SCHOOL-BASED HIV AND AIDS INTERVENTIONS FOR GIRLS WITH VISUAL IMPAIRMENTs (GVIs) IN SELLECTED SECONDARY SCHOOLS IN TANZANIA

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CERTIFICATION

I, the undersigned, hereby certify that have read the Thesis and find it to be in a form acceptable for examination in fulfillment of the requirement for the degree of Doctor of Philosophy of the Open University of Tanzania.

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Prof. Honoratha M. K. Mushi

(Supervisor)

……

Date

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DECLARATION

I, Agnes Elianshiwanga Masawe, do hereby declare that this Thesis is my original work and that it has not been submitted for a similar degree in any other University.

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Signature

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Date

DEDICATION

Glory be to God, to whom I dedicate this work. He has guided me in the decision of conducting this research. He strengthened me from the start, continued pushing me on and now He has enabled me complete this thesis. It was challenging and tiresome but by the Grace of God the challenge is over. I also dedicate this thesis to my beloved husband Satiel, our beloved son Walter, and daughters Faith and Nora and our sons in law Samwel and Rogers, who have always stood by my side, anxiously waiting for the completion of this work for my academic and professional progress.

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ABSTRACT

Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) exist among girls with visual impairments (GVIs) but little research has been done in addressing this concern. There is so far no information about the number of GVIs who have been infected or died through HIV/AIDS in Tanzania. Campaigns on HIV/AIDS prevention have not targeted GVIs. These aspects make GVIs vulnerable to HIV/AIDS. The study traced school-based HIV/AIDS interventions aimed at preventing HIV/AIDS among GVIs. Qualitative methods were used to collect data from two selected secondary schools in Tanzania. The sample consisted of 36 GVIs and 4 teachers. Findings showed that HIV/AIDS teaching methods were teacher centred and HIV/AIDS topics were hipped in only two subjects, i.e. Civics and Biology. GVIs developed sufficient knowledge about life skills, attitudes and intention for abstinence from sexual practices but not for condom use. GVIs faced challenges including discrimination, labeling, condom inaccessibility and sexual abuse. The following recommendations were made: School HIV/AIDS educators to ensure school adolescents without and with disabilities study HIV/AIDS; HIV/AIDS teachers be sufficiently trained and supplied with materials such as Braille for teaching visually impaired school adolescents. School inspectors should monitor and evaluate school curriculum implementation. Curriculum developers ensure linkages between life skills and ability to act among school adolescents with disabilities. Education policies guide integration of HIV/AIDS to address students with disabilities, additional studies on the subject of HIV/AIDS relation to students with disabilities and HIV/AIDS topics to be integrated in subjects other than Biology and Civics.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AWDs	Adolescents with Disabilities
AWVIs	Adolescents with Visual Impairment
BCM	Behaviour Change Model
CBE	Competence Based Education
CCBRT	Comprehensive Community Based Rehabilitation in Tanzania
CCI	Cross cutting issues
FGD	Focus Group Discussions
GVIs	Girls with Visual Impairments
HIV	Human Immunodeficiency Virus
IEC	Information Education and Communication
MoEVT	Ministry of Education and Vocational Training
NACP	National AIDS Control Programme
NMSF	Multi-sectoral HIV and AIDS Strategic Framework
PWDs	People with Disabilities
PVIs	Persons with Visual Impairments
STIs	Sexuality Transmitted Infections
TACAIDS	Tanzania Commission for AIDS
TIE	Tanzania Institute of Education
TPB	Theory of Planned Behaviour
UN	United Nations
UNAIDS	United Nations Programme on AIDS
UNESCO	United Nations Educational Scientific and Cultural Organization

UNICEF	United Nations Children's Fund
URT	United Republic of Tanzania
USAIDS	United States Agency for International Development
WHO	The World Health Organization
ZANAB	Zanzibar National Association for the Blind

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background to the Study

Since early 1980s, most countries in the world have been facing escalating spread of the Human Immunodeficiency Virus (HIV) which causes Acquired Immune Deficiency Syndrome (AIDS) and weakens human immune system. AIDS is lack of the body's natural defenses against disease-causing organisms (UNESCO, 2005). To date there is no cure for AIDS although a lot of effort has been made to find cure for HIV.

As soon as HIV was identified in 1983, scientists started trying to understand where it had originated and why it had spread (Carmichael, 2006). In Africa, in retrospect, the first cases of AIDS seem to have appeared in Uganda and Tanzania shortly after the Ugandan liberation war from 1978 to 1979. The AIDS epidemic in the Democratic Republic of Congo was situated around the same time, although HIV infection might have been present in the population many years before that time. Antibodies against HIV were detected in a serum sample collected from a Kinshasa resident in 1959 (Becker and Denis, 2006). Lack of awareness during the early years and even now can also be considered to be a major reason for the fast spread of HIV (Home Health Testing, 2010).

Currently the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (HIV and AIDS) is a concern of all nations as it has threatened the lives of

people of all ages with more impact to youths. Despite factors affecting girls as youth they are also affected by social and biological factors. Thus female adolescents are more vulnerable than male adolescents but due to disability challenges female adolescents with disabilities such as albinism, deaf and mute, deaf and blind, mental impairment, multi-impairment, visual impairment and physical impairment are the most vulnerable to HIV and AIDS. AIDS is still a threatening problem for young people including individuals with disability worldwide, a problem that is still largely unrecognized by both the AIDS and the disability advocacy communities. Altogether, behavioral risk factors for HIV related to sexual activity among individuals with disability are identical to those for the general population (Groce, 2004). Worse still there are misconceptions that individuals with disability are not sexually active and therefore they are less likely to be contracted with HIV.

In response to the devastating impact of HIV and AIDS, all nations have declared HIV and AIDS education a tool for bringing to an end further spread of HIV. The necessity for and the importance of HIV and AIDS education has been given prominence through periodical global forums and documents from the early 1980s as a strategy for addressing the spread of HIV. The worldwide and local concern about the ongoing HIV and AIDS situation has called for the need to support people to develop knowledge, values and positive attitudes towards healthy practices to avoid HIV and AIDS. The United Nations (UN) has been contributing resources including human skills to stimulate increased access to HIV and AIDS prevention measures, care services and treatment as well as impact mitigation programmes. Despite UN's assistance, HIV and AIDS prevalence prevails. The following section presents

UNAIDS (2013) estimates on HIV and AIDS prevalence across all age groups in Tanzania.

1.1.1 Statistics on HIV Prevalence in Tanzania

The regional statistics on HIV and AIDS indicates that Sub-Saharan Africa is still experiencing the HIV and AIDS epidemic which has exerted negative social and economic impacts on the general population. Worldwide, the number of people newly infected continues to fall (UNAIDS, 2012). In 2014, it was estimated that 25. 8 million people were living with HIV in Sub-Saharan Africa. Women account for more than half the number of people living with HIV in Sub-Saharan Africa. The statistics also shows that HIV infections declined by 41% between 2000 and 2014. In 2014, there was an estimated 1.4 million new HIV infections while Sub-Saharan Africa accounted for 66% of the global total of new infections with an estimated 790,000 AIDS-related deaths (UNAIDS, 2014).

Tanzania, similar to other countries in Sub-Saharan African is highly affected by HIV and AIDS infections although the Tanzanian National HIV and AIDS Policy adopted in 2001 provided a long-term orientation to the fight against HIV and AIDS. The overall objective was to reduce the rate of HIV infection and mitigate the impact of the epidemic through national response programmes (CCBRT, 2012). The national response to HIV and AIDS is guided through the implementation of the Tanzanian Multi-sectoral HIV and AIDS Strategic framework NMSF I-III (URT, 2013).

However, Tanzania still has the highest level of infections as estimated in Table 1.1.

The HIV and AIDS situation in Tanzania as illustrated in table 1.1 indicates that by the end of 2013, the estimated HIV positive prevalence was about 1.6 million people. Among these the prevalence among adults aged 15-49 was 5.0% (UNAIDS, 2013); generally women and youths constituted the most vulnerable population (TACAIDS, 2012).

Table 1.1: HIV and AIDS in Tanzania

Group of People	**Estimates**
Population	40,253,000
People living with HIV	1,400,000
Adults aged 15 to 49 prevalence rate	5.0%
Adults aged 15 and up living with HIV	1,200,000
Women aged 15 and up living with HIV	690,000
Children aged 0 to 14 living with HIV	250,000
Deaths due to AIDS	78,000
Orphans due to AIDS aged 0 to 17	1,200,000

Source: Epidemiological Facts Sheet on HIV and AIDS (UNAIDS 2013)

USAID (2012) indicates that women have experienced higher HIV infection rates at all ages except those aged 35 to 39. It was reported in 2007 that among the 15 to 24 year-old age group, females are more than three times likely than males to be living with HIV prevalence at 3.6% compared with 1.1% among men. Among those aged 15 to 49, HIV prevalence among women was 6.6% compared with 4.6% among men. This statistics indicate that the prevalence of HIV infections among age group15 to 49 is higher among women compared to men, suggesting that females are more vulnerable than males.

1.1.2 Girls' Vulnerability to HIV and AIDS

Whereas young people are at a higher risk for HIV compared to adults, they are recognized as key resource for altering the course of HIV pandemic. The likelihood that young people will be a source altering the course of HIV pandemic is influenced by a host of factors relating to the individual and the environment around. It is evident that both biological and social factors limit girls' choices in healthy behaviours.

Tigalawana 2010 and UNESCO (2010) identified biological and social factors that make women and girls more vulnerable to HIV and AIDS. Biological factors include the fact that a woman's sexual organ is internal; hence there is less likelihood for most of them to know that they have sores from sexuality transmitted infections (STIs). As women engage in sexual intercourse they are likely to be infected. In addition, female genital mutilation or a young woman's vagina which is underdeveloped is also likely to cause vagina rupture more easily during sex and allow absorption of HIV and AIDS viruses.

Further; women receive greater quantities of HIV viruses while having sexual intercourse with men who are infected with HIV and AIDS because generally such men deposit semen which hold concentrated amounts of the HIV viruses. These facilitate HIV transmission during sexual intercourse.

Social risk factors that make women and girls more vulnerable to HIV and AIDS include among others taboos related to speaking about sex that limit women and girls

in negotiating whether or not to have sex or how and when to have sex. Gender roles also do not permit women and girls to participate in sexual or reproductive decisions often give power to men to make the sexual and reproductive health decision for the family and the couple. Thus women and girls have been inactive on deciding in protective measures against HIV infections. Further, extreme poverty encourages women and girls to engage in unsafe sex for exchange for money, school fees, or food and belief that a man can cure AIDS by sleeping with virgin girls is one of the factors that encourage HIV infected men to have sex with virgin girls. Furthermore, lack of female control of HIV and AIDS prevention methods, and violence against them, including sexual abuse, sexual assault, and trafficking increase HIV infections.

Although all young people are at higher risk for HIV than adults, the synopsis about biological and social factors that make girls more vulnerable presented by Tigalawana (2010) and UNESCO (2010) suggest that the risk to acquire HIV is not shared equally among boys and girls. These factors can influence the likely hood that girls can be limited in being both responsive to HIV prevention and effective promoters of healthy behaviours to control the spread of HIV. Evidence shows that PWDs are at the greater risk of HIV infection than non-disabled people (Edwards and Yousafzai, 2004) and women with disabilities are even more vulnerable as argued in the section that follows.

1.1.3 Persons with Disabilities' Vulnerability to HIV Infections

Disability can be understood on three different levels; namely impairment, activity limitation, and participation restriction levels. At the first level, disability as

impairment is often a result of acquired health conditions, the other two levels are a result of inaccessible environments that cause disability by creating barriers to participation and inclusion (WHO, 2011). The World Report on Disability highlights several risk factors that drive impairment and/or disability. These factors include infections such as HIV (Hanass-Hancock, Naidoo and Regondi, 2013). Impairment or disability in a person's life can be the main factor to HIV infection due to insufficient access to HIV prevention and support services. Consequently, PWDs may engage in behaviours which place them at risk of HIV infection, such as unprotected sex (UNAIDS, 2009).

Since inaccessible environments can cause disability and create barriers to participation and inclusion, on the other hand, lack of information on the prevalence and factors associated with HIV and AIDS infection among the disabled can lead to under estimations of the problem of HIV and risky sexual behaviours (Katuta, 2011) leading to vulnerabilities among people with disabilities (PWDs). Interventions to prevent HIV among PWDs require a broad focus that encompasses but not limited to sexual behaviour among PWDs, and their knowledge about HIV. One of these broad focuses is based on a survey done in Tanzania. The survey shows that PWDs are sexually active and they engage in high risk sexual activities. Yet they are less educated about HIV than their peers and more likely to be excluded in critical HIV services (TACAIDS, CCBRT and NACP, 2009).

The survey made by the organizations listed above was conducted among 40 respondents with a disability. The survey found that:

- Less than half knew about HIV and AIDS.
- Even those who knew about HIV and AIDS had misconceptions about its transmission.
- Half of the respondents had had sex by the age 19.
- Almost a quarter of the respondents had had sex with a non-regular partner.
- Most of the respondents (78%) did not use condom when doing so.
- A quarter of the respondents who were sexually active said they ‘never’ used condoms.
- Fifteen per cent of them had had an STI.
- Nine per cent of the respondents who were tested were found to be HIV positive.
- Forty per cent of the respondents said they knew a disabled person who had been raped.
- The majority of the respondents thought it was not easy to access HIV/AIDS services.
- Stigma and discrimination were reported as key barriers to accessing services.

Given that less than half of the respondents knew about HIV and AIDS and even those who knew about it had misconceptions about its transmission, the impact of HIV and AIDS interventions is most likely to be ineffective. Misconception about HIV transmission is thus most probably a result of faulty understanding of the pandemic because the target groups do not know actual facts about HIV transmission and prevention. Although there is misconception that PWDs are not sexually active

(Grose 2004; Kyaruzi 2004; Murangira, 2004) the data show that 50% of young PWDs are engaged in sexual practices at their teen age with non-regular partner. The percentage of those PWDs who did not use condom (78%) was high.

The survey also indicates that PWDs who were sexually active were not using condom suggesting risky sexual practices which lead to 15% and 9% STIs and HIV positive respectively. The fact that 40% of the respondents knew a disabled person who had been raped is proof that PWDs are sexually abused, a situation which positions PWDs at high risk. Stigma and discrimination were reported as key barriers to accessing HIV/AIDS services, it is no wonder that the majority of the respondents thought that it was not easy to access HIV services. This is another factor that attributes to high risk of contracting HIV.

The situation presented under the preceding information might be shocking, taking into account that PWDs are sexually active with a significant percentage of 15% of STIs and 9% of HIV positive, yet stigmatized and discriminated in accessing HIV services. Human Right Watch (2011) provides added shocking information in the growing body of research which shows that HIV infection rate among PWDs is up three times as high as people without disabilities. Additionally, PWDs face a wide range of human rights abuse which increases their risk of HIV such as higher risk of violence, and lack of legal protection, education and sexual health information.

Policy makers, implementers and major actors on HIV and AIDS have not acknowledged PWDs as a distinctive group of people that calls for the rights to

special interventions (Murangira, 2004). Since their needs are not addressed, PWDs, including adolescents with disabilities (AWDs) in HIV and AIDS interventions experience barriers due to severity of impairment, discrimination, low self-esteem, and low self-efficacy. These barriers prevent the individuals from accessing adequate information about HIV and AIDS and affect their control of safer sexual relationships (Edwards, D'Allesandro, Lindströmand and Yousafzai, 2005).

The Ministry of Education and Vocational Training (MoEVT) developed a strategic plan for developing life skills curricula in schools (TACAIDS, 2012). The statistics provided and the biological and social factors explained can provide a glimpse of the insight of the prevalence of vulnerability of women in general and enable readers to imagine how PWDs such as GVIs are likely to be more vulnerable to HIV/AIDS as presented in the subsection that follows.

1.1.4 HIV Vulnerabilities among Persons with Visual Impairments

NMSF III in Tanzania for HIV and AIDS 2013/14-2017/18 targets for the elimination of new HIV infections, HIV-related deaths, and HIV stigma and discrimination in order to improve the quality of life for all Tanzanians (The United Republic of Tanzania- URT, 2013). The strategic result framework describes the process through which the long term impacts of zero new HIV infections, zero AIDS-related deaths, and zero stigma and discrimination will be tracked and achieved. However, NMSF III does not indicate how it is tracked among PWDs such as Persons with visual impairments (PVIs) and reach them through HIV and AIDS messages, clinical care

and reproductive health services with the existing unique driving disability factors discussed in the section that follows.

Vulnerability of PVIs to HIV and AIDS is intensified by traditional beliefs and myths that presume them to be at no risk of contracting HIV and AIDS. For instance people have developed the tendency to seek for girls with visual impairments (GVIs) for what they consider safe sex. Out of the GVIs' ignorance they have given in to unsafe sex only to their detriment. In a number of cases such girls end up suffering double stigma, they remain visually impaired and they contract HIV and AIDS (Zanzibar National Association for the Blind - ZANAB, (2008).

Alice, Sangok and Patrick (2013) noted that there were cultural factors in some societies that increase PVIs' vulnerability to HIV and AIDS. According to these scholars, some tribes consider PVIs outcasts; in order to avoid bad fortunes associated with the visual impairment individuals with such impairments get isolated from the societies. Other tribes consider visual impairment as evil spell caused by somebody due to her/his failure to do right things to other persons. Consequently, PVIs are hidden and cannot access and utilize HIV and AIDS information and services. In cases of infections PVIs victims face multiple discriminations from disability, poverty, and HIV positive. Due to social stigma that HIV/AIDS victims face, HIV and AIDS services rarely reach them. Such experiences accelerate or exacerbate immunity deficiency for the victims which, ultimately shortens the victims' lives.

Alice, Sangok and Patrick (2013) assert that dependency of some of the PVIs on others for financial support leaves them at a greater risk of not accessing and

utilizing HIV and AIDS services. Moreover, even when access to the services is available it is not always confidential due to dependency on the use of guidance from others. Besides, some of the PVIs failure to go to health facilities for antiviral drugs, condoms, voluntary counselling and testing because of their low economic status, they cannot afford to pay the guides who charge them for the services they are offered. Eventually, PVIs develop elements of self-stigmatization intensified by their poverty, illiteracy, lack of self-confidence, and low self-esteem. This situation makes them feel discriminated against and therefore they fail to generate the confidence to utilize the already existing HIV and AIDS services.

HIV and AIDS awareness among adolescents has been reported to be higher among sighted adolescents compared to adolescents with visual impairments (AWVIs) because HIV and AIDS education on transmission and preventive measures has not particularly targeted AWVIs (Kendi, Kinai, and Mweru, 2012). They lack information about condom and most of them hear people talking about condoms but they have never held one (Edwards and Yousafzai, 2004) to get the knowledge of what it actually is.

One educational priority for people with visual impairments is correct condom use, for which use is often demonstrated visually rather than explained orally or interactively (Philander and Swartz, 2006). Traditional methods which include textbooks in print, diagrams, billboards, video shows, newspapers, magazines and television adverts do not make much sense to the PVIs because they cannot access HIV and AIDS information from such methods. Inaccessibility to information,

education and communication (IEC) for the blind and persons with low vision, however, means that they have limited knowledge on how to live positively with or how to care for others who are either infected and affected (Alice, Sangok and Patrick, 2013). Failure to exhaustively and accurately communicate important HIV/AIDS information puts PVIs at risk for HIV/AIDS and other sexually transmitted infections (Philander and Swartz, 2006). Research concerning HIV Prevention among PVIs shows that more work is needed in the area of HIV and AIDS prevention for PVIs (Philander and Swartz, 2006). This is because PVIs might be the most vulnerable victims since they are likely not only to be affected by common HIV and AIDS related health problems, but also by HIV and AIDS as a driving factor to visual impairment as described in the section that follows.

1.1.5 HIV and AIDS as a Driving Factor to Visual Impairment

Blindness and visual impairment are public health problems that already constitute important social-economic burden in Sub—Saharan Africa (Boitte, Omgbwa and Traoré, 2005). There is relationship between HIV and AIDS and visual impairment because HIV and AIDS can result in visual impairment since it can cause HIV and AIDS - related eye problems such as red eyes, cancer of eyelids and eyeballs, swollen eyelids and vision loss or blindness (Melwa and Oduntanb, 2O12). This relationship shows that the consequence of HIV and AIDS infections, harmful opportunistic organisms may gain access into human eyes and become threats to the eyes (Boitte, Omgbwa and Traoré, 2005). This suggests the need for awareness programmes to vulnerable individuals including PVIs whose eyes are likely to cquire HIV and AIDS related eye- health problems and worsen the condition of their eyes.

Within these considerations the researcher’s choice of GVIs as major study participants makes sense. The vulnerability of this group to HIV and AIDS is not compounded not only by their social and biological factors as females but also by the HIV and AIDS related eye problems if the GVIs happen to contract HIV and AIDS. It was important to focus on school-based interventions in which adolescents such as GVIs are expected to be assisted to develop healthy behavior so as to avoid contracting HIV and AIDS that are potentially lethal in causing eye problems related to the diseases.

1.1.6 School-based HIV and AIDS Interventions

Intervention is a process that provides skills and strategies to modify an individual's behaviour (Bowen, Horward and Jenson, 2004; Roberts, 2002). HIV and AIDS interventions constitutes interventions designed to targeted group for empowering them with skills and strategies that can enable them to translate knowledge, attitudes and values into actual abilities for HIV and AIDS protection. HIV and AIDS interventions are designed to target various settings such as schools, colleges, organizations or communities. School-based interventions are intervention strategies for educating school adolescents about HIV and AIDS (Olveras and Sarma 2013).

HIV and AIDS epidemic vary greatly in different regions of the world, but in each of these epidemics, young people are at the centre in terms of new infections and the greatest potential force for change if the youths can be reached through effective interventions (Dick, Ferguson and Ross, 2006). Since most youths attend schools,

they are expected to develop intended life skills from school-based HIV and AIDS interventions.

In Tanzania, strategies such as Tanzania Third National Multi-Sectoral Strategic Framework for HIV and AIDS (NMSF III) (2013/14 – 2017/18) has provided a common understanding for all HIV and AIDS stakeholders and reflects current normative guidance in the national response effort. By 2018 NMSF III aims at achieving three over aching results of reducing HIV incidence rate from 0.32% of prevalence rate in 2012 to no more than 0.16%, incidence from a baseline of 0.32% in 2012, a significant reduction of AIDS-related deaths and a reduced HIV related stigma and discrimination among People Living with HIV and AIDS in the society (URT), 2013).

Ministry of Education and Vocational Training (MoEVT) is one of the stakeholders interested in HIV and AIDS issues hence, the ministry provides HIV and AIDS education to its staff and students. Among the ministry's effort are interventions based in schools to equip school youths with basic HIV and AIDS information and life skills (Agh and Rosseim, 2004; TACAIDS, 2012). Ministerial interventions target reduction of risky behaviour of sexual intercourse among the most-at-risk and vulnerable populations who include school youths. HIV/AIDS and life skills education curricula contain relevant content of HIV and AIDS and life skills education within the Tanzanian school curricula. The curricula are aimed at enabling teenagers to develop self-awareness and use the acquired knowledge to solve daily problems and challenges (Rushahu, 2015). HIV and AIDS related topics,

objectives and competences are integrated in school syllabi. Further, materials and methods of teaching and learning are suggested with openings for teachers' dynamic innovations.

Panchaud, Pii and Poncet (2005) identify various curriculum approaches used by school HIV and AIDS educators. These approaches include HIV and AIDS as a stand-alone subject, clearly labelled and including all aspects of HIV and AIDS education; HIV and AIDS integrated in one main carrier-subject that contains most of the material to be learned; HIV and AIDS as a cross-curricular issue, integrated in a few subjects clearly defined as containing some specific aspects of HIV and AIDS education, in a complementary and coordinated approach; HIV and AIDS infused throughout the curriculum, with, or without any specific mention of HIV and AIDS in specific subject areas, and in general without defining how to provide a comprehensive and coordinated approach of all topics related to HIV and AIDS.

HIV and AIDS education can also be taught as extra-curricular activities outside classroom. Kamuzora, Karen and Rutagumirwa (2006**)** observed that in Tanzania there were approaches such as integration of HIV and AIDS education in secondary school curriculum and extra-curricular activities aimed at helping students make informed decisions about how to avoid AIDS–related risk behaviours. From these interventions, school youths have attained basic information about HIV and AIDS, which have raised awareness to HIV and AIDS and its consequences (Kyaruzi, 2004). However, available awareness campaigns against HIV and AIDS are not disability friendly (Ministry of Labour, Youth Development and Sports, 2004). The

safe use of a condom is for instance diagrammatically expressed and only meant for those with sight. Imparting of certain skills to the visually impaired can only succeed through an individualized, one-to-one training process, for example, in the demonstration of safe use of condoms. As a result of this deficiency, majority of the PVIs know little about HIV and AIDS related issues and consequently do not utilize the limited available HIV and AIDS services (Alice, Sangok and Patrick, 2013).

This indicates that to gain know and skills and be able to use the learnt intervention approaches is important. Further, distinguishing the skills gained and identifying challenges encountered by various school youth groups such as those with or without disability are very important requirements in assisting school youths to understand what works best for them.

From the overview spelt above, there are several questions that readers may wish to ask, such questions as; “What is the content of the HIV and AIDS school curricula and how is such content taught? Does the content include aspects of HIV and AIDS prevention techniques?”; “How do the teaching processes of the HIV and AIDS prevention contents assist GVIs in generating knowledge and attitudes required in developing healthy behaviours for HIV and AIDS prevention?” and “How are GVIs’ challenged in their intention for HIV and AIDS prevention? According to the empirical literature surveyed so far, such questions have not received attention. Hence, the questions motivated the researcher to initiate this study so as to fill the existing gap. A critical survey of the HIV and AIDS school curricular content, stakeholders’ experiences and instructional approaches employed in the teaching of

HIV and AIDS content were considered rich sources from which the questions posed above could receive appropriate responses and the study's intentions gained.

1.2 Statement of the Problem

The preceding section shows that despite the various interventions to prevent HIV and AIDS the pandemic remains a threat in Tanzania. New infections with worse impact to young women are rampant (Edwards et al, 2005). Women and girls with disabilities in particular, are positioned at increased risks of contracting HIV as a result of their increased exposure to sexual violence (Basu and Menon, 2011). People with physical, intellectual, mental or sensory disabilities are just as likely to encounter risks of HIV infection (Groce, 2004). They are the most vulnerable because disability is always associated with negative attitudes, stigma and misconceptions leading people to think that people with disabilities are not sexually active (Murangira, 2004; Otieno, 2009). Their activities have been restricted because of obstacles imposed to them by societies in which they live (Interagency Coalition on AIDS and Development, 2008).

Despite being sexually active as well as vulnerable to rape attempts and other forms of sexual abuse, people with visual impairments (PVIs) are overlooked within national HIV prevention strategies because policy makers do not perceive such people as sexually active (Sibanda, 2013). There has been minimum effort expended to address the specific needs of disabled people and practice shows that they have been discriminated in HIV and AIDS educational initiatives, as well as in related prevention and treatment programmes (Jones, Maharaj and Padmore, 2009). As a

consequence they have been largely forgotten in HIV and AIDS prevention interventions (TACAIDS et al, 2009).

The Africa Campaign on Disability and HIV and AIDS - spearheaded by Handicap International and the African Union of the Blind - aims to provide equal access to HIV information and services (TACAIDS et al, 2009). However, the general literature on HIV and AIDS is contained in printed materials that PVIs such as GVIs cannot access and read (Macha, 2008). Their reliance on the use of touch puts PVIs, especially women in a vulnerable position. Their inability to read makes HIV information, education and communication programmes inaccessible to them since such material are in developed and supplied in printed materials (South African National AIDS Council, (2007).

While every group has been affected by HIV and AIDS in one way or another, it is the PVIs for whom the repercussion of HIV and AIDS has been severe and by far the most disastrous. PVIs, specifically GVIs are the most affected by the repercussion of HIV and AIDS basing on their characteristics such as been females and youths who are more affected by social and biological factors. Their vulnerability is further exacerbated by HIV and AIDS which can be a driving factor to eye health related problems (Boitte, Omgbwa and Traoré, 2005; Melwa and Oduntanb, 2O12).

Although the Government of the United Republic of Tanzania has developed some HIV and AIDS intervention programmes to address HIV and AIDS, PWDs have received little attention in the implementation of such programmes (Kayunze and Mtauchila, 2014). Therefore, this study on school-based HIV and AIDS interventions

for GVI in secondary schools was conducted with the intention of determining existence and impact of school-based interventions on HIV and AIDS to prevent infections of the disease among GVIs in selected Tanzanian secondary schools.

1.3 The Purpose of the Study

The purpose of this study was to trace the influence of school-based HIV and AIDS interventions aimed at preventing HIV and AIDS among GVIs. It was deemed necessary to explore existing school-based HIV and AIDS interventions to find out how the school curricular contents embedded HIV and AIDS prevention schemes that were relevant and appropriate to learners, specifically GVIs. The researcher considered it important to explore how the school HIV and AIDS curricular contents were taught; how the processes for teaching the HIV and AIDS contents captured HIV and AIDS prevention elements and how such elements assisted GVIs in developing knowledge, skills and attitudes required for their healthy behavior that encouraged or triggered prevention of HIV and AIDS infections. It further aimed at revealing how GVIs were challenged in their attempts to prevent contacting HIV and AIDS. The following were thus the three research objectives developed to guide this study.

1.4 Research Objectives

Three objectives were developed to guide the researcher’s investigation in relation to the quest to find out school-based HIV and AIDS interventions designed to prevent these diseases among secondary school GVIs. These objectives were to:

i. Explore school curriculum contents related to HIV and AIDS interventions for prevention, and how such contents are taught.
ii. Explore how the teaching processes of the contents related to HIV and AIDS prevention assisted GVIs to develop knowledge and attitudes required for the healthy behaviour of HIV and AIDS prevention.
iii. Explore how GVIs were challenged in their intention for preventing HIV and AIDS infections.

1.5 Research Questions

In line with the research objectives stated above (item 1.5), the following research questions were developed:

i. What are the school curriculum contents related to HIV and AIDS prevention and how are such content taught as school-based interventions?
ii. How do the teaching processes of the contents related to HIV and AIDS prevention assist GVIs in developing knowledge and attitudes required for the healthy behaviours for HIV and AIDS prevention?
iii. How are GVIs challenged in their intention for HIV and AIDS prevention?

1.6 Significance of the Study

The study has the potential of raising awareness among Tanzanian citizens, especially secondary school GVIs about school-based HIV and AIDS interventions and the influence of HIV and AIDS prevention among GVIs. Specifically, the study had the potential of raising awareness of the HIV and AIDS related topics that are

embedded in the school curriculum and how such topics are taught. Likewise the study has the potential of raising awareness of how teaching processes of life skills-related contents assist GVIs in developing knowledge and attitudes required for healthy behaviour for HIV and IDS prevention. Further, the study had potential of raising awareness on how GVIs are challenged in their intention for HIV and AIDS prevention. Given such awareness the findings of this study are potential in responding to TACAIDS et al (2009) suggestion of adjusting and adapting the Tanzanian current responses to HIV and AIDS in order to reach school AWDs such as GVIs in school-based interventions.

The study can also trigger positive political actions in addressing HIV and AIDS school-based intervention through designing policies that proactively prioritize resources allocation to secondary schools to enable such schools develop infrastructure and procure tools that are suitable for the delivery of HIV and AIDS related curricular.

1.7 Limitations of the Study

The following factors were regarded as limitations of this study. First, some respondents did not honestly respond to interview questions because they feared to disclose information they considered confidential. On this basis, the findings might not be comprehensively reliable. To minimize this limitation, the researcher established good rapport with the study participants, so as to inform them of the rationale of the study. Further, the researcher assured respondents of keeping their names confidential during and after the research.

The second limitation was the fact that HIV and AIDS topics were not openly and clearly stated in the curricular but were only posed by implications, Biology and Civics subject teachers could decide not to teach such topics. In secondary schools where such a thing happened, students are most likely to graduate from the secondary schools without the necessary knowledge and skills to prevent contacting HIV and AIDS infections.

1.8 Delimitations

This section provides characteristics limiting the scope of the investigation as determined by the exclusionary and inclusionary decisions that were made when the proposal was developed. The choice of the research problem as opposed to other related problems that could have been chosen but were rejected or were screened off from enquiry is delimitated by the fact that HIV and AIDS intervention and healthy behaviour for HIV and AIDS prevention is a vast subject of study. It has many components which are difficult to study in depth. The study confined itself to School-based HIV and AIDS interventions for GVIs in secondary schools. Other sexuality transmitted infections (STIs) caused by unsafe sexual practices, were not considered and as opposed to HIV which is incurable and devastating, most of the other STIs are curable.

Girls and women are more vulnerable to HIV and AIDS than men but women and girls with disabilities are the most vulnerable. Since it was not easy to address all disabilities for all women and girls, participation of this study was delimited to Form One to Four girls with visual disabilities studying in secondary schools which had

been in the schools for at least one year. Participation was also delimited to teachers teaching Biology and Civics in secondary schools because the focus of the study was on subjects to which HIV and AIDS related issues were embedded.

The research was delimited to methods including one-to-one interviews, focus group discussion (FGD) and documentary review. Participant observation method which involves participating in a situation, while, at the same time, recording what is being observed (Brown, Holtham and Lacono, 2009) was not used. This was due to time constraint because it requires a considerable amount of time in the field. Participant observations could have highlighted other aspects of the exploration because the method could provide the researcher with ways to check for nonverbal expression of feelings, determine interaction in the teaching and learning processes, grasp how participants communicate with each other and check on how much time was spent on different teaching and learning activities. For instance, participant observation would allow the researcher to observe demonstrations on the use of male condoms and note situations that the GVIs were unable to participate because of disability challenges.

This could make the researcher aware of misrepresentations or imprecisions about GVIs characteristics such as low self-esteem and lack of confidence justifying why GVIs were seemingly excluded from the active participation in the teaching and learning processes. To address this concern, interview themes and the interview guide were verified to ensure that all the questions were appropriately phrased to capture sensitive issues which were considered necessary to understand GVIs participation from their characteristic point of view which were not raised directly.

1.9 Behaviour Models and Emerging Conceptual Framework for this Study

Conceptual framework is a network of interlinked concepts that together provide a comprehensive understanding of a phenomenon or phenomena (Jabareen, 2009). It is a written or visual presentation that explains either graphically or in narrative form, main or key factors, concepts or variables to be studied and the presumed relationships among them (Huberman and Miles, 1994).

Conceptual framework outlines major aspects of inquiry in relation to problem definition, purpose, literature review, methodology, data collection and analysis (Shields and Tajalli, 2006). In light of these definitions, conceptual framework is a theoretical sketch which outlines a guiding mental map giving direction of the relationships of variables which are to be studied, the way these variables will be studied and the way they might affect each other to yield the intended findings.

The conceptual framework in Figure 1.3 guided this study. It was developed from the Theory of Planned Behaviour (TPB) developed by Ajzen (1991) presented in Figure 1.1 and Behaviour Change Model (BCM) developed by Peace Corps (2000) presented in Figure 1.2.

1.9.1 The Theory of Planned Behaviour

Theory of Planned Behaviour (TPB) is important and applicable in this research because it explains how human action is guided by beliefs. As indicated in Figure 1.1, there are beliefs about the likely outcomes of behaviour and the evaluations of the outcomes referred to as behavioural beliefs. Figure 1.1 is the Model for the TPB.

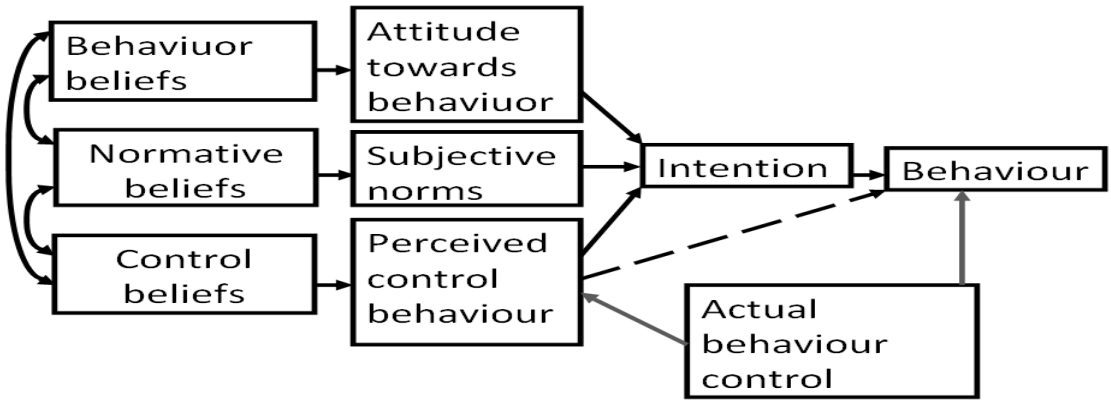

Figure 1.1: The Model for the Theory of Planned Behaviour

Source: Ajzen (1991)

Beliefs about the normative expectations are expectations according to the standard accepted of others and motivation to comply with the expectations. This condition is referred to as normative belief. Belief about presence (or existence) of factors that may facilitate or impede performance of the behaviour and the perceived power referred to as control beliefs. In their respective aggregate, behavioural beliefs produce a favourable (or unfavourable) attitude toward certain behaviour. Normative beliefs result in perceived social pressure or subjective norm and control beliefs which give rise to perceived behavioural control.

Attitude toward individuals' behaviour is an individual's positive (or negative) evaluation of self-performance of the particular behaviour. It is the degree to which performance of the behaviour is positively (or negatively) valued. It is determined by the total set of accessible behavioural beliefs which are an individual's belief about the consequences of particular behaviour linking the behaviour to various outcomes and other attributes.

Subjective norms are perceived social pressures to perform (or not to perform) preferred behaviours and perceived behavioural control is the perceived ease or difficulty of performing the behaviour. Perceived behavioural control has two aspects; how much control a person has over the behaviour and how confident he/she feels about being able (or unable) to perform the behaviour. Perceived behaviour control is determined by control beliefs about the power of both external and internal factors to inhibit or to facilitate the performance of the intended behaviour. In combination, behavioural attitude, subjective norms and perceived behaviour control lead to the formation of behavioural intentions. Perceived behavioural control is presumed to affect the actual behaviour both directly and indirectly through behavioural intentions. The extent to which an individual perceive that he/she has control over the intended behaviour can stand for actual behaviour control and contribute to the prediction of the behaviour under consideration. The more the attitude and the subjective norms are favourable the greater the perceived control of the intended behaviour.

1.9.2 Behaviour Change Model

The Behaviour Change Model (BCM) proposed by Peace Corps (2000) is illustrated in Figure 1.2. It demonstrates a visual form of presenting life skills for behaviour change among young people.

In line with behavioural attitude, subjective norms and perceived behaviour control lead to the formation of behavioural intention which signifies that skills are important elements of school based intervention. BCM indicates that skills act as

useful planks that form a bridge to enable young people move safely to positive healthy life styles. Performance of healthy behaviours also depends on overall methods that help clients to overcome challenges and then practice positive healthy behaviours.

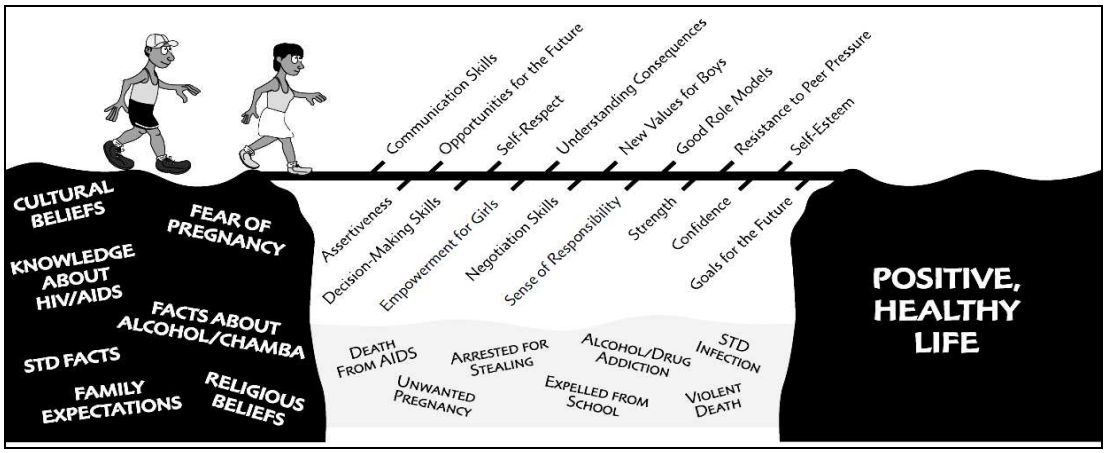

Figure 1.2: Behaviour Change Model

Source: Peace Corps (2000)

In order to form a behavioral intention and perform actual behaviour (delineated in TPB) performance of some behaviours such as healthy HIV and AIDS behaviour among school adolescents depends to some degree on factors such as life skills. These can be developed through school-based interventions programmes (Peace Corps, 2000; O'Hare, 2009). As depicted in Figure 1.3 life skills and other variables including teaching methods and materials are predictor variables integrated in figure 1.3 and described below in section 1.10.

1.10 Integrating BCM and TPB into the Conceptual Framework of the Study

This section summarizes the conceived factors from the TPB and BCM into the conceptual framework of the study. With reference to GVIs in schools, who were the

main focus of this research, HIV and AIDS prevention is aimed at assisting their understanding of the life skills such as decision making, communication, refusal skills that are taught in secondary school-based HIV and AIDS intervention programmes. Understanding ways through life skills are developed and the challenges encountered as presented in Figure 1.3 as well as the role these two factors play in enabling GVIs make choices is essential in predicting behavioural intention for HIV and AIDS prevention. Figure 1.3 was therefore based on various variables comprised of several factors conceived after a thorough study of TPB and BCM in relation to the specific objectives for this study.

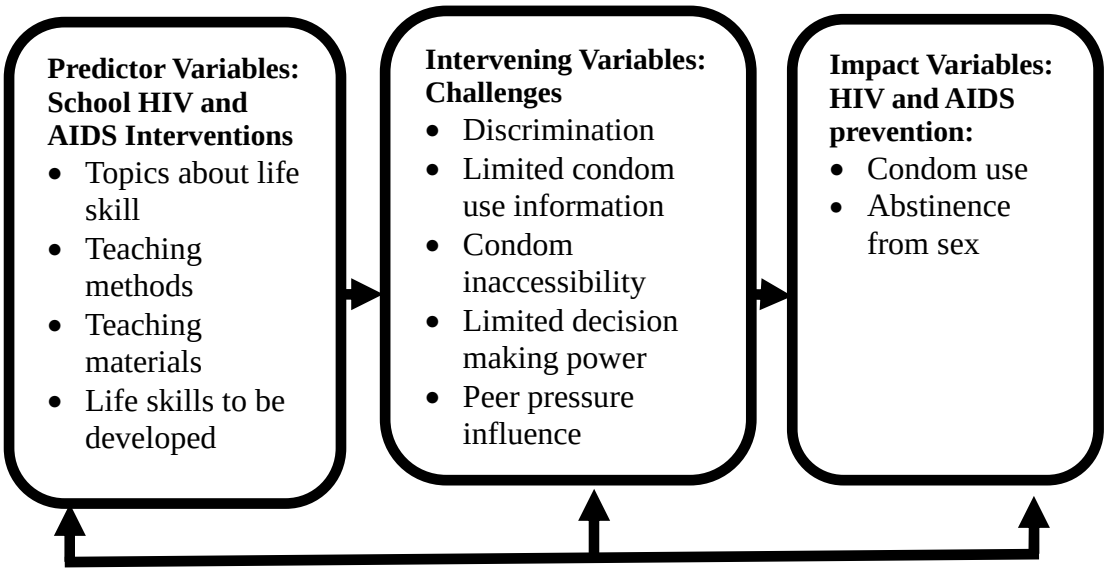

Figure 1.3: The impact School Based Intervention on HIV and AIDS prevention

Figure 1.3 was developed by the researcher as a guide for explaining the impact of the secondary school based interventions. The conceptual framework was developed based on the assumption that no one concept could be used to provide a framework to describe all the potential factors in a useful way in the attempt to explain the

impact of secondary school-based interventions on GVIs' behaviour for HIV and AIDS prevention. The conceptual framework was thus based on TPB and BCM as well as on the framework's role of providing the research with a general focus enabling defining the research variables and the way they relate to each other as shown in figure 1.3.

The conceptual framework indicates three major components of variables namely predictor, intervening and outcome variables. The predictor variables comprise of School HIV and AIDS Interventions as major dependable variables to which other variables such as life skill-related topics, teaching methods, teaching materials and Life skills that GVIs achieve from the school-based interventions.

The study was based on the assumption that predicting variables determine the impact variables. It was also based on the assumption that intervening variables as the factors which occur as outcomes of pressure from predicting variables or from social context that may condition a GVI sooner or later in terms of attendance to the classes, participation and monitoring of their achievement. Intervening variables include prejudice or discrimination, condom use information, condom accessibility, the power for decision making, influence of peer pressure, and sexual violence. The variables may influence the impact variables which in turn could lead to HIV and AIDS prevention intervention as a major impact variable that involves intention for condom use and intention for abstinence from sexual intercourse. Although reducing a number of sexual partners is also an explicit impact variable, it was not included in the impact variable for this study.

When the methods and materials of teaching life skill topics are not conducive, they may cause GVIs' poor participation, and even unproductive life skills. School-based interventions characterized by explanations, demonstrations or whole class discussion methods and non-Braille materials that do not focus on the needs of the GVIs may limit their skills to act responsibly in HIV and AIDS prevention. Poor skill-based depiction among GVIs, which might have been influenced by poor quality of school-based interventions implemented, may also be influenced by social factors which may also cause poor acquisition of skills, failure to use condom and rely on abstinence from sexual intercourse as the only behaviour intention. Despite GVIs' intention for abstinence from sex, they may fall into risky behaviours such as unsafe sex when they decide to engage in sex and contract HIV which can lead to AIDS due to lack of skills in condom use.

1.11 Summary

This chapter provides the background to the research problem. The chapter begins with an introduction to the research problem with a focus on HIV and AIDS as a cross cutting issue (CCI) which has had negative impact across the world.

The background sets the foundation of the research problem highlighting school-based interventions which have been considered the main predictor variables as the impact variables (HIV and AIDS prevention intentions) for this study. School-based interventions, which are targeted for promoting life skills, have been considered crucial although statistics show that young PWDs are engaged in sexual practice even at the teen age phase of their lives. This is an age at which most of them are school youths. The background to the research problem also indicates that although

PWDs, including AWDs, are sexually active they are considered asexual and that they lack sexual health information because policy makers and other major actors in HIV and AIDS prevention hardly acknowledge the needs of PWDs within the HIV and AIDS context.

The statement of the research problem, purpose of the study, research objectives and research questions were formulated on the preceding background information. Following suit, the significance of the study, its limitations and delimitations have been stated. The chapter ends with interlinking concepts and provides an explanation to clarify the research problem through visual presentations that provide the main factors studied in their presumed relationships as provided in Figure 1.3.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

This chapter presents a review of literature related to this study. The review narrates what was already known about the research problem. The literature review was aimed at reviewing theories used to explain the subject matter under investigation as a basis for reflecting on questions that were still unanswered and what had not yet been studied about school-based HIV and AIDS interventions and their impact on HIV and AIDS prevention among GVIs.

To date there is no vaccine for HIV and AIDS prevention. Neither is there cure for AIDS. However, HIV and AIDS prevention is possible. The literature to a variety of issues including some practices developed to prevent the spread of syndrome. From the review, it is noted that there are several ways that can be employed for HIV and AIDS preventions. WHO (2004) observed that HIV and AIDS prevention includes abstinence from sex. Another preventive measure involves having sex with only one partner who is neither a drunkard nor a drug abuser, a partner who observes safe sex principles and is willing to use safe sex materials such as male and female condoms. Such a partner should, have few or no other sex partners and always use new unused needles.

Furthermore, if a woman is pregnant and is HIV positive, she may receive treatment during pregnancy to reduce the baby's risk to contract HIV infection. Besides, HIV positive mothers should not nurse their children because HIV can be transmitted

from mother to child via breast milk. Such mothers should receive alternative options from their physicians on how to feed their babies. However, it should be known that getting tested is the only way to be sure of the HIV status and in case the test is negative, health care providers ought to provide required information about what is to be done to sustain the negative HIV condition. If the HIV test indicate positive, counselling should be provided to prevent the spread of HIV and to encourage the tested person to consider the condition a challenge that can be positively addressed. The positively tested person should also be instructed on mechanisms to be employed to ensure that he/she continues with the HIV status without developing into the second stage of the disease, i.e., AIDS.

In order to educate people about these prevention measures HIV and AIDS prevention education programmes have been developed. There are programmes which are based at work places, communities, colleges and schools to mention but a few. For instance school-based HIV and AIDS prevention education programmes are programmes that are aimed at decreasing sexual risky behaviours among school youths including delaying first sexual intercourse; reducing the number of sexual partners (Addy, Escobar-Chavez, Markham, Peskin, and Shegog, 2010). These programmes are also aimed at decreasing the number of times school youths have unprotected sex and increasing condom use (Banspach, Baumler, Coyle, Glassman and Kirby, 2006).

Knowledge about HIV and AIDS can be considered with respect to at least mode of HIV transmission, knowledge about HIV and AIDS prevention, and misconception

about means of HIV transmission (Barnett and Whiteside, 2006). Exploring the knowledge about HIV and AIDS can be effective when targeted at a specific group that is particularly at risk of HIV infection. As such GVIs are among individuals whose vulnerability is not only based on biological and social factors described in the preceding sections but also on HIV and AIDS eye health related factor described in the section that follows.

2.2 General Information on Persons with Visually Impairments

By 2012, there was still low attention to PWDs shown by the fact that, until 2012, it was only 71 countries which reported that their multi-sectoral AIDS strategies had integrated efforts to address PWDs (UNAIDS 2013). It was reported by Semkuya (2006) in Kayunze and Mtauchila (2014) that Tanzania was one on the countries in which there was low attention to the PWDs specifically in Dares Salaam in which HIV and AIDS activities were increasingly being done by only few PWDs who were included in the interventions. Also in HIV and AIDS campaigns people with disabilities' inclusion and participation was inadequate.

Knowledge about HIV and AIDS in Tanzania is high (TACAIDS et al, 2012) but PWDs have hardly been reached (Kayunze and Mtauchila, 2014). Worse still, girls and women have until recently been highly invisible in both research and intervention programs (Aase, 2013) because programmes geared toward the vulnerable groups, have not been adequately addressing the specific needs of the PWDs (U T, 2007). Girls and women with disabilities have been experience even more discrimination than men with disabilities and women without disabilities

(Pelaez, 2010). Thus women with disabilities experience the combined disadvantages associated with gender and disability.

While disability correlates with disadvantage, not all PWDs are equally disadvantaged (Nagata, 2003). Individuals such as PVIs can be among individuals who are more disadvantaged because HIV causes a breakdown of body's immune system and all areas of the body are susceptible to infection, including the eye (American Academy of Ophthalmology, 2012) the part of the body of PVIs which is already affected. To prevent HIV among PVIs such as GVIs is central in the prevention of health conditions associated with disability and it can reduce the incidence of health conditions leading to deteriorating the their disability.

2.2.1 GVIs' Information about HIV and AIDS

Visually impaired youths have various mistaken ideas about HIV and AIDS and sexuality because they have less access to information on HIV and AIDS and sexuality than do their non-handicapped peers (Groce, 2003). All the same visual impairment is likely to influence the amount of HIV and AIDS information a visually challenged person has access to. It may limit accessibility to some kind of HIV and AIDS information thus negatively affecting the level of knowledge that a visually impaired person may possess. In turn this affects perception of risk of infection with HIV and AIDS and consequently their attitude towards safer sex practices (Lydia, 2010).

Findings show that, in Tanzania, school-based interventions have impacts in HIV and AIDS prevention among adolescents (Kyaruzi, 2004). However, adolescents such as

GVIs are less likely to receive information and resources to ensure safe sex because common prevention programmes do not include disability-specific approaches. They are more likely to be excluded from or deprived of education, particularly sex education (Hanass- Hancock, 2009). Tanzania needs to adjust and adapt its current HIV and AIDS response in order to reach PVIs (TACAIDS et al, 2009) because there is still silence in this area of study.

2.2.2 School-based Interventions and HIV and AIDS Prevention among GVIs

HIV and AIDS have reached epidemic level among young people and it has been one of the most threatening behaviour problems. HIV and AIDS education for young people plays a vital role in global efforts to end the AIDS epidemic. In 2012, more than one third of all new HIV infections were among young people aged 15-24 (780,000). While this number is falling, HIV-related deaths have been on the rise among this group (WHO, 2014). Success in bringing to an end the further spread of HIV and AIDS depends largely on the efforts taken (Nyirenda and Schenker, 2002) to ensure that the intended knowledge, skills and attitudes required for HIV and AIDS prevention reach children and youths in time. This effort can reinforce school youths' positive health behaviours and halt unhealthy behaviours that put them at HIV and AIDS risk.

Schools are the key settings for educating children about HIV and AIDS and for bringing to an end further spread of HIV and AIDS infection. Specifically the central obligation of schools in fighting HIV infection is to teach young people to either avoid HIV infections or to serve as a catalyst for the development of HIV and AIDS-

related policies that are grounded on the most recent scientific knowledge about HIV and AIDS (Nyirenda and Schenker, 2002). Thus effective School-based HIV and AIDS intervention programmes are needed to reach children and adolescents between the age of 5 and 8 who can learn and interact with each other to protect themselves against HIV and AIDS. In line with this view, schools-based HIV and AIDS intervention programmes are responsible to plan and use effective approaches to increase accurate knowledge about life skills to young people for consistent practice of healthy behaviours for HIV and AIDS prevention (Griffiths, 2005).

Centres for Disease Control and Prevention (2014) identified two kinds of HIV and AIDS/STIs prevention programmes implemented by schools. These include prevention education programmes designed specifically to reduce sexual risk behaviour and youth assert-development programmes which provide adolescents with more general skills and help them engage in behaviours and solve problems.

School-based HIV prevention programmes can significantly reduce sexual risk behaviours among students (Centres for Disease Control and Prevention, 2014) because information, knowledge, and life skills developed from such interventions can promote HIV and AIDS prevention (UNESCO, 2005). While HIV and AIDS educators identify enduring and effective programme that have impact to PWDs' HIV and AIDS related behaviour, there are aspects of disabilities which are obviously considered impediment. For instance, GVIs can be excluded from intervention activities with a view that they are unable to perform tasks. Nonetheless given opportunity, PVIs can learn just like the non-visually impaired peers and make

healthier choices associated to HIV and AIDS (Miller, 2006) and reduce sexual risk-taking behaviour by using life skills.

Youth Asset-Development Programs are intervention programmes that seek to increase the skills of children and adolescents to avoid health risk, including sexual risk behaviours. Such programmes include those conducted in schools and teach youth how to solve problems, communicate with others and plan for the future. They also help youths develop positive connections with parents, schools and communities. Such programmes typically address multiple health behaviours (Catalano, David-Ferdon, Gavin, Gloppen and Markham, 2010). However, while all adolescents are at risk, some adolescents are at increased risk due to factors related to biological and social factors gender and age (Tigawalana 2010; UNESCO, 2010) and disability (TACAIDS et al, 2009).

GVIs can gain key attributes of competences and confidence despite myths that the general public holds about PVIs including belief that they are asexual (Philander and Swartz, 2006). This attitudinal barrier can exclude GVIs from participating in various activities planned for HIV and AIDS prevention awareness for them due to lack of activities which suit their needs. Vision Aid Team (2012) noted that, GVIs could be trained, with the help of vision enhancement, vision rehabilitation, and assistive technology to perform most daily tasks more confidently at home, and in school.

Thus by exposing things out in a form of well planned activities that include all individuals despite their diversities, some form of awareness is created. For instance, with HIV and AIDS Brail materials and activities that actively involve them in

practicing the use of life skills for HIV and AIDS prevention, HIV and AIDS educators can make the HIV and AIDS pandemic perceptible among individuals with disabilities such as GVIs.

Well implemented school-based HIV and AIDS prevention programmes have shown to reduce HIV and AIDS particularly when they go beyond the provision of information, and help young people to gain knowledge, attitudes and life skills needed to protect themselves against HIV and AIDS (UNICEF, (2003). As discussed earlier, gender, biological, social and disability related factors should also be a focus of the programmes so that all adolescent benefit from the HIV and AIDS programme despite their differential factors affecting them.

2.3 The Role of Life Skills

Life skills is a comprehensive behaviour change approach that goes beyond providing information to the development of whole individual and concentrates on the development of the skills needed for communication, decision–making, problem solving thinking, managing emotions, assertiveness, self–esteem building, resisting peer pressure, and relationship building (Peace Corps, 2000). Life skills focus on knowledge, attitudes and interpersonal skills. They support people/children for taking a greater responsibility of their own lives. Life skill-based education addresses real life application of knowledge, attitudes and skills and makes use of participatory and interactive teaching and learning methods (Dhanya and Safeera, 2013) and enable individuals to deal effectively with the demands and challenges of everyday life (WHO, 1997). Approaches designed for prevention of HIV are based on principles.

One of these principles in life skill approaches is that knowledge, attitudes and skills are the focus, as opposed to the traditional focus which is based on knowledge as the only pre-requisite for HIV and AIDS prevention. The following are roles of life skills approaches.

2.3.1 Translating Knowledge, Attitudes and Values into Practices

Most individuals have knowledge, attitudes and values about a certain preferred behaviour. However, they have failed to adhere to the preferred behaviour because they lack actual abilities to act. Abilities to act are mainly life skills whose role is to develop a person's ability to comprehend the basic knowledge of HIV and AIDS infection and develop positive attitudes and values which are associated with the prevention of HIV and AIDS (The Centre for British Teachers, 2006). People become the behaviour change agents among their peers and within the general community (The World Bank, 2008). Life skills link knowledge, attitude and values with the preferred behaviour. Consequently, in HIV and AIDS interventions, given life skills, an individual can figure out knowledge provided about HIV and AIDS. With life skills, an individual can develop positive attitudes and values linked to healthy behaviours and act responsibly (Peace Corps, 2000).

In school-based interventions for HIV and AIDS prevention, the major target is to encourage sexual behavioural changes among students and school staff. One of the factors with potential to positively contribute to behavioural change among school youths is raising awareness to the pandemic and utilization of positive life skills. Such skills are important to enable school members translate knowledge, skills,

attitudes and values into positive healthy practices. Hence, it is expected adolescents in schools can acquire specific life skills guiding them to behave in a manner that prevent them from contracting HIV.

2.3.2 Delaying the Age of First Sexual Intercourse

Teenagers' sexual experiences are complicated and such experiences influence their future development and relationship (Prigg, 2012).On average, teenagers have sex for the first time at about age 17 (Abma, Chandra, Jones, Martinez and Mosher, 2002). Eventually, they are likely to be infected by HIV while they are still young. As HIV and AIDS has reached epidemic level among young people, sexual intercourse at early ages is one of the most threatening behaviour problems that have resulted in negative outcomes such as early pregnancies, HIV and AIDS and other STIs.

The most obvious ways for teenagers to avoid early and unintended pregnancy, childbearing, and STIs are by delaying sexual initiation or if teenagers are sexually experienced, by reducing levels of sexual activity and the number of sexual partners and by increasing condom use (Cottingham, Humen, Manlove and Terry, 2006).

Life skills education has proven more effective and is required to delay the first sexual intercourse and increase safe sex behaviour among sexually active youths through increasing use of condoms and minimizing the number of sexual partners, among teenagers (Ruchismita, 2011). Peace Corps (2000) noted that where life skills were well developed and practiced, they developed full potential of individuals by promoting the state of mental well being as this motivated them to promote risk free

behaviour and further, enabled effective communication, decision–making, problem solving, reflective thinking, managing emotions, assertiveness, self–esteem building, resisting peer pressure, and relationship building.

2.3.3 Avoiding and Overcoming Obstacles in Relationships

From birth, people interact with others in their lives and they live every day in the context of relationships but when these relationships are unhealthy, the effects can be overwhelming to a human being. Due to obstacles, people have experienced poor healthy relationships. In their study, AIDS Campaign Team for Africa (2010) found out that young people including physically challenged girls such as girls with visual and hearing impairment faced obstacles in sexual relationships. They were sexually abused and faced enormous obstacles in reporting sexual and gender based violence and other types of violence and in bringing perpetrators to justice.

Various scholars have tried to answer the question; “How can young people avoid and overcome obstacles in building healthy relationship?” Kerpelman and Kelly (2012) demonstrated that in order to avoid and overcome obstacles among adolescents, life skills could be utilized in maintaining good communication with relationships based on commitment and loving prior to engaging in sexual activity. They could work through disagreements in a productive way, and build respect, intimacy and trust within a romantic relationship and express their views and needs, wishes and uncertainties and seek for information, advice and support. In this way they could avoid unhealthy risk-taking and get help sooner if they found themselves in a physical or emotional upheaval, uncompromising relationship, and dating

violence involving sexual abuse or psychological and emotional abuse. Further, life skills could provide youths with self-awareness so that they could recognize themselves, their characters, strengths, weaknesses desires and dislikes. These skills could enable them to imagine, and understand with tolerance, what life was like to other persons.

On the one hand this synopsis suggests that the condition to bring change from unhealthy to healthy HIV and AIDS related behaviour is automatically available either to PWDs or to people without disabilities. On the other hand this is not the case because of individual differences mainly caused by disability or other social or biological factors that can limit PWDs in using skills and strategies for acting responsibly. This impression is consistent to Groce, Trasi and Yousafzai (2008) who declares that HIV and AIDS prevention education may not reach all the intended individuals for whom they could have positive benefits. For instance, radio campaigns will not reach individuals who are deaf or those who have hearing impairments, billboard and print campaigns will not reach those who are visually impaired. AIDS messages, that convey too much information, or that use euphemism for AIDS and safe sex may be confusing to individuals with intellectual impairment.

2.4 Impact of School-Based HIV and AIDS Prevention on School Adolescents

Literature review shows that various studies have been undertaken to provide information on the impact of the school-based HIV and AIDS prevention interventions implemented in schools. Fisher, Kuller and Ma (2014) did a survey in United States among High-school students participating in youth risk behavior.

Multiple regression models assessed the association between HIV and AIDS education and risky sexual behaviours, and academic grades. HIV and AIDS education was associated with delayed age at first sexual intercourse, reduced number of sex partners, reduced likelihood to have forced sexual intercourse and better academic grades, for sexually active male students, but not for female students. Both male and female students who had HIV and AIDS education were less likely to inject drugs, drink alcohol or use drugs before last sexual intercourse, and more likely to use condoms. Minority ethnic female students were more likely to have HIV testing. Risk behaviour reduction indicated in this survey implies that the intended school youths were able to use knowledge and skills to act responsibly.

Ang, Kinsler, Morisky and Sneed (2004) evaluated intervention for HIV and AIDS prevention among Belizean adolescents. The purpose of the study was to evaluate the impact of a cognitive-behavioral peer-facilitated school-based HIV and AIDS education program on knowledge, attitudes and behavior among primary and secondary students in Belize. One hundred and fifty students were recruited from six schools in Belize City.

A quasi-experimental research design was used to assess the impact of a 3-month intervention. Seventy-five students received the intervention and 75 students served as controls. At the follow-up assessment, the intervention group showed higher HIV knowledge, was more likely to report condom use, had more positive attitudes toward condoms and adolescents were more likely to report future intentions to use condoms than the students in the control group.

Overall, the findings indicated that the intervention had a positive impact on participants. Given the current situation of HIV and AIDS, especially among adolescents, this study has important lesson for HIV and AIDS educators in implementing effective school-based interventions to adolescents.

Overall, these western based studies suggested that HIV and AIDS intervention programmes could have impacts on behaviours among young people. However, these studies did not conclude whether (or not) such programmes had the same impact on adolescents in developing countries. Neither do the studies imply that the programmes had the same impact on school adolescents with disabilities such as GVIs in secondary school. The most important lesson learned from the findings of these studies is that they had impact on behaviour because they met the needs of effective programmes for behaviour change.

In developing countries, researchers have studied the impacts of HIV and AIDS interventions. Agh and Rossem (2004) for instance did a study to determine whether school-based intervention in Zambian secondary schools had impact on adolescents' belief about abstinence, and condom use. The study revealed that the intervention programmes reduced multiple sexual partnerships and increased the use of condom and positive changes for preventing unwanted pregnancy and sexually transmitted diseases. The snag with this study is researchers silence in acknowledging the existence of youths with disabilities as if the findings are applicable or generalizable to youths of all status. Benner and Card (2008) indicated that prevention programmes among African-American adolescents had effective prevention strategies which

improved knowledge and attitudes on HIV and AIDS and STIs prevention. Further, in an evaluation of thirty nine programmes on peer health education program in developing countries, James, Magnani, Murray, Senderowitz and Speizer (2002) found out that there was an increased use of modern contraceptive methods and increased the use of condom among youths in the case study versus youths who did not participate in the study.

Brieger (2001) evaluated peer education programmes in schools and out-of-school settings in Ghana and Nigeria. Findings showed that, youths who were involved in the programme increased the use of condom from 47% to 56%. These researchers have however remained silent about the impact of school-based HIV and AIDS prevention interventions on individuals with disabilities such as GVIs and their intentions for practicing healthy behaviours.

Kamuzora and Rutagumirwa (2006) did a study in Tanzania which sought to examine the extent to which HIV and AIDS prevention interventions in Tanzanian secondary schools are participatory. They found out that HIV and AIDS intervention education was integrated in the school extra-curricular activities. In this approach there were activities such as role plays, debate, drama, songs, poems, comedies, bongo hip hop music, sports and games, cartoon drawing, article writing and activities based on riding bicycles as part of physical exercises (Kamuzora and Rutagumirwa, 2006**).** Some of these activities might be challenging and are likely to limit the intended impact to adolescents with disabilities (AWDs) such as GVIs. For instance GVIs

cannot ride the type of bicycles procured for their use at school sports and games events.

Findings showed that although school-based programmes through extra-curricular activities were more participatory in nature compared to outside school programmes in some schools, girls played passive roles in participating in these programmes. It was also noted that since students were joining voluntarily in these programmes; in most cases only students with abilities, talents and interest were active participants. Findings of this study bring into view two issues. First the passive role played by girls is alarming because it is questionable as to how they can make use of the intended knowledge and skills for HIV and AIDS prevention. Second, given that students with abilities, talents and interest join the programmes voluntarily, this situation leaves the readers with several unanswered questions. For instance, do adolescents with disabilities such as GVIs have abilities, talents and interest to join the programmes voluntarily?

Generally, Kamuzora and Rutagumirwa (2006) in their study provided this study with some insight about the likelihood of marginalization of girls in the HIV and AIDS prevention interventions and probably exclusion of girls with disabilities such as GVIs hence contributed to the research problem of this study.

2.5 Impact of School-based HIV and AIDS Interventions on AWVI

Visual impairment can socially isolate a student, impede typical social interactions, or limit social skill development. A student with a visual impairment who is not able

to see facial expressions and subtle body language to participate in conversations and activities may experience awkward and confusing interactions. Social skills that sighted children are able to observe and imitate may need to be taught to a child with a visual impairment (Virginia Development of Education, 2010) in HIV and AIDS/STIs prevention programmes implemented by schools. One of the Education sector priorities in Tanzania for 2011/12 was life skills targeting sexual behaviour change for the improved sexual reproductive health targeting learners at all levels of education (Joint Education Sector Annual Review, 2012).

In view of this priority, the impact of school-based interventions on the actual intention on performing healthy behaviours for HIV and AIDS prevention among individuals with disabilities such as AWDs brings into view questions such as: Which are the experiences of GVIs in schools? In a focus group discussion undertaken with Malawi Union of the Blind, Suka (2006) found out that sometimes students with disabilities were likely to come across negative experiences. These experiences included threats and actual sexual abuse from specialist teachers, class room (contact) teachers and blind boys. Others experiences included false promises for marriage as proposed by visually impaired adults in leadership positions in organizations where GVIs study or work.

Edwards, et al (2005) studied the situation experienced by AWDs. Findings revealed that AWDs lacked adequate access to information about HIV and AIDS due to the nature and severity of the impairment, marginalization of disabled people from HIV and AIDS services and low self-esteem. Although these studies focused on

adolescents with disabilities the results may not reflect the experiences of GVIs in particular. After all the nature of this study does not claim that the results would explicate the impact of school-based intervention on GVIs' behaviour for HIV and AIDS.

Kendi, Kinai, and Mweru (2012) did a study to find out HIV and AIDS knowledge level, and perception of risk of infection with HIV and AIDS, of visually impaired and sighted pupils in Kenya. Their study revealed that sighted pupils were more informed than visually impaired pupils who had low levels of knowledge and misconceptions regarding HIV and AIDS issues. This indicated that visually impaired pupils were discriminated in addressing needs concerning their health.

Macha (2008) revealed that in school programmes where visual materials such as video programmes were used, visually impaired individuals did not enjoy. Neither materials such as condoms nor explanation about how to use the condoms were offered to GVIs. Elaborating the situation, printed booklets were offered to visually impaired participants to read while they could not read the materials and no persons were assigned the task to assist the visually impaired girls by reading the booklets to GVIs. This situation demonstrates that GVIs do not benefit from school intervention programmes given that they are not involved in the processes of teaching and learning.

Generally, examining the findings of these researches and literature review in general, one can tell that the impact of the HIV epidemic among GVIs has been a

neglected area and therefore needs to be investigated. When a GVI is infected with HIV and AIDS, she is likely to be neglected, stigmatized, leave school and consequently become poor, intellectually handicapped and die of AIDS. She can become subject to alarming burdens of social and biological factors affecting her as a girl and as an individual with disability.

This review of literature addresses the gaps that exist based on marginalized groups on the ground of disability, gender and HIV and AIDS. Since interventions are common but have unique pathway towards prevention, this situation calls for better understanding of where individuals such as GVIs are in the process of behaviour change towards preventing HIV and AIDS infections in schools.

2.6 Predicting the Impact of HIV and AIDS Interventions among GVIs

In this research the researcher did not intend to investigate the direct evidence of the impact of school interventions on HIV and AIDS prevention such as using condom during sexual intercourse. Rather, the researcher collected data to predict whether GVIs would practice safe behaviours in response to life skills learned from school-based HIV and AIDS interventions.

In order to predict whether an individual will act in a certain way, the simplest way and probably most efficient approach is to ask that person whether he/she intends to do so (Sheth and Wong, 1985). A basic proposition of TPB which guided this study is that the stronger a persons' intention to perform a particular behaviour, the more likely the individual will perform the behaviour but only if she has control over the behaviour (Ajzen, 1991).

Likewise, this research studied the impact of school-based HV and AIDS interventions on HIV and AIDS prevention on the GVIs behaviour for HIV and AIDS prevention in schools. It was based on life skills that GVIs had gained from school-based HIV and AIDS interventions and the way these GVIs were likely to use the skills to practice healthy behaviours such as using condoms and abstinence from sexual intercourse.

2.7 Challenges that GVIs Experience in HIV and AIDS Interventions

HIV and AIDS education in school curriculum has a number of common limitations observed by UNESCO (2006). First, HIV and AIDS education is added to already crowded curricula and there is no enough space and time allocated for it. When the issue of HIV and AIDS is part of the curriculum, it is only covered in a limited manner and is concentrated on the technical or scientific aspects such as ways through which HIV and AIDS is spread, symptoms and prevention measures.

Second, teaching and learning materials about HIV and AIDS are poorly developed and designed or not available. All the same, teaching methods are not appropriate, notably concerning issues related to life skills education for prevention of HIV and AIDS. This is because teachers of HIV and AIDS education are not adequately trained or supported to develop adequate HIV and AIDS materials and methods. Effective interventions during adolescence protect public health investments in child's survival and early child development (WHO, 2014) but limitations presented here are likely to impose challenges to the youths on behaviour change.

Lives of individuals with disabilities such as GVIs are already complicated by their disability. HIV and AIDS interventions might be exacerbating for such individuals and cause challenge. For instance students with disabilities may have few friends and lack support and experience threats (Suka, 2006) and fail to utilize HIV and AIDS information and health services (An Action on Disability and Development, 2005).

In schools, students with special needs require special education services and facilities but they are not available because HIV and AIDS and disability movements worldwide overlook GVIs and partially sighted individuals in planning and implementation of intervention (Blokland, Lovich, Macha, Mittal and Sodergren, 2008). This claim is confirmed by Macha (2008) who noted that HIV and AIDS related topics were taught by using booklets or video programmes and materials such as condoms were neither given to visually impaired girls to feel. They were not provided with explanation about how to use the condoms. Individuals with visual impairment such as GVIs could not see what was happening on the video, read the booklets or use condoms. As such they can remain naive about safe behaviours such as abstinence from sexual intercourse and the use of condom if they indulge in sex.

2.8 Summary

Review of literature indicates that since there is no vaccine or cure for HIV and AIDS, prevention interventions have been developed to prevent the spread of syndromes. Social and biological factors that affect women and girls make them more vulnerable to HIV and AIDS but PWDs are the most vulnerable. In order to educate people about these prevention measures for HIV and AIDS prevention,

education programmes have been developed in various settings such as work places, communities, colleges and schools.

In schools settings, there are HIV and AIDS prevention education programmes aimed at educating the school youths about the spread and prevention of HIV and AIDS. In Tanzania, similar to other countries, school-based interventions have proved to have positive impact in HIV and AIDS prevention but adolescents such as GVIs are less likely to receive information and resources to ensure safe sex because they are more likely to be excluded from or deprived of education, particularly sex education (Hanass- Hancock, 2009). This is because they are considered unable to perform the tasks.

Review of literature indicated that various studies on the impact of school-based interventions show HIV and AIDS education reduces risky behaviours because school adolescents can use knowledge and skills for healthy behaviours. Findings of studies on the experiences of AWDs in schools reveal negative experiences and sexual abuses from classroom teachers and visually impaired boys (Suka, 2006). Studies on HIV and AIDS prevention among AWDs indicate that AWDs have some information about HIV and AIDS but they are marginalized and have low self-esteem Edwards, et al, 2005).

Other studies confirm that due to discrimination visually impaired pupils have low level of knowledge compared to the sighted pupils (Kendi, Kinai, and Mweru, 2012) because the school HIV and AIDS programmes use materials which visually

impaired students could not access information from (Macha, 2008). They have various mistaken ideas about HIV and AIDS and sexuality because they have less access to information on HIV and AIDS and sexuality than do their non-handicapped peers (Groce, 2003). The review of literature also indicated that the role of life skills among adolescents include translating knowledge, attitudes and values into practices. This translation delays the age of first sexual intercourse and enable them to avoid and overcome obstacles in relationships. Studies show that the school-based interventions have impact on behaviour change among school adolescents but visually impaired students do not benefit because materials and methods are not user friendly to them. For example, they could not read the non-Braille materials which were used in teaching. In this case GVIs can be infected with HIV and they are likely to be neglected, stigmatized, leave school and as a result become poor, intellectually handicapped and die of AIDS.

In order to predict whether an individual will act in a certain way, the simplest way and probably most efficient approach is to ask that person whether he/she intends to do so (Sheth and Wong, 1985). Thus predicting the impact of HIV and AIDS interventions among GVIs involved interviewing them on whether they intended to practice safe behaviours in response to life skills learned from school-based HIV and AIDS interventions. Also lliterature review indicated that there are challenges that GVIs experience in HIV and AIDS interventions. Teachers of HIV and AIDS education are not adequately trained or supported to develop adequate HIV and AIDS materials and methods of teaching thus GVIs cannot benefit from HIV and AIDS education.

Although the review of literature found studies which were focused on AWDs, most of these studies did not reveal the link between the life skills from school-based intervention and the actual application of these life skills on the preferred behaviours among GVIs. It is from this review of literature the gap was identified and to address this gap this study focused on the school-based HIV and AIDS interventions for GVI in secondary schools in Tanzania.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 Introduction

This chapter is about research methodology. Methodology in research refers to how the researcher goes about practically finding out whatever he or she believes can be known (Antwi and Hamza, 2015). The purpose of this chapter is to describe the methodological aspect which aims at describing how data was collected, analyzed and interpreted and arrived at the findings, conclusion and recommendations. The chapter begins with an explanation about the research design, followed by a description of the area of the study. Further, it discusses the research population, the sample, sampling technique, data collection, data presentation, data analysis, and interpretations techniques. The chapter concludes with a section about data verification for this study.

Qualitative research explores the inner experiences of individuals that cannot be easily captured by the use of quantitative methods. It is based on participatory perspectives and uses inquiry strategies such as narratives, phenomenology, ethnographies, grounded theory studies or case studies (Creswell, 2010).

A qualitative research generally provides participants the opportunity to express their detailed points of view. Avison and Myers (2002) observe that researchers can better understand the point of view of their study participants from their social context using research instruments such as interviews and focussed group discussions. In

qualitative research there is flexibility to rephrase research questions to enable the research participants to understand the question clearly before they respond. Under this approach, the researcher is also allowed to ask probing questions where necessary to help him/her understand their research participants and social and cultural context within their experiences (Creswell, 2003; Denzin, and Lincoln, 2011; Patton, 2001). The theory underlying qualitative research assumes that reality does not exist 'out there' for everyone to see and experience in the same way (Merriam, 2009), rather people may react differently to varying interviewing systems that are used in social research.

3.2 Research Design

Research design is a strategy or plan of action that links research questions to the choice of research methods and the desired outcomes of research (Creswell, 2010). A research design is a logical task undertaken to ensure that the evidence collected enables researchers to answer questions or to test the validity of theories (De Vaus, 2013). In accordance to this perspective, research design is a logical structure of the inquiry which consistently and logically integrates different components of the study to yield research findings that answer the research questions and provide a ground for solid conclusions and recommendations.

In this study phenomenological design was considered appropriate. A phenomenological research study is a study that attempts to understand people's perceptions, perspectives and understanding of a particular situation (Manen, 2014). The rationale of choosing this design was grounded on the researcher's intention to

explore the authentic, intricate and unnoticed sets of factors such as skills acquired from school-based interventions for developing GVIs' attitudes on healthy behaviours for HIV and AIDS prevention. The act of getting out into the field using phenomenological inquiry enabled the researcher to gain a deeper understanding of GVIs' thoughts, beliefs, interpretations, and feelings about the school-based school-based HIV and AIDS interventions and their behaviour intention for HIV and AIDS prevention in Tanzanian secondary schools.

Another rationale of using this design was associated with the nature of the main research participants who were GVIs. As opposed to qualitative instruments which involve individual interview or focused group interview, quantitative instruments such as questionnaire would necessitate translation of the questionnaires into the brail format to enable GVIs' access, understand and respond to the questionnaires and thereafter translate the same into normal print for the researcher. This would be inappropriate for this study since translation would open up for the likelihood of distorting the intended meanings of the questionnaires and confidentiality.

3.3 Area of the Study

In this study, research work was conducted at Korogwe Girls Secondary School in Tanga Region and in Tabora Girls' Secondary School in Tabora Region. Both secondary schools are in Tanzania and they use the same Biology and Civics syllabi into which HIV and AIDS issues were embedded. The rationale for choosing the two schools was based on the fact that they both enrol GVIs who were the main participants of this research. Since the two schools operate as boarding schools, the

researcher was able to physically meet GVIs individually as well as collectively during and after school hours. The face to face meetings provided conducive and safe spaces where the researcher could freely ‘talk’ with the GVIs about HIV and AIDS and related issues. Further, the heads of the two schools agreed to the researcher’s requests to involve their GVIs in the researcher, the heads were also willing to participate in the research. The heads of schools’ willingness was granted despite that by the time the researcher was to start collecting data, some of the targeted schools were about to conduct their Mock Examinations and the students were busy with preparation for the exams. In other schools teachers who were teaching Biology were busy with preparations of practical lessons. Since these teachers were also targeted in the study because Biology was one of the two lessons subjects in which HIV and AIDS topics were included. It would have been inappropriate to target schools whose teachers would not be available to participate in the study as active participants.

3.4 Population

Research population refers to all members involved in issues or events that the researcher intends to study and draw conclusions (De Vaus, 2013). It is a group of cases or items such as individuals, events, or objects. This population should possess the characteristic that is questioned in a study (Castillo, 2009). Research population or target population can be described as a large group of persons or items with common characteristics or qualities to which the researcher focuses the inquiry so as to yield research data or findings. In most cases, a population is often too large to study in its entity, so researchers mostly decide to select and study only a portion of the population to represent the rest. In this study, population constituted all secondary

school students with disabilities in Tanzanian secondary schools. In 2013, when the researcher collected data for the study, data showed that students with disabilities, who were enrolled in schools had disabilities including albinism, deaf/mute, deaf/blind, mental disabilities, multi impaired, physical impairments and visual impairments. Table 3.1 summarises the number of students with disabilities in secondary schools by disability and sex in Tanzania Mainland in 2013.

Table 3.1 Students with Disabilities in Secondary Schools

Disability	Male	%	Female	%	Total	%
Albino	294	5.51	262	4.91	556	10.42
Deaf/mute	314	5.84	269	5.04	583	10.9
Deaf Blind	156	2.92	123	2.34	279	5.23
Mentally Impaired	130	2.43	92	1.7	222	4.16
Multi Impaired	32	0.60	33	0.61	65	1.21
Physically Impaired	1,850	34.6	1,201	22.52	3,051	57.2
Visual impaired	299	5.6	278	5.21	577	10.8
Total	3075	58	2258	42	5333	100

Source: The United Republic of Tanzania: The National Bureau of Statistics (NBS) (2014)

Statistics in this Table indicate that the total number of students with disabilities in secondary schools in Tanzania Mainland was 5,333. The total number of visually impaired students was 577 while GVIs were 278 and that was 5.21% out of all the visually impaired students and it was 10.8% of all students with disabilities in Tanzania Mainland. Statistics of shows students with disabilities in Secondary Schools by Type and Sex in Tanzania Mainland 2013 is summarized in Table 3.1.

The information in table 3.1 suggests that there was a considerable number of students with disabilities and of these there was also a substantial number of GVIs.

The rationale of using students with disabilities as the study's population was that, within this population GVIs could be identified, the GVIs were highly significant to this study since they were the focus of the research. Students with disabilities provided the researcher with insights about students with different types of disabilities from which the research problem emanated. According to Trull (2005) insight means a total understanding of the unconscious determinants of those irrational feelings, thoughts, or behaviours that are producing one's personal misery. Kendrick (2009) asserts that an insight is the ability to gain a relatively clear and deep understanding of the real, often hidden and usually complex nature of situations or problem.

The purpose of qualitative research is to gain a detailed understanding of a certain phenomenon, to identify socially constructed meaning of the phenomenon and the context in which the phenomenon occurs. This does not only require a small number of participants so that issues can be explored in depth but also necessitates the recruitment of participants with specific characteristics that can best inform the research topic (Bailey, Hennink, and Hutter, 2010). Generally, it would not be easy to study the whole population and therefore the researcher had to determine an appropriate sample to include in the study as presented in the section that follows.

3.5 The Sample and Sample Size

Sample in this context refers to a subgroup of the population selected for participation in a study (Birks and Malhotra, 2007). From this definition, a sample is a smaller group of people selected from the total population from which a researcher

is determined to collect data and draw conclusions of the study. In this study the expected sample of the main participants were 36 GVIs from two selected schools, two teachers who were teaching Civics and two teachers who were teaching Biology from each school. The degree of visual impairment ranged from girls who were totally visually impaired and cannot see at all and those who were partially visual impaired who could see minimally and with a lot of difficulty, these needed aid if they were to function well with minimum difficulty.

Qualitative sampling strategies are fluid and flexible and are intentionally and thoughtfully revised as the data analysis suggests new avenue to explore or aspects that need additional focus (McCabe and Macnee, 2008). They may change in size during research because there are not closely defined rules for a sample size (Patton, 2001). Choosing a sample size of a study does not influence the importance or quality of the study in qualitative research. The number of required research subjects usually becomes obvious as the study progresses, as new categories, themes or explanations stop emerging from the field the researcher stops data collection and continue with other steps of the research process (Mason, 2010). With respect to the qualitative research, lack of information about the sample size would make it difficult for the reader to determine the extent to which the researchers obtained data saturation. Therefore the sample of thirty six (36) GVIs, the main research participants was used to mark a point of saturation.

In this research the number of required GVIs became obvious after interviewing sixteen (16) GVIs from each school when the researcher started hearing same trends

- same types of responses until when there was no new information coming out from the respondents. Thus thirty (32) GVIs were interviewed in both one-to-one interview and focus group discussion.

3.6 Sampling Techniques

Sampling involves selecting a unit or units of analysis which is referred to as the individual case or group of cases that the researcher wants to express something about when the study is completed and is therefore the focus of all data collection efforts (Tashakkori and Teddlie, 2009). Unit of analysis may include people, groups, artefacts, and settings that can provide the researchers with the ability to gain answers to research questions set forth in a study. In the light of this explanation, sampling can be defined as a process of selecting participants to take part in the research on the basis that they can provide detailed information required for the intended study.

The study used a purposeful sampling technique which focuses on cases that were rich in information (Patton, 2001). Purposive sampling is the selection of research participants who have information or experience of the area under investigation. Purposeful sampling was used to select secondary schools which had GVIs since the researcher was interested with girls with visual impairment characteristics. Maximum variation sampling technique was used. According to Patton (2001), maximum variation sampling technique involves purposefully picking of a wide range of variation on dimensions of interest. Maximum variation allowed identification of the diverse characteristics of the population and then sample

participants that matched these characteristics. Girls from form one, two, three and four were included in the study. Table 3.2 shows the Sample of the Study.

Table 3.2: The Sample of the Study

NO	Sample Category	Expected Sample	Actual Sample
1	GVIs	36	32
2	Civics teachers	4	4
3	Biology teachers	4	4
Total Sample		**44**	**40**

The targeted GVIs were purposefully sampled basing on dimensions including thirty six (36) GVIs in two inclusive girls' secondary schools; eighteen GVIs who had studied in the selected schools for a period of at least one year were selected from each of the focus secondary schools. The GVIs were sampled from the four levels of the ordinary secondary schools, i.e., one girl from each of the forms/levels- form one, two, three classes, and four. In form four six GVIs participated in the study. The study also collected data from two teachers one was teaching Biology classes and one was teaching civics classes at each of the two selected secondary schools.

3.7 Data Collection Methods

Data is raw material or information; it is a fact or a piece of information (Harris, 2011). In research, data is required to provide the researcher with facts, such as values or measures that can be in forms of numbers, words, measurements, for describing a situation under study. Therefore, data collection is a process of gathering and measuring information on variables of interest, in an established systematic way that enables one to answer stated research questions. In this study, the methods of collecting data were in-depth interviews, focused group discussion and documentary analysis.

3.7.1 Interview Method

The study used in-depth interview to collect data. This is a technique, which is used to systematically ask questions, record and document the responses of the research respondent to probe for deeper meaning and understanding (David, Debra and Lisa, 2011). This type of interview permits the interviewer to encourage an interviewee talking at length about the topic of the research and yield insight of the interviewees' thoughts, feelings, and behaviour on issues of the researcher's interest.

This study adopted semi-structured interviews. These were typically planned carefully before the interview was carried out. The researcher developed an interview procedure that included a list of topics to be addressed in the interview with all participants. The interview procedure helped guide the collection of data in a systematic and focused manner. The interview was semi-structured in that the researcher could change the order of questions, omit questions, or vary the wording of the question depending on what happens in the interview. The researcher added other questions during the interview to probe unexpected issues that emerged; a strategy suggested by Lodico, Spaulding and Voegtle (2010). This strategy allowed the researcher to rephrase the question and add further inquiries such as who, where, when, why, and how, based on the interviewees' flows of responses. Rationale of using this kind of interview was to allow flexibility in how and when to ask the questions.

The researcher prepared a framework of questions to be explored in the interview. In this study the interview was guided by a list of open ended interview questions to

ensure that detailed information was obtained from interviewees through following up questions emerging in the process of the interview.

There were 8 and 7 interview questions which were asked to students (GVIs) and teachers who were involved in the study respectively. The researcher posed the interview questions while the respondents listened. The respondents were given the freedom to build conversation within the subject area and enabled the researcher to view and experience the target groups, directly through discussion and understand the research problem.

3.7.2 Focused Group Discussion

Focus group discussion (FGD) entails discussion of research questions in a small group of people (Wong, 2008) normally six to eight people on a specific topic (Patton, 2001). In this study, the entire number of Sixteen (16) GVIs from each school was divided into two (2) FGD of eight participants (8). Time allocated for each FGD was one and a half hours and the FGD lasted for about one to one and a half hours. Eight (8) questions were prepared for FGD reflecting on the three thematic areas of the research questions. Each question was asked at a time and GVIs were asked to listen carefully and critically reflect on the given interview questions. The researcher posed probing questions to ensure that the necessary information was explored in every thematic area of the study.

FGD enabled the researcher to check and confirm data and issues that had emerged from data collected from individual respondents in one-to-one interview session.

They also promoted interaction among the participants by stimulating them to state feelings, perceptions, and beliefs that were not expressed when they were interviewed individually. The researcher facilitated, monitored and took notes.

The researcher did not need research assistant because she wanted to have primary data collected by her to ensure the data collected was of high standard in that all desired data would be obtained accurately, and in the format it was required and there was no fake/cooked, useless or unnecessary data. The researcher tried to tape the conversation but noted that there was no need to do so because GVIs' responses to the interview questions were bit by bit in such a way that the researcher was able to take notes of all the required responses without any difficult.

Teachers who were teaching Biology and Civics in which HIV and AIDS related topics were embedded in both schools were not involved in FGD because they were not the main study participants. Their involvement was needed to check and confirm data and issues that emerged from interview responses of GVIs.

3.7.3 Documentary Review

Documentary review is a research method that involves the study of existing documents, either to understand their substantive content or to illuminate deeper meanings (Crinson and Leontowitsch, 2011). Documentary review enables the researcher to cross validate and augment evidence obtained from other sources (Yin, 2009). In this study, documentary review was used to collect data in order to gain additional data that verified the data collected through interviews and focused group discussion.

Data from documentary review focused on key document areas that were relevant to the research questions. Documents which were reviewed included secondary school Biology and Civics syllabi and some of the related text books. These were used to find out HIV and AIDS related topics as embedded in the life skills areas of the curricula, the methods and materials which were used to develop students' knowledge, skills and attitudes for HIV and AIDS prevention.

3.8 Data Analysis Technique

Data analysis is a systematic process of working with data, organizing and breaking the data into manageable units. It further involves synthesizing units, searching for patterns of meaning (themes), discovering what is important and what is to be learned and deciding what to tell others (Biklen and Bogdan, 2007). Data analysis in this study was basically qualitative using meaning condensation, which is technique suggested by Kvale (1996). This technique involved summarizing data that the researcher expected to secure for analysis in a table. The table was developed with columns in which the researcher filled in the meanings of each interview question responses and its derived central theme. Data analysis involved analysis of reviewed documents, analysis of interview and focused group discussion responses. Four steps were involved in analysing interview responses. Interview responses that were collected with dates and numbers of informants were read through for correcting grammatical errors and for developing logic or sense of the data collected. The researcher read each interview transcript carefully to determine the meanings as expressed by the study participants. Then the researcher developed categories or clusters by meaningfully relating units of the data. Data analysis was guided by the

research questions. The categories resulting from the data were assigned numerical numbers, which were matched with the units of data through several readings and scrutinizing the recorded transcripts. Information from the data that did not fit in any of the identified categories was retained under an independent category. Further, the essential non-redundant themes of the entire interview results under each category were tied together into descriptive statements for further coding and classification.

Under each category developed, data were scrutinized and assembled under dominant themes corresponding to the subject matters resulting from the theoretical framework and literature review. Then, data was organized and condensed to make them meaningfully manageable, and easy to analyze and organize. This was a form of analysis that sharpens sorts, focuses, discards, and organizes data in such a way that conclusions can be drawn and verified (Huberman and Miles, 1994). Under scrutiny of each category, if new ideas and themes came into view, the researcher classified them either as justification of some ideas in the study or as possible suggestions and conclusion. Then the researcher did a thorough review of literature on certain subject matters, which was obvious as related to the intended study but had not been considered or reviewed in detail in the earlier review of literature.

Finally, the researcher integrated ideas from literature review to the themes to enlighten the researcher with the emerging themes and what they meant in relation to the research objectives. This review of literature directed the researcher’s way of

thinking on observed themes and directed the researcher to code themes which were related to the research.

3.9 Data Interpretations and Discussions

In research, interpretation is done so as to give meaning to the data to be analyzed or data that has been analyzed but need further interpretation for deriving conclusions and recommendations. Egger (2008) observes that data interpretation is an attempt to explain the pattern and trends uncovered through analysis, bringing all of their background knowledge, experience, and skills to bear on the question and relating their data to existing scientific ideas. Since research is an on-going process, the researcher continued to reflect about the data in each step, asking analytical questions and taking notes as new ideas emerged throughout the steps. This enabled the researcher to move deeper into understanding of the data, representing the data and making an interpretation of the larger meaning of the data. In so doing the researcher developed an analysis from the information generated for the research report.

3.10 Ethical Considerations

In this research, ethical consideration as observed by Trochins (2006) refers to principles that protect the rights of the study informant such as asking voluntary participation and informed consent, the principle that the research participants should not be exposed to situations where they might be at risk of physical or psychological harm as a consequence of taking part in research.The researcher obtained permission to carry out the study from the heads of the institutions. Also the researcher asked the consent from the head of the schools to allow the GVIs who were below the age

of 18 to participate in the study. Then the researcher talked, and informed the research participants about the purpose of the study and its objectives. The researcher asked them to voluntarily participate in in-depth interview and in focused group interview and agreed to appointment for the interview and group discussion sessions. Confidentiality was guaranteed and none of the study informant's name was mentioned in the research report except by representative numbers. Further, the research participants were ensured that findings would truly be reported without manipulation or exaggeration of the data collected.

3.11 Validity

Validity of qualitative research implies the accuracy of the findings from the standpoint of the researcher, the participant or the readers (Creswell, 2003). Researchers who do qualitative research examine their own conceptions and assumptions, and ask themselves whether they are capturing the thoughts, feelings, and actions of their participants in the context of their lives. The truths that emerge in their studies are always contingent that is, they are true only for the people, time, and setting of their particular study (Stringer, 2004). This means that their work is local in scope and procedures for ensuring the reliability and validity used in experimental research are inappropriate (Zambo, 2004).

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Therefore, qualitative researchers adopt alternative criteria including credibility, transferability, dependability, and confirmability to establish trustworthiness in their research methods and analysis (Anney, 2014). Since this was a qualitative research the researcher adopted these criteria to ensure trustworthiness of the findings.

3.11.1 Credibility

It refers to the confidence that the researcher and user of the research can have in the truth of the findings of the study (Macnee, McCabe, Gersch and Rebar, 2011). It is the extent to which results are credible or believable from the perspective of the participants in the research (Trochim, 2006). Strategies to ensure trustworthiness include examining the study to ensure the study was conducted in an appropriate and a systematic manner (Pitney and Parker, 2009). Reviewers, including the member of the Thesis committee, and a peer who had formal training and experience in qualitative research were asked to investigate important components including: background information; data collection procedures; data management process; data analysis procedures and research findings.

Feedback from the reviewer helped the researcher to improve the quality of the inquiry findings. Also to prove that findings represent reality, methodological triangulation is used (Carpenter, Speziale and Streubert, 2011). In this strategy the researcher collects data from different sources of data such as interviews, focus group discussion or participant observation (Anney, 2009). The researcher used interviews, focus group discussion and documentary review of the school curriculum materials such as syllabi and text books to look at the phenomenon from different sources.

3.11.2 Transferability

Qualitative research yields findings that only need to be valid for the case(s) under study (Boeije, 2010) because by the nature of qualitative findings are highly contexts

and case dependent. The focus is often in understanding and illuminating important cases rather than on generalization from a sample to a population (Patton, 2001). Thus in qualitative research a researcher cannot holistically generalize findings, but can give some ideas about similarity of the research situation studied with other similar settings (Cottrell & McKenzie, 2010). Qualitative study has to do with similarities between and among contexts.

The results of qualitative study may be transferred but transferability is beyond the researchers' control. Eventually, decision of transferability belongs to a study's reader and the researcher must provide as much thick description as possible when describing the context and research finding so that readers can best apply the results to the particular context (Macnee, McCabe, Gersch and Rebar, 2011). To ensure transferability, the researcher ensured extensive set of details concerning the research process from data collection, context of the study, to production of final report. Further, the researcher produced thick descriptive data to allow making judgment about how school context in which the GVIs were learning life skills for HIV and AIDS prevention fit to other possible contexts with GVIs or with other students with disabilities to which transfer might be contemplated to make judgment about it.

3.11.3 Dependability

In qualitative research, dependability focuses on whether the results found are consistent with the data collected (Shenton, 2004). Researchers seek to describe and understand the world rather than to measure it. They consider whether the results make sense and are consistent and dependable (Bogdan and Biklen, 2007). Thus,

dependability refers to stability of findings over time. To ensure dependability, different sources of information are used to collect data (Zambo, 2004). The researcher collected data from different sources. For instance, teacher interviews were conducted to better understand the experiences of GVIs and documentary review were used to better understand interview responses from teachers and GVIs. The weakness inherent in one source of collecting information was compensated by the strength of another source.

3.11.4 Confirmability

The term confirmability refers to the degree to which results could be confirmed or corroborated by others (Lightman, 2010). Confirmability is achieved with processes that ensure that data collected are neutral and objective. To ensure confirmability, the researcher uses triangulation (Zambo, 2004) to prove that findings represent reality (Carpenter, Speziale and Streubert, 2011). In this research, the researcher used triangulation of three data sources which provided varied information that the researcher used to confirm the conceptual framework developed for the study. Interviews, FG and documentary review, all connected, pointed to the same themes, categories, and conclusions. Having provided a thick description of the data sources and analysis, then the researcher presented the themes and connected them to the related literature about School-based HIV and AIDS interventions for GVI in secondary schools.

3.12 Summary

Chapter three is about the research methodology of the study. The chapter clarifies

the methodological aspects including research design area of the study, population, the sample size and sampling techniques. Other aspects include data collection methods, Data presentation and discussion, ethical consideration, validity and reliability.

The researcher used a phenomenological design that attempts to understand people's perception, perspectives and situation (Manen, 2014). This design was chosen because it was considered appropriate for exploring the authentic intricate and unnoticed set of factors in the school-based intervention that were required to develop knowledge, life skills and attitudes HIV and AIDS prevention.

The study was conducted in two selected schools at Korogwe and Tabora high schools which are located in Tanga and Tabora Regions respectively. These were schools whose students and teachers who were teaching both Civics and Biology were free to participate in the study.

Data in Table 3.1 indicates that population of the study involved five thousand and three hundred and thirty three students (5333) with disabilities in Tanzanian Secondary Schools Mainland. This population was considered appropriate because it comprised visual impaired students such as GVIs. Thirty six (36) GVIs out of two hundred and seven seventy eight (278) female visually impaired girls were sampled to participate in the study. Purposeful sampling a technique which focuses on cases that are rich in information (Patton, 2001) was used to sample the study participants. This sampling technique was used to select the GVIs who had characteristics of

being visually impaired. Data collection methods included interview, FGD and documentary review.

Data analysis was qualitative involving meaning condensation, a technique including summarizing data for analysis in a table, then reading through for developing sense out of the meaning, developing categories, doing a review of literature and integrating ideas to the themes emerging from data and then data was discussed. Ethical consideration was also observed, including asking the consent from the heads of the schools to allow GVIs who were below 18 to participate in the study. It also involved asking voluntary participation and assuring confidentiality to the study participants. Validity was also observed with a focus on credibility, transferability, dependability, and confirmability.

CHAPTER FOUR

4.0 PRESENTATION OF RESEARCH FINDINGS

4.1 Introduction

This chapter presents findings of the study on school-based HIV and AIDS interventions for GVIs in secondary schools in Tanzania. The findings are presented with respect to the core research questions that guided the study. The first question interrogated how the secondary school curricular contents related to HIV and AIDS prevention and how the content was taught. Findings to this concern have been presented in one main section namely content analysis on the school curricular.

The second question investigated the teaching processes of the contents related to HIV and AIDS prevention to find out how such processes assisted GVIs in developing knowledge and attitudes required for HIV and AIDS prevention. This question was designed for exploration of the teaching processes that deal with the contents related to HIV and AIDS prevention and assisting GVIs in developing knowledge and attitudes required for healthy behaviours that prevent HIV and AIDS infection. The findings are presented in a section categorized as developing HIV and AIDS related knowledge about life skills.

The third question sought to uncover the challenges that GVIs encounter in their intention for HIV and AIDS prevention. Findings for this question have been presented under a section titled challenges limiting GVIs' intentions for HIV and AIDS prevention. Hence, the chapter only focuses on reports about the data from the field; in-depth discussions about the data have been delegated to chapter 5.

4.2 Content Analysis on the School Curricular

This section presents data responding to the research question one which sought to explore the school curricular contents related to HIV and AIDS' prevention and how such contents were taught. Analysis of the findings was mainly based on Biology and Civics syllabi that constituted the main syllabi within which HIV and AIDS prevention related contents were embedded. The documentary review of the syllabi documents sought out aspects of the documents that linked to HIV and AIDS contents, teaching methods and other study materials used to complement teaching and learning of the suggested contents. The documentary analysis involved coding and classifying data from the selected documents to make sense of the data collected and to highlight important findings.

4.3 Targeted HIV/AIDS Competences and Objectives in the Biology Syllabus

The ultimate aim of teaching HIV and AIDS related topics as stated in the Biology and Civics syllabi was to develop learners' knowledge, skills and competences for preventing HIV and AIDS. Both Biology and Civics syllabi stated their general objectives and specific competences that learners were expected to develop in order to prevent HIV and AIDS diseases. A competence is the ability to apply or use knowledge, skills and capabilities required to successfully perform critical work, functions or tasks in a defined work setting (Arguelles and Gonczi, 2000).

In the context of preventing HIV and AID diseases through school-based intervention techniques, a competence is considered to be the ability to apply or use knowledge gained, skills acquired and abilities to successfully act responsibly in the prevention

of HIV and AIDS for healthy life. Therefore, school-based interventions are expected to be competence-based. Learners are expected to demonstrate competences by using knowledge and life skills required to effectively prevent themselves from the HIV and AIDS diseases in various situations.

A learning objective is a statement which specifies an idea in terms of measurable behaviour, i.e., what a learner will be able to do as a result of educational instruction. It describes the intended outcome of teachers' instruction rather than a description or summary of the content (Morrison, 2004). The reviewed syllabi indicated that learning objectives were derived from specified competences.

The Biology syllabus indicated four competences that the learners were expected to demonstrate by the end of their four years secondary school programme. Through implementation of the Biology syllabus for HIV and AIDS prevention, one competence was directly related to general Biology competences for life skills aimed at HIV and AIDS prevention as presented in extract 1 (a).

Extract 1 (a): The General Biology Syllabus Competence

The general Biology syllabus competence stated that, "By the end of four-year course, the student should have ability to demonstrate knowledge and skills in combating health related problems such as HIV and AIDS, drug and drug abuse, and sexual and reproductive health" (Tanzania Institute of Education- TIE, 2010, p. iv). In order to build this competence, the syllabus specified a related general objective presented here as extract 1 (b).

Extract 1 (b): The General Biology Syllabus Objective

The general Biology syllabus objective stated, “By the end of the four-year course, the student should be able to: Acquire basic knowledge and apply appropriate skills in problems related to HIV and AIDS/STIs, gender, population, environment, drugs/substance abuse, sexual and reproductive health” (TIE, 2010, pp. IV). The syllabus also indicated some life skills related topic referred to as “Management of STIs and HIV and AIDS” (TIE, 2010, p. 17). A specific objective to build the stated competence and the general objective with a focus on these life skills related topic is presented in extract 1 (c).

Extract 1 (c): Specific Objective

The specific objective states that, “the students should be able to demonstrate necessary knowledge and skills for avoiding risky behaviours, practices and situations” (TIE, 2010, pp.17). The knowledge and skills referred to in extract 1 (a) through (c) are expected to be developed through teaching and learning of the subject matter from the list presented in Table 4.1. Content analysis showed that there were specific objectives which were set to indicate what was to be attained in relation to the HIV and AIDS related contents. These specific objectives are presented in Extract 2.

Extract 2 (a): Specific Objective

The specific objective states that, “The student should be able to explain the concepts of health and immunity” (TIE, 2010, pp. 11). Extract 2 shows one of the specific objectives based on the sub-topic- “The concept of Health and immunity”. After

reviewing this objective, a key concept that was thought to be reflective of HIV and AIDS was identified to have a theoretical basis, i.e., knowledge of HIV and AIDS because health and immunity are important whether an individual has HIV and AIDS or not. This objective is thus not HIV and AIDS specific, it is only implicit in nature.

Extract 2 (b): Specific Objective

This other specific objective states that, "*The student should be able to explain the meaning of HIV and AIDS, STIs and STDs*" (TIE, 2010, pp. 15).

This objective was based on the subtopic: Human immune Deficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and other Sexually Transmitted Infections (STIs); management of STIs and HIV and AIDS. The sub-topic which was skill-based in focus was in the area of the management of STIs and HIV and AIDS. The following extract constitutes a specific objective set for the sub-topic.

Extract 2 (c): Specific Objective

Another specific objective states that, "*The students should be able to explain ways through which they can avoid risky situations, risky behaviour and practices"* (TIE, 2010 syllabus pp.17). In relation to this objective, students were provided with class notes under the title "R*isky behaviours, situations and practices which may lead to STIs and HIV and AIDS*." The notes were written in content point forms without any elaborations similar to the content points written under the same title in TIE (2010) Biology for Secondary Schools Form 1& 2, (pp. 69). The book represented the notes in point forms which were further summarized in learners' exercises books as exemplified below in extract 2 (d).

Extract 2 (d): Risky behaviours, situations and practices leading to STIs and HIV and AIDS

i. Sharing unsterilized tools such as needles and blades
ii. Transfusion using unscreened blood
iii. Having many sexual partners
iv. Failing to report sexual abuse or rape case
v. Having unprotected sex
vi. Alcoholism, smoking and use of other drugs such as cocaine, bang,
vii. Use of transparent clothes
viii. Road accidents
ix. Bars

Source: students' notes for Biology

Extract 2 (d) is part of learners' notes that learners, including GVIs, are expected to keep for further referencing and for reminding themselves about the risky behaviours, situations, and practices which may lead to contracting STIs and HIV and AIDS. Although the researcher could not read the GVIs' notes because of lack of knowledge and skills for using Braille alphabets; when the researcher requested the GVIs to read their notes from their Braille texts they demonstrated having served the same content related to the topics suggested in the syllabus and in the text books as presented earlier. However, the GVIs demonstrated difficulty in reading their own notes. The difficulty condition was evidenced existence of a lot of grammatical errors and pronunciation of vocabulary items/words copied in their brailed notes.

Competences and specific objectives specified in the Biology syllabus were basically to provide the teachers with insights of the capabilities that they were to build to their students focusing specifically on HIV and AIDS related contents identified from the syllabus and presented in the section that follows.

4.3.1 HIV and AIDS Related Contents Targeted for Biology Course

The data summarized in Table 4.1 was extracted from the Secondary Schools Biology Syllabus (TIE, 2010, pp. 17-193). The syllabus was developed by the Tanzania Institute of Education (TIE) which is responsible for developing primary, secondary school and Teacher Education syllabi. Documents other than the syllabi highlighted in the preceding presentations were reviewed to find out more topics and subtopics about HIV and AIDS which were taught to school adolescents. The reviewed documents included Biology Form 1 & 2 Student Books (TIE, 2005).

These books were used in both schools (X and Y) that were selected for this study, the books form the key sources for teaching HIV and AIDS related topics at this level of education. The text book has a subtopic, titled "*Management of STIs and HIV and AIDS*" (Biology for Form 1, pp. 45-49). Findings presented in Table 4.1 show that secondary schools have HIV and AIDS interventions reflected in the knowledge and life skills based curriculums as reflected in Biology syllabus.

An examination of this data shows that there were various subject matters suggested for knowledge and skills on HIV and AIDS prevention embedded in the Secondary school Biology text books for forms I-IV. As noted by Jiang, Liao, Yang and Zeng

(2010), life skills based curriculum can improve HIV and AIDS related knowledge and self-perceived skills.

Table 4.1: HIV and AIDS Topics and Methods for Biology Course

Class level and HIV and AIDS related subtopics	**Suggested Teaching and Learning Methods**
Form I: Health and immunity (TIE 2010, pp. 11) **Sub-topic:** Management of STIs and HIV and AIDS (TIE 2010, pp. 11)	• Discuss ways of avoiding risky situations, behaviours and practices; • The students present group deliberations in plenary and the teacher guides them in making necessary corrections; and • Roles play life skills in risky situations, behaviours and practices and then discuss their effects and consequences.
Form II: Gaseous exchange and respiration (TIE 2010, pp. 73) **Sub-topic:** Disorders of the respiratory System (TIE 2010, pp. 83)	• Questions and answers about the relationship between the respiratory system disorders and HIV and AIDS. Record and summarize responses and the teacher makes clarifications.
Form III: Reproduction (TIE 2010, pp. 133) **Sub-topic:** Sexuality and sexual health (SSH) and responsible sexual behaviour (SB) (TIE 2010, pp. 153	• Discuss the meaning of sex and sexual health (SSB) and sexual behaviour (SB); • Role play and discuss responsible and irresponsible SB and their impact on oneself, family and community; and • Role play the use of life skills for sexuality and SB, outline messages in the role-play, mention the appropriate life skills; self-esteem, problem solving, and decision making for their sexuality and sexual behaviour.
Form IV:HIV and AIDS , and other STIs (TIE 2010, pp. 191) **Sub-topic:** Management and control of HIV and AIDS and STIs (TIE 2010, pp. 193)	• Discuss the management and control of HIV and AIDS and STIs; • Teacher prepares extracts from magazines on the management of HIV and AIDS and STIs; and • Discuss life skills needed for management and control of HIV and AIDS and STIs and role play how to use life skills in the management and control of HIV and AIDS and STIs.

Table 4.1 presents HIV and AIDS related topics, subtopics and materials for teaching the topics. Whereas topics and subtopics are summarized in the left column of the table, the right column of the table summarizes teaching and learning methods corresponding to the topics and subtopics in the left column. As also indicated in this Table, there were three teaching and learning methods suggested for teaching HIV and AIDS topics.

These methods include group discussion, role play, and question and answer method. The table also shows that some of the methods occur in more than one class level. For instance, the discussion method is suggested for teaching topics in Form I, III and IV while role play is suggested for teaching topics in form I and III. Questions and answer method was suggested for teaching form II only.

A close analysis of the information on the table also shows that one of the two methods is suggested for each class. The question and answer method is suggested for teaching the topics in Form II and Form IV respectively while discussion and role play are methods suggested for both Forms I and II. The Table also shows that the teaching and learning materials were used to teach both knowledge and life skill based topics.

The topics or subtopics which were knowledge based focused on explaining the targeted concepts as represented in specific objectives extracted from the secondary school Biology syllabus which is cited in Extract 2. In this context topics and subtopics related to life skills were focused on developing life skills for HIV and

AIDS prevention. The first column of the table shows the class level for which the syllabus is targeted and the levels are form I-IV in secondary schools. The same column shows HIV and AIDS related topics and subtopics. Data show that there is one HIV and AIDS related topic exemplified in the table for each class level. The topics proposed include: health and immunity, gaseous exchange, respiration, reproduction, and HIV and AIDS and sexual behaviours targeted for form I, II, III and IV respectively. Under each topic there is one subtopic proposed about HIV and AIDS.

Other materials including text books were also reviewed to find out topics which were related to the topics and subtopics indicated in the syllabus. For instance it was found out that in Form II the subtopics presented in table 4.1 in the Biology syllabus (TIE 2010, pp. 83) titled “Disorders of the respiratory System” corresponded to a topic titled “Infections and diseases of the respiratory system” from TIE, (2010), titled Biology for Secondary Schools Form 1& 2, (pp. 69).

In form III, the subtopic titled “*Sexuality and sexual health and responsible sexual behaviour*” corresponds to the topic in in Biology Form 3 & 4 in the Students’ Book (TIE 2005, pp. 122-123). The topic is referred to as “*Sexuality and sexual behaviour*” The syllabus seems to imply that these topics were similar and ‘outstandingly’ related to HIV and AIDS because sexuality and sexual behaviours are the main concern in HIV and AIDS prevention. This implication can be extended to the title “*Management and control of HIV and AIDS and STIs”* which was similarly presented within the Biology Form 3 & 4 Students’ Book (TIE, 2005, pp. 225-227).

4.3.2 Materials of Teaching HIV/and AIDS Topics in Biology Syllabus

Data collected from documentary review indicated that, the Biology and Civics syllabi in which HIV and AIDS related issues were integrated suggested various teaching and learning materials for teaching life skills. These materials are summarized in table 4.2. The table has two columns. On the left part of the table, the column shows a list of materials which have been suggested for teaching HIV and IDS related topics in Biology classes. The second column on the right side of the table indicates examples of the HIV and AIDS related topics which were to be taught using the materials listed on the left side of the table.

The materials were categorized as visual materials including written materials and no-written materials. Written materials were meant for reading. For instance the list of written materials which were suggested in the Biology syllabus include: texts, brochures, cards, fliers, reports, manual and extracts about HIV and AIDS related issues. Non-written materials included charts, posters, pictures, photographs about HIV and AIDS which were not accompanied with written texts. Table 4.2 summarizes the teaching materials suggested for teaching HIV and AIDS topics extracted from Biology syllabus for Form III and IV. The lists of suggested materials show that they also include audio materials. These were materials related to sound or sound recording. In both syllabi, these materials included tapes and radio. The third group of materials were audio visual materials which involved both hearing and seeing senses. In both syllabi, the audio visual materials indicated were visible part of television transmission or video. As the name suggests the material were meant to be ‘watched and heard’.

Table **4.2: Teaching Materials for HIV/and AIDS Related Topics in Biology**

Form III: Materials	Topics
Pictures, photographs, radio, brochures, fliers, texts, depicting cases of sexuality and sexual behaviours, tapes recorded materials, pictures, and photographs showing people with different sexual behaviour –both responsible and irresponsible behaviours, Video recorded tapes, , charts showing different life skills required to cope with adolescent sexuality and sexual behaviour	Sexuality and sexual health and responsible sexual behaviours
Form IV	
Charts on AIDS in Africa Reports on HIV and AIDS and STIs Charts on AIDS in Africa/World/Tanzania	Relationship between HIV and AIDS and STIs
Manual on management of HIV and AIDS and STIs Reports on HIV and AIDS and STIs Extracts of texts on HIV and AIDS and STIs Extracts/texts on life skills for management of HIV and AIDS/STIs Brochures and fliers on methods of handling people living with HIV and AIDS and Charts on HIV and AIDS/STIs in Africa/world/Tanzania	Management and control of HIV and AIDS/STIs Life skills manual

This condition has implication for GVIs since they cannot watch the materials due to their eye impairments, they can only hear narratives in such materials. Since some of the materials are presented in foreign languages such as English, and this language is not adequately understood by many students at that level of education in Tanzania; it is most likely that the GVIs miss important information despite their participation in classes where such study materials are used for teaching.

The table also shows that there were audio materials; these were related to sound or sound recording. In both syllabi, such materials included recorded tapes and radio broadcasts. The third group of materials was composed of audio visual materials which engaged the students' hearing and seeing/visual abilities. In both syllabi, the audio visual materials indicated presence of visible parts of television transmissions

or video recorded clips. As the name suggests the materials were meant to be seen or watched and be heard of. However, when the researcher wanted to see the materials suggested in the syllabi, the teachers informed that they were not available, only the text books were supplied. For example, the books which were used for teaching Biology subject were text books with the following titles of publication: Biology Form 1 & 2 Students Book and Biology Form 3 & 4 Students Book. The sole author of all the text books was the Tanzania Institute of Education (TIE, 2007). Another text book used had title of "Biology for Secondary Schools Forms 1 and 2" and the author was the same, i.e., TIE (2010).

4.3.3 Competence and Objective Targeted in the Civics Syllabus

In teaching the suggested topics in Civics, the general competence that the learners were expected to demonstrate was also stated in the syllabus which is presented in extract 3 (a) and the general subject objective is presented in 3 (b).

Extract 3 (a): The General Competence

The general competence expected is to develop learners' ability to: "*Demonstrate knowledge of cross-cutting issues (CCI) and their impact on our society and take appropriate action"* (Ministry of Education and Vocational Training (2010, pp. V).

Extract 3 (b): The General Subject Objective

The general subject objective is to assist the learners so that they gain knowledge and skills to enable them: "*Promote an understanding of CCI, their impact upon the society and intervention steps to be taken for our own national interests"* (MoVT, 2010, pp. VI).

General competence and the general objective presented in extract 3 (a) and 3 (b) respectively are presented here in the syllabus context of HIV and AIDS as one of the CCI because HIV and AIDS is not just a community wellbeing problem affecting individuals' health but also an issue which is affecting individuals, socially and economically with devastating consequences to the Tanzanian nation and the whole world. Thus the objectives set in Civics course about CCI were aimed at enabling the learners to promote understanding of issues including HIV and AIDS which is also a CCI as pointed out above.

The general competence and the general objective in extract 3 were general statements from which the specific objectives in extract 4 were derived. In promoting understanding of HIV and AIDS several topics and methods of teaching were suggested in the syllabi.

The syllabus showed that, each subtopic had several specific objectives. The following extracts represent specific objectives for promoting life skills.

The extract is based on one of the topics that is taught in Form I under the subtopic *"Meaning and types of life skills"* extracted from MoEVT (2010) pp. 3-5 as extract 4.

Extract 4: Specific Objectives of 'Teaching Meanings and Types of Life Skills':

There were four specific objectives which stated that, (a) "The student should be able to explain the meaning and types of life skills;" (b) "The student should be able to illustrate the importance of life skills;" (c) "The student should be able to demonstrate how to use social skill" and (d) "The student should be able to analyze the consequences of not applying social skill."

Objectives (a) and (b) indicate that the teaching of life skills was focused on developing the theoretical understanding of life skills. The focus was to “explain” the meaning and types of life skills and “illustrate” the importance of life skills. Since to explain and illustrate entail giving details, learners were expected to listen to the explanations aiming at enabling them to understand essential life skills rather than developing practical applications.

Objective (c) indicates that the focus is to “demonstrate,” which means to show and in (d) the focus is to “analyze” which entail examining or investigating. Thus in (c) and (d) the focus is on the practical use of the life skills that the students gained from the taught topics. Further, the review of the syllabus indicated that the attainment of the specific objectives set was measured through assessment questions asked by teachers after teaching each topic related to HIV and AIDS. Each assessment question in extract 5 (a) through (d) extracted from the syllabus corresponded to each specific objective in extract 4.

Extract 5: Assessment questions

The following are assessment questions specified in the Civics syllabus for Secondary Schools for Form 1-IV (MoEVT, 2010, pp. 3-5). There were four questions which asked;

(a) “Are the students able to explain: (i) the meaning of life skills? (ii) the types of life skills”? (b) “Are the students able to illustrate the importance of life skills”? (c) “Are the students able to demonstrate how to use different social skills”? (d) “Are the students able to analyze the consequences of not applying social skills”?

These assessment questions allowed the teacher to make judgments of what to do in responding to the actual competences demonstrated by the learners in the processes of teaching and learning. The trend was the same for the rest of the topics in form II and III. This review indicated that the syllabus has specified what had to be taught about life skills for HIV and AIDS prevention and how the teaching of the specified topics was also to be assessed.

The review of the documents also indicated that there were books which have been used to teach the suggested topics. For instance, a reference book written by Bukagile (2008) indicated that there was a topic referred to as *"Promotion of life skills"* which had various subtopics about life skills and their importance. Under the subtopic *"Positive relationships"* (p.1-21) there was elaboration providing information about life skills. The rationale of studying life skills was too general since the content did not focus on life skills in the context of the HIV and AIDS pandemic. The focus was on enabling students to generate competences such as self-worth, confidence, good relations with other people in the community as well as imparting knowledge of being good leader in a society, which believes in team work for the achievement of intended goals" (Bukagile, 2008, pp.1).

The review indicated that teachers had notes concerning "*Promotion of life skills"*. In X school for instance, the teacher who was responsible for teaching life skills in Form I had clear notes on the *"Meaning and types of life skills"*. The students' notes reflected the teachers' explanations of the meaning of life skills, the types of life skills, and the importance of the life skills to be learnt. Whereas teachers' notes were

detailed, some of the students' notes were presented or recorded in point forms.

4.3.4 HIV and AIDS Contents to be developed through the Civics Subject

This section presents data from the Civics syllabus from which several topics were extracted. Data show that in each class there was one topic about HIV and AIDS knowledge and skills, except for Form III. Further analysis shows that the first topic in Form III is referred to as "*Promotion of life skills*". However, the life skills referred to in this topic are related to leadership and team work in general without any reference to HIV and AIDS. Table 4.3 presents topics and methods suggested in the Civics Syllabus for developing knowledge and life skills to address HIV and AIDS which is one of the CCI affecting most people including school adolescents.

Table 4.3: Topics and Methods Suggested in the Civics Syllabus

	Suggested methods
Form 1: Topic 2 Promotion of life skills **Sub-Topic:** Meaning and types of life skills.	• Brainstorming and writing the meaning of life skills; • Discuss and identify various life skills from written texts; • Read written sources, identify and discuss the importance of life skills; • Students use case studies or role play social skills such as understanding their roles, building positive relationships, communicating effectively, taking responsibility, and copying with stress.
Form II: Topic: Promotion of life skills **Sub-topic:** Social problem solving techniques	• Brainstorm on the meaning of problem solving techniques; • Role play case study on the use of problem solving techniques; • Use a story/ case study/role play and discuss the steps in the problem solving process; • Use real life problems/conflicts to discuss and solve the real problems/conflicts.
Form III:	None of the topic is about life skills
Form IV: Topic: Culture **Sub-Topics:** Promotion of life skill	• Role play situations to show application of life skills; • Group discussion on different situations or problems and identify life skills demonstrated in the role play; • Suggest the most appropriate solutions to the problem or situation.

In Table 4.3 the topic titled “Promotion of life skills” was suggested for both Forms I and II. Whereas in Form I this topic was based on a subtopic that was focused on “meaning and types of life skills,” in Form II the same topic was focused on a subtopic referred to as “Social problem solving techniques” In Form IV, the review indicated that the topic about HIV and AIDS was “Culture” which had one sub-topic called “Promotion of life skills.” The syllabus showed that, each subtopic had several specific objectives. The following extracts represent specific objectives for promoting life skills. Specific objectives of teaching the meaning and types of life skills have been presented under extract 4 which constitutes such objectives are presented as sub-extracts - (a) through (d).

Extract 4

(a) “The student should be able to explain the meaning and types of life skills;”

(b) “The student should be able to illustrate the importance of life skills”;

(c) “The student should be able to demonstrate how to use social skill” and

(d) “The student should be able to analyze the consequences of not applying social skills”.

The sub-extract are based on the topic that was taught in Form I under the subtopic *“Meaning and types of life skills”* extracted from MoEVT (2010, pp. 3-5) as extract 4. Objectives (a) and (b) indicate that the teaching of life skills was focused on developing the theoretical understanding of life skills. The focus was to “explain” the meaning and types of life skills and “illustrate” the importance of life skills. Explaining and illustrating entail giving details. Learners were expected to listen to

the explanations aimed at enabling them to understand essential life skills rather than developing practical applications.

Objective (c) indicates that the focus was to “demonstrate,” which means to show and in (d) the focus was to “analyze” which entail examining or investigating. In (c) and (d) the focus entailed the practical use of the life skills that the students gained from the topics taught. Further, the review of the syllabus indicated that the attainment of the specific objectives set was measured through assessment questions asked by teachers after teaching each topic related to HIV and AIDS. Each assessment question in extract 5 (a) through (d) extracted from the syllabus corresponded to each specific objective in extract 4.

Extract 5: Assessment questions

The following are assessment questions indicated in the Civics syllabus for Secondary Schools for Form 1-IV (MoEVT, 2010, pp. 3-5). There were four questions which asked the following: (a) “Are the students able to explain (i) the meaning of life skills? (ii) the types of life skills?” (b) “Are the students able to illustrate the importance of life skills?” (c) “Are the students able to demonstrate how to use different social skills?” and (d) “Are the students able to analyze the consequences of not applying social skills in their lives?”

These assessment questions allowed the teacher to make logical judgments of what to do in responding to the actual competences demonstrated by the learners in the processes of teaching and learning. The trend was the same for the rest of the topics in

Form II and IV. This review indicated that the syllabus has specified what had to be taught about life skills for HIV and AIDS prevention and how the teaching of the specified topics was also to be assessed. Review of documents also indicated that there were books which have been used to teach the suggested topics. For instance, a reference book written by Bukagile (2008) indicated that there was a topic referred to as *"Promotion of life skills"* which had various subtopics about life skills and their importance. Under the subtopic *"Positive relationship"* (p.1-21) there was elaboration providing information about life skills.

The rationale of studying life skills was too general because the content did not focus on life skills in the context of HIV and AIDS. The focus was on enabling an individual to generate competences such as self-worth, confidence, and good relations with other people in the community as well as imparting knowledge of being good leader in society, who believes in teamwork for the achievement of intended goals (Bukagile, 2008). Further, the review indicated that teachers had notes concerning "Promotion of life skills". In X school for instance, the teacher who was responsible for teaching life skills in form I had clear notes on the "Meaning and types of life skills". The students' notes reflected the teachers' explanations of the meaning of life skills, types of life skills, and importance of the life skills to be learnt. Whereas teachers' notes were detailed, some of the students' notes were presented or recorded in point forms.

4.3.5 Methods of Teaching Life Skills Suggested in the Syllabi

This section presents data documented from Civics and Biology syllabi about methods of teaching life skills. The sections of these syllabi were represented in

seven columns consisting of the topics and sub-topics to be covered, specific objectives, teaching and learning strategies, teaching and learning materials, assessment and number of sessions or class periods to cover the subject area or topics. Teaching and learning strategies are presented in the fourth column. For instance, the Biology syllabi described “teaching and learning strategies” as “activities of the teacher and the learners during the teaching and learning processes of a particular topic” (TIE, 2010, pp. v).

Since these strategies were referred to here as “activities,” in this research the term strategies is used synonymous with methods consistent with Kizlik (2014) who describes methods as learning-objective oriented “activities” and flow of information between teachers and learners. The following sub-section presents methods of teaching life skills as represented in Civics syllabus.

Both syllabi indicated that the specific objectives of the syllabi outline the target competences or skills required for HIV and AIDS prevention. For example, Civics syllabus, in Form I, students were expected to apply several methodological skills such as “brainstorming,” “case study,” “group discussion,” “role play,” and “demonstration” by the time they completed learning the topics for which the objectives were developed. These competences or skills were based on topics which were embedded in the Civics syllabus. Among the topics for which the methods were to be used during teaching and learning processes in Civics classes was “Promotion of life skills” and for one of the sub-topics it was the “meaning and types of life skill” (see table 4.3).

Extract 6 (a)-(d)

Extract 6, comprises detailed information indicating how teachers could use these methods to teach the topics as proposed by the MoEVT (2010, pp. 3-5) in the Civics Syllabus for Secondary Schools. There were four methods represented at this level, the method indicated that: (a) “The teacher guides students to brainstorm and write down the meaning of life skills. The method is further elaborated when it instructs the teacher thus (b) “Using written texts, on life skills, the teacher guides groups of students in the class to discuss and identify various life skills that they know;” (c) “The teacher guides each group to present its discussion and clarify results from their own experiences and the texts from which they obtained information about life skill” and (d) “The teacher uses case studies or role play to guide learners to demonstrate social skills such as understanding their roles, building positive relationships, communicating effectively, taking responsibility in communities, and coping with stress.”

The method in extract 6 (a) included teaching and learning processes which involved thinking about the meaning of life skills and putting the thoughts into writings. Extract 6 (b) entails a method through which learners work together in groups to “discuss and identify” life skills from written texts.

In 6 (c) the method involved presentation of group ideas discussed and identified from written texts. Under this method, the role of the teacher was clarifying ideas that arose from the students. In extract 6 (d), case study and role play were two different methods which were to be combined to enable the learners demonstrate social skills.

4.3.6 Knowledge-based HIV and AIDS Related Topic in Biology Syllabus

The subtopics which were knowledge based focused on explaining the targeted concepts. This is evidenced in the represented specific objectives extracted from the secondary school Biology syllabus and cited in Extract 2.

Extract 7 shows these methods as verbatim represented in the syllabus.

Extract 7 (a) – (c): Methods Represented in the Syllabus

(a) "Students discuss the meaning of sexuality and sexual health (SSH) and sexual behaviour (SB) and the teacher organizes students' responses and use them to lead a discussion on the meaning of SSH and responsible sexual behaviour;"

(b) "The teacher uses questions and answers to guide the students to outline the preventive and control measures of HIV and AIDS, STIs and STDs" and

(c) "Students work in groups and use guidelines to role play on appropriate use of life skills to cope with their Sexuality and sexual behaviour" (MoEVT, 2010, pp. 153-155).

Extract 7(a) entails discussion method focusing on the meaning of SSH and SB. Through this method, the students give their responses to the whole class and the teacher organizes the responses to lead whole class discussions. In 7(b) the question-answer technique is used to outline the intended topic. Here the teacher asks questions and in turn, the students answer the questions. Extract 7(c) suggests that group work should engage the students to role play some of the life skills. The suggestion does not however indicate what exactly should be role played, that is the part of life skills that would be role played to build the target skills. This gives room

for the teacher and his/ her students to make their own decisions of what they want to demonstrate through role playing in their classroom contexts. However, the review of the documents including the texts designed for the civics course and teachers' notes did not indicate application of the methods in teaching the suggested topics. This is demonstrated by sections from texts such as Abeid and Olotu's (2009) Civics for Secondary schools; Form IV (pp 32-34). Observations made of the teacher's notes showed that the notes were weak. Notes from one Civics Teacher with a pseudo name '# 2' of Form IV in school X is evidence of this finding. He writes:

> Life kills are problem-solving behaviours used appropriately and responsibly in the management of personal affairs. They are a set of human skills acquired via teaching or direct experiences that are used to handle problems and questions commonly encountered in daily human life.

Source: Civics teacher # 2 at Y School

This type of notes shows weakness in several ways. First, the meaning of life skills was copied from the text book and examples were not provided from the learners own context for determining clarity of the meanings to the students. Second, the teachers' notes did not include any information from the pictures provided in the same book that was used for teaching the topics (Abeid and Olotu, 2009, p. 33). The picture represented an ongoing "*School Baraza,"* translated as a 'School General Meeting'. The picture is aimed at promoting learners' understanding about the targeted life skills including communication and interpersonal skills and decision-making and critical thinking skills on page 32 and 33 respectively.

Other targeted life skills were copying and self-management skills and problem solving presented on page 33 and 34. Teacher's notes did not show any traces of

activities such as questions prepared to engage the learners in the methods suggested in Civics syllabus including role play and group discussions as summarized in Table 4.3. Learners would have learned creatively and gained learning outcomes such as their own mental pictures related to the life skills and answers or ideas from the role play and group discussion. In this way, the methods would have been participatory and more effective.

4.3.7 Methods used in the Process of Teaching and Learning

The following subsections present data from interview responses showing the methods used in teaching life skills in school-based HIV and AIDS interventions. Data were collected from interviews from teachers who were teaching Civics and Biology courses and GVIs in the selected schools. These methods were categorized as explanations, demonstrations, and whole class discussions as represented in the following sub-sections.

4.3.7.1 Explanation Method

Extract 8 (a)-(c): Teachers' Responses

(a) Biology teacher # 1 at X School

> I teach HIV and AIDS related topics such as Health and immunity, reproduction and HIV and AIDS and other STIs through explanation as a method of teaching. After explaining certain topics, I ask questions and write notes on the chalk board. While I explain and write notes, learners listen and copy the notes in their exercise books. Form IV GVIs can also listen and summarize my notes using Braille materials as I teach. Although we encourage GVIs to come with their Braille typing/writing machines, GVIs in Form I, II and III do not come with the machines. They normally want to copy notes after classes because they cannot competently listen and write their own notes at the same time.

(b) Civics teacher # 2 at Y School

> I explain the life skills such as decision making, refusal and communication skills which are necessary for HIV and AIDS prevention. While explaining I continually ask questions. Learners listen, answer questions and copy notes that I write on the chalk board. Afterwards GVIs' 'assisting readers' read notes for the GVIs to copy using the Braille typing/writing machines.

Extract 8 (a)-(b) show that "explanation" is a method of teaching and learning HIV and AIDS related topics. This method is represented by narratives from teachers who were teaching Civics and Biology in the two selected schools. Extract 8 (a), indicates that teachers initiate the processes of teaching and learning. In extract 8 (a) and 8 (c), teachers do tasks which are represented in activities such as "explaining," "asking questions" and "writing notes on the chalk board."

(c) GVI # 1 at School Y

> The teacher provides explanations about the topic on life skills for HIV and AIDS prevention, asking questions and writing notes on the chalk board for SGs to copy. I don't copy notes because I can't read non-Braille materials but I don't take summaries because I can't listen and write the summaries at the same time. My readers read the teacher's notes for me to copy with Braille typing machine later, i.e., after classes. So during the lesson I only listen.

Extract 8 (c) is a representation from GVIs who were interviewed in school Y. Similar to the teachers' responses, GVIs responses indicated that explanation method was used by the teacher in teaching life skills for HIV and AIDS prevention. Tiwari (2010) argues that explanation in a class is like a discourse on a particular subject or topic that is for the entire class or public. The extract indicates that explanation method was used for describing life skills for HIV and AIDS preventions.

All extracts showed that explanation method was represented by the verbal noun "explanation" as is the case with the citations in extract 8 (a), (b) and (c). GVIs' responses in 8 (c) showed that they identified methods such as explanation that were used in the teaching and learning processes. They confirmed that their response to the method was basically to pay attention to the monological teaching method. This experience is exemplified by GVIs' responses such as, "I don't copy" but also "I don't take summaries" and in "I don't write notes or summaries during the lesson" in 8 (c).

4.3.7.2 Demonstration Method

In this study, the findings show that demonstration method was used in teaching life skills as exemplified in extract 9. In extract 9 (a) through (d) teachers' responses are presented while GVIs' responses are presented in 9 (e) and 9 (f).

Extract 9 (a)-(d): Responses from Biology and Civics Teachers at School X and Y

Extract 9 (a): Demonstration method by a Guest speaker

(a) Biology teacher # 2 at Y School

> In teaching prevention measures for HIV and AIDS, I invite an HIV and AIDS focal person who explains and demonstrates the use of male condoms. Then I clarify some of the concepts where necessary, ask questions and give tasks and notes for the learners to write in their exercise books. Of course, as opposed to sighted peers who can see, demonstrate and summarize what is talked about and demonstrated; GVIs can only listen to the explanations about the condom use and do the assignments after classes with the support from their sighted peers.

Extract 9 (a) represents demonstration on the use of condom by a guest speaker who was invited as an expert in HIV and AIDS preventive measures with a focus

on condom use. In the extracts the demonstration method was used by a non-professional teacher, that is an “HIV and AIDS Focal person” The extract shows the guest speaker’s role was to demonstrate and delegate tasks such as asking questions, and providing notes for students to the responsible teacher.

The extract also indicates that after guest speakers’ demonstration, the teacher makes additions on what has been talked about in the demonstration as it is exemplified in the phrase “clarify some of the concepts.” When the demonstration is completed learners are expected to positively respond to situations that call for application of the skills gained from the demonstration in the class. From the extracts such response could be associated with the students’ actions of listening, observing, answering questions and copying notes. It is worth noting that the GVIs in the classes “can’t see the demonstrations” so they listen to the explanations and work on the assignments after classes. Generally, the represented examples indicate that teachers who are teaching Biology use the demonstration method to show the application of male condoms and they make use of professional experts for demonstrations of the condom use.

Extract 9 (b) and 9 (c): Demonstrations Conducted by the Learners

(b) Civics teacher # 1 at X School

> I give learners scripts to read about case studies to guide them to identify and show social skills for healthy life such as effective communication, assertiveness, and negotiation skills and how they can be used in various situations. GVIs listen to sighted peer as they read the scripts and then they all prepare the demonstrations together with sighted peers. Normally sighted peer are the ones who volunteer to do the demonstrations. Then they answer questions and write notes in their exercise books for future reference and for more understanding.

(c) Civics teacher # 2 at X School

> I guide the learners to show application of life skills such as negotiation, refusal skills and effective communication. GVIs do not participate in the demonstrations they just listen to the explanations except one outstanding girl who completed form four last year. She was very active and she would volunteer in most of the activities. The rest of them are always reserved even in answering questions.

Extract 9 (b) and (c) exemplify representations of demonstrations which are conducted by the learners in Civics. In these extracts, demonstrations are based on life skills in Civics lessons. These life skills include communication, assertiveness and negotiation as exemplified in (b). In this method the information in the extract indicates that teachers involve the learners to "read and demonstrate what they learn" based on the reading scripts. Demonstrations are mainly done by the SGs because they are the "ones who volunteer to do the demonstrations" while "GVIs listen."

Extract (b) indicates that although the GVIs are also involved in the preparation for the demonstrations, they are not involved in the demonstration. Extract (c) shows that Civics teachers use the demonstration method to teach life skills such as "negotiation, refusal skills and effective communication." It also indicates that "GVIs do not demonstrate" instead they listen to the explanations that feature during the demonstration."

In extract 9 (c) there is a situation which surpasses what is common about physical ability of GVIs. The extract exemplifies an active GVI who is willing to "volunteer in most of the activities" during the lesson. This representation is contrary to the situation in which GVIs are expected to be, that is, individuals who are "reserved even in answering questions." In this case the extract indicates that GVIs, through

this method can actively participate in learning life skills for HIV and AIDS prevention. This deviation is an identified ability of GVIs having a specified ability to act which indicates that GVIs can participate effectively given opportunity and assistance.

Extract 9 (c) indicates that learning through the teaching method as represented in this case is learner centred. The teachers' role is that of guiding the learners to determine how to go about accomplishing the task. As it is represented in the same extract, the situation shows that mostly, GVIs do not participate in demonstrations because of self-restraint and reticent represented by the phrase they are "always reserved even in answering questions."

Extract 9 (d)-(f): Responses from GVIs

9 (d) GVI # 7 at Y School

> Showing the use of condom for HIV and AIDS prevention in Biology is done in front of the class by an invited expert guest. We listen to his/her explanations and from SGs who are better in demonstrations because they can see and observe what others do. The teacher generally asks questions and provides notes that we write after classes using Braille type writers.

9 (e) GVI # 11 at X School

> The teachers invite somebody to talk about the use of condoms and show us how male condoms are used. We are asked to do the same and we do it in groups but the sighted peers are the main actors who help us to understand the use of male condoms because they can see. Of course I 'follow' the demonstrations with the assistance of the SGs but I've not practiced it on my own.

9 (f) GVI # 11 at Y School

> In Civics classes, the teacher explains and demonstrates the use of life skills such as communication, refusal and decision making regarding HIV and AIDS prevention. She also writes notes on the chalk board and asks us to perform the same demonstrations but I feel uncomfortable to demonstrate because I fear I might do it in a wrong way and others might

> laugh at me. Later on the teacher asks us to answer some questions orally. After classes SGs assist us to write notes using Braille type writers.

Extract 9 (d) and 9 (f) represent how the demonstration method is used to teach HIV and AIDS related issues. Extract 9 (d) represents demonstrations which are conducted in teaching Biology while extract 9 (e) represents the use of the same method in Civics. In 9 (d) and 9 (e) GVIs confirm what the teachers said about inviting guest speakers whose demonstrations are based on technical "use of condom for HIV and AIDS prevention". Through this method learners "listen to the explanations" and learn from SGs peers how to demonstrate the same. As it is represented in both extracts, GVIs' feel that they "depend" on SGs to learn through this method. In (d) this dependence is represented in the phrase "we do the same demonstrations with the assistance of the SGs." In (e) the dependence is represented in the clause "sighted peers are the main actors who help us to demonstrate the use of condom." Further, extract (e) indicates that condom use is not practiced repeatedly as it is represented in the phrase "I've not practiced it on my own."

The demonstration method represented in 9 (f) addresses important components of HIV and AIDS awareness and preventions in Civics classes to provide them with skills represented as "communication, refusal and decision making." Similar to the rest of the extracts in 9, the method entails teachers' demonstrations, questioning and learners' responses in doing the same demonstrations, responding verbally to the questions, and putting records of what has been learnt through writing notes.

This extract also represents a condition that influences and surrounds GVIs. This situation is represented in the statement "I feel uncomfortable to do the

demonstration because I fear I might do it in a wrong way and others might laugh at me." This situation represents GVIs' fear of making mistakes as they perform the tasks. The fear is further associated with expression of scorn represented by the verb "laugh," a condition that can intimidate even sighted individuals.

Extract 9 (g) and (h): Responses from teachers

9 (g) Biology teacher # 1 at Y School

> Sometimes I give my students written scripts containing various situations which require them to categorize the life skills for HIV and AIDS prevention. I further ask them to demonstrate the situations and ask oral questions about issues emanating from the demonstrations and also give them notes on the chalk board for copying. I ask SGs to assist GVIs to demonstrate. However, GVIs are generally very slow in responding. In most cases they are anxious especially when they don't understand.

9 (h) Civics teacher #1 at X School

> I ask my students to show certain situations such as risks for pregnancy and unintended sex or pregnancy due to lack of life skills. SGs help the GVIs to understand what to do and how to do it on their own. Normally GVIs, don't volunteer to perform the tasks such as answering questions or demonstrating the situations because, I think, they need more time to listen and see the situation in their own mind before they respond.

Extract (g) and (h) indicate teachers' representations of the demonstration method. In both extracts it is shown that teachers have concern about GVIs because the extracts indicate that SGs are assigned tasks to assist their GVI peers. The two extracts show that despite SGs' concern in supporting, GVIs are very slow in responding" or "they don't volunteer to perform the tasks" as represented in (g) and (h) correspondingly. This representation indicates that although the GVIs listen to the explanations, their responses to the tasks is limited by situations such as "they have anxiety especially when they don't understand." represented in (g) because "they need more time to

listen and see the situation in their own mind before they respond" as is observed by the teacher in (h).

4.3.7.3 Whole Class Discussion

This section presents extracts from research participants which indicate that whole class discussion was also a method used in teaching and learning HIV and AIDS related issues in Civics and Biology. The findings are presented in extract 10 (a) through (f)

Extract 10 (a) and (b): Representations from Teachers Responses

10 (a) A Civics teacher # 1 at Y School

> Another method is asking a question for learners to discuss. Each learner is supposed to contribute ideas. The aim of using this method is to enable learners to express their ideas to others giving them chances to think about such ideas from each other. In this way the learners learn from one another. All along these learning processes, GVIs learn together with SGs in the classes. Experiences of using this method show that GVIs are mostly inactive as opposed to the SGs who actively contribute their ideas. GVIs, similar to SGs, listen as discussions progress in the classes but GVIs don't participate much because they their self confidence in talking and performing tasks in class is relatively lower than their counterparts, i.e., SGs.

10 (b) Biology teacher # 2 at X School

> I ask questions about HIV and AIDS related issues, to the whole class for both GVIs and SGs. The rationale of using this method is to encourage learners to think critically about the answer and share their views with others and also think about other's responses. I encourage each individual to give their views in respect of the questions posed. In most cases, SGs are the ones who contribute their ideas. GVIs have low self-esteem about themselves and so they rarely respond to questions or respond to other activities that require movement in the class.

Extract 10 provides examples of narratives indicating those targeting teaching life skills for HIV and AIDS prevention and teachers use whole class discussion

methods. Generally, a question which is set for the whole class becomes the basis for learners' thinking who in turn communicates their thoughts about the question to the others.

The rationale of using this method is to enable the learners to communicate their thinking to others as represented in extract 10 which indicates that the method enables the learners to communicate their thoughts to others as implicated in teachers' narratives in 10 (a) in a phrase "enable learners to express their ideas" and "give contribution to other learners" in 10 (b). Further, the two extracts indicate that in this method learners reflect on the thinking of others represented by a phrase "think about ideas of others," in 10 (a) and "think about others' responses" in 10 (b). In extract 10(a) the extract indicates that GVIs participation is limited because of what is represented as lack of participation in a phrase "GVIs don't participate much" because they lack belief in themselves and their abilities represented in a phrase "they don't have self–confidence." In extract 10 (b) the extract indicates GVIs' doubtful feelings about themselves represented by "low self-esteem."

Extract 10 (c) and 10 (d): Representations of GVIs Responses

10 (c) GVI # 3 at Y School

> When the teacher teaches HIV and AIDS related issues, he poses questions for everyone to contribute ideas. Each time a new idea is given; the teacher writes it on the chalk board and encourages others to give more ideas. I listen to the ideas and can also develop some knowledge of what is being discussed because in this way different ideas are presented several times by different individuals in different ways.

10 (d) GVI # 6 at X School

> Questions which are asked are discussed mainly by each individual to give an idea about the question. Each time ideas are given, the rest of the learners listen and add more ideas and the teacher continues to motivate

> others for more responses and write the points on the chalk board. I listen to the ideas presented and talked about by various individuals and generally, I get the points.

Extract 10 (c) and 10 (d) represent whole class discussion method as a way of teaching HIV and AIDS related issues. Through this method GVIs can listen to the ideas and comprehend the topic in discussion. In extract 10 (c) GVIs' comprehension is explicitly represented by a statement "I listen to the ideas and can also develop some knowledge of what is being discussed" and "I get the points" in extract 10 (d).

Findings show that teaching continues because of the nature of repetitive responses of different learners who respond to the same question. In (c) the idea of repetition is represented in a phrase "different ideas are presented several times by different individuals" and in a statement "Each time ideas are given, the rest of the learners listen and add more ideas" in (d). These extract indicate that the method develops knowledge to the GVIs. Table 4.4 presents a summary of the methods identified in the interviews as was of teaching and learning life skills that may be tied together for improvement.

Table 4.4: Summary of the Methods Represented in the Selected Responses

Respondents' meaning	**Central Theme**
Method	**What is represented as constitutive of the method**
Explanation method	Explanation, description, or clarification of the targeted topic; Teachers ask questions for learners to answer; Teachers provide notes that GVIs copy using Braille Type Writers after the lesson.
Demonstration	It entails demonstrating life skills in the classroom; Guest speaker/ teacher/ learners perform a role, an idea or a concept;
Whole class discussion	Question for discussion is posed to the whole class; learners communicate their thoughts to others, they then reflect together the meaning and implications of each thought within the context of the focus area.

Similar to representations in extract (c) and (d) as pointed out, the representation here indicates that the teacher's role is that of a facilitator in which he/she makes the discussion continues by inspiring the learners, This role is represented by a verbs "encourages" in (e) and "motivate" in (f).

4.3.8 Life Skills for HIV and AIDS developed in the School Curriculum

Extract 11 (a)-(c) Represent GVIs responses on life skills and their influence on condom use. Extract (a) is a represented response which is cited from one-to-one interview responses from GVIs.

Extract 11: Responses on the Life Skills Learned

11 (a) GVI # 7 at X School

> I've learned and understood some of the important life skills such as "communication, decision making and refusal skills." These skills are "important" to enable an individual in responding to various situations such as HIV and AIDS prevention but they have not influenced the intention for condom use. Apart from explanations, discussions and demonstrations methods that were used and involved me theoretically, I have not received information from any other sources. So, I'm not confident in negotiating with the sexual partner in the actual use of these skills.

11 (b) GVI # 8 Y School

> We have learned different life skills. I can remember some of them which include communication, refusal and decision making skills that we can use to prevent HIV and AIDS but I can use them for abstinence but not for condom use.

11 (c) GVI # 1 at X School

> We were taught life skills for HIV and AIDS prevention. These are skills to refuse, decide and to communicate. I can use them in abstinence because I can refuse to have sex but I cannot use the skills to communicate and decide to use condoms. After all how do I get condoms?

11 (d) Biology teacher # 1 at X School

> I‘ve taught life skills including communication, refusal, decision making and negotiation skills. GVIs and other students can use these life skills to respond to various situations for HIV and AIDS prevention.

11 (d) Civics teacher # 2 at Y School

> There are several life skills that I‘ve taught. Examples of these life skills are negotiation, refusal, communication, assertiveness and decision making skills. Of course all students including GVIs learn the life skills

The GVIs’ response in extract 11 (a), (b), and (c) indicate they have learned life skills for HIV and AIDS prevention. In extract (a) and (b) they confirm that they have “learned “communication, decision making and refusal skills” which are represented as “important” tool for “HIV and AIDS prevention” in (a) but there are some facts which point to a contrary conclusion indicating that learning of these life skills have not enabled the learners to make use of these life skills. The conjunction “but” in GVIs’ extracts introduces the conclusion which is stated in a phrase “have not influenced the intention for condom use” in (a) “but not for condom use” in (b) and “I cannot use the skills to communicate and decide to use condoms.” The adverbial phrase “apart from explanations and discussions and demonstration methods which were used” indicates that these are the only methods used in teaching life skills and nothing else was taken into consideration because GVIs “have not received information from any other sources” It is from this context the GVIs validate their claim that they are “not confident” in the actual application of the life skills in negotiating with the sexual partner about the use of condoms. The adverb “after all” in (c) emphasizes something to be considered and this is the rhetorical question “how do I get condoms?” This suggests difficult in getting

access to condom. The represented extracts indicates that, from their experiences, GVIs in extract 11 (a) through (c) associate life skills learned from school-based intervention and their ability to abstain from sexual intercourse as one of the ways for HIV and AIDS prevention.

In all the extracts, the use of conjunction “but” introduces something on the contrary to the expectation. Since the GVIs declare that they have learned life skills it is expected that they could also use the life skills not only for abstinence from sex but also for condom use but in all the extracts it is stated that GVIs cannot use condoms and they do not intend to use them.” This is because they were “not confident” and they could “not use the skills to communicate and decide to use condoms” as revealed in (a) and (b) respectively.

4.4 Developing HIV and AIDS Related Knowledge about Life skills for GVIs

In the previous section, data from documentary review showed that the school curriculum incorporates contents related to HIV and AIDS which are taught in secondary schools. Also data showed that there were methods and materials which were used in the processes of teaching and learning these curriculum contents.

This section presents data showing how the processes of teaching and learning of the HIV and AIDS related contents in school-based interventions assists GVIs in developing knowledge about life skills for HIV and AIDS prevention in secondary school. The section comprises two parts. The first part presents data showing the teaching methods and how they assist GVIs in developing knowledge about life skills

and attitudes required for HIV and AIDS prevention among GVIs. The second part presents data showing how the teaching materials assist GVIs in developing knowledge about life skills and attitudes required for HIV and AIDS prevention.

4.4.1 The influence of Teaching Methods on Knowledge about Life skills

Various methods were used in school-based interventions to enable the school adolescents to attain these life skills presented in the preceding section. This sub-section presents ways through which methods categorized as explanation, demonstration and whole class discussion can assist GVIs' develop knowledge about life skills and attitudes required to form intention for HIV and AIDS prevention. Each of the categorized method has its own characteristics and ways in which they assist learning of life skill for HIV and AIDS prevention. Below are some extracts presented to illustrate the ways in which teaching methods assist GVIs' in developing knowledge and attitudes in using the life skills for HIV and AIDS prevention.

4.4.1.1 The Influence of Explanation Method

Extract 12 (a)-(c): Responses from FGD

12 (a) GVI # 4 at X School:

> In explanation method used in teaching life skills I can listen to the teacher and learn information about life skills required for condom use. However, information alone without practice is not enough to develop my intention for condom use. My intention is to abstain from sex because I can decide to say no to sex.

12 (b) GVI # 5 at Y School

> Explanation entails listening to the teacher, I get information about skills. Since condom use requires understanding on how it works, I cannot understand it well without practicing its use. Unless I have its practical knowledge I can't dare to use them. But abstinence from sex is easy; it requires decision to do so.

12 (c) GVI # 2 at School X

> The teacher gives explanation about life skills for HIV and AIDS prevention. As I listen, I get theoretical knowledge. Explanation does not show the practical use of condoms, so I cannot think of using condoms because I might use it in a wrong way. I've learned about abstaining from sex which is the safest method. It doesn't need practice but a decision which is within my reach. So my intention is abstaining from sexual practices.

In extract 12 (a) through (c) the narratives exemplify representations from FGD pointing out the power of the methods on GVIs' influence in the intention to use life skills for HIV prevention. This influence is represented by a statement; "I can listen to the teacher and get the intended information about life skills required for condom use" in12 (a), I get information about skills" in 12(b) and "I get theoretical knowledge" in 12 (c). Extract 12 (a) through (c) indicates that through explanation, GVIs' intention for condom use is not influenced. Instead, abstinence is influenced because as reflected in 12 (a) "abstinence to sex is easy, and it requires decision to do so." The GVIs say that their intention is to abstain from sex represented by "to abstain from sex" in 12 (a) "abstinence to sex" in 12 (b) and "abstaining from sex" in 12 (c).

These extracts show that GVIs have opted for abstinence from sex rather than condom use because they have learned decision making skill required in abstinence from sex. However, the extracts indicate that when the intention of using condom is compared to the intention for abstinence from sex, the later intention is possible to implement. This possibility is represented by their narratives in "It doesn't need practice but a decision which is within my reach in"12 (a), "Abstinence from sex is easy; it requires decision to do so" in 12 (b)" and "It doesn't need practice but decision which is within my reach" in 12 (c).

As indicated in the extracts, the influence of this knowledge about decision does not reach the extent of influencing the intention of using condom exemplified in expressions such as “Information alone without practice is not enough to develop my intention” in 12 (a), in the expression “Unless I have practical knowledge of condom use I can’t dare to use condoms” in 12 (b) and “I cannot think of using condoms” in 12 (c). Their beliefs and feelings about the use of condom is fear to use them represented by phrases such “I can’t dare to use condoms”

The represented extracts indicate that given an opportunity to practice the life skills GVIs’ attitudes for the intention for using condom can be formed as it is represented by the conjunction “Unless” in extract 12 (b) which is used to introduce a condition that has to be fulfilled.

The explanation method represented in the FGD indicates that information is developed mostly from listening from the teacher and that learning through this method is not sufficient for developing adequate skills to use condoms. However, this scenario indicates that they have positive attitude towards both abstinence and condom use for HIV prevention but life skills are limited to abstinence only.

Extract 12 (d)-(e): Representations from One-to-One Interview Responses

12 (d) GVI # 8 at X School

> The method cannot develop intention to use condom because even though you listen as the teacher, and you understand perfectly well, still, all you get is the abstract knowledge. Intention for using condom also requires visual presentation to develop the practical skill. The method has influenced my intention for HIV and AIDS prevention through

> abstinence from sex because I can decide, and say no to sex. I have listened and understood what to do to remain abstinent from sex.

12 (e) Civics teacher # 1 at Y school

> I think the life skills that GVIs have learned can influence their intention for HIV and AIDS prevention methods used in teaching. This is why we teach them. They can use the skills to refuse sex but I'm not sure if they can have access to condoms and negotiate with the sexual partner over the use of condoms because they are not confident.

Extract 12 (d) indicates that explanation method is all about getting concepts represented by a phrase "all you get is the abstract knowledge" in (d). GVIs are of the opinion that condom intention requires practical skills which are not available in explanation method. The extracts indicates that prior to the use of condoms, knowledge about life skills obtained theoretically from explanation method are important and because of their importance, an individual needs clear knowledge about these skills. However, the knowledge needs to be visualized as represented by a phrase "visual presentation" in 12 (d).

Teachers represented responses are consistent with GVIs' feelings about lack of ability to access condoms as well as lack of life skills to negotiate for the use of condoms. Teachers responses represented in extract 12 (e) indicate that, although teacher were teaching HIV and AIDS related contents, teachers had doubts about the influence of the life skills in GVIs intention for HIV and AIDS prevention. This is represented by the use of the phrase "I'm not sure". Also teachers have doubt about accessibility of condoms and lack of confidence among GVIs.

GVIs require "practices" or "practical skills" as it is represented in 12 (d) and in addition to the explanation method. It indicates that the influence of the method in

teaching the life skills on knowledge does not develop belief in the intention to use condom because of the theoretical knowledge which is not enough to influence the use of condom.

The influence of the method to life skills knowledge required for abstinence among GVIs is positively considered because in extract 12(a) the respondent says that she has “listened and understood what to do to remain abstinent from sex.” The extracts indicates that the respondents have skills such as decision making and refusal skills represented by “decide, and say no to sex” and “decision making and refusing sex” in (b) and (c) respectively.

4.4.1.2 The Influence of Explanation Method

Extract 13 (a)-(c): Representations from FGD

13 (a) GVI # 11 at Y School

> The method increases my knowledge about life skills because as the teacher gives instructions for condom use, I can listen and understand what is going on. I hesitate to say that it has influence on my intention for condom use because I did demonstration once and of course with the assistance of a sighted peer. Since then I’ve never touched the condom again, let alone practicing its use.

13 (b) GVI # 13 at X School

> Demonstrations, which were done on how to use life skills, have influenced my intention on abstinence using refusal skills to reject sexual behaviour. Refusal skills entail ability of making firm decision to decline what someone else wants you to perform/execute. I didn’t personally get involved in the condom use demonstrations in the class, but only participated through listening and discussion with friends who could see. Hence my intention on condom use is not influenced much. I’m not certain whether I can use condoms appropriately.

13 (c) GVI # 14 at Y School

> Life skills required for condom use were demonstrated and I understood them. However, if I’m to use the life skills for condom use, actually this is challenging because we are not given time and assistance to

> demonstrate the required life skills so that we can use the same skills on our own without any doubt.

Representations of the responses from FGD about the demonstration method used in teaching life skills and its influence on condom use intentions indicate a number of things as represented in 13 (a) through (c). In the extracts, narratives indicate that the demonstration method increases GVIs' knowledge about life skills. In 13 (a), for instance, it is clearly stated in the first sentence in the phrase; "demonstration increases my knowledge about life skills." In extract 13 (b), the phrase "have influenced my intention on abstinence thus using refusal skills for sex rejection" implies knowledge of abstinence which is also represented in extract 13 (c) in the expression "I understood them."

The knowledge expressed in these phrases indicates that demonstration method can assist GVIs in learning and gaining knowledge about life skills required for HIV and AIDS prevention. Nonetheless, the practicability of the method does not stand for GVIs' belief in using the knowledge for condom use as indicated in extract 13 (a) in a phrase "I hesitate to say that it has influenced my intention for condom use." This extract represents a hold back in uncertainty in the intention of condom use.

In a phrase "my intention on condom use is not influenced much" in extract 13 (b) represent an influence which is negatively expressed by an adverb "not" and by an adjective "much" which is used to quantify the influence. The same extract ends with a concluding statement; "I'm not certain as to whether I can use it appropriately" indicating uncertainty in the ability to use condom, which is also an indicator of lacking influence in condom use.

In 13 (c) the phrase “to use the life skills for condom use, actually this is challenging” indicates that GVIs lack ability to use condoms. This challenge is a result of limited time and assistance in the demonstration in the processes of teaching and learning, an observation, which is made by the expression “we are not given enough time and assistance to do demonstrations” in extract 13(c).

In all the extracts, representations indicate that GVIs are uncertain about their intention on condom use, a situation which has given rise to the hindrance to the limited intention to condom use. Specifically the hindrance to their intention for condom use is represented in different reactions such as “I hesitate” in extract 13 (a), “I’m not certain in 13 (b)” and “doubt” in 13 (c).

Extract 13 (d)-(f): Representations from One-to-One Interview Questions

13 (e) GVI # 12 at Y School

> The demonstration method which is used in teaching life skills does not have much influence on my intention for condom use because I didn’t get enough knowledge about the practical use of condom. During demonstrations on life skills I listen and have learned about the use of condoms but I can’t use them. So my intention is on abstinence to sexual intercourse because I have skills to decide and refuse sex.

13 (f) GVI # 12 at Y School

> In fact, the demonstration method used to teach life skills has provided me with some knowledge about condom use. In this method life skills are demonstrated in front of the class by a few learners but I need more practice and involvement in demonstration method to influence my intention for condom use. Through this method I listen to others as they demonstrate and I’ve been influenced in abstinence from sexual intercourse.

Extract 13 (e) indicates that GVIs do not have the required knowledge as represented in a statement; “I didn’t get enough knowledge about the practical use of condom.”

The statement indicates that the demonstration method enable GVIs to gain knowledge about condom use. Since the method does not allow enough practice, it does not have much power to influence GVIs' intention for condom use. The represented phrase in extract 13 (f) indicates that they "need more practice and involvement."

Extract 13 (d) through (f) indicate that gaining knowledge through demonstration is possible to GVIs and the influence of the life skills gained from this method is important. The impact of the method to the knowledge gained is also important, but its influence to condom use is the most important issue that has raised concern in the represented influence to the GVIs' inability to use the learned life skills for condom use for HIV and AIDS prevention.

4.4.1.3 The Influence of Whole Class Discussion Method

Extract 13 (g-h): Representations from FGD

13 (g) GVI # 9 at X School

> The whole class method has influenced my intention for abstinence from sex as an option to condom use. This is because we gained knowledge about life skills in the class from ideas such as saying "NO" to sexwhich cannot be applied in the practical use of condom. A life skill such as refusal skills is easy to use by refusing to have sex and remain abstinent from sexual intercourse as long as I have decided to abstain from sex. In this case my only choice is to use all means possible including the use of strict and convincing language so as to sustain my refusal stance of not having sexual intercourse out of marriage. I believe I can succeed through this approach because the other alternative, i.e., using condoms is out of my bound since I have never been exposed to knowledge, skills and practices of using condoms. Such usage requires practice and familiarity.

13 (h) GVI # 4 at Y School

> Mostly, the method is based on developing ideas about life skills for HIV and AIDS prevention such as the awareness of the pandemic and

> purposive strategic decision making. The ideas further develop critical and reflective communication and healthy relationship building techniques which include refusal skills. Since the method does not engage us in practical use of the skills for condom use, to me, using condoms is not so far highly regarded as something worth trying. The discussion method is used in a way that we are only exposed to listening and responding to issues arising from our discussions. HIV and AIDS is seriously a deadly disease as a consequence prevention of the disease needs equally serious practical methods of which the discussion method does not offer.

In Extract 13 (g) the required skills for condom use intention is limited by the discussion method. This method brings about knowledge through discussions which, on its own is only a foundation for ideas that remain within the cognitive domain of 'thoughts' and not practical actions. For instance, the phrase "has influenced my intention for abstinence as an option to condom use" indicates that their intention for using condom is redirected to abstinence as an alternative to the condom use due to the fact that they cannot use the theoretical knowledge from discussions for the practical use of condoms in order to prevent HIV and AIDS infections. Further the extract shows that given knowledge of some skills exemplified by "refusal skill," an individual can make choice to avoid sex, but this same skill is considered by the respondent as not being sufficient enough for fulfilling the intention of using condom.

In extract 13 (h) the representation of the FGD focuses on whole class discussion having an unfavourable outcome as regards intention for condom use indicated by a phrase "using condom is not so far highly regarded as something worth trying." This phrase shows GVIs' attitude involving beliefs, feelings, values and personality regarding the intention to use condom.

Explicitly extract 13 (h) indicates that the method does not influence GVIs intention for condom use in the phrase that indicates the need for "serious practices for which

the discussion method does not offer." The phrase also implies that HIV and AIDS cause fear to GVIs because they have shown knowledge about HIV and AIDS as a pandemic in the phrase "HIV and AIDS is a seriously deadly disease." In both extract 13 (g) and (h) GVIs have come up with important suggestions that address the current use of the discussion method. In (h), GVIs' suggestions are based on improvement of the methods suggested in statements such as "prevention needs equally serious practice" for "the actual performance of the practice." In extract 13 (g), GVIs suggest that "condom use requires practical familiarity with life skills."

Extract 13 (i): Representations from One-to-One Interview Questions

13 (i) GVI # 10 at X School

> Whole class discussion method used in teaching life skills does not develop my intention to use condom. This method is mostly limited to thinking and sharing ideas with others, it continues until you have exhaustively explored the answer to question. The method does not consider GVIs because we cannot see the contextual relevance of the life skills under discussion so as to be able to use them in various situations such as when using condoms. This method has influenced my intention to abstain from sex because I can say "NO" to sex.

In extract 13 (i), the extent to which the method influences GVIs intention for condom use is illustrated as having no power to influence GVIs' intention for using condoms. Lack of this power is represented by the phrase "does not develop my attention to use condom." The extract also indicates that, failure of the GVIs to develop intention for condom use is an end result for the whole class discussion method which includes "thinking" and "sharing" ideas. GVIs concern about this method is that they **"**cannot see the contextual relevance of the life skills" to make the use of condom perceptible for the actual practical use of condom use.

Another observation from this extract is the use of whole class discussion method which does not consider the needs of GVIs because the extract shows the whole class discussion method does not assist them to contextualize the “relevance of the life skills under discussion.” Consequently; GVIs have opted “to abstain from sex.” In this extract, the main concern about the whole class discussion method is the contextual application of life skills which is not put into consideration. This observation is exemplified in the phrase indicating that GVIs “cannot see the contextual relevance of the life skills under discussion.” This phrase shows that it is not enough to discuss and give views about life skills; rather, it is essential to see how the uses of these life skills function in various situations and how these life skills influence GVIs’ abilities to use them in the context of HIV and AIDS.

Similar to explanation and demonstration methods, the effect of the whole class discussion method, in learning life skills is largely theoretical based on understanding life skills and the information required for condom use and for abstinence from sexual intercourse. The use of the whole class discussion method in the processes of teaching and learning knowledge and skills does not provide GVIs with the ability and belief to make use of the knowledge of life skills required for the actual competence or ability to use condom. GVIs’ intention is only based on abstinence from sexual intercourse. Table 4.5 presents a summary of the methods used in the teaching and learning processes on the knowledge about life skills and the belief to use the same life skills for HIV and AIDS prevention in the selected responses.

The table has two columns including a column showing the respondents’ meaning

about the methods which were used along the progress of teaching and learning continuum. The other column shows the summary of the central themes presented by the GVIs' narratives of each method. The methods indicated in the table include explanation, demonstration, and whole class discussion and the central theme represented in the narratives is provided for each method.

The central theme exemplified in the explanations method indicates that explanation method was represented by descriptions or clarification to assist comprehension of theoretical knowledge of life skills that GVIs listened to. This theme is built by GVIs' impression of theoretical learning that does not influence their intention for using condom.

Table 4.5: Summary of Teaching Methods' Influence on Life Skill Knowledge

Respondents' meaning:	**Central Theme:**
Method	**What is represented through teaching methods as assistive to learning life skills and their influence to condom use**
Explanation	Explanations, descriptions, and clarification methods only assist comprehension of theoretical knowledge about Life Skills that GVIs heard in class. However learning that is basically theoretical does not influence learners' intention for using condom.
Demonstration	Life skills demonstrated by others, which are associated with talking, develop ideas or concepts that GVIs listen to during these demonstrations but they do not provide practical knowledge to develop intentions for using condom.
Whole class discussion	Questions for discussions posed to the whole class enabled GVIs to think and reflect on others' thinking and gain knowledge but on its own whole class discussion method cannot develop intentions for condom use. Learners need practical methods that can involve them in practical learning.

Through the demonstration method, life skills are shown and verbally expressed through students' class work or project presentations. The method is associated with 'speech'/'talking about' characters or artefacts that show things with the aim of developing ideas or concepts. In this case the demonstrations are targeted at showing and talking about things that GVIs get exposed to during life skills classes which capture issues on HIV and AIDS. The representation of the extract indicates that this method does not provide practical knowledge to develop intention for using condom among GVIs. The table also indicates that whole class discussion method included questions for discussions which were posed to the whole. It shows that the method involves GVIs in thinking and reflecting on the thinking of others and gain knowledge and life skills for practicing healthy life but it develop intention for condom use among GVIs. GVIs need practical methods that can involve them in practical learning because the methods provide some theoretical knowledge and skills that have influenced GVIs intention for abstinence from sexual intercourse; the behaviour that GVIs consider easy to perform compared to condom use which requires a multifaceted understanding of life skills required for condom use.

4.4.2 The influence of Teaching and Learning Materials on Knowledge about Life Skills

This part presents findings about the materials which were used in teaching HIV and AIDS related topics and their influence on GVIs' knowledge about life skills for HIV and AIDS prevention. Findings were collected from documentary review and interviews. The main materials which were used in the processes of teaching and learning were text books with information about HIV and AIDS, male condoms, and

penile models. Text books provided teachers with detailed content about HIV and AIDS while male condoms and penile models were used to demonstrate the use of condoms. The influence of these materials on knowledge about HIV and AIDS prevention is presented in extracts 14 (a) through (d). The influence of books which were used to teach information about HIV and AIDS prevention is presented in extract 14 (a) and (b) and the influence of male condoms and penile models is presented in extract 14 (c) and (d).

Extract 14 (a-b): Extracts from One-to-one Interviews

14 (a) GVI # 5 at X School

> HIV and AIDS materials available at our school are books. Lack of materials through which I can access information about life skills limits my knowledge because we GVIs can't get any information from books. Intention for HIV and AIDS prevention cannot be developed through information written in these books because I can't read them.

14 (b) GVI #13 at Y School

> Most of the required information about HIV and AIDS is contained in non-Braille such as text books. Without Braille materials those who have visual impairment cannot access information about HIV and AIDS content within the life skills syllabus. This information is necessary for understanding HIV and AIDS prevention and intension for healthy life.

Extract 14 (a) and (b) provide narratives about the types of print based materials used for life skills intended for preventing HIV and AIDS. These extracts suggest some characteristics of the materials. One of the characteristics of the materials is that they are not user friendly to GVIs because they are not in Braille form. Consequently, the condition leads to limited knowledge about life skills for behaviour intentions. In (a), the materials do not aid GVIs in learning life skills as implied in the statement which says, "Intention for HIV and AIDS prevention cannot be developed through

information written in these “books”. The same extract (a) shows that GVIs “cannot access information from these books” to facilitate understanding and intention for HIV and AIDS prevention. In (b) it indicates that it is because “most of the required information is in non-Braille materials.”

These extracts show that intentions for HIV and AIDS prevention are constrained by limited information. As far as the GVIs are concerned, even the limited information does not directly reach them since they cannot ‘see’, GVIs get information through listening to their teachers and their sighted peers.

14 (c)-d): Responses from FGD

14 (c) GVI # 15 at X School

> Materials used in teaching how to avoid HIV and AIDS are male condoms, and penile model. The use of these materials has given me some knowledge about condom use. However, these materials “do not influence” my intention for the use of condom because I’ve not learned enough about such use. Instead I’m inclined to abstain from sexual intercourse because I don’t have confidence on condom use unless I get more information and access to condom.

14 (d) GVI # 10 at Y School

> The knowledge about the materials used such as male condoms and penile model has influenced my way of thinking about healthy practices to avoid HIV and AIDS. On the other hand, to me the use of these materials does not influence my intention to use them” because I didn’t have opportunity to practice well, but also I’m not sure I can access condoms even if I intend to use them.

The response in extract 14 (c) represents materials used in teaching and learning and the way they influence GVIs’ “knowledge about condom use.” The narratives in the

extract indicates GVIs' acknowledgement showing that the "male condoms and the penile models" have influenced their "knowledge about condom use." In extract 14 (d), the influence of materials used in teaching how to avoid HIV and AIDS is expressed in a narrative which states that "knowledge about the materials used such as condoms and penile model has influenced my way of thinking about healthy practices to avoid HIV and AIDS."

In extract 14 (c) there is an exemplified circumstance which indicates materials "do not influence" GVIs' intention for condom use. This circumstance is lack of confidence demonstrated in a statement which states that "I don't have confidence on condom use." In extract 14 (d) the circumstance that indicates materials and their uses impede GVIs in developing intention for condom use is reflected in the GVIs narratives stating that she "didn't have opportunity to practice well." In the same extract another circumstance that shows GVIs restricted intention for condom use is represented in the GVIs' justification stating that, "'I'm not sure I can acess condoms even if I intend to use them." Intention to "abstain" represented in (c) does not have direct relationship with the use of materials. Rather the GVIs' intention for condom use stands as an alternative option to the use of condom because of lack of "confidence" to use condom and therefore they cannot use condoms.

Extract 14 (e): Representation form One-to-One Interviews

14 (e) GVI # 6 at Y School

> Using materials such as condoms and penile model in learning does not guarantee the actual ability of using condom because learning and getting information is one thing but influence to the intention to act is a different concern. After all intention to use condom is not a personal issue. It also

> depends on the sexual partners' intention to use them and your ability to convince him to use them. So my intention for now is to abstain from sexual practices.

The narrative in extract 14 (d) and (e) indicates the use of "condoms and penile model" in teaching and learning processes cannot "guarantee the influence to the actual ability to use condom." In extract (e) it is stated that "learning" alone is not sufficient to bring "influence to the intention to act." The conjunction "but" is used to introduce something in contrast because the cognitive processes of acquiring skills or knowledge (learning) is expected to enable individuals "to act" according to the knowledge. In a different statement of the respondent, an adverb "after all" is used to emphasize that in spite of everything "intention to use condom is not a personal issue."

Further the extract represents a state of being controlled by someone else in the "intention to use condom." This intention "depends on the sexual partners' intention to use condoms" and on the GVIs' "ability to convince him to use them." Apart from consideration of sexual partners as a hindrance to the intended intention, the situation is compounded by the information in the extracts that indicates GVIs cannot use or access condoms. If condom access is a problem as it is presented in (c) "intention for abstinence" from sexual intercourse it is taken as an alternative to condom use.

Table 4.5 shows that male condoms and penile models were used in the demonstration to provide knowledge about condom use but findings show that GVIs do not learn enough from life skills demonstrations. Since the knowledge is not

enough GVIs are not confident in using condoms. However, knowledge has influenced GVIs' way of thinking about healthy practices. On the other hand, the opportunity, which GVIs are given for practicing how to use condom is limited. Apart from lack of adequate practice for condom use, GVIs are not sure to access condoms when they need to do so.

Table 4.5 below summarizes ways through which teaching and learning materials can influence knowledge about life skills for behaviour intentions.

Table 4.5: Teaching and Learning Materials as Influencing Behaviour Factor

Respondents' meaning:	**Central Theme:**
Materials	**What is represented in materials as an influencing factor to condom use**
Male condoms and penile models	They provide knowledge about condom use. Learning is not enough. GVIs do not have confidence in using condom. Knowledge has influenced way of thinking about healthy practices. Opportunity to practice condom use is limited. GVIs are not sure to access condoms. Sexual partners can limit intention GVIs condom use intention. Materials do not influence condom use intention. GVIs have opted for abstinence to sexual intercourse as an alternative to condom use.

The table also indicates that sexual partners can limit intention for GVIs' intention for condom use. Further, materials that are used in teaching the use of condom do not influence condom use intention among GVIs. Consequently, GVIs have opted for abstinence to sexual intercourse as an alternative to condom use.

4.5 Challenges Limiting GVIs' Intention for HIV and AIDS Prevention

This section presents findings of the third research question about challenges that GVIs face as limiting factors to intention for healthy behaviours for HIV and AIDS

prevention. Findings are presented in two main parts. The first part presents limitations emanating from implementation of the school curriculum. Specifically implementation of the school curriculum is based on teaching and learning processes of the HIV and AIDS related curriculum contents. The second part presents limitations emanating from the social context.

4.5.1 Teaching and Learning processes as a Limiting Factor

Data showing teaching and learning processes as a limiting factor for GVIs' knowledge and attitudes for intention for healthy behaviours for HIV and AIDS prevention is presented in extract 15 (a) through (d). Whereas extract (a) and (b) represents data from FGD, extract (c) and (d) represent data from one-to-one interviews.

Findings from both FGD and one-to-one interviews confirm that discriminative teaching and learning processes was one of the challenges limiting GVIs' knowledge and attitudes for healthy behaviours such as the use condoms.

Extract 15 (a) and (b): Data from FGD

15(a) GVI # 14 at X School

> Demonstration about the use of condoms was modelled by a guest speaker who was invited to explain to us about condom and their uses. Then a few SGs volunteered to do the demonstration in front of the class. I could not see what was happening and until now I've never touched a condom. Even though I know that condoms are effective for HIV and AIDS prevention, how could I use something that I've no idea about its use?

15 (b) GVI # 2 at Y School

> With the exception of explanations and demonstration which were done by a nurse who was invited to teach us about condoms, I've not touched

> them let alone practicing how they are used. During the lesson, some of the sighted peers were asked to practice the use of condoms but GVIs were not encouraged or assisted to practice how condoms are used. The way in which condom were taught is a limiting factor to my intention to use condoms"

Extract 15 (c) and (d): Data from One-to-one interview

15 (c) GVI # 16 at X School

> I can't imagine how I can use condoms because demonstrations about how condoms are used were done by the teacher through brief explanation and demonstrations in front of the class. The teacher invited a few SGs to do the same demonstration but none of the GVIs was given a condom to touch, feel and demonstrate its use.

15 (d) GVI # 16 at School Y

> I don't know how condoms are used and so far I don't have intention for using condom because the teacher did not assist us to practice. The teacher was not comfortable talking about condoms so she invited a guest speaker and after the demonstration nobody assisted GVIs to do the same demonstration.

15 (e) Biology teacher # 2 at Y School

> GVIs can face several challenges that can limit their intention for HIV and AIDS prevention. The challenges can include the fact that since they cannot see, it can be challenging for them to understand clearly some of the skills. It is also difficult to for them to access condoms due to their restricted movement. Further, even when they are decided to remain abstinent from sexual practices, they can be forced to engage in such practices. Since they cannot see the abuser, they cannot run away from for their safeness.

In extract 15 (a) through (d) there are obvious challenges related to discrimination in the teaching and learning processes that limit GVIs' knowledge about life skills and attitudes for intention for behaviour such as condom use. Themes emerge from the representations that combine to explain situations that are the causes of challenges. A unifying theme presented in extract 15 is concerned primarily with theoretical learning among GVIs rather than practical consideration.

Various remarks demonstrate discrimination in the practice required to provide the intended school youths with knowledge and skills to use condoms. In extract 15 (a), the theoretical learning is represented by a question, “how do I use something that I’ve no idea about its use?” This sentence is formulated as a question but it is not meant to be answered. It is used to emphasize ideas presented in the statements that precede it. Specifically, the point which is being emphasized is that GVIs cannot use condoms that they do not have practical knowledge about their uses.

In 15 (b), lack of skills to use condom is easily perceived in a statement “I’ve not touched the condoms let alone practicing how condoms are used.” The last statement in this extract also concludes that, intention for using condom is limited by the way life skills are taught. In 15 (c) a failure to have skills to use condom is represented by the following statement that is emphatic and explicit. “I can’t imagine how I can use condoms.” and in 15 (d) it is represented by a statement, “I don’t know how condoms are used” As negative sentences, they represent a form of lack of mental image about the use of condoms.

This representation indicates that GVIs do not have a clear mental image because of the reasons provided in the phrases including the reason that “none of the GVIs was given a condom to touch, feel and demonstrate its use,” in (c). The concluding remarks in the last sentence of extract 15 (d) states that, “After the demonstration nobody assisted GVIs to do the same practice.” The responses represented in extract 15 from both on-to-one interviews show that, GVIs have theoretical knowledge about condoms which they cannot use for HIV and AIDS prevention. In the light of

the theoretical knowledge, GVIs do not form attitudes towards HIV and AIDS prevention through the use of condoms.

Table 4.6 summarises GVIs responses about teaching and learning processes as a limiting factor for GVIs' knowledge and attitudes for healthy behaviours. On the left side of the table, the challenge that limits GVIs intention to use condoms is lack of practice to use condoms. On the right side, the table shows that this challenge affect GVIs' intention to use condoms due to the theoretical skills learned through explanation and demonstration methods.

GVIs can listen to the explanations but they cannot see the demonstrations done about the condom use because they do not touch the condoms or practice its use, therefore it is difficult to use condoms for HIV and AIDS prevention.

Table 4.6: Processes of Teaching and Learning as a Limiting Factor for GVIs' Knowledge and Attitudes for Healthy Behaviours

Respondents' meaning:	**Central Theme:**
Challenge	**What is represented in the challenges**
Lack of practice to use condoms	GVIs learn theoretical skills due to discriminative methods that deny GVIs participation in demonstrations
	They can listen to explanations but: They don't see demonstrations on condom use They don't touch condoms They are not assisted to practice the use of condom. Thus it is difficult to use condoms

4.5.2 Social Factors Limiting GVIs' Intention for HIV and AIDS Prevention

In the preceding part, data show that teaching and learning processes is a factor that limits GVIs' knowledge and attitudes for condom use as one of the healthy behaviours for HIV and AIDS prevention. Consequently, GVIs knowledge about life skills for HIV and AIDS prevention was limited to abstinence from sexual practices. However, findings show that there are social factors that are likely to mediate between their intention that is within their knowledge, beliefs and attitude towards the actual performance of behaviour for HIV and AIDS prevention. This indicates that GVIs can engage in sexual practices despite their intention for abstinence from sexual practices due to social factors including peer group influence, sexual abuses, limited access to condoms and social discrimination.

4.5.2.1 Pee Group Influence

Peer group influence on GVIs' intention for HIV and AIDS prevention is presented in Extract 16 (a) represented by GVI # 15 at School Y said that, "Our friends give us their experiences about their behaviours. They can affect our intention because instead of sticking to your intention you can be motivated by their experiences and their expectations".

In extract 16 (b) GVI # 9 at Y School said that, "Although I have intention to abstain from sex, some of my friends have different intention. Peers can influence others' behavioural intention in engaging in sexual practices".

In extract 16 (c) GVIs # 13 at School X said that, "You see, friends can suggest behaviours that they think appropriate for them. While your intention is to abstain

from sex some friends talk about sex. It is possible for your behaviour to be influenced negatively or positively".

Extract 16 (d) presents GVIs # 15 at Y School who said that, "Your Intention to perform HIV and AIDS related behaviour can be influenced by perception of what others think and do. For example when they hear you talk about abstinence, they laugh at you and call you antisocial".

Extract 16 (a) through (d) present peer group influence that are represented as hindrances to behaviour intention. In these extracts, GVIs have established their awareness of the influence of their peers on their behaviour intention. This awareness is represented in a statement which indicates that they "can be motivated by their experiences and their expectations" in (a).

Table 4.7: A Summary on Peer Group Influence on Behaviour Intention

Respondents' meaning:	**Central Theme:**
Challenges	**What is represented in the challenges**
Peer group influence	Peers share experiences Experiences influence intention of each other Friends can suggest behaviours that they think appropriate for them. Behaviour intention is influenced by perception of what others think and do

GVIs are also aware that "Peers can influence others' behavioural intention such as engaging in sexual practices" as presented in (b). In (c), the influence is directly related to friends who can even suggest behaviours that they think appropriate for

them." Further, GVIs represented responses in (d) indicates that "behaviour can be influenced by perception of what others think and do". Table 4.7 provides a summary showing how peer group influences GVIs' intention for HIV and AIDS prevention.

4.5.2.2 Sexual Abuses

Extract 17 shows that GVIs lack protection in harmful situations such as sexual abuses. These situations are presented in extract 17 (a-d).

17 (a) GVI # 4 X School

> I have an example of a GVI who was sexually abused by the teacher last year. She told me that the teacher insisted to have sex with her and she could not resist because she could not fight back. She also told me that she feared the teacher could punish her and she never reported the incidence. Since then she has been very frustrated and miserable.

17 (b) GVI # 1 at Y School

> Although I'm determined to abstain from sex, it needs a lot of precautions because while you are determined to protect yourself, you can be sexually abused. For example, in a place where I come from, a GVI was sexually abused because she went out of their family without any precaution.

17 (c) GVI # 3 at Y School

> One of the challenges about me is that my intention to abstain from sex for HIV and AIDS prevention can be limited by inability to protect sexual abuses. One girl was sexually abused by her boyfriend who insisted to have sex with her and promised to marry her. She feared to lose him, she became pregnant and he never married her."

17 (d) GVI # 5 School X

> I strongly intend to protect myself from HIV and AIDS but the environment is not always conducive to enable me to fulfil my intention because there are risky situations. One GVI was sexually abused last year by her boyfriend. She became pregnant and was expelled from school.

In Extract 17 (b) and (c) narratives from GVIs are represented as having harmful situations in a form of sexual abuse. GVIs are represented as having intention to "abstain from sex" as indicated in extract (a) and (d). Intention for HIV and AIDS protection is important but the actual protection is yet a big issue because of the following reasons; GVIs' "inability to protect sexual abuses," narrated in (c); "environment which is not always conducive" for behaviour intention narrated in (d); lack of "precaution" exposed in (b), "fear" to resist abusers in (a) and fear to lose relationship in (c)

In the findings presented in extract 17 it indicates that there is lack of supportive environment on sexual violence prevention in school environment and outside the school environment. In extract 17 (a) the GVI is sexually abused in school environment and in the rest of the extracts (b-d) the represented abused GVIs takes place outside of school. It also indicates that GVIs can be sexually abused by people they know such as boyfriends as presented in extract 17 (c) and (d). Although schools are places where knowledge and skills for HIV and AIDS prevention are provided, the environment is not safe. Extract 17 (a) indicates that GVIs are sexually abused in school by the teacher. Extract 18 (a) through (d) are representations from GVIs' responses from FGD.

18 (a) GVI # 11 at X School

> My intention for condom use is challenged by the limited power to decide. In condom negotiation, if a sexual partner is of "different opinions" towards the use a condom, his decision can be final and it is worse to an individual like me who cannot run away, and I can't fight back. He can force me into sex without condom whether I like it or not.

In extract 18 (a) GVIs are represented as having limited decision making power that is a challenge to their intention for condom. The specificity of the challenge is given evidence by a situation in which a "sexual partner" has a "different opinion" on condom use, and the decision making power of the GVIs is absolutely restricted. The same limited decision making power is presented in GVIs narratives extract 18 (b) and (c).

18 (b) GVI # 13 at Y School

> It is not necessarily that ones' intention for condom use or abstinence from sexual intercourse is fulfilled because when a male partner's intention is have sexual with or without condom you can explain to him your will about your intention but still he can insists and force to have unsafe sex. Obviously it's difficult to resist and maintain your intention unless you have somebody for rescue. In case I face such a situation, I don't know what I would do.

In extract 18 (c) GVI # 14 at X School said that, "Your intention does not guarantee you to fulfil it because it needs negotiation which has to be considered not by yourself but also by the sexual partner." Extract 18 (b) presents examples of situations which are also reflected in extract 18 (a). The fact that their intention for "condom use" or "abstinence from sexual intercourse" is challenged by lack of decision making power is represented in phrases such as "he can insists and force to have sex without condom." This is because as it is stated in (b) intention is "to be considered not by you but also by the sexual partner." Therefore as indicated in (c) if the two of them do not come into consensus the weaker one and of course the GVI becomes the victim of the circumstance.

Of concern in extract 18 (b), there are issues emerging from this extract in several phrases. For instance in a phrase, it "is not necessarily that ones' intention for

condom or abstinence from sexual intercourse is fulfilled” and in a phrase “intention does not guarantee you” in (c). These phrases indicate that GVIs’ intention for condom use or abstinence from sex is regarded in such a manner that it could not be otherwise because a male partner’s intention places limits to GVIs who are inevitably bound to their partners’ intention. Consequently, their intention for HIV and AIDS prevention is likely to be directed to the opposite direction of unsafe sex.

A similar proceeding which covers a wide range of the extract appears in a statement, “It is difficult to resist and maintain your intention unless you have somebody for rescue” in 18 (b). This is a subject worth to note because the expected response in this phrase is “to resist and maintain intention.” The reality claims that are made in this phrase are also represented as having sustained intention but the conjunction “unless” indicates that their intention in unlikely to have effect if not they “have somebody for rescue.” “Somebody” in this phrase must be an important person who is able and willing to rescue but this somebody has to be considered in a broader perspective so that the response is relative to the intention for condom use and the intervening factors such as “forced to have sex without condom” in (b) and “force me into sex without condom” in (a). Specifically a broader perspective could be that looks at it in terms of safe environment to ensure the safety to these girls and other adolescents with disabilities in schools.

Another aspect of the representation in extract 18 (b) is the dilemma represented in “I don’t know what I would do.” This is a statement of uncertainty that makes an individual unable to think clearly, and consequently call for an alternative connected

to equally unfavourable alternatives. GVIs are taught life skills that are useful to respond to various situations, but they "don't know what to do." This is a point of view coming into being suggesting that the knowledge of life skills alone is not enough for the GVIs to respond to various situations discussed in extracts (d).

18 (d) GVI # 10 at Y School

> Even if I have intention for condom use, who knows that a sexual partner will agree to use condom? The main issue is the ability to negotiate and understand your partner's intention and respond according to your intention of which I think it might be very challenging to me. For instance, responses such as, "freeing myself and running away are impossible."

In 18 (d) the extract starts with an adverb "even," which is used to indicate something unexpected. The statement "I have intention for condom use," on its own indicates that there is a plan to use condom. The adverb "even if" contradicts the statement. This contradiction is further symbolized by the rhetorical question, "who knows that a sexual partner will agree to use condom?" This rhetorical question is used to persuade the listener to understand how it is not possible to know whether the sexual partner will be willing to use condoms.

Further, the extract indicates that there is the issue of "ability" which is doubtful in situations in which there is requirement to "negotiate and understand your partner's intention." This phrase indicates that not only is negotiation skill required but also there is need to "understand the partners' intention." The partner's intention presented here is not necessarily that it should concur with the girls' intention. Otherwise to "respond according to your intention" indicates that it is likely that the

other person could have a different intention. In the phrase “I think it might be very challenging,” represent a concept that brings into mind an act of negotiation and responding to the represented “challenging” situations such as self “freeing” and “running” away from forced and unprotected sex.

Extract 18(e): Extract from One-to-one Interview Responses

18 (e) GVI # 15 at Y School Y

> I have a feeling that as a GVI, my intention for condom use is not only centred on my own decision but also to the sexual partner. This is because if the male partner does not want to use condom and he really means it, my intention for condom use will end in vain because the man can force me to have unsafe sex even if I resist.

This extract indicates a feeling of concern about intention of a “sexual partner” as one of the challenges that hinder GVIs’ “intention for using condoms.” One of the represented concepts is “intention for condom use.” Similar to most of the responses in the above extracts, the intention for condom use is limited by GVIs’ “feelings”. The feelings are negatively perceived and represented by situations represented in the following statement “it is not only centred on my own decision.” The feeling is presented in a statement “I have a feeling.” In this statement, the word “feeling” indicates that an individual is experiencing a state characterized by emotions about their physical situation which is a challenge on its own. It is expected that the male partner who “does not want to use condom,” predetermine situations such as decision of the sexual partner can “force” the GVIs to “unsafe sex.”

The consequences of one’s intention which is not expected to meet the requirements such as condom use are the feelings of the future expectations such as failure to

"resist" force. These feelings cannot be taken for granted as a message expressing an opinion based on feelings because even the intention for condom use is an anticipated outcome that is intended or guides by a planned action for HIV and AIDS prevention. Since condom use intention is a planned action about the actual use of condom then feelings of those who are expected to carry out the intention are central so they are presented in extract 18 (f) because of this importance.

18 (f) GVI # 12 at X School

> I always think of intention for condom use but mostly, my fear is the instance in which a sexual partner does not have the same intention as mine. Definitely I cannot free myself from him because I know he will force me for sex without condom. So I would better not consider intention for condom use instead, I'm for abstinence from sex although a male partner can force to have sex without my will.

In this extract, attention is based on "fear" that is beyond doubt as it is expressed by the adverb "definitely." The use of the word definitely brings the sense of certainty and because of this certainty, the "fear" is carefully weighed because the respondent uses the verb "know" indicating that she possesses specific information that the sexual partner will "force" her to have "sex without condom." This "fear" conforms in every aspect of the situation presented in this extract because it further makes the GVIs' intended behaviour to deviate from intention for condom use to "abstinence." The result which indicates that she "would better not consider condom use" is marked by despair or loss of hope. However, abstinence as an alternative to condom use indicates a different way to avoid HIV and AIDS which is also highly recommended. With everything considered, intention for abstinence does not have a sense of changing direction to a disadvantaged way because it is also one of the expected healthy behaviour for adolescents.

Table 4.8 is a summary showing limited decision making power to use condom which is confined to a combination of circumstances facing them as females and as individuals with visual impairment.

Table 4.8: Decision Making Power as a Challenge to GVIs' Behaviour Intention

Respondents' meaning:	**Central Theme:**
Challenges	**What is represented in the challenges**
Limited decision making power	Despite GVIS' intention for intention for condom use, their decision making power is limited because: • Male sexual partners have more power over decision to use condom than female sexual partners. • GVIs' intention for condom use is limited. • They can easily give in to unsafe sex practices

From the female GVIs point of view, the table shows that male sexual partners have more power over decision to use condom than female sexual partners. Therefore, similar to other girls GVIs' decision to use condom is determined by men. Findings show that, GVIs' intention for condom use is limited because GVIs can easily give in to unsafe sex practices because they cannot see and resist.

4.5.2.3 4 Limited Access to Condom

Extract 19: Interview Responses about Limited Access to Condom

19 (a) GVI # 16 at X School:

> If I'm to engage in safe sex, I need to have someone else to accompany me to places where I could get condoms. To me, to plan to possess condom is a private issue which should involve personal initiatives so it can be very embarrassing for someone else even my friend to know that I'm looking for condoms. It will prove that I'm going to have sex.

19 (b) GVI # 16 at Y School

> Intention to use something is determined by one's ability to access this something. Most of us cannot walk freely; we are accompanied by

> sighted peers. You can imagine how embarrassing it is to ask someone to accompany you to the shop or to the clinic to get condoms. This means to expose your confidential matters to others. So to have access to condom is a challenge and frankly speaking I don't think I can let someone else know my intention for accessing condom. By asking somebody to assist in getting condoms would suggest intention for sex.

In extracts19 (a) and (b) representations of the GVIs narratives show that different situations challenge GVIs' intention for condom use. For instance GVIs' mobility is limited because they require a guide or somebody to accompany them to go to places where they can access condoms. Further, the extracts show that since GVIs need a companion to go to places where they can access condom, their intention to possess condoms will lose privacy. The concept of privacy is represented by various adjectives in including "private" as indicated in extract (a). It is represented as "confidential" in (b). Because of this confidentiality, access to condom involves personal initiatives and GVIs do not feel at ease.

GVIs do not feel at ease because they think that intention for condom suggests intention for sex. In extract 19 (a) for example the represented narrative states that, "It will prove that I'm going to have sex," In (b), it is indicated in a statement "By asking somebody to assist in getting condoms would suggest intention for sex. GVIs are not at ease to be accompanied to places where they can access condoms. This concern is represented by various emotional sensitivity in relation to their dignity in an expression such as "it can be very embarrassing"in (a), "I don't think I can let someone else know my intention for accessing condom." In (b), given that accessing condom needs somebody to accompany the GVIs, they feel that it is "embarrassing" for somebody else to know that they have intention for doing sex suggested by

intention to access condoms. Table 4.9 Summarizes data on how condom inaccessibility limits GVIs intention for HIV and AIDS prevention.

Table 4.9: Condom Inaccessibility as a Challenge to GVIs' Behaviour Intention

Respondents' meaning:	**Central Theme:**
Challenges	**What is represented in the challenges**
Limited access to condom	GVIs cannot access condom without companion GVIs are not at ease to be accompanied Condom is a private issues Intention for condom suggest intention for sex

Table 4.9 indicates that limited access to condom challenges GVIs' intention to use condoms. The challenges exist because GVIs cannot access condom without companion, and when GVIs are to be accompanied, they are not at ease because they consider that accessing condoms is a private issue.

4.5.2.4 Social Discrimination

In this sub-section, data show discrimination as a challenge that limits GVIs intention for condom use presented in extract 20 (a) through (d).

Extract 20 (a) and (b) are responses from one-to-one interviews and extract (c) represents responses from FGD.

20 (a) GVI # 7 at X School

> Many people think that GVIs are not normal and we don't have feeling. Sometimes you could hear somebody asking a GVI, and you blind, do you also engage in sex? Whenever I think about such remarks I get a feeling that I might be treated in the same way in the processes of looking for condoms. So my intention to look for condom is threatened by fear of other peoples' negative attitude towards disability."

20 (b) GVI # 5 at Y School

> When a girl with disability such as a GVI, gets pregnancy, our fellow peers without disabilities are surprised and they start gossiping and wonder how a GVI could get pregnancy. This situation makes you to hide your intention for condom use let alone looking for condom.

20 (C) GVI # 2 at Y School

> I've experienced a situation in which a GVI expressed her intention to go to a health centre to get condoms. She became the centre of attention of other girls because they started talking about her, asking why she should want condoms while she was visually impaired. It was an embarrassing moment because it was as if GVIs are not normal. This experience de-motivated that girl and others to engage in the discussion. So the intention to use condom is not even limited by our own challenges but also by feeling of others about use of condoms among GVIs.

Extract 20 shows repeated responses representing discrimination as a challenge limiting GVIs' intention for condom use. Various situations which show challenges are encored in all the extracts and are more or less the same. For example, negative perception about GVIS is represented in extract 20 (a) and (b) in a statement "people think that GVIs are not normal and we don't have feeling." The same applies to the GVIs' response in (c) in which they find themselves creating self-conscious about their experiences pertaining to their intention.

This self-conscious is represented by the following clear declaration. "It was an embarrassing moment because it was as if GVIs are not normal." Such attitudes towards GVIs set back their intentions for condom use exemplified in a statement, in a statement "my intention to look for condom is threatened by fear of other peoples' negative attitude towards disability" in (a); and "the intention to use condom is not even limited by our own challenges but also by feeling of others about use of condoms among GVIs" in (c).

In extracts 20 (a) discrimination is represented in a mocking questions, “and you blind do you also engage in sex?” In 20 (b), the same concept of discrimination is represented in a different way in which a GVI is trying to express her experiences about reactions of a sighted peer on GVIs on the issue of pregnancy. It is represented in the following statement, “And they start gossiping and wonder how a GVI got pregnancy.”

Discrimination in the context of negative perception, in which GVIs are considered abnormal and are sexually inactive, has brought into view the ground under which their intentions are challenged by discouragement associated with negative attitudes that intimidate them in the process of looking for condom as presented in a phrase “looking for condom is threatened by fear of other peoples’ negative attitude towards disability.” In 20 (b) an intimidation is reflected in the chitchat represented in a phrase “they will start gossiping and wonder how a GVI got pregnancy.” In 20 (c) the intimidation is represented in part of the last statement indicating that “intention to use condom is not even limited by our own challenges but also by feeling of others about use of condoms among GVIs.” This circumstance makes them hide their intention as represented in extract (b).

Represented responses are summarized in Table 4.10. It is a summary showing how discrimination challenges GVIs’ condom use intention. Data summarized in this table indicates that, GVIs feel that they are discriminated and this discrimination is one of the challenges limiting them in the intention to use condoms. GVIs consider they are discriminated because they are regarded that they are not normal; a situation

that makes them to be negatively perceived. Further, GVIs feel that they are discriminated because their sighted peers consider them asexual.

Table 4.10: Summary of Discrimination in Limiting Condom Use Intention

Respondents' meaning:	**Central Theme:**
Challenges	**What is represented in the challenges**
Discrimination	**Ways in which GVIs are discriminated** It is considered that they are not normal They are negatively perceived They are considered asexual
	Discrimination intimidates GVIs in: Discriminative chitchat about GVIs' pregnancy. Doubtful speculation on why they need condoms
	Their intention for using condom is: Threatened by their own feelings and that of other people Is hidden or descended

Discriminations take place in expressive judgements such as light informal conversation about occurrences of pregnancy among GVIs' and assumption that GVIs do not need condoms. GVIs are threatened by their discrimination that emanates from their own feelings and that of other people. Consequently GVIs hide their intention for using condom.

4.6 Summary

Chapter four comprised of data presentation in different sections and sub-sections. The first section presented data about first research question which was focused on the school curriculum contents related to HIV and AIDS prevention and how they were taught in the school-based interventions. Data presented was collected from school curriculum materials with a focus on competences and objectives which the students were expected to attain, topics which were embedded in the Biology and

Civics syllabi, methods and materials which were suggested for teaching these topics. Data analysis indicated that the competences which were to be developed included the ability to demonstrate knowledge and skills in combating health related problems such as HIV and AIDS. In order to achieve the competences and objectives stated, knowledge and skills related topics were taught to students to develop attitudes towards HIV and AIDS preventions. Teaching and learning processes involved the use of explanation, whole class discussion and demonstration of skills to use condoms. The main materials which were used included penile model and male condoms.

The second section presented data about the second research question. This question was aimed at finding data on how the teaching processes of the contents related to HIV and AIDS prevention assist GVIs in developing knowledge and attitudes required for the healthy behaviours for HIV and AIDS prevention. First, data showed that the teaching and learning processes assisted the GVIs to develop communication, decision making and refusal skills. Second, data showed that, the methods and materials used in the teaching and learning the HIV and AIDS curriculum contents developed knowledge and skills for HIV and AIDS prevention among GVIs. However, data showed that GVIs had learned theoretical life skills.

The third section presented data about the third research question which focused on how GVIs' are challenged in their intention for HIV and AIDS prevention. Findings showed that there were curriculum and social related factors that challenged GVIs in their intention for HIV and AIDS prevention. Curriculum related challenges included

discriminative teaching and learning methods and materials which did not assist GVIs to participate effectively. Social related factors were peer group influence, sexual abuses, limited decision making power, limited access to condoms and social discrimination.

CHAPTER FIVE

5.0 DISCUSSION OF THE FINDINGS

5.1 Introduction

This chapter discusses the research findings based on the research problem on school-based HIV and AIDS interventions for GVIs in selected secondary schools in Tanzania. The research was intended to answer three key research questions, each with a major theme discussed under the ascribed objectives in chapter one.

According to Øvretveit (2010) context could influence outcomes of a research, on this basis the context of this study was a major concern. The research was conducted under complex context due to the condition that existed at the material time of the research. For example, in secondary schools where the study could have been conducted the schools were engaged in mock examinations. It was therefore difficult to obtain respondents in such schools. Even in schools that were not engaged in the mock examinations a condition that could allow them to participate in the research, classes were going on during the research. Hence, respondents from the latter attended to interviews while in a hurry to complete the exercise and move on with their day to day activities. This made the researcher move fast through the task or wait for the respondents to attend the interview sessions at their own convenient time.

Another limitation was GVIs' fear and reservation to maintain relaxed mood during the interview sessions, they indicated feelings of suspicion or uncertainty since they could not see the surrounding environment to assure themselves of privacy for the

information that they divulged. Obtaining syllabi and subject text books as well as supplementary material was not also easy for the researcher; these were not obtainable at the schools where the researcher conducted the study. The researcher had to visit schools other than the ones that were sampled in order to obtain the texts for the research activity.

Data from the findings showed contents for HIV and AIDS prevention were only embedded within the Biology and Civics syllabi. Within these subjects such topics as health and immunity for form one classes were taught. Under this main topic only one subtopic related to HIV and AIDS was provided and this was management of STIs and HIV and AIDS. Another key topic was gaseous exchange and respiration involving disorders of the respiratory system. This second topic was designed for form two classes while in form three classes reproduction in which sexuality and sexual health (SSH) and responsible sexual behaviour (SB) were included. In form four classes HIV and AIDS and other STIs formed the key topics. Generally these contents (topics) were taught through whole class discussions, explanations, and demonstration methods.

Along the continuum of teaching HIV and AIDS content in secondary schools GVIs encountered several challenges which cut across study materials, teaching methods and social related factor. The issues that have been highlighted under this introduction to chapter five are detailed under the subheadings that follow.

5.2 HIV and AIDS Prevention Curriculum Contents and how they are Taught

In depth discussion of the findings in this section is based on the findings collected

from school-based intervention programme documents that were reviewed by the researcher. Biology and Civics syllabi, text books and supplementary texts relevant to HIV and AIDS prevention contents formed the basis of the comprehensive review. This review revealed that implementation of HIV and AIDS prevention curriculum was based on developing knowledge and attitudes for HIV and AIDS prevention by using materials and methods of teaching presented in the sections that follow.

5.2.1 Developing Competences for HIV and AIDS Prevention

Analysis of data showed implementation of school-based HIV and AIDS intervention for prevention was directed through the school curriculum. Specifically, data showed that HIV and AIDS topics were embedded in the Biology and Civics syllabi. The suggested topics about HIV and AIDS were intended for developing knowledge and attitudes for HIV and AIDS prevention. This was implied by clearly stated competences in the reviewed syllabi.

Competence is an ability to apply or use knowledge, skills and abilities required to successfully perform critical work, function or tasks in a defined work setting (Arguelles and Gonczi, 2000). In the context of HIV and AID in school-based interventions, competence is an ability to apply or use the learned knowledge, skills and abilities to successfully act responsibly in the prevention of HIV and AIDS for healthy life. School-based interventions were expected to be competence-based. GVIs and other school adolescents were expected to demonstrate competences by using knowledge, attitudes and life skills required to effectively prevent themselves from HIV and AIDS in various situations.

A general competence was stated for the whole course and for each class /level of Biology and Civics courses and the class level competences were derived from the class level objectives. For instance the general competence for the whole course of Biology syllabus indicated that the students were expected to demonstrate knowledge and skills in combating health related problems such as HIV and AIDS. Consideration of competences in both syllabi implies that teaching of HIV and AIDS related education in school-based interventions in secondary schools was competence based education (CBE).

CBE is an institutional process that moves education from focusing on what academics believe graduates need to know (teacher-focused) to what students need to know and be able to do in varying and complex situations (student-focused) (Jones, Paulson and Voorhees, 2002). CBE focuses on observable, measurable behaviors, although they are not simply concrete actions that are easily imitated. On the contrary, competencies can be manifestations of some underlying intent that are driven by a person's basic motivations, personality, attitude, values, or self-concept (Thinktwice, 2007).

Observable and measurable behaviours that school youths such as GVI were expected to demonstrate was reflected on the abilities to apply life skills in behaviours including the use of condoms and abstinence from sexual intercourse. Such behaviours were targeted for HIV and AIDS among secondary school adolescents in Ordinary level (Form I-IV) in order to enable them to appropriately respond to the devastating healthy problems including HIV and AIDS which is

incurable. The general objective for each course was stated in general terms to indicate the range of content to be covered within each course. Implication which is inferred here is that when the stated objectives are achieved, then the expected competences are realized by the students including GVIs.

Analysis of the data also revealed that there were only a few topics about HIV and AIDS in the texts and only two subjects embedded HIV and AIDS content. HIV and AIDS could have been embedded in all secondary school subjects since the pandemic is a cross cutting issue. HIV and AIDS is a topic that can encourage multi- and trans-disciplinary teaching approaches that are contemporarily promoted in line with the global knowledge economy which requires citizens that can communicate and understand each other along technologically driven environments and activities.

HIV and AIDS issues could be included in Mathematics, Geography, History, Languages, Home economics, Agriculture, Physics and Chemistry. As an example, if a Geography teacher teaches a topic on population growth and mortality rates the impact of HIV and AIDS could be called forth under the topic. A teacher teaching mathematics or any other subject can also bring in topic about HIV and AIDS as deemed fit within the teaching context.

In addition to the limited subject areas for which HIV and AIDS topics are involved in the secondary school syllabi, HIV and AIDS topics that featured in the Biology and Civics syllabi were found to be very few in relation to the vast topics that need to be covered if students at secondary school levels are to graduate with comprehensive

knowledge, skills and attitudes that enable them to live healthy lives at and after graduation.

The topics had been derived from the class level competences and objectives. However, analysis of the syllabus indicated that HIV and AIDS education in secondary schools was integrated in the already crowded curriculum. For example the biology syllabus comprised 22 topics while topics which were related to HIV and AIDS were only 4, one topic for each class. These topics included (i) health and immunity, (ii) gaseous exchange and respiration, (iii) reproduction and (iv) HIV and AIDS and other STIs. These topics were meant for form one, two, three, and four respectively. Each topic had only one sub-topic targeted for HIV and AIDS prevention including (i) management of STIs and HIV and AIDS, (ii) disorders of the respiratory system, sexuality and sexual health (SSH), (iii) responsible sexual behaviour (SB) and (iv) management and control of HIV and AIDS and STIs.

Data analysis showed that such topics were based on knowledge about management of STIs and HIV and AIDS, disorders of the respiratory system, sexuality and sexual health and responsible sexual behaviour. Although type of themes were not stated in the syllabus, it was implied from the thematic topics embedded in the Biology syllabus indicating that all the topics were basically factual knowledge on the HIV and AIDS related issues.

Findings of this research are consistent to researchers including Kwegyir-Afful, Perkins, Prather, Spriggs and Stennis (2014) who concluded that knowledge and

awareness alone do not lead to necessary adoption of safer behaviours. Finding of this research also showed that there were only a few life skills related topics including meaning and types of life skills, social problem solving techniques and promotion of life skill embedded in the Civics syllabus.

GVIs had knowledge about the meaning and types of life skills such as communication, decision making, and refusal skills necessary for condom use but they felt they could not use the life skills for condoms. This implies that, although information is necessary is not sufficient to influence an individual to reasonably deal well with behavioural change in the contexts of difficulties or challenges among youths such as GVIs or other AWDs.

Findings of this study concur with UNESCO (2006) who also noted that HIV and AIDS education is integrated in the already crowded curricular. Nganyi, Nganyi and Anangwe (2015) in their study found out that although introduction of HIV and AIDS prevention was generally positive, it was perceived challenging because it represented an additional task in the already crowded curriculum. In order for anyone to be able to comprehensively understand the pandemic and be able to live successfully one needs to be aware of what the pandemic entails, how it spreads, how it can be prevented, how its negative effect and impact can be minimized.

It is also necessary for secondary graduates to have knowledge and skills of living with the pandemic for those who unfortunately happen to get infected. Such individuals can as well be trained to counsel newly infected persons. It is also of

value to train those with HIV and AIDS to cope with the sort of social discrimination that sometimes accompany them.

Major teaching methods used to teach the official HIV and AIDS topics only included whole class discussions, explanations, and demonstration methods. These three methods are largely teacher-centered. The teacher leads and controls all class procedures and makes choices for materials used in-class. Students are not given ample opportunities to ask questions or suggest methods to be used for teaching. Teacher-centered methods have always been disqualified and associated with rote memorization and stagnation of learning. The recommendation is to use active methods centred on the child, because that is the best way to involve the child in his/her own learning (Passos, 2009). Participation of the GVIs in their own learning through the use of active methods would lead them to attain the life skills set in the school curriculum. The findings has shown that teachers who were teaching HIV and AIDS related topics preferred to use teacher-centred methods because they lacked training that hindered them in employing active methods and using relevant teaching and learning materials. GVIs were learning the intended topics for HIV and AIDS prevention through memorization rather than creating and inventing new ideas through inquiry learning approaches to develop knowledge and attitudes for HIV and AIDS prevention discussed in the section that follows.

5.2.2 Materials and Methods of Teaching about HIV and AIDS

Other than abstinence, protected sex remains the most effective prevention against acquisition of HIV and other sexually transmitted diseases (STDs) (Austin, Buehler,

Macaluso, Stone and Warner, 2006). Safe sex includes not only the use of condoms but also their correct use because incorrect condom-use cannot protect STI/HIV transmission thus it reduces the effectiveness of condoms (USAID, 2015). In this study the data analysis of the represented interview responses indicated that the promotion of both use and correct use of condoms was typically one of the core components of HIV and STD-prevention in the school-based interventions.

The researcher attempted to find out materials which were used in teaching about protected sex for HIV and AIDS prevention. Data showed that materials which were used were basically male condoms and penile models to demonstrate the use of male condom. Both male condom and penile models were used to assist in teaching the students on the correct use of male condoms during classroom demonstrations.

Analysis of finding showed that the actual classroom teaching and learning processes were not consistent to the methods of teaching HIV and AIDS related issues suggested in the syllabus. The methods suggested in the Biology and Civics syllabi included brainstorming, using written texts on life skills, to discuss and identify various life skills and make presentations. Other methods were case studies, role play and demonstrating social skills.

The suggested methods of teaching life skills and the actual classroom practice showed a practice that departs from expectations since non-participatory methods such as explanation and whole class discussion involved exchange of ideas. The

method focused on interactions in which the learners' participation promoted active learning and student accountability because the learners must share their knowledge. Findings suggest that as opposed to other methods such as explanation and demonstration whole class discussion method is considered to have ability to make the learners responsible to offer their ideas (Hoover and McLeonard, 2003). Dooly (2008) confirm that these ideas can be related to the goals and the discussion can construct knowledge. This is because by interacting with peers and responding to varying viewpoints and arguments that may arise during whole class discussion, the method may make learners to continually challenge their own preconceptions, understand and make conclusions. It may also imply that the method may develop learners' abilities and grow more confident in using their skills within the whole group and in the related contexts outside the group.

In explanation method, teaching about HIV and AIDS was limited to provide factual knowledge. The actual classroom practice represented by the explanation method with regards the methods suggested in the syllabus and analyzed in extract 8 does not show a reciprocal relationship. Learners were considered recipients of the taught information whose response was expected to feature through activities including "listening to the teacher" The methods suggested in the syllabi were participatory.

Learners were expected to engage in activities such as brainstorming, reading texts about life skills and discussing the life skills identified from the texts but explanation method was not participatory. UNICEF (2012) contends that participatory methods

are important for promoting intention for healthy behaviours but there are no traces in the extracts indicating GVIs' participation because their involvement was limited to listening and copying notes from the chalk board.

Methods such as explanation and the way it involved GVIs in the processes of teaching and learning in which GVIs did not actively participate implicitly suggested that it is not always true that teaching of life skills can bring about learning outcomes. This is explicitly suggested by GVIs' experience represented in the statement "during the lesson we listen only," The use of this method indicated that the processes of teaching and learning life skills was teacher-centred approach which was based on teachers' notes, the syllabi, key course text books, and the context of teaching and learning. Al-Zu'be (2013) argue that in teacher–centred approach, the curriculum relies on the teacher to use their expertise in helping the learner understand and make connections where the students take in a receptive role in the learning. While the teacher acts as a knowledge transmitter, the student acts as the receiving end.

On the basis of the preceding proposition, the researcher argues that the teaching methods used may systematically fail to influence abilities to learn life skills to learners such as GVIs because although they can listen they cannot understand and remember and later put into practice the abilities learned. Silberman (1996) in Upadyaya (2013) conclude that, what I hear, I forget; what I hear and see, I remember a little; what I hear, see and ask questions about or discuss with someone else, I begin to understand; what I hear, see, discuss and do, I acquire knowledge and

skill. This implies that the ability to learn is a process which does not only involve hearing but also seeing, asking questions, discussing and doing.

In contrast, learner centred approach emphasizes a variety of different types of methods that shifts the role of the instructor from givers of information to facilitating student learning (Blumberg, 2008) and reinforce learning among learners. In school-based HIV and AIDS interventions, learner-centred approach can develop learners' ability to respond appropriately to positive healthy behaviours for HIV and AIDS prevention. For student to suceed accademically whether they have disability or not they should have the ability to access the classrom curriculum materials such as books and other resourceful materials which contain the intended contents. For instance, GVIs require provision of appropriate format such as Braille, large print, and audio.

Finding show that, teachers were providing chalkboard notes to the learners during the lesson. GVIs were not able to take notes during the lesson although they had Braille type writers. They copied notes from their sighted peers and as it was noted by most of them writing notes from their sighted peers allowed them to go back and remember important ideas whenever they wanted to do so. As pointed out earlier their notes had grammatical errors that were likely to hinder them to have important ideas as they were presented by their teachers.

It is noteworty however, that teachers facilitation depends on their commitment to search for students activities and additional materials and their commitment to help

the GVIs. If this is not the case, they use the same content materials which do not provide students activities and sufficient information about the intended topic. This situation might have failed to cause the desired knowledge about life skills mainly on account of inadequate instructions from both the syllabi and the text books. The situation may also account for GVIs' inability to generate knowledge and meaning from an interaction between their experiences about their ideas of life skills and their ability to ransfer what is learned through the HIV and AIDS interventions.

The information conveyed to the readers is lack of active interraction between the tasks, teachers and the GVIs. Eggen and Kauchack (2004) suggest that knowledge is first constructed in a social context and then appropriated by individuals. Analysis of data indicates that the knowledge is based on teacher-centred approach and the social context of teaching and learning does not show significant interaction between the learners themselves in the learning environment. This information suggests that there is urgent need for MoEVT to focus more on the school curriculum in which HIV and AIDS related topics are embeded to include instructions on how to teach the HIV and AIDS related contents and interractive activities. It also suggests training to teachers on how to teach both students with and without disabilities in the same classess. This calls for increased budget for inservice training and for school inspection and teacher supervision to ensure learner-centred approach that include learners with and without disabilities such as GVIs.

Malawi Institute of Education (2004) observes that learners are different and they learn through different ways and so there is no single method on its own which can

satisfy the learning needs of all the learners. It is no wonder that when explanation method was used on its own it did not enable GVIs to effectively “demonstrate necessary knowledge and skills for avoiding risky behaviours, practices and situations” as stated in extract1 (c). The truth of this claim is confirmed by the fact that explanation does not involve demonstration of the life skills.

Analysis of data also shows that demonstration method suggested in the syllabus was associated with various activities. For instance, learners were required to read case studies about life skills and demonstrate the skills in the classroom. Guest speaker/ teacher/ learners perform a role, an idea or a concept related to the life skills in question and learners summarize teachers’ explanations of the life skills. They also answer the teachers’ questions and copy notes in their exercise books.

A meaning that is not explicitly stated but can be established is that when the teaching and learning processes use demonstration method, learners can have opportunity to watch someone doing the intended task. Unlike explanation, method discussed in the previous section which, entails visualizing an idea or concept on their own, demonstration enables the learners to process and observe the concept directly which in turn makes learning easier. As a teaching technique, demonstration can make the learners learn by doing.

While learning by doing is ideal for life skills content based, adopting this approach was difficult for GVIs. With learners such as GVIs, vision limitation necessitated support to enable them to engage in participation. Demonstrations of male condoms done by the teachers or guest speaker introduced the learners into the specific

equipment for safe sex and showed them how they were used. All the same, demonstration method can draw learners' attention to the psychomotor skill needed for carrying out delicate tasks of using condoms.

Learning is enhanced by increasing students' engagement (Callan, Crouch, Fagen, and Mazur, 2004). More importantly, demonstrations can provide learners with opportunities to develop key procedures. Learners can be encouraged to make predictions and announce or record their observation as they watch the demonstrations.

Good demonstrations of condom use or any other life skills for healthy life were expected to provide opportunities for learners to use the skills. However, data from interviews in extract 14 (a) through (e) summarized in Table 4.5 shows that demonstration of condom use provide GVIs with knowledge but learning is not enough due to limited opportunity to practice how they are used. Consequently GVIs intention for using condom was not influenced by demonstrations. Logically, the inferred meaning from this consequence is that, GVIs cannot carry out fair demonstrations and identify key factors that need to be considered about the use of condoms. Therefore it suggests that the intended objectives and competences targeted for life skills for HIV and AIDS prevention in school-based interventions were not achieved Findings can also suggest that even other students with disabilities are likely to have the same experience in the traditional kind of teaching methods that are teacher–centred such as explanation or other non-disability friendly methods highlighted here.

GVIs and other school adolescents with disabilities need to gain life skills to help them deal effectively with the demands and challenges of everyday life in the context of HIV and AIDS and other health issues. Life skills can help them develop their life as a whole and reach their full potential despite their disabilities. WHO (2009) contends that to cope effectively with the demands and challenges, learners need to have the knowledge and attitudes, which will assist them to develop positive behaviours and ways of responding to life's challenges. They need to practice skills and behaviours that enable them to participate in taking care of their health and enhance all aspects of their health.

Effective teaching methods employed in educating about HIV and AIDS prevention differ from more traditional subject areas (Nyirenda and Schenker, 2002) and abilities to learn are influenced by teaching/learning methods which were active. Bonwell and Eison (2013) characterize active learning methods and indicate that they comprise: Students' involvement in more than passive listening; engaging learners in activities such as reading, discussing and writing; placing less emphasis on information and greater emphasis on developing students' skills; placing greater emphasis on exploration of attitudes and values; increasing learners motivation; giving learners immediate feedback and involving students in higher order of thinking.

In summary active learning is an approach in which the responsibility of learning is placed upon learners, often performing activities and reflecting on the activities performed.

Providing school AWDs with information about HIV and AIDS it is essential for them to develop meaningful skills and attitude necessary for HIV and AIDS prevention so that they can stay uninfected. In order for school-based interventions to achieve this goal teaching and learning methods must change from the explanation methods style in which school teachers explain and provide chalk board notes to more participatory teaching and learning methods in which AWDs play active roles in the learning processes. Further, although methods such as whole class discussion and demonstration were participatory in the nature in which they were used they were not disability friendly. Thus, teachers should also be educated on how to effectively use participatory and interactive methods which are essential to enable GVIs and other AWDs to move from information-based HIV and AIDS education to methods that are skill-base to assist them to develop abilities for adaptive and positive behaviour that can enable them to avoid HIV infections.

To ensure that all children have access to quality HIV and AIDS education in the school-based interventions, teachers who are teaching courses in which HIV and AIDS related topics are embedded, should critically consider the school HIV and AIDS related policies and practices to make sure they encourage and facilitate the development knowledge, skills, attitudes and participation of all learners regardless their differences.

5.3 Teaching of the Contents and Knowledge and Attitudes Developed

This section discusses teaching processes of the Curriculum Contents and the way they assist GVs in developing knowledge skills and attitudes required for HIV and

AIDS prevention. Data analysis shows that to some extent the teacher assumed the role of a facilitator to promote, guide and helped students' learning activities in demonstrations and discussions.

While GVIs expressed positive view of the objectives of assisting GVIs in developing knowledge and attitudes required for HIV and AIDS prevention, they raised a number of concerns over how the school-based interventions would work in practiced. GVIs were concerned about cooperative learning and maximum participation in whole class discussion and doing a series of logical activities required in demonstrations on how to use condoms.

This situation suggests that teaching and learning methods are not exhaustive because teaching and learning methods excluded the GVIs. Their participation was insignificantly considered. Experience shows that behavioural skill development and internalization of values and attitudes require practice through learner-centred interactive processes within an atmosphere of tolerance and trust (UNESCO, 2006).

5.3.1 Implication of Teaching and Learning Processes on GVIs' Behaviours

The most critical shift in education over the past 20 years has been a move away from a conception of "learner as sponge" toward an image of "learner as active constructor of meaning (Peterson and Wilson, 2006). However, with respect to HIV and AIDS education in the contexts in which students with visual impairments and other students with different disabilities are learning, methods such as explanation, discussion and demonstrations were not disability friendly. Since the teaching and

learning processes were not learner centred and disability friendly because they were not significant consideration of their participation, this suggests that the required behaviour for HIV and AIDS prevention, skills and internalization of values and attitudes were not developed by the methods and materials which were used in teaching and learning about HIV and AIDS. A meaning that is not expressly stated but can be inferred is that teaching and learning approach in which HIV and AIDS is addressed in the context of unfriendly methods students with disabilities such as GVIs cannot be concerned about their health and well-being.

To identify the implications of the findings for positive attitudes towards HIV and AIDS prevention, discussion is based on the implications in relation to the interventions which were in place in the secondary school-based interventions at the time of the study. The main objective of the Biology course for instance was to enable the students to acquire basic knowledge and apply appropriate skills in problems related to HIV and AIDS/STIs. However, implications of the findings in the context of the move towards more attainable objectives other than meeting the needs of youths in general pertaining knowledge and skills required, need to set objectives that influence knowledge and skills to meet the needs of youths with disabilities.

While the methods and the use of the related materials were expected to be participatory to develop healthy behaviours among secondary school youths, in this study they were not user friendly to GVIs. This suggest that the teaching and learning processes did not facilitate learning with a practical and holistic, life skills

approach that replicate the natural processes. Through this approach school youths with disabilities such as GVIs would learn the theoretical and practical life skills to assist them to develop knowledge and attitudes required for healthy behaviours such as the use of condom and abstinence from sex for HIV and AIDS prevention.

All skills that are needed to perform behaviour, such as negotiation skills, refusal skills, communication skills, but also practical skills such as skills to correctly use a condom are needed (Engleberg, Meijer and Tiendrebéogo, 2003). If young people can practice skills, it is much more likely they will be able to use them (WHO, 2009). The opposite is also true and it is the case in this study.

Findings confirm that school youths with disabilities such as GVIs, were not given an opportunity to practice, life skills. This situation suggests a poor link between information that GVIs have learned about life skills and the actual ability to use the life skills. It is no wonder that GVIs said they did not have intention for using condoms and so they were not likely to use condoms.

Generally, in a broader perspective, findings demonstrate that life skills specified in the curriculum were taught. Whereas teachers explained, asked questions, engaged students in whole class discussions, and in demonstrations, students responded accordingly through listening, answering questions, discussing, demonstrating the use of condoms and in copying notes which were provided on the chalk board. However, GVIs participated passively because neither could they see what was happening nor engage in practical skills such as demonstrations. They listened to

what was being said and they were assisted to copy notes later after classes. Thus the processes of teaching and learning assisted them to acquire theoretical knowledge about life skill including negotiation, communication, decision making, and refusal skills. Thus learning was knowledge based and therefore it was not enough to prevent HIV and AIDS. Other studies have also reported that that knowledge alone is not enough to prevent HIV and AIDS (Abdurahim, Maimaiti, Maimaiti, Shamsuddin and Tohti, 2010; Kwegyir-Afful, Perkins, Prather, Spriggs and Stennis, 2014*).* GVIs developed positive attitude and perceived social pressure for the intention for HIV and AIDS prevention. These internal factors and life skills including refusal and decision making contributed to perceived control over intention for abstinence. However, GVIs perceived it difficult to use condoms since positive attitude and perceived ability of use of condoms was insufficient to facilitate perceived control behaviour over condom use intention.

Lack of practice presented in extract 13 (a) provides justification given by GVIs about their uncertainty in using life skills characterized in situations in which GVIs “hesitate” and they are “not certain” and hence they had “doubt,” situations presented in extract 13 (a), (b) and (c) respectively.

In extract 14 (b) and (c) GVIs are also depicted as individuals who lack ability to use life skills and are uncertain in their ability to use condoms. Inability to use condoms implies that they do not intend to use condom. This is consistent with Ajzen (1991) in the TPB who indicates that, a persons’ behaviour is determined by his/her intention to perform the behaviour and that this intention is, in turn, a function of

his/her attitude towards the behaviour and his/her subjective norms. The model indicates that the best predictor of behaviour is intention. TPB suggests that intention is considered to be the immediate antecedent of behaviour. Narratives in extract 13 do not indicate the intention to use condom and since this antecedent of behaviour is not there, prediction for the actual use of condom is also missing.

Teaching processes of the curriculum contents assisted GVIs to develop knowledge and attitudes required for HIV and AIDS prevention among GVs. Findings suggest the school intervention was not successful in assisting GVIs on practicing the required behaviour including the use of condom and implement their plans. Peace Corps (2000) and Deutschman (2009) observe that life skills for planned behaviour involve approaches to enable the targeted group to move from information to intention of the behaviour. Providing health information is important but not always sufficient for developing intention for HIV and AIDS for healthy life. Because youth who are visually impaired engage in sexual activity, they should be provided age-appropriate sex education that incorporates meaningful methods and tangible materials (Kapperman and Kelly, 2012) that provide them with the opportunity to participate in appropriate and effective sex education.

5.3.2 Prediction of GVIs' Behaviour Intention

In line with the TPB, which is explained by Ajzen (1991), data analysis represented in extract 13 GVIs' behaviour such as a planned behaviour for using condom is also determined by intention to perform the behaviour. In extract 13 (a) through (c) the planned behaviour is not predicted by the behaviour intention. The life skills learned

have influenced intention on abstinence because they can use refusal skill to sex rejection. On the contrary the life skills learned cannot be used for all the planned behaviours other than abstinence from sex. This is implied in statements such as “my intention on condom use is not influenced much” and “I’m not certain as to whether I can use it appropriately.”

The absence of the intention which is the best predictor of the actual condom use is also implicated by GVIs lack of behaviour control inferred in the GVIs doubts about the ability to use condom. Lack of behaviour control in using condom is caused by lack of practice that lead to lack of confidence and therefore it is surrounded by the state of no hope that the actual application of life skills for condom use will be favourable for her.

GVIs consider life skills as important tool that provide them with an ability to respond appropriately in the actual application of these skills to enable them to reach a desired goal. It indicates that they have “doubt” about the life skills required for using condom. It also indicates that promotion of knowledge, life skills and attitudes towards HIV and AIDS prevention basing on GVIs’ ability to “listen and understand what is going on” suggests processes of teaching and learning of the curriculum contents for HIV and AIDS prevention that is not disability friendly.

A number of scholars have acknowledged that promotion of life skills can help influence condom use intention (Hoffmann and Olson, 2007; James, Magnani, Murray, Senderowitz, Speizer, and Stewart, 2002 and WHO, 2001). On the other

hand, the extent to which intentions affect behaviour may depend on the skills of the individuals to implement their intentions and environmental support for the intention (Coyle, Kirby, Robin and Rolleri, 2011). However, life skills learning cannot be facilitated on the basis of information gained from explanation or discussion alone, but also teaching and learning processes must include experimental learning with practical experience and reinforcement of the skills for each student in a supportive learning environment (WHO, 1999) to develop attitude towards behaviour. Finding of this study converge with evidence from Kremer (2006) who demonstrated that many countries, including Kenya, have incorporated HIV and AIDS education into the curriculum. Evidence on the effectiveness of these policies is beginning to emerge, but many key questions remain: can teachers deliver the curriculum? Will the curriculum affect knowledge, attitudes or behaviour? What should the content emphasise?

In this study questions posed here by Kremer (2006) are addressed in this study. First, findings suggest that teachers cannot effectively deliver the curriculum to GVIs. This claim is evidenced by the fact that an important measure in understanding GVIs' behaviour is to know that teachers were not able to address GVIs' disability that limits them from most of the personal experiences such as seeing and practicing the use of condoms.

Although GVIs were denied opportunities to practice life skills, a denial expressed in extract 13 that developed "fear," on the one hand curriculum can affect knowledge, attitudes and abstinence from sexual practices as one of the most important

behaviour for HIV and AIDS prevention among youths. On the other hand, the curriculum cannot affect knowledge, attitudes and condom use behaviour among GVIs they considered intention for abstinence at the expense of sexual intercourse, behaviour they consider easy to perform.

5.4 Challenges Encounter by GVIs in HIV and AIDS Prevention Intention

The data analysis shows that school-based interventions were expected to develop knowledge about life skills that in turn promote attitudes and intention for HIV and AIDS prevention among school youths by teaching a range of topics using several suggested methods and materials in the Biology and Civics syllabi.

5.4.1 Materials and Methods of Teaching as Challenges on Behaviour Intention

Even though analysis of both extracts 14 (c) and e) indicated that the materials used did not have the “influence” on the actual ability to “use condom,” the respondent had the intention to “abstain.” represented in (a). The respondent used the adverb “instead” to show that “condom” was not the only alternative but also there is abstinence to sex.

When the concept of “learning,” in extract 14 (e) is thought about in the context in which an individual is to demonstrate abilities to learn life skills, it may not suggest that learning is represented as a source of “influence” to act among GVIs. The inherent capacity of the teaching materials to bring into abilities to learn life skills is symbolized as instruments of facilitating learners to gain “information” stands as “one thing” which does not bring into being the other thing which is “influence to the

intention to act." Learning is important for "information" required for behaviour change that can enable individuals to practice the required behaviours such as condom use or abstinence from sexual intercourse.

Findings of this study concurred with Kendi, Kinai and Mweru (2012) who concluded that pupils with visual impairment had low level of knowledge due to discriminative ways of addressing the needs of pupils with visual impairment in the teaching and learning processes. Similarly, Macha (2008) observed that visually impaired individuals did not enjoy learning because knowledge about the use of condoms was not provided to them. An Action for Disability and Development (2005) has also established that students with disabilities cannot utilize information about HIV and AIDS prevention. This is due to the fact that the school-based interventions lacked special services for students with special needs such as GVIs because they were overlooked and excluded from the teaching and learning processes of HIV and AIDS related topics.

Abilities to learn are influenced by teaching/learning methods which are active. Bonwell and Eison (2013) characterize active learning methods and indicate that they comprise: Students' involvement in more than passive listening; engaging learners in activities such as reading, discussing and writing; placing less emphasis on information and greater emphasis on developing students' skills; placing greater emphasis on exploration of attitudes and values; increasing learners motivation; giving learners immediate feedback and involving students in higher order of thinking. In summary active learning is an approach in which the responsibility of

learning is placed upon learners, often performing activities and reflecting on the activities performed.

Teachers who are teaching HIV and AIDS related issues in school-based HIV and AIDS interventions should consider GVIs' learning environment in the presence of factors such as giving GVIs an opportunity to interact with the methods and materials so that they can learn life sills. These methods and materials have proved to help improve knowledge, attitude, skills to develop abilities to learn life skills required to avoid risk behaviours (UNICEF, 2002). Thus, in teaching the teacher must apply methods and materials that allow every learner to speak with the teacher, answer questions share their ideas whether they have disability or not. This suggestion might not provide enough information to enable the readers to make informed judgement about the proposition made in the extracts indicating that the use of materials such as male condoms and penile models used in teaching and learning life skills do not influence GVIs ability to learn life skills.

Readers cannot authenticate from the extracts whether the arguments made are meaningful or not because individuals with disabilities are considered asexual and so it could not matter whether people with disabilities such as GVIs have abilities to learn life skills or not. As the researcher of this study presents this information to readers, it may be the basis on the importance of understanding the methods and materials used in teaching and their influence on GVIs' ability to learn life skills. Active learning among GVIs can be possible only by engaging in active activities that engage learners to work with the materials to learn knowledge and skills which

demands an equitable opportunities to interact with the materials regardless their social status. Several scholars have made observation including the fact that, life skills programmes are an important prevention measure to respond to HIV and AIDS (Edwards, et al, 2005; Ruchismita, 2011; UNESCO, 2006) and enable school adolescents to respond appropriately to situations of risks for HIV and AIDS prevention.

For Many years most programmes have been focusing on information, education, and communication (IEC) materials needed for HIV and AIDS protection but the hoped-for changes in behaviour and attitudes in response to this information have not materialized (Engleberg, Meijer and Tiendrebéogo, 2003). This synopsis is similar to the findings of this study which indicated that the hope for change is impossible because as also noted by Edwards and Yousafzai (2004), information about condoms is theoretical and therefore GVIs and other AWVIs cannot know what condoms are and how they are used. This indicates that information may change and improve people's knowledge about a certain health related problem and contribute change in their attitude towards it, but there is a difference between information about a problem and doing something about it.

The only time where information is likely to lead directly to a change in behaviour is when lack of knowledge is the only barrier to change. Studies have shown little correlation between information and behaviour change because information and education is not enough to change behaviour (UNICEF, 2002) unless life skills are used. It is from this interpretation the researcher considered life skill related topic as

an important predictor in addition to HIV and AIDS information that most GVIs require. Whereas an additional study might be important to provide more substantiation to the claims presented, about the methods of teaching and learning materials, it is also necessary that the researcher gives an account of how disappointing it can be for GVIs to fail to participate in the activities provided and they are likely to be considered as low achievers or slow learners while it is not the case.

Teachers instigate and value learners' performance especially when the learners perform well and in response, learners get motivated and work harder and harder (Jones, 2005). Since GVIs are not doing most of the activities, it implies that teachers do not value GVIs' performance and so GVIs are not motivated to work hard and they can also be disappointed. Similar to other individuals, PVIs require skills for the correct use of condom. (Philander and Swartz, 2006). As regards the school curriculum skills about the correct use of condoms is attained from demonstrations and not through mere explanations. It should be accompanied with suitable examples for a better understanding of the students. Explanation can be clubbed with the modeling processes that involve the use of visual aid in the teaching and learning processes. Modeling facilitates explanation and enable the human brain absorbs more information and understands better for more effective and a long-lasting effect on the learners (Tiwari, 2010). Further, non-Braille materials such as textbooks in print, diagrams, billboards, video shows, newspapers, magazines and television adverts cannot provide information to VIPs since they cannot access practical information about proper use of condoms for HIV and AIDS prevention.

Programmes that work to prevent adolescents from contracting HIV and AIDS or other STI's should not only focus on developing life skills but also on the factors that differentiate the adolescents. For instance, GVIs who are the focus of this study are at the most increased risk because they are affected by all these factors. As girls, they are affected by factors associated to gender and further by biological and social factors and as girls with visual impairment they are affected by factors associated to disability because loss of sight limits their movement to access health services in health centres or in other places. They are also limited in accessing knowledge and skills which are provided in non-Braille prints.

HIV and AIDS educators can feel the implication represented here to be sensitive with a view that there are still new HIV infections, but there is probably no social sector that has been inflicted by the on-going situation of the way through which GVIs are learning life skills in schools in Tanzania. It is a discriminatory experience from school-based interventions although such interventions have been depicted as centres of learning because there is a sense of bias in teaching life skills for HIV and AIDS prevention to GVIs. This experience might conflict with readers' expectation while considering the so promising school based interventions that have turned into constrained education centres for school adolescents with disabilities such as GVIs.

The researcher intentionally brings about this experience so that readers can get basic ideas about discriminatory teaching and learning processes which use methods and materials that GVIs cannot easily interact with in learning life skills in school-based

interventions. Similarly, this experience has become an important juncture where the researcher is recollecting her memories and revisiting the moments where she got in touch with GVIs. During interview sessions they prompted the researcher to think more about the influence of the teaching materials and methods used for teaching life skills which were based on information without the required skills for HIV and AIDS prevention.

5.4.2 Self-efficacy Belief on the Intention to Use Condoms

The concept of self-efficacy beliefs is referred to as beliefs about what an individual is capable of doing (Lopez and Snyder, (2002). It is the extent or strength of individual belief in his/her personal ability to accomplish tasks and reach the target. Ones self-efficacy determines the ability accomplish tasks. If an individual believes she/he has ability to accomplish the tasks, the individual will have intention to act. Intention is what an individual says she/he will probably do; and intentions are influenced by a number of factors, including, but not limited to, efficacy beliefs (Lopez and Snyder, 2002). In this case intention is a planned action which is expected to be performed.

Self-efficacy beliefs and intention for HIV and AIDS prevention are taken into consideration with a view that self-efficacy beliefs increase prediction of behavioural intention. GVIs' perceived efficacy that they could stick to abstinence as preventive behaviour was a good behaviour predictor indicating that they adopted the preventive practice. However, perceived lack of self-efficacy on the use of condoms is also a predictor indicating that GVIs lacked self-belief in their capability to use the required

life skills. All the same perceived lack of self-efficacy is associated to the curriculum-based challenges in developing knowledge about life skills and attitudes of HIV and AIDS prevention. Justification of the curriculum-based challenges is comprehensible from the represented narrative in extract 11 (a) indicating that the methods used in teaching and learning life skills required for developing competence "involved" GVIs "theoretically." Documentary review indicated that the school curriculum was based on HIV and AIDS knowledge and life skills. Learning was specifically aimed to develop positive healthy behaviours in the context of HIV and AIDS. Life skills approach was expected to address three components including knowledge (information), attitudes and life skills.

When these three components are considered in the context of healthy functioning behaviour, life skills have fundamental components which are considered as planks. These planks build the bridge from knowledge to the healthy life styles as they appear in Figure 1.2. The components within life skills comprise psychosocial skills such as assertion, negotiation, decision making, empathy building, value clarification, stress and copying skills (Peace Corps, 2000). In developing or changing behaviour, skill-based approaches are the most effective methods (Rakhi, 2011) to develop competence and confidence.

The curriculum effect on students seem to be having a positive effect on students' knowledge and awareness of HIV and AIDS, but they do not adequately meet the goals of the national policy – namely, to promote healthy behaviour and positive attitudes (Thaver, 2012). This is consistent to the findings of the study. Documentary

review indicated that school-based interventions can enhance competence and confidence of school youths by teaching a range of topics using several interactive methods such as role play, discussion, debate and demonstrations.

However, one of the challenges related to curriculum was limitation in developing beliefs about what GVIs were capable of doing (self-efficacy beliefs) although the school curriculum indicated knowledge and skills which were necessary to develop positive attitudes required for HIV and AIDS prevention intention.

Findings of this study indicated that although learning is a process involving practice which result in behaviour changes, GVIs' narratives suggested that learning was theoretical in which traditional way of teaching combined listening and thinking during the teaching and learning processes. In this kind of learning, learners did not comprehend concepts and experience through reflective observation and therefore this kind of learning was not competence based. While competences define the applied skills and knowledge that enable people to successfully perform the required tasks, learning objectives should be specific to a course of instruction (Arguelles & Gonczi, 2000). Thus teachers need to interpret information from the subject syllabus about the stated specific objectives and specified competences and create reciprocal relation to the methods of teaching life skills in relation to the processes of teaching and learning among students with disabilities including GVIs.

The implication of learning which is not competence based is that the school-based interventions have not been providing HIV and AIDS education that can assist GVIs

and other school adolescents with disabilities to develop HIV and AIDS related knowledge, skills and attitudes. Consequently, beliefs about what GVIs and other school adolescents with disabilities are capable of doing can negatively influence their feelings, thought and motivation about performing healthy behaviours the use of condoms for HIV and AIDS prevention.

GVIs are more disadvantaged when they are involved in a theoretical way of learning due to the visual impairment that impede them to combine thinking and watching what is done while the lesson continues. Consequently, GVIs do not develop confidence, a situation indicated in GVIs narratives represented in several extracts in narratives such as “I’m not confident to negotiate with the sexual partner in the actual use of these skills” in extract 11 (a), and “I don’t have confidence unless I get more information” in extract 14 (c). Hamilton, Hamilton and Pittman (2004) indicate that confidence flows from competence and the two mutually reinforce each other. School youths develop confidence not because they are told that they are confident but because of their consciousness about the ability or competence that they have developed for achieving the required behaviours.

Intention as an antecedent of the actual behaviour is determined by competence and confidence which develop self-efficacy. GVIs’ self-efficacy belief was affected by their ability to act because they cannot see. People could have particular expressions in particular situations. For instance there is an expression such as “seeing is believing” that is used in situations related to the perceptual experience of seeing and believing. It means you only believe something if you see it. This situation suggests

that if you do not see it you do not believe it is true. This expression can be true in some situations but it is not always true especially when the expression is considered in situations where there are individuals such GVIs who do not see at all. If the expression is true to individuals such as GVIs, then learning would not take place at all because they read materials in Braille form and respond to information they get from Braille materials. In the world there are examples of visually impaired individuals who have grown professionally and are performing significant roles in their societies. For example in Tanzanian education system there are successful individuals in education system ranging from primary school teachers to university lectures. Their success is rooted on their academic experiences which developed competences and self-efficacy that has influenced their abilities to excel. This indicates that given the required opportunity GVIs can develop competences and self-efficacy beliefs for behaviour intention not only in academic subjects but also in HIV and AIDS related issues.

The following account can enable the readers to see the implication of the current school interventions on the GVIs' self-efficacy beliefs on behaviour intention. In extract 11 (a) for instance, the GVIs have the knowledge indicated by the phrase "have learned and understood some of the important life skills such as communication, decision making and refusal skills." GVIs also acknowledge that "skills are important to enable an individual in responding to various situations such as HIV and AIDS prevention" but life skills "have not influenced the intention for condom use." Since they are not confident, it implies that they lack the practical knowledge of these skills.

The, situation exemplified in extract 11 (a) is portrayed as theory based kind of learning among GVIs. Learning does not provide them with abilities because information about ‘life skills which is important to respond to various situations such as HIV and AIDS prevention is “perceived mentally.” Further, extract 11 (b) shows that the GVI did not know how she could overcome likely obstacles related to the application of these skills. This finding is consistent to Lydia (2010) whose findings revealed that the visually impaired individuals suffer many limitations, the major one being inability to use their sight because a lot of information on HIV and AIDS is visual, for example information is in print media such as pamphlets, books and magazines; other information is on posters and television. Visual impairments impede them to associate thinking and what is done while the act of demonstration is performed as the lesson continues. Consequently, they do not develop confidence, a situation which is conducive for low self-esteem.

Although life skill approach is an effective ways that can address HIV and AIDS, transferring what is learned from one context to another context such as from the classroom to the real world is often not successful (Fadel and Trilling, 2009). Experience shows that behaviour is substantially more difficult to change and requires more intensive approaches than knowledge and attitude change (Rakhi, 2011). It is no wonder that HIV and AIDS education is being taught but there are still new infections. In order to make it visible and explain GVIs’ responses to challenges represented in the extracts, the researcher considered proposal that implication of teaching for action is not limited to knowledge (Wurdinger, 2011) but also to life

skills implications on teaching and challenges related to self-efficacy and its influence on intention for HIV and AIDS prevention.

The point of departure of knowledge and skills on the proper use of condoms cannot be GVIs' attendance in the classes, but must be functions and practices that the GVIs can carry with the targeted knowledge and skills learned in classes. The subject matter in question is the uncertainties posed by the following questions. For those who do not have knowledge and skills on the proper use of condoms, the question remains; can they be taught this knowledge and skills? How and when? If the GVIs have opted for abstinence from sexual intercourse, are they going to remain abstinent forever? What is going to happen when need arises for them to engage in sexual practices and they really engage in such practices? These are some of the questions that need to be given attention concerning the concept of condom use intention. These questions did not seem to have been addressed in the context of school-based interventions and its logical relations in this study.

A relation implicated by the fact that the GVIs continue to be inadequately informed, then it is true that they will continue to be unable to make healthy choices such using condom and at risk of HIV and AIDS infections. Thus life skills should be acknowledged and reflected in classroom practices to develop GVIs' ability to act and further build self-efficacy beliefs required for behaviour intention. In so doing knowledge and skills learned can enable the learners including GVIs in minimizing challenges that are likely to impede application of the life skills for HIV and AIDS prevention. Further, an additional study may be required to substantiate the claim that

GVIs' behavioural intentions such as condom use is challenged by lack of self-efficacy due to lack of practical skills to perform the required behaviour.

5.4.3 Challenging Social Factors

In this study, findings showed that GVIs had learned HIV and AIDS related knowledge and life skills from school-based interventions. However, despite challenges that emanated directly from the curriculum implementation, there were also other factors that were also likely to challenge GVIs in their intention for HIV and AIDS prevention among. These factors included disability, decision making power, social discrimination, labeling and condom inaccessibility.

5.4.3.1 Disability and Decision Making Power

Although there have been a number of reasons why GVIs are challenges by the curriculum-based challenges on self-efficacy that limit their intention for HIV and AIDS prevention, findings also suggest the underlying decision making power as a factor limiting their intention for HIV and AIDS prevention due to gender inequality. Gender inequality is encored in in GVIs declaration exemplified by extract 18 (a) which indicates that GVIs have "limited power to decide" in the use of condoms and lack of ability to resist sexual abuses. This implies that men have power over decisions on whether to use condoms or not. Thus there is a link between the spread of HIV and the power imbalance that exists between men and women. There is also evidence about this power imbalance from researchers in the previous studies such as the ones done by Tigawalana (2010) and UNESCO (2010) from which it was noted that gender roles have given men more power to make sexual and reproductive health

decisions. Findings also suggest that gender inequalities and disability are strong drivers of hopelessness which in turn overpower decision making powers, one of the conditions required for condom negotiation.

Previous studies have also proved that the issue of disability worsens their position as men and women in society with respect to various aspects such as decision-making roles. Women with disabilities are disempowered by both their gender and their disability in terms of their ability to influence decisions that affect them. They are conspicuous by their absence from decision-making (Choruma, 2007). Further, gender inequality and discrimination harm girls' and women's health directly and indirectly, throughout the life cycle; and neglect of their health needs prevents many women from taking a full part in society (Temah, 2007).

In this study several conditions can account for GVIs' decision making roles. GVIs' responses represented in Extract 17 indicated that intention for HIV and AIDS prevention through abstinence from sexual practices is challenged by several related reasons including environment for HIV and AIDS prevention which is not supportive. For instance narrative in extract 17 (a) indicated that GVIs are sexually abused by their teachers. These findings compared with the previous study of Suka (2006) who observed GVIs' sexual abuses by the specialist and classroom teachers. Lack of GVIs' precaution on sexual risks, fear to resist abusers, fear to loose relationship and inability to protect sexual abuses due to disability and lack of competence that can give way to lack of confidence is also indicated in extract 11. Data concurs with Grose (2004) and Booi (2013) that PWDs such as GVIs' are

vulnerable to sexual violence. When they find themselves in such situations they are not able to protect themselves from sexual abuses because they are overwhelmed either physically because GVIs cannot fight the abuser or psychologically as a result of accepting sex for money or for maintaining relationship indicated.

This situation justifies GVIs' doubt about their self-efficacy which is comprehensible from the represented narrative in extract 11 (a) indicating that the methods used in teaching and learning life skills required for developing competence involved GVIs theoretically.

An implication which is implicitly made is lack of skills to deal with challenging situations. This interpretation is based on the fact that if the "ability to negotiate" is "challenging" as indicated in Extract 15 (d), it can symbolize lack of confidence in negotiation skills and further it can lead to doubt their self-efficacy. GVIs' beliefs about their ability to prevent themselves from HIV and AIDS are not simply predictions about behavior intention for condom use, but about what they believe they cannot do. Behaviour change is facilitated by a personal sense of control.

If people believe that they can take action to solve a problem instrumentally, they become more inclined to do so and feel more committed to decide (Conner & Norman, 1995). GVIs lacked beliefs on their ability to use condoms indicated by their declarations such as intention for using condom was "challenging" because of the predetermined doubt represented in a rhetorical question asking, "Who knows that a sexual partner will agree to use condom?" This rhetorical question presents

doubt about the sexual partners will to agree to use condom. The doubt represented in this question is a barrier and without a strong will to overcome such a barrier, GVIs cannot adapt the intended behaviours for HIV and AIDS prevention. GVIs' lack of belief is surrounded by various situations such as lack of "the ability to negotiate and understand the sexual partner's intention." which are "challenging" and the belief that they cannot free themselves and run away. This indication is similar to Piper (1989) in Lopez and Snyder (2002) who declares that on the one hand, self-efficacy influences what action the learners decide on, how much effort they put forth, how persistent they are in the face of the difficulties, and the difficulty of the goal they set. On the other hand, learners with low self-efficacy do not expect to do well, and they often do not achieve at a level that is appropriate with their abilities. They do not believe they have skill to do well so they do not try. Being visually impaired girls is an additional risk factor. GVIs face unique challenges in preventing HIV infection, because of their marked risk of sexual violence.

Several dynamics have been postulated for an indirect link between sexual violence and HIV risk including reduced self-esteem. This factor associated with or resulting from gender based violence increases the risk of HIV by increasing the likelihood of high-risk behaviours (Gwandure, 2007). Given that disability and gender-based sexual abuses are taken into account, readers can acknowledge the need for teaching and learning processes that appropriately accommodates the adolescents with disabilities such as GVIs in teaching and learning processes. However, the conditions under which GVIs respond in situations in which compromise for using condom is not reached is worth to address in further researches and suggest how best GVIs

should be empowered to respond appropriately to negotiations for using condoms and responses to the partners who refuse to use them.

5.4.3.2 Discriminative Challenges Limiting GVIs' Behaviour Intention

There has been policy pronouncement against persistence of discrimination against individuals with disabilities in health institution in which there are unfriendly behaviours of service providers. On the contrary, there is lack of special programmes targeting physically challenged individuals on HIV and AIDS and persistent negative attitude of health service providers and the community towards individuals with disabilities (Murangira, 2004).

The data analysis shows that communities practice social discrimination on individuals with disabilities such as GVIs and this discrimination can hamper HIV and AIDS prevention efforts among GVIs. Taking a holistic conceptualization of disability, findings demonstrate prejudice and discrimination. Prejudice is an unjustified or incorrect attitude usually negative towards an individual's membership of a social group without knowledge of the group. Discrimination is treating individuals in a less favourable way because they are member of a particular group; it is prejudice in action (Kreidler, 2004). Discrimination in the context of negative perception, in which GVIs are considered abnormal and are sexually inactive, has brought into view the ground under which their intentions are challenged by discouragement. This discouragement is rooted on negative attitudes that intimidate them in the act of looking for condom presented in phrases such as "looking for condom is threatened by fear of other peoples' negative attitude towards disability."

Intimidation is also embedded in the chitchat represented gossip, wondering how a GVI would get pregnancy. This circumstance makes them hide their intention for using condom let alone looking for condom. This implies that intimidation is an integral part of the challenges to condom use intention. It indicates that intention to use condom is not only limited by their personal challenges but also by feeling of others about use of condoms among GVIs.

In this study findings show that people think that GVIs are not normal and that they do not have sexual feeling and therefore they do not engage in sex. Further, the GVIs' conscious about discrimination plays a considerable role in the formation of their intention for HIV and AIDS prevention. Findings of this study are similar to Grose (2004), Kyaruzi (2004), Murangira (2004) and Philander and Swartz (2006), who found out that, PWDs are considered asexual. Thus, this barrier prevent them from accessing adequate information about HIV and AIDS prevention as also noted by Edwards, et al (2005).

GVIs are also discouraged by the negative attitudes of the service providers who are likely to express doubtful speculation on why GVIs need condoms. In such situations, GVIs face discrimination which in this particular situation causes a discouraged intention for using condom and further self-denial to the ability to condom accessibility. Under such circumstances, disability becomes a social-cultural context which clearly defines itself as a barrier to participation on the fight against HIV and AIDS among GVIs and other school adolescents with disabilities. Such situations also create discriminatory attitudes and social practices based on individual

status. Similar to Carlson (2013) findings of this study suggested that PWDs are not only misunderstood but also they are mistreated. There are traditional views of disability, making the characterized traits more visible as individuals who are incapable, failures, defeated, or impaired. Such situations make GVIs defeated psychologically and fail to fulfill their goals including intention for having access to condoms or using them.

Given that GVIs are learning life skills in Civics and in Biology courses, it is expected that they could have gained knowledge skills and further to have confidence on their decisions. Also, the fact that GVIs are discriminated in learning because methods are not user friendly; it implies lack of awareness about disability and the needs of individuals with disabilities such as GVIs. Given awareness, HIV and AIDS educators and other individuals would respond positively to reduce discrimination surrounding sexuality issues concerning individuals with disabilities.

For instance teachers can raise concern about discrimination among adolescents with disabilities and the way this discrimination affects their entire life. With this awareness they can address discrimination on the basis of disability and supported AWDs such as GVIs in learning so that GVIs can interpret knowledge, values and life skills for behavioural intention.

Generally, findings indicate various situations attached to the limited intention to use condom among GVIs. Such situations are associated to negative attitudes that are a result of most of individuals' feelings marked by the naive assumption that

individuals with disabilities are not normal and therefore are asexual. The naive assumption that GVIs are getting knowledge and skills that can help them to respond appropriately to measures such as intention for using condom is something that people believe but is false.

In light of conceptualization of disability and discrimination above, findings concur with Subrahmanian (2009), who contends that, discrimination could be in adverse way of reinforcing negative stereotypes or promoting the internalization of feelings of powerlessness. This situation upholds the existing state of affairs about disability and discrimination.

5.4.3.3 Labelling as a Challenge Limiting GVIs' Behaviour Intention

The effect of teacher expectation on the GVIs performance is a topic of interest which has also prominent feature in this research. The findings demonstrate that VGs' failure to perform certain tasks related to HIV and AIDS prevention is directly related to the expectations that the teachers and their fellow peers hold for GVIs.

Several extracts including extracts 9 (b) and (c), 10 (a) and (b) are discussed in this section with a focus on the labelling of GVIs in school-based interventions. In these extracts there are statements concerning labelling stated by teachers from their own observation. They associate the disabilities of the GVIs with various characteristics which are barriers to the required support that the teachers would provide to the GVIs. In extract 9 (b) and (c) for instance, the teachers' opinion about learners is represented in a two directional ways. The first opinion about GVIs is a negative one in which they are considered "inactive" in extract 10 (a).

GVIs are condemned with respect to their performance. For instance there are condemnations such as “GVIs don’t participate much because they don’t have self–confidence” in extract 10 (a), “GVIs have low self-esteem about themselves and so they do not respond to questions or to other activities that require movement” in extract 10 (c) and “they are very slow in responding” in extract 9 (i). Given this synopsis the implication can be consistent to Wistrom (2012) who observes that, when the label of disability is given to a child it can affect the ability of the classroom teacher to observe and interpret the child’s behaviour objectively.

A close analysis of this data would suggest that the teachers’ opinion about GVIs is irrational because of the following reasons. From the GVIs’ point of view about learning especially in the whole class discussion, represented in 10 (a), the low self-esteem and lack of confidence has been constructed. Teachers are echoing on their feelings about GVIs. Such feelings are the low self-esteem and lack of confidence.

The GVIs confirm that they “listen” and “generally” they “get the point.” The GVIs understand what goes on in the teaching and learning processes which is proved by the represented statement in extract 10 (d) which states that “Each time ideas are given, the rest of the learners listen and add more ideas” but teachers do not take initiatives to ensure effective participation of the GVIs. This claim is implicated by GVIs in statement such as; “the teachers motivate others for more responses” but it is too general because GVIs are not given close assistance to build confidence and self-esteem that would enable them to act.

This situation can also imply that teachers are completely ignorant about set of facts that surround GVIs especially the fact that they are labelling them. It is expected that teachers would show some efforts to respond to the GVIs' low self-esteem but none of the teacher showed any response to the GVIs' low self-esteem represented in the labelling. In extract 11 (a), in GVIs' statement, "I've learned and understood some of the important life skills such as communication, decision making and refusal skills" clearly state their ability to learn. In an opposing direction, the GVI declares that she is "not confident to negotiate with the sexual partner in the actual use of these skills" because "Apart from explanations, discussions and demonstrations that I perceived mentally, I've not received information from any other sources." From this scenario readers can consider the fact that labelling GVIs is socially constructed as a result of limited opportunities in learning that influence teachers or sighted peers to look upon the GVIs as slow learners who lack characteristics such confidence and self-esteem and further fail to participate effectively in learning and consequently unable to act.

Labelling in the context of the extracts presented above is negatively perceived by teachers who are teaching HIV and AIDS related issues, and peers. This negative perception reduces their potentials and aspirations for what GVIs are capable of achieving. This is evidenced from the GVIs' low expectations and low self-esteem. Also data show that GVIs have a sense of helplessness especially in their feelings that they are not able to fulfill their intentions. With the exclusion of labelling, GVIs would have intention to access condom freely without fear of what they refer to as "gossip" from their peers or from service providers.

On the one hand, social and academic success is viewed as less attainable for individuals with label (Hunt, 2006) such as visual impairment. On the other hand, labelling could have positive effect given that labelling is well utilized (Wistrom, 2012). Labelling can prompt teachers in providing specific assistance to the GVIs by providing individualized plans, activities and materials so that they can provide additional learning designed for helping GVIs succeed in developing self-confidence and high self-esteem required for behaviour intention.

Teachers can plan instructional activities at the individual level of GVIs of performing specific function at their relative speed of learning and progress in relation to the required knowledge and skills. At the individual level, GVIs can receive repetitive instructions in a much smaller contexts and environment which are more favourable to their learning abilities.

With regards the above proposition, labelling needs to be given a careful consideration so that it yields positive effect rather than negative effects. Teachers who are teaching HIV and AIDs education in Civics and Biology may need training on awareness that can awaken them on their ignorance about attitudes towards the GVIs ability in learning and remove the barrier related to labelling. In this case GVIs can also overcome challenges affecting them in the fight against HIV and AIDS not only as girls but also as visually impired individuals.

Further, finding calls for the need to provide GVIs with opportunities to practice and build self-confidence or self-esteem and eliminate labelling which challenges

adolescents with disabilities to perform certain tasks related to HIV and AIDS prevention.

5.4.3.4 Condom Inaccessibility

Data show accessing condom among GVIs is a challenge that limits GVIs' intention for condom use as one of the prevention measures for HIV and AIDS. For instance, extract 19 (a) makes some claims about "embarrassing" situations associated to the need for someone to accompany her to access condoms. The representation also proposes a truth claim about issues related to condom as "confidential." Further, in 19 (b) it shows that in case a GVI asks for assistance to access condom it would "suggest intention for sex" and the person who guides the GVI will get to know all about her intention. In the phrase "frankly speaking I don't think I've the courage to let someone else know my intention for accessing condom" the adverb "frankly" is used as an intensifier reflecting the speakers' attitude, indicating that it is sincerely the case that the speaker does not have the courage to let someone else to know her intention for accessing condom.

This representation indicates some factors that are inhibiting intention for using condom, concurrent to Mushi, Mwakolo and Njau (2013) who found out that sexual behaviour change is a complex issue influenced by complex variables which are intrinsic and extrinsic. Fraser, Prata and Vahidnia (2005) confirm that the use of condoms is influenced by social and democratic characteristics, knowledge about reproductive health, self-efficacy and attitudes regarding condoms, and issues of access and affordability.

In extract 19 (e) there is a psychological barrier to access condoms and intention to use them caused by service providers who query about the need for GVIs to access condoms indicating that GVIs do not need condoms. The psychological barrier represented in this extract results to negative feelings to go to the places where condoms are available. In extract 19 (e) GVIs state that they “don’t feel good to go to health centres because both the guide and the health service providers are likely to query about the intention.” Further, “there is nobody to collect condoms for GVIs.”

In a statement “there is nobody who is making it possible for us to access condom without much effort” implies that if there were easy access to condoms, GVIs would have intention to use condom. This condition would change their “intention” which was said to be “totally limited” into a strong wish to use condom stated in the opening statement of extract 19 (e).

In this study, democratic characteristics are self-governing characteristics such as imagination of “how embarrassing it is to ask someone to accompany you to the shop or to the clinic to get condom” in extract 19 (b). The imagination, which is socially constructed, is a challenge limiting individuals to access condom because condom issues are considered confidential. Although one of the goals of the school-based interventions is to increase self-efficacy to school adolescents, GVIs seem to have low self-efficacy towards ability to access condom use.

GVIs’ belief about accessing condom is limited by confidentiality issues about condom and they avoid asking a companion. GVIs cannot have condom at hand on

their own when needed. So with respect to intention for condom use and condom accessibility, it is an act of intending in which volition to act may change once GVIs consider that accessibility to condom is “a private issue” all together is “embarrassing” exemplified in extract 19 (b). If GVIs feel reluctant to ask a sighted peer to accompany them to access condoms, unwillingness to intend to use condom is contrary to their intention for HIV and AIDS prevention because it is directly affected despite the knowledge about life skills. GVIs have been included in school based interventions but still their intention for HIV and AIDS is limited. On the basis of this premise, it can be concluded that not every school youth exposed to school-based interventions will have an exert influence on intention for condom use for HIV and AIDS prevention because of factors associated to their characteristics and ways to which they view, think and value themselves. For instance GVIs beliefs about their ability to get condom can be affected by factors such as self which include dispositional behavioural and emotional information that they hold about themselves.

Proponents of abstinence programmes argue that only abstinence allows youths to avoid the risks of unwanted pregnancies and sexually transmitted diseases; using condoms or other forms of contraceptives merely reduces these risks (Kirby 2008). This implies that GVIs do not only need knowledge, skills and attitudes for abstinence to avoid the risks but also they require knowledge, skills and attitudes for using condoms to reduce the risks.

Peer pressure is referred to as demands for conformity to group norms and demonstration of commitment and loyalty to group members. In the context of

adolescent, members outside the group form expectations that reinforce their connections to specific peer groups and prohibit their movement to others. Similarly an individual who becomes a member of a group is more acceptable to the social system than one who does not form conformity to the group (Newman and Newman, 2012). In this view peer pressure can affect an individual negatively or positively.

Findings of this study show that peer pressure can influence GVIs' ways of thinking and acting negatively specifically in their intention to abstain reflected in the represented extracts in Extract 19. In this extract the influence is represented in situations such as being laughed at, suggestions on what they should do or sharing experiences. Such situations tend to bring about influence to the adolescents behaviour because they want to be accepted in the social system.

Findings demonstrated in extract 19 are consistent to Gardner and Steinberg (2005), who indicated that peers can influence each other to engage in risky behaviours. Since GVIs are highly motivated by the expectations of their peers represented in the extracts, such expectations can be associated with behaviours and there are greater chances for behaviour to change negatively and risk their lives.

WHO (1997) shows an abstract mental location of the life skills as a causal connection between motivating factors of knowledge, attitude and values, and positive health behaviour and the way it contributes to the prevention of health problems. Peace Corps (2000) and WHO (1997) confirm that for an individual to have positive health behaviour for prevention of health problems, knowledge, attitudes and values are required. They also require life skills that are likely to

provide psychosocial competences to translate knowledge into actual abilities of what to do and how to do it. Analysis and discussion of the findings also indicated that apart from factors specifed in WHO (1997), GVIs need specified activities that suit them in learning. They also need behaviour renforcements such as practicing the required behaviour to familiarize them to various situations through the learner centred approach as opposed to teacher-centred approach.

The findings of the study show that there are several risk factors that may make GVIs more likely to give in to peer pressure. Some of the risk factors include poor self esteem and confidence, the way they think about themselves and the way their teachers feel about them. The existing peer influence to behaviour intention implies that GVIs should be given the necessary skills to analyze the situation and make the appropriate decision. This includes helping them develop the skills for behaviour analysis. These skills should be concerned with teaching them to look at both the negative and positive sides to making a decision related to the peer influence. For instance, if being pressured to sexual practices, GVIs should be able to think about the possible outcomes. These possible outcomes may include peer acceptance, excitement about trying sexual practice as new practices with the possible unwanted outcomes such as unplanned pregnancy, HIV infections and other health related problems.

Maria (2007) emphasizes that copying with peer pressure requires readiness to face peer pressure and win. There are many strategies that develop teens' positive aspects such as abilities and self-esteem to promote positive self-concept and self-worth so

that they can resist negative peer pressure. Strategies include saying “NO” and stick to the choice. However, saying “No” to negative peer pressure must be complemented by healthy alternatives. This might be possible when an individual has skills to do so because this response implies having skills to communicate. In this case therefore, GVIs need skills which are more practical as opposed to the theoretical skills that the GVIs said they gained from the school-based interventions.

The lesson learned from this research is that, knowledge, attitudes, values and lifeskills are not the only factors that affect behaviour. The comprehensive framework developed for this research in Figure 1.3 cofirm that there are challenges that are likely to impede VGs’ motivation and ability to appropriately make use of knowledge, and life skills to act responsiblly in behaviours such as using condoms or abstaining from sexual intercourse.

Since the focus of this research was based on the use of condom and abstinence from sex for HIV and AIDS prevention, findings of this research may serve as a model for reviewing how other healthy behaviours such as reducing multiple partners are influenced by school-based interventions. They may also serve as a model for reviewing the impact of school-based interventions on HIV and AIDS prevention among adolescents with other disabilities.

5.5 Summary

This part presents the summary of chapter five. The chapter has discussed findings of data which were collected from the school curriculum materials such as the Biology and Civics syllabi, text books and data from individual and FGD responses.

Discussion of data was based on the three research questions. The first research question was designed to explore curriculum content related to HIV and AIDS prevention and how they are taught. Findings showed that HIV and AIDS related topics were embedded to Biology and Civics course. Thus the school-based school HIV and AIDS intervention guided by the school curriculum which also guided the teachers to teach the HIV and AIDS related knowledge and skills. Findings showed that the teaching and learning of the curriculum contents were guided by objectives and competences which were clearly stated.

In the analysis and discussion of the findings, there were two main areas of concern. First, the topics which were specified for developing HIV and AIDS related knowledge, skills and attitudes were embedded to the already crowded curriculum suggesting additional tasks in the teaching and learning processes. Specified topics were essentially factual knowledge about transmission and prevention of HIV and AIDS.

Second, most of the materials which were suggested in the syllabus were not available in the schools which were involved in the study, and even the available materials and methods were not interactive among GVIs. The only materials which were used to teach were penile models and male condoms to demonstrate the use of male condoms. Implication made by the absence of the required materials and the use of methods which were not interactive is that the teaching and learning processes depended on the available materials. In most cases findings suggested that the teaching of the curriculum contents were theoretical.

Discussion of the data for the second research question was based on how the teaching processes of the contents related to HIV and AIDS prevention assist GVIs in developing knowledge and attitudes required for the healthy behaviours for HIV and AIDS prevention. Findings showed that teaching and learning of the curriculum contents about HIV and AIDS were essentially focused on assisting the students in developing knowledge and attitudes required for the healthy behaviours for HIV and AIDS prevention. Nonetheless, the focus was basically for the students without disabilities because the materials and methods used in the processes of teaching and learning were not disability based. For instance the Brail materials for students with visual impairment were not available and neither were the methods user friendly to the GVIs. This implies that the school-based intervention did not consider the varied needs of the learners specifically the needs of the AWDs such as GVIs.

In the light of this observation findings suggested that the knowledge and skills developed by the GVIs were sufficient to assist them for developing knowledge, skills and attitudes required for the intention and the actual behaviour of abstinence from sexual practices. On the other hand the findings suggested that knowledge, skills and attitudes developed was not sufficient for HIV and AIDS prevention through the use of condoms.

Implication made by such situation is that, since the GVIs lacked sufficient knowledge, skills and attitudes towards the use of condoms, GVIs could fall into risky behaviours of unsafe sex when they decide to engage in sexual practices due to lack of skills to use condom. This is because the findings did not suggest that they

would remain abstinent for the rest of their lives. The third research question was based on how GVIs were challenged in developing knowledge skills and attitudes for HIV and AIDS prevention. In this study it was conceptualized that school-based intervention as a major predicting variable specifies knowledge and life skill related topics to be taught, teaching methods and materials and competences to be developed. These variables were expected to produce the major impact variable namely HIV and AIDS prevention intentions including condom use and abstinence from sexual practices. Discussion of the findings indicated that GVIs face challenges which are likely to limit their intention for using condoms. These were social and curriculum related challenges.

Curriculum related challenges were based on the teaching and learning methods and materials which were not user friendly. Consequently, GVIs did not learn effectively and so they did not attain functional life skills required for developing favourable attitudes for perceived behaviour control over the use of condoms.

Discussion and analysis of the findings show that although GVIs' responses represent intention for HIV and AIDS prevention, there were intervening variable from the social context that come in as challenges limiting GVIs intention for HIV and AIDS prevention. Factors represented in the extracts are un-conducive social factors which limit them to fulfil their intention because of risky situations which they cannot resist. These social challenges are identified as lack of decision making power because of disability and gender inequality, condom inaccessibility, peer pressure influence, discrimination and labelling. These were forces which were likely to

overpower GVIs in negotiation on HIV and AIDS prevention. In their totality or in isolation these challenges, together with challenges that emanate from the teaching and learning processes obstruct the GVIs intention developed from school-based interventions.

In the light of the broad depiction of the school-based intervention (predictor variables), challenges (intervening variable) and HIV and AIDS prevention intention (Impact variables) findings suggest that school-based interventions provide life skills to GVIs but their impact on GVIs' behaviours for HIV and AIDS prevention was mainly limited to abstinence from sexual practices.

CHAPTER SIX

6.0 SUMMARY, CONCLUSIONS AND RECCOMENDATIONS

6.1 Introduction

This chapter comprises of three sections. The first section summarizes the research report, the second part concludes the report and the third part provides recommendations. The summary of the report and the conclusion are based on the three research objectives and recommendations are based on what the researcher considered worth to act upon for improving the school-based interventions that can enable the GVIs to make use of life skills for HIV and AIDS prevention.

6.2 Summary of the Report

The research problem emanated from the spread of HIV and AIDS which has become a pandemic. Statistics show that Sub-Saharan Africa is the most affected with an estimate of 25.8 million people living with HIV (UNAIDS, 2014) with more impact to women and girls due to social and biological factors (Tigalawana, 2010; UNESCO, 2010). Literature shows that PWDs are at the greatest risk of HIV infection compared with non-disabled people (Edwards and Yousafzai, 2004). Women with disabilities are even more vulnerable due to factors including insufficient access to HIV and AIDS because their disability create barriers to participate efficiently in various prevention intervention which have been put in place to respond to HIV and AIDS, sexual abuses and discrimination. Girls with disabilities such as GVIs are more vulnerable compared to adult women because of factors affecting them as youths.

HIV and AIDS have necessitated interventions based at different settings such as at schools, communities, colleges and universities. Such interventions are mostly designed to educate the targeted groups on HIV and AIDS prevention. Literature shows that there are misconceptions that individuals with disabilities are asexual and at low risk to contract HIV while these individuals are at the same or greater risks. They are thus denied access to HIV and AIDS education (Groce, 2004; Murangira, 2004). Little was until now known about the impact of the interventions on their intention for HIV and AIDS prevention. For instance, it was not documented how school-based interventions could assist adolescents with disabilities such as GVIs in their intentions for HIV and AIDS prevention. It was from this background, the problem related to School-based HIV and AIDS interventions for GVIs in secondary schools was chosen as an important research problem that triggered this study.

The purpose of the study was therefore to unveilthe influence of school-based HIV and AIDS interventions on HIV and AIDS prevention among GVIs. There were three research objectives including to explore; how school curriculum contents related to HIV and AIDAs were taught, how teaching and learning processes of the contents related to HIV and AIDS prevention assist GVIs in developing knowledge and attitudes required for the healthy behaviours for HIV and AIDS prevention and how GVIs were challenged in their intention for HIV and AIDS prevention.

The study was qualitative in design therefore the researcher adopted a phenomenological design to study the school-based HIV and AIDS interventions and their impact on (GVIs) intention on HIV and AIDS prevention in secondary schools.

The researcher used one-to-one interview, FGD, and documentary reviews to collect data from two selected secondary schools at Korogwe and Tabora high schools located in Tanga and Tabora Regions respectively. The rationale of using these two schools was that the school enrolled whose students and employed teachers who taught both Civics and Biology and had free time dedicated to participate in the study according to the researchers' preliminary inquiry.

Population for the study included five thousand and three hundred and thirty three students (5333) with disabilities enrolled in mainland in Tanzanian Secondary Schools. The rationale of involving this population was that it comprised GVIs who were the intended group with characteristics of visual impaired girls. Data presentation and analysis was qualitative.

Findings were summarized and condensed in a table, a technique referred to as meaning condensation. Then, meaning and categories were developed and integrated with ideas from the review of literature. Themes were developed from the data discussed. The researcher observed ethical issues including asking the research participants to take part in the study voluntarily. They were assured of confidentiality and permission was sought form the heads of the selected schools include the participants who were under the age of 18 years.

Discussion of the findings was presented in relation to the three research questions. The research had three research questions related to each of the research objectives. The first research queried how the school curriculum contents related to HIV and AIDS prevention were taught. The question was designed to explore curriculum

content related to HIV and AIDS prevention and how they were taught. Specifically, the findings were based on school curriculum contents about HIV and AIDS prevention. Findings grounded on the first research objective showed that school-based interventions were aimed at assisting school adolescents so that they could attain life skills for HIV and AIDS prevention. This was evidenced by the existence of the school HIV and AIDS education which was embedded in the school curriculum in the Biology and Civics syllabi. Findings showed that, GVIs were learning topics about life skills and other academic topics in the same classes with the SGs.

Findings from reviewed documents included Biology and Civics syllabi, texts, students/teachers notes, and interview responses. These revealed that the main way of developing life skills was teaching topics about HIV and AIDS embedded in the syllabi. Further, implementation of the school-based intervention for developing life skills for HIV and AIDS prevention was guided by the syllabi which specified competences that the school youths were expected to develop. Developing competences was also guided by specific objectives which were clearly stated to indicate abilities or competences that learners were expected to demonstrate.

Materials and methods of teaching and learning topics about HIV and AIDS were also specified in the syllabi. In both the Biology and Civics syllabi, methods specified included discussion, role play, question answer technique and reading extracts about management of HIV and AIDS and answer questions. Findings showed that none of the suggested method was used. Teachers used explanation, demonstration and whole class discussion methods.

The materials suggested for teaching about HIV and AIDS included; texts, brochures, cards, fliers, reports, manual and extracts about HIV and AIDS. However, none of the specified materials were available except books which contained life skills related topics. In teaching Civics there were two additional materials; male condoms and penile models which were used to demonstrate the use of male condoms.

The second question interrogated the teaching processes for contents related to HIV and AIDS prevention and how the process assisted GVIs in developing knowledge and attitudes required for the healthy behaviours for HIV and AIDS prevention. This concern was intended to explore how the teaching processes of the contents related to HIV and AIDS prevention assist GVIs in developing knowledge skills and attitudes required for their intention for HIV and AIDS prevention.

Exploration of this aspect indicated that school adolescents achieved life skills such as communication, decision making, and negotiation skills. Further, findings showed that GVIs could not link these life skills and the ability to act responsibly in both condom use and abstinence from sexual practices due to theoretical learning that did not provide them opportunity to make out the learned skills to practice. Whereas life skills were intended for developing intention for HIV and AIDS prevention practices such as condom use and abstinence from sexual practices, the life skills achieved did not develop GVIs intention for HIV and AIDS prevention for condom use. Their intention was limited to abstinence from sexual practices.

Specific objectives specified to develop the competences were not attained among GVIs because the methods used which included explanation, demonstration and

whole class discussions were not interactive among GVIs. Further, findings showed that the use of materials such as male condoms and penile models which were used to demonstrate the use of condoms did not involve GVIs because they were not given opportunity for demonstrations on how condoms are used.

Generally, findings of the study demonstrated that, the teaching and learning processes did not improve GVIs' ability to attain practical skills such as those required for condom use. This was because the methods through which school-based interventions were taught and materials for developing life skills for HIV and AIDS prevention were not interactive among GVIs. Such methods were more theoretical than practical.

The third research question asked how GVIs' were challenged in their intention for HIV and AIDS prevention. This concern was intended to explore various challenges that GVIs faced and the way the challenges limited GVIs' intention for healthy behaviours for HIV and AIDS prevention. Findings showed that GVIs experienced challenges that were likely to limit their intention for HIV and AIDS prevention. Their own beliefs about their ability to make use of the knowledge limited their self-efficacy which was an important determinant to their personal ability to use condoms. Another challenge was associated to limitations on condom accessibility. This limitation was complicated by their restricted mobility which necessitated a companion to go to places where condoms were accessed. Their limitation to the intention to use condom was further intensified by decision making power which was also influenced by gender issues implicated by their feelings that male sexual partner

determined whether to use condoms or not. Thus GVIs could not negotiate for condom use with a sexual partner, and they were not even taught about the female condoms which they could use even without the need to negotiate with their partner. This situation implied that GVIs lacked information about female condoms.

Social discrimination on disability is also a factor that was considered a challenge to the GVIs' intention for HIV and AIDS prevention. This is because people held misconceptions about GVIs which lead to discrimination on the basis of negative attitudes with a view that they were not sexually active and therefore, for them, it was questionable why they should access condoms. Such discrimination limited GVIs intention to assess and use condom for HIV and AIDS prevention.

In the research findings/ labelling was also considered a barrier in learning that in turn limited instructional activities. Teachers labelled GVIs as inactive learners who had low self-esteem. Likewise Behaviour change motivational factors were also considered as challenges that were likely to limit GVIs intention for prevention. Such factors included sexual abuses which were found to occur among GVIs or peer pressure influence which was likely to influence their intention for HIV and AIDS prevention.

6.3 Conclusions

The findings of this study evidence teaching and learning processes that may indirectly challenge rather than assist GVIs in developing abilities to apply the learned knowledge and skills for HIV and AIDS prevention. Consideration of both limited topics about HIV and AIDS taught and insubstantial teaching and learning

methods and materials used are to be given attention if secondary school based HIV and AIDS interventions are to sufficiently engage GVIs in order to enable them develop the required life skills for HIV and AIDS prevention.

Represented interviews in this study indicate that most teachers naturalize the false claim that position GVIs as inactive and largely dependent on listening to the explanation and discussion without assistance in practicing the teaching and learning processes. Whatever school based interventions contribute to GVIs intention for HIV and AIDS is either trivialized or subdued in the processes of teaching and learning HIV and AIDS education. Most of the responses represented school based interventions as lacking materials and teachers who are uninventive and mostly silent about the concern of methods that actively involve GVIs in the teaching and learning processes.

While the researcher agrees that the school based interventions are not provided with the resources needed, it is important to note that schools are not bare environments. Schools have abundant resources such as boxes, clay and glue that could be tapped to prepare Braille materials and other non-braille materials that would assist GVIs to develop knowledge and attitudes required for the healthy behaviour for HIV and AIDS prevention.

The non-acknowledgement of the interdependence between the teaching and the learning processes and knowledge, skills and attitudes required for HIV and AIDS prevention is a phenomenon the researcher believes to be largely worthy to consider. This is specifically because knowledge, skills and attitudes influence behaviour

intention but prior to developing behaviour intention teachers could not actively engage GVIs to gain both knowledge and practical skills. The proposition arrived at by logical reasoning is that teaching methods such as explanation, whole class discussion and demonstration limited GVIs' information rather than practicing the learned life skills. Such limitations restricted GVIs to theoretical life skills hence limited intention for using condoms.

GVIs require guided practice which should always take place at school in a classroom where the teacher can observe and actively interact with all learners including those with disabilities such as GVIs. Learners with disabilities such as GVIs cannot learn independently without assistance from the teacher or other learners.

The responses analyzed indicated that school HIV and AIDS educators do not explicitly acknowledge that schools depend on the environment around for the teaching and learning materials and teachers in form of intellectuals who are represented as innovative. This implies that in school based HIV and AIDS interventions, teaching and learning processes do not necessarily ensure effective learning. This is specifically when AWVIs including GVIs are expected to deal with sexual behaviours such as using condoms which are marked with intricately challenges caused by teaching and learning processes which were discriminative. GVIs learned life skills but GVIs' ability to use life skills to avoid HIV and AIDS languished under the domination of discriminative teaching and learning processes owing to the silence on the impact of the teaching and learning processes for

behaviour intention among GVIs. As noted earlier, the same challenges that limit GVIs' intention for HIV and AIDS prevention were the same that dominate GVIs self-efficacy belief on the intention to use condoms.

Within the social factors, the existing challenges that Tigalawana (2010) refers to are unconsciously established within the school based interventions and in other settings. One of the things that make the responses that the researcher analyzed focused on social challenges is the fact that, most of the challenges were socially constructed, and the impacts represented were predominantly focused. This observation led to further conclusion that GVIs' intention is limited by challenges such as limited decision making power, discrimination, negative labelling, condom inaccessibility and peer pressure. These factors were bound to GVIs' physical challenges and their perceived low self-efficacy beliefs that they could not use condoms. The social factors were also bound to the sexual abuses as an external force which was more powerful than GVIs' attitudes towards intention for HIV and AIDS prevention.

While it was important that school based interventions serve to promote competences for HIV and AIDS prevention, efforts to address social factors were inconceivable. This is because social factors affecting GVIs and their impacts on their intention for HIV and AIDS prevention were not understood and acknowledged within the context of unequal and unjust experiences among GVIs.

Generally, findings of this study established that the method and materials used in the teaching and learning processes assisted GVIs to acquire life skill such as

negotiation, communication, decision making, and refusal skills. They developed positive attitude and perceived social pressure for the intention for HIV and AIDS prevention. On the one hand life skills learned including refusal and decision making facilitated GVIs' intention for abstinence. On the other hand, positive attitude and perceived social pressure for HIV and AIDS prevention were insufficient to facilitate perceived control behaviour over condom use intention.

6.4 Recommendations

School curriculum has integrated HIV and AIDS related issues in the Civics and Biology syllabi with coverage of life skills which are universally agreed life skills required by school adolescents in secondary schools. The majority of the data analyzed in this study show that curriculum developers have taken silent consent about the existence of adolescents with disabilities such as GVIs in the teaching and learning processes. This silent consent is also reflected in the implementation of the curriculum. Neither the methods nor the materials used in the processes of teaching the classroom implementation of the school school-based intervention address GVIs needs. In the light of this view, and based on the discussion and analysis of the findings above, the recommendations listed below are crucial and intended for different people such as, MoEVT officials, School teachers who teach HIV and AIDS education, school inspectors, curriculum developers, policy makers, researchers and the general public.

The first recommendation is that, policy makers should review the HIV and AIDS prevention policy to guide the integration of HIV and AIDS education in basic

education which is guided by the overall objectives of education policies and relevant national prevention strategies including the national HIV and AIDS policy.

Second, curriculum developers should conduct a review of the school curriculum for the subjects to which HIV and AIDS related issues are embedded to include a more comprehensive link between the life skills and the ability of GVIs to act.

Third, the MoEVT should develop tailored prevention programmes in schools to address AWDs needs and challenges associated to their intention for HIV and AIDS prevention. This proposition however requires further studies to identify areas of specificity to understand practical realities in such programmes concerning the predetermined challenges inflicted on GVIs by dogmatic regimes embodied in the secondary school HIV and AIDS curriculum and cultural and societal discrimination imposed to GVIs.

Fourth, the MoEVT should also train teachers who are teaching courses in which HIV and AIDS related topics are embedded to equip them with knowledge and skills to teach the life skills related topics to both adolescents with and without disabilities. The MoEVT officials should also provide reading materials required for teaching HIV and AIDS related topics for developing the necessary life skills. They should include materials in Braille form to enable GVIs to access life skills during the lessons and later after classes for more understanding, clarity or for bringing back knowledge about life skills from memory.

Fifth, since information alone is not enough to enable school youths to develop

competences, teachers in the school-based interventions should provide the school adolescents with the ability to use life skills. The life skills can assist the school youths to build a link from information about HIV and AIDS to the actual behaviours that prevent HIV and AIDS. In so doing, these teachers will ensure that the specific objectives are attained by teaching the specified topics through the specified interactive methods to develop the specified competences needed.

Sixth, teachers who are teaching HIV and AIDS education in secondary school based interventions should ensure that school adolescents including those with disabilities such as GVIs are actively involved in practical teaching and learning processes that involves demonstrations of important concepts such as condom use to make learning practical and assist GVIs in attaining workable life skills from school-based interventions for HIV and AIDS prevention. Therefore, teachers should ensure that GVIs do not only attend classes but also they should monitor GVIs participation in the teaching and learning processes and support them so that they can achieve the intended knowledge and skills required for HIV and AIDS prevention intention.

Seventh, teachers should raise concern about discrimination among adolescents with disabilities and the way this discrimination could be addressed. In so doing, those who are discriminated on the basis of disability can be appreciated and supported in learning so that they can interpret knowledge, values and life skills for behavioural intention.

Eighth, awareness campaigns should be provided to the general public to appreciate

individual differences and eliminate negative feelings about individual differences such as differences caused by gender and disabilities including visual impairment that can give rise to exert power to the subordinate, prejudice and discrimination, sexual abuse and denial to social services.

REFERENCES

Aase, C.C. (2013). The Voices of the Invisible Girls: Reintegration of Former Female Child Soldiers in Burundi (Unpublished Master Thesis). University of Agder. Burundi. [http://www.brage.bibsys.no/.../Aase,%20Camilla%20Carlsen%20] site visited on 07/09/2015.

Abdurahim, A., Maimaiti, M., Maimaiti, R., Shamsuddin, K. & Tohti, N. (2010). Knowledge, Attitude and Practice Regarding HIV/AIDS among University Students in Xinjiang. Global Journal of Health Science 2010 October; (2) 2:51-59. [http://www.www.ccsenet.org/journal/index.php/gjhs] site visited on 09/10/2015.

Abeid, R. S. & Olutu, S. R. (2009). Civics for Secondary Schools: Form Two. Dar es Salaam: Oxford University Press. 89pp.

Abma, C., Chandra, A., Jones, I., Martinez, M., & Mosher, D. (2005). Fertility, Family Planning, and Reproductive Health of U.S. Women: Data from the 2002 National Survey of Family Growth, Vital and Health Statistics. [http://www.cdc.gov/nchs/data/series/sr_23/sr23_025.pdf] site visited on 18/02/2013.

Addy, Escobar-Chavez, Markham, Peskin, & Shegog. (2010). it's Your Game: Keep it Real: Delaying Sexual Behavior with an Effective Middle School Program. Journal of Adolescent Health 2010; 46(2):169–179.

AIDS Campaign Team for Africa (2010). HIV and AIDS & Disability: Three Country studies South Africa, Uganda, and Zambia. Washington: Danvers, 56pp.

Ajzen I. (1991). The Theory of Planned Behavior. Organizational Behavior and Human Decision Processes, (edited by Smith J.; Alexander S.), Psychology Press: London. pp. 179-211.

Alice Y., Sangok A. & Patrick M. (2013). Accessibility and Utilization of HIV and Aids Services among the Persons with Visual Impairments in Kenya. American International Journal of Social Science. (2) 8; December 2013. [http://www.aijssnet.com/journals/Vol_2_No_8.../18] site visited on 20/07/2015.

Al-Zu'be, A. F. M. (2013). The Difference between the Learner-centred Approach and The Teacher-centred Approach in Teaching English as a Foreign Language.[http://www.erint.savap.org.pk/PDF/.../ERInt.2013(2.2-04)] site visited on 13/9/2014.

American Academy of Ophthalmology (2012). How Does HIV and AIDS Affect the Eye? [http://www.geteyesmart.org/eyesmart/diseases] site visited on 03/09/2015.

American Foundation for the Blind (2013). Accommodations and Modifications at a Glance: Educational Accommodations for Students Who Are Blind or Visually Impaired. [http://www.familyconnect.org/info/education/] site visited on 17/6/2014.

An Action on Disability and Development (ADD) (2005). Challenges faced by PWDs (PWDs) in Utilizing HIV and AIDS Communication and Related Health Services in Uganda 2005. [http://ww.hpod.pmhclients.com/pdf/human-rights-approach.pdf] site visited on 13/072013.

Ang, A., Kinsler, J., Morisky, D. & Sneed, C. (2004). Evaluation of school-based intervention for HIV and AIDS prevention among Belizean Adolescents. Journal of Health Education Research. 19 (6) 730-738. [http://www.hr.oxfordjournals.org] site visited on 19/1/2009.

Anney V. N. (2014). Ensuring the Quality of the Findings of Qualitative Research: Looking at Trustworthiness Criteria. Journal of Emerging Trends in Educational Research and Policy Studies (JETERAPS) 5(2): 272-281. [http://www.eteraps.scholarlinkresearch.com/.../Ensuring%20] site visited on 01/10/2015.

Antwi S. K. & Hamza K. (2015). Qualitative and Quantitative Research Paradigms in Business Research: A Philosophical Reflection. European Journal of Business and Management; (7)3, 2015. [http://www.iiste.org/Journals/index.php/EJBM/article] site visited on 26/09/2014.

Arguelles, A. & Gonczi, A. (eds) (2000). Competency Based Education and Training: A World Perspective. Mexico: Noriega. 229pp.

Austin, H., Buehler, J., W. Macaluso, M., StoneK. & Warner, L. (2006). Condom Use and Risk of Gonorrhea and Chlamydia: A Systematic Review of Design and Measurement Factors Assessed in Epidemiologic Studies. Sex Transmission Disease. 2006 Jan; 33(1):36-51.

Avison, E. & Myers, D. (Eds.) (2002). Qualitative research in Information System. London: Sage. 312pp.

Bailey, A. Hennink, M. & Hutter, I. (2010). Qualitative Research Methods. London: SAGE. 328pp.

Banspach S., Baumler E., Coyle K., Glassman J. & Kirby D. (2006). All for You! A Randomized Trial of an HIV, other STDs and Pregnancy Prevention Intervention for Alternative School Students: AIDS Education and Prevention 2006; 18(3):187–203.

Barnett, T. & Whiteside, A. (2006). AIDS in Twenty First Century, Disease and Globalization (2nd edn). New York: Palgrave Macmillan. 646 pp.

Basu, A. & Menon, R., (2011), Violence against Women, HIV and AIDS Vulnerability and the Law. Working Paper Presented in the Third Meeting of the Technical Advisory Group of the Global Commission on HIV and the Law, 7-9 July 2011. [http://www.unwomen.org/.../csw58-advancedunedited-l5_a.] site visited on 02/09/2015

Becker C. & Denis P. (eds.) (2006).The HIV and AIDS Epidemic in Sub-Saharan Africa in a Historical Perspective [http://www.rds.refer.sn/IMG/pdf/ AIDSHISTORYALL] site visited on 20/10/2014.

Benner, T. & Card, J. (2008). Model Programs for Adolescent Sexual Health: Evidence-Based HIV, STI, and Pregnancy Prevention Interventions. New York: Springer. 408pp. [http://www.books.google.co.tz/books?isbn= 0826197639] site visited on 07/07/2014.

Benner, T. (2004). Impact of School-Based Peer Sexual Health Education on Nomative Beliefs, Risk perceptions, and Sexual Behaviour of Zambia Adolescents. Journal of Adolescent Health. 34 (5): 441-452.

Biklen, S. K. & Bogdan, R. C. (2007). Qualitative Research for Education: An Introduction to Theories and Methods. Pearson Education: Mexico: 304pp.

Birks, D. & Malhotra, N. (2007). Market Research: An Applied Orientation – European Edition. London: Prentice Hall. 832pp.

Blokland, B., Lovich, R., Macha, E., Mittal, A. & Sodergren, T. (2008). Draft Resolutions in World Blind Union in Geneva. In; 7th General Assembly.18 - 22 August 2008.

Blumberg, P. (2008). Developing Learner-Centered Teachers: A Practical Guide for Faculty. San Francisco: Jossey-Bass. [http://www.usciences.edu/teaching/ Learner-Centered/] site visited on 16/09/2014.

Boitte J. P., Omgbwa E. A. & Traoré J. (2005). Ocular Disorders Causing Blindness in Working-age Outpatient: A Prospective Study at the African Institute of Tropical Ophthalmology. Sante, 15 , 241-245.

Bonwell, C. & Eison, J. (2013). Active Learning: Creating Excitement in the Classroom. [http://www.files.eric.ed.gov/fulltext/ED336049] site visited on 3/62014.

Booi, N. (2013). The Vulnerability of the Visually Impaired to HIV and AIDS: A Study of the HIV and AIDS Outreach Efforts for Visually Impaired People. A Dissertation for Award of Master of Philosophy at Stellenbosch University, Stellenbosch, South Africa. 47pp. [https://ww.scholar.sun.ac.za/.../booi_ vulnerability_2013.p...] site visited on 10/3/ 2014.

Bowen, J., Horward, S. & Jenson, W. (2004). Externalizing Disorders in Children and Adolescents: Behavioural Excess and Behavioural Deficits. In The Oxford Handbook of School Psychology (Edited by Melissa A. Bray, Thomas J. Kehle). New York: Oxford University Press. pp. 379- 410.

Brieger, W. (2001).West African Youth Initiative: Outcome of a Reproductive Health Education Program.Journal of Adolescent Health, 29:436-446.

Bukagile, G. R. (2008). Civics for secondary Schools: Book Three. Dares Salaam: Nyambari Nyangwine Publishers. 90pp.

Callan, J. P., Crouch, C., Fagen, A. P. & Mazur, E. (2004). Classroom demonstrations: Learning tools or entertainment? [http://www.unco.edu/.../ Interactive%20Lecture%20] site visited on 3/5/2014.

Carlson T. (2013). 6 Instances of Discrimination PWDs Face Every Day. [http://www.huffingtonpost.com/tiffiny-carlson/discrimination-people-disabilities] site visited on 25/09/2015.

Carmichael, M. (2006). How it began; HIV and AIDS before the Age of AIDS. [http://www.pbs.org/wgbh/pages/frontline/aids/virus/origins.html] site visited on 18/10/2014.

Castillo, J. (2009). Research Population. [http://www.experiment-resources.com /research-population.html] site visited on 24/4/2012.

Catalano, R. David-Ferdon, C, Gavin L., Gloppen K, & Markham C. (2010). A Review of Positive Youth Development Programs that Promote Adolescent Sexual and Reproductive Health. Journal of Adolescent Health 2010; 46:S75–S91.

Cater, J. J., Michel, N., & Varela O. (2009). Active versus passive teaching styles: An empirical study of student learning outcomes. Human Resource Development Quarterly (20)4: 397-418 [http://www.sbaer.uca.edu/research /sbi/2009/St.../04.pd] site visited on 01/06/2014.

Centres for Disease Control and Prevention (2014). Adolescent and School Health. [http://www.cdc.gov/healthyyouth/about/hivstd_prevention.htm] site visited on 17/07/2014.

Choruma, T. (2007). The Forgotten Tribe:PWDs in Zimbabwe. [http://www.progressio.org.uk] site visited on 1/6/2014.

Comprehensive Community based Rehabilitation in Tanzania- CCBRT (2012). From Exclusion to Part of the Solution Lessons Learned along the Way: Making HIV and AIDS Strategies Inclusive of PWDs in Tanzania. [http://www.cbmus.org/.../CBM-LESSON-LEARNED] site visited on 15/8/2013.

Conner, M., & Norman, P. (1995). Predicting Health Behaviour: Research and Practice with Social Cognition Models. [http://www.userpage.fu-berlin.de/gesund/publicat/conner9] site visited on 23/09/2015.

Cottingham, S., Humen, P. Manlove, J. & Terry, E. (2006). Trends and Recent Estimates: Sexual Activity among U.S. Teen. [http://www.childtrends.org /.../2006-08TeensSexualActivity] site visited on 19/10/2012.

Cottrell, R. & McKenzie, J. (2010). Health Promotion and Education Research Methods: Using the Five Chapter Thesis. [http://books.google.co.tz/books/about site visited on 25/7/2012.

Coyle, K., Kirby, D., Robin, L. & Rolleri, L. (2011). Reducing Adolescent Sexual Risk: A Theoretical Guide for Developing and Adapting Curriculum-Based Programs. [http://www.pub.etr.org/upfiles] site visited on 01/8/2013.

Creswell, J. W. & Plano C, V. L. (2010). Designing and Conducting Mixed Methods Research (2nd ed.). Thousand Oaks, CA: Sage.

Creswell, W. (2003). Research Design. Qualitative, Quantitative and Mixed Methods Approaches, (2nd ed.). London: Sage. 246pp.

Crinson, I. & Leontowitsch, M. (2011). Principles of Qualitative Methods: Section 5. Data Collection Methods. [http://www.healthknowledge.org.uk] site visited on 03/07/2013.

Crosby, R. A., DiClemente R. J., Levine, D., Rose, E., & Salazar, L. F (2005). Condom Failure among Adolescents: Implications for STD Prevention. J Adolesc Health. 2005; 36:534–6.

David, C. Debra, M. & Lisa, A. (2011). Conducting an In-depth Interview. [http://www.edis.ifas.ufl.edu/fy393] site visited on 04/05/2012.

De Vaus, A. (2013). Surveys in Social Research.Unwin Hyman, London. 378pp.

Denzin, N. K. & Lincoln Y. S. (Eds.) (2011). The Sage Handbook of Qualitative Research. London: Sage Publications Ltd. 759pp.

Deutschman, A. 2009. Change or Die. New York: Harper Collins Publishers. 256pp.

Dhanya N. & Safeera A. (2013). Life Skill Education and Enrichment for Tribal Adolescents. Saarbrucken: Saarbrücken LAP LAMBERT Academic Publishing. 92pp.

Dick, B., Ferguson, J. & Ross D, (eds) (2006). Preventing HIV and AIDS in young people: A Systematic Review of the Evidence from Developing Countries: UNAIDS Interagency Task Team on HIV and Young People. [Uwww.unicef.org/aids] site visited on 30/08/2015.

Dooly, M. (2008). Constructing Knowledge Together.[http://www.peterlang.com/ PDF/Buecher/.../11523_Intro] site visited on 30/06/2014.

Eagly, A. & Chaiken, S. (2006). The Psychology of Attitudes. (Edited by Leone, C.), New York: Harcourt Brace College Publishers. pp. 459-466.

Edwards, K. & Yousafzai, A. (2004.) Double Burden: A Situation Analysis of HIV and AIDS and Young PWDs in Rwanda and Uganda. London: Save the Children. 76pp. [http://www.biomedcentral.com/1758-2652/12/34] site visited on 20/6/2013.

Edwards, K., D'Allesandro, C. Lindstrom L. & Yousafzai, A. (2005). HIV and AIDS information and services: The Situation Experienced by Adolescents with Disabilities in Rwanda and Uganda. [http://www.ncbi.nlm.nih.gov/ pubmed/16372430] site visited on 02/04/210.

Eggen, P. & Kauchak, D. (2004). Educational Psychology: Window on Classrooms (6th edition). New Jersey: Pearson Education. 650pp.

Egger, A. (2008). Data Analysis and Interpretation. [http://www.visionlearning.com] site visited on 6/5/2012.

Engleberg, G., Meijer, S. & Tiendrebéogo, G. (2003). Life Skills and HIV Education Curricula in Africa: Methods and Evaluations. [http://www.pdf.usaid.gov/pdf_ docs/PNACT985.pdf] site visited on 24/04/2004.

Fadel, C. & Trilling, B. (2009). 21st Century Skills: Learning for Life Skills in Our Times. New York: John Willey. 240pp.

Fisher, M. A.,Kuller, L. H. & Ma, Z. Q. (2014). School-based HIV and AIDS Education is Associated with Reduced Risky Sexual Behaviours and Better Grades with Gender and Race/ethnicity Differences. Health Education Research.29 (2):330-339 [http://www.her.oxfordjournals.org/content] site visited on 12/4/2013.

Fraser, A., Prata, N. & Vahidnia, F. (2005). Gender and Relationship Differences in Condom Use among 15-24-Year-Old in Angola. International Family Planning Perspectives, 31(4): 192-199.

Galbally, R. (2013). Shut Out: The Experience of PWDs and their Families in Australia. [http://www.dss.gov.au/.../disability...research/shut-out-] site visited on 20/05/2014.

Garbutt, C. (2013). What is Visual Impairment? [http://www.newsmedical.net/health/what-is-visual-impairment.aspx] site visited on 05/11/2013.

Gardner, M. & Steinberg L. (2005). Peer Influence on Risk Taking, Risk Preference, and Risky Decision Making in Adolescence and Adulthood: An Experimental Study. [http://www.peerroleinrisktaking] site visited on 30/03/2014.

Griffiths, J. (2005). International Comparative Education: HIV and AIDS Intervention Programs in Africa: The Role of Grassroot Soccer: A Monograph in Partial Fulfillment of the Requirements for the Degree of Master of Arts. [http//:www.grassrootsoccer.org/wp-content/.../final] site visited on 09/10/2014

Groce, N., Trasi R. & Yousafzai A. K. (2008) Guidelines for Inclusion of Individuals with Disability in HIV and AIDS. [https://www.ucl.ac.uk/.../hivguidelines/HIV_Guidelin] site visited on 05/09/2015.

Groce N. (2003). HIV and AIDS and People with Disability. The LANCET, 361:1401-1402.

Groce, N. (2004). Global Survey on HIV and AIDS and Disability. [http://www.circa.med.yale.edu/globalsurvey] site visited on 26/1/2010.

Guba, E. G. & Lincoln, S. (1985). Naturalistic Inquiry. Newbury Park, CA: Sage. 416pp.

Gwandure, C. (2007). Sexual assault in childhood: risk HIV and AIDS behaviours in adulthood. AIDS Care; 19:1313–1315.

Hamilton, M. A., Hamilton, S. F., & Pittman, K. (2004). Principles for Youth Development. [http://www.dspace.library.cornell.edu/.../2/PrinciplesYD.pdf] site visited on 12/06/2014.

Hanass-Hancock, J. (2009) Disability and HIV: A Systematic Review of Literature on Africa. Journal of International AIDS Society 12, 2009 [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2788347] site visited on 03/09/2015.

Hanass-Hancock, J., Naidoo K. & Regondi I. (2013). Disability and HIV: What drives this relationship in Eastern and Southern Africa? African Journal of Disability 2(1). [http://www.ajod.org/index.php/ajod/article/view/25/69#4] site visited on 29/08/2015.

Harris, J. (2011). Data Information and Knowledge Management. [http://www.ocdqblog.com/home/data-information-and-knowledge-management] site visited on 10/4/2012.

Hoffmann, A. M. & Olson, R. (2007). Life skills education and sustainable human development in a world with HIV and AIDS. [http://www.cedol.org/wp-content/.../216-221-2007.] sit visited on 20/4/2014.

Home Health Testing (2010). A History of the HIV Epidemic. [http://www.homehealthtesting] site visited on 20/10/2414.

Hoover, J. F. & McLeonard, J. (2003). Key Elements of Classroom Management. [http://www.ascd.org/publications/books/103008/] site visited on 20/5/2014.

Huberman, M. & Miles, M. (1994). Qualitative Data Analysis (2nd ed.). London: Sage. 249pp.

Huitt, W. (2011). Bloom's Taxonomy of the Cognitive Domain. Educational Psychology Interactive. [http://www.steenberg.weebly.com/.../classroom_ management_pla...] site visited on 23/5/2013.

Human Rights Watch (2011). Fact Sheet: HIV and Disability [http://www.hrw.org/... /HIV_Disability_Fact_Sheet_FINAL] site visited on 09/09/2015.

Hunt, F. (2006). The Effect of Labelling and Social Desirability on Perceived Success of a Learning Disabled Student [http:///www.library.wcsu.edu/dspace/ bitstream/0/30/1/hunt.pdf] site visited on 03/04/2014.

Interagency Coalition on AIDS and Development (2008). HIV and AIDS and Disability. [http://www.icad-cisd.com/pdf/HIV_AIDS_Disability] site visited on 25/07/2013.

Jabareen, Y. (2009). Building a Conceptual Framework: Philosophy, Definitions, and Procedure. [http://wwwejournals.library.ualberta.ca/index.php/IJQM] site visited on 17/10/2014.

James, T., Magnani R., Murray, N., Senderowitz, J., Speizer, I. & Stewart, L. (2002). Intervention Strategies that Work for Youth: Summary of the FOCUS on Young Adults End of Program Report.Youth Issues (1). [http://www.fhi360.org/.../Intervention%20Strategies%20tha...] site visited on 12/05/2012.

Jiang, J., Liao, W., Yang B. & Zeng X, (2010). A life-skills-based HIV and AIDS prevention education for rural students of primary schools in China: what changed? What have we learned? [http://www.ncbi.nlm.nih.gov/pubmed/21112490] site visited on 20/06/2013.

Joint Education Sector Annual Review, (2012). Education Sector Development Programme. [http///www.tanzania.go.tz/.../Aide_Memoire_JESR_29-201..] site visited on 30/03/2013.

Jones E., Paulson K. & Voorhees R. (2002). Defining and Assessing Learning: Exploring competency-based initiatives. Paper presented in Washington, DC: Council of the National Postsecondary Education Cooperative in 2002. [http://www.ceph.org/assets/Competencies_TA.] site visited on 15/09/2014.

Jones, A., Maharaj, P. E. & Padmore, J. (2009) HIV-AIDS and Social Work Practice in the Caribbean: Theory, Issues, and Innovation. Kingston: London. [http://www.books.google.co.tz/books?isbn=9766373566] site visited on 20/01/2014.

Jones, C. A. (2005). Assessment for Learning. UK: Learning and Skills Development Agency.[http://www.dera.ioe.ac.uk/7800/1] site visited on 3/07/2014.

Kalbag, A. (2013). What Is Passive Learning? [http://www.education.blurtit.com/72424/what-is-passive-learning] site visited on 13/5/2014.

Kamuzora P. & Rutagumirwa S. (2006). Secondary School Students' Voice in HIV and AIDS Prevention Interventions in Tanzania: A Case study of Mbeya Region. Paper Produced as Part of a Capacity Building Programme of the Regional Network on Equity in Health in East and Southern Africa (EQUINET). February, 2006. pp15.

Kapperman G. & Kelly S. (2012). The ‘Ins and Outs’ of Safer Sex Instruction for Individuals with Visual Disabilities. Paper Presented in the Association for Education and Rehabilitation of the Blind and Visually Impaired International Conference2012. [http://www.aerbvi.org/.../TheInsandOutsofSaferSex] site visited on 07/08/2014.

Kasper, E. (2006). Internal Research & Development Markets. [https://www.books.google.co.tz/books?id]site visited on 10/10/2015.

Katuta S. (2011). Sexual Behaviours and Vulnerabilities to HIV: A Case Study of the Hearing and Visually Impaired Pupils of Munali Boys and Munali Girls High Schools in Lusaka. Medical Journal of Zambia, (3)38) from http://www.ajol.info/index.php/mjz/article] site visited on 29/08/2015.

Kayunze, K. A. & Mtauchila P. D. (2014). HIV and AIDS Related Knowledge and Sexual Behaviour among Disabled People in Dar es Salaam City, Tanzania. Developing Country Studies, 4(2), 2014. [http://www.digitallibrary.ihi.or.tz/2443/.../Pili_Daniel_Mtauchila] site visited on 20/10/2015.

Kendi L, Kinai T. & Mweru M. (2012). HIV and AIDS Knowledge and Risk Perception of Visually Impaired and Sighted Pupils in Kenya. European Scientific Journal (8)8. [http://www.eujournal.org/index.php/esj/] site visited on 30/7/2013.

Kendrick, S. (2009). Curiously Persistent. [http://www.curiouslypersistent.wordrress.com] site visited on 9/10/2009.

Kerpelman, J. (2012). “Relationship Smart” Youth: A Statewide Study of Relationship Education for High School Students, Arizona. In: The 74th National council of Family Relations: Annual Conference. October 31, 2012 – November 3, 2012,

Phoenix, Arizona. [http://www.ncfr.org/sites/.../111-01-ncfr_syposium] site visited on 12/6/2013.

Kirby, D. B. (2008). The Impact of Abstinence and Comprehensive sex and STD/HIV Education Programs on Adolescent Sexual Behavior: Sexuality Research & Social Policy 2008; 5(3):18–27.

Kizlik, B. 2014. Instructional Methods Information. [http://www.adprima.com/teachmeth.htm] site visited on 21/7/2014.

Kreidler, W. (2004). Dealing with Stereotyping, Prejudice, Discrimination, and Scapegoating. [http://www.esrnational.org/otc/lesson.../ESR_Stereotypes.p] sited visited on 06/04/2014.

Kremer M. (2006). HIV and AIDS Prevention: The Potential of Primary Education. Centre Piece Autumn 2006: 22-24.

Kvale, S. (1996). Interviews: An Introduction to Qualitative Research Interviewing. London: Sage. 326pp.

Kwegyir-Afful A. E., Perkins E. L., Prather A., Spriggs V. T. & Stennis K. B. (2014). Is Knowledge Enough? Considering HIV and AIDS Risk Behaviors and HIV and AIDS Knowledge with African American Women. International Journal of High Risk Behaviour Addiction. 2014 Sep; 3(3) [http://www.ncbi.nlm.nih.gov/pmc/articles] site visited on 15/09/2015.

Kyaruzi, S. J. (2004). Important Lesson Learnt from a Programme of Peer Education Focusing on HIV and AIDS and Adolescence Sexual Reproductive Health in Schools and Community in Tanzania, Thailand. In: 5th International AIDS Conference– 11-6 July, 2004, Bangkok, Thailand. [http://www:aegs.com/countries/tanzania.htm] site visited on 26/10/2007.

Lightman, M. (2010). Qualitative Research in Action: A Users Guide (2nd edn.). New Dekhi: Sage Publications [https://www.books.google.co.tz/books] site visited on 02/10/2015.

Lodico, M. G., Spaulding, D. T. & Voegtle K. H. (2010). Methods in Educational Research: From Theory to Practice [http://www.books.google.co.tz/books] site visited on 17/10/2014.

Lopez, S. J. & Snyder, C. R. (Eds) (2002). Self-efficacy: The Power of Believing you can. In: Handbook of Positive Psychology. New York: Oxford University Press. pp. 277–287.

Lydia, K. (2010.). HIV and AIDS Knowledge, Risk Perception, and Attitude Towards Safer Sex Practices of Visually Impaired and Sighted Pupils in Thika Municipality, Kenya: A Research Thesis Submitted in Partial Fulfillment for the Degree of Master of Education (Educational Psychology) In The School of Education of Kenyatta University December 2010 (unp.).

Macha, E. (2008). Equalize it: The Visually Impaired and HIV and AIDS Programmes. Pambazuka News: Pan African Voices for Freedom and Justice. [http://www.pambazuka .org/en/category/comment/52369] site visited on 03/05/2010.

Macnee, C. L., McCabe S., Gersch C. J. & Rebar C. R. (2011). Understanding Nursing Research: Using Research Evidence-based Practice. [http://www.rhc.ac.ir/.../nursingbooks/Understanding%20Nursing%20Research%2] site visited on 29/09/2015.

Malawi Institute of Education (2004). Participatory Teaching and Learning: A Guide to Methods and Techniques. [http://pdf.usaid.gov/pdf_docs/Pnade007] site visited on 20/07/2015.

Manen, M. V. (2014). Phenomenology of Practice: Meaning-Giving Methods in Phenomenological Research and Writing (Developing Qualitative Inquiry). Left San Francisco: Coast Press Inc. 412pp.

Maria, R. T. (2007). Friendships, Peer Influence, and Peer Pressure during the Teen Years. [http://www.ianrpubs.unl.edu/epublic/live/g1751/build/#target2] site visited on 20/09/2015.

Mason, M. (2010). Sample Size and Saturation in PhD Studies Using Qualitative Interviews. [http://www.qualitative-research.net/index.php/fqs/.../3027] site visited on 12/03/2013.

McCabe, S. & Macnee, L. C. (2008). Understanding Nursing Research: Using Research in Evidence-based Practice. Lippincott Williams & Wilkins, New York. [http://www.books.google.co.tz/books?isbn=0781775582] site visited on 20/8/2013.

Melwa, I. T. & Oduntanb O. A. (2O12). The Perception amongst a Population of High School Students in South Africa about Ocular Manifestations of HIV and AIDS. South Africa Optom, 71(3), 117-122. [http.www.avehjournal.org/ index.php/aveh/article/.../78/48] site visited on 30/08/2015.

Merriam, S. B. (2009). Qualitative Research: A Guide to Design and Implementation. San Francisco: Jossey-Basss. 293pp.

Miller, T. M. (2006). Social Skills for Children & Youth with Visual Impairments [https://www.secure2.convio.net/.../SPageServer?...SocialSkill] site visited on 20/4/2010.

Ministry of Labour, Youth Development and Sports (2004). National Policy on Disability. 54pp. [http://www.tanzania.go.tz/.../NATIONAL%20POLICY] site visited on 29/06/2013.

Morrison, K. (2004). A Definition of Instructional Objectives. [http://www.cw.routledge.com/.../07DefinitionOfInstructionalObje] site visited on 10/06/2014.

Murangira, A. (2004). HIV and AIDS and Disability Experience. National Union of Disabled Persons of Uganda (NUDIPU). In: The Round Table Discussions in Washington. 28 March 2004 Washington DC 18pp. [http://www.siteresources.worldbank.org/.../HIVAIDSDisAmbrose] site visited on 12/4/2011.

Mushi, D., Mwakolo V. & Njau, B. (2013). Correlates of Use of Condoms among Sexually Active Youth in Southern Highlands, Tanzania. [http://www.sgo. sagepub.com/content/3/2/2158244013491406.full.print] site visited on 10/07/2013.

Nagata, K. K. (2003). Gender and Disability in the Arab Region: The Challenges in the New Millennium. Asia Pacific Disability Rehabilitation Journal, 2003, 14(1):10-17.

Newman, B. M. & Newman, P. R. (2012). Development through Life: A Psychosocial Approach. [https://ww.books.google.co.tz/books] site visited on 20/09/2014.

Nganyi, D. L., Nganyi J. E. & Anangwe J. (2015). Teachers' Attitude towards Implementation of HIV and Aids Education in Secondary Schools of Hamisi Sub-County in Kenya. International Journal of Academic Research in Business and Social Sciences April 2015, (5) 4: 325-337

Niaz, M. (2007). Can Findings of Qualitative Research in Education be Generalized? [http://link.springer.com/.../10.1007%2Fs11135-006-9015-...] site visited on 22/02/2014.

Nyirenda, J. & Schenker, I. (2002). HIV and AIDS Education in Schools. [http://www.ibe.unesco.org] site visited on 25/02/2014.

O'Hare, T. (2009). Essential Skills of Social Work Practice: Assessment, Intervention. Boston: Lyceum Books, Inc, 399pp.

Olveras, E. & Sarma, H. (2013). Implementing HIV and AIDS Education: Impact of Teachers' Training on HIV and AIDS Education in Bangladesh. Journal of Health Population and Nutrition 2013 March; 31(1):20-7. [http://www.ncbi.nlm.nih. gov/pubmed/23617201 0753090051] site visited on 10/04/2014.

Otieno, P. A. (2009). Biblical and Theological Perspectives on Disability: Implications on the Rights of Persons with Disability in Kenya. [http://www.dsq-sds.org/article/view/988/1164] site visited on 14/03/2014.

Panchaud, C., Pii, J. & Poncet, M. (2005). Assessment of Curriculum Response in 35 countries for the Education for all Monitoring Report 2005: The Quality Imperative. [http://unesdoc.unesco.org/images/0014/.../142301e] site visited 09/01/2015.

Passos, A. F. J. (2009). A Comparative Analysis of Teacher Competence and its Effect on Pupil Performance in Upper Primary Schools in Mozambique and other Sacmeq Countries. Thesis Submitted in Fulfilment of the Requirements for the Degree of PHD: Policy Studies. [http://www.Ana_Passos_Doctoral_Thesis_ 14July2009] site visited n 18/09/2015.

Patton, M. (2001). Qualitative Research and Evaluation Methods (3rd edn.). New York: Sage Publication, Inc. 688pp.

Peace Corps Centre for Field Assistance and Applied Research Information Collection and Exchange Centre for Field Assistance ad Applied Research Information Collection and Exchange (2000). Life Skills Manual. Washington: Information Collection Exchange (ICE). 427pp.

Pelaez, A. (2010). Cross-sectionalities of Gender, Disability, and Development: Towards Equality for Women and Girls with Disabilities. Paper presented in Fifty-fourth session of the Commission on the Status of Women. 4th March 2010, United Nations Headquarters, New York.

Peterson, P. L. & Wilson S. M. (2006). Theories of Learning and Teaching: What Do They Mean for Educators? [http://www.files.eric.ed.gov/fulltext/ED495823] site visited on 23/09/2015.

Philander, J. H. & Swartz, L. (2006). Needs, Barriers, and Concerns Regarding HIV Prevention among South Africans with Visual Impairments: A Key Informant Study. Journal of Visual Impairment and Blindness. 2(100), 111-114. [http//www.files.eric.ed.gov/fulltext/EJ728843] site visited on 30/08/2015.

Pitney, W. A. & Parker, J. (2009). Qualitative Research in Physical Activity and the Health Professions [https://www.books.google.co.tz/books?] site visited on 02/10/2015.

Prigg, M. (2012). How Long Should you Wait? [http://www.dailymail.co.uk/ sciencetech/article-2219689] site visited 3/5/2011.

Rakhi, N. S. (2011). Life Skills Education. [http//www.universityof calicut.info/.../Life_skill_education] site visited on 05/05/2014.

Roberts, A. (Ed.) (2002). Crisis Intervention Handbook: Assessment, Treatment, and Research. New York: Oxford University Press. 119pp.

Ruchismita, M. (2011). Role of Life Skill Education in the Context of HIV/ AIDS and Adolescent Education. [http://www.preservearticles.com/.../role-of-life-skill-education-in-the-conte] site visited on 19/05/2012.

Rushahu, B. G. (2015). Assessment of HIV and AIDS and Life Skills Delivery in Primary Schools in Tanzania. World Journal of Education, (5) 1, 131-143 [http://ww.sciedupress.com/journal/index.php/wje/.../3926] site visited on 31/08/2015.

Shenton, A. K. (2004). Strategies for Ensuring Trustworthiness in Qualitative Research Projects: Education for Information 2(22): 63–76 [http://www.zotero.org › People › Jason Mickel › Library] site visited on 04/05/2013.

Sheth, J. & Wong, L. (1985). Explaining Intention-Behaviour Discrepancy –A Paradigm. [http://www.researchgate.net/...Sheth/...Explaining_Intentio..] site visited on 12/10/12.

Shields, P. & Tajalli H. (2006). Intermediate Theory: The Missing Link in Successful Student Scholarship, Journal of Public Affairs Education 12(3): 313-334. [http://www.ecommons.txstate.edu/polsfacp/39] site visited on 30/10/2009.

Sibanda, N. (2013). HIV and AIDS Initiatives Sidelining People with Disabilities. [http://www.voazimbabwe.com] site visited on 01/09/2015.

South African National AIDS Council (2007). Nothing about us without us: HIV, AIDS and Disability in South Africa. [http://www.heard.org.za/.../nothing-about-us-without-us-hi] site visited 02/09/2015.

Stringer, E. (2004). Action Research in Education. Upper Saddle River: Prentice Hall. pp262.

Subrahmanian, R. (2009). Introduction: Exploring Processes of Marginalization and Inclusion in Schools. Institute of Development Studies, (34)1: 1-8. [http://www.onlinelibrary.wiley.com] site visited on 23/4/2012.

Suka, A. (2006). Violence against Blind/VI Girls in Malawi. In the 12th International Council on Education for People with Visual Impairment World Conference in Malaysia. 16 - 21 July 2006. [http://www.wecando.worldpress.com] site visited on 26/01/2009.

Tanzania Commission for AIDS (TACAIDS) (2008). Tanzania HIV and AIDS and Malaria Indicator Survey 2007-2008. [http://www.avert.org/hiv-aids-tanzania.htm#sthash.nRoijCD7] site visited on 19/10/2014.

Tanzania Commission for AIDS (TACAIDS) (2012). National Behaviour Change Communication Guidelines on HIV and Aids Interventions.Tanzania Commission for AIDS (TACAIDS): Dar es Salaam.

Tanzania Commission for AIDS (TACAIDS), National AIDS Control Programme (NACP), & Comprehensive Community Based Rehabilitation Tanzania (CCBRT) (2009). The Forgotten HIV and AIDS and Disability in Tanzania. TACAIDS, NACP, and CCBRT: Dar es Salaam

Tanzania Commission for AIDS TACAIDS (2014). National HIV and AIDS Response Report 2013 Tanzania Mainland [http://www.tacaids.go.tz /index.php?option=com] site visited on 07/09/2015.

Tanzania Institute of Education (2007). Biology Form 1 & 2 Students Book. Dar es Salaam: Pearson Longman.

Tanzania Institute of Education (2007). Biology Form 3 & 4 Students Book. Dar es Salaam: Pearson Longman.

Tanzania Institute of Education (2010). Biology Syllabus for Secondary Schools: Form II-IV.

Tanzania Institute of Education (2010). Civics Syllabus for Secondary Schools: Form II-IV.

Tashakkori, C. & Teddlie, C. (2009). Foundation of Mixed Methods Research: Integrating Quantitative and Qualitative Approaches in the Social and Behavioural Sciences. London: Sage. 400pp.

Temah, C. T. (2007). Gender inequality and HIV and AIDS epidemic in Sub-Saharan Africa [http://www.csae.ox.ac.uk/conferences/.../037] site visited on 25/09/2015.

Thaver, L. (2012). Sexual and HIV and AIDS Education in South African Secondary Schools. [http://www.osisa.org/buwa/south-africa] site visited on 24/09/2015.

The Centre for British Teachers (2006). Primary School Action for Better Health (PSABH) Course A &B: School and Community Training. [http://www.odi. org.uk/resources/docs/7812.pdf] site visited on 10/2 2013.

The National Association of Special Education Teachers (2007). Introduction to Learning Disabilities. [http://www.naset.org › Publications › LD Report] site visited on 22/3/2013.

The United Republic of Tanzania (2013). Tanzania Third National Multi-Sectoral Strategic Framework (NMSF III) for HIV and AIDS (2013/14 – 2017/18). [http://www.tacaids.go.tz/index.php?option=com] site visited on 01/20/2015.

The United Republic of Tanzania (URT) (2007). The Second National Multicultural Strategic Framework on HIV and AIDS (2008 – 2012). Dar es Salaam: TACAIDS.

The United Republic of Tanzania: The National Bureau of Statistics (NBS) (2014). Statistical Abstract 2013. [http://www.nbs.go.tz/nbs/.../Statistical%20] site visited 08/09/2015.

The World Bank (2008). A Resource Book of HIV and AIDS Prevention Programmes Volume 2: Education sector Wide Approaches. [http://www.siteresources. worldbank.org/.../SourcebookofHIVAIDSvolume2] site visited on 11/3/2014.

Thinkwise (2007). Using a Competency-Based Approach: Linking core competencies to your business strategy. [http://www.thinkwiseinc.com/.../Competency-Based-Approach] site visited on 20/07/2015.

Tigawalana, D. (2010).Why African Women are more Vulnerable to HIV/AIDS. [http://www.rnanews.com/health/4206-why-african-women-are-more-vulnerable-to-hivaids] site visited on 27/01/ 2012.

Tiwari, M. (2010). Teaching Methods in Education.[http://www.buzzle.com/articles/teaching-methods-in-education.html] site visited on 20/5/2014.

Trochin, W. (2006). Design Research Methods Knowledge Based (2nded.). New York: Wadsworth. 421pp.

Trull, T. (2005). Clinical Psychology. Belton: Thomson. 620pp.

UNAIDS (2009). New Policy Brief on Disability and HIV. [http://www.unaids.org] site visited on 29/08/2015.

UNAIDS (2012). UNAIDS Report on the Global AID Epidemic Report 2012. [http://www.unaids.org/.../unaids] site visited on 18/10/2014.

UNAIDS (2013). United Republic of Tanzania: HIV and AIDS estimates (2013). [http://www.unaids.org/en/Regionscountries]site visited on 19/10/2014.

UNAIDS (2014).How AIDS Changed Everything: Fact sheet: 2014 Global Statistics. [http://www.unaids.org/en/resources/campaigns/HowAIDSchangedeverything] site visited on 31/08/2014.

UNESCO (2005). Reducing HIV and AIDS Vulnerability among Students in the School Setting: A Teacher Training Manual Asia and Pacific Regional Bureau for Education. Bangkok, UNESCO Asia and Pacific Regional Bureau for Education. [http://www.unesdoc.unesco.org/images/0013/001389/138910e.] site visited on 04/08/2013.

UNESCO (2006). Manual for integrating HIV and AIDS education in school curricula: Issues Regarding Integration of HIV and AIDS Education into the

Official Curriculum. [http://www.ibe.unesco.org/.../HIV_and_AIDS site visited on 16/09/2015.

UNESCO (2010). Globalization and Women' Vulnerabilities to HIV and AIDS: Gender Equality Series. [http://www.unesdoc.unesco.org/images/0019/.../191501e] site visited on 12/12/2013.

UNICEF (2002). Lesson Learned about Life skills-based Education for Preventing HIV and AIDS Related Risk and Related Discrimination. [http://www.eldis.org/go/home&id=18439&type=Document] site visited on 05/05/2013.

UNICEF (2003). Life Skills: Girls, HIV and AIDS and Education. [http://www.unicef.org/lifeskills/index_8657] site visited on 16/8/2013.

UNICEF (2012). What is the Life Skill Approach? [http://www.unicef.org/teachers/teacher/lifeskil.htm] site visited on 10/05/2014.

United Nations (2013). United Nations Development Assistance Plan: Annual Report 2012-2013. [http://tz.one.un.org/index.php/what-we-do/hiv-and-aids] site visited on 17/10/2014.

Upadyaya, A. (2013) Active Vs Passive Learning. [http://www.blog.edubrite.com/2013/.../active-vs-passive-learning] site visited on 03/07/2014.

USAID (2015). Condom Fact Sheet. [https://www.usaid.gov/sites/default/files/documents] site visited 09/10/015.

Virginia Development of Education (2010). Guidelines for Working with Students who are Blind or Visually Impaired in Virginia Public Schools. [http://www.doe.virginia.gov/.../visually_impaired_blind/vis] site visited on 04/09/2015.

Vision Aid Team, (2012). Vision-Aid: Serving the Visually Disadvantaged in Under-Served Areas. [http://www.visionaid.org/?gclid] site visited on 26/9/2013.

WHO (1997). Life Skills Education for Children and Adolescents in Schools: Introduction and Guidelines to Facilitate the Development and Implementation of Life Skills Programmes. [http://www.asksource.info/.../31181_lifeskillsed] site visited on 12/02/2013.

WHO (1999). Mental Health Promotion. [http://www.who.int/mental_health/media/en/30.pdf] site visited on 20/3/2013] site visited on 10/11/2013.

WHO (2001). Training and Resource Manual on School Health and HIV and AIDS Prevention. Geneva: International Bureau of Education. [http://www.siteresources.worldbank.org] site visited on 03/06/2013.

WHO (2004). Position Statement on Condoms and HIV and AIDS Prevention. [https://www.unfpa.org/.../condom_statement.pdf] site visited on 25/5/2014.

WHO (2009).Learning for Life: Classroom Activities for HIV and AIDS Education. [http://www.ibe.unesco.org/.../efa%20monitoring%20report] site visited on 06/06/2014.

WHO (2011). World Report on Disability. [http://www.who.int/disabilities/world_report/2011/report] site visited on 28/08/2015.

WHO (2014). Health for the World's Adolescents. A Second Chance in the Second Decade. [http://www.apps.who.int/adolescent/second-decade] site visited on 06/09/2015.

Wistrom, E. (2012). How the Learning Disabled Label Affects Students. [http://www.brighthubeducation.com/.../97167-how-labels-a] site visited on 22/03/2014.

Wong, L. (2008). Focus Group Discussion: A Tool for Health and Medical Research. Singapore Med Medical Education J 2008; 49(3): 256 [http://www.smj.sma.org.sg/4903/4903me1.pdf –] site visited on 3/5/2012.

Wurdinger, S. (2011). Time for Action: Stop Teaching to the Test and Start Teaching Skills. [http://www.books.google.com › ... › Administration › General] site visited on 2/6/2014.

Yin, R. K. (2009). Case study Research: Design and Methods. London: Sage Publications. 240pp.

Zambo, Z. (2004). Using Qualitative Methods to Understand the Educational Experiences of Students with Dyslexia. The Qualitative Report (9)1 March 2004 80-94. [http://www.nova.edu/ssss/QR/QR9-1/zambo] site visited on 02/10/2015.

Zanzibar National Association for the Blind (ZANAB) 2008). Forum SYD HIV and AIDS Programme: Sampled Case Studies. [https://www.forumsyd.org] site visited on 24/7/2013.

APPENDIXES

Appendix 1: Interview questions for GVIs for one-to-one interview and FGD

1. Which methods are used in teaching HIV/AIDS related contents?
2. How do methods used in teaching HIV/AIDS related contents assist you in developing knowledge about life skills and attitudes required for HIV/AIDS prevention?
3. Which materials are used in teaching HIV/AIDS related contents?
4. How do materials used in teaching HIV/AIDS related contents assist you in developing knowledge about life skills and attitudes required for HIV/AIDS prevention?
5. Which life skills have you learned for HIV/AIDS prevention?
6. How have the life skills influenced your intentions for abstinence? How have the life skills influenced your intentions for condom use?
7. Which challenges limit your intention for HIV/AIDS prevention?
8. In which ways do these challenges limit your intention for HIV/AIDS?

Appendix II: Interview Questions for Teachers

1. Which methods do you use in teaching life skills for HIV/ADIS prevention?
2. In which ways are the methods used in the school-based interventions facilitate GVIs in learning life skills for HIV/AIDS prevention?
3. Can you please explain the materials that you use in teaching life skills for HIV/AIDS prevention?
4. Can you please explain how these materials assist GVIs in learning life skills for HIV/AIDS prevention?
5. Which HIV/AIDS prevention life skills have you taught to your learners?
6. Which challenges do you think are likely to limit GVIs' intention for HIV/AIDS prevention?
7. In which ways do these challenges limit GVIs' intention for HIV/AIDS prevention?

Appendix III: Documentary Review Guide in Biology and Civics syllabi

1. Competences targeted for developing knowledge and life skills for HIV and AIDS prevention

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2. Objectives targeted for developing knowledge and life skills for HIV and AIDS prevention

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3. Suggested Topics/subtopics for developing knowledge and life skills for HIV and AIDS

   Form I

   Topic:

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   Sub-topics:

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   Form II

   Topic:

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Sub-topics:

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Form III

Topic:

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Sub-topic:

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Form IV

Topic:

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Sub-topics:

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4. Suggested Methods for teaching topics concerning HIV and AIDS

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5. Suggested Materials for teaching topics concerning HIV and AIDS

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