries or own knowledge to seek information. They then select and process information again by themselves or by the use of intermediaries. Each stage of the information seeking process is intertwined with the support of other variables until the closure of solving the information need or a problem.
The techniques of information seeking and communication can be compared to ADA patients when they experience a need to seek information. During information seeking, the ADA patients may experience intervening variables, which may include psychological unpreparedness, language barriers, and physical condition among others. This results in them exhibiting a certain type of behaviour. In doing so, they use various channels of communication or other intermediaries to seek information. The communication channels they use are able to give feedback on whether their information seeking was successful or unsuccessful.

Figure 2.2: Niedzwiedzka Model of Information Behaviour (2003)
2.3 Review of Related Literature

2.3.1 Information as a Concept
There is no universally acceptable definition of information. Various academic disciplines define information based on their context. Floridi (2010) explains that information is notorious for coming in many forms and having many meanings. It can be associated with several explanations, depending on the perspective adopted and requirements and desiderata one has in mind. In information technology, information can be defined as data that has been processed in such a way as to be meaningful to the person who receives it.

The word “information” is used, in the context of user-studies research, to denote a physical entity or phenomenon (as in the case of questions relating to the number of books read in a period of time, the number of journals subscribed to, and so on the channel of communication through which messages are transferred (as when we speak of the incidence of oral versus written information), or the factual data, empirically determined and presented in a document or transmitted orally (Wilson, 2000).

Information forms the basis by which societal and human growth depends on and thus an information society evolves. An information society depends on the systematic organization and dissemination of information, which revolves around an information life cycle. The information life cycle, according to Floridi has the following phases: occurrence (discovering, designing, authoring, and so on), transmission (networking, distributing, accessing, retrieving, transmitting, and so on), processing and management (collecting, validating, modifying, organizing, indexing, classifying, filtering, updating, sorting, storing, etc) and usage (monitoring, modeling, analyzing, explaining, planning, forecasting, decision making, instructing, educating, learning, etc.)
For a society to get along, it needs information. This enables the society to identify its needs so as to make changes and improvement. Information is a resource that can be used in making important decisions in various capacities, and acquiring important knowledge. It can thus be concluded that that information is a multidisciplinary concept. With this in mind, ADA patients in rehabilitation centres form part of a society that require and use information for various purposes.

2.3.2 Information Needs

People have information needs. The need to get informed depends greatly on the role someone plays, for example a doctor, a lawyer, student, teacher etc, or a specific situation that would make someone to seek information. Information needs have been defined by different authors depending on their interests and expertise. Case (2012) defines information need as a recognition that your knowledge is inadequate to satisfy a goal that you have.

Information professionals, more often than not, provide information to their clientele without knowing what their needs are. Nicholas (2000) asserts that people often talk about information needs, when in fact, they are referring to wants and use. He further states that we should evaluate the need people have for information, the wants they express for it and the demands and use they make for it. Nicholas and Herman (2009) distinguish information wants, information demands from information needs. They state that Information wants are what an individual would like to have – like being the operative word here. They describe an information demand as a request for an item of information believed to be wanted.
Studies have been conducted about the information needs of patients suffering from other kinds of ailments aside from alcohol and drug abuse. Patients suffering from various ailments need information concerning their disease, treatment procedures and recovery processes. ADA patients need a basic understanding of their ailment. Likewise, people who are constantly in contact with ADA patients need to have information on alcohol and drug abuse. These include family, friends and colleagues.

A study conducted on the information needs of adult Type 2 diabetic patients at Addington Hospital, Durban revealed that the patients had different information needs which were dependent on the patients’ health related problems at the time. These include Long term complications, such as amputations, ways to better manage their diabetes and ways to treat existing diabetes related problems. Likewise, ADA patients may need information on the complication of addiction, how to manage their addiction and how to treat their addiction.

A study on Information needs of people with multiple sclerosis and the implications for information provision based on a national UK survey was conducted in the UK and their information needs were determined. The study revealed that people with multiple sclerosis had diverse information needs. These include;

i) Information about multiple sclerosis

ii) Information that helps the person with multiple sclerosis interact with the world around them. This distinction may seem misdirected in that it could reinforce the mistaken perception of seeing the person with MS primarily in terms of their condition rather than as a person. As mentioned earlier, it would be good design practice to provide information through life situations as well as through a “directory” of topics.
The above study on multiple sclerosis tells us that patients suffering from various ailments would require information regarding what they are suffering from. Even ADA patients need information about their substance addiction and information that would help them interact with the world around them.

From the researcher’s point of view, service providers in the rehabilitation centres would need to have a better understanding of the information needs of ADA patients to guide the patients while undergoing treatment and recovery. This can be well achieved by conducting information needs analysis to determine the information needs of ADA patients.

### 2.3.3 Access to Information

In Kenya, information access is a constitutional right of every Kenyan. In this study, access to information is applicable in the Library Science context. As has been the trend, libraries and information centres were concerned with equipping their libraries with different volumes of book titles and ensuring that journal subscriptions have been made. How information is packaged and stored will determine how it can be accessed. For example, if information is stored in print format, it means it has to be accessed physically. If the information is stored in an electronic format such as a database, it can be accessed remotely. Today, the electronic environment has enabled access to information easier, manageable and convenient. As stated by Al-Suqri (2014), ‘information and knowledge access, sharing and communication can be made reliably possible with the electronic information technology which overcomes limitations of a distance barrier.’ This clearly shows that advancements in technology has made information access easier.
Libraries and information centres have to ensure that despite being equipped with these materials, the patrons should be able to access them. It is therefore the onus of libraries and information centres to ensure that their patrons are equipped with knowledge on how to access and retrieve information. Al-Suqri (2014) states that ‘Access to information can only be meaningful if the users actually know how to use the complex electronic environment via information technologies, and also to know when the information technology would be useful in discharging their duties adequately.’ This is quite agreeable because without the knowledge of how to use an electric platform, information access is impossible. Several platforms have enabled information access become easy. The existence of search engines such as google, social networking sites such as Facebook, touch screen technology such as smart phones and web 2.0 have ensured that information is easily accessible.

The conventional methods of accessing information however still exist to complement the new technological trends. Information that is easily accessible ensures satisfaction from the clientele.

2.3.4 Information Use

Cole, (2015) defines information use as ‘From the user or cognitive perspective, information use is the modification of the user’s knowledge structure.’ International Standard Organization (ISO) defines usability as ‘the effectiveness, efficiency and satisfaction with which a specified set of users can achieve a specified set of tasks in a particular environment.’

How people use information will largely depend on their situations, needs and goals. Albers (2012) states that ‘People need access to relevant task information that is immediately understandable and is properly positioned within the
situation. Sometimes people may not be aware of the existence of irrelevant information but they still use it to satisfy their need. Albers (2012) further states that ‘A major problem is that people cannot tell if the information is complete, incomplete, ambiguous, conflicting, or irrelevant. Yet, people try to work with this information and integrate it into their understanding of the situation.

There are different ways that people may interact with information such as reading, viewing, touching and hearing. From these interactions, relevant information can be extracted for the task at hand or draw meaningful conclusions or ultimately make informed decisions. The ultimate goal of using information is to obtain an answer to a specific information need. Responsible use of information is key ensuring that information is not misused by the end user. The society has set its guidelines and expectations on how information should be used, that is why there are laws guiding the use of information. It is upon the individual to make judgement on what is good use of information and what is bad.

ADA patients in this case would use information for their personal development while at the rehabilitation centre. This will depend largely on their information needs.

2.3.5 Information Sources

Information seeking is conducted from various sources. These information sources include books, journals, conference proceedings, manuscripts, internet sources and monographs. Information is usually presented in two major formats. These are non-print formats and print formats.

The library is the major custodian of these information sources. However, internet sources can be accessed remotely at the individual’s preference.
Information sources can be classified into three major categories; primary, secondary and tertiary.

University of Maryland gives definitions and examples of the three categories of information sources as follows:

a) Primary Information Sources
Primary information sources are original materials. They are from the time period involved and have not been filtered through interpretation or evaluation. Primary sources are original materials on which other research is based. They are usually the first formal appearance of results in physical, print or electronic format. They present original thinking, report a discovery, or share new information.

Examples of print format include; newspapers, journals, magazines, newsletters, bulletins, reports and so on.

Non print formats include;
  i) Audio visual materials. Examples include; television programmes and documentaries, video recordings etc
  ii) Electronic material. Examples include; emails, websites, etc
  iii) Microforms. Examples are microfilms, microfiche

b) Secondary Information Sources
Secondary information sources are accounts written after the facts have been established from primary sources. They are interpretations and evaluations of primary sources. Examples include: Dictionaries, directories, Encyclopedias, atlases, maps, manuals/handbooks, monographs, textbooks, almanacs, etc
c) Tertiary Information Sources

Tertiary information sources consist of information which is a distillation and collection of primary and secondary sources. Examples include: Bibliographies, indexes and abstracts.

(http://www.lib.umd.edu/ues/guides/primary-sources)

Different categories of users consult different sources of information. A study carried out by Bilodeau, BA …et al (1996) on Information needs, sources of information, and decisional roles in women with breast cancer revealed that the women preferred personal sources of information (physician, nurse, friend, or relative) over written sources. The level of development can also influence the source of information preferred. Elly and Silayo (2013) in their study on Agricultural information needs and sources of the rural farmers in Tanzania realized that traditional and interpersonal means of communication remain the most reliable sources of information among rural farmers in the current situation. This was attributed to the fact that certain areas in Tanzania are more developed than others. On a similar note, the level of education and exposure could also influence the source of information preferred. Olatokun and Ajagbe (2010) conducted a research on Analyzing traditional medical practitioners’ information-seeking behaviour using Taylor’s information-use environment model which showed that traditional medical practitioners relied more on informal sources. The probable reason for this finding could be as a result of the inaccessibility of the practitioners to formal sources due to their low level of education.

2.3.6 The Concept of Information Seeking Behavior

People tend to behave in certain ways when seeking information, thus certain behaviours are manifested when seeking information. Information need will drive an
individual to information which will trigger a certain type of behaviour. Wilson (2000) states that information seeking behaviour is the purposive seeking for information as a consequence of a need to satisfy some goal. In the course of seeking, the individual may interact with manual information systems or with computer-based systems.

Case (2012) defines information seeking as a conscious effort to acquire information in response to a need or gap in your knowledge. He further states that information behavior encompasses information seeking as well as the totality of other unintentional or passive behaviours (such as glimpsing or encountering information), as well as purposive behaviours that do not involve seeking, such as actively avoiding information.

Mavodza (2011) conducted a study on Information seeking behaviour of library users at Metropolitan College of New York. She based her study on the use of library databases and found out that the databases are highly used from 11am to 9 pm when assumingly students are on campus rather than when they are away. The statistics of database usage was higher on particular months when the semester was halfway. The findings suggested that database usage statistics can give insight into information behaviour and help inform collection management decisions.

The type of sources available would influence information seeking behaviour. Ajiboye and Adeyinka (2007) examined the information seeking behaviour of undergraduate students in the University of Botswana. The result of the study revealed that the internet is the most consulted source, followed by students’ class notes and handouts.
With ADA patients, there could be varied factors that influence their information seeking. For example an illiterate person could be driven to seek information from an audiovisual material rather than using printed materials.

2.3.7 Provision of Health Information Services

Ocholla, D.N. and Ojiambo, J.B. (1993) define an information service as a unit designed and organized to provide information to users. According to Wyatt and Sullivan (2006) health information is a health service provided, or to be provided, to an individual; that is also personal information; or other personal information collected to provide, or in providing, a health service; or other personal information about an individual collected in connection with the donation, or intended donation, by the individual of his or her body parts, organs or body substances; or genetic information about an individual in a form that is, or could be, predictive of the health of the individual or a genetic relative of the individual.

Health information services can be categorized into two namely;

a) General Services

These are information services that are not specific or limited to a particular area or field. One of the basic information services is answering ready reference service questions. These questions are normally handled at the reference desk or reception of the facility. Normally, these questions do not take long to be answered for example one can ask the direction to the nurses’ station. Examples of general information services include ready reference services, video conferencing, online discussion groups and emails.
b) **Special Services**

These are information services that are specific and are designed for a particular purpose. They deal with specialized information resources and services within the health sector. Examples of special health information services include current awareness services, selective dissemination of information, abstracting and indexing services, consumer health information service, lending services and information literacy services.

Health information covers an extensive range of issues, it comes from a wide range of providers – family, peers, professionals and industry, public bodies and authorities and includes information on products, services, treatments, and health promotion and prevention. Recognizing the value of information to behavioural choice, health professionals, civil society organizations (including patient associations) public bodies and authorities and market actors have long sought to deliver sound and understandable information to individuals to help them make healthy choices (European Union (EU) health policy forum 2005). Health information has to be of good quality. This affects the source and credibility of the health information.

### 2.3.8 Standards on Health Information Services Provision

The European Union (2005) established standards to be followed on health information service provision which can also apply to ADA patients. These include:

i) **TRANSPARENCY**: health information providers should build trust by providing verifiable, credible information, the source of information and of funding, and their motivations for providing that information. Health information providers should also include references to persons or organisations that users can contact if they have additional questions and
require further information. Information users should be wary of the information when these facts cannot easily be discerned from either the published material or the interaction.

ii) OBJECTIVITY: information providers need to make clear the context within which they operate and make every effort to ensure that the information provided is complete and balanced especially where commercial interests are involved. Information users should be aware that information that is left out of a communication may also be important.

iii) TIMELINESS: health information providers should regularly update and review information. Information users should be vigilant to check that information is current. Information should be available at the time of need.

iv) RELEVANCE: health information providers should do their utmost to ensure that information is understandable, relevant and in an appropriate format for the target group and that it does not conflict with cultural and religious traditions.

v) CONFIDENTIALITY: information provision often develops into a two-way exchange of information. Full disclosure of how any data collected during such an interaction will be used must be made available to all parties concerned. Full consent to the collection, storage and use of such data must be obtained.

Public and medical libraries play a major role in disseminating health information. Other sources where consumers can obtain health information include the mass media, the internet, from colleagues among others.
IFLA suggests that if libraries prioritize access to health information they provide a platform with which they can support the health services offered by doctors, clinics and hospitals. Libraries can help the community access health information through:

i) Skills: these are skills that librarians have (acquiring, organizing and presenting information) or skills that librarians can teach – Information Literacy

ii) Materials: this includes providing Health information corners for the public, Bibliographies and documents for doctors and researchers

iii) Premises: providing premises for meetings and using the premises for publicity through posters and events

Other areas that the library can help in providing health information have been summarized below by IFLA:

The library health information corner can be used to display leaflets, manuals and other materials created by government agencies and NGOs. The library can make them available for users to take away home or consult the library if only one copy is available.

i) Learning groups and clubs: The library can organise activity and learning groups (especially for children). Librarians can lead such groups, using posters and other materials for learning purposes. Visits by nurses, project workers etc. can form part of the group’s programme. Showing of films or videos is useful, if possible.

ii) Librarians outside the library: Librarians can promote health information by visits to venues such as schools, churches, and other meeting places such as Markets, bus and railway stations. Librarians can organize publicity in local newspapers
and radio stations Libraries need to be represented at community and development project meetings.

iii) Information literacy activities: People need help in understanding Health information pamphlets and brochures, Prescriptions and doctor’s instructions and Publicity materials such as posters.

iv) Librarians can help individuals interpret information. They can also work with groups to improve general information literacy.

2.3.9 Bibliotherapy Services

Bibliotherapy is a technique for structuring interaction between the client and the therapist based on mutual sharing of literature in fulfilling the client’s therapeutic needs, (Hussin and Abdullah 2008). As Pardeck (1994) states, Bibliotherapy dates back to the 1930s when librarians began compiling lists of written material that helped individuals modify their thoughts, feelings, or behaviors for therapeutic purposes.

In the earlier days, the bibliotherapy approach tended to be more reactive meaning that the process focused on getting individuals to react positively or negatively to the reading material. However, in recent years, the therapeutic process has been more interactive. In order to conduct bibliotherapy, the user needs must be put into consideration. Heath …et al (2005) states that successful bibliotherapy is dependent on literature that appropriately addresses students needs. Those who provide bibliotherapy must understand those needs. In the long run, bibliotherapy has its own benefits. Pardeck (1995) describes the ultimate goals of bibliotherapy as follows:

i) To provide information

ii) To provide insight into a specific experience or situation
iii) To provide alternative solutions to the problem.

iv) To stimulate a discussion of what the actual problem is

v) To communicate new values and attitudes with regard to the problem

vi) To help students understand that they are not the only one who has experience this problem.

Bibliotherapy can be used for clinical purposes as a therapeutic method to help patients in their recovery and in the classroom to help children in their development. This is known as clinical bibliotherapy and developmental bibliotherapy respectively. Hebert & Kent, (2000) differentiate between the two ‘Clinical bibliotherapy involves psychotherapeutic methods used by skilled practitioners with individuals experiencing serious emotional problems. Developmental bibliotherapy is helping students in their normal health and development. One of the advantages of this approach is that teachers can identify the concerns of their students and address the issues before they become problems, helping students to move through predictable stages of adolescence with knowledge of what to expect and examples of how other teenagers have dealt with the same concerns.’

Bibliotherapy involves various stages. To sum it up Pardeck (1993) came up with four major steps in bibliotherapy namely:

i) Identify the problem, situation, behavior, or skill to be acquired;
   The therapist or teacher needs to understand the problem and the needs.

ii) Select an appropriate work of literature;
   The therapist or teacher needs to make a selection of the right book, poem or literature that will be appropriate to the particular need or problem. The literature selected should be of age appropriate for the reader to identify with
the characters and should identify with the situation.

iii) Present the literature;

The presentation of literature is done in a manner which will enable the student or patient relate with the characters in the literature. In addition to the examination of themes, however, participants have to be helped to relate to one or more characters presented in the books or poems, Hussin and Abdullah (2008).

iv) Follow up the reading with a discussion.

The follow up stage involves analyzing and sharing of what has been learnt in the literature that involves the readers i.e. student or patient. This reaction is called catharsis. Here, the role of catharsis is to help the readers come to terms with their weaknesses and help them recover emotionally. Cook, Earles-Vollrath and Ganz (2006) state that once this catharsis has occurred, the student will have greater insight into the problem, and ideally he or she will be able to work with the adult proactively to identify solutions for similar situations that may arise.

With regards to addicts of substance abuse, bibliotherapy helps the addicts to recover. A study conducted by Hussin and Abdullah (2008) on Reading to Recover: Exploring Bibliotherapy as a Motivational Tool for Recovering Addicts revealed that there was evidence of change in behavior as an outcome from the bibliotherapy technique in working with addicts. The results of the study showed that literature consisting of true accounts of successful recovering addicts can be a helpful recovery tool to boost motivation to change as well as to help improve cognitive distortion of individuals who are in the treatment process. Sharing true stories of recovering addicts helps clients to investigate and be aware of their personal strengths in preparing themselves to change.
Apodaca and Miller (2003) on their study on A Meta-Analysis of the Effectiveness of Bibliotherapy for Alcohol Problems was about a review of studies carried out evaluating the effectiveness of self-help materials. Their study revealed that heavy drinkers appear to be able to reduce their alcohol consumption and/or problems significantly with bibliotherapy materials to a larger extent and more rapidly than without such materials.

2.3.10 Use of ICT in Provision of Health Information

ICTs have enhanced the access and use of health information in various capacities. In general, the term ICT usually refers to hardware and software for processing electronic information and the communication technology required to transmit the information from place to place, (Moahi 2009). Gatero (2010) declares that Utilizing ICTs can offer the healthcare professionals with enhanced access to: key data at all levels from international to local, electronic libraries of evidence, peer reviewed research and practice guidelines, and network of professionals in health and related disciplines.

Use of ICT in provision of health information can be utilized using the following media:

i) Audio material. This includes the radio which is a communication system based on electromagnetic waves.

ii) Internet: the internet provides a platform whereby information can be shared and exchanged in various forms. These platforms include:

   a) Social media. Examples of social media include face book, twitter and blogs.
b) Teleconferencing. This is the use of television video and sound technology as well as computers to enable people in different locations to see, hear and talk with one another.

iii) Audio visual. These include;

   a) Television which is a telecommunication system that transmits images of objects (stationary or moving) between distant points.
   b) Video. This is a recording of both the visual and audible components especially one containing a recording of a movie or television program.

Kenya has a Health Information Systems Policy (2010 – 2030). The clause on Application and use of Information and Communication Technology states that the application of information and communication technology (ICT) in the health sector aims to simplify administrative processes and reduce data gathering and processing costs. It also aims to facilitate the delivery of health related information to remote locations within the sector. The application of information technology in the health sector is of paramount importance to align the multiple stakeholders towards a common reporting mechanism and objective.

The use of e-resources plays a major role in the provision of health information. A study conducted by Kamau and Ouma (2005) on The impact of E-resources in the provision of health and medical information services in Kenya indicated that the most popular e-resources is the internet, followed by CD-ROM. However, the use or e resources may be minimal due to the lack of awareness. On the other hand Gatero (2010) in his study on Utilization of ICTs for Accessing Health Information by Medical Professionals in Kenya: A Case Study of Kenyatta National Hospital revealed that the level of awareness of these online health information initiatives
varied and was generally low. He further stated that even those who had some awareness of these health information databases did not appear to use them. Some medical professionals described difficulties and frustrations on logging in to some websites and especially those that require passwords.

ICT plays several roles in accessing and disseminating health information. A study carried out by Omona and Ikoja-Odongo (2006) on Application of information and communication technology (ICT) in health information access and dissemination in Uganda revealed that all respondents agreed that ICT has revolutionized the way in which health information can be accessed and utilized. The respondents explained that ICT:

i) assists in presenting quality, up-to-date information and data;

ii) avoids geographical boundaries, so people from all corners of the world can access information;

iii) gives current and worldwide information about the latest developments in the field of health;

iv) enables faster access to relevant information sources;

v) leads to improved knowledge on health and therefore health care services;

vi) arouses interest in learning as well as stimulating research;

vii) enhances distance learning and instructions and links health care providers with the service consumers; and

viii) brings the whole world onto one's desktop and saves time and effort when accessing information.
2.3.11 Challenges of Accessing and Provision of Health Information

In the ICT sector, several challenges are experienced. Gatero (2010) cites limited access to the Internet and electronic information resources, lack of information skills and computer competencies, lack of time and incentives to access information, and lack of general awareness of what is available. Omona and Ikoja-Odongo (2006) reveal bureaucracy and red tape in institutional management; information overload; lack of information resource sharing and exchanges among libraries; and too much reliance on donor funding, especially with respect to ICT projects, which means that the projects collapse as soon as donors stop funding them due to lack of funds to sustain their continuing operation, were the other problems identified as associated with the use of ICT in health information access and dissemination.

Other factors contribute to the challenges of access and provision of health information. Maxfield …et al (1998) established that barriers to accessing health information include cost, geographic location, illiteracy, disability, and factors related to the capacity of people to use these technologies appropriately and effectively.

The Kenya health Information System Policy identifies to lack of a policy and legal framework to harmonize and enforce the data and information management at all levels since the establishment of Health Information System in 1972 as a weakness in the provision of health information service. Other factors include Culture of information generation and use remains under-developed or is limited, inadequate capacities of staff in HIS, many parallel data collection systems, lack of policy and guidelines, poor coordination, and limited funding.
2.3.12 Chapter Summary

Information is a key element that is needed in all spheres of life. Without information, activities will stagnate as different individuals need information for different purposes. This study has reviewed different literature that affects the provision of information in different scenarios, information seeking behavior, information needs including challenges of accessing and provision of health information, with the focus being on ADA patients.
CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

In this chapter, procedures that have been used to do the study have been described step by step. This section of the study describes the research design, the population, the sampling method, the instruments used in collecting data and the presentation.

3.2 Research Design

This study adopted a case study design.

Case study design was used because it is a very valuable tool for assessing opinions and trends that are specific to alcohol and drug abuse patients.

3.3 Research Approach

The research approach used was qualitative method. According to Kothari (2014) qualitative approach to research is concerned with subjective assessment of attitudes, opinions and behavior. Research in such a situation is a function of researcher’s insights and impressions.

Qualitative research was used in this study because opinions were sought through conducting interviews at Asumbi treatment centre. The respondents gave their opinions and experiences while at the rehabilitation centre. The researcher was able to gain insights and give a holistic description of the regarding access and use information services in rehabilitation centres in Nairobi County.

3.4 Study Population

The study targeted ADA patients and staff representatives from Asumbi Treatment centre. Asumbi Treatment Centre in Karen, being a branch of the main treatment Centre in Asumbi, had one permanent staff who was the administrator. The management staffs were based at the main treatment Centre in Asumbi. The rest of the
staffs were employees on part time basis who had no authority to speak on behalf of the rehabilitation Centre.

3.4.1 Study sample Size

The study sample involved 77% of patients and one staff representative in the rehabilitation centre.

Table 3.1: Study Sample Size

<table>
<thead>
<tr>
<th>Category</th>
<th>Population</th>
<th>Sample size</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADA Patients</td>
<td>30</td>
<td>23</td>
<td>77</td>
</tr>
<tr>
<td>Administrative staff</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 3.1 above shows the total number of patients in the rehabilitation centre which was 30 and one administrative staff. This brings the total study population to 31.

At the time of the interview the population of the patients was at 30 out of the possible bed capacity of 50 patients. Out of the 30 patients, the researcher was able to interview only 23 patients and one administrative staff. The rest of the patients declined to be interviewed for their own personal reasons.

3.5 Census Inquiry

Kothari (2014) states that a complete enumeration of all items in the population is known as a census inquiry or census survey.

In this study, the population under study was 31. The researcher opted to use all the population since picking a sample would have a significant reduction on the total number of people to collect data from. Therefore the researcher opted for a census instead of selecting a sample from the total population.
3.6 Data Collection Methods

The most common methods of data collection in qualitative research include interviews, observations, review of documents and audiovisual materials as described by Creswell (2007). In this study, interviews were used as the data collection method.

3.6.1 Interviews

This is the most common method of collecting data in qualitative research. One needs good interviewing skills to be able to collect data. This method involves the following:

i) Conduct an unstructured, open-ended interview and take notes;

ii) Conduct an unstructured, open-ended interview, audiotape the interview and transcribe it;

iii) Conduct a semi structured interview, audiotape the interview, and transcribe the interview;

iv) Conduct a focus group interview, audiotape the interview and transcribe it;

v) Conduct different types of interviews: email, face to face, focus group, online focus group, telephone interviews Creswell, (2009).

In this study, face to face interviews were conducted to collect data from all the respondents. The interviews were conducted to the ADA patients within a stipulated time frame. The researcher was obliged to clarify in areas where the respondents did not understand the questions clearly. Interview schedules were prepared by the researcher and pilot tested prior to the interview to test the suitability of the questions and the expected reception among the respondents. This aided in refining the questions to improve their effectiveness.
3.7 **Data Collection Instruments**

These include the interview schedule, observation checklist, collection of documents and audiovisual material.

In this study, semi structured interview schedules were used as the data collection instrument, and the responses were noted down by the researcher. The interview schedules included the following key themes: information needs, information seeking behavior, sources of information, use of information and challenges of accessing information.

3.8 **Validity and Reliability of Data Collection Instruments**

3.8.1 **Validity of Data Collection Instrument**

Validity is a test of how well an instrument that is developed measures the particular concept it is intended to measure. In other words, validity is concerned with whether we measure the right concept, Sekaran (2010). Several types of validity tests are done to test the goodness of the data collection instrument.

A more accurate way to assess the validity of a research instrument is to ask experts in the area to give their opinion on the validity of the tools. In this study, to test the validity of the data collection instrument, a pretest of the data collection instrument was done and it involved recovering addicts.

3.8.2 **Reliability of Data Collection Instrument**

Reliability is a test of how consistently a measuring instrument measures whatever concept it is measuring. In other words, the reliability of a measure is an indication of the stability and consistency with which the instrument measures the concept and helps to assess the “goodness” of a measure (Sekaran, 2010).
One of the easiest ways to determine the reliability of empirical measurements is by the retest method in which the same test is given to the same people after a period of time. The reliability of the test (instrument) can be estimated by examining the consistency of the responses between the two tests.

In this study, the data collection instrument was administered to the respondents on two different occasions. After reviewing the responses on the two occasions, the researcher was satisfied with the data collection instrument after establishing the consistency in the responses given from the pretest done.

3.9 Pretesting Data Collection Instrument

The data collection instrument for ADA patients was pretested and the validity and reliability determined using a pretest checklist. This was achieved by interviewing a sample of ADA patients prior to data collection to determine the validity and reliability of the questions. The participants included ADA patients who were about to be discharged from the rehabilitation centre and therefore would not participate in the actual data collection process. Before conducting the interview, the researcher had to ensure the following:

a) Identify an appropriate set up that would be favourable for the interview to take place. This included the interview location which was away from noise and distraction.

ii) Familiarization with the participants prior to the interview. The researcher had to make a brief introduction and explain the nature of the research and give a presentation of a topic of choice in order to establish a rapport with the participants.

The areas pretested included whether the questions were too many, clear or logical.
Other areas pretested were; grammatical mistakes present, jargons or technical terms used in the questions that were difficult to understand and whether the objectives have been adequately covered and the general view of the diversity of questions. Upon completion of the pretest, the researcher reviewed the interview questions for clarity in the areas where the respondents had difficulties in understanding.

3.10 Ethical Considerations

This research adhered to the regulations and guidelines approved by Moi University for preparation of theses and dissertations. These include all the requirements and regulations set up by Moi University. A permit was sought from the concerned authority for the purpose of conducting research.

The researcher cited and acknowledged all references used in the study to avoid plagiarism. All participants were notified on the purpose of the research and how long the procedure of data collection will take place. The participants had the right to decline to participate, therefore nobody was forced to participate in the research. Finally, all data collected was treated with utmost confidentiality. The researcher reassured the participants that the data collected would not be compromised or used anywhere for any other purpose.

3.11 Chapter Summary

This chapter gives an overview of the research method that was used in this study. The research design which was descriptive in nature has been explained in terms of the study. The research design adopted was a case study, with the population drawn from Asumbi Treatment Centre. The census inquiry had to be used because of the existing small population. Interviews were used to collect data for this kind of study. All the ethical considerations considered have been discussed in the chapter.
CHAPTER FOUR: DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1 Introduction

In this chapter, the findings of the study on the provision and use of information to ADA patients in rehabilitations centres are discussed. The findings have been presented in tables, text, figures and percentages and analyzed qualitatively. The data presented was collected through face to face interviews as discussed in chapter three.

4.2 Characteristics of Respondents under Study

The interview conducted targeted 30 patients. However, only 23 patients were interviewed. Seven patients declined to be interviewed. One staff representative was also interviewed, who was the administrator of the facility. The patients were asked questions relating to their duration of stay at the rehabilitation centre. 12 patients (52%) had stayed for three months, five patients (23%) had stayed for two months, two patients (9%) had stayed for one month, and one (4%) had stayed for three years, 18 days, six weeks and five months each.

Table 4.1: Patients’ Duration of Stay

<table>
<thead>
<tr>
<th>Duration of stay</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 months</td>
<td>12</td>
<td>52</td>
</tr>
<tr>
<td>2 months</td>
<td>5</td>
<td>23</td>
</tr>
<tr>
<td>1 month</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>3 years</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>18 days</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>6 weeks</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>5 months</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>
As evidenced in Table 4.1, most patients had stayed at the rehabilitation centre for at least three months. Their duration of stay at the rehabilitation centre was varied, but were all following the same treatment programme.

Regarding the employment status, the research found out that most of the patients were in employment as shown in Table 4.2. Seven (31%) were formally employed, six (26 %) were self-employed while ten (43 %) were jobless. This meant that most of the patients were in different professions and would obviously have different information needs. The researcher found out that the patients that were jobless had not completed secondary education and others were still students. Other patients said that they were not able to sustain their employment due to addiction. Those who were in formal employment had been dismissed from their employment, while those who were in self-employment were no longer able to run their businesses.

Table 4.2: Patients’ Employment Status

<table>
<thead>
<tr>
<th>Employment status</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formally employed</td>
<td>7</td>
<td>31</td>
</tr>
<tr>
<td>Self employed</td>
<td>6</td>
<td>26</td>
</tr>
<tr>
<td>Jobless</td>
<td>10</td>
<td>43</td>
</tr>
</tbody>
</table>

The age of the respondents were clustered into four major age groups. Three (13 %) were under 20 years, nine (39 %) were between 21 – 30 years, eight (35 %) were between 31 – 40 years and three (13 %) were above 40. Table 4.3 summarizes the age of the respondents, which shows that most patients were still within their youth and still had time to rebuild their lives once they leave the rehabilitation centre. They
would have diverse information needs and exhibit different information seeking behaviour.

Table 4.3: Age of Respondents

<table>
<thead>
<tr>
<th>Age bracket</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>21 – 30</td>
<td>9</td>
<td>39</td>
</tr>
<tr>
<td>31 – 40</td>
<td>8</td>
<td>35</td>
</tr>
<tr>
<td>Above 40</td>
<td>3</td>
<td>13</td>
</tr>
</tbody>
</table>

The patients were asked about their level of education. Seven (30 %) of patients had attained secondary education. Eight (35 %) had attained diploma, three (13 %) had attained degree and postgraduate level respectively. Only two (9 %) had no education. As indicated in Table 4.4, most patients had achieved post-secondary education with a big number having had tertiary education. They were clearly well educated and therefore had diverse information needs.

Table 4.4: Education Level of Respondents

<table>
<thead>
<tr>
<th>Education level</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No education</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Secondary</td>
<td>7</td>
<td>30</td>
</tr>
<tr>
<td>Diploma</td>
<td>8</td>
<td>35</td>
</tr>
<tr>
<td>Degree</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Post graduate</td>
<td>3</td>
<td>13</td>
</tr>
</tbody>
</table>
4.2.1 Information about Asumbi Treatment Center

The administrator was interviewed about the rehabilitation centre gave insights on Asumbi treatment centre. According to the administrator, Asumbi Treatment Centre is a Faith Based Organization that was established in 1978 by Turbeg Brothers in Asumbi – Homabay. Asumbi treatment centre in Karen was established in May 2005 which has a capacity of 38 patients. It caters for only male patients who are above 18 years of age who come from all areas in the country.

The rehabilitation centre offers residential drug free treatment approach, which is based on Alcoholic Anonymous and narcotics Anonymous program. The patients pay for treatment, though no one is turned away due to lack of fees.

4.3 Status of Alcohol and Drug Abuse

According to the administrator, alcohol and drug abuse is on the rise in the country because it is readily available. Alcohol is readily available despite many laws that have been passed to control alcohol menace. The administrator pointed out that all types of alcohol are abused depending on the social and economic status of an individual. The society has been infiltrated with these drugs too and when young people try out these drugs, they eventually become addicted, pointing out heroin as the most abused drug.

The administrator added that the media has had a hand in the prevalence of alcohol and drug abuse, owing to the availability of information available on commercial advertisements and social media platforms. The administrator also pointed out that most young patients engage in alcohol and drug abuse as an experiment, and soon become addicts.
It can be concluded that availability of information plays a role in contributing to drugs and alcohol abuse.

### 4.4 Information Needs

#### 4.4.1 Patients’ Information Needs

In this research, information needs for ADA patients meant the inspiration that make patients go out of their way to seek information. The patients’ information needs were varied depending on their interests. The patients gave multiple information needs as summarized in Table 4.5.

Information on behaviour change (30-43%) was the most sought after need. The major reasons they gave for wanting information on behaviour change was that they wanted to change their lives, they wanted to become better people in society and that they don’t want to stress their loved ones or care givers. This shows that they were determined to recover from theory addiction. After all, the patients go to the rehab to seek help in order to stop their alcohol or drug addiction.

20.08 % of the patients needed information on how to recover from drugs and alcohol use. Also, 20.08 % needed information on how to cope with life after rehabilitation. On further probing they indicated that they wanted to start a new life, and know how to deal with stigma and people’s negative perceptions. A 21.37 % needed information on the effects of drug intake. This was important for them to monitor how their bodies are recovering from addiction.

13.04% needed advanced writings about alcoholism and drug abuse. They further said the information would help them keep their character in check and to set a good example by becoming a counselor or a campaigner against alcohol and drug abuse.
Information on business was a need by most patients at 21.73%. Some patients said they wanted to start their own business while others wanted to write their business plans and to seek funding for their business. This means that the patients were determined on having their own business startups once they left the rehabilitation centre.

Other information needs included information on gardening (8.69%). The patients wanted to start their own gardens once they left the rehabilitation centre. Another said that he wanted to do gardening as a hobby when he returned home while another said that gardening would be a stepping stone into his farming business.

One responded needed information on sign language (4.35%). The patient wanted to know become an instructor on sign language and therefore was interested in doing sign language. A further 17.39% needed information on career choice. They were interested in advancing their education once they leave the rehabilitation centre, since they had been given a new lease of life. Those that needed information on current affairs (17.39%) were interested in knowing getting adequate news on what was happening around them.

From the responses in Table 4.5 on information needs, it was clear that ADA patients needed additional information apart from guidance and counseling which they got at the rehabilitation centre. The different areas of information requirements meant that the patients had an urge to learn more on their own while at the rehabilitation centre.
Table 4.5: Patients’ Information Needs

<table>
<thead>
<tr>
<th>Information need</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business information</td>
<td>5</td>
<td>21.73</td>
</tr>
<tr>
<td>Information on gardening</td>
<td>2</td>
<td>8.69</td>
</tr>
<tr>
<td>How to recover from drugs and alcohol use</td>
<td>6</td>
<td>20.08</td>
</tr>
<tr>
<td>How to cope with life after rehab</td>
<td>6</td>
<td>20.08</td>
</tr>
<tr>
<td>Effects of drug intake</td>
<td>5</td>
<td>21.73</td>
</tr>
<tr>
<td>More literature about alcoholism and drug abuse</td>
<td>3</td>
<td>13.04</td>
</tr>
<tr>
<td>Information on sign language</td>
<td>1</td>
<td>4.35</td>
</tr>
<tr>
<td>Information on career choice</td>
<td>4</td>
<td>17.39</td>
</tr>
<tr>
<td>Information on behavior change</td>
<td>7</td>
<td>30.43</td>
</tr>
<tr>
<td>Current affairs</td>
<td>4</td>
<td>17.39</td>
</tr>
</tbody>
</table>

The administrator was interviewed about the patients’ information needs and pointed out that the patients sought a lot of information regarding their addiction and recovery. The administrator also noted that most patients are usually anxious about leaving the rehabilitation centre, hence seek information on how to cope with life after recovery and to take up new challenges. However, not all information needs could be met at the rehabilitation centre, as the administrator pointed out. Some of the patients were interested in using the internet but it was against the rules of the rehabilitation centre. The administrator also pointed out that they were not equipped some patients were interested in reading books but the rehabilitation centre was not equipped with books for patients.
4.2 Information Seeking Behaviour

4.2.1 Information Seeking Strategies

Information seeking strategies result in the behaviour that one exhibit while seeking information. According to the administrator, the patients sought information from the counselors a lot. They also read newspapers, chatted amongst themselves and watched television. ADA patients had their information seeking strategies while at the rehabilitation centre and they gave multiple responses regarding their information seeking strategies as summarized in Table 4.10.

Consulting the counselors was a popular strategy practiced by the ADA patients at the rehabilitation centre, having 12 (52%) of responses. They explained that the counsellors were the only available intermediaries that they could consult whenever they needed information.

Six (26%) said that they were comfortable with the information available. On further probing, most of the patients said that their main focus was getting better and therefore they did not need to seek any other information besides what they had. Four patients (17 %) consulted colleagues and listened to radio and TV respectively. 13% asked friends. 2 patients preferred to read newspapers. They said that they were interested in updating themselves with the current affairs. Another one said he was mainly interested in applying for a college and that is why he sought for college adverts in the newspapers.

One patient carried out his own investigations while another one consulted the sessions at alcoholics anonymous and narcotics anonymous respectively. The administrator was interviewed about the information seeking strategies of the patients. He pointed out that most patients sought information from the counsellors at the
rehabilitation centre. Others preferred to ask questions during the group therapy sessions. Some of the patients consulted the administrator on information regarding their stay at the rehabilitation centre and on any other general information. As mentioned above, on the information needs of patients, not all the information needs could be addressed by the rehabilitation centre as pointed out by the administrator.

It was evident that within the rehabilitation centre, the most popular strategy was consulting counselors, friends and colleagues, alcoholics anonymous and narcotics anonymous. This showed that the patients have information needs within the rehabilitation centre, but there were few options available to seek information from.

Table 4.6: Information Seeking Strategies

<table>
<thead>
<tr>
<th>Information seeking method</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consulting the counsellors</td>
<td>12</td>
<td>52</td>
</tr>
<tr>
<td>Consulting colleagues</td>
<td>4</td>
<td>17</td>
</tr>
<tr>
<td>Listening to radio and TV programs</td>
<td>4</td>
<td>17</td>
</tr>
<tr>
<td>Reading newspapers</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Asking friends</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Doing own investigations</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Consulting during alcoholic anonymous sessions</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Consulting during narcotics anonymous sessions</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Comfortable with the available information</td>
<td>6</td>
<td>26</td>
</tr>
</tbody>
</table>

4.3 Information Resources and Services

4.3.1 Information Services Available

The administrator was interviewed regarding provision of information services at the rehabilitation centre. According to the administrator, the rehabilitation centre did not
have a library for staff or for patients. The administrator indicated that they did have a collection of about ten books that they used during counseling and therapy sessions. According to the administrator, the print information sources available included newspapers and educative posters hung on the walls of various rooms in the rehabilitation centre. The non print information services provided included watching television, watching videos with information regarding alcohol and drug addiction and;

The administrator was also asked whether the rehabilitation centre offers bibliotherapy services as a source of treatment to the patients. There was no bibliotherapy offered to patients. The administrator pointed out that they were not able to offer bibliotherapy because it was not part of the 12 step treatment program that they use for treatment and that it was also not a part of the recommended guidelines offered by NACADA.

The patients were also interviewed about the information services available in the rehabilitation centre. They mentioned the following available services:

i) Watching television/video. The patients said that they often watched television and video at designated times. Television was watched mostly during their free time that is during lunch breaks or in the evening. However, the television stations or channels were limited to three only. They said that videos were watched mostly during therapy or during group sessions. They videos bore information regarding alcohol and drug abuse.

ii) Listening to radio. On further discussion, the patients said that they listened to the radio also during their free times, same times as the televisions.

iii) The patients mentioned indoor games as a recreational activity offered by the rehabilitation centre. The indoor game available was table tennis.
iv) Reading materials. The patients identified the reading materials available in the rehabilitation centre which included newspapers, pamphlets and charts. The patients further said that the newspapers were availed during their free time. They read the newspapers to catch up with current affairs. The patients said that the charts and pamphlets had information concerning alcohol and drug abuse. The charts were available on the walls whilst the pamphlets were usually made available during counseling sessions or group therapy sessions.

v) Counseling sessions. The patients said they sought a lot of information from the counselors during therapy sessions.

vi) Group discussions. The patients said that they do have group discussions at given times to talk about issues affecting their treatment and recovery. They said they are able to share information with each other and learn from each other.

The rehabilitation did not have a library, which could be a great source of information for the patients. The patients had diverse information needs, which could be met if a library was available and equipped with different reading materials. This is a disadvantage since not all their information needs were met.

4.3.2 Sources of Information

The study sought to find out the sources of information available at the rehabilitation centre for patients. The patients were asked what information sources they sought at the rehabilitation centre. They had multiple responses and indicated that they seek information from various sources. As indicated in Table 4.9, most patients sought information from their counselors while at the rehabilitation centre. A big number also preferred reading newspapers and books. 4 (17%) sought from former addicts. They
said that the former addicts usually visit the rehabilitation centre to give talks to the patients and share their experiences on their journey to recovery from addiction. A further 4 (17%) sought information from television. They said that they relied on television mostly to find out about current affairs while others said that they got entertainment from television. 3 (13%) sought information from books. The books were limited copies that were available for use by the therapists. Other available books were personal copies belonging to the patients. Another 3 (13%) of patients consulted friends, who would come to visit. They said that friends mostly updated them on any information they wanted. 2 (9%) of the patients said that they used their own intuition. They said that they had their own perception of things around them. Another 2 (9%) said that they used internet. On further inquiry the patients said that was not available in the rehabilitation centre, but it was possible to access the internet during visits from relatives who had gadgets like mobile phones that enabled them access the internet.

**Table 4.7: Sources of Information**

<table>
<thead>
<tr>
<th>Information source</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Television</td>
<td>4</td>
<td>17</td>
</tr>
<tr>
<td>Counselors</td>
<td>7</td>
<td>30</td>
</tr>
<tr>
<td>Friends</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Newspapers</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td>Intuition</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Books</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Internet</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Former addicts</td>
<td>4</td>
<td>17</td>
</tr>
</tbody>
</table>
The counselors proved a popular source of information because they provided an instant link between the patients and their information needs. Their questions and concerns were answered on consultation.

### 4.3.3 Preferred information formats

The patients were asked which information formats they preferred. From the interview, the patients preferred mostly electronic information formats as shown in Table 4.6. These majorly included use of computers and internet.

**Table 4.8: Preferred Information Formats**

<table>
<thead>
<tr>
<th>Information format</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic (computers and audio visual)</td>
<td>11</td>
<td>47.83</td>
</tr>
<tr>
<td>Print (newspapers, books)</td>
<td>8</td>
<td>34.78</td>
</tr>
<tr>
<td>Hand written</td>
<td>2</td>
<td>8.69</td>
</tr>
<tr>
<td>Verbal</td>
<td>1</td>
<td>4.35</td>
</tr>
<tr>
<td>Any format</td>
<td>1</td>
<td>4.35</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>100</td>
</tr>
</tbody>
</table>

Based on the demographic data, the use of electronic formats was mostly preferred because nearly all the patients were in employment and had diverse information needs. Most of the patients were within their youth, an age which is accustomed to using electronic devices to search, retrieve, use and communicate information.

However, at the rehabilitation centre, electronic information formats was limited to availability of radio and television. The other electronic information formats preferred by patients included the use of computers, which were not provided at the rehabilitation centre.
4.3.4 Availability of Information

In terms of the availability of information, this research aimed at finding out the time and frequency information was usually available to the patients. At the rehabilitation centre, information was usually available at different times depending on the patients’ information needs. From the summary in Table 4.7, it was clear that most patients got information during therapy sessions. The media also played an important role since a good number got information from watching television or video and reading newspapers.

Table 4.9: Availability of Information

<table>
<thead>
<tr>
<th>Availability of information</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>1</td>
<td>4.34</td>
</tr>
<tr>
<td>Any time</td>
<td>1</td>
<td>4.34</td>
</tr>
<tr>
<td>During therapy sessions</td>
<td>8</td>
<td>34.78</td>
</tr>
<tr>
<td>Unless sought</td>
<td>3</td>
<td>13.04</td>
</tr>
<tr>
<td>When watching television or video</td>
<td>5</td>
<td>21.73</td>
</tr>
<tr>
<td>When reading newspapers</td>
<td>3</td>
<td>13.08</td>
</tr>
<tr>
<td>Never</td>
<td>2</td>
<td>8.69</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

4.3.5 Adequacy of Information

The patients were asked whether the information was adequate or not. Apart from giving a yes or no answer, some patients were not sure or did not know whether they had adequate information or not.
Table 4.13 indicates that seven (30%) of patients find information adequate, ten (44%) said they did not find information adequate, four (17%) were not sure while two (9%) did not know. Most of the patients did not find the information in the rehabilitation centre adequate, and cited various reasons and what information they preferred. Some of these reasons included: no internet facility, no library available and the information available only concentrated on the patients’ recovery.

**Table 4.10: Adequacy of Information**

<table>
<thead>
<tr>
<th>Adequacy of information in the rehab</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>7</td>
<td>30</td>
</tr>
<tr>
<td>No</td>
<td>10</td>
<td>44</td>
</tr>
<tr>
<td>Not sure</td>
<td>4</td>
<td>17</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

The patients who felt that the information was not adequate were asked about additional information resources that can be acquired in the rehabilitation centre. They gave the following recommendations

i) **Internet.** The patients really wanted to be able to access the internet. On further inquiry some patients said the internet would help them be able to get more information concerning their recovery. Others said that they wanted the internet to be able to communicate with their friends and family, even if it would be provided for a limited time and others said the internet would meet their information needs.

ii) **Books for patients.** The patients were interested in having books on diverse subjects that they could consult
iii) Magazines and journals. On further probing, the patients said they would prefer magazines and journals on various subjects, provided the information would be beneficial to them.

4.3.6 Responsibility for Information Dissemination

The patients were asked to mention who they thought was responsible for availing information to them. They only had three different answers namely, the counsellors, the administration and the management as indicated in Table 4.15. Most of the patients mentioned that information should be disseminated by the counselors (52%). From the responses given, the researcher concluded that either there was no designated person to avail information to the patients or any person could address the patients’ information needs at any given time.

Table 4.11: Responsibility for Availing Information

<table>
<thead>
<tr>
<th>Responsibility for availing information</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselors</td>
<td>12</td>
<td>52</td>
</tr>
<tr>
<td>Administration</td>
<td>6</td>
<td>26</td>
</tr>
<tr>
<td>Management</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

4.4 Information Use

The patients were asked how they utilize the available information. They gave multiple responses regarding how they utilize information.

As indicated in Table 4.11, information was very important to the patients and they found different ways of utilizing the information. As mentioned earlier, a lot of information was received from the counselors, who gave them direction on how to
deal with their addiction and helped them in their journey to recovery. Practicing what they learn was a popular way of utilizing information in the rehabilitation centre, a response given by 7 patients. They said putting what was learnt in practice was important in improving oneself. Others said that it would help them become better people.

6 patients also recorded information for future reference. They further said that for them to practice what they learn, it was important to record it down so that it would be easy to remind them of what has been learnt. Another 6 said that they shared information when they gathered together to talk about their experiences. They said that they were able to learn a lot from each other. 5 patients said that they used information to come up with solutions regarding any challenges. Some of these challenges they mentioned included, coping with anxiety, withdrawal symptoms and acceptance, all of which did not need any form of oral medication.

Other ways that the patients utilize information included: meditation, writing list of priorities and used information as referrals. Only one patient reported that he did not have any information to be utilized.

Table 4.12: Utilization of the Available Information

<table>
<thead>
<tr>
<th>Utilization of information</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record down for future reference</td>
<td>6</td>
<td>26.08</td>
</tr>
<tr>
<td>Put the information they have in practice</td>
<td>7</td>
<td>30.43</td>
</tr>
<tr>
<td>Meditation</td>
<td>1</td>
<td>4.34</td>
</tr>
<tr>
<td>Sharing with others</td>
<td>6</td>
<td>26.08</td>
</tr>
<tr>
<td>Write list of priorities</td>
<td>3</td>
<td>13.04</td>
</tr>
<tr>
<td>Use information as referrals</td>
<td>4</td>
<td>26.08</td>
</tr>
<tr>
<td>Come up with solutions regarding any challenges</td>
<td>5</td>
<td>21.73</td>
</tr>
<tr>
<td>Nothing to be utilized</td>
<td>1</td>
<td>4.34</td>
</tr>
</tbody>
</table>
4.4.1 How Information can help ADA Patients

Information is helpful in various ways. The patients had a lot to share on how the existing information could help them and they gave multiple responses. The responses were diverse on how information could help the patients in the rehabilitation centre as indicated in Table 4.18. For example, information would help the patients change their lives with 35% of the patients asserting to this while 30% of the patients felt that information would help them plan on how to live and move on with life after rehabilitation and also understand the happenings in the outside world. The patients said they were interested in rebuilding their lives once they left the rehabilitation centre. The patients also felt that information would help them broaden their knowledge concerning alcohol and drug abuse with 26% of the patients stating that information would help them know how to prevent one from taking drugs. Another 22% felt that information would widen their field of knowledge about alcohol and drug abuse and gain broader perspective on how to deal with alcohol and drug abuse. Information on alcohol and drug abuse was popular since it was the main agenda that was discussed by the counselors and the patients also shared their experiences with alcohol and drugs.

However, one patient felt that information was not helpful at all. He felt that he was being detained in the rehabilitation centre and he was not getting any help, therefore preferred information on farming, which he liked and by so doing would help him quit drugs.
Table 4.13: Helpfulness of Existing Information

<table>
<thead>
<tr>
<th>Helpfulness of the existing information</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>understand the happenings in the outside world</td>
<td>7</td>
<td>30</td>
</tr>
<tr>
<td>Feel satisfaction and be at peace</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>plan on how to live and move on with life after rehab</td>
<td>7</td>
<td>30</td>
</tr>
<tr>
<td>know the negative and positive effects of alcohol and drug abuse</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td>Boost recovery process</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>help in awakening their understanding</td>
<td>4</td>
<td>17</td>
</tr>
<tr>
<td>widen their field of knowledge about alcohol and drug abuse</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td>gain broader perspective on how to deal with alcohol and drug abuse</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td>Know how to prevent oneself from taking drugs</td>
<td>6</td>
<td>26</td>
</tr>
<tr>
<td>help to change their life</td>
<td>8</td>
<td>35</td>
</tr>
<tr>
<td>Gain new knowledge</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Have deep knowledge on how drugs work</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Grow intellectually and socially</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Learn more about what is being taught at the rehab</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Not helpful at all</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Be a role model to others</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>To maintain sobriety</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Empower and help in personal growth and recovery</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

4.4.2 Ways of Information Sharing

The patients were asked to say ways in which they shared information with other patients. They gave multiple responses with regard to ways of sharing information. 18 (78%) said that they shared information through group discussions at the rehabilitation centre. The patients said that group discussion was the major forum that they got to share information regarding different topics affecting their lives. Another
15 (65%) shared information during their free time. They said that it was the most appropriate time to exchange views and ideas. Two (9%) of the patients exchanged notes. They said that they were able to compare notes that they took during different sessions and clarify on what they missed or misunderstood. Another two (9%) did share reading materials. On further inquiry, they said that the reading materials were mostly their personal collection of books.

**Table 4.14: Ways of Sharing Information**

<table>
<thead>
<tr>
<th>Ways of sharing information</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having group discussions</td>
<td>18</td>
<td>78</td>
</tr>
<tr>
<td>Chatting during free time</td>
<td>15</td>
<td>65</td>
</tr>
<tr>
<td>Exchanging notes</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Sharing reading materials</td>
<td>2</td>
<td>9</td>
</tr>
</tbody>
</table>

### 4.5 Challenges of Accessing Information

#### 4.5.1 Existing Information Access Challenges

Access to information within an institution is important to the patrons. However, challenges are encountered from time to time. During the research, it was important to ask the ADA patients of the challenges they faced regarding access to information within the rehabilitation centre. Table 4.16 shows the multiple responses from the patients. Six (6%) of the patients revealed that they did not have enough information resources. Five (22%) of the patients shared that there are limited ways in which information could be accessed and that there was no internet respectively.

Five (22%) of the patients said that internet use is popular but it is not available within the rehabilitation centre. The rehabilitation centre does not have a library, and therefore there are no books that may be relevant to the patients. Four (17%) of the
patients indicated that they did not know how to search for information. The researcher assumed that patients lack information searching and retrieval skills that they could use both within and outside the rehabilitation centre. The patients revealed that they were limited to watching only three television channel. Since the television is only one, three (13%) of the patients revealed that disagreements arose on what channel should be watched by everyone, since differed people preferred specific channels. Sometimes the ideas suggested in the process of recovery were incomprehensible as suggested by five (22%) of the patients. Lack of a library as was indicated by five (22%) of the patients posed a challenge to information access in the rehabilitation centre. Four (17%) of patients found information irrelevant and one patient (4%) shared that he did not experience any challenge.

**Table 4.15: Information Access Challenges**

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited information resources</td>
<td>6</td>
<td>26</td>
</tr>
<tr>
<td>Limited ways to access information</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td>No internet</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td>Lack of information searching skills</td>
<td>4</td>
<td>17</td>
</tr>
<tr>
<td>Disagreements on what television channel to watch</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Incomprehensible ideas</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td>No library</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td>Irrelevant information</td>
<td>4</td>
<td>17</td>
</tr>
<tr>
<td>No challenge</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

The administrator on the other hand was asked about the challenges of provision of information services. According to the administrator, the rehabilitation centre could only offer what they have, which was limited. Some of the challenges they faced include;
i) There was no library in the rehabilitation centre where the patients can have private study. However, the administrator pointed out that there were a few available books that were only accessible to the counselors and staff. It was not possible for the patients to access the few available books.

ii) Sometimes it was not possible to answer all the questions that the patients asked and this was necessitated by further consultations to provide answers.

iii) The patients wanted to engage more with their friends and family, but visiting days were only limited to once a month as a policy at the rehabilitation centre.

iv) Some patients want to use the internet but it is not allowed at the rehabilitation centre. On further probing, the administrator indicated that the internet would distract, slow down or compromise the rehabilitation process.

4.5.2 Influence of the Challenges to the Patients

The challenges mentioned above have a negative influence on the patients during their stay at the rehabilitation centre. As revealed by ten (43%) of the patients said that they got discouraged. They said that they got discouraged when they did not find what they are looking for or find answers to their questions. Six (26%) of the patients said they felt withdrawn. They explained that they do feel withdrawn especially when their specific information needs were not fully addressed. Eight (35%) of the respondents said that they missed out on the opportunity to learn and gain new knowledge while at the rehabilitation centre. They explained that when information was not available they were disadvantaged. They further explained that apart from treatment, they were also willing to learn new things and gain new ideas.

One patient (4%) said the he ended up developing a lower IQ compared to the one he had initially because he would be left not knowing how to deal with life when he left
the rehabilitation centre. Five (22%) of the patients said they experienced low morale. They further explained that sometimes the information they got did not address some of their needs and expectations. However, two (9%) of the patients gave no response.

Table 4.16: Effects of Information Access Challenges

<table>
<thead>
<tr>
<th>Effect of information access challenge</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discouragement</td>
<td>10</td>
<td>43</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>6</td>
<td>26</td>
</tr>
<tr>
<td>Missed opportunity to gain new knowledge</td>
<td>8</td>
<td>35</td>
</tr>
<tr>
<td>Lowered IQ</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Low morale</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td>No response</td>
<td>2</td>
<td>9</td>
</tr>
</tbody>
</table>

4.6 Suggestions on Enhancing Access and Use of Information Services

The patients were asked to give solutions to how information access and use can be addressed, and they gave multiple suggestions. Some of the information services that the patients wanted to be availed at the rehabilitation centre were not allowed within the policy of the rehabilitation centre. The proposed suggestions were as follows:

i) **Invite motivational speakers**

The patients explained that they would appreciate if the rehabilitation centre would invite different speakers to speak to them on various topics of their choice. Some patients said that experts from different fields would be beneficial to them if they come and give a talk to them at the rehabilitation centre.
ii) **Set up a library**

The respondents wanted a library to be set up and be equipped with books on various subjects.

iii) **Permit mobile phones**

The respondents suggested that mobile phones would be necessary to communicate with their family members once in a while.

iv) **Having computer lab with internet**

The patients said that it was necessary to have an equipped computer lab to do research on their personal information needs to enhance their scope of knowledge.

v) **Include more therapy sessions**

The patients felt that the therapy sessions offered at the rehabilitation centre were not adequate. They said they needed more therapy sessions included in their program.

vi) **Career choice counseling**

The patients wanted more advice on career choice. They stated that it would help them make informed decisions on what career to take once they left the rehabilitation centre.

vii) **Permit lap tops**

The patients wanted to be allowed to bring their own laptops for use while at the rehabilitation centre. One of the patients stated that he would want to keep an account of his stay at the rehabilitation centre and a laptop would be ideal platform to record his day to day activities.

viii) **Have personalized information**

The respondents wanted information made available to them on an
individualized basis. They further said that each individual had their own different information needs and it would be better if each need be addressed individually as need arises.

The administrator was interviewed on what can be done to improve provision of information services in the rehabilitation centre. According to the administrator, it was not possible to address all the information needs of the patients. The administrator argued that it was not also easy to know the information needs of patients. Based on the experience at the rehabilitation centre, the administrator gave the following suggestions:

i) It would be beneficial to have a small library put in place equipped with books on various subjects.

ii) Use of ICT would be ideal in delivering of information especially during group therapy sessions. The ICTs include computers or laptops and projectors.

iii) The administrator pointed out that it would be ideal if the treatment guidelines could be reviewed by the governing bodies like NACADA in order to incorporate provision of information services at a better level.

Table 4.17: Suggestions of Enhancing Information Access and Use

<table>
<thead>
<tr>
<th>Additional information services</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of mobile phones</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Allowed to use laptops</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Personalized information</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Have a library in place</td>
<td>6</td>
<td>26</td>
</tr>
<tr>
<td>Have motivational speakers talk on different topics</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td>Career choice counseling</td>
<td>6</td>
<td>26</td>
</tr>
<tr>
<td>Have a computer lab with internet</td>
<td>7</td>
<td>30</td>
</tr>
<tr>
<td>More counseling sessions</td>
<td>2</td>
<td>7</td>
</tr>
</tbody>
</table>
4.7 Chapter Summary

This chapter presented interpreted and analyzed data that was collected at Asumbi Treatment Centre. Data in this study was presented in tables to help in organizing the data and to discover patterns and relationships that helped in drawing conclusions. The results of this study were analyzed using the content analysis method. Content analysis enables the researcher to analyze textual information and systematically identify its properties such as the presence of certain words, concepts, characters, themes or sentences, Sekaran, (2010).

The research finding revealed that ADA patients did have information needs that were unique to each of them. These needs would complement the treatment and recovery program since they have indicated a lot of ways in which information could help them. The study showed that ADA patients mainly relied on counsellors to get information. They shared information with their fellow patients in different forums. Other sources have proved to be inadequate since they cited various challenges that they experienced in accessing information.
CHAPTER FIVE: SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction
This chapter presents the summary of the findings, conclusions and recommendations. Recommendations have been proposed to facilitate the provision of information to ADA patients in rehabilitation centres. The purpose of this study was to evaluate the provision of information services to patients of alcohol and drug abuse in rehabilitation centres in Nairobi County and suggest ways in which they can be enhanced. The findings are summarized according to the respective research objectives.

5.2 Summary of Major Findings
This chapter has presented analysed, interpreted and discussed data that was collected at Asumbi Treatment Centre relating to the objectives of this study which focused on the subject of the research. The study sought to find answers to the following questions:

i. What are the information needs of ADA patients?

ii. How do ADA patients seek information?

iii. What are the information resources and services available in ADA in rehabilitation centres?

iv. How do ADA patients use information resources and services available in ADA rehabilitation centres?

v. What challenges do the ADA patients face in accessing and using information?

vi. How can rehabilitation centres enhance provision of information services to ADA patients?
5.2.1 Information Needs of ADA Patients

From this study, various information needs of ADA patients were identified, some of which were met within the rehabilitation centre while others were not available. These information needs included: business information, information on environment, information on gardening, how to recover from drugs and alcohol use, how to cope with life after rehab, effects of drugs e.g. bhang/alcohol, advancement on writings about alcoholism and drug abuse, sign language, career choice, how to stop alcohol and drug abuse, how to change and to achieve something better in life, reading books and newspapers and current affairs. Information needs relating to alcohol and drug abuse was readily available in the rehabilitation centre through counselling, therapy sessions and group discussions. Other information needs like career choice, business information, or sign language were not available at the rehabilitation centre. Each patient had his own unique needs and more information sources would cater for their information needs.

Given the advancements in technology, most of the patients preferred electronic information sources, most of which were not available in the rehabilitation centre. These included the internet. Some of the information available was not always relevant as evidenced in the diverse information needs. For recovering patients, information was very important. The patients gave a number of insights on how information could help them.

5.2.2 Information Seeking Behaviour

Most of the patients referred to the counsellors whenever they had an information need. Others watched television, listened to the radio, chatted amongst themselves, consulted alcoholics and narcotics anonymous, or did their own investigations.
Whatever information the patients came across, they were able to utilize in various ways like: recorded for future use, put it into practice, meditated, shared with others, took down the priorities, used it as referrals and solved challenges. The patients found ways of sharing the available information.

The setup of the rehabilitation centre did not have many options that the patients could utilize in information seeking. For example, mobile phones and laptops were not allowed in the rehabilitation centre. There was also no provision of internet and there was no library or information centre. This limited the approaches that the patients could use to seek information.

5.2.3 Provision of Information Services

The study revealed that information services available in the rehabilitation centre were limited. The main services included availability of television, radio and newspapers. Counselling and therapy sessions as well as watching videos that had information on alcohol and drug addiction was part of treatment at the rehabilitation centre. The patients felt that this information was not adequate as it did not address their diverse information needs as mentioned above. The study found out that most patients preferred non print information formats which included computers, audio visual material and word of mouth. The print formats preferred included newspapers, books and hand written. At least one person preferred any format.

The patients felt that additional information services could be availed to cater for their diverse information needs. Some of these services included setting up a library and a computer lab with internet, being allowed to use mobile phones and laptops, having motivational speakers speak on different topics, more counselling sessions including career choice counselling.
5.2.4 Use of Available Information

The fourth objective of this study was to find out how patients utilize information available at the rehabilitation centre. The patients used information in the following ways:

i) Record down for future reference

ii) Put the information they acquire into practice

iii) Meditation

iv) Share with others

v) Define their priorities

vi) Use information as referrals

vii) Come up with solutions to challenges

The patients also gave insights on how information can help them while at the rehabilitation centre. They gave multiple ways in which information can help them. The research also found out that patients do share information in various ways.

5.2.5 Challenges of Accessing Information

Information was important ADA patients. In the rehabilitation centre, the patients faced various challenges of accessing information. Information resources were limited within the rehabilitation centre. The provision of television was limited to the fact that there were only few channels available, which the patients disagreed on what to watch.

The limited ways of accessing information was an evidence of the limited number of information services available in the rehabilitation centre. While it was not allowed in the rehabilitation centre, the patients who are already exposed to internet use preferred
to use internet. Apart from the limited information resources, some patients lacked skills on how to search for information.

As the research revealed, the patients had different education levels. Some found the ideas shared in the rehabilitation centre incomprehensible. This meant that they missed out on crucial information that was shared across the facility. There was no library or information centre, the patients could do their own private study or investigations. Some patients found the information available irrelevant because it did not address their information needs. It was not possible to satisfy the individual information needs of the patients.

5.3 Conclusion
The study set out to evaluate the provision of information services to patients of alcohol and drug abuse in rehabilitation centres in Nairobi County. Coming from different backgrounds and different factors affecting the society, it could be concluded that ADA patients have diverse information needs while at the rehabilitation centre. This is in agreement with Wilson (1997) who states that ‘a person identifies a need and begins to seek information’. On the other hand, they use intermediaries like the counsellors or the administrator to seek information as supported by Niedzwiedzka’s model on information behaviour.

Apart from the information they get during counselling and therapy sessions, most of the information available did not address their individual needs. Patients in Asumbi Treatment Centre mostly relied on the counsellors when they sought information. Apart from the patients consulting each other, the counsellors were the only individuals that could be consulted with information needs. They may not give the right or accurate information depending on the patients’ information needs.
Information services at Asumbi Treatment Centre were limited and inadequate to satisfy the information needs of the patients; therefore the patients were not able to employ different strategies to seek information.

The study revealed that patients experienced challenges of accessing information, considering the fact that information services were inadequate. The use of ICT proved to be popular among the patients and there was need for ADA rehabilitation centres to consider adopting the latest trends in ICT to enable the patients satisfies their information needs. This can be supported by Omona and Ikoja-Odongo (2006) whose study revealed that ICT has revolutionized the way in which health information can be accessed and utilized.

It is important to understand the information needs of patients. An information needs analysis would play a great deal in enhancing the provision of information services in ADA rehabilitation centres according to the expectation of its patients. This is supported by Nicholas (2000) who states that ‘we should evaluate the need people have for information, the wants they express for it and the demands and use they make for it.’

Bibliotherapy services, if included in the rehabilitation programme could help a great deal in the recovery process. Research findings have shown that bibliotherapy services have enabled addicts to recovery faster and boost their motivation.

5.4 Recommendations
The government of Kenya, through NACADA should formulate a policy that would enable ADA rehabilitation centres to offer information services to its patients, which includes a library or an information centre. The following are the immediate and long-
term recommendations made with a view on improving provision of information services to patients of alcohol and drug abuse:

5.4.1 Recommendations for Immediate Implementation

i) Carry out an information needs analysis

This study revealed that ADA patients have diverse information needs. ADA rehabilitation centres should carry out an information needs analysis for the patients with the help of information officers. They should assess the information resources and services available and determine what needs to be acquired and maintained in line with the information needs of ADA patients.

ii) Offer bibliotherappy services

Asumbi treatment centre focused on the 12 steps of the AA program treatment for its patients. Bibliotherapy was not among them. Suppose a library was available, some patients would not find it easy to read on their own. Bibliotherapy services come in handy whereby the patients sit and listen to the literature being read, and derive meaning from it. Different topics could be discussed that would be beneficial to the patients. During this time, questions and answers would be exchanged between the reader and the patients to give dialogue a chance and to exchange meaningful ideas. Bibliotherapy services would also benefit those patients who are illiterate and cannot be able to read on their own.

iii) Provide forums for motivational speakers

ADA rehabilitation centres need to have motivational speakers come to speak to the patients from time to time. Different topics can be talked about to enlighten the patients. This would be a good avenue for the patients to learn new things and improve on their intellectual capacity. These talks would break away from the monotony of only having counsellors talk to the patients regarding their addiction and
recovery. For example, a talk on career choice would help the school or college dropouts have an insight on what career path to take once they leave the rehab.

iv) Permit more visiting days

Visiting days were limited to once in a month only at the rehabilitation centre. The patients felt that they were disconnected from their families and friends. Allowing more visiting days would ensure that patients connected with the outside environment. The patients would use this opportunity to seek information and get updated on the happenings outside the rehabilitation centre.

v) Assign tasks and assignments

The recovery program in ADA rehabilitation centres could be adjusted to accommodate assignments and tasks to the patients. When the patients are given assignments and tasks, they would set out to look for information based on what they have been asked to do. After accomplishing these tasks and assignments, they would then present their findings before other patients and their facilitators. A lot of information and ideas would be shared during presentation and discussions. This would be another avenue to enhance provision of information and to encourage the culture of information seeking.

5.3.1 Recommendations for Long-Term Implementation

i) Establish a library

ADA rehabilitation centres need to provide adequate information services which can be relied on by their patients. The rehabilitation centres should establish libraries, with a bias on literature about alcohol and drug addiction. However, other varieties of information materials could be availed to address the patients’ information needs. From the information needs analysis, the rehabilitation centre will have a better understanding of the diverse information needs.
ii) **Set up a computer lab with internet**

Technology is here with us and has become a way of life. The study has proven that patients were conversant with ICT which includes of computers and mobile phones. It is therefore necessary for the ADA rehabilitation centres to establish a computer lab equipped with internet facility. However, as per the rehabilitation centre policy, use of computers and mobile phones is prohibited and it is argued that internet would be detrimental to the recovery of the patients since there was a possibility of visiting unsolicited sites. However, the researcher suggests that this could be controlled by blocking any unsolicited sites from being accessed by the patients. The main reasons for this would be to enable the patients expand their wealth of knowledge and make new discoveries.

### 5.4 Suggestions for Further Research

This study evaluated the access and use of information services to patients of alcohol and drug abuse in rehabilitation centres in Nairobi County and made suggestions on addressing the challenges facing the provision of information to ADA patients. For further research, a study should be carried out on evaluating the provision of information services to the following vulnerable categories of ADA patients whose disabilities and/or lifestyles can hinder access and use of information services in Nairobi County:

- vi) Persons with disabilities (mental, physical, visual and aural)
- vii) Sex workers (prostitutes)
- viii) Slum dwellers
- ix) The illiterates
- x) Prisoners
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Cook, K. E. … et al (2006). *Bibliotherapy. Intervention in School and Clinic* 42 (2) 91-100


International Day Against Drug Abuse and Illicit Traficking, (26th June 2016). Daily Nation


Ormandy P. ...et al (2007). *Identifying chronic kidney disease patients’ priorities and preferences for information topics.* Institute for Health and Social Care Research Report, University of Salford


**Web references**

http://www.ala.org/tools/bibliotherapy


http://www.interior.go.ke

http://www.nacada.go.ke/about/nacada

http://www.thenewsmanual.net/Manuals%20Volume%203/volume3_59.htm

www.whitehouse.gov

http://www.who.int/topics/substance_abuse/en/
APPENDICES

APPENDIX I: INTRODUCTION LETTER

Moi University,
School of Information Sciences,
P.O. Box 3900,
ELDORET.

Dear respondent,

Re: Data Collection for Academic Research

As part of the requirement for the award of Master of Science in Library and Information Studies of Moi University, the undersigned who is a student at the Department of Library and Information Studies is required to write a thesis.

The attached interview schedule has been developed to gather data on evaluating access and use of information services to ADA patients at the Asumbi Rehabilitation Centres in Nairobi County, Kenya. All information accorded will be used for academic purposes and will be treated with utmost confidentiality.

Your cooperation will be highly appreciated.

Thank you in advance

Yours faithfully,

Janet A. Kalangi
APPENDIX II: INTERVIEW SCHEDULE FOR ADMINISTRATIVE STAFF

SECTION A: Data on the rehabilitation centre

1. Is the rehabilitation centre government owned or privately owned?
2. When was the rehabilitation centre established?
3. For what reason(s) was the rehabilitation centre established?
4. What is the capacity of patients in the rehabilitation centre?
5. Is it government owned, NGO owned, FBO owned and CBO owned?

SECTION B: Classification of patients

1. Does the rehabilitation centre cater for male or female patient or both?
2. Does the facility offer in-patient, out-patient or both?

SECTION C: Status of alcohol and drug abuse

1. In your opinion, what is the status of alcohol and drug abuse in Nairobi County?
2. What kind of alcohol is abused?
3. Which drugs are being abused?

SECTION D: Services provided in the rehabilitation centre

1. What services are provided to ADA patients in the rehabilitation centre?
2. Are the services free of charge or paid for by the patients?

SECTION E: Patients’ information needs

1. What kind of information do the patients seek in the rehab?

SECTION F: Provision of information services

1. Does the rehabilitation centre have a library or information centre?
   Yes [___]  No [___]
2. If yes, what kinds of information resources are available in terms of:
   a) Print resources e.g. books, newspapers, magazines, dictionaries, encyclopedias, maps among others
   b) Non-print resources (electronic and audio visual) e.g CD-ROM databases, electronic books and journals among others

3. Does the rehabilitation centre offer bibliotheray services?
   Yes ☐  No ☐

SECTION G: Patients’ information seeking habits

1. What are the information seeking strategies of patients?

SECTION H: Challenges of provision of information

1. What challenges do you experience concerning provision of information

SECTION J: Suggestions of enhancing provision of information

1. In your opinion, what can be done to improve information services in the rehabilitation centre?

THANK YOU FOR YOUR COOPERATION.
APPENDIX III: INTERVIEW SCHEDULE FOR ADA PATIENTS

SECTION A: Demographic data

NAME OF REHABILITATION CENTRE

DURATION OF STAY

OCCUPATION

GENDER

AGE

[ ] Under 20
[ ] 21 - 30
[ ] 31 - 40
[ ] Above 40

SECTION B: Information needs

1. What information do you require at the rehabilitation centre?

2. Where else do you look for information?

SECTION C: Information seeking behaviour

1. In what other ways do you get information apart from the information available in the rehab?

SECTION D: Provision of information services

1. What information resources are available for patients in the rehab centre?

   For example library lending, reading space, watching TV/video, cultural activities, among others

2. What are the information sources available at the rehabilitation centre?
3. What information formats do you always prefer in terms of:
   a) Print?
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   b) Non Print?
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

4. When is information usually readily available?

3. Is the information available adequate?
   Yes [ ] No [ ]

4. If no to no.2 above, what additional information do you think can be provided
   by the rehabilitation centre?

5. Who is responsible for availing information to patients?

SECTION E: Information use

1. How do you utilize the information available?

2. How do you think information can help you as ADA patient?

3. In what ways do you share information with others at the rehabilitation centre?
SECTION E: Challenges of accessing information

1. What challenges do you face when accessing information?

2. Do these challenges affect your recovery? If yes how?

   Yes ☐    No ☐

SECTION F: Suggestions of enhancing information access

1. How can the challenges of accessing information be addressed? Provide possible solutions

2. Please provide any additional information that you think might be helpful in the provision of information to ADA patients in rehab centres.

THANK YOU FOR YOUR COOPERATION
APPENDIX IV: PRETEST CHECKLIST

Research title: Evaluating provision of information services to patients of alcohol and drug abuse in selected rehabilitation centres in Nairobi County, Kenya.

Objectives of the study

The objectives of the study were to:

i. Determine the information needs ADA patients in the rehabilitation centre

ii. Establish information seeking habits of ADA patients

iii. Establish the information resources and services available in ADA rehabilitation centres.

iv. Find out how ADA patients use information resources and services available in ADA rehabilitation centres

v. Find out the challenges faced by ADA patients in accessing and using information

vi. Suggest ways of enhancing provision of information services to ADA patients

Pre-test questions.

1. Are the questions too many? Yes [ ] No [ ]

   If yes, what do you recommend?
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………

2. Are the questions clearly understood? Yes [ ] No [ ]

   If not, identify those that need clarification
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………

3. Is the sequence of the questions logical? Yes [ ] No [ ]
If no, kindly give your proposition.

4. Are there any grammatical mistakes identified among the questions? Yes ☐ No ☐

If yes, identify the mistakes.

5. Are there jargons or technical terms used in the questions that are difficult to understand?

Yes ☐ No ☐

If there is any, please indicate.

6. Are the objectives of the study adequately covered in the interview questions?

Yes ☐ No ☐

If no, explain.

7. What is your general view on the diversity of questions?

…………………. …………………………………………………………………………………….
APPENDIX V: NACADA ACCREDITED REHABILITATION CENTRES IN NAIROBI REGION

1. Alcoholics Anonymous  
Tel: 0727659130, 0727234092

2. Cross Roads Community Trust  
Box: 52869 - 00200 Nairobi  
Phone: 0725386840, 0722852593/0733874925  
Email: info@crossroads-community.com, administration@crossroads-community.com  
Physical Location: Kisames, behind Ngong hills

3. Brightside Treatment And Rehabilitation Center  
P.O. Box 16942 – 00620, Nairobi  
Tel: 0722847130  
Email: brightsidedart@yahoo.com  
Website: www.brightsiderehabilitation.org  
Physical Location: Kitusuru, Kirawa Rd

4. Chiromo Lane Treatment Center  
P.O. Box 1501- 00606 Nairobi  
Tel: 020 - 8155742, 0729-359501, 0786265143  
Fax: 3746103  
Email: info@clmc.co.ke  
Physical Location: Chiromo Lane, Muthithi Road

5. Eden Village Treatment and rehabilitation center  
P.O. Box: 41187 -00100 Nairobi  
Tel: 0722867693, 0726552476, 0722901804  
Email: justin.farrar@yahoo.com, bonifacendirangu@yahoo.com  
Website: edenhousefoundation.co.ke  
Physical Location: Lower Kabete

6. Eden Halfway House  
P.O. Box: 41187 -00100 Nairobi  
Tel: 0722867693, 0726552476, 0722901804  
Email: justin.farrar@yahoo.com, bonifacendirangu@yahoo.com  
Physical Location: Limuru Road

7. Kenyatta National Hospital-Department of Mental Health  
P.O. Box: 20723-00202 KNH  
Tel: 0713033028, 2726300-9 Ext. 44101: Fax: 2725272  
Email: dmh.knh@gmail.com, j.kariuki@knh.or.ke  
Physical Location: Kenyatta National Hospital

8. Bustani Treatment Centre  
Box 1501-00606 Nairobi  
Phone: 020-2017962, 0733778609  
Email: bustani@clmc.co.ke  
Physical Location: Lavington, Muthangari Road, House No. 37
9. **The Bridge Treatment & Counseling Centre**  
   Box 21396 00505 Nairobi  
   Phone: 0719 284001, 0722 518776  
   Email: itskaggiah@yahoo.com, info@bridgetreatmentkenya.org  
   Web: www.bridgetreatmentkenya.org  
   PhysLoc: New Garden Estate, Thome V, Eden Road - Off Thika Road

10. **Mathari Hospital Treatment and Rehabilitation Centre**  
    P.O. Box 40663 - 00100  
    Tel: 3763316/7/8, 0703 848536, 0721336017  
    Physical Location: Muthaiga off Thika Rd, opp. Muthaiga Police Station

11. **Nairobi Outreach Services - NOSET Maisha House**  
    P.O. Box: 1207-00502 Nairobi  
    Tel: 020-2396597, 0733901657, 0720401793  
    Email: nairobioutreach@yahoo.co.uk  
    Physical Location: Ngara - Ramesh Gautama Road (opposite fig tree hotel)

12. **Nairobi Place Addiction Treatment and Specialized Medical Centre**  
    P.O. Box 139-00502, Karen  
    Tel: 020-267839, 0735-550000, 0733-440000  
    Fax: (020) 3884352  
    Email: info@nairobi-place.org, admin@nairobi-place.org  
    Website: www.nairobiplace.org  
    Physical Location: Magoyety Road West- Karen (off Lang’ata road)

13. **SAPTA (Support for Addictions Prevention and Treatment in Africa)**  
    Outpatient Counseling Services and Family Therapy  
    P.O. Box 21761-00505, Nairobi  
    Tel: 0724511709, 0722216032  
    Email: evans@sapta.or.ke  
    Website: www.sapta.or.ke  
    Physical Location: Corner House – Kimathi Street, Nairobi

14. **Serenity Place – KahawaSukari**  
    P.O Box 42111 – 00100 Nairobi Kenya  
    Email: serenityplace2013@yahoo  
    Website: [http://www.serenityplace.co.ke](http://www.serenityplace.co.ke)
APPENDIX VI: RESEARCH PERMIT

NATIONAL COMMISSION FOR SCIENCE,
TECHNOLOGY AND INNOVATION

Telephone: +254-20-3471,
2541349,110571,2319/220.
Fax: +254-20-311245,311240
Email: secretary@nacost.go.ke
Website: www.nacost.go.ke
When replying please quote
Ref.No. NACOSTIP/16/46015/8954

Janet Akinyi Kalangi
Moi University
P.O Box 3900-30100
ELDORAD.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on "Evaluating access and use of information services by patients of alcohol and drug abuse in Nairobi County: A case study of Kamiti Treatment Centre," I am pleased to inform you that you have been authorized to undertake research in Nairobi County for a period ending 2nd April, 2017.

You are advised to report to the County Commissioner and the County Director of Education, Nairobi County before embarking on the research project. On completion of the research, you are expected to submit two hard copies and one soft copy in pdf of the research report/thesis to our office.

BONIFACE WANYAMA
FOR: DIRECTOR-GENERAL/CEO

Copy to:
The County Commissioner
Nairobi County.

The County Director of Education
Nairobi County.