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The Lived Experiences And Perceived Determinants Of Quality Of Life Among Visually Impaired Adults In Osun State, Nigeria

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Abstract
Background: *Visual impairment remains a significant global public health challenge, particularly in low- and middle-income countries where limited access to eye care services contributes to reduced wellbeing and social functioning among affected individuals. Beyond clinical disability, visual impairment substantially influences physical independence, emotional wellbeing, social participation, and overall quality of life. Despite increasing evidence on the burden of visual impairment, limited qualitative research has explored how visually impaired adults in Nigeria perceive the determinants shaping their quality of life. This study therefore explored the lived experiences and perceived determinants of quality of life among visually impaired adults in Osun State, Nigeria.*
Materials and Methods: *An exploratory qualitative study with a phenomenological approach was conducted among 40 visually impaired adults purposively selected from communities in Osun State, southwestern Nigeria. Data were collected through in-depth interviews conducted in English and Yoruba between October 2024 and January 2025 using a semi-structured interview guide. Interviews were audio-recorded, transcribed verbatim, translated where necessary, and analyzed using reflexive thematic analysis supported by ATLAS.ti version 23.*
Results: *Findings revealed that quality of life was influenced by multiple interrelated factors including severity of vision loss, delayed diagnosis, limited independence in performing daily activities, emotional distress, social exclusion, stigma, inadequate access to rehabilitation services, and financial barriers to assistive technologies. Participants reported reduced mobility, psychological distress, restricted social participation, and dependence on caregivers. However, adaptive coping strategies including spirituality, resilience, family support, and environmental adaptation positively influenced wellbeing.*
Conclusion: *The study demonstrates that quality of life among visually impaired adults is shaped by a complex interaction of medical, psychosocial, economic, and environmental factors. Holistic interventions that integrate rehabilitation services, psychosocial support, improved access to assistive technologies, and inclusive health policies are essential to improve wellbeing and promote independence among visually impaired adults.*
Keyword: *Visual impairment, quality of life, lived experiences, qualitative study, Nigeria.*

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I. Introduction

Visual impairment and blindness remain major global public health concerns, affecting an estimated 2.2 billion people worldwide, with a disproportionate burden in low- and middle-income countries where access to eye care services remains limited World Health Organization[1]. Vision loss extends beyond a clinical condition; it is a multidimensional challenge that affects physical functioning, emotional wellbeing, social participation, and economic productivity[2]. Because vision contributes about 80% of human sensory input, its impairment significantly disrupts daily activities such as mobility, reading, self-care, and occupational performance, often resulting in reduced independence, increased dependency, and higher risk of accidents and functional decline[3,4]. Quality of life among individuals with visual impairment is a multidimensional construct encompassing physical health, psychological wellbeing, independence, and social relationships. Vision-related quality of life reflects satisfaction with visual functioning and its impact on daily living[5]. Empirical evidence consistently shows that visual impairment is associated with poorer quality of life, with severity of impairment showing a strong inverse relationship with wellbeing and functional capacity[6,7]. In addition, affected individuals often experience psychological distress, including depression, anxiety, frustration, and difficulty adapting to vision loss[8].

Although many studies focus on older adults, emerging evidence indicates that younger and working-age adults may experience even greater disruption due to expectations of productivity, employment, and social

contribution[9]. However, psychological resilience factors such as self-efficacy, positive worldview, and adaptive coping strategies have been shown to buffer these negative effects and improve quality of life outcomes[10,11]. Beyond individual factors, lived experiences are also shaped by broader social determinants, including stigma, unemployment, loneliness, and exposure to adverse life events such as bullying and abuse, all of which are associated with poorer mental health and reduced quality of life[12,13]. Conversely, social support, rehabilitation services, and coping resources contribute positively to wellbeing. In Sub-Saharan Africa, the burden of visual impairment remains particularly high due to preventable causes such as cataract, glaucoma, and uncorrected refractive errors, compounded by weak health systems, poverty, and limited access to eye care services[14,15]. Nigeria contributes significantly to this burden, with millions of adults affected by visual impairment largely due to avoidable causes[16]. Beyond the clinical condition, individuals often face discrimination, unemployment, social exclusion, and inadequate rehabilitation services, which further compromise their quality of life[17,18,19]. Despite increasing research, existing studies remain fragmented and largely biomedical, with limited integration of psychological and socio-cultural perspectives. Furthermore, there is a paucity of research focusing on how visually impaired adults themselves perceive the determinants of their quality of life, particularly within Nigerian contexts. Understanding these lived experiences is essential for developing holistic, person-centred interventions that extend beyond clinical care to include social inclusion and psychological support. Therefore, this study explores the lived experiences and perceived determinants of quality of life among visually impaired adults in Osun State, Nigeria, aiming to generate context-specific evidence that can inform policy development, rehabilitation strategies, and improved support systems for enhanced wellbeing.

II. Material And Methods

Research Design

This study employed an exploratory qualitative design informed by a phenomenological orientation to explore the lived experiences and perceived determinants of quality of life among visually impaired adults in Osun State, Nigeria. Phenomenology is particularly suited to understanding how individuals interpret and make meaning of their experiences within their social and environmental contexts. The approach enabled an in-depth exploration of how visual impairment influences participants' physical, psychological, social, and functional well-being and how these experiences shape their perceptions of quality of life.

Research Setting

The study was conducted in Osun State, located in southwestern Nigeria. Osun State comprises 30 Local Government Areas distributed across three senatorial districts and is characterized by a mixture of urban and rural communities. The state has a well-established healthcare system that includes primary, secondary, and tertiary health facilities. Participants were recruited from communities within selected Local Government Areas in Osun East and Osun Central Senatorial Districts, where eye care and rehabilitation services are available through secondary and tertiary healthcare institutions. The diversity of the study setting provided an opportunity to capture a broad range of experiences among visually impaired adults from different socioeconomic and cultural backgrounds.

Participants and Sampling

The study population comprised visually impaired adults aged 18 years and above residing in selected communities in Osun State. Participants were recruited using purposive maximum variation sampling to ensure diversity in age, gender, educational attainment, occupation, ethnicity, marital status, and severity of visual impairment. This sampling strategy facilitated the inclusion of participants with varied lived experiences and perspectives regarding quality of life.

A total of 40 visually impaired adults participated in the study. Participants included both men and women aged 21–66 years and represented diverse educational, occupational, and sociocultural backgrounds. Recruitment continued until data saturation was achieved, at which point no new concepts or themes emerged from subsequent interviews.

Inclusion and Exclusion Criteria

Participants were eligible for inclusion if they were adults diagnosed with visual impairment by a qualified eye care professional, were receiving or had previously received eye care services, were able to communicate verbally in either English or Yoruba, and provided informed consent to participate in the study.

Individuals with temporary visual conditions not classified as visual impairment, those with severe cognitive or mental health conditions that could impair communication, and those unwilling to participate were excluded from the study.

Data Collection

Data were collected through individual in-depth interviews conducted between October 2024 and January 2025. A semi-structured interview guide was developed based on the study objectives and existing literature on visual impairment and quality of life. The guide explored participants' experiences of living with visual impairment, perceived determinants of quality of life, coping mechanisms, social relationships, access to healthcare and support services, and factors influencing their overall well-being.

Interviews were conducted in either English or Yoruba, depending on participants' preferences. Participants selected interview locations that were convenient and comfortable for them to encourage open discussion. Each interview lasted approximately 30–45 minutes and was audio-recorded with participants' permission. Field notes were taken during and immediately after interviews to document contextual observations and emerging reflections.

Interviews conducted in Yoruba were transcribed verbatim and subsequently translated into English. To ensure linguistic accuracy and preservation of meaning, translated transcripts were reviewed alongside the original recordings before analysis.

Data Analysis

Data were analyzed using reflexive thematic analysis as described by Braun and Clarke[20]. Audio recordings were transcribed verbatim and imported into ATLAS.ti version 23 to facilitate data management and coding. The analysis followed six iterative stages: familiarization with the data, generation of initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the final report.

The researchers repeatedly read the transcripts to gain familiarity with participants' narratives and identify meaningful patterns. Initial codes were generated inductively from the data and subsequently organized into broader categories. Related categories were grouped into overarching themes that reflected participants' lived experiences and perceived determinants of quality of life. Throughout the analytical process, interpretations were refined through continuous comparison across transcripts and discussions among the research team.

Trustworthiness

The trustworthiness of the findings was established using Lincoln and Guba's criteria of credibility, transferability, dependability, and confirmability[21].

Credibility was enhanced through prolonged engagement with participants, the use of open-ended interviews, member checking, and continuous immersion in the data. Participants were given opportunities to clarify and validate interpretations of their experiences.

Transferability was strengthened through the provision of rich descriptions of the study context, participant characteristics, sampling procedures, and analytical processes, enabling readers to assess the applicability of the findings to other settings.

Dependability was ensured through the systematic documentation of all stages of data collection and analysis. An audit trail consisting of interview recordings, field notes, coding records, analytical memos, and methodological decisions was maintained throughout the study.

Confirmability was promoted through reflexive journaling, maintenance of detailed records, and regular discussions among members of the research team to minimize personal biases and ensure that interpretations were grounded in participants' accounts.

Researcher Reflexivity

The lead researcher is a nurse with experience in visual impairment care and rehabilitation. Recognizing that professional experiences may influence data interpretation, reflexive practices were employed throughout the study. A reflexive journal was maintained to document assumptions, methodological decisions, emerging insights, and emotional responses during data collection and analysis. Regular discussions with supervisors and experienced qualitative researchers provided opportunities to challenge assumptions and enhance analytical rigor.

Ethical Considerations

Ethical approval was obtained from the Health Research Ethics Committee of the Institute of Public Health, Obafemi Awolowo University, Ile-Ife (IPH/OAU/12/3131), and the Health Planning, Research and Statistics Department of the Osun State Ministry of Health (OSHREC/PRS/569T/743). Written informed consent was obtained from all participants prior to data collection.

Participants were informed about the purpose of the study, their right to decline participation, and their freedom to withdraw at any stage without consequence. Confidentiality and anonymity were maintained through the use of identification codes rather than personal identifiers. Audio recordings, transcripts, and study documents were securely stored and accessible only to authorized members of the research team. All procedures were conducted in accordance with established ethical principles governing research involving human participants.

III. Results

Characteristics of Participants

Table 1: Socio-demographic Characteristics of In-depth Interviewees

S/N	Gender	Age	Marital Status	Religion	Ethnicity	Occupation	Qualification
1	Female	25	Single	Muslim	Yoruba	Student	Tertiary
2	Male	38	Married	Christian	Igbo	Other	Primary
3	Female	41	Married	Christian	Yoruba	Self employed	Primary
4	Male	38	Married	Christian	Yoruba	Civil servant	Tertiary
5	Female	40	Married	Christian	Yoruba	Self employed	Secondary
6	Female	53	Widow/widower	Muslim	Yoruba	Civil servant	Secondary
7	Male	57	Married	Christian	Igbo	Self employed	Secondary
8	Female	25	Single	Muslim	Yoruba	Student	Tertiary
9	Male	46	Married	Christian	Yoruba	Non-employed	Secondary
10	Male	55	Widow/widower	Christian	Igbo	Self employed	Secondary
11	Female	33	Married	Muslim	Yoruba	Self employed	Secondary
12	Female	35	Married	Christian	Yoruba	Self employed	Secondary
13	Male	66	Widow/widower	Christian	Yoruba	Self employed	Secondary
14	Female	35	Married	Muslim	Yoruba	Other	Tertiary
15	Male	61	Married	Christian	Yoruba	Self employed	Secondary
16	Male	21	Single	Christian	Igbo	Student	Secondary
17	Female	33	Married	Christian	Yoruba	Civil servant	Tertiary
18	Female	45	Married	Christian	Yoruba	Civil servant	Tertiary
19	Male	23	Single	Christian	Yoruba	Students	Tertiary
20	Female	55	Married	Muslims	Yoruba	Self employed	Secondary
21	Female	25	Single	Muslim	Yoruba	Student	Tertiary
22	Male	46	Married	Christian	Yoruba	Non-employed	Secondary
23	Male	55	Widow/widower	Christian	Igbo	Self employed	Secondary
24	Female	33	Married	Muslim	Yoruba	Self employed	Secondary
25	Female	35	Married	Christian	Yoruba	Self employed	Secondary
26	Male	21	Single	Christian	Igbo	Student	Secondary
27	Female	33	Married	Christian	Yoruba	Civil servant	Tertiary
28	Female	53	Widow/widower	Muslim	Yoruba	Civil servant	Secondary
29	Male	57	Married	Christian	Igbo	Self employed	Secondary
30	Female	25	Single	Muslim	Yoruba	Student	Tertiary
31	Male	46	Married	Christian	Yoruba	Non-employed	Secondary
32	Female	35	Married	Muslim	Yoruba	Other	Tertiary
33	Male	61	Married	Christian	Yoruba	Self employed	Secondary
34	Male	21	Single	Christian	Igbo	Student	Secondary
35	Female	33	Married	Christian	Yoruba	Civil servant	Tertiary
36	Female	33	Married	Muslim	Yoruba	Self employed	Secondary
37	Female	35	Married	Christian	Yoruba	Self employed	Secondary
38	Male	66	Widow/widower	Christian	Yoruba	Self employed	Secondary
39	Female	35	Married	Muslim	Yoruba	Other	Tertiary
40	Male	61	Married	Christian	Yoruba	Self employed	Secondary

The socio-demographic characteristics of the 40 in-depth interview participants reveal a diverse yet demographically consistent sample. The group comprises both male and female respondents, with a slight predominance of females. The ages of participants range from 21 to 66 years, and the average age is approximately 41 years, suggesting that most respondents are middle-aged adults. Marital status indicates that the majority of participants are married, while a few are single or widowed. In terms of religion, Christianity is the dominant faith among respondents, followed by Islam, reflecting the religious diversity of the study setting. The ethnic composition shows a majority of Yoruba participants, with a smaller number of Igbo individuals, aligning with the population structure of Osun State. Occupationally, the participants include self-employed individuals, civil servants, students, and the non-employed, suggesting a mix of economic roles and levels of engagement in formal and informal sectors. Educationally, the majority have completed secondary education, while a significant number possess tertiary qualifications, and a few have only primary education.

Level of Vision Perception

Participants described varying degrees of visual impairment, ranging from mild blurriness to complete loss of sight. These self-assessments often reflected their ability to navigate the world around them and perform daily tasks. For some, the loss was progressive, making their current visual status difficult to accept. Others described their vision in terms of specific limitations, such as the inability to recognize faces, read, or distinguish colours and movement. Their experiences also pointed to how they personally rated their vision and the impact on their independence.

Some individuals retained partial vision, often limited to light perception or shadows, while others described complete blindness. The way participants articulated their visual capacity revealed how deeply their impairment shaped their daily experiences, confidence, and quality of life.

"I can see light, but everything else is just a blur. I can't recognize faces, not even my own family unless they talk." **(CP1, 25 Years, Male)**

"My left eye is completely blind, and the right one only gives me shadowy images. I'd say my vision is around 1 out of 5." **(CP15, 61 Years, Male)**

"It's hard to describe. I'm not totally blind, but I can't read, I can't drive, and I struggle to walk on my own." (**CP6, 61 Years, Male)**

Medical Conditions and Disease Onset

Understanding the origin of visual impairment among participants revealed a variety of medical causes, often marked by either gradual or sudden onset. Many individuals attributed their vision loss to underlying health conditions, including chronic diseases such as glaucoma, cataracts, and diabetes-related retinopathy. For some, the condition developed slowly over time, making early detection difficult. One participant recalled,

"It started with blurry vision. I thought it was stress or old age until it became worse and I had to see a doctor." **(CP23, 55 Years, Male)**

"It happened suddenly. One morning, I just couldn't see properly out of one eye," **(CP22, 46 Years, Male)**

"The doctor told me it was cataract, but I couldn't afford the surgery." **(CP27, 33 Years, Female)**

Delayed Detection and Diagnosis

A recurring thread across participant narratives was the issue of delayed detection and diagnosis of their visual impairment. Many individuals attributed the delay to a lack of awareness, limited access to eye care services, and the tendency to dismiss early symptoms as age-related or insignificant. These delays often resulted in preventable progression to more severe or even irreversible vision loss. One participant recalled,

"I noticed my sight was not as sharp as before, but I didn't take it seriously until it started affecting my movement." **(CP1, 25 Years, Female)**

"It was the eye doctor who told me I had cataracts and explained what it meant. That was the first time I understood what was wrong," **(CP25, 35 Years, Female)**

Theme Quality of life

Understanding the quality of life among individuals with vision impairment involves exploring how their condition influences various aspects of daily living. Many participants described significant challenges in performing routine tasks such as moving around safely, preparing meals, or managing personal hygiene. These difficulties often led to increased dependence on family members or caregivers, reducing their sense of independence and self-worth. One participant shared how simple activities became a daily struggle, emphasizing the pervasive impact on their lifestyle.

"Everyday tasks that I used to take for granted now feel like mountains to climb. I have to ask for help even for small things, and that's hard." **(CP19, 23 Years, Male)**

"Walking outside is risky; uneven sidewalks and obstacles make me afraid of falling. I avoid going out alone because I can't always see what's in front of me one wrong step and I could end up seriously hurt. Even with a cane, I still miss things like curbs, potholes, or toys left on the walkway. It's not just the walking; it's the constant anxiety of not knowing what I might run into or trip over. The streets feel like an obstacle course, and I move slowly and cautiously because I've fallen before and I'm terrified of it happening again." **(CP19, 23 Years, Male)**

"I need help with simple things like buttoning my clothes or cutting my food because I can't see well enough. Everyday tasks that others take for granted become major challenges for me. It's frustrating to lose that sense of independence—even dressing or eating requires assistance. Sometimes I feel helpless, not because I'm incapable, but because my vision limits what I can safely do on my own." **(CP39, 35 Years, Female)**

"I can no longer move freely in my own house without bumping into things; everything has to be in the same place all the time. If something is moved even slightly, I risk tripping or knocking it over. My home used to be a place of comfort, but now it feels like a maze I have to navigate carefully. This constant need for control over my environment is exhausting, but it's the only way I can maintain a sense of safety." **(CP39, 35 Years, Female)**

Emotional and Psychological Effects

The emotional and psychological toll of visual impairment was deeply felt by participants, with many describing experiences of frustration, sadness, anxiety, and even depression. The shift from independence to dependence, along with the abrupt change in lifestyle, left several individuals feeling isolated and emotionally vulnerable. One participant reflected,

"I sometimes cry alone because I can't do what I used to do. It makes me feel useless. There's a deep sadness that comes with losing the ability to carry out simple tasks independently. I don't always talk about it, but the frustration builds up being dependent on others for things I once did effortlessly has taken a toll on my self-worth." **(CP13, 66 Years, Male)**

"There are days I just sit quietly, thinking about how my life has changed. I feel like I'm a burden. I used to be active and independent, but now I rely on others for so many things. It's hard not to feel like I'm in the way, even when my family doesn't say it. The silence sometimes feels heavy, filled with memories of the life I used to live." **(CP16, 66 Years, Male)**

"People don't know how to talk to me anymore. Some just stare. It makes me want to stay indoors. I feel invisible or awkwardly noticed, like I no longer fit in. Instead of offering help or treating me normally, many avoid me altogether. That kind of reaction hurts—it's easier to stay at home than to face the discomfort and judgment outside." **(CP22, 46 Years, Male)**

Sub theme: Social Participation and Relationships

Participants consistently emphasized that visual impairment significantly affected their ability to engage in social activities and maintain relationships. Many described a gradual withdrawal from community events, religious gatherings, and even casual outings with friends or family due to mobility challenges, fear of stigma, or feelings of inadequacy.

"Since my sight got worse, I hardly go out. I miss going to church and visiting friends, but I don't want to be a burden. I used to enjoy being part of the community, sharing moments with others, but now I worry that people have to go out of their way to help me. That thought alone keeps me from reaching out or accepting invitations it's easier to stay home, even though it's lonely." **(CP28, 53 Years, Female)**

"I used to be very active in my local women's group, but now I just stay at home. It's like I've lost a part of myself." **(CP14, 35 Years, Female)**

Social stigma emerged as a recurring theme. Some participants felt judged or pitied in public spaces, which discouraged them from engaging socially. one individual expressed

"When people look at me with pity, it makes me feel small. I don't want sympathy I want respect. Their stares and expressions make me feel like less of a person, like I'm broken or helpless. It's not my eyesight that hurts the most—it's how people react to it." **(CP27, 33 Years, Female)**

Coping Strategies and Adaptation

Participants in the study revealed a wide range of coping mechanisms and adaptive strategies they developed over time to navigate life with visual impairment. These strategies were both emotional and practical, reflecting resilience, resourcefulness, and determination in the face of ongoing challenges. Emotionally, many participants turned to faith and spirituality as a primary source of comfort and meaning. They described prayer, religious gatherings, and trust in a higher power as central to maintaining hope. One participant shared,

"When I feel down or overwhelmed, I just pray. It calms me and gives me strength to carry on. In moments when everything feels too heavy—when my vision limits me or I feel alone—prayer becomes my refuge. It reminds me that I'm not completely powerless, and it helps me find peace even in difficult times." **(CP28, 53 Years, Female)**

Another echoed this, saying,

"God is my source of courage. Even when people don't understand me, I feel that He does. There are times when I feel completely alone or misunderstood, but knowing that God sees and understands my struggles gives me comfort. My faith helps me stay strong, even when others fall away or fail to support me." **(CP40, 61 Years, Male)**

Access to Support Services

Access to support services emerged as a critical factor influencing the lived experiences of participants with visual impairment. While some participants had benefited from occasional support, many voiced concerns about the inadequacy, inaccessibility, or complete absence of structured services such as counseling, rehabilitation, assistive technologies, and orientation and mobility training. Participants frequently highlighted a lack of awareness about existing services. Some had never been informed of available programs or organizations that could assist with their visual needs.

"No one ever told me where to go for help. After I started losing my sight, I felt completely lost there was no guidance, no direction. I didn't know who to ask or what services were available. I had to figure things out on my own, and that made everything even more overwhelming." **(CP10, 55 Years, Male)**

"I only found out about the eye clinic through a friend. No one from the hospital or health center mentioned it to me. If she hadn't told me, I would still be sitting at home thinking nothing could be done. It shouldn't be this hard to get help." **(CP10, 28 Years, Female)**

Even when services were available, affordability posed a barrier. Assistive devices such as white canes, talking watches, magnifiers, or screen readers were often beyond reach. lamented one participant.

"They told me I could get a device to help me read, but it costs too much. I really wanted it, it would have made things easier but there's no way I can afford it. Sometimes it feels like only the rich can cope with blindness." **(CP10, 28 Years, Female)**

IV. Discussion

The socio-demographic profile of the participants comprising mostly middle-aged adults with a moderate level of education and diverse occupational status mirrors previous findings in Nigeria where visual impairment disproportionately affects adults of working age[22,23]. Middle-aged individuals, in particular, face dual challenges of economic dependency and family responsibility, which amplify the psychosocial burden of vision loss. Moreover, the predominance of Yoruba participants reflects the local ethnic distribution, but also indicates a shared cultural understanding of disability and dependence, which shapes coping mechanisms and social inclusion. Religion emerged as an essential factor, as participants' spiritual beliefs often acted as buffers against emotional distress a finding consistent with Venkatesan, who identified spirituality as a key adaptive resource among people with sensory disabilities[24].

Participants' narratives highlighted varying degrees of visual impairment, from mild blurriness to total blindness, which significantly influenced their autonomy and quality of life. Individuals with partial vision often retained some level of functional independence, while those with total blindness reported greater emotional strain and reliance on others. This is consistent with Khorrami-Nejad et al., who found that the severity of vision loss correlates inversely with perceived quality of life, particularly in mobility, communication, and self-care domains[25]. Furthermore, the emotional distress caused by progressive vision loss echoes the findings of Kozakova, et al., who reported that the unpredictability of sight deterioration contributes to anxiety and a sense of helplessness among visually impaired individuals[26]. This present study revealed that chronic eye diseases such as cataract, glaucoma, and diabetic retinopathy were the most common causes of visual impairment. This finding is consistent with national and global data from Xulu-Kasaba, & Kalinda**,** which identify these conditions as leading causes of avoidable blindness in sub-Saharan Africa[27]. Participants' experiences of delayed diagnosis and treatment reinforce the structural health system barriers noted by Maduakolam, et al., who observed that poor access to specialized eye care, limited awareness, and financial constraints contribute to preventable visual disability[28]. The lack of follow-up care and inconsistent patient education reported by participants highlights systemic gaps in continuity of ophthalmic services an issue also reported in Nwazulu, et al., where patients with glaucoma failed to attend follow-up appointments due to poor communication and cost burden[29]. This present study identify inability to perform basic daily tasks independently was one of the most emotionally taxing aspects of participants' experiences. This aligns with Demmin & Silverstein, who found that vision impairment reduces independence and increases dependence on others, thereby lowering self-esteem and life satisfaction[8]. Participants' accounts of frustration, sadness, and feelings of worthlessness reflect the psychological distress associated with vision loss, consistent with Dike, et al., who reported that depression and anxiety are prevalent among adults with acquired blindness[30]. Furthermore, fear of injury, social withdrawal, and stigma mirrored findings from Palencia-Flórez & Oviedo-Cáceres in Colombia, where visually impaired adults described their environments as "unsafe" and "emotionally isolating"[31]. These experiences reinforce the concept of "disability-environment interaction" proposed by the Social Model of Disability, suggesting that quality of life is not only determined by impairment itself but by how society accommodates or excludes individuals with disabilities. Participants' withdrawal from social life due to stigma, mobility challenges, and overprotection by family members reflects both social and attitudinal barriers. Similar findings were documented by Oladosu, who noted that social exclusion and pity-based attitudes remain significant challenges to community integration for the visually impaired in Nigeria[32]. Despite these challenges, participants demonstrated resilience through adaptive coping mechanisms, including faith, emotional acceptance, environmental familiarity, and the use of assistive technologies. The strong reliance on spirituality resonates with Ahmed, et al., who found that religious coping enhances emotional adjustment among persons with disabilities in Nigeria[33]. Similarly, learning to navigate familiar spaces and use voice-activated phones or tactile devices reflects a growing trend of self-initiated adaptation, as documented by Batool, et al[34]. The use of adaptive tools not only restores a sense of control but also enhances social connectedness, consistent with the findings of Alimovic, who observed that access to assistive technologies significantly improves the psychosocial quality of life among adults with visual impairment[35]. Furthermore, access to structured rehabilitation and support services emerged as a critical determinant of quality of life. Most participants reported inadequate access, lack of awareness, and unaffordability of assistive devices. This reflects systemic gaps noted by Alimovic, emphasizing that eye health and disability support services in remain underdeveloped, poorly coordinated, and inaccessible to low-income populations[35]. Where rehabilitation or mobility training was available, participants reported remarkable improvement in confidence and independence.

V. Conclusion

The study demonstrates that the quality of life among visually impaired adults is shaped by a complex interplay of individual resilience, medical accessibility, social inclusion, and environmental support systems. The findings reinforce the importance of a holistic and rights-based approach to visual disability one that integrates medical care with psychosocial, technological, and community interventions. The experiences of participants advocate for stronger public health education, improved early detection, and accessible rehabilitation programs that prioritize dignity and independence. Empirically, the study aligns with global evidence that visual impairment is not merely a sensory loss but a life-altering condition that redefines identity, relationships, and well-being.

Implications for Nursing Practice

This study highlights the vital role of nurses in improving the quality of life of visually impaired adults through holistic, person-cantered, and culturally sensitive care. Nursing practice should address not only physical vision loss but also emotional, psychological, and social well-being. Nurses should provide comprehensive assessment, health education, and rehabilitation support, including the use of assistive devices and strategies that promote independence. Empathic counselling and mental health support are equally important to help patients adjust and build resilience. Furthermore, nurses should advocate for inclusive health policies and collaborate with other professionals to ensure coordinated care, while continuous training in visual rehabilitation remains essential for effective practice.

Suggestions for Further Study

This study has provided valuable insights into the lived experiences and determinants influencing the quality of life of visually impaired adults. However, there remain several areas for further exploration. Future research could adopt a longitudinal qualitative design to examine how quality of life evolves, particularly as individuals adapt to changing levels of vision and social support. Such an approach would help in understanding the dynamic process of psychological adjustment and resilience among visually impaired adults. Further studies could also explore gender-specific or age-specific perspectives, as men, women, and older adults may experience visual impairment and its psychosocial impact differently. Comparative studies between urban and rural populations may reveal disparities in access to eye care, rehabilitation services, and assistive technologies.

Conflict of interest

No conflict of interest was declared by the authors

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