FAMILY LIFE AND HIV/AIDS EDUCATION (FLHE) AS PREDICTOR OF KNOWLEDGE AND ATTITUDE TO HIV/AIDS AMONG ADOLESCENTS WITH HEARING IMPAIRMENT IN SOUTH-WEST, NIGERIA

BY

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ABSTRACT

The menace of HIV/AIDS is a serious concern globally, especially the rate at which the disease spreads among adolescents with hearing impairment. This has been attributed to poor knowledge of and attitude to the incidence of HIV/AIDS, lack of personal skills coupled with inability of adolescents with hearing impairment to hear, comprehend and translate information about HIV/AIDS to functional use that could have helped them to cope with life challenges. Several studies have been carried out on the influence of Sexuality Education on adolescents without hearing impairment. However, there is a paucity of studies on the influence of Sexuality Education on adolescents with hearing impairment's knowledge of and attitude to HIV/AIDS. This study, therefore, investigated Family Life and HIV/AIDS Education as predictors of knowledge of and attitude to HIV/AIDS among adolescents with hearing impairment in South-West, Nigeria.

The study adopted survey research design of ex-post facto type. Multi-stage sampling technique involving stratified random sampling, purposive and simple random sampling were employed to select states, schools and the participants in South-West, Nigeria. A total of 450 adolescents with hearing impairment were selected. Data were collected through research scale tagged Family Life and HIV/AIDS Education inventory consisting of Self-esteem Inventory (0.80), Goal Setting Inventory (0.62), Decision-making Inventory (0.60), HIV/AIDS' Knowledge Inventory (0.62) and HIV/AIDS Attitudinal Inventory (0.60). Six research questions were answered at the 0.05 level of significance. Data were analysed using descriptive statistics, Pearson Product Moment Correlation and Multiple regression.

The independent variables namely, Self-esteem, Goal-setting and Decision-making showed significant relationship with the knowledge of adolescents with hearing impairment about HIV/AIDS in the following order: decision-making ($r=0.551$; $p<.05$), self-esteem ($r=0.510$; $p<.05$) and goal-setting ($r=0.487$; $p<.05$). The joint effect of the independent variables yielded a coefficient ($R=0.616$, $p<.05$). Decision-making mostly contributed to knowledge of HIV/AIDS among adolescents with hearing impairment ($\beta=0.289$, $t=5.548$; $p<0.05$) while goal-setting was the least ($\beta=0.188$, $t=3.898$; $p<0.05$). The independent variable, Self-esteem, Goal-setting and Decision-making also showed significant relationship with attitude of adolescent with hearing impairment to HIV/AIDS in the following order: decision-making ($r=0.568$; $p<0.05$), self-esteem ($r=0.492$; $p<0.05$) and goal-setting ($r=0.488$; $p<0.05$). There was a joint effect of the independent variables on the attitude of adolescents with hearing impairment to HIV/AIDS ($R=0.618$; $p<0.05$). Decision-making also contributed mostly to attitudes of adolescents with hearing impairment to HIV/AIDS ($\beta=0.334$, $t=6.438$, $p<0.05$) while goal-setting was the least ($\beta=0.181$, $t=3.762$; $p<0.05$).

Family Life and HIV/AIDS Education skills in Self-esteem, Goal-setting and Decision-making showed significant influence on knowledge of and attitude to HIV/AIDS among adolescents with hearing impairment. Therefore, Federal government as well as other stakeholders concerned with education of adolescents with hearing impairment should be more pragmatic on the implementation and monitoring of Family Life and HIV/AIDS Education programme. This will help to reduce the spread of HIV/AIDS among adolescents with Hearing Impairment in Nigeria and enable them to achieve overall adjustment in life.

Keywords: Family Life and HIV/AIDS Education, Knowledge, Attitude, Adolescents with hearing impairment

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CERTIFICATION

I certify that this work was carried out by Mr. Samuel Olufemi ADENIYI in the Department of Special Education, University of Ibadan, Nigeria.

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DEDICATION

This study is dedicated to:

The Almighty God

The Author of life and the I am that I am

and

The ADENIYIS

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"For I am what I am today by the grace of God and His Grace which was bestowed upon me is not in vain (I Corinthians 15:10a)". I give thanks to the Most High who has given me strength, courage, wisdom and opportunity to start this programme and by His mercies has helped me to complete successful inspite of terrible constraints from the kingdom of darkness. I know and I am convince that He makes everything beautiful in His time. May the name of the Lord be praised for ever amen.

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CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Adolescence, a period of transition from childhood to adulthood is the most challenging and tasking phase in the developmental process of the human organism with age ranges from 10-21 years (Amao-Kehinde, 2008). It is a very delicate phase of life that is full of challenges. The challenges include biological, psychological and social pressures. The challenges faced at this stage are sometimes traumatic in the sense that adolescents are confronted with tasks of biological, social, emotional, sexual, and physical maturity as well as adults cum societal induced pressure.

These developmental challenges are universal characteristics associated with all adolescents not minding the various degree of variability. Ademokoya and Oyewumi (2001) and Adeniyi (2007) all observed that both hearing and deaf teenagers go through the same adolescents' developmental tasks with slight variability in social, emotional and biological experiences due to slight developmental delay as a result of their impairment.

For adolescents with or without hearing impairment to cope with these challenges, Uwakwe (1998) notes that this process of maturation which is mostly dependent on personal control of the adolescents may often result in intra-personal conflicts which the youngsters may attempt to resolve by engaging in inappropriate and socially undesirable patterns of behaviours such as risk-taking behaviour.

Risk-taking behaviours may be defined as those potentially destructive behaviours such as smoking, drug abuse and sexual risk behaviour which young people with limited or no experience engage in, and the immediate or long term consequences, of which they may not appreciate, often result in major mortalities and morbidities (Irwin, 1986 in Uwakwe, 1998). On the other hand, sexual risk-taking can then be defined as an act of engaging in unprotected or unsafe sexual activities that can lead to unwanted pregnancies, death or sexually transmitted diseases. It must be noted that sexual risk-taking is not only limited to adolescents without disabilities. It is a common developmental behaviour prevalent among adolescents generally. Osowole and Oladepo (2001) and Adeniyi (2007) agree that like other youths, the deaf may have sex (unprotected sex) because they have deep feeling of love and attraction for their partners or may engage in high risk or rebellious sexual activities because they are emotionally troubled and may get infected with sexually transmitted

infections (STIs).

Sexual-risk taking has been widely reported to be common among adolescents of all categories (Asuzu, 1998; Ademokoya & Oyewumi, 2004; Osowole & Oladepo, 2001; Fakolade, Adeniyi & Tella, 2005). Many dangers are however inherent in unguided sexual behaviour of adolescents (Ademokoya & Oyewumi, 2004). Most prominent and highly disturbing outcome of such negative act is the spread of widely celebrated pandemic disease called HIV/AIDS.

HIV which is an acronym for Human Immunodeficiency Virus and it is a profound immune dysfunction that allows opportunistic infections in Acquired Immunodeficiency Syndrome (AIDS) patient.

Kelly and Kalichman (1995) and Uwakwe (1999) observe that an overwhelming majority of HIV/AIDS infections are contracted through sexual intercourse. Santrock (2002) revealing the danger of unprotected sex or risky sexual behaviour postulates that in a single act of unprotected sex, a teenage girl has 1% chance of getting HIV/AIDS, a 30% risk of acquiring genital herpes and 50% chance of contracting gonorrhea. This projection does not exempt adolescents with hearing impairment.

The HIV/AIDS epidemic is the most serious threat to health worldwide, with developing countries accounting for over 95% of new infections (Philander and Swartz, 2006). Since HIV/AIDS was first identified in December 1981, UNAIDS (2006) reports that an estimate of 25 million people have died because of this disease. Ensure a Better Tomorrow (2005) reports that out of 40.3 million adults and children living with HIV/AIDS worldwide, an estimate of 25.8 million adults and children are in sub-Sahara Africa with 3.2 million cases newly infected. By 2010, it was projected that over 45 million new HIV infections would be recorded with potential explosive capacity in developing countries (Goliber, 2002).

In Nigeria, the issue of HIV/AIDS situation is disturbing. Nigeria's epidemic is characterised by one of the most rapidly increasing rates of new HIV/AIDS cases in West Africa (USAID, 2002). The growing trend in 1999 was put at about 5.4 million with its toll on the adolescents (Federal Ministry of Health, 1999). Currently, the projection shows an increase in the number of new AIDS cases from 250,000 in year 2000 to 360,000 by 2010 (USAID, 2002). More importantly, the growing rate of HIV/AIDS among generation of youths especially the adolescent cluster calls for serious concern and instant effort to stem the tide. The alarming growing rate among

youths with and without disabilities point to the fact that they are sexually active and often take risk with little reflection on the consequences (Fakolade, Adeniyi & Tella, 2005).

Predominantly in Sub-Sahara Africa especially in Nigeria, the mode of transmission of HIV/AIDS is unprotected heterosexual sex (WHO, 2002). However, there are other ways by which the diseases can spread such as using unsterilised needles and blades, tooth brush of the affected person, blood transfusion, unprotected contact with the blood of affected person and men to men sex. Since there is no cure yet for HIV/AIDS, the prevention is essential. Unfortunately, majority of these young adults especially adolescents with hearing impairment are grossly ignorant of information about the risk of unprotected sex and how to avoid the infection. World Youth Report (2003) corroborates this assertion when submitting that studies around the globe have established that vast majority of young people remain uninformed about HIV/AIDS. The case is worse with people with disabilities. This is because many people believe that persons with disabilities are not sexually active and therefore need less awareness of sex education (Osowole & Oladepo, 2001; Groce, 2003; Kelly, Ntlabai, Oyosi, Van der Reit & Parker, 2003).

Akinola, Ikujuni and Oyewumi (1998) and Osowole and Oladepo (2001) report that special needs individuals especially adolescents with hearing impairment like the non-special needs, acquire less information about HIV/AIDS and sexuality education. The non-provision or inadequate HIV/AIDS information and education to adolescents with hearing impairment is fraught with serious consequences (Sugar, 1990, in Osowole & Oladepo, 2001). Akinyemi (1998) notes with concern that the deaf adolescents' inability to hear and speak often make it very difficult to disseminate sex information to them. This makes them to be disadvantaged in term of acquisition of information about sexuality and consequences of engaging in risky sexual behaviour. An inherent danger in this unfortunate development is that the uninformed adolescents with hearing impairment who continue to go on having unprotected reckless sexual adventures will continue infesting or spreading the yet to get cure disease (AIDS).

Generally, documentary evidence of casual sex, teenage pregnancy, increase incidence of STIs (sexually transmitted infections) and HIV/AIDS indicate poor knowledge and attitude on how the disease spreads especially those involving people with hearing impairment. Researches by Bisol, Superb, Breiver, Kate and Shor-Posner

(2008), Groce, Yousafzai, Van-der Mass (2008) and Bekele (2003) all report that hearing impaired participants have low knowledge of the spread of sexually transmitted infections especially HIV/AIDS. Also, Fakolade, Adeniyi and Tella (2005) comparing the level of awareness and knowledge of HIV/AIDS among 120 adolescents with and without hearing impairment in some schools in South-west, Nigeria found similarity in the awareness of HIV/AIDS but recorded a wide gap and disparity in the knowledge about HIV/AIDS and its spread. Ojile (2001) also, discovers a low level of knowledge about HIV/AIDS as displayed on billboards, handbills and leaflets. The study informed that eighty percent of the respondents did not understand the message displayed on those billboards and handbills while eighteen percent of the respondents associated the messages on the print media with advertisement products. The remaining two percent of the respondents were able to associate some of the pictures on the billboards with health education programme. It was discovered that there was a media bias in terms of information dissemination with respect to improving hearing impaired knowledge. However, Doyle (1995) reports that there was high and moderate knowledge of HIV/AIDS among eighty-four deaf participants at Gallandet University, United States of America as a result of education and information about HIV/AIDS.

Attitude, on the other hand is another key factor that contributes to the spread of HIV/AIDS among adolescents with and without hearing impairment. This is because adolescents are sexually active, mobile and more importantly they like to experiment what they have seen or heard. A survey carried out in Brazil by Nieuwinckel, Kroops, Pippe and Van Hnue (1990) among sexually active adolescents students showed that 75 percent of the males and 45 percent of the females reported to have had sexual intercourse for the first time, forty five percent of the adolescents had not taken precautionary measures at the first intercourse and 25 percent reported recent sexual intercourse. The rate of early sexual experience among adolescent with and without hearing impairment can be attributed to negative attitude to right sexual behaviour. World Youth Report (2003) survey from 40 countries including Nigeria indicated that 50 percent of young people habour serious misconceptions about transmission of HIV/AIDS. In a related research, UNICEF (2000) reports a survey it conducted in 1999 among sexually active adolescents in Burkina Faso, Nigeria and Tanzania. The outcome revealed that adolescents did not feel at risk of contracting HIV/AIDS. It further revealed that even when youths know the risks, however, many

believe that they are invulnerable. In Zimbabwe, over fifty per cent of young women interviewed said they were not at risk of HIV/AIDS, and in Nigeria, ninety-five per cent of girls aged 15-19 years perceived their risk of HIV infection to be minimal. Despite the devastation caused by AIDS, young people including adolescents with hearing impairment may not change their risky behaviour because the consequences of their actions are not immediately apparent.

In general population, statistics reveal significant gender differences in HIV infection (World Youth Report, 2003). Where heterosexual transmission of HIV is dominant, generally more young women are infected than young men. Studies researching young people's understanding of AIDS-related issues found that while both sexes were vastly uninformed, the level of unawareness was particularly high for girls aged 15-19 years. In countries with generalised epidemics such as Cameroon, Nigeria, Equatorial Guinea and Sierra Leone, more than 80 percent of young women aged 15-24 years did not have sufficient knowledge about HIV (World Youth Reports, 2003). This accounts for risky sexual practices among adolescents with and without hearing impairment.

Already, many awareness campaigns have been carried out to intimate the youths of the impending danger of risky sexual behaviour. Unfortunately, most of these campaigns have their shortcomings. For instance, Fakolade, Adeniyi and Tella (2005) observe that the campaigns against HIV/AIDS have centred mostly on the adolescents without disabilities. With this flaw, the disabled especially the hearing impaired, blind and mentally retarded members of Nigeria population are seriously at risk and stand at a disadvantage in relation to information and education about HIV/AIDS (UNESCO, 2003; Osowole & Oladepo, 2001).

The rise in incidence of STIs and HIV/AIDS among youths give indication that there is the need for a formalized programme or education to address the sexuality and sex-related issues among adolescents (Falaye and Moronkola, 1999). Such programme and or education must be such that will empower the youths especially adolescents with hearing impairment with necessary skills and information and thereby positively influence their sexual behaviour.

Evidently, Family Life and HIV Education (FLHE) had been introduced into Nigeria School Curriculum since 2003. The education which is fashioned to address adolescents sexuality is an arrangement that is believed will have great influence on the development of skills, acquisition of right knowledge and attitude which will lead

to healthy sexual behaviour among adolescents especially those with hearing impairment. This is because of its comprehensive curriculum contents and strategies for programme dissemination (Nigeria Educational Research and Development Council, 2003). Family Life and HIV/AIDS Education (FLHE) is a planned process of education that fosters the acquisition of factual information, formation of positive attitudes, beliefs and value as well as development of skills to cope with biological, physiological, socio-cultural and spiritual aspects of human being.

The main goal of Family Life and HIV/AIDS Education (FLHE) is to promote preventive education by providing learners with opportunities to:

- develop a positive and factual view of self
- acquire the information and skills they need to take care of their health including preventing HIV/AIDS
- respect and value themselves and others; and
- acquire the skill needed to make healthy decision about their sexual health and behaviour (NERDC, 2003).

The curriculum of Family Life and HIV/AIDS Education (FLHE) is structured to improve knowledge and attitude and also to equip adolescents with skills to cope with sexual and other life challenges that would make adolescents to be more rational in their behaviours. These skills include self-esteem, goal setting and decision making (NEDRC, 2003).

Self-esteem as a skill to be developed by adolescents through the teaching of Family Life and HIV/AIDS Education is a principal component of mental and psychological health of man (Jambo & Elliot, 2005). Rosenberg (1979) in Morris, Young and Jones (2000) define self-esteem as a person's summary evaluation of their worthiness as a human being. Person worthiness is the value placed on self after personal assessment, and it is believed to have a pervasive and powerful impact on human cognition, motivation, emotion and behaviour (Cambel & Lavallee, 1995). Studies have shown that it correlates highly with overall psychological well-being (Rosenberg, Schobler, Schoenbach & Rosenberg, 1995), achievement (Cambel & Lavallee, 1993), and ability to cope with stressful life events (Cambel & Lavallee, 1993). Self-esteem as a concept is of two types, that is, high and low self-esteem. The two exert great influence on total make up of man, either hearing or hearing impaired.

Literatures have indicated that some aspects of self-esteem such as high and

low self-esteem are related to sexual involvement. Stratton and Spitzer (1967) in Morris, Young and Jones (2000) in their study on college students found that the sexually permissive subjects displayed lower self-esteem, as measured by the Rosenberg self-esteem scale than those subjects who did not hold sexually permissive attitudes. Orr, Wilbrandt, Barack, Rauch and Ingersoll (1989) in Morris, Young and Jones (2000) investigate Junior High students from Blue Collar Homes. It was discovered that self-esteem of sexually active girls were significantly lower than that of virginal girls. Pollack (1993) also finds that college students with a wide variety of sexual experiences scored lower on the Rosenberg self-esteem scale than students with a narrow range of sexual experience.

However, Rosenthal, Moore and Flynn (1991) find that for both males and females, high risk behaviour were practiced by those with higher level of self-esteem. Cole and Slocumb (1995) and Hollar and Snizek (1996) also in their studies of college students, both males and females with high self-esteem are found to be significantly more likely to engage in what is termed as risky forms of conventional sexual behaviour. With the above findings it is clear that self-esteem can influence sexual activities of anybody be it adolescents with and without hearing impairment.

Furthermore, goal-setting as one of the skills in Family Life and HIV/AIDS Education is believed to be a predictor of man's achievement which has been confessed by most successful people as part of their reasons for success in personal and professional life. This is because it gives a clear picture of expectation and where to focus and eventually gives a sense of accomplishment when the goals are reached (Odion, 2009). Thus goal-setting makes adolescents and adults to be directional and disciplined in order to achieve a set goal.

Locke, Fredrick and Bobko (1984), Locke and Latham (1990) and Tanaka and Yamauchi (2001) note that man's behaviour is influenced by goals. This implies that whatever behaviour any man exhibits depends largely on mind set, which can either be good or bad. Bandura (1986, 1991) notes that goal-setting increases people's cognitive and affective reactions. This implies that goal-setting can increase the consciousness of man and the essence of his activities which can bring about modification. Goal also prompt self-monitoring and self-judgement of performance attainment (Bandura & Cervone, 1983, 1984; Locke, Cartiledge & Knerr, 1970). In essence, ability to set goals will regulate man's behaviour sexually and asexually. In the nature of adolescents, they struggle with setting and striving for goals that require

sustained self-discipline (Duckworth, Grant, Loen, Oettingen & Gollwitzer, 2009). This probably has accounted for some negative behaviours such as risky sexual behaviour as a result of conflict of motive which adolescents with hearing impairment are predisposed to leading to infection of deadly sexual disease called HIV/AIDS. It is generally believed that knowledge and ability to set goals by adolescents with and without hearing impairment will reduce proliferation of some risky behaviours such as risky sexual behaviour which will in turn reduce the spread of HIV/AIDS.

Moreso, decision-making is another judgemental disposition of man that can either mar or make success and achievement of human being. This is because before any action is taken, mind judgement would have been concluded. In summary, man's action is based on decision arrived at.

Adolescence is considered as a period that is full of challenges in the developmental phase of man. Among challenges that may face adolescents with and without hearing impairment is how to take decision that will positively influence their lives. Decision about sexuality is highly sensitive and adolescents are sometimes confused due to tendency to experiment their sexual feelings. Decision to engage in early sexual activities might be as a result of biological and social pressures. Action Health Incorporation (1992) in Inyang (2007) in a study carried out in Benin City revealed that fifty-five per cent(55%) of secondary school girls had decided to have sexual intercourse before the age of sixteen (16). In the same vein Brahim (1995) in Akinawo and Owanikin (2007) also report in his study among teenagers that 80% of those between 17 and 19 years had experienced sexual intercourse without preventive measure because they perceived that sexual knowledge is for enjoyment. In similar revelation, Nguyet, Beland and Piea (1994) report early sexual intercourse among their subjects. The study also revealed that some male adolescents have decided to have sexual intercourse as early as age thirteen much earlier than the expected year. The above revelations indicated that adolescents generally take inordinate decisions when it comes to the issue of sexual feelings and experience because of inadequate sex education and guide by the adults.

From the foregoing, it is obvious that some practices among adolescents especially risky sexual behaviour may be the outcome of lack of some developmental skills that might help adolescents whether with or without hearing impairment to cope with life challenges. Therefore, there is the need to find out how Family Life and HIV/AIDS Education programme has imparted positively on adolescents with hearing

impairment sexual behaviours.

1.2 Statement of the Problem

Adolescents with hearing impairment like any other adolescents are confronted with life challenges such as social, psychological, developmental, health as well as sexual difficulties. These have predisposed them to so many risks.

This situation is further compounded by inability to hear and comprehend messages when it comes to information about their sexual health, seeking and translating sensitive information to functional use, healthy relationship with their peers and other in their environment as well as taking vital decision that can affect their lives. These could have being the reasons for poor attitude and knowledge of HIV/AIDS and inability to develop personal skills that should have helped adolescents with hearing impairment to cope with their sexual challenges. Several studies have been carried out on the influence of sexuality education on adolescents without hearing impairment especially on the issue of personal skills, knowledge and attitude towards HIV/AIDS. However, there is a dearth of information on how sexuality education has influenced sexual behaviour of adolescent with hearing impairment. Hence, the present study investigated the impact of Family Life and HIV/AIDS Education on adolescents with hearing impairment in Southwest, Nigeria.

1.4 Purpose of the Study

The study investigated the influence of Family Life and HIV/AIDS Education (FLHE) on the knowledge and attitude of adolescents with hearing impairment towards HIV/AIDS.

Specifically, the study:

a. ascertained how self-esteem skills influence the knowledge and attitude of adolescents with hearing impairment towards HIV/AIDS;
b. investigated the influence of goal-setting skills on the attitude and knowledge of adolescents with hearing impairment towards HIV/AIDS; and
c. assessed the influence of decision-making on knowledge and attitude of adolescents with hearing impairment about HIV/AIDS.

1.4 Scope of the Study

The study was on Family Life and HIV/AIDS Education as predictors of knowledge of and attitude to HIV/AIDS among adolescents with hearing impairment in South-West, Nigeria. The research was carried out in special, integrated and inclusive secondary schools in Oyo, Osun, Ogun, Ondo, Ekiti and Lagos States, the six states in South-West, Nigeria. The participants were drawn from J.S.S. 1 to SSS 2 in special, integrated and inclusive schools in the state used for the study.

1.5 Significance of the Study

The results from this study would provide a basis for developing a more effective method for teaching Family Life and HIV/AIDS Education (FLHE). This will help adolescents with hearing impairment to acquire relevant knowledge, improve their attitude and also develop skills that will help them to cope with life challenges. The expected result of this study should be of relevant to teachers and caregivers in the education and training of students with hearing impairment in using every avenue of teaching, dynamism of methods and skills to promote the teaching of Family Life and HIV/AIDS Education among their students and wards as the teaching received by these students will help in acquisition of relevant skills thereby promoting healthy behaviour among adolescents with hearing impairment. It would also provide empirical assistance and framework for special educators, regular classroom teachers, counsellors, parents, public health workers, governmental and non-governmental organizations and other related professionals in their efforts towards assisting adolescents particularly adolescents with hearing impairment in the acquisition of relevant skills as this will serve as working tool for all stakeholders in being pragmatic towards the issue of HIV/AIDS among adolescents with hearing impairment.

1.6 Research Questions

1. Would there be significant relationships among the independent variables (self-esteem, goal-setting, decision making) and knowledge of adolescents with hearing impairment in South West Nigeria about HIV/AIDS?
2. To what extent when combined will the independent variables (self-esteem, goal-setting, decision making) predict knowledge of

adolescents with hearing impairment in South West Nigeria about HIV/AIDS?

3. To what extent will each of the independent variables (self-esteem, goal-setting, decision making) predict knowledge of adolescents with hearing impairment in South West Nigeria about HIV/AIDS?
4. Would there be significant relationships among the independent variables (self-esteem, goal-setting, decision making) and attitude of adolescents with hearing impairment in South West Nigeria to HIV/AIDS?
5. To what extent when combined will be independent variables (self-esteem, goal-setting, decision-making) predict attitude of adolescents with hearing impairment in South West Nigeria to HIV/AIDS?
6. To what extent will each of the independent variables (self-esteem, goal-setting, decision making) predict attitude of adolescents with hearing impairment in South West Nigeria to HIV/AIDS?

1.7 Operational Definition of Terms

Family Life and HIV/AIDS Education: This refers to a planned process of education that aids acquisition of information, formation of positive attitude, belief and value as well as development of skills to cope with life by the adolescents. These include self-esteem, goal-setting and decision-making.

Knowledge: Knowledge in this study refers to the facts, skills, understanding and considerable degree of familiarity of an adolescent with hearing impairment to learning or experience about HIV/AIDS.

Attitude: This refers to the opinions and feelings that individuals with hearing impairment develop towards HIV/AIDS.

Decision-making: This refers to judgemental disposition of an adolescent with hearing impairment after a period of discussion or thought about sexuality education.

Self-esteem: This refers to the general evaluation of adolescent with hearing impairment worthiness as human beings in a particular society.

Goal-setting: This refers to general drive to reach a clearly defined end by adolescent with hearing impairment.

Adolescents: In this study, adolescents refer to young individuals who are between ten and twenty-one (10-21) years of age. The young individuals are at the period of puberty trying to attain physical and emotional maturity.

Adolescents with hearing impairment: This refers to adolescent with full or partial loss of the ability to detect or discriminate sound information due to an abnormality associated with anatomy, physiology or function of the ear.

Hearing Impairment: This refers to a full or partial loss of the ability to detect or discriminate sound information due to an abnormality associated with anatomy, physiology or function of the ear.

CHAPTER TWO

LITERATURE REVIEW

2.0 Theoretical Review of Literature

This chapter will review literature on the following:

2.1 Historical emergence of HIV/AIDS

2.2 Global Distribution of HIV/AIDS

2.3 HIV/AIDS in Nigeria

2.4 HIV/AIDS Transmission in Nigeria?

2.5 Hearing Impairment

2.6 Adolescence

2.6.1 Adolescents with Hearing Impairment and Characteristics

2.7 Family Life and HIV/AIDS Education (FLHE).

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2.7.2 Self-esteem

2.7.3 Decision-making

2.8 Adolescents Knowledge of HIV/AIDS

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2.10.3 Theory on Decision-making

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2.11.2 Adolescents' Knowledge of HIV/AIDS

2.11.3 Gender and Adolescents Sexuality

2.11.4 Self-esteem and Adolescents' Sexual Behaviour

2.11.5 Decision making and Adolescents' Sexual Behaviour

2.11.6 Goal-setting and Adolescents' Sexual Behaviour

2.12 Summary of the Literature Review

2.13 Conceptual Framework for the Study

2.1 Historical Emergence of HIV/AIDS

The origin of AIDS and HIV has puzzled scientists ever since the illness first came to light in the early 1980s (AVERT, 2010). For over twenty years, it has been the subject of fierce debate and the cause of countless arguments, with everything from a promiscuous flight attendant to a suspect vaccine programme being blamed.

The first recognised cases of AIDS occurred in U.S.A. in the early 1980s. A number of gay men in New York and California suddenly began to develop rare opportunistic infections and cancer that seemed stubbornly resistant to treatment. At this time, AIDS did not yet have a name, but quickly became obvious that all the men were suffering from a common syndrome.

The discovery of HIV, the Human Immunodeficiency Virus was made soon after. HIV is a lentivirus, and like all viruses of this type, it attacks the immune system. Lentivirus are in turn part of a larger group of viruses known as retroviruses. The name 'lentivirus' literally means 'slow virus' because they take such a long time to produce any adverse effects in the body.

Investigations have shown that the virus of HIV is found in a number of different animals including cats, sheep, horses and cattle. However, the most interesting lentivirus of HIV is the Simian Immunodeficiency Virus (SIV) that affects monkeys. It is now generally accepted that HIV is a descendant of a Simian Immunodeficiency Virus (SIV) because certain strains of SIVs bear a very close resemblance to HIV-1 and HIV-2, the two types of HIV.

In Africa, doctors were also coming across patients with unusual symptoms. In Kigali, Rwanda and Kinshasa in Zaire, there was in 1980 an increase in the disease cryptococcal meningitis. In Rakai district in Uganda, a disease was found where young people dramatically lost weight and died. In 1983, a similar incident was reported in Canada.

In 1983, Luc Montagnier from the Pasteur Institute in France isolated a virus from the blood of AIDS patients which he called Lumphademopathy Associated Virus or LAV. In 1984, Robert Gallo and his fellow workers at the National Cancer Institute in the United States isolated a virus that they called the Human T Cell Lymphotrophic Virus (HTLVIII).

By February 1999, a group of researchers from the University of Alabama announced that they had found a type of Sivcpz that was almost identical to HIV-1. This particular strain was identified in a frozen sample taken from a captive member

of the sub-group of chimpanzee known as P.t troglodytes (P.t troglodytes) which were once common in West Central Africa.

The researchers led by Paul Sharp of Nottingham University and Beatrice Hahn of University of Alabama made the discovery during the course of a 10-year long study into the origins of the virus. They claimed that the sample proved that chimpanzees were the source of HIV-1 and that the virus had at some point crossed species from chimps to humans.

Their findings were published two years later in Nature Magazine. In the article, they concluded that wild chimps had been infected simultaneously with two different simian immunodeficiency viruses which had 'viral sex' to form a third virus that could be passed on to other chimps and, more significantly was capable of infecting humans and causing AIDS. These two different viruses were traced back to a SIV that infected red-capped mangabeys and one found in greater spot-nose monkeys. They believe that the hybridisation took place inside chimps that had become infected with both strains of SIV after they hunted and killed two smaller species of monkey.

They also concluded that all three groups of HIV-1 namely group M, N and O came from the SIV found in P.t. troglodytes and that each group represented a separate cross over 'event' from chimps to humans.

In January 2002, the results of new study suggested that the first case of HIV-1 infection occurred around 1931 in West Africa. The estimate was based on a complex computer model of HIV's evolution.

However, a study in 2008 dated the origin of HIV between 1884 and 1924, compared the viral sequence from 1959 to newly discovered sequence from 1960. They found a significant genetic difference between them, demonstrating diversification of HIV-1 occurred long before the AIDS pandemic was recognised.

The authors suggest a long history of the virus in Africa and call Kinshasa the epicentre of the HIV/AIDS pandemic in Africa. They proposed that the early spread of HIV was concurrent with development of colonial cities, in which crowding of people increased opportunities for HIV transmission. Until recently, the origin of the HIV-2 has remained relatively unexplored. HIV-2 is thought to come from the SIV in Sooty Mangabeys rather than chimpanzees, but the crossover to humans is believed to have happened in a similar way through the butchering and consumption of monkey meat.

In May 2003, a group of Belgian researchers led by Dr. Anne-Mieke Vandamme, published a report of proceedings of the National Academy of Science. By analysing samples of the two different sub-types of HIV-2 (A and B) taken from infected individuals and SIV samples taken from sooty mangabeys. They concluded that sub-type A had passed into humans around 1940 and sub-type B in 1945. They further reported that the virus had originated in Guinea-Bissau and that its spread was most likely precipitated by the independence war that took place in the country between 1963 and 1974. Their theory was backed up by the fact that the first European cases of HIV-2 were discovered among Portuguese veterans of war. So, given the evidence we have already looked at, it seems likely that Africa was indeed the continent where the transfer of HIV to man first occurred.

2.2 Global Distribution of HIV/AIDS

The most disturbing trend is the dimension of the spread of HIV/AIDS worldwide. The impact of AIDS have been most serious in sub-Sahara Africa. The region contains almost three quarters of all young people living with HIV/AIDS, even though only 10 percent of the world's youth are Africans. Some 8.6 million of the 28.5 million Africans living with HIV/AIDS are young people. Majority of new infections in the region are among those 15-24 years of age. HIV/AIDS has become generalised among youths in almost half of the sub-Sahara Africa nations. In nearly 20 centuries in the region, it is estimated that at least 5 percent of young women aged 15-24 years are infected with HIV.

Substantial differences exist in HIV/AIDS prevalence among African nations. Southern Africa has the worst epidemic, especially among young girls. Many researchers assumed that the high prevalence rates in some countries would have reached a plateau, but this has not yet occurred. In Botswana, median HIV prevalence among pregnant women was 38.5 percent in 1997 and has risen to 44.9 percent since. These prevalence rates, as devastating as they are, do not entirely reflect the actual toll AIDS is taking on certain population groups. Women 25-29 years old receiving antenatal care in urban areas of Botswana had a prevalence rate of 55.6 percent, and for those in Zimbabwe, the rate was 40.1 percent.

Until recently, HIV prevalence remained low in most West and Central African countries. However, rapid increases in infection rates are now being reported in Cameroon and Nigeria. Other countries in the region, including Cote d'Ivoire,

Senegal and Togo, have thus far been able to keep their rates steady. In the Middle East and North Africa, HIV infection among young people exists, but the numbers are small. According to Statistics published by the Organisation of Islamic Conference, 0.3 percent of males in the region were living with HIV/AIDS at the end of 2001. Sexual interaction remains the dominant route of transmission in the region, though new research indicates that injecting drug use is on the rise. All countries in the region except Sudan and Yemen have reported HIV transmission through injecting drug use. This may soon beget a wave of infection that could increase overall HIV rates among young people.

In East and the Pacific, Cambodia, Myanmar and Thailand have the highest infection rates and are the only countries in the region with HIV prevalence greater than 1 percent among youth. Drug injection is leading to the explosive growth of HIV infections in several areas including Kathmandu, Nepal, where over half the injecting drug users (IDUs) have HIV, up from less than 1 percent in the early 1990s. In Asia, sexual transmission of HIV is predominantly through men having sex with other men (MSM), though high rates among sex workers have been noted for many years.

While HIV prevalence in Central Asia and Eastern Europe is relatively low, this region is experiencing the fastest-growing rate of infection worldwide. There were an estimated 250,000, new infections in 2001, bringing the total number of people living with HIV/AIDS in the region to 1 million. In the Russian Federation, increases in HIV infection continue, with new reported diagnoses nearly doubling annually since 1998. In Ukraine, more than I percent of young men aged 15-24 years are currently infected. The epidemic is spreading most rapidly among young men because of unsafe drug injection practices. There is also evidence that young males and females in several parts of the regions are becoming sexually active at an earlier age.

In Latin America and the Caribbean HIV prevalence continues to vary widely. The Caribbean is the second most affected region after sub-Saharan Africa, with 2.3 percent of 15-19 year olds infected. In Bahana, Dominican Republic, Guyana, Haiti and Trinidad and Tobago, at least 2 percent of young women infected with HIV, and transmission is predominantly through sexual contact. In contrast, Central and South America continue to report epidemics driven by sexual transmission of HIV between men having sex with men (MSN). For instance, although adult prevalence in Mexico is under 1 percent, prevalence among MSM is 15 percent. Drug injection is a growing

social phenomenon in the region, affecting Argentina, Brazil and Uruguay in auricular.

Only a few industrialised countries have infections rate of 0.5 per cent or higher. These countries and territories had a combined total of about 243,000 youth living with HIV/AIDS in 2001 (World Youth Report, 2003). However, there is cause for concern as the rise in sexually transmitted infection (STIs) has been observed among youth in many industrialised countries (UNAIDS, 2002). In the industrialised world, the number of young men infected with HIV/AIDS is twice that of young women because sexual transmission of HIV is predominantly through men having sex with men (MSM) and injecting drug use. In 1999, half of the AIDS cases in young men aged 13-24 years in the United Sates were among those who had sex with other men (United States Centres for Disease Control and Prevention, 2000).

2.3 HIV/AIDS in Nigeria

Nigeria's epidemic is characterised by one of the most rapidly increasing rates of HIV/AIDS cases in West Africa. Adult HIV prevalence increased from 1.8 percent in 1991 to 5.8 percent in 2001 (USAID, 20002).

The first two cases of HIV/AIDS in Nigeria were identified in 1985 and were reported at an international AIDS Conference in 1986 (AVERT, 2010). In 1987, the Nigerian health sector established the National Advisory Committee which was shortly followed by the establishment of the Nation Expert Advisory Committee on AIDS (NEACA). At first, the Nigerian government was slow to respond to the increasing rate of HIV transmission and it was only in 1991 that the Federal Ministry of Health made the first attempt to assess Nigeria's AIDS situation. The result indicated that about 1.8 percent population of Nigeria were infected with HIV. Subsequent surveillance reports revealed that during the 1990s, HIV prevalence rose from 3.8% in 1993 to 4.5% in 1998.

When Olusegun Obasanjo became president of Nigeria in 1999, HIV prevention, treatment and care became one of government's primary concerns. The President Committee on AIDS and National Action Committee on AIDS (NACA) were created and in 2001, the government set up a Three Year HIV/AIDS Emergency Action Plan (HEAP). All these efforts were made to stem the tide and the exploit of HIV/AIDS in Nigeria.

USAID (2000) stated that the current prevalence rate of HIV infection is

between 6.7 percent and 7 percent which mean that over 2 million Nigerians are living with the virus and disease.

Currently, there is proportionate distribution of HIV/AIDS on age and gender in Nigeria (Nwagbara, 2003). High growth rate are reported among adults and youths. The growth rate among adolescents (youths) between aged 15-25 years was put at average of 49 percent. This revealed that there is high incidence of the virus among youths.

USAID (2002) survey on HIV prevalence reports that, there is a high and steady increase in the rate, with a national seroprevalence rate from 1.8% in 1991, 3.8 in 1993, 4.5 percent to 5.4 percent in 1999 and 5.8% in 2001 among males and females between the ages of 15-49 years. AVERT (2010) reports that in Nigeria, an estimate of 36 percent of the population are living with HIV/AIDS. Although HIV prevalence is much lower in Nigeria than other African countries such as South Africa and Zambia, the size of Nigeria's population (140 million) meant that at the end of 2009, there were almost 3 million people living with HIV. In 2009 alone, it was reported that approximate of 192,000 died as a result of AIDS. With AIDS claiming as high as 192,000 in 2009 alone, it means that Nigeria's life expectancy has declined significantly.

Despite the fact that Nigeria is ranked the largest exporter of crude oil in Africa and the 12th largest in the world, Nigeria is ranked 158 out of 177 on the United Nations Development Programme (UNDP) Human Poverty Index. This poor economic position has meant that Nigeria is faced with huge challenges in fighting its HIV/AIDS epidemic.

Clinical Manifestation of HIV/AIDS

A current understanding of the clinical manifestation of HIV infection in children, adolescents and adults has emerges over the first fifteen years of the epidemic (Lucey and Chanock, 1998). It is evident that a number of clinical complication is observed in HIV infested persons. Patients with the infection are plagued with chronic problems of persistent fevers, weight loss, diarrhea and night sweats. Moreover, alteration in host defence by loss of T-lymphocyte or of humoral antibody response render patients susceptible to a spectrum of opportunistic infections (Lucey and Chanock, 1998).

HIV infection in children, in particular, in children with perinatally acquired

infection, manifests clinical features that are different from those in adults with HIV infection. Children with HIV infection are proned to recurrent or serious bacteria infection, neurodevelopmental abnormalities and lymphotic interstitial pneumotic with salivary gland enlargement. On the other han, children are likely to develop Kaposi's Sacoma, other cancer and the opportunistic infection toxoplasmosis, cruptocosis, and histoplamosis, which are usually a consequence of reactivation in the adult population (Chanock and Pizzo, 1995), these differences between children and adults with HIV/AIDS infection during the normal development of immunity, blunted responses to standard pediatric vaccines and immunosuppression secondary to co-infections with opportunistic pathogens (Lucey and Chanok, 1998). Older children who acquire infection after birth and adolescent frequently progress in manner Sinular to adult patient (Gayle and D' Angelo, 1991).

Because immunodeficient young children may have higher CD4+ T-lympocyte counts than immunodeficient. Older children and adults serious infection may develop when their CD4+-lymphocyte counts are higher compared with those in older children and adults (McKinney and Wilfert, 1992; ErKeller-Yuksil, Deneys and Hannet, 1992).

2.4 HIV/AIDS Transmission in Nigeria

AVERT (2010) submits that there are three main HIV transmission routes in Nigeria. These are: heterosexual sex, blood transfusion and mother-to-child transmission.

Heterosexual sex: An approximate of 80-95 percent of HIV infection in Nigeria is as result of heterosexual sex. Factors contributing to this include lack of information about sexual health and HIV, low levels of condom use and high level of sexually transmitted diseases. Women are particularly affected by HIV. In 2009, women accounted for 56 percent of all adults aged 15 and above living with the virus (UNGASS, 2010).

Blood transfusion: HIV transmission through unsafe blood accounts for the second largest source of HIV infection and spread in Nigeria. Not all Nigerian hospitals have the technology to effectively screen blood and therefore there is a risk of using contaminated unscreened blood. However, in the recent times, the Nigeria Federal Ministry of Health have responded by backing legislation that requires hospital only to obtain blood from the National Blood Transfusion Services which has far more

advanced blood-screening technology.

Mother-to-child transmission: Mother-to-child transmission contributes to the fast growing of HIV in Nigeria. Each year around 57,000 babies are born with HIV (UNGASS, 2010). It is estimated that 220,000 children are living with HIV in Nigeria through mother to child infection (UNAIDS, 2008).

The last mode is the least significant in Nigeria and this is prevalence among injecting drug users. Few researches have indicated the prevalence of HIV in Nigeria through this medium. However, it appears to be accounting for an increasing number in new HIV infection.

2.5 Hearing Impairment

Hearing impairment is a generic term, which describes any condition that reduces the hearing acuity of an individual and makes it impossible for him or her to perceive and interpret auditory signals (sound) (Okuoyibo, 2006). This condition ranges from mild to profound which includes those who are deaf and those who are hard of hearing. Kirk and Gallaher (1994); Oyewumi (2003) maintain that there are many terms used to describe hearing impairment e.g. deafness, hearing disability, hearing disable. Telford and Savney (1997) are of the view that aural or acoustic handicap can be used to describe hearing impairment e.g. deaf and mute. In same vein most educators and professionals in the field of special education refer to it as auditory disability who educationally could be helped through the use of special educational services in order for them to gain maximally. Erika (2004) sees hearing impairment as a condition characterised by being partially or completely incapable of hearing and it is sometimes commonly referred to as communication disorder rather than physical disability. In the view of Geheart (1980), hearing impairment is a disability characterised by loss of hearing sensitivity, partially or absolutely.

The Conference of Executives of American Schools for the Deaf Washington identifies that individuals suffering from this disability can be categorised into two, the deaf and hard-of-hearing using the severity of their hearing loss as basis of differentiation. National Information Centre on children and youth with disabilities (NICHCY, 2002) and Alade (2005) define deafness as a hearing impairment, so severe that the child is impaired in processing linguistic information through hearing, with or without amplification that adversely affects the child. While being hard-of-hearing is defined as "an impairment in hearing, whether permanent of fluctuating,

not adversely affecting a child's educational performance" but is not included under the definition of deafness. The above descriptions indicate that though the affected persons may have or have not some usable hearing, anybody that suffers from auditory defects be it severe, moderate or mild is being referred to as "hearing impaired or person with hearing impairment". And so, the only option to the above problem is the use of amplification devices which is believed will help the person to be able to hear speech in form of sound.

Mba (1995) and Okuoyibo (2006) remark that hearing impairment varies from person to person depending on the following factors: the degree or level of impairment, the time of onset of impairment and the place of impairment or site of pathologies.

i. **Degree or level of impairment:** Paul and Quigley (1994) describe hearing in degree as mild or severe. The mild or severity of loss is determined by individual's reception of sound as measured in decibels (dB). A loss between 15-20 dB is considered slight, increasing degrees of loss range from mild to severe and profound hearing loss or, to use a more common term, deafness (Moores, 2000). Jerger (1980) using audiometer, classified hearing loss in decibel (dB) as follows:

- normal hearing – 0dB - 20dB
- mild/moderate loss – 21dB – 60dB
- severe loss – 61dB – 80dB
- profound loss – 81dB and above

In a more recent classification of degree of hearing loss, the International Symbol for Deafness (ISD) (2009) recommended the following classification of degree of hearing loss.

Sound Intensity	Degree of Hearing Loss
10-15dB	Normal hearing
25-40dB	Mild hearing loss
40-55dB	Moderate hearing loss
55-70dB	Severe hearing loss
71-90dB	Profound hearing loss

ii. **Time or age of onset of impairment:** Mba (1995) and Okuoyibo (2006) present that hearing loss can be congenital, that is a condition occurring at or before birth or acquired (adventitious) which is a condition of the impairment of hearing occurring after birth or after the individual developed oral language. Individuals who are prelingually deaf become deaf before they learn to speak and understand language. They are either born deaf or lose their hearing as infants. Approximately 95 percent of all deaf children and youths are prelingually deaf. Individuals who are postlingually deaf experience profound hearing loss after they have learned how to speak and understand language (Okuoyibo, 2006). Majority of these individuals are able to retain their abilities to use speech and to communicate with others orally.

iii. **The Place of Impairment or site of pathologies:** Okuoyibo (2006) asserts that knowledge of deafness according to place of impairment is useful for the sake of amplification. Hence, classification according to the place of impairment can be as follows: conductive, sensorineural and mixed hearing losses.

Conductive hearing loss occurs when something blocks the sound passing through the outer to inner ear (March of Dimes, 2000). The blockage can be caused by wax, infection (otitis external or media) or any type of malformation of the ear canal. This type of loss is usually temporary and can be corrected by surgery or medication (NIDCD, 1999; Herter, Knightly & Steinberg, 2002).

Sensorineural hearing losses are caused by defects in the inner ear (cochlea) or auditory nerves, particularly in the delicate sensory hairs of the inner ear or in the nerves that supply them. Those nerves transmit impulses to the brain (Newton & Stoke, 1999).

Mixed hearing losses result from problems in the outer ear as well as in the middle or inner ear (NICD, 1999). Person with this kind of loss may hear distorted sounds as well as have difficulty with sound level.

The central hearing losses result from changes in the reception of hearing area in the brain, a damage to the pathway of the brain (Kirk, Gallagher, Anastassiow & Coleman, 2006). Central hearing losses are not frequently encountered.

Characteristics of Students with Hearing Impairment

Hearing disability is a condition that can make the affected persons exhibit some strange behaviours that contravene associated time, frequency and a set of norm in the society.

These signs, according to Okuoyibo (2006), Alade (2005), Adesina (2001) and Mba (1995) include:

- not responding to or confusing verbal direction;
- indifference to sound;
- complaining of ringing or buzzing sound in the ear;
- not responding when called from distance;
- discharge from the ears;
- frowning or bending forward in order to hear or understand what is said to him or her;
- gazing at the lips of a person speaking to him instead of the person's eyes;
- requesting for a repeat of a statement;
- low tolerance for noise or changes in sound pattern;
- disarticulation of simple words;
- speaking arbitrarily loud or low;
- bending towards speaker's mouth;
- showing no surprise or being startled in situation that would normally provoke such response;
- complaining that normal sound or noise is too loud;
- responding only when he or she sees speaker's face or gesture;
- exhibiting temper tantrum;
- avoiding situation that may require him or her to talk;
- banging of head when emotional problem is involved; and
- monotonal quality of voice.

Effects of Hearing Impairment

Several studies have revealed that disability of hearing create barriers to the general developmental process of the affected person. The most important among them is barrier to general development of language. Mba (1995) and Lillo-Martin

(1997) note that children who are born deaf or hard of hearing are no different from children born hearing. During the first year of life, which is referred to as pre-linguistic period, they will exhibit the same behaviour such as crying, making comfort sounds and babbling to parents. These behaviours are innately programmed and they appear whether the infant can hear or not (Kirk, Galleher, Anastasion & Coleman, 2006).

However, language behaviour disappears shortly, after babbling stage. Bakare (1988), Mba (1995), Okeke (2001) and Onwuchekwa (2005) state that early hearing loss deprive the affected person of the natural ability to acquire verbal language which impedes normal development of language. Poor language or lack of it robs the hearing impaired person of the ability to develop language adequately.

Apart from language problems, hearing impaired persons suffer social and emotional problems Okuoyibo (2006) and Kirk, Gallagher, Anastasion and Coleman (2006) all submit that hearing impaired child may exhibit some personality problem such as emotional instability, lack of self-confidence, a negative self-image, immature behaviour, impulsiveness and or depression. Meadow (1980) in Kirk, Gallagher, Anastasion and Coleman (2006) state that personality inventories have consistently shown that deaf children have more adjustment problem than hearing children. When deaf children without overt or serious problems have been studied, they have been found to exhibit characteristics of rigidity, egocentricity, absence of inner control, impulsivity and suggestibility. Meyen (1990) and Fraber (1990) in their separate studies find that the hearing impaired show a greater degree of emotional maladjustment than their non-hearing impaired peers. Moores (1996) presents that the hearing impaired have feeling of severe isolation and detachment with aggressive, almost desperate attempt to compensate and thereby maintain interpersonal contacts.

Hearing loss can also have a strong negative effect on a person's academic success. Johnson (2002), Moore (2001) and Onwuchekwa and Alade (2005) note that a long-term problem for deaf individuals is their academic achievement, particularly in the area of reading. It must be noted that reading skills help comprehension of students at all level. Kirk, Gallagher, Anastasion and Coleman (2006) also note that achievement of reading skill is a challenge for many students who are deaf. This is unfortunately creates great barrier to academic success because virtually all aspects of learning involve reading.

It is also gathered that children who did not acquire any form of speech will

have more problems in learning how to speak than those who became deaf after acquiring some form of linguistic sounds but their speech development is impaired as a result of non-auditory feedback from the sounds they make. Studies by Quigley and Paul (1990), Moores (1996) and Laad (1998) reveal that infants who are born deaf turn to enter babbling stage at the same time as hearing infants but they don't maintain it. Meyen (1990) also affirms that hearing loss has serious effect on how a person is able to hear spoken language and other related environmental stimuli since it brings about insensitivity to generated sound. Fraser (1990) in line with the above says that hearing loss affect development of temporal sequencing skills as well as the ability to process and develop conventional language. Researches on cognitive development of students with hearing impairment found that majority of deaf students lag behind compared with their hearing counterparts (Moored, 1996; Heward, 2001).

Furthermore, individuals with hearing impairment are also faced with communication problem. It must be noted that communication is enhanced through a range of experience which individual with deafness is deprived off. Sokale (1994) and Mba (1995) remark that not to hear is not to hear spoken language and not to hear spoken language will make one completely ignorant of the basic tool for human communication. Oyewumi (2003) states that the development of the hearing impaired child and in fact of any child's potential requires an early environment that provides a wealth of stimulation and relevant experience that are made meaningful for the child through interaction with other people by means of a fluent and intelligible communication system. Generally, the effect of hearing impairment on the affected individuals cannot be over-emphasised because the whole personality is distorted thereby making the individual to be socially, academically and psychologically misfit in any environment.

Causes of Hearing Impairment

The prevalence of hearing loss in children may be due to a number of conditions. Over half of the causes of permanent deafness or of being hard of hearing are pre-natal in origin (Mba, 1995; Newton & Stokes, 1999; Alade, 2005). The causes are estimated to be one-third genetic, one third environmental or acquired, and one-third unknown (Harter, Knightly & Steinberg, 2002). Some authorities divide the causes into one-half genetic and one-half environmental (NICD, 2000). There are seventy documented genetic syndromes as well as many other single genetic causes of

deafness and partial deafness (Harter, Knightly & Steinberg, 2000).

Genetic causes of hearing impairment are disorders inherited from one or both of the parents. More than two hundred different types of genetic deafness have been identified and can be inherited from either a hearing parent or a non-hearing parents (NICD, 1989 in Kirk, Gallagher, Anastasion & Coleman, 2006). Some hearing losses that may be inherited as a genetic trait either alone or as part of a syndrome along with other abnormalities are skeletal deformities of treacher-callins syndrome or the abnormal pigmentation of the Wardenburg syndrome (Frasser, 1976; Mba, 1995). Other associated problem is Down Syndrome (a genetic disorder associated with mental retardation) in which the affected person has narrow ear canal and are prone to middle ear infections, which may cause hearing losses. Individual with cleft palates may also have repeated middle ear infections which can result in conductive hearing losses (Roizen, 1997; Herter, Knightly & Steinberg, 2002). Sank and Kallman (1993) present that up to half all cases of early deafness may be genetically caused, with perhaps thirty six to forty-five different recessive genes and several dominant genes involved.

Congenital conditions such as Rh (hyperbilirubihemia) otherwise known as Rhesus incompatibility may lead to condition of congentical hearing loss. This may occur when a mother who is Rh-negative carries a fetus that is Rh-positive. The mother immune system begins to destroy the fetus red blood cells when they enter the mother circulatory system. As a result the fetus becomes anemic and dies in uterus or if survives he or she may have a high frequency of hearing loss (Kirk, Gallagher, Anastasion & Coleman, 2006). All cases of hearing loss that are of genetic origin may appear at birth or some months or years after as a result of heredity (Boothroyd, 1988; Harter, Knightly & Steinberg, 2002).

Environmental factors that can lead to hearing loss may occur before the birth of the baby as a result of associated problem of illness or infections the mother may have had during pregnancy. Kirk, Gallagher, Anastasion and Coleman (2002) note that uncontrolled diabetes in the mother may cause a hearing loss in her child. More specifically, a group of infections that affect the mother labelled TORCHS can cause severe hearing losses in the fetus (Newton & Stokes, 1999). The TO stands for toxoplasmosis, a parasitic disease common in Europe that may be contacted by handling contaminated cat feaces or eating infected lamb not cooked sufficiently (Batshaw & Perret, 1992). R stands for rubella otherwise known as German measles

which can be contracted by the mother, can cause not only hearing loss in child alone but also blindness, mental retardation, multiple conditions of impairment and physical disabilities.

The C stands for cytomegalovirus (CMV), an infection in the mother's uterus which is a major environmental cause of deafness. Cytomegalovirus (CMV) is a harmful virus that passes through the mother placental to the fetus and is associated with low-birth weight and premature infants that has been considered as a possible cause of prematurity as well as of the resulting hearing loss (Strauss, 1999; Kirk, Gallagher, Anastasion & Coleman, 2006). The H stands for Herpes Simplex Virus which if left untreated can lead to the death of 60 percent of infected infants. Those who survive may have serious neurological problems and potential hearing loss.

Noise pollution, particularly loud noise can cause hearing loss. It is suspected that the noise produced by isolettes for premature babies is related to hearing loss, but this has not been proven (Betshaw & Perret, 1988; Mba, 1995). Infections such as meningitis which is an inflammation of the membranes covering the brain and spinal cord can damage the auditory nerve. Batshaw and Perret (1992) note that care must be taken as the antibodies being used for the treatment may also cause damage to the auditory nerve thereby leading to hearing impairment.

Otitis external and media are universal infections of the outer and middle ear that may cause a hearing loss if persistent or recurrent but otitis is usually associated with mild-to-moderate hearing losses (Kirk, Gallagher, Anastasion & Coleman, 2006).

Otoschlerosis which is a growth of a spongy bone around the footplate of the stapes can lead to conductive hearing loss. Okuoyibo (2006) states that this growth fixes the stapes permanently on the walls of the oval window preventing it from making the normal in and out movements. Asphyxia (lack of oxygen) during the birth process may bring about a hearing loss (NIDCO, 2000). This is because oxygen is highly essential to keep the brain cells of a life baby alive and functioning. So, if there is cut off of oxygen, the brain cells, may die thereby causing damage to the auditory brain stem area responsible for hearing.

Premature and low-birth weight infants weighing under two pounds and those born weighing less than four pounds are at greater risk of hearing loss (Kirk, Gallagher, Anastasion & Coleman, 2006). Researches have also revealed that the increasingly successful life saving technique being used in neonate nurseries has

increased cases of infants with hearing losses (Newton & Stokes, 1999; Rais-Bahrami, Short & Batshaw, 2002).

Other causes like accident, X-ray, perforation of eardrum, mumps, poor nutrition and ototoxicity can cause various degree of hearing impairment in children and adults (Mba, 1995).

2.6 Adolescence

Adolescence originates from the Latin word "adolescere" which means to "grow into maturity" or "grow up". Adolescence is the term given to one of the stages, precisely, the third stage of human growth and development (Amao-Kehinde, 2008). Another name for this period is teenager because of the age bracket of 13-19 years which majority fall into. It is a period that terminates childhood and marks the entry of adult life. It is a critical and challenging period in human development because it is during this period that an individual begins to develop a stance towards the world or an identity.

Different definitions have been given to the word "Adolescence". Most definitions of adolescence emphasised the difficulty and tension associated with the period while others emphasised the biological changes that are genotypically and phenotypically evident at this particular stage.

Amao-Kehinde (2008) defines adolescence as a "period of storm and stress", a "crisis looming period" a no man's land characterised by overlapping forces and expectation. Falaye (2001) views adolescence as a period of being caught between two worlds. The two worlds (childhood and adulthood) may lead to crises in the life of an adolescent. Gleitman, Fridlund and Reisberg (2004) express that traditionally, adolescence is a period of emotional stress. This notion goes back to the romantic movement of the early nineteenth century when major writers such as the German poet, Johann Wolfgang von Groethe (1749-1833) wrote influential works that featured youths in desperate conflict with cynical adult world that drove them to despair, suicide, negative sexual activities or violent rebellion.

Steinberg (1996) taken from developmental changes point of view defines adolescence as a time of transition and include important biological, social, emotional and cognitive changes that take place quite rapidly over a relatively short period of time accompanied by turmoil. Orji and Anikweze (1998) in Amao-Kehinde (2007) defines adolescence in term of social responses beginning with the increase in interest

in the other sex which is a sign of sexual maturity. He further states that adolescence end with the attainment of social and financial independence. The individual, at this stage has assumed adult age and is accepted in most ways as an adult by his reference group whom he refers his behaviour to, for approval. While Chauhan (1988) describes that adolescence as a process rather then a period; a process of achieving the attitudes and beliefs needed for effective participation in the society. It is obvious that before acceptable and active participation of an individual in the society, he/she needs to achieve attitudes and beliefs that authoritative adults adjudge to be in line with the norms of the society.

Sokan and Akinade (1994) present that, at adolescence period, both boys and girls increase in weight and skeletal structures. The digestive system becomes more mature and spacious. The heart grows bigger about 10-12 times its size at birth. The coronary arteries and vein grow moderately. The brain reaches about 95 percent of adult brain weight. Vital capacity of male lungs is greater than that of girls. These biological metamorphosis helps adolescent to achieve some developmental tasks. Action Health Incorporated (2003) notes that adolescence is a time when young people are learning a great deal about themselves and adjusting to rapid change in their bodies. During early adolescence, many experience a new uncertainty about their bodies and how they function. They need information and assurance about what is happening to them. As they mature, some feel confused about what they are supposed to do in a variety of situations. This includes making sense of evolving relationships with family and peers, coping with new sexual feelings and trying to assess conflicting messages about who they are and what is expected of them.

From the foregoing, adolescence is a critical stage and it actually dictates what adult will be in term of life disposition (personality), adjustment and achievement.

Adolescents with Hearing Impairment Characteristics

Adolescence period is a transition period that is characterised by a lot of developmental crisis. Though transiting from childhood to adolescent stage varies due to social and biological differences, the characteristics peculiar to this stage are universally the same.

Changes such as rapid physical development, which is a product of maturation characterised by developed sexual organs and by this, adolescents tend to acquire new social perspectives and uncertainties unfold because many adolescents are not sure of

the future they are growing into (Oyewumi, 2003). This often brings confusion to adolescents because he or she lacks the experience and coping skills. Oyewumi (2003) states that, the question of right and wrong choices in terms of religion and morality, adequate study which and habits as well as overall adjustment to school situation are among serious knotty problems that confronts the adolescents. These social and psychological pressure may drive adolescents to some for risky behaviour.

Adeniyi (2007) observes that, like all other adolescents, adolescents with hearing impairment are confronted with similar developmental challenges coupled with the impairment they have suffered from. Osowole (1998) citing Schlensinger and Meadow (1972) holds that going by Erickson developmental stages, the deaf child approaches life with delayed or incomplete resolution of the previous crises, that is, trust, autonomy, initiative and competency. The posit that academic, conceptualisation and hearing about interpersonal relationship are deeply affected by language deprivation. This creates confusion as whether to identify with deaf community and hearing society. Ademokoya and Oyewumi (2000) note that hearing impairment leaves an imprint on the child's total development and adjustment. The effect of hearing loss according to them pervades all aspect of communication including, speaking, reading, writing as well as hearing. These factors pose some challenges for adolescents with hearing impairment.

Mba (1995), Onwuchekwa (2005), Alade (2005) and Adeniyi (2007) state that adolescents with hearing impairment also face developmental pressure such feeling as to have sex, expression of love, day dreaming, fantasies and masturbation. In a bid to cope with these challenges, they often engage in risky behaviours such as smoking, drinking and unprotected sexual activities. Osowole (1998) observes that, most adolescents have a consuming interest in everything sexual. There is great interest in finding information about sexual intercourse, including a preoccupation with heterosexual, day dreaming and masturbatory fantasies.

The adolescents with hearing impairment may also be in a state of dilemma when it comes to issues of culture and norms owing to language difficulties which sometimes make them to confuse roles and societal desire. This may result into poor self-image. However, Osowole (1998) opines that some adolescents with hearing impairment can easily associate and even identify with hearing community. Some of them make friends with non-hearing impaired and with this, their self-concept and esteem could be influenced positively.

Conclusively, it is obvious, the same biological, social and psychological phenomenal universally apply to all adolescents not minding the degree of variability in physical, psychological, social and biological attributes. However, owing to the impact of loss of sensory organ and its effect on family, normal situation may be termed as abnormal. Therefore, in order to help adolescents with hearing impairment adapt effectively, Mba (1995) and Osowole (1998) advise that with high and realistic expectation, acceptance of reality, empathy, parent support, creative and thoughtful planning by education and social agencies, adolescent with and without hearing impairment can be helped to live a positive life.

2.7 Family Life and HIV/AIDS Education (FLHE)

The structure of the Nigerian population in the early 1980s brought about the emergence of the population/Family Life Education (Pop/FLE) programme, which the Nigerian Education Research and Development Council (NEDRC) has successfully implemented in Nigeria to date. However, the resolution and programme of action of the 1994 International Conference on Population and Development (ICPD) made it imperative that emphasis should now be on Reproductive Health including Family Planning and Sexual Health amongst other issues of human population.

Furthermore, the global concern and the recent scourge of HIV/AIDS in Nigeria brought to the fore the urgent need to deal with adolescents' reproductive health issue without further delay. In 1998 for instance, 60 percent of all reported cases of HIV/AIDS came from the age of 15-24 years, which constitute more than 50 percent of the national population. In order to vigorously mainstream HIV/AIDS prevention in schools, the sexuality education curriculum had to be reviewed and re-designated as Family Life and HIV/AIDS Education (FLHE) Curriculum of Primary, Secondary and Tertiary levels of education in Nigeria. Precisely, the directive of the 49th session of the National Council on Education (NCE) in September 2002 which authorised total inclusiveness of state concerns about culturally acceptable humanity terms gave rise to Family Life and HIV/AIDS Education (FLHE).

What is Family Life and HIV/AIDS Education (FLHE)? Family Life and HIV/AIDS Education (FLHE) is a planned process of education that fosters the acquisition of factual information, formation of positive attitudes, beliefs and values as well as development of skills to cope with the biological, psychological, socio-cultural and spiritual aspects of human living (NERDC, 2003). Association for

Reproductive and Family Health (ARFH) and Independent living for people with disabilities (ILPD) (1999) define Family Life and HIV/AIDS Education (FLHE) as a planned programme of education about human development, relationships, sexuality and the development of personal skills. The National Guidelines Task Force (1996) defines sexuality education otherwise known as Family Life and HIV/AIDS Education (FLHE) as a long life process of acquiring information and forming attitudes, beliefs, values identity, relationship and intimacy. It encompasses sexual developments, reproductive health, interpersonal relationship, affection, intimacy, body image and gender roles.

The main goal of Family Life and HIV/AIDS Education (FLHE) is the promotion of preventive education by providing learners with opportunities:

- to develop a positive and factual view of self.
- to acquire the information and skills they need to take care of their health including preventing HIV/AIDS.
- to respect and value themselves and others,
- and to acquire the skills needed to make health decision about their sexual health and behaviour (NERDC, 2003).

Family Life and HIV/AIDS Education (FLHE) becomes imperative in schools and colleges because adolescence or young adulthood stage is a time when young people are learning greatly about themselves and adjusting to rapidly changing bodies. During early adolescence, many experience a new uncertainty about their bodies and how they function. They need information and assurance about what is happening to them. Even as they mature, some feel confused about what they are supposed to do in a variety of situations making sense of evolving relationship with family and peers, experiencing new body feelings, and trying to assess conflicting messages about who they are and what is expected of them (NERDC, 2003; ARFH & ILPD, 2006).

The curriculum of Family Life and HIV/AIDS Education (FLHE) is structured in such a way that it provides a framework for the acquisition of knowledge of self and family living from childhood to adulthood. It also reflects a comprehensive approach to HIV/AIDS prevention education from primary to tertiary level of education. Hence, the curriculum is organised around six themes. These are human development; personal skills; sexual health; relationship; sexual behaviour and society and culture.

Each item covers knowledge, attitude and the necessary skills that are age-appropriate.

The following, according to NERDC (2003) describes the special attributes of the Family Life and HIV/AIDS Education (FLHE) curriculum:

- it is learner-oriented as the many activities are geared towards making learning practical and pupil-centred;
- the content to be learnt are spirally arranged so that there is continuity and rising depth of content as the student moves from one level to the other;
- the content has been selected and organized using thematic approach because of its robustness and ability to accommodate more content without necessarily overloading the school curriculum; and
- the curriculum as structured will lead to the comprehensive coverage of the topic listed; leading to the achievement of intended learning outcomes.

Unfortunately, many people still believe that teaching about sexuality would encourage sexual experimentation even though several studies have been conducted to determine whether Family Life and HIV/AIDS Education (FLHE) programmes actually increase young people body abuse (ARFH & ILPD, 2006; NERDC, 2003). Harrison and Hillier (1999) affirm that sexuality education programme emphasises more on the dangers rather than pleasures of human relationship and sexuality. It must be noted that Family Life and HIV/AIDS Education (FLHE) serves as a life long process of learning and acquiring information and adequate knowledge, attitude, beliefs and value about identity relationship and intimacy. According to ARFH (2006), sexuality education or Family Life and HIV/AIDS Education (FLHE) would expose children, adolescents and adults to sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image and gender roles. This points to the fact that sexuality education addresses the biological, socio-cultural, psychological and spiritual dimensions of sexuality through the cognitive and affective domain to behavioural dimension which include the skills for effective communication and making responsible decision.

Family Life and HIV/AIDS Education (FLHE) seeks to assist individuals in having a clear and factual view of sexuality, since it is an integral part of life long

learning process, beginning with early childhood and continuing into adult life. It is also hoped that this type of education will serve as forum for enlightenment, encouragement, searchlight for children, youths and adults to be able to develop positive attitude towards their sexual life and coping skills against life challenges.

Oloyede (2000) notes that youths want opportunity to clarify attitudes and values which will help them to consider how they will adjust to moral code. In this wise, youths must be led through a comprehensive programme that will make them to be rational in all ramification. The whole curriculum of Family Life and HIV/AIDS Education (FLHE) desired outcome is to make Nigerian youths and adults be able to explore and assess their sexual attitudes in order to develop their own value, enhance self-esteem and to develop insight concerning relationship with others and especially members of both sexes, and understand their obligation and responsibilities to others.

Jonathan-Ibeagha, Adedimeji and Ibeagha (1999) in their study on involving the church in the provision of Family Life Education record outstanding improvement in knowledge and skills needed to cope with life challenges among Christian participants. It is therefore imperative to note that Family Life and HIV/AIDS Education (FLHE) will help both youths and adults to acquire right knowledge and attitude and the skills needed to live successful life. NERDC (2003) notes that the youths should be helped via different media to develop a positive sense of their own self by creating opportunities for them to consider all aspects of humanity. This is because understanding the facets of one's humanity is a life long process. It involves acquiring information and forming attitude and values about identity, relationship and intimacy.

Specifically, Family Life and HIV/AIDS Education emphasises the training of personal skills which are considered as tools to fight life challenges. The skills are self-esteem, goal setting, decision-making, values, communication, assertiveness, negotiation and finding help (AHI, 1996; NERDC, 2003 and ARFH, 2006). It is worthy to note that healthy sexuality requires the development and use of specific personal and interpersonal skills.

2.7.1 Self-esteem

Self-esteem refers to global evaluations of self and it can also be regarded as self-worth or self-image (Santrock, 2002). For example, a person may perceive that he or she is not merely a person but a good person. This is a clear indication of

worthiness of that person. Branden (1997) defines self-esteem as the disposition to experience oneself as being competent to cope with the basic challenges of life and of being worthy of happiness. To him, it is confidence in the efficacy of our mind, in our ability to think. By extension, it is confidence in our ability to learn, make appropriate choice and decisions, and respond effectively to change. It is also the experience that success, achievement, fulfillment and happiness are right and natural for us (Brunden, 1997). Rosenberg, Scholars, Schoenbach and Rosenberg (1995) refer to self-esteem as the totalities of personal attributes rather than a single dimension. In this sense, self-esteem can be considered as the reflector of the personality of man's social, psychological and cognitive disposition. Jambor and Elliott (2005) in line with the above assert that self-esteem is a principal component of mental health.

Self-esteem is an important concept since it is shown to have a pervasive and powerful impact on human cognition, motivation, emotion and behaviour (Campbell & Lavallee, 1993). Studies have shown that it is highly correlated with overall psychological well-being (Rosenberg, et al 1995); achievement (Campbell & Lavallee, 1993), ability to cope with stressful life events (Campbell & Lavallee, 1993) and sexual behaviour (Morris, Young & Jone, 2000). It is therefore worthy to say that individual's self-esteem determine the extent of his or her life accomplishment.

Researches have shown that self-esteem is not innate and can change (Branden, 1997 & Santrock, 2002). It can be high and low (Santrock, 2002; Jambor & Elliott, 2005) and can be built over a period of time and not induced by drug (Branden, 1997). Santrock (2002) posits that self-esteem can change especially in response to transition in life. For example, when children go from elementary school to middle school, their self-esteem usually drops (Hawkins & Berndt in Santrock, 2002). Low self-esteem is linked with depression (Harter, 1998). The failure to live up to one's standard is especially implicated in connection between low self-esteem and depression. And also low self-esteem is linked with membership of minority group. Jambor and Elliott (2005) argue that minority membership especially people with disabilities have relatively low self-esteem owing to their lower status in society. Several studies conducted on ethnic minorities and disabilities status lend supports to the fact there is significant influence of the variables of self-esteem on individuals (Verkuyten, 2003; Way & Robinson, 2003; Bat-Chara, 1993).

Branden (1997) notes that, self-esteem is not euphoria or buoyancy that may be temporarily induced by drug, a compliment or a love affair. It is not an illusion or

hallucination. If it is not grounded in reality, if it is not built over time through the appropriate operation of mind, it is not self-esteem. He therefore presented six pillars of building self-esteem namely:

The practice of living consciously: Respect for fact; being presented to what we are doing while doing it; seeking and being eagerly open to any information, knowledge, or feedback that bears on our interests, values, goal and projects; seeking to understand not only the world external but also our inner world, so that we do not get out of self-blindness.

The practice of self-acceptance: The willingness to own, experience, and take responsibility of our thoughts, feelings actions, without evasion, denial or disowning and also without self-repudiation, giving oneself permission to think one's thoughts, experiences one's emotions and look at one's actions without necessarily linking, endorsing, or condemning them; the virtue of realism applied to the self.

The practice of self-assertiveness: Being authentic with others; treating our values and persons with decent respect in social context; refusing to fake the reality of who we are or what we esteem in order to avoid disapproval; the willingness to stand up for ourselves and ideas in appropriate ways in appropriate contexts.

The practice of self-responsibility: Realising that we are the author of our choices and actions, that each one of us is responsible for life and well-being and for the attainment of our goals; that if we need the cooperation of other people to achieve our goals, we must offer value in exchange; and that question is not "Who's to blame" but always "what needs to be done?"

The practice of living purposefully: Identify our short-term and long-term goals or purposes and the actions needed to attain them (formulating an action plan); organising behaviour in the service of those goal, monitoring action to be sure we stay on track; and paying attention to outcome so as to recognise if and when we need to go back to the drawing-board.

The practice of personal integrity: Living with congruence between what we know, what we profess and what we do; telling the truth, honouring our commitments exemplify in action the value we profess to admire. What all these practices have in concern is respect for reality. They all entail at their core, a set of mental operations which naturally have consequences in the external world.

Since self-esteem virtually affects the total activities of man, studies have indicated that there is correlation between self-esteem and sexual behaviour of people

which in turn may influence the rate of vulnerability to diseases. Studies by Stratton and Spitzer (1967) in Morris and Young (2000), Stimson, Stimson and Doherty (1980) all find that low self-esteem could influence sexual permissiveness. However, MacCorquodale and DeLamater (1979), Hally and Pollack (1993), Cole and Slocumb (1995) and Hollar and Snizek (1996) all report that high self-esteem could influence risky sexual behaviour. It is reasonable here to conclude that self-esteem plays significant roles in making and marring personality of individual in the society.

2.7.2 Goal-setting

Goal-setting, according to Locke and Lathan (1990), is defined as a drive to reach a clearly defined end and this end is a reward in itself Glenn (2003) in his book Motivate to Educate define goal-setting as the act of taking the necessary steps to transferring dreams and or intentions to a format whereby achieving a goal constitute the primary motivating force behind work behaviour. The purpose of goal to him is to ultimately empower, authorise and enable one to move from dependency to independence or self-dependency.

Hanson (2007) notes that most children know little about goal-setting and most receive no instruction on how to do it. This might account for several unexpected outcome in term of behaviour or academic achievement. It must be noted that without goals, one seldom accomplishes anything. Hanson further observes that successful goal attainment furthers students' motivation in learning. This he believes that teaching of goal-setting skill in school to the adolescent will aid self-monitoring and evaluation.

The concept of goal pursuit is critical in students' achievement and motivation. Several studies have examined correlation among students' measure of cognitive ability, self-motivation, scholastic achievement and goal-setting and most studies have focused primarily on effects of goal-setting, self-efficacy and attribution on self-motivation (Itiemstra, 1996). Wood and Bandura (1989) in Pi-Yueh and Wen-Bin (2010) studied graduate students' self-efficiency in goal-setting and task achievement. The outcome of the study reflects that goal-setting influence ability and motivation to learn. Moreover, goal theorists agreed that perceived competence is influenced by goals (Ames, 1992; Urdan & Maehr, 1995). In addition, Locke, Fredrick and Bobko (1984) in Pi-Yueh and Wen-Bin (2010), Tanaka and Yamauchi (2001) and Locke and Lathan (1990) all note that task performance is influenced by

goal-setting. Also, Wright, O'leary-Kelly Cortina, Klein and Hollenbeck (1994) find that goal commitment was correlated statistically significantly with task performance. In essence a life without goal is not rational and will definitely be empty of achievement be it in behavioural and academic terms.

Goal-setting helps individual to achieve more since it provides one with a sense of direction and enable one to avoid distraction (Ajufo, 2003; Arina, 2005). In line with the above Covington (2000) notes that like academic goals, the pursuit of social goal can help organise, direct and empower individuals to achieve more fully.

Goal-setting increases an individual's motivation to achieve (Donohue, 2002). This is possible because the process of achieving goals and seeing this achievement gives confidence that one will be able to achieve higher and more difficult goals. It also increases pride and satisfaction and confidence in one's achievement. In addition, goal-setting helps to eliminate attitude that could hold an individual back and cause stress and unhappiness.

Therefore, goal-setting is desirable in all sphere of life be it academic, social, spiritual and sexual life as this helps individuals to be self-regulated and self-actualised.

2.7.3 Decision-making

Decision-making is a conscious and rational process in which a person carefully considers all options and corresponding outcome (Curry, 2004). The process of decision-making is constantly guided by cognitive capacities and some related characteristics. This is why making a decision is not just merely a cognitive process (Byrness, 2002; Cauffman & Steinberg, 2000; Scott, Reppucci & Woolard, 1995). Early theories of decision-making (Furby & Beyth-maron, 1992; Janis & Mann, 1997; Shaklee, 1979; Goldberg, 1968) are grounded in utility theory models burrowed from economic theory. In these theories, decision-making was idealized as a conscious, rational process in which a person considers options and its corresponding outcomes. The utility theory believes that people can and do associate appropriate probabilities with each outcome and then add personal utility or preference indices to each. It is suggestive of this theory that people make rational selection after considering all relevant information in order to maximise their personal utility or to minimise personal risk (Curry, 2004). This theory serves as basis for "normative" decision-making.

In normative decision-making models, the following processes are involved: These processes are: (i) identification of all possible choices (ii) the gathering of all relevant information pertaining to those options, including the likelihood of various consequences of selecting or not selecting each action (iii) identification of relevant goals of the decision (iv) evaluation of each possible outcome based on personal beliefs and values (v) a method of selection among all options and (vi) review of decision before implementation (Furby & Beyth-Marom, 1992; Ormond, Luszez, Mann & Beswick, 1991). Rolison and Scherman (2002) in their study on decision-making find that before a decision is reached, the benefits and disadvantages of the decision would have been evaluated. Hence, any decision reached by anybody is a product of consideration of good and bad sides and it comes out of mind judgement.

2.8 Adolescents with Hearing Impairment Knowledge of HIV/AIDS

Adolescent period is reported to be a time of confusion, experimentation, conformity and discovery of what adulthood is. This developmental pressure predisposes adolescents of all category to so many risks especially sexual risk which is a major form for the spread of HIV/AIDS.

HIV/AIDS is widely reported to be common among adolescents because they are sexually active, mobile and want to experiment what adults do. Of concern, the impact of AIDS has been most serious in Sub-Saharan Africa as the region contain almost three quarters of all young people living with HIV/AIDS (World Youth Report, 2003).

Unfortunately, studies from around the globe have established that the vast majority of young people including the hearing impaired remain uninformed about HIV/AIDS (World Youth Report, 2003). It must be noted that education is closely linked to a young person's ability to avoid HIV/AIDS (Bankole, Singh, Woog & Wulf, 2004). UNICEF and WHO (2002) reported that young people's understanding of AIDS related issues are vastly low as male and female adolescents were found to be uninformed with high unawareness level among girls aged 15-19 years in Sub-Saharan Africa. The finding above also includes adolescent with hearing impairment.

Bankole, Singh, Woog and Wulf (2004) note that despite the international attention that the HIV/AIDS epidemic has received, knowledge of the disease is not universal among young people in Sub-Saharan Africa in which Nigeria is a prominent country. They argue further that even those who know about HIV/AIDS, perception

of personal risk are sometimes at odd with reality. This to a large extent account for high incidence of this pandemic disease among adolescents whether with or without disability.

Studies researching young people's understanding of AIDS-related issues especially among countries with generalised epidemic such as Nigeria, Cameroon, Equatorial Guinea, Sierra Leone indicated that more than 80 percent of young woman aged 15-24 years did not have sufficient knowledge about HIV/AIDS. Half of the girls in this age group did not know how to protect themselves from the virus (World Youth Report, 2003). Corroborating the above finding, UNICEF and WHO (2002) argue that though a large number of adolescents may have some knowledge about AIDS, their understanding unfortunately often lack depth. This inability of adolescents to fully comprehend the extent of their exposure to risk and the potentially dangerous situation results make them vulnerable.

Of greater concern is the paucity of studies and information among disabled youths especially the deaf on the issues of the HIV/AIDS among them (Osowole & Oladepo, 2001).

Osowole and Oladepo (2001) argue that adolescents with hearing impairment like any other ones may have sex because they have deep feelings of love and attraction for their partners or may engage in high risk or rebellious sexual behaviour because they are emotionally troubled and may get infected with sexually transmitted infections including HIV.

Sugar (1990) in Osowole and Oladepo (2001) intimate that studies have revealed that disabled especially the hearing impaired received little or no sexuality education. This reason was hinged on the assumption that people with disabilities are not or should not be sexually active. This assumption portend great danger as adolescents with hearing impaired may continue to spread their disease through their unprotected sexual adventure because of the neglect and lack of information (Groce, 2003; Kelly, et al, 2002).

Ademokoya and Oyewumi (2004) corroborating the above state further that the special needs students, especially those with hearing impairment unlike non-special needs individuals acquire less information from sources such as books, casual conversation and television because of challenge in internalising verbal language and often confuse some human activities on electronic media because of their auditory dysfunction. Thus inability to hear and speak often make it very difficult to

disseminate sex information to them (Akinyemi, 1998; Woodroffe, Gorenflo, Meador & Zazove, 1998). As a result, adolescents with hearing impairment tend to have low level of literacy, poorly educated and highly marginalised as messages of AIDS carried over television, radio and public discussion often do not reach them. To worsen the situation, confusion caused by the actual translation of HIV/AIDS messages into sign language without adequate understanding of the local sign language or deaf community is of concern because of potential inaccuracies (Peinkofer, 1994; Mba, 1995; Gasking, 1999). It is obvious that adolescents with hearing impairment stand double jeopardy as they suffer neglect from their environment as well as the condition of their disabilities.

Generally, the inability of adolescents with hearing impairment to fully comprehend the extent of their exposure to risk and lack of adequate skills to cope with developmental challenges make them vulnerable. Lacking the judgement that comes from experience, adolescents generally often cannot appreciate the adverse consequences of their behaviour. Younger adolescents in particular may lack the ability to use abstract thought to predict how their actions may relate to future or to understand the consequences of certain acts (World Youth Report, 2003). All these account for adolescent low or poor knowledge about HIV/AIDS.

2.9 Adolescents with Hearing Impairment Attitude to HIV/AIDS

Despite the devastation caused by AIDS, young people may not change their risk behaviour because the consequences of their actions are not immediately apparent owing to the long incubation period between infection and disease onset (World Youth Report, 2003).

Bekele (2005) reports that adolescent with disabilities especially the hearing impaired demonstrated poor attitude to the message of HIV/AIDS as they don't see anything bad in having unprotected sex with their partners as well as having more than one partners. This attitude is in no small measure contributed to unabated spread of HIV/AIDS. Osowole and Oladepo (2001) also inform that attitudinal disposition of adolescents with hearing impairment to perceived susceptibility to AIDS was low as they reported to be engaging in multiple sex partners.

Vandel (1999) avers that many people do not see themselves being vulnerable to HIV infection or transmission because of misconception in some questions. World Youth Report (2003) note with great concern that even when youths know the risks,

however many adolescents especially adolescents with hearing impairment believe themselves invulnerable. UNICEF and WHO (2002) finding reveals that 95 percent of girls aged 15-19 years in Nigeria perceived their risk of HIV infection to be minimal.

In another dimension, Makinwa-Adebusoye (2003) reports that many adolescents in Sub-Saharan Africa dislike the use of condom because they believe it reduces sexual pleasures or is perceived to be ineffective or defective. With this mindset and uncontrolled sexual adventure, HIV/AIDS prevention and control cannot be easily achieved.

Furthermore, Campbell (2000) notes that even when the risk of infection is understood by the adolescents, especially adolescents with hearing impairment, some of them ignore it. Many young people purposely downplay or overlook the risks because they are afraid to ask about a partner's history or that a condom be used, for fear it might endanger their relationship. Others engage in risky sex for money which may seem, or indeed be, a more urgent priority (Gardner, Blackburn & Padhyau, 1999). The attitudes reported above are common with people with hearing impairment.

At times, adolescents cannot calculate the risk of their behaviour because they are under the influence of mind-altering drugs. The lack of inhibition associated with high alcohol consumption and some drugs used may result in unprotected sex (Campbell, 2000). World Youth Report (2003) also note that intoxication can complicate condom use and the ability to negotiate safer sex with another person. This uncalled for attitude might be hinged on lack of counsel and skills needed to cope with developmental challenges.

Significantly, adolescence is a time when young people naturally explore and take risks in many aspects of their lives including sexual relationships. Those who have sex may change partners frequently, have more than one partner at the same time or engage in unprotected sex. All of these behaviours increase young people's risk of contrasting HIV.

2.10 Theoretical Background

Interventions to stem the spread of HIV/AIDS throughout the world are as varied as the contexts in which we find them. Not only is the HIV/AIDS epidemic dynamic in terms of treatment options, prevention strategies and disease progression, but sexual behaviour, which remains the primary target of AIDS prevention efforts

worldwide, is widely diverse and deeply embedded in individual desires, social and cultural relationship, and environmental and economic processes (UNAID, 1999). This makes prevention of HIV, which could be an essentially simple task, enormously complex involving a multiplicity of dimensions. Either implicitly or explicitly, all preventions and interventions are based on theory. The theories are reviewed in view of variables considered.

2.10.1 Theories on Attitudes and Knowledge/Health Belief Model

The Health Belief Model, developed in the 1950s, holds that health behaviour is a function of individual's socio-demographic characteristics, knowledge and attitudes. According to this model, a person must hold the following beliefs in order to be able to change behaviour.

1. Perceived susceptibility to particular health problem ("am I at risk of HIV?").
2. Perceived seriousness of the condition ("how serious is AIDS; how hard would my life be if I get it?")
3. Belief in effectiveness of the behaviour ("condoms are effective against HIV transmission")
4. Cues to action ("witnessing the death or illness of a close friend or relation due to AIDS")
5. Perceived benefits of preventive action ("if I start using condom, I can avoid HIV infection")
6. Barriers to taking action ("I don't like using condom")

In this model, promoting action to change behaviour includes changing individual personal beliefs. Individual weighs the benefits against the perceived costs and barrier to change. For change to occur, benefits must outweigh costs. With respect to HIV, interventions and preventions often target perception of risk, benefits in severity of AIDS ("these is no cure") belief in effectiveness of personal skills or delaying of sexual relationship.

2.10.2 Social Cognitive (or Learning) Theory

The premise of the social cognitive or social learning theory (SCT) states that new behaviours are learned either by modelling the behaviour of others or by direct experience. Social learning theory focuses on the important roles played by vicarious,

symbolic and self-regulatory processes in psychological functioning and looks at human behaviour as interaction between cognitive behavioural and environmental determinants (Bandura, 1977). Central tenets of the social cognitive theory are:

- self-efficacy – the belief in the ability to implement the necessary behaviour.
- outcome experiences – beliefs about outcomes. Programmes built on social cognitive theory (SCT) integrate information and attitudinal change to enhance motivation and reinforcement of risk reduction skills and self-efficacy. Specifically, activities focus on the experience people have in talking to their partners about sex AIDS prevention method, and the types of environmental barriers to risk reduction.

The theories on knowledge and attitude hold that both knowledge and attitudes are major determinants of efficacy of a particular behaviour and they are learnt construct. In essence, according to the theories both attitude and knowledge can be influence by presentation of appropriate information. This attitude to, knowledge of, perception and belief about HIV/AIDS can be improved by given relevant information or messages and teaching of relevant behavioural coping skills.

2.10.3 Theory on Decision-making

The theory of reasoned action was advanced in mid-1960s by Fishbein and Ajzen. The theory is based on the assumption that human beings are quite rational and make systematic use of information available to them to take action. People consider the implications of their actions in a given context at a given time before they decide to engage or not engage in a given behaviour, and that most actions of social relevance are under volitional control (Ajzen, 1980). The theory of reason action is conceptually similar to the health belief model but adds the constraint of behavioural intention as a determinant of behavioural intention as a determinant of health behaviour. The theory of reasoned action specifically focuses on the role of personal intention in determining whether a behaviour will occur. A person's intention is a function of two basic determinant (i) attitude (toward the behaviour) and (ii) subjective norms i.e. social influence. Normative beliefs play a central role in the theory and generally focus on what an individual believe of other people, especially influenced people, what would expect him or her to do.

The implication of this theory is that to every decision taking by man, the cost and the gain would have been weighed before arriving at a particular action (decision-making). Hence, sexual activities of the adolescents are greatly influenced by the perceived gain they will derive from the act. The perceived gain may bring positive and negative dividends.

2.10.4 Goal-setting Theory

Goal-setting theory is one of the most popular theories in organisation psychology. The theory was postulated by Edwin A. Locke in the mid 60s and research still continues on it till today.

Locke derived the idea for goal-setting out of Aristotle's theory of final causality. According to Aristotle, action is caused by purpose; thus Locke starts researching the impact of goals have on individual achievement. For goal to increase achievement, it is imperative that they are difficult and specific. Achievement tends to be lower with easily attained goal than with more difficult goals. A vague goal is not likely to enhance achievement. A specific goal can be given through quantification or enumeration, which is using a certain number or a list, such as increasing productivity by 20% or by giving certain task that need to be completed (Locke, 1996).

Goals can affect achievement in three ways. First, goals narrow attention and direct efforts to goal relevant activities and away from undesirable and irrelevant actions. Second, goals can lead to more effort. Third, goals influence persistence. You are more likely to try harder, if you are pursuing a goal (Locke, 2002)

The goal achievement relationship is subject to various moderators. Goal commitment is the most influential moderator. Goal commitment is especially important with difficult of complex goals. Self-efficacy is a second moderator in goal-setting theory. The higher someone's self-efficacy regarding a certain task, the more likely they will be able to set higher goal and the more persistent they will be in achieving it (Lock, 2001).

Goal theory has revealed that setting goals and commitment to such goals influence attainment of desired vision (achievement). Obviously, anybody without any mind set and desire will not achieve anything in life. However, pupils and students at pre and secondary level of education are frequently ignored in the area of goal setting. This adversely affects the adolescents in all areas of life including sexual life. It is therefore imperative to inculcate goal-setting spirit in children as a skill that

will help them to achieve life vision. This can regulate the rate of sexual adventure of young people be it hearing and non-hearing individuals.

2.10.5 Theory of Self-esteem/Self-worth Theory

The self-worth theory propounded by Covinton (1998) and Covinton and Berry (1976) assume that the achievement of goals whether learning oriented or performance oriented reflect a promethean life-spacing struggle to establish and maintain a sense of worth and belonging in a society that value competency and doing well.

In effect, in our society individuals are widely considered to be only as worthy as their ability to achieve. For these reasons, the kinds of grade students achieve are the unmistakable measure by which many, if not most, youngster judge their worth as students.

Yet, although a grade focus dominates, it is the way students define success that is the all-important factor by which self-esteem mechanisms operate to effect achievement. For example, students who are success oriented define success in terms of becoming the best they can be irrespective of the accomplishment of others. They also value pushing the envelope of their current skills and understanding through diligence and hard work. Success oriented students value ability as much as do others, but as a tool or resources to achieve personally meaningful goals. By contrast, other students value ability as a matter of status which means defining competency in term of doing better than other academically and in the process, they are often force to avoid failure or at least avoid the implication of failure.

This theory has basically revealed that view about oneself goes a long way to effecting the kind of behaviour that would be exhibited which may invariably affect life goal. It is therefore worthy to note that self-esteem whether positive or negative, high or low can affect man's disposition sexually.

2.11 Empirical Studies

2.11.1 Adolescents with hearing impairment Attitudes to HIV/AIDS

Behavioural, physiological and socio-cultural factors make young people with and without hearing impairment more vulnerable than adults to HIV infection. Adolescence is a time when young people naturally explore and take risks in many aspects of their lives, including sexual relationships.

Bisol, Sperb, Brewer, Kato and Shor-Posner (2008) carried out a research on HIV/AIDS knowledge and health-related attitudes and behaviours among 42 deaf and 50 hearing adolescents in Southern Brazil find no significant differences in the health-related attitude and behaviour among the participants. However, the report indicated a high rate of sexual abuse by deaf participants and a large number of the deaf adolescents having friends with AIDS victims. The result above evidently showed poor attitude to HIV/AIDS. Also, Fakolade, Adeniyi and Tella (2005) in their study on comparative of risk behaviours and HIV/AIDS awareness among 60 adolescents with hearing impairment and 60 non-hearing impaired adolescents indicate that there is significant difference in risk behaviours of the participants. The hearing impaired were found to be highly involved in risky sexual activities. This might be as a result of limited information about the deadly disease called HIV/AIDS.

Also, Osowole and Oladepo (2001) investigate knowledge, attitude and perceived susceptibility to AIDS among 304 deaf secondary school students in two southwestern cities in Nigeria found low attitudinal disposition to the issue of HIV/AIDS. This is a clear indication of negative disposition and lack of sexual coping skill. In a related study by Bekele (2003) on knowledge, attitude and behaviour of students with disabilities about HIV/AIDS preventive measure, it was found that out of 80 hearing impaired participants, over 60% of the participants demonstrated poor attitude to HIV/AIDS spread and precaution. The implication of the above is that students with hearing impairment are greatly at risk of this deadly disease.

Osowole (1998) reports that (CDC, 1992 and Kolbe, 1990) carried out a national school-based Youth Risk Behaviour Survey in District of Columbia, Pilleto Rico and Virgin Colands. The questionnaire comprised of the following: (i) Have they ever had sexual intercourse? (ii) Have they partners been told by a doctor or nurse that they had STD? (iii) Did their sex partners used condoms to prevent STDs in the recent time they had sexual intercourse? The results showed that 55 percent reported ever having had sex and forty percent had sex in the last three week before the survey. Among the sexually active students, 78 percent of male and 77.8 percent of female students did not practice safer sex during their last sexual intercourse. 5 percent of the subjects reported having had sexually transmitted disease and 50 percent of the male and 41 percent of the female students reported that their sexual partners used condom during sexual intercourse.

In Ibadan, Nigeria, a study was carried out to identify risky sexual behaviour among 30 selected males in a secondary school, and it was discovered that 75 percent have had man to woman sexual intercourse in the last twelve months, 54 percent with commercial sex workers and 60 percent of them had more than one sexual partners (Jinadu & Odesanmi, 1993). In the same line, Makinwa-Adeboye (1992) finds that high percentage adolescents in urban areas in Nigeria of both sexes had sporadic sexual behaviour especially males having multiple sexual partners. It must be noted that adolescents with hearing impairment are not left out of the practice.

In Tanzania, Ndeki, Klepp and Mliga (1994) carry out a survey on knowledge, perceived risk of AIDS and sexual behaviour among primary school children in two areas of Tanzania, discovered girls than boys and 38 percent of boys had more sexual intercourse against 15 percent girls.

However, a study by Doyle (1995) on AIDS knowledge, attitude and behaviours among 84 deaf college students in Gallaudet University revealed that students in the sample reported moderate degree of comfort in discussing safe sex issues with their sexual partners. The result in the study above is however not enough evidence of generalisation.

From the above revelations, it is obvious that adolescents are sexually active and have poor attitude to safe sex which may make them vulnerable to sexually transmitted diseases including the monster "HIV/AIDS".

2.11.2 Adolescents with Hearing Impairment Knowledge of HIV/AIDS

Currently, there are studies on adolescents and HIV/AIDS worldwide. Majority of the studies have centred on the adolescents' knowledge of HIV/AIDS. Osowole (1998) reports a study carried out in U.S.A. by Gonzale and Lukner, (1993) among people with hearing impairment and those hard of hearing on what they know and think about HIV/AIDS. They discovered that adolescents with hearing impairment have a general idea about HIV/AIDS and the effect on a person. However, they had no knowledge about the transmission and prevention of HIV/AIDS and who is infected. They recommended educational package on HIV/AIDS for adolescents with hearing impairment considering the fact that the signs may not manifest for a long time.

Also, Groce, Yousafzai and Van der Mass (2005) carried out a survey comparing knowledge about HIV/AIDS among 100 deaf and hard of hearing

participants in Nigeria. The result revealed significance difference in levels of understanding about certain aspects of how AIDS is spread as well as differences in available resources for access accurate information among deaf members of the population. They strongly recommended the need for the development of intervention that include people with disability in public health and HIV/AIDS strategies that address their specific vulnerabilities.

In a related finding, Bisol, Sperb, Brewer, Kato and Shor-Posner (2008) conducted a study on HIV/AIDS knowledge and health-related behaviour: a hearing versus deaf or a boy versus girl issue among 92 participants find that deaf participants had lower levels of HIV/AIDS knowledge and of school education. The result calls for an improved school based instruction. Studies by Groce, Yousafzai, Dlamini and Wirz (2004) on HIV/AIDS knowledge among 191 deaf population in Swaziland revealed significant difference in level of knowledge about HIV/AIDS. The deaf population was significantly more likely to believe in incorrect mode of transmission and HIV prevention.

Also, survey from 40 countries indicate that over 50 percent of young people habour serious misconception about HIV transmission. In Lesotho and South Africa for example 50 to 75 percent of females age 15-19 years do not know that a person with HIV may look healthy. The inability of adolescents including adolescents with hearing impairment to fully comprehend the extent of their exposure to risk and the potentially dangerous results make them vulnerable (World Bank Report, 2003).

Furthermore, Osowole and Oladepo (2001) in their study in knowledge, attitude and perceived susceptibility to AIDS among 304 deaf school students revealed high HIV/AIDS awareness with demonstrated gabs in knowledge particularly in terms of causation, transmission and prevention. The outcome is the suggestion of developing and implementing school health education programmes on AIDS.

However, Bekele (2003) investigation on knowledge, attitude and behaviour of 160 students with disabilities about HIV/AIDS preventive measures indicates that the participants had correct knowledge about the preventive measure of HIV/AIDS. Also, in a related research, Doyle (1995) in his survey of AIDS knowledge, attitude and behaviour among 84 deaf college students reveals high levels of HIV/AIDS knowledge and moderate degree of comfort in discussing safe sex issue with sexual partners.

Premmanik, Chartier and Koopman (2006) investigated HIV/AIDS stigma and knowledge among 186 predominantly middle-class high school students in New Delhi revealed that, they generally lacked accurate knowledge about the disease. Female adolescents were found to have demonstrated lesser knowledge about HIV/AIDS compared with male adolescents, while the males reported significantly greater exposure to HIV/AIDS education compared with the females. These revelations call for a more proactive approach to issues about HIV/AIDS among all stakeholders in the education of people with hearing impairment.

2.11.3 Gender and Adolescent Sexuality

Behavioural, physiological and socio-cultural factors make young people more vulnerable than adults to HIV infection. Despite the international attention that the HIV/AIDS epidemic has received, knowledge of the disease is not universal among young people in Sub-Sahara Africa (Bankole, Singh, Woog and Wulf, 2004). In a study carried out by Bankole et al (2004), on risk and protection, the result indicated that more than half (51-59%) of women aged 15-19 spontaneously mentioned having more than one sexual partner. In a related finding by Bankole et al (2004) on young people's sexual and marital behaviours, in nine countries in Sub-Sahara Africa, half of young women aged 20-24 have intercourse before marriage and before they turn 20, and in ten others roughly 25-50 percent do so. Among young men also, more 70 percent in 12 countries in Sub-Sahara Africa have premarital intercourse before age 20. The above findings do not exempt adolescents with hearing impairment both male and female. This is clear indication that both male and female adolescent be it hearing and hearing impaired lack basic knowledge and skills to cope with their sexuality and thereby fall prey of developmental pressure.

Premmanik et al (2006) in a study carried out on adolescents knowledge of HIV/AIDS found that female adolescents have lesser knowledge about HIV/AIDS while their male counterparts demonstrated some level of exposure. Yet the level of exposure does not prevent them from engaging in risky sexual activities. It must be noted that knowledge of HIV/AIDS alone may not prevalent the spread of the deadly disease except one develops skills that can help in coping with environmental and developmental pressures. This is obviously lacking in all adolescent whether with or without hearing impairment.

Verga (1997) finds that 61 percent of the participants in his study felt that

AIDS related issues were not appropriate to discuss with partners before having sex as it indicates infidelity among young lovers. This negative decision on the parts of adolescents emanated as a result of poor self value.

However, Cole and Slocumb (1995) revealing impact of self-esteem on sexual behaviour reported that male and female adolescents with high self-esteem were likely to practice risky sexual behaviour because they count it as part of socialisation. On the other hand, Haly and Pollack (1993) reported that adolescents with lower self-esteem may likely engage in inordinate sexual activities.

Based on the above findings, it is obvious that for adolescents to practice safe sex, they need training that will equip them with skills to cope with their developmental pressure (be adolescents with and without hearing impairment).

2.11.4 Self-esteem and Adolescents with Hearing Impairment Sexual Behaviour

Self-esteem which is considered the principal component of mental health is believed to have a pervasive and powerful impact on human cognition, motivation, emotion and behaviour (Campbell & Lavallee, 1993). According to earlier theories of self-esteem, deaf people was believed to have low self-esteem since they belong to a devalued minority group and are likely to internalise the negative attitude of the hearing majority (Lane, 1992). Nonetheless, few empirical studies conducted on self-esteem of deaf individuals do not support this thesis (Bat-chara, 1993, 1994). Rather, these studies argue that deaf people do not inevitably have low self-esteem (Jambo and Elliot, 2005). With these controversies, it can be concluded that people with hearing impairment may have high and low self-esteem.

However, of concern is the paucity of literature that link self-esteem of people with hearing impairment with positive and negative sexual behaviours. It therefore reasonable to affirm that whatever implication that self-esteem has on sexual bahviour of hearing ones will also be applied to individuals with hearing impairment. Literature indicates that at least some aspects of self-esteem are related to early sexual behaviour (knowledge and attitude) (Morris, Young & Jones, 2000).

Stratton and Spitzer (1967) in Morris, Young and Jones (2000), in their study of college student found that their sexually permissive subjects displayed lower self-esteem, as measured by the Rosenberg self-esteem scale than those subjects who did not hold sexually permissive attitudes. These authors explained their result by indicating that lower self-esteem existed among those that were sexually permissive

because the attitude displayed by the subjects was a departure from acceptable societal standard. It must be borne in mind that the major problem of students with hearing impairment is the problem of low self-esteem occasioned by their impairment. Risky sexual activities among them might be traced to low self-esteem with great consequence on their health.

Also, Hally and Pollack (1993) find that college students with wide variety of sexual experiences scored lower in the Rosenberg self-esteem scale than students with narrow range of sexual experience. In line with the above, Orr, Wibrandt, Barrack, Rauch and Ingersoll (1989) in Morris, Young and Jones (2000) in their study of Junior High Students from Blue Collar Homes found that the self-esteem of sexually active adolescent girls was significantly lower than that of virginal girls.

Youg (1989) in Morris, Young and Jones (2000) also find that among early adolescents age 13-15, virgins displayed higher school self-esteem than non-virgins. Also virgins and non-virgins who had no sex in the last few weeks, displayed higher school self-esteem, when compared to non-virgin who indicated they had participated in sexual intercourse at least on time in the last month.

However, Flynn's (1991) study of college students with population of 1,788 found that high self-esteem was directly related to risky sexual behaviour which can influence the contraction of HIV/AIDS. Also, Cole and Slocumb (1995) in their study of college male and female students find that those with high self-esteem as measured by Rosenberg self-esteem scale were likely to practice risky sexual behaviours. Additionally, Hollar and Snizek (1996) using the Rosenberg self-esteem scale, found that in their sample of college students, both males and females with high self-esteem were found to be significantly more likely to engage in what they termed, risky sexual behaviour. And conversely, students with low levels of self-esteem were more likely to participate in non-conventional sexual behaviour.

Also, Walsh (1991) finds in his study, that high self-esteem males and females as measured by Rosenberg's scale, had significantly greater number of sexual partners than their low self-esteem subjects. The attitude displayed above make adolescents to be vulnerable to sexually transmitted disease especially HIV/AIDS.

Vincenzi and Theil (1992) in their study of the impact of AIDS education on 49 participants, found non-significant relationship between self-esteem and safer sex practices. Miller, Christensen and Olson (1987) in Morris, Young and Jones (2000) used the Rosenberg self-esteem scale to examine the relationship of self-esteem and

sexual attitude and behaviour among 2,423 high school students attending public school in Utah, New Mexico and California. The researchers find that in the total sample self-esteem was negatively correlated with sexual attitudes and behaviour. Robinson and Frank (1994) investigate the relationship of self-esteem and sexual activities among a sample of adolescents attending two university-affiliated high schools. They find no significant different in self-esteem as measured by the Coopersmith self-esteem scale, between sexually active and non-sexually action participants, Benson and Torpy (1995) also examine the relationship of self-esteem and other variables in self-reported virginity among the junior high students grades 6-8 in Chicago. They found that when considered in the context of logistical regression analysis, self-esteem was not associated with the age at first sexual intercourse and subsequent ones.

Based on the findings above, it is suggestive to conclude that there is inconclusive evidence to say that self-esteem is or is not related to sexual behaviours and the spread or control of HIV/AIDS.

2.11.5 Decision-making and Adolescents with Hearing Impairment Sexual Behaviour

Many psychologists believe that a major goal of adolescence is to develop a sense of personal identity that is separate from one's parents (Keating, 1990). One of the ways in which adolescents attempt to achieve this goal is by engaging in behaviour that are inconsistent with the norms and values of their parents and other authority figures of conventional society (Curry, 2004). Conventional sexual activities has been perceived to be adolescents greater problem, which is a widely publicised forum through which HIV/AIDS is contracted (Millstein & Halpern-Felsher, 2002). Conventional sexual activities are mostly common among adolescents with hearing impairment because of misconception and misinterpretation of the act and activities (Adeniyi, 2007).

Qualitative works exploring various AIDS-related aspects of African adolescents' sexuality and decision-making especially adolescents with hearing impairment are scarce (Varga, 1997). LeClerc-Madlala (1997) examines black South African youths' reaction to the threat of AIDS and its potential effect on sexual behaviour and attitudes toward sexual relationships. Fear of dying alone was offered by participants as rationale for purposeful attempts to spread HIV by engaging in

unprotected sex with multiple partners. The mind set above may also be conceived in adolescents with hearing impairment.

In another development, Varga and Mukubalo (1996) find AIDS to be a minor issue among teenage girls, with violence and over-riding factor in the sexual decision-making. Oribuloye, Caldwell and Caldwell (1993) explore sexual empowerment of Nigeria (Yoruba) women. The respondents' apparent success in refusing unwanted intercourse was attributed to their economic independence. However, economic dependency of most people with hearing impairment may account for risky decision in term of sexual activities. In Central Africa, McGrath, Rwadakwali and Schumann (1993) worked with Ugandan (Baganda) women. Despite a high level of AIDS awareness, women accepted multiple sex partners for economic need or sexual satisfaction.

Milstein and Halpern Felsher (2002) in their study find a negative correlation between age and perceived vulnerability to the negative consequences of alcohol use and sexual activity but report that all adolescents are more vulnerable to sexually transmitted diseases than young adults because of their tendency to experiment sex and the benefit therein.

In a research carried out by Bankole, Singh, Woog and Wulf (2004), it was discovered that many young people in sub-Saharan Africa dislike condom and do not use it because it reduces sexual pleasure or are perceived to be ineffective or defective. This disposition, of course encourages the spread of sexually transmitted diseases (STDs) and HIV/AIDS. The study further revealed that among teenagers aged 15-19, 10 percent of men and 4 percent of women used a condom at last intercourse. The percentage of adolescents' compliance to preventive measure is too low and may not encourage the reduction or eradication of this deadly disease.

Also, Ajuwon, Olley, Iwalola and Olagoke (2001) surveyed 1,025 adolescent students and apprentices in Ibadan, Nigeria to document their sexual behaviour, they found that males and females that are sexually experienced have multiple partners. Males were found to have had sex with commercial sex workers while most females exchanged sex for money and gifts.

In addition, Varga (1997) carried out a study in sexual decision-making and negotiation in midst of AIDS in South Africa. The study revealed that 61 percent of female participants felt that AIDS related issues were not appropriate to discuss with partners. The male participants did not see any reason for discussing such issues as it

portends infidelity and lack of trust. With special needs especially adolescents with hearing impairment, discussion about such topical issue is totally avoided because they thought that they are invulnerable.

The statistics and attitude indicate that potentially risky sexual behaviour are emerging during adolescence. However, it is likely that the proclivities that underlie sexual risk taking are in place before youngsters become sexually active. Individuals enter adolescence with a set of personality disposition and behavioural tendencies that influence their subsequent behaviour (Raffaelli & Crockett, 2003).

2.11.6 Goal-setting and Adolescents Sexual Behaviour

Locke, Freederick and Bobko (1984), Locke and Latham (1990) and Tanska and Yamauchi (2001) note that task performance is influenced by goal-setting. Wright, O'Leary-Kelly, Klein and Hollebeck (1994) also find goal-setting and commitment to be statistically correlated significantly with task performance. For example, the achievement of college students would be greater if their goals higher. It therefore implies that goal-setting motivates achievement, be it in academic or social life.

Researches that directly link goal-setting and sexual behaviour and goal-setting with adolescents with hearing impairment 's sexual behaviour are a little bit scarce, however, it will be reasonable to adapt the influence of goal-setting in academic achievements to sexual life. According to Social Cognitive Theory (Bandura, 1986, 1991), goals increase people's cognitive drive because goal specify the requirement for personal success. Marzano (2003) finds students' achievement scores in classes whose clear learning goals are more established have higher variation in achievement compared to students who did not clearly established learning goals. In support of the finding, Latham and Locke (1991) agree and suggest that maximum effort is not attained under a "do your best". This they regard as vague performance goal, because the uncertainty in doing one best allows people to give themselves the benefit of the doubt in evaluating their performance. In a related research, Seijts, Latham, Tasa and Latham (2004) find that participants who had both a specific and challenging learning goal performed better than those who have neither and were urged to do their best. Lathan and Locke (1991) also discover a direct correlation between goal-setting and achievement of students.

Ajufo (2003) also in a research carried out to ascertain the effectiveness of goal-setting and self-efficacy technique in enhancing job seeking behaviour of unemployed graduates find that subjects exposed to goal-setting and self-efficacy techniques demonstrated greater degree to achieve than the control group. She further discovers that goal-setting yielded better result. Dhar, FIshback and Zhnag (2006) find that the successes recorded as a result of setting goal drive individuals toward another similar type of goal or a greater goal. Overall, the level of goal commitment depends on how attractive the goal was to the individual. It can therefore be concluded that success in all sphere of life is directly linked to goal-setting. Therefore, one can conclude that the ability to set goal, commitment to such goal can help adolescents with hearing impairment to engage less in risky sexual activities.

2.12 Appraisal of Literature Review

HIV/AIDS epidemic has world widely generated a lot of concern. Interventions to stem the spread throughout the world are as varied as the contexts in which we find them (UNAIDS, 1999).

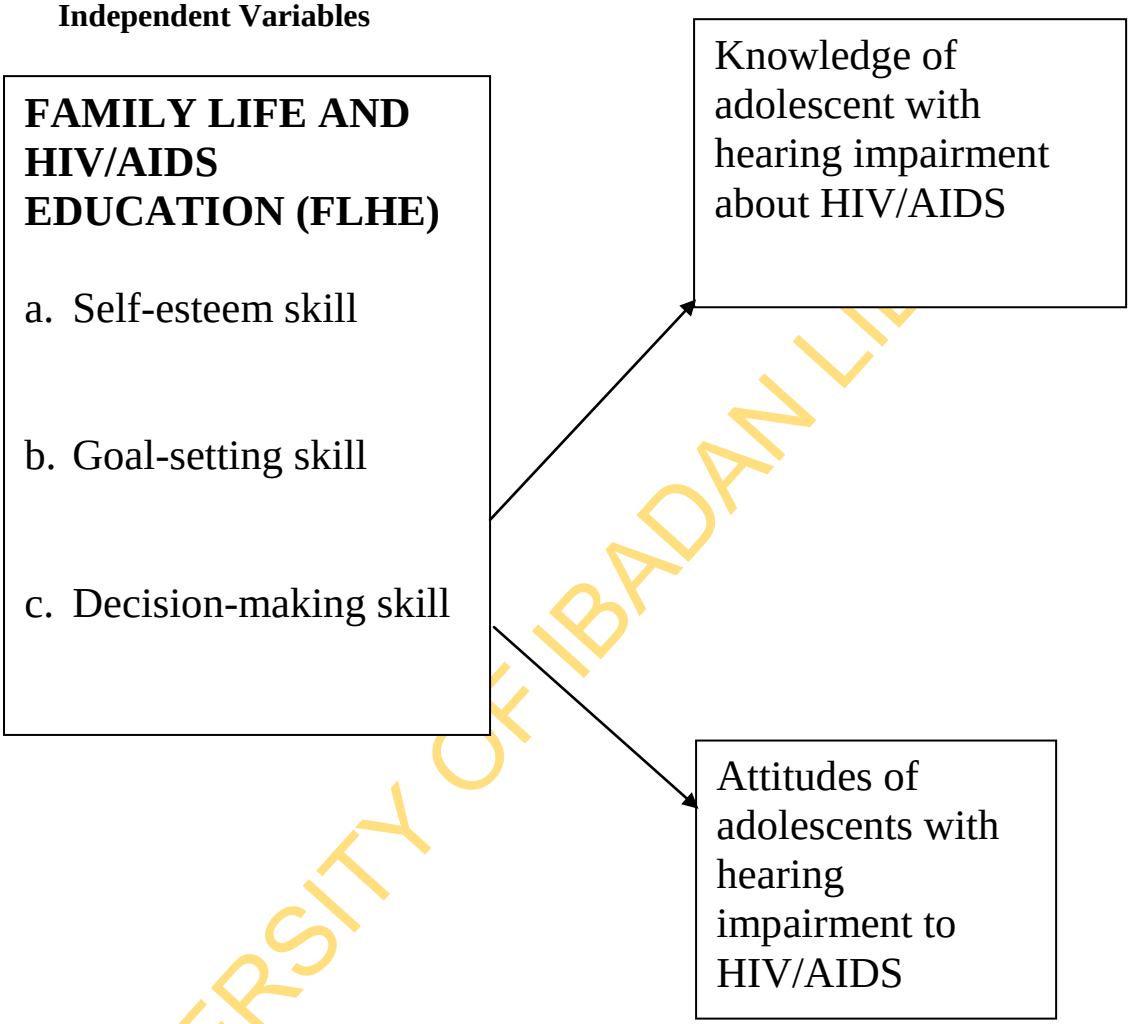
Family Life and HIV/AIDS Education is a Nigeria designed sexuality programme that is geared to impact self-esteem, goal-setting and decision-making skills as well as improving the knowledge and attitude of adolescents especially adolescents with hearing impairment about HIV/AIDS risks.

Literatures reviewed have evidently revealed that the growing trend of HIV/AIDS among adolescents need instant measures, in view of this, Family Life and HIV/AIDS Education skills are believed to be life changing education as revealed by the impact of those skills in coping with life challenges as revealed in the literatures reviewed and various theories. With proper and adequate training and acquisition of those skills by adolescents with hearing impairment, HIV/AIDS will be reduced to the barest minimum.

2.13 Conceptual Framework of the Study

Dependent Variables

Independent Variables



Source: Adeniyi (2012)

Family Life and HIV/AIDS Education (FLHE) as Predictors of Knowledge of and Attitude to HIV/AIDS among Adolescents with Hearing Impairment in South West Nigeria

CHAPTER THREE
METHODOLOGY

3.0 Introduction

This chapter is concerned with the methodology used in carrying out the study. It is discussed under the following sub-headings: research design, variables of the study, population, sample and sampling technique, instruments, procedure for data collection and data analysis.

3.1 Research Design

This study adopted survey research design of ex-post-facto type because the study will only investigate the existing variables without any manipulation of the variables.

3.2 Variables of the Study

The independent variable of the study is Family Life and HIV/AIDS Education Skills i.e. self-esteem, decision-making and goal-setting while the dependent variables are knowledge and attitude of HIV/AIDS of the adolescents with hearing impairment. The study investigated the extent to which Family Life and HIV/AIDS Education predicted knowledge and attitude of adolescents with hearing impairment about HIV/AIDS.

3.3 Population

The target population comprised all the adolescents with hearing impairment in South West Nigeria, from JSS 1 to SS 2 in the schools selected. The reason for excluding SSS3 was because the SSS 3 students were participating in Senior Secondary School Leaving Certificate Examination.

3.4 Sample and Sampling Technique

This study employed multistage sampling techniques involving stratified random sampling, purposive and simple random samplings. Stratified random sampling was used to select the states in south-west zone where the research was carried out. And by simple geography, south-west zone in Nigeria had been stratified to six states. Purposive sampling was used to select schools used for the study because of the concentration of majority of the schools in the state capital and their limited

numbers. Proximity to elite communities and constant monitoring and supervision by government was also considered in chosen these schools. Simple random sampling was employed to select participants in each location. This technique gives all members of the population equal chance of being selected without any form of bias.

Selection of sample for the study

The participants for the study were 450 adolescents with hearing impairment drawn from states in southwest, Nigeria. The participants in this study were randomised as follows:

S/N	Name of Schools	State	Number of participants
1.	St. Peters College, Abeokuta	Ogun	50
2.	Ondo State School for the Hearing Impaired, Akure.	Ondo	90
3.	Amoye Grammar School (Special Unit), Ikere-Ekiti	Ekiti	70
4.	Osun State Secondary School for the Handicapped, Osogbo.	Osun	60
5.	Methodist Grammar School, Bodija Ibadan.	Oyo	55
6.	Andrew Foster College, Ibadan.	Oyo	30
7.	Ijokodo High School, Ibadan	Oyo	25
8.	Ipakodo Junior Grammar School (Inclusive Unit), Ikorodu	Lagos	20
9.	State Grammar School (Inclusive Unit) Eric Moore, Surulere.	Lagos	50

The participants in each location represented fifty per cents of the population of adolescents with hearing impairment.

Criteria for Selection

(1) Adolescent students with hearing impairment were selected for the study.

(2) The participants were selected based on their age and expectation that they have reasonable idea of Family Life and HIV/AIDS Education as stated in secondary school curriculum.

(3) The participants were from JSS 1 to SSS 2.

(4) SSS III students were excluded because they were participating in Senior Secondary School Certificate Examination.

3.5 Instruments

The researcher made use of the Family Life and HIV/AIDS Education Inventory, consisting of self-esteem scale, goal-setting inventory, decision-making inventory, HIV/AIDS knowledge scale and HIV/AIDS attitudinal scale.

3.5.1 Description of the Instruments

Family Life and HIV/AIDS Education Inventory consisted of two sections, namely Section A and B. Section A of the inventory contained the bio-data of the respondents (school, age, sex, nationality, state and town). Section B contained five different scales designed to measure the variables involved in this study. These are Self-esteem Inventory developed by Rosenberg (1965) (adopted), Goal-setting Inventory developed by Rushall and Fisdel (1992) (adapted), Decision-making Inventory by Nola, Hughes, Terry, Astrow and Thompson (2009) (adapted), HIV/AIDS' Knowledge Inventory (HKS) and HIV/AIDS' Attitudinal Inventory (HAS) were self-developed. The scales were constructed in four Likert scale type ranging from Strongly Agreed (SA), Agreed (A), Disagreed (D) and Strongly Disagreed (SD) with ten items each. The following were the samples of the inventories used: **Self-esteem Inventory** (I feel that I am a person of worth, at least on an equal plane with others; I feel that I have a number of good qualities); **Goal-setting Inventory** (Having goals make me feel happy; I feel proud when I achieve my goal); **Decision-making Inventory** (I am prepared to train for many years to become what I want to be in future; I am prepared to avoid things that will tarnish the image of my family); **HIV/AIDS' Knowledge Inventory** (Family Life and HIV Education teaches distinct way of coping with the task of biological, sexual and physical maturity among students; Family and HIV Education promotes morality and good

behaviour among students); **HIV/AIDS' Attitudinal Inventory** (I believe it is appropriate to teach Family Life and HIV Education in schools; I believe there is nothing wrong with young boys and girls having sexual intercourse if they love each other even though they have knowledge of Family Life and HIV Education).

3.5.2 Validity and Reliability

To validate the instrument, the researcher ensured that the items on the questionnaire correspond with the objectives of the study in order to ascertain the content validity of the instrument.

Further validation was carried out by the researcher to determine the reliability and validity of the instrument by subjecting the instrument to a pilot study. The data obtained were computed using Cronbach Alpha method. The reliability analyses of the inventories are as follows:

Self-esteem scale by Rosenberg = 0.80

Goal-setting Inventory = 0.62

Decision-making Inventory = 0.60

HIV/AIDS' Knowledge Inventory = 0.62

HIV/AIDS' Attitudinal Inventory = 0.60

3.6 Procedure for Data Collection

The researcher after collecting a letter of introduction from the Head of Department of Special Education, University of Ibadan employed the services of two research assistants for the purpose of the research. He thereafter visited the Ministries of Education in the Southwest to gather information about the special, integrated and inclusive secondary schools for students with hearing impairment. The administration of the instrument took eight weeks. Permission was sought from the principals of the schools selected upon making the intention of the research known to them. And this was adequately granted.

During the selection of the participants in various locations used, they were duly informed about the purpose of the exercise. This enhanced objectivity of the study. Research assistants and teachers that assisted in the exercise were briefed about the vital instructions and modality of the exercise. Thereafter, the questionnaire copies were distributed among the participants. Both researcher and the research assistants waited to collect the questionnaires at different locations after they have been

adequately attended to and they were properly checked by the researcher and research assistant to see that there were no error in each of the questionnaire.

3.7 Method of Data Analysis

For the analysis of the data collected, both inferential and qualitative statistics were employed.

Pearson Product Moment Correlation was used to test the relative influence of the variables while Multiple Regression Analysis was employed to test the joint influence of all the main variables.

Pearson Product Moment Correlation and Multiple Regression were employed in the analysis of the data because the study aimed at establishing whether Family Life and HIV/AIDS Education could predict knowledge and attitude of adolescent with hearing impairment in southwest Nigeria to HIV/AIDS. Pearson Product Moment Correlation establishes relationship between independent and dependent variables while multiple regression established composite influence among variables under study (independent and dependent). It is therefore expedient to employ moment correlation to establish relationship between independent and dependent variables so as to know variables that will be eventually be involved in multiple regression analysis in the study.

CHAPTER FOUR

PRESENTATION OF RESULTS

4.0 Introduction

This chapter presents the results of the findings. The study examined self-esteem, goal-setting and decision making as correlates of HIV/AIDS' knowledge and HIV/AIDS' attitude.

Six research questions were tested using Multiple Regression Analysis and Correlation Matrix. The summary of the findings were presented in the following tables.

4.1 Research Question One

Would there be significant relationships among the independent variables (self-esteem, goal-setting, decision making) and knowledge of adolescents with hearing impairment in South West Nigeria about HIV/AIDS?

Table 4.1: Descriptive Statistics and Correlations among the variables

	Self-esteem	**Goal-setting**	**Decision-making**	**Knowledge**
Self-esteem	1			
Goal setting	.480**	1		
Decision-making	.582**	.616**	1	
Knowledge	.510**	.487**	.551**	1
Mean	21.24	20.44	20.35	21.08
Standard deviation	4.51	4.64	5.20	590

** = the values is significant at p = 0.01

* = the values is significant at p = 0.05

Table 4.1 shows Mean, Standard Deviation and zero order correlation among the variables. It was observed that there was significant relationship between the independent variables and the dependent variable (HIV/AIDS' Knowledge) in the following order of decision making (r = 0.551. P<.05), self-esteem (r = 0.510. P<.05) and goal setting (r = 0.487, P < 0.05).

4.2 Research Question Two

To what extent when combined will the independent variables (self-esteem, goal-setting, decision making) predict knowledge of adolescents with hearing impairment in South West Nigeria about HIV/AIDS?

Table 4.2: Joint Effect of the independent variables

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	616[a]	.379	.375	4.66738

ANOVA[b]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	5938.913	3	1979.638	90.874	.000[a]
	Residual	9715878	446	21.784		
	Total	15654.791	449			

a Predictors: (Constant), decision-making, self-esteem, goal-setting

b. Dependent Variable: knowledge

Table 4.2 shows that there was joint effect of the independent variables (self-esteem, goal setting, decision making) on knowledge of adolescents with hearing impairment in south west Nigeria about HIV/AIDS; R = 0.616, P<.05. The table further reveals 37.5% (Adj. R^2 = 0.375) of the variance in HIV/AIDS' Knowledge of hearing impairment adolescents were accountable for by the linear combination of the independent variables. The ANOVA results from the regression analysis shows that there was significant effect of the independent variables on the dependent variable: $F_{(3,446)}$ = 90.874. P<0.05.

4.3 Research Question Three

To what extent will each of the independent variables (self-esteem, goal-setting, decision making) predict knowledge of adolescents with hearing impairment in South West Nigeria about HIV/AIDS?

Table 4.3: Relative Effect of the Independent Variables on the Dependent Variable

	Unstandardized Coefficients		Standardized Coefficients	t	
Model	**B**	**Std. Error**	**Beta**		**Sig.**
1 (Constant)	2.523	1.191		2.119	.035
Self-esteem	.330	.061	.252	5.389	.000
Goal-setting	.239	.061	.188	3.898	.000
Decision-making	.328	.059	.289	5.548	.000

a. Dependent Variable: knowledge

Table 4.3 above shows that three independent variables showed relative contribution to HIV/AIDS" Knowledge among adolescents with hearing impairment. The variables include the following: self-esteem (β= 0 .252. t = 5.389, P <0.05), goal setting (β = 0.188, t= 3.898, p < 0.05), decision-making (β = 0.289. t = 5.548, p < 0.05). It was observed that decision making was the most potent contributor to HIV/AIDS' Knowledge (β = 0.289. t = 5.548. p<0.05) while goal setting was the least (β = 0.188, t = 3.898, P < 0.05).

4.4 Research Question Four

Would there be significant relationships among the independent variables (self-esteem, goal-setting, decision making) and attitude of adolescents with hearing impairment in South West Nigeria to HIV/AIDS?

Table 4.4: Descriptive Statistics and Correlations among the variables

	Self-esteem	**Goal-setting**	**Decision-making**	**Attitude**
Self-esteem	1			
Goal setting	.480**	1		
Decision-making	.582**	.616**	1	
Attitude-	.492**	488**	.568**	1
Mean	21,24	20.44	20.35	21.13
Standard deviation	451	4.64	520	5.00

** = the values is significant at p = 0.01

* = the values is significant at p = 0.05

Table 4.4 shows Mean, Standard Deviation and zero order correlation among the variables. It was observed that there was significant relationship between the independent variables and the dependent variable (HIV AIDS' attitude) in the following order of magnitude: decision making (r = 0.568, p<.05), self-esteem (r = 0.492, p<.05), goal-setting (r = 0.488. p<0.05).

4.5 Research Question Five

To what extent when combined will the independent variables (self-esteem, goal-setting, decision-making) predict attitude of adolescents with hearing impairment in South West Nigeria to HIV/AIDS?

Table 4.5: Joint Effect of the independent variables

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.618[a]	.382	.378	3.94319

ANOVA

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	4283.768	3	1427.923	91.835	.000[a]
	Residual	6934.756	446	15.549		
	Total	11218.524	449			

a. Predictors: (Constant), decision-making, self-esteem, goal-setting

b. Dependent Variables: attitude

Table 4.5 shows that there was joint effect of the independent variables (self-esteem, goal setting, decision making) on HIV/AIDS' attitude among adolescents with hearing impairment in south west Nigeria; R = 0.618, $p<0.05$. The table further reveals 37.8% (Adj. R^2 -- 0.378) of the variance in HIV/AIDS' attitude of hearing impairment adolescents were accountable for by the linear combination of the independent variables. The ANOVA results from the regression analysis shows that there was significant effect of the independent variables on the dependent variable: $F_{(3,446)} = 91.835$, $p<0.05$.

4.6 Research Question Six

To what extent will each of the independent variables (self-esteem, goal-setting, decision making) predict attitude of adolescents with hearing impairment in South West Nigeria to HIV/AIDS?

Table 4.6: Relative Effect of the Independent Variables on the Dependent Variable

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	5660	1.006		5.625	.000
	Self-esteem	.233	.052	.210	4.504	.000
	Goal-setting	.195	.052	.181	3.762	.000
	Decision-making	.321	.050	.334	6.438	.000

a. Dependent Variable: attitude

Table 4.6 above shows that three independent variables have relative contribution to HIV/AIDS' attitude among adolescents with hearing impairment. The variables include the following: self-esteem (β = 0 .210. t = 4.504, $p<0.05$), goal setting (β=0.181. t = 3.762, $p<0.05$), decision-making (β = 0.334, t = 6.438, $p<0.05$). It was observed that decision making was the most potent contributor to HIV/AIDS' attitude (β = 0.334, t = 6.438, $p<0.05$) while goal setting was the least (β = 0.181, t = 3.762, $p<0.05$).

4.7 Summary of Findings

The findings of the study are summarised below:

1. It was observed that there was significant relationship between independent variables (self-esteem, goal-setting, decision-making) and knowledge of adolescents with hearing impairment in South-West Nigeria to HIV/AIDS.
2. The study revealed combined prediction of knowledge of adolescents with hearing impairment to HIV/AIDS South-West Nigeria by the independent variables.

3. The study revealed that decision-making mostly contributed to knowledge of HIV/AIDS among adolescents with hearing impairment than other independent variables.
4. The study also revealed that there was significant relationship between independents variables (self-esteem, goal-setting and decision-making) and the independent variable i.e. attitude of adolescents with hearing impairment to HIV/AIDS in South-West, Nigeria.
5. The study revealed combined prediction of attitude of adolescents with hearing impairment to HIV/AIDS in South-West, Nigeria by the independent variables.
6. The study further revealed that decision-making was the most potent contributor to the attitude of adolescents with hearing impairment in South-West, Nigeria to HIV/AIDS.

CHAPTER FIVE

DISCUSSION OF FINDINGS AND RECOMMENDATIONS

5.0 Introduction

This chapter discusses findings, educational implication, limitation, recommendation, contribution to knowledge and suggestion for further study.

5.1 Discussion of Findings

This study is on Family Life and HIV/AIDS Education as predictors of knowledge of and attitude to HIV/AIDS among adolescents with hearing impairment in southwest Nigeria. Each of the six research questions was based on the responses of the participants (adolescentS with hearing impairment). The results from the study are discussed as follows:

Research Question One

Would there be significant relationships among the independent variables (self-esteem, goal-setting and decision-making) and HIV/AIDS' knowledge among adolescents with hearing impairment in southwest Nigeria?

The results on table 4.1 indicated that there was significant relationship between the independent variables and the dependent variable (HIV/AIDS' knowledge) in the following order of decision-making ($r=0.551$, $p<.05$), self-esteem ($r=0.510$, $p<.05$), goal setting ($r=0.487$, $p<.05$). The finding supports Adeniyi (2007) who noted that decision to engage in conventional sexual activities are mostly common among adolescents with hearing impairment because of misconception and misinterpretation of the act and activities. The finding also confirmed that self-esteem has direct relationship with knowledge or sexual experience which are directly linked to the causes and reasons for the spread of HIV/AIDS among adolescents especially adolescents with hearing impairment. This result is also in line with Campbell and Lavallee (1993) that affirmed that self-esteem has a pervasive and powerful impact on human cognition, motivation, emotion and behaviour. This implies that self-esteem of adolescents with hearing impairment can influence their knowledge of HIV/AIDS since self-esteem is a powerful drive of human cognition.

Also, the relationship between goal-setting and adolescents with hearing impairment HIV/AIDS knowledge revealed by this study corroborated Bandura (1986, 1991), Locke and Latham (1990), Tanaka and Yamanchi (2001) and Marzano (2003) concluded that goal-setting increases people's cognitive drive and performance of task in both academic and social life. The implication is that, goal-setting by adolescents with hearing impairment can modify their sexual behaviours which is the main objective of HIV/AIDS education thereby reducing the spread of HIV/AIDS among adolescents clusters.

Research Question Two

To what extent when combined will the independent variables (self-esteem, goal-setting, decision-making) predict HIV/AIDS knowledge among adolescents with hearing impairment in South West Nigeria?

The results in table 4.2 showed that there was joint effect of independent variables (self-esteem, goal-setting and decision-making) on HIV/AIDS' knowledge among adolescents with hearing impairment in southwest Nigeria, R=0.616, p<.05. The table further revealed 37.5% (Adj. R_2=0.375) of the variance in HIV/AIDS' knowledge of hearing impairment adolescents were accountable for by the linear combination of the independent variables. The analysis of variance results from the regression analysis showed that there was significant effect of the independent variables on the dependent variable; $F_{(3,446)}$=90.874, p<.05. Though there were scanty literatures that collectively addressed the significant effect of the independent variables (self-esteem, goal-setting, decision-making) on dependent variable (knowledge of HIV/AIDS) among adolescents with hearing impairment, nevertheless, the results corroborated the studies by Jonathan-Ibeagha, Adedimeji, Okpala and Ibeagha (1999) and Adeniyi, Oyewumi and Fakolade (2010) that found that Family Life and HIV/AIDS Education has imparted significantly on adolescents knowledge of HIV/AIDS.

The finding is supported by studies by Jambo and Elliot (2005), Cole and Slocum (1995), Hollar and Snizek (1995), Tanaka and Yamauchi (1995), Latham (2004) and Gilmore, DeLamater and Wagstaff (1995) that revealed significant contribution of each independent variable i.e. self-esteem, goal-setting and decision-making on adolescents sexual behaviour and achievement.

Research Question Three

To what extent will each of the independent variables (self-esteem, goal-setting, decision-making) predict HIV/AIDS' knowledge among adolescents with hearing impairment in South West Nigeria?

The results in Table 4.3 revealed that three independent variables showed relative contribution to HIV/AIDS' knowledge among adolescents with hearing impairment. The variables include self-esteem ($\beta = 0.252$, $t = 5.389$, $p<0.05$), goal-setting ($\beta = 0.188$, $t = 3.898$, $p<0.05$), decision-making ($\beta=0.289$, $t=5.548$, $p<0.05$). It was therefore observed that decision-making was most potent contribution to HIV/AIDS' knowledge ($\beta = 0.289$, $t = 5.548$, $p<0.05$) while goal-setting was the least ($\beta = 0.188$, $t = 3.898$, $p<0.05$). The implication of this is that decision-making contributed significantly to adolescents with hearing impairment knowledge of HIV/AIDS. Therefore, decision to engage or not to engage in risky sexual behaviour is directly related knowledge of adolescents with hearing impairment about HIV/AIDS. The findings corroborated the study by Gilmore, DeLamater and Wagstaff (1995) on sexual decision-making by inner-city black adolescent males that young men view sexual behaviour, sexual partners and condom use as elements within a complex script which governs heterosexual interactions.

The finding also supported Adeniyi (2007) that discovered that conventional sexual activities are mostly common among adolescents with hearing impairment because of misconception and misinterpretation given to sexual activities. From these it is obvious that there is a powerful connection between knowledge and decision of adolescents especially adolescents with hearing impairment to engage in risk sexual activities that are detrimental to their health.

Research Question Four

Would there be significant relationships among the independent variables (self-esteem, goal-setting, decision-making) and HIV/AIDS' attitude adolescents with hearing impairment in southwest Nigeria?

The results on table 4.4 showed that there was significant relationship between the independent variables and dependent variable (HIV/AIDS' attitude) in the following order of magnitude: decision-making ($r=0.568$, $p<0.05$), self-esteem ($r=0.492$, $p<0.05$), goal-setting ($r=0.488$, $p<0.05$). The findings corroborates Morris,

Young and Jones (2000), Hollar and Snizek (1996), Cole and Slocumb (1995) and Hally and Pollack (1993) who all established a relationship between self-esteem and safer and unsafe sexual practices among adolescents generally. This implies that self-esteem has a great impact on attitude of adolescents to risky sexual practices.

The finding is also in line with Bankole, Singh, Woog and Wulf (2004), Verga (1997) that all reported direct correlation between decision-making of adolescents and attitudes toward safer sexual activities which can reduce the spread of HIV/AIDS. The findings also corroborated Seijts, Latham, Tasa and Latham (2004) and Ajufo (2003) who found that goal-setting influenced achievement of tasks. Since sexual self-control is a decision-making strategy which is relative to goal-setting, it is reasonable to infer that goal-setting will influence attitude of adolescents to HIV/AIDS. However, the findings is contrary to the report by Robinson and Frank (1994) who found no significant difference in self-esteem and sexual behaviour of their participants as measured by Coppersmith self-esteem scale.

Research Question Five

To what extent when combined will the independent variables (self-esteem, goal-setting, decision-making) predict HIV/AIDS' attitude among adolescents with hearing impairment in South West Nigeria?

The results on table 4.5 showed that there was joint effect of the independent variables (self-esteem, goal-setting, decision-making) on HIV/AIDS' attitude among adolescents with hearing impairment in southwest Nigeria, 0.618, $p<0.05$. The table further revealed 37.8% (Adj. $R^2=0.378$) of the variance in HIV/AIDS attitude of the hearing impairment adolescents were accountable for by the linear combination of the independent variable. The ANOVA results from the regression analysis showed that there was significant effect of the independent variables on the dependent variable; $F_{(3,446)}=91.835$, $p<0.05$. This finding is in line with Adeniyi, Oyewumi and Fakolade (2010), Jambo and Elliot (2005), Hollar and Snizek (1995) and Gilmore, DeLamater and Wagstaff (1995) that revealed overwhelming contribution of the independent variables, self-esteem, goal-setting and decision-making to the dependent variable i.e. attitude of adolescent to negative sexual behaviour.

The finding also corroborated Vandel (2009), Bekele (2003), World Youth Report (2003) and Oladepo and Osowole (2001) which submitted that many adolescents especially adolescents with hearing impairment are confident and believe

themselves invulnerable to HIV/AIDS. Hence, involving in risky sexual practices by the adolescents can be attributed to perception of worthiness, self-determination and whatever one intend to be in life.

Research Question Six

To what extent will each of the independent variables (self-esteem, goal-setting, decision-making) predict HIV/AIDS' attitude among adolescents with hearing impairment in South West Nigeria?

The results in table 4.6 revealed that the three independent variables showed relative contribution to HIV/AIDS' attitude among adolescents with hearing impairment. The variables include the following: self-esteem ($\beta = 0.210$, $t=4.504$, $p<0.05$), goal-setting ($\beta = 0.181$, $t = 3.762$, $p<0.05$), decision-making ($\beta = 0.334$, $t = 6.438$, $p<0.05$). It was observed that decision-making was the most potent contribution to HIV/AIDS' attitude ($\beta = 0.334$, $t = 6.438$, $p<0.05$) while goal-setting was the least ($\beta = 0.181$, $t=3.762$, $p<0.05$). The implication is that though the three independent variables i.e. self-esteem, goal-setting and decision-making relatively contributed to HIV/AIDS' attitude of adolescents with hearing impairment, decision-making showed more potent contribution compared to other variables. This finding is in line with the study by Black, Sun, Rohrbach and Sussman (2011) which reported a strong link between decision-making and attitude of their adolescent participants to HIV/AIDS through condom use link.

The finding is also supported by Akwara, Madise and Hiude (2003) and Gilmore, DeLamater and Wagstaff (1995) that found a strong positive association between perceived risk of HIV/AIDS and risky sexual behaviour among young unmarried men and women in Kenya.

However, the findings contradicted the study carried out by Visser (2005) that revealed no direct link between decision-making skills and attitude of adolescents to HIV/AIDS among participants in life skill training as HIV/AIDS preventive strategy in secondary schools. It reported that life skills training did not impact on attitude of adolescents to HIV/AIDS.

Summarily, the main objective of this study was to establish whether or not Family-Life and HIV/AIDS Education skills (self-esteem, goal-setting and decision-making) predict knowledge and attitude of adolescents with hearing impairment to HIV/AIDS. The study established that the independent variables (self-esteem, goal-

setting and decision-making) relatively contributed to knowledge and attitude of adolescents with hearing impairment to HIV/AIDS in South-West, Nigeria. This study revealed the efficacy of Family-Life and HIV/AIDS Education skills on attitude and knowledge of adolescents with hearing impairment about HIV/AIDS in South-West, Nigeria. Hence Family-Life and HIV/AIDS Education will be a better tool for reducing the spread of HIV/AIDS among adolescents globally.

5.2 Educational Implication of the Study

The study has established that Family Life and HIV/AIDS Education Skills (self-esteem, goal-setting and decision-making) are significantly related to HIV/AIDS' knowledge and attitude of adolescents with hearing impairment in southwest Nigeria. The study therefore has several implications for government, non-governmental organisations, classroom teachers, school administrators, counsellors, psychologists, parents, guardians and public health workers.

Government should see Family Life and HIV/AIDS Education Skills acquisition as a serious programme and therefore creating enabling environment for the programme to be more functional at various levels of education in Nigeria. In view of this, seminars and workshops should be organised for school administrators and teachers so as to enable them acquire basic strategies to disseminate the knowledge to their students effectively.

Non-governmental organisations should evolve programmes that empower adolescents with the skills that will help them to cope with their developmental challenges rather than lay more emphasis on the publicity and medication to HIV/AIDS and this can be better achieved through Family Life and HIV/AIDS Education.

School administrators and teachers should see Family Life and HIV/AIDS Education as a potent programme that would equip adolescents with skills that will help them cope with sexual challenges. As such, teaching of Family Life and HIV/AIDS Education curriculum should be vigorously implemented.

Parents and counsellors should also work in conjunction with schools in order to strengthen transfer of knowledge and skills among adolescents with hearing impairment. This would also help in curbing the proliferation of HIV/AIDS in Nigeria.

Public health workers should de-emphasise the use of medication as a control measure but redirect energy towards equipping adolescents with the skills that would help them to cope with their development and sexual challenges by adopting Family Life and HIV/AIDS Education as a blueprint for reducing HIV/AIDS incidence among the younger generation.

5.3 Limitation of the Study

This study has some limitations because the dependent variables were limited to three skills i.e. self-esteem, goal-setting and decision-making as predictors of knowledge of and attitude to HIV/AIDS among adolescents with hearing impairment. Other skills such as values, communication, assertiveness, negotiation and finding help are also necessary to be investigated because Family Life and HIV/AIDS Education is a wholistic programme. The study is also limited to adolescents with hearing impairment in six states of South-West, Nigeria because of the scope of the research.

5.4 Suggestion for Further Research

This study established the effectiveness of self-esteem, goal-setting and decision-making on knowledge and attitude of adolescents with hearing impairment to HIV/AIDS in southwest Nigeria. In addition to the effectiveness of the skills investigated (self-esteem, goal-setting and decision-making), there is a need to also establish the potency of other skills such as values, communication, assertiveness, negotiation and finding help on knowledge and attitude of adolescents with hearing impairment towards HIV/AIDS.

Similar research should also be carried out in other geo-political zones among both adolescents with and without hearing impairment to ascertain the implementation of the educational blueprint and its relative effectiveness on adolescents.

5.5 Contribution to Knowledge

This study has made significant contribution to knowledge in the following ways:

It has demonstrated that self-esteem, goal-setting and decision-making are related to adolescents with hearing impairment knowledge of HIV/AIDS.

The study also revealed that self-esteem, goal-setting and decision-making are related to adolescents with hearing impairment attitude to HIV/AIDS. The study further revealed that decision-making was the most potent contributor to HIV/AIDS knowledge and attitude of adolescents with hearing impartment.

This study would therefore provide empirical basis and framework for improving Family Life and HIV/AIDS Education in Nigeria.

5.6 Recommendations

The findings of this study are searchlight to another dimension of restructuring knowledge and attitude of adolescents generally to the issue of HIV/AIDS which has been a global threat to the world population. In view of this, it is recommended that Family Life and HIV/AIDS Education should enjoy more attention from government and non-governmental organisations because of its potential to reduce the spread of HIV/AIDS compared with various publicity and campaigns previously adopted. With this, government is encouraged to be more pragmatic in the implementation of the blue print at various levels of education as necessary assistance and encouragement should be given to officers that are in the mainstream of policy implementation. Non-governmental organisations should lend support to government by using Family Life and HIV/AIDS Education to conduct seminars and workshops for people with and without hearing impairment outside the four walls of classrooms.

Parents and guardians should also view the programme as a life changing education to be adopted by different homes as parts of home training activities for their wards. Hence, this life planning programme should be incorporated as co-activities at different homes which can translate to permanent culture in the society. With this the incidence of HIV/AIDS will be reduced to bearest minimal.

At schools, Family Life and HIV/AIDS Education should be handled with more seriousness by teachers and administrators to facilitate proper implementation of the programme as poor attitude may mar the good intention of the programme. The programme should be monitored by school administrators and ministry of education to see that the blue print is properly implemented.

Public health workers and other related professionals should see making the programme a reality as collaborative approach is needed to make the life saving blueprint more functional to achieve its intended goals. This can be done by using the blue print to educate women attending ante-natal, adolescents visiting hospital for information and check-up as well as adults as this will make the blue print to be adequately taught to every segment of the society.

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APPENDIX I

UNIVERSITY OF IBADAN, IBADAN, NIGERIA

DEPARTMENT OF SPECIAL EDUCATION

ACTING HEAD

G. Babalola OJO
B.Ed, M.Ed, Ph.D. (Ibadan)

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VISION:

To make the Department a world class centre of excellence in learning, research and rendering quality in special educational services within and outside the university.

Our Ref:.....

31 March, 2011

TO WHOM IT MAY CONCERN

LETTER OF INTRODUCTION: ADENIYI, SAMUEL OLUFEMI Matric. No.: 80154

I write to introduce the above named who is a Ph.D student in our department.

He is carrying out his Ph.D Post field research and wants to make use of your centre as a case study.

Please assist him.

Thank you.

Dr. G.B. Ojo
Ag. Head

SPECIAL EDUCATION UNIVERSITY OF IBADAN 31/03/11

FORMER ACTING HEADS/HEAD

MBA, P.O. (July 1977 - July 1981), BAKARE, C.A. (1st Aug., 1981 - 31st July 1983), ADIMA, E.E. (1st Aug., 1983 - 31st July, 1985)
ADESOKAN, E.O. (20th March, 1990 - 1992), ABOSI, C.O. (20th March, 1992 - 31st Oct. 1992), ONWUCHEKWA, J.N. (1st Nov. 1992 - 31st, Dec. 1996).
OYEBOLA, M. (1st Jan. 1997 - 1st Jan. 1999) NWAZUOKE, I.A. (4th Jan., 1999 - 3rd Jan. 2001), ABIODUN, K. (4th Jan., 2001 - 4th Jan. 2003).
ENIOLA, M.S. (5th Jan. 2003 - 4th Jan. 2005). I.A. NWAZUOKE (6th Jan. 2005 - 5th January 2008)
J.A. ADEMOKOYA (5th Jan., 2008 - 31st Jan. 2010)

APPENDIX II

DEPARTMENT OF SPECIAL EDUCATION, UNIVERSITY OF IBADAN, IBADAN

FAMILY LIFE AND HIV/AIDS EDUCATION INVENTORY

Dear Respondents,

This questionnaire is aimed at obtaining information for research purpose. All information given here would be treated with strict confidentiality.

Thanking you in anticipation of your co-operation.

SECTION A: BIO-DATA

School: _____

Class: _____

Age: _____

Sex: _____

Nationality: _____

State: _____

Town: _____

Onset of Loss: Pre-lingual H.I. [ ] Post-lingual H.I. [ ]

Degree of Loss: Mild/Moderate [ ] Severe/Profound [ ]

SECTION B: SELF-ESTEEM SCALE

Please, use the scale below to rate yourself on each of the following items.

SA = Strongly Agree; A = Agree; D = Disagree; SD = Strongly Disagree

S/N	STATEMENT	SA	A	D	SD
1	I feel that I am a person of worth, at least on an equal plane with others.				
2	I feel that I have a number of good qualities.				
3	All in all, I am inclined to feel that I am a failure.				
4	I am able to do things as well as most other people.				
5	I feel I do not have much to be proud of.				
6	I take a positive attitude toward myself.				
7	On the whole, I am satisfied with myself.				
8	I wish I could have more respect for myself.				
9	I certainly feel useless at times.				
10	At times I think I am not good at all.				

SECTION C: GOAL SETTING SCALE

Please use the scale below to rate yourself on each of the following items.

SA = Strongly Agree; A = Agree; D = Disagree; SD = Strongly Disagree

S/N	ITEM	SA	A	D	SD
1	Having goals make me feel happy.				
2.	I feel proud when I achieve my goal.				
3.	I feel that I disappoint other people if I do not achieve my goals.				
4.	My friend and I compete to see who can achieve his/her goals in contests.				
5.	I have deadlines for accomplishing goals in my life.				
6.	What I want to be in future gives me reasons for setting the goals that I desire to achieve.				
7.	When I fail to achieve my goals I feel disappointed.				
8.	The more goals that I achieved, the more confident I became.				
9.	Once I establish a goal, I do not change them.				
10.	Setting goals is not necessary in life.				

SECTION D: DECISION MAKING SCALE

Please use the scale below to rate yourself on each of the following items

SA = Strongly Agree; A = Agree; D = Disagree; SD = Strongly Disagree

S/N	ITEM	SA	A	D	SD
1	I am prepared to train for many years to become what I want to be in future.				
2.	I am prepared to cope with the challenges of my life without help.				
3	I would never contemplate on changing my behaviours that will not respect my dignity.				
4	I am prepared to avoid things that will tarnish the image of my family.				
5.	I am prepared to engage in activities that will promote my wellbeing.				
6.	I would never engage in activities that will affect my health.				
7.	I would never engage in any activity that are not consistent with my faith beliefs.				
8.	I would never be influenced to engage in risk behaviour.				
9.	I would always avoid activities that will make me a bad representative of my community.				
10.	I am prepared to make myself a good example on to my friends.				

SECTION E: HIV/AIDS' KNOWLEDGE SCALE

Please use the scale below to rate yourself on each of the following items

SA = Strongly Agree; A = Agree; D = Disagree; SD = Strongly Disagree

S/N	ITEM	SA	A	D	SD
1	Family Life and HIV Education teaches distinct way of coping with the task of biological, sexual and physical maturity among students.				
2.	Family Life and HIV Education promotes morality and good behaviour among students.				
3	Family Life and HIV Education prevents the occurrence and spread of HIV/AIDS.				
4	Family Life and HIV Education is adequate to promote sexual health and behaviour among students.				
5.	Family Life and HIV/AIDS Education addresses all aspects of HIV/AIDS.				
6.	Family Life and HIV/AIDS Education can reduce the rate of sexual activity among students.				
7.	Family Life and HIV/AIDS Education gives details on danger of premature sexual relationship.				
8.	Family Life and HIV/AIDS Education prevents the occurrence and spread of HIV/AIDS.				
9.	Family Life and HIV/AIDS Education makes students familiar with his or her society and culture?				
10.	Teaching of Family Life and HIV/AIDS Education should be encouraged in schools.				

SECTION F: HIV/AIDS' ATTITUDINAL SCALE

INSTRUCTION

Please use the options below to rate yourself on each of the following items:

SA = Strongly Agree; A = Agree; D = Disagree; SD = Strongly Disagree

S/N	ITEM	SA	A	D	SD
1	I believe it is appropriate to teach Family Life and HIV Education in schools.				
2	I believe there is nothing wrong with young boys and girls having sexual intercourse if they love each other even though they have knowledge of Family Life and HIV Education.				
3	I believe that the only way to prevent the spread of HIV/AIDS among students is to give them Family Life and HIV Education.				
4	All aspects of veneral diseases including AIDS should be taught in form of Family Life and HIV Education.				
5	Family Life and HIV Education will encourage boys and girls to remain virgins until they marry.				
6	Increased rate of sexual involvement, unwanted, pregnancies and abortions among students could be curbed through teaching of Family Life and HIV Education in schools.				
7	I believe it is not necessary that Family Life and HIV Education focuses on the teaching of morality and good behaviour.				
8	Students make good decisions about his/her future when he learnt about Family Life and HIV Education in schools.				
9	I believe that the nature of our society will make Family Life and HIV Education capable of making students familiar with our culture.				
10	I believe there is a need for our society to deal with students' Sexual behaviour through Family Life and HIV Education.				

APPENDIX III

Correlations

		Self-esteem	Goal-setting	Decision-making
Self-esteem	Pearson Correlation	1	.480**	.582**
	Sig. (2-tailed)		.000	.000
	N	450	450	450
Goal-setting	Pearson Correlation	.480**	1	.616**
	Sig. (2-tailed)	.000		.000
	N	450	450	450
Decision-making	Pearson Correlation	.582**	.616**	1
	Sig. (2-tailed)	.000	.000	
	N	450	450	450
Knowledge	Pearson Correlation	.510**	.487**	.551**
	Sig. (2-tailed)	.000	.000	.000
	N	450	450	450
Attitude	Pearson Correlation	.492**	.488**	.568**
	Sig. (2-tailed)	.000	.000	.000
	N	450	450	450

** Correlation is significant at the 0.01 level (2-tailed).

Correlations

		Knowledge	Attitude
Self-esteem	Pearson Correlation	.510**	.492**
	Sig. (2-tailed)	.000	.000
	N	450	450
Goal-setting	Pearson Correlation	.487**	.488**
	Sig. (2-tailed)	.000	.000
	N	450	450
Decision-making	Pearson Correlation	.551**	.568**
	Sig. (2-tailed)	.000	.000
	N	450	450
Knowledge	Pearson Correlation	1	.660**
	Sig. (2-tailed)		.000
	N	450	450
Attitude	Pearson Correlation	.660**	1
	Sig. (2-tailed)	.000	
	N	450	450

** Correlation is significant at the 0.01 level (2-tailed).

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Self-esteem	450	10.00	33.00	21.2444	4.51306
Goal-setting	450	10.00	41.00	20.4356	4.64092
Decision-making	450	10.00	35.00	20.3467	5.20149

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Knowledge	450	10.00	39.00	21.0844	5.90474
Attitude	450	10.00	40.00	21.1289	4.99856
Valid N (listwise)	450				

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.616[a]	.379	.375	4.66738

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	5938.913	3	1979.638	90.874	.000[a]
	Residual	9715.878	443	21.784		
	Total	15654.791	449			

a. Predictors: (Constant), decision-making, Self-esteem, Goal-setting

b. Dependent Variable: knowledge

Coefficients[3]

	Unstandardized Coefficients		Standardized Coefficients	t	
Model	B	Std. Error	Beta		Sig.
1 (Constant)	2.523	1.191		2.119	.035
Self-esteem	.330	.061	.252	5.389	.000
Goal-setting	.239	.061	.188	3.898	.000
Decision-making	.328	.059	.289	5.548	.000

a. Dependent Variable: knowledge

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.618[a]	.382	.378	3.94319

a. Predictors: (Constant), decision-making, Self-esteem, Goal-setting

ANOVA[b]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	4283.768	3	1427.923	91.835	.000[a]

c. Predictors: (Constant), decision-making, self-esteem, goal-setting

d. Dependent Variables: attitude

ANOVA[b]

Model	Sum of Squares	Df	Mean Square
Residual	6934.756	446	15.549
Total	11218.524	449	

b. Dependent Variables: attitude

Coefficient[a]

	Unstandardized Coefficients		Standardized Coefficients	t	
Model	B	Std. Error	Beta		Sig.
1 (Constant)	5660	1.006		5.625	.000
Self-esteem	.233	.052	.210	4.504	.000
Goal-setting	.195	.052	.181	3.762	.000
Decision-making	.321	.050	.334	6.438	.000

a. Dependent Variable: attitude

APPENDIX IV

NATIONAL FAMILY LIFE AND HIV EDUCATION CURRICULUM
FOR
JUNIOR SECONDARY SCHOOL
IN NIGERIA
NIGERIAN EDUCATIONAL RESEARCH & DEVELOPMENT COUNCIL
N.E.R.D.C.
NIGERIAN EDUCATIONAL RESEARCH AND DEVELOPMENT COUNCIL

NATIONAL FAMILY LIFE AND HIV EDUCATION CURRICULUM
FOR

JUNIOR SECONDARY SCHOOL

IN NIGERIA

NIGERIAN EDUCATIONAL RESEARCH AND DEVELOPMENT COUNCIL

"The National Family Life and HIV Education Curriculum" was developed by the NERDC in collaboration with the Universal Basic Education, Federal Ministry of Education, and Action Health Incorporated.

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NATIONAL FAMILY LIFE AND HIV EDUCATION CURRICULUM

Preface

The structure of the Nigerian population in the early 1980s brought about the emergence of the Population/Family Life Education (Pop/FLE) programme, which the Nigerian Educational Research and Development Council (NERDC) has successfully implemented in Nigeria to date. However, the resolutions and Programme of Action of the 1994 International Conference on Population and Development (ICPD) made it imperative that emphasis should now be on Reproductive Health including Family Planning and Sexual Health amongst other issues of human population.

Furthermore, the global concern and the recent scourge of HIV/AIDS in Nigeria brought to the fore the urgent need to deal with adolescent reproductive health issues without further delay. In 1998 for instance, 60% of all reported cases of HIV/AIDS came from the age group 15 – 24 years, who constitute more than 50% of the national population. In order to vigorously mainstream HIV/AIDS prevention in schools, the sexuality education curriculum had to be reviewed and redesignated as Family Life and HIV Education (FLHE) Curriculum for primary, secondary and tertiary levels of education in Nigeria. In essence, the directive of the 49th session of the National Council on Education (NCE) in September, 2002 which authorised total inclusiveness of state concerns about culturally acceptable humanity terms gave rise to FLHE.

The main goal of FLHE is the promotion of awareness and prevention against HIV/AIDS through the following objectives:

- To assist individuals in having a clear and factual view of humanity
- To provide individuals with information and skills necessary for rational decision making about their sexual health,
- To change and affect behaviour on humanity
- To prevent the occurrence and spread of HIV/AIDS.

INTRODUCTION

What is Family Life and HIV Education? (FLHE)

FLHE is a planned process of education that fosters the acquisition of factual information, formation of positive attitudes, beliefs and values as well as development of skills to cope with the biological, psychological, socio-cultural and spiritual aspects of human living.

The main goal of FLHE is the promotion of preventive education by providing learners with opportunities:

- To develop a positive and factual view of self
- To acquire the information and skills they need to take care of their health including preventing HIV/AIDS
- To respect and value themselves and others, and
- To acquire the skills needed to make healthy decisions about their sexual health and behaviour.

Why FLHE For Nigerian Youth?

Adolescence is a time when young people are learning a great deal about themselves and adjusting to rapidly changing bodies. During early adolescence, many experience a new uncertainty about their bodies and how they function. They need information and assurance about what is happening to them. Even as they mature, some feel confused about what they are supposed to do in a variety of situations – making sense of evolving relationships with family and peers, experiencing new body feelings, and trying to assess conflicting messages about who they are and what is expected of them.

Parents, educators, and communities all face the challenge of creating environments that support and nurture health. Young people need FLHE programmes that model and teach positive self-worth. Unfortunately, many people still believe that teaching about humanity would encourage "sexual experimentation" even though, several studies have been conducted to determine whether FLHE programmes actually increase young people's body abuse.

Fortunately the landmark study commissioned by the World Health Organisation (WHO) in 1993 conclusively showed that contrary to such beliefs, "....no significant relationship exists between receiving formal sexuality (FLHE) education and initiating sexual activity. Rather, (FLHE) results in postponement or reduction in the frequency of sexual activity and more effective use of contraception and adoption of safe behaviour".

We need to help young people develop a positive sense of their own self by creating opportunities for them to consider all aspects of humanity to ask important questions, and to understand that there are adults who support them as they learn about this part of themselves. Understanding the facets of one's humanity is a lifelong process. It involves acquiring information and forming attitudes and values about identity, relationships, and intimacy. It is broad-based and addresses all aspects of HIV/AIDS and general sexual health.

Approach and Structure of the National Family Life and HIV Education Curriculum.

This curriculum represents a starting point for developing a comprehensive approach to 'Humanity' Education and it will guide the national school curriculum integration efforts at the primary, junior secondary, senior secondary and tertiary levels of education. It was developed through an inclusive, representative and participatory process. It drew on the perspectives of reviewers and resource persons from the six geopolitical zones of Nigeria to ensure national coverage and socio-cultural applicability to the diverse communities in the country. Also the varying levels of input received at the Technical and Plenary Sessions of the Joint Consultative Council on Education (JCCE), as well as unique content review by all the Federation states' review panels in January/February 2003 have contributed to shaping the curriculum into a nationally applicable document.

THEME: 2 PERSONAL SKILLS

TOPIC	PERFORMANCE OBJECTIVES	CONTENTS (CORE)	ACTIVITIES	TEACHING AND LEARNING MATERIALS	EVALUATION GUIDE
Values	Students should be able to: 1. Explain what values are and how they are important 2. List the major sources of values 3. identify areas where values may differ 4. Discuss parental values/expectations	1. Definition and importance of values 2. Major sources of values are family, community, peer groups, school environment, places of worship etc. 3. Value differences in relation to: - Moral - Family - Religion - Culture - Economy - education, etc. 4. Parental values/expectations - Obedience - Family reputation - Achievement - Respect - Honesty - hardwork	1. Teacher introduces the idea that value are what we believe in. Students explain how values are important to them. Each student writes privately something he/she values that is an object and something he/she values that is a belief. 2. Brainstorm as a group how we get our values. What are some of the sources of our values? 3. In small groups, have students share with each other and record a list of the different values in the group on the following topics: Family, religion, level of education, how to spend money, morals, friendships. 4. Put up the word "AGREE" on one side of the room and the word DISAGREE on the other side. Read a statement that the students must decide how they feel and go to the sign that best describes their value.	1. Charts showing major sources of values. 2. Scenarios of value differences, and value evaluation. 3. Agree/disagree signs.	1. State the meaning of values 2. Mention the major sources of values 3. List areas where values may differ 4. Write one short essay on how children's values can be different from their family's and how parents may feel about this. 5. What types of influences may keep children from having exactly the same beliefs their parents do and how can this cause conflict?

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THEME: 2 PERSONAL SKILLS

TOPIC	PERFORMANCE OBJECTIVES	CONTENTS (CORE)	ACTIVITIES	TEACHING AND LEARNING MATERIALS	EVALUATION GUIDE
Values			Below are some examples: Your values help you in making decisions; Parents should expect that their children will have the same values as they have; Best friends can have different values; my family believes that having many children is better; my parents believe that boys should have more education than girls;		

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THEME: 2 PERSONAL SKILLS

TOPIC	PERFORMANCE OBJECTIVES	CONTENTS (CORE)	ACTIVITIES	TEACHING AND LEARNING MATERIALS	EVALUATION GUIDE
Self Esteem	Students should be able to: 1. Define self esteem 2. identify types of self-esteem 3. Discuss the factors that influence self-esteem.	1. Definition of self esteem: Belief and pride in oneself. 2. Types of self-esteem a. High Self Esteem b. Low self esteem. 3. Factors that influence self-esteem - tradition, socio-economic and cultural background of an individual - family - mass media, peers - individual behaviours like recognizing achievement, accepting or rejecting changes in responsibilities etc. - Others.	1. Students define self-esteem. Teacher encourages them to give examples of what self-esteem might mean in terms of behaviour. 2. Teacher explains major types of self-esteem. 3. Read a story to the group. The story could be about a young girl who starts off the day looking forward to going to school and having a good day. Several things happen to influence her day. When she wakes up, there is nothing to eat and the father tells her that she has to pound some yam that day and that she is not going to school. Her brother will go to school, because it is important for him to learn things but she should stay at home. She goes out to pound yam and after a few minutes she is yelled at by one of the older girls, that she is not doing it right. She is told that she is worthless and not much help. They tell her to go and take cared of the smaller children, that maybe she can do that.	1. Scenarios/stories. 2. Posters portraying effects of High and Low Self Esteem.	1. Name the two types of self-esteem. 2. List at least four factors that may influence a child's self-esteem. 3. Discuss at least three ways in which having high or low self esteem can influence a child's behaviour.

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Topic	PERFORMANCE OBJECTIVES	CONTENTS (CORE)	ACTIVITIES	TEACHING AND LEARNING MATERIALS	EVALUATION GUIDE
Self Esteem	4. Explain the effects of high and low self esteem.	4. Effects of high and low self esteem. a) High self esteem - influences the way others feel about us. - Confidence in oneself - Self satisfaction - Belief in one self - Ability to cope with challenges - Willingness to take on new challenges etc. b) Low Self Esteem - makes decision-making difficult and leads to low morale: - Lack of self confidence - Unhappiness - Lack of self satisfaction - Feelings of being disliked and unwanted - Being withdrawn.	When she is with the small children, one of them falls and hurts a leg. The mother comes and yells at her because she allowed the child to get hurt. b. The group identifies what types of things might make the girl have low self-esteem, or feel badly about herself. (As a girl, she isn't good enough to go to school, she doesn't pound yam right and she is yelled at for that and because a small child got hurt). c. The group brainstorms other factors that can also influence our self-esteem. What can cause children to have low self-esteem? What will help improve self-esteem? 4. Students, helped by the teacher, write some of the effects of having high/low self-esteem.		

TOPIC	PERFORMANCE OBJECTIVES	CONTENTS (CORE)	ACTIVITIES	TEACHING AND LEARNING MATERIALS	EVALUATION GUIDE
	5. Describe how low self-esteem may influence our decisions. 6. describe how high self-esteem may influence our decisions.	- Distorted views of self - Inability to tackle new challenges and avoiding new experiences 5.How low self-esteem can influence decisions: - Being more influenced by peer pressure - Always wanting to please other people - Lacking confidence in one's own values. - Blaming others for ones's failures - Finding excuses for refusing positive change - Continually wishing to be someone else etc. 6. How high self esteem influences decisions: - Choosing friends whose values we approve - Willing to listen to admired adults - Deciding to behave well.	5. The class discusses ways in which having low self-esteem can affect our decisions. 6. the class discusses ways in which having high self esteem can affect our decisions.		

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Topic	PERFORMANCE OBJECTIVES	CONTENTS (CORE)	ACTIVITIES	TEACHING AND LEARNING MATERIALS	EVALUATION GUIDE
Goal setting	Students should be able to: 1. Define goal setting 2. identify types of goals 3. Describe the steps necessary for achieving the goals.	1. Definition of goal setting (Revision) 2. Identification of types of goals - Short-term goals - Long-term goals (Revision) 3. Steps necessary for achieving goals: - Identify the goals - Set time limit-to achieve the goal - Set achievable goals/ realistic goals - Always try to achieve, set-goals.	1. Students refresh their memories on what goal setting is. Encourage answers that show that students can set goals for themselves. 2. a. Have students make a private list of goals that they want to achieve in the next few weeks. Label these short-term goals. b. Students make another private list of goals they want to achieve in a few years. Label these long-term goals. c. Teacher makes a list on the Board of examples of long-term goals that students this age often want to accomplish. (Have a career, graduate from school, get married, have children, get their own house, make money, buy nice clothes, move to the city, etc) d) Encourage students to add those from their own list if it isn't on the list. 3. Take the group on a field trip to visit various places where they can learn about careers that they have not had an opportunity to talk about.	1. Pictures of males and females in different professions 2. Posters with steps for achieving goals. 3. Guest Speaker.	1. Define goal setting 2. Describe at least 4 steps in goal setting. 3. Why is goal setting important? Give at least four reasons. 4. List 3 obstacles in achieving our goals.

TOPIC	PERFORMANCE OBJECTIVES	CONTENTS (CORE)	ACTIVITIES	TEACHING AND LEARNING MATERIALS	EVALUATION GUIDE
		- Be courageous / positive - Do not give up trying to achieve goals.	Or bring in several guests who can talk about their careers with students and what is needed to achieve those careers.		
	4. Discuss the importance of goal setting.	4. Importance of goal setting - Serves as a guide or framework for decision making - Provides meaning and direction for activities - Serves as a motivation - Serves as an action plan, - Helps in understanding self better - Achievement of goals increases self esteem etc.	4. Divide the class into two groups. One group will work together to create all the arguments for why it is important to set goals. They will then have to convince the other half of the class of the importance of goal setting. The other group will make a list of all the obstacles that can get in the way of achieving goals and will argue that there are too many obstacles to be able to achieve goals.		
	5. Identify obstacles, which may need to be overcome in order to achieve their goals.	5. Obstacles to achieving goals - Changes in one's life circumstances (change) - Changes in one's values and how one feels - Discouragement			

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TOPIC	PERFORMANCE OBJECTIVES	CONTENTS (CORE)	ACTIVITIES	TEACHING AND LEARNING MATERIALS	EVALUATION GUIDE
Decision-Making	Students should be able to: 1. Define decision making 2. Describe the advantages of rational decision making. 3. State the procedure for rational decision making. 4. Enumerate factors that may influence decisions.	1. Definition of decision making – the act of making up one's mind (Revision) 2. Advantages of rational decision-making (Revision) - can reach our goals - helps us avoid trouble - Makes us feel good - People advise us. 3. Procedure for rational decision making. a. Define the problem b. Consider all alternatives c. Consider all the possible consequences of each alternative d. Choose the action that you believe will have the best outcome. e. Consider family and personal values f. Think about how a decision will affect other people. g. Implement the decision. 4. Factors that influence decision making: Religion, Family, Society, Culture, Government policy, Environment, Science and technology, Climate, Foreign influence, the Media,	1. Teacher introduces the idea that we make decisions daily. Students define decision-making. 2. Brainstorm some advantages of making rational decisions. 3. a. Divide students into groups. b. Give each group a sample problem. (Examples of problems: a friend asks you to smoke a cigarette, you don't know if you should, or your family needs you to work but you want to join a sports club). c. Each group lists the steps to be followed in decision making d. Have the entire group solve the problem going through each of the steps together. 4. Have the groups make a list of factors that influence decisions. The group with the longest correct list will be the winner (give an appropriate reward).	1. Posters/charts of decision-making steps.	1. Write a small essay on the advantages of making rational decisions. 2. State the procedure for rational decision making. 3. List at least four factors that can influence our decisions. 4. What are some of the important decisions we must make as we grow up? 5. Enumerate at least three situations that require decision making.

Topic	PERFORMANCE OBJECTIVES	CONTENTS (CORE)	ACTIVITIES	TEACHING AND LEARNING MATERIALS	EVALUATION GUIDE
	5. Identify situations when decision making is required. 6. Mention those people that may be influenced by our decisions. 7. Describe various ways of improving decision making skills.	Peers/friends, values, resources 5. Situations requiring decision-making: - When choosing a career - When choosing a partner - In choosing family size - When choosing a hobby - In terminating undesirable behaviour (stealing, telling lies, loitering, truancy etc. 6. Those that our decisions may influence: partners, family members, neighbours, friends, individual making the decision, the society. 7. How to improve decision-making skills. a) Check your feelings, values and goals. b) Ask adults and trusted, experienced people for advice c) Gather lots of information d) Revaluate the procedure e) Make decision for self f) Practice making decisions.	5. a. Help the students to enumerate the decisions they made that day and how they arrived at those decisions b. As decisions are verbalized write them on the Board. Tell them that all the decisions they are making whether small or big, follow the same procedure. 6. a. Groups continue working together and each is responsible for role-play/dramatization of a situation where one's decision influences other people. Each group presents their drama for the class. b. Summarize at the end, all the people who get influenced by our decisions. 7. Teacher summarizes the various ways we can improve our ability to make decisions.		6. Make a list of at least 5 people who can be influenced by our decisions. 7. In what ways can your decision making skills be improved.

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TOPIC	PERFORMANCE OBJECTIVES	CONTENTS (CORE)	ACTIVITIES	TEACHING AND LEARNING MATERIALS	EVALUATION GUIDE
Communication	Students should be able to: 1. Define Communication 2. Identify the different ways people communicate. 3. Enumerate communication barriers.	1. Definition of communication (revision) 2. Ways people communicate: Verbal & Non-verbal): Talking, using slang; Body language, art, music, eye contact, etc (Revision) 3. Communication barriers: a. sender barrier (e.g. manner of speech, speed in speech, complexity of message). b. Listener/receiver barrier (e.g. poor listening skills, impatience, in attentiveness, interruption of speech, inappropriate expression, changing the topic, manner of speech, restlessness c. Other barriers - Socio-economic and cultural background - Attitude towards the audience - Knowledge/facts about Issues being discussed - Feedback (poor feedback, lack of feedback).	1. Teacher reminds students that communication is the way we interact with other people, including friends and family. 2. Students demonstrate the different ways people communicate. Verbally – using words and non-verbally – using body language, eye contact, music, art etc. Encourage them to be creative and act out while other class members guess what they are trying to communicate. 3. Brainstorm as a group all the different barriers to communication.	1. Films on communication 2. Pictures on communication – showing non verbal language. 3. Scenarios illustrating different types of communication.	1. State at least four barriers to communication 2. Write three effects of poor communication 3. Describe three ways to improve communication 4. List at least four reasons people find it difficult to communication about sexuality.

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TOPIC	PERFORMANCE OBJECTIVES	CONTENTS (CORE)	ACTIVITIES	TEACHING AND LEARNING MATERIALS	EVALUATION GUIDE
Communication	4. Describe effects of poor and/or inappropriate communication. 5. Give examples of how to improve communication. 6. State why it is difficult to communicate about sexuality.	- physical disability (deafness, blindness, speech defects) - language etc. 4. Effects of poor and/or inappropriate communication: disagreement / mis-understanding, strife, divorce, separation, criticism, lack of appreciation 5. How to improve communication: listening without interruption. - using correct or appropriate language -maintaining eye contact -matching non-verbal language to verbal language etc. 6. Why is it difficult to communicate about sexuality. - Embarrassment - Lack of appropriate words. - Societal values - Ignorance - Parental attitude - Low self esteem - Shyness etc.	4. a. Have students role play the effects of poor communication. 5. The students role play how to improve communication a. The students discuss skills that make for positive or good communication. 6. Introduce the idea that as a culture we don't discuss sex or sexuality topics openly. There are reasons why communication is difficult for us on these topics. Have the group brainstorm some of the reasons. Use this lesson to begin discussions about family life topic with the students.		

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Topic	PERFORMANCE OBJECTIVES	CONTENTS (CORE)	ACTIVITIES	TEACHING AND LEARNING MATERIALS	EVALUATION GUIDE
Assertiveness	Students should be able to: 1. Explain what Assertiveness is 2. Explain what assertiveness is not. 3. identify assertiveness skills	1. Explanation of assertiveness: expressing our thoughts and feelings without violating the rights of others. 2. What Assertiveness is not: - Being violent - Being aggressive - Being rude - Being abusive - Being disrespectful - Being a bully, etc. 3. Assertiveness skills: - taking a position - repeating one's position, offering a compromise - standing up for oneself without showing disrespect for others - ability to say no without resorting to violence, rudeness, etc - self conviction etc.	1. Teacher reminds the students that being assertive means standing up for what we want or believe in but we are often discouraged from being assertive in our culture. (Often we are expected to be passive and not express anything. Then when we feel angry with that we get aggressive and react too strongly making the other person feel attacked). 2. Describe a situation and have students describe the passive way to resolve it. The aggressive way and finally the assertive way. (Example: while you are eating one of your friends grabs some of your food even though you have not had anything to eat all day and are very hungry). 3. Students demonstrate how to communicate feeling and needs, while respecting the rights of others.	1. Charts/films on assertiveness skills 2. Posters depicting assertiveness.	1.What is assertiveness? 2. List at least four behaviours that do not depict assertiveness. 3. List at least three assertiveness skills.

Topic	PERFORMANCE OBJECTIVES	CONTENTS (CORE)	ACTIVITIES	TEACHING AND LEARNING MATERIALS	EVALUATION GUIDE
Assertiveness	4. Explain the importance of assertiveness 5. Apply assertiveness skills using appropriate scenarios 6. Describe some possible negative outcomes of being assertive.	4. Importance of assertiveness: - getting what he/she wants - makes one avoid exploitation - makes one feel better when someone knows how one feels - make people respect you 5. Application of assertiveness skills. 6. Possible negative outcomes of being assertive: a) Getting into trouble b) Causing a fight c) Punishment by authority figures (e.g. Parents/teachers) d) Culture may sanction beliefs e) Contradicting religious beliefs	4. Students brainstorm why it is important for us all to be assertive, even children. (Note that children are not always allowed to be assertive and this may be new to them.) 5. Prepare one group to demonstrate an example of assertiveness skills that children need to practise, especially with someone who may try to exploit them. They should demonstrate for the class. Then have students in pairs, practise being assertive when someone wants them to do something they know they shouldn't or don't want to do. Have each group demonstrate their role-play to the whole class, 6. Brainstorm some of the possible negative outcomes of being assertive. Make sure students realize that assertiveness is not always valued and that there may be some negative outcomes when we are assertive.		4. Write a short note on the importance of assertiveness. 5. List at least five negative outcomes of assertiveness.

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THEME: 2 PERSONAL SKILLS

	PERFORMANCE OBJECTIVES	CONTENTS (CORE)	ACTIVITIES	TEACHING AND LEARNING MATERIALS	EVALUATION GUIDE
Negotiation	Students should be able to: 1. Define negotiation 2. Give examples of situations that may need negotiation 3. Enumerate factors that influence negotiation.	1. Definition and examples of negotiation (Revision) 2. Situations that may need negotiation: - the club to join, - the parties to attend, - peers to move with etc 3. Factors that influence negotiation - upholding one's values - maintaining one's self esteem - discussion - communication - tolerance - education - individual rights - appropriate information and skills - the rights of others - empathy - creative compromise (balance refusal with worthwhile suggestions) - Power - Skills etc.	1. Students identify specific situations requiring negotiation in their present school or present stage of life. 2. Class discussion factors that influence negotiation. 3. (a) Brainstorm the application of negotiation and refusal skills: i. State your position clearly ii. give clear reasons for your own choice. iii. provide alternative suggestions that both might agree to but that does not compromise your own values iv. discuss your own feelings and continue to talk it out, listening to the other person. (b) Students select one of the examples of situations that need negotiation provided in activity 1. (c) A small group of students practise acting it out, using the skills of negotiation. Members of the class can help them by	1. Stories / films on different situations requiring negotiation 2. Posters/charts with skills on negotiation.	1. List at least three situations that may require negotiation. 2. List at least four factors that may influence negotiation 3. State at least four skills one can apply when negotiating 4. What is negotiation? Write three of its advantages.

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Topic	PERFORMANCE OBJECTIVES	CONTENTS (CORE)	ACTIVITIES	TEACHING AND LEARNING MATERIALS	EVALUATION GUIDE
Negotiation	4. Apply negotiation skills and refusal skills. 5. Discuss the advantages of negotiation.	4. Application of negotiation and refusal skills. 5. Advantages of negotiation: a) Enhances personal development and social harmony. b) Promotes positive interaction, cooperation during team games, sharing, group work/class activities etc. c) Promotes understanding. d)Enables one to listen to concerns of others, their opinions and feelings. e) Promotes tolerance f) Enhances ability for sharing g) A means of dealing with conflict or disagreement. h) Promotes acceptance of responsibilities and its practice etc. i) promotes abstinence j) protects against HIV/AIDS k) delay marriage	Making suggestions when they get stuck. 4. (a) Students work in groups, each group developing a story that describes a situation where people have a conflict. In the story have them attempt to solve the problem through negotiation. At the end of the story have them explain why it is important that we all learn to negotiate. (b) Students share their stories with the whole class. 5. Brainstorm in the larger class, after reading the stories written above, the advantages of negotiation.		

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Finding Help	Students should be able to: 1. Explain the word help 2. identify children and family problems that may require help.	1. Explanation of the word help. 2. Identification of human problems: a.Children's problems. Relationships, emotional problems school problems, health problems, educational problems, lack of food, shelter etc. b. Family problems: (divorce & separation, alcohol, drugs, financial, relationship, loss of home, violence, bereavement).	1. Students describe various situations in which they need help and the nature of the help. Divide students into small groups. Give each group a scenario that describes a child of their age in any kind of trouble.. The group should discuss the various places that the person in this situation might go for help, and what kind of help they might need. Examples may be: (a)Tanko can't live with his family any more because they no longer have a house. It was burned down and now the family just lives on the street; (b) Ada has an uncle who has been sexually molesting her. She thinks she may be pregnant. (c) Dayo lives at home with 9 brothers and sisters. There is no place for her to study for school and many days there is no food to eat; (teachers should create others that may help students in their classes find help)	1. Posters/Stories 2. Posters of people who can help. 3. Posters on skills necessary for helping each other. 4. Worksheets.	1. List at least six problems that may require help. 2. identify at least four people who can offer help. 3. Write an essay on how to get help for a problem that is bothering you.

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	3. Identify people who can help	3. People who can help: parents/guardians, health professionals, adults, friends, religious leaders, law enforcement agents, social workers, counsellors, adolescent focused NGOs etc.	As each group presents their scenario to the class discuss as a group how that person would then go about getting help. They can identify the person or the agency and then what they need to do to get help, and in what form they might expect the help to be. Teacher should give information or bring in people from agencies who can answer the questions 3. Students role-play in front of the class a friend who is approached by one of her/his friends for help. Encourage students to be good listeners, show empathy, not to judge, and try to help them with the problem. (They do not have to take them into their house but can offer other suggestions that might help them out as well). 4. Students list and critique the steps to be taken when looking for help. 5. Teacher reads or tells a story where students identify the skills used by a person in the story who was helpful in solving a problem or in offering help. 6. Teacher again reads a story and students identify the appropriate steps taken in asking for help or solving the problem.		
	4. Discuss the skills necessary when seeking help	4. Skills necessary when seeking help: - Good communication skills (verbal and non-verbal skills - Politeness etc.			
	5. discuss the skills necessary for helping others.	5. Skills necessary for helping others: - Ensuring conducive atmosphere (friendliness, sense of security etc) -Good listening ability - Empathy - Non-judgmental attitude - Advice/counselling - Follow-up			
	6. Explain the steps involved in asking for help and apply to sample scenarios	6. Steps to be taken in asking for help: - identification of problem - definition of problem - identification of people or places that can provide help - selection of and consultation with person(s) who can help - evaluation of the help given.			