HIV and AIDS Prevention, Care and Support for Children Infected and Affected by HIV and AIDS in Vietnam Project

Report on Knowledge-Attitude-Practice survey in relation to HIV and AIDS of In-Out of school children and Needs Assessment of Children Infected and Affected by HIV and AIDS in Binh Thanh, Go Vap and Hoc Mon Districts of Ho Chi Minh City

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<table>
<thead>
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<th>Description</th>
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</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Human Immunodeficiency Disease</td>
</tr>
<tr>
<td>STDs</td>
<td>Sexually transmitted diseases</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus group discussion</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>KAP</td>
<td>Knowledge, Attitude, Practice</td>
</tr>
<tr>
<td>VWU</td>
<td>Vietnam Women's Union</td>
</tr>
<tr>
<td>Life</td>
<td>The Quality of Life Promotion Centre</td>
</tr>
<tr>
<td>HCMC</td>
<td>Ho Chi Minh City</td>
</tr>
<tr>
<td>CPFC</td>
<td>Committee for Population, Family and Children</td>
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</tbody>
</table>
Executive Summary

This surveyed was commissioned to Life Quality Promotion Centre (Life Centre) by Save the Children UK with the main objectives to (i) find out KAP of children and youth related to HIV and AIDS and other related topics, and (ii) assess the needs for care and support of HIV and AIDS-infected and affected children and youth. The main informant groups were (i) schooling children (ii) dropouts (iii) HIV and AIDS-infected/affected children; (iv) family members of HIV and AIDS-infected/affected children; and (v) officials of local communes in proposed project districts of Binh Thanh, Go Vap, and Hoc Mon. The survey employed a combined quantitative and qualitative method.

Main findings on KAP related to HIV and AIDS of children in and outside school and other related topics

Most of the surveyed children had heard about HIV and AIDS. Most of the surveyed children had insufficient and in appropriate knowledge about HIV and AIDS. 77.31% of children were able to mention correctly the three main routes of HIV transmission. The percentage to provide correct answers on prevention methods was only 39.79%. Less than 5% of the children could answer correctly the examples of symptoms or could name all the examples of STDs.

More than half of the surveyed children held negative attitude of children towards those infected by HIV or having STDs. However, most of the children expressed willingness to care for their relative or friends if they were infected by HIV and AIDS. More than half of the children thought their home districts had HIV and AIDS-infected people and 39.59% of children thought they were also at risk of being infected.

Children’s practices were recoded indirectly through self assessment. The number of children who claimed to follow positive practices was low. About one third of the children (31.33%) of the children knew where condom was sold or handed out free of charge. 16.07% of children claimed to know how to use condom. The majority (64.56%) of children thought their peers had already had sex and most of them used condom.

There were no significant differences in terms of KAP among the groups due to age, level of education, or genders. Impacts of peer educators were low in improving KAP for children in and outside school.

Most of the children (81.24%) had heard about rights of children and youths, mainly from their schools. Most of the children agreed with the probing examples of rights.

The entertaining information sources were preferred by children. Communication through small groups or personal communication was preferred by less than 30% of the children. However, the project needs to pay attention to this channel of information because at the moment KAP of children remained very superficial and there were still some important confusion. The role of peer educators in the project needs to be strengthened both in terms of coverage and quality of their work.

Needs of HIV and AIDS-infected/affected children

The population of HIV and AIDS-infected people tends to rapidly become younger. Most of the victims only discover that they are infected when there were obvious symptoms or when they go for a health check up. Most of the surveyed children were living in areas with many infected people and/or drug addicts. Most of them live in poor families where 03 generations were sharing a roof. The children expressed that they did receive love and care from their family members, but they rarely discussed with families members their private issues.

Public media and family members were the main sources of information for HIV and AIDS-infected and affected children. More schooling children were able to provide correct answers on main routes of HIV
and AIDS transmission than dropouts. This group also had more positive attitude towards those infected.

HIV and AIDS-infected/affected children were faced with the risks including (i) transmission from relatives, (ii) living in anxiety or nursing a complex of shame, (iii) lacking access to education (iv) being discriminated, lacking friends and support. Besides, HIV and AIDS-infected/affected also had the needs for information on HIV and AIDS, the needs to participate in peer clubs, and to be cared for in case of being orphaned.

Needs of children’s families were mainly about support for prevention/treatment, job support, and reduction of discrimination.

**The program on HIV and AIDS prevention, care, and support**

Prevention and combating HIV and AIDS received much attention from the local government and organizations in the surveyed areas. The main prevention interventions were communication for prevention and treatment of drug addiction. The main information sources were public media and community counselling centres.

The HIV and AIDS care and support programs for children and their families were being conducted by the government and organizations at different levels. The intervention programs were working in different areas including counselling, discovering and treating opportunistic diseases, home care, preventive treatment, income and job support, and establishing care centres.

The main limitations of the current programs were that the need for a highly effective management system providing psychological support to HIV and AIDS-infected/affected children had not received due attention.

**Recommendations**

The recommendations focus mainly on:

(i) Strengthening communication on HIV and AIDS for children both in and outside school.

(ii) Providing early education on life skills and knowledge on sexuality.

(iii) Providing support to ensure that HIV and AIDS-infected/affected children are treated equally and could have access to education and entertainment.

(iv) Establishing a management system providing support to HIV and AIDS-infected/affected children and other children in the community.
Chapter 1. Objectives and Methodology of the Assessment

1.1 Context and objectives of the assessment

Since 2004, Save the Children UK has conducted a project on HIV and AIDS prevention for children and support for HIV and AIDS-infected/affected children in Hai Phong, Bac Giang, Ho Chi Minh City, and Long An. In Ho Chi Minh City and Long An Province, Save the Children UK, in collaboration with the Committee for Population, Family, and Children to conduct the project from 2004 to 2007 with the main objective to protect children in project area from HIV and AIDS and provide appropriate support and care measures to minimize negative impacts from HIV and AIDS to children life.

From the practical results during the last 02 years in Tan Phu District, District 6, and District 8, Save the Children UK has decided to expand the project area to Binh Thanh, Hoc Mon, and Go Vap districts in Ho Chi Minh City. This survey is a first step serving the expansion of the project.

The Quality of Life Promotion Centre (Life Centre) has been commissioned by Save the Children UK to conduct a survey with the following objectives:

- To gain an understanding of knowledge, attitude and practice of in- and out- school children in the three project districts in relation to HIV and AIDS, sexually transmitted diseases (STDs), sex and sexuality and child’s rights in the context of HIV and AIDS.

- To assess the needs of infected and affected children for care and support.

- To develop recommendations for the stakeholders to address issues and needs to be identified during the assessment.

To achieve these objectives, the assessment is also intended to identify existing infected and affected children support programs, their accessibility and needs to support the children more effectively.

1.2 Assessment sites

This assessment was undertaken in the three districts that the project is to be implemented being Binh Thanh, Go Vap and Hoc Mon Districts. In each district, 2 wards/communes and 2 high schools (senior and/or junior level) were selected to conduct the assessment. After discussing with the project partners (CPFC) and in consultation with the local authorities, the following sites were selected.

- Ward 12, Ward 26, Le Van Tam Junior High school and Truong Cong Dinh Senior High school of Binh Thanh District.

- Ward 3, Ward 12, Truong Son Junior High school and Nguyen Trung Truc Senior High school of Go Vap District.

- Tan Xuan Commune, Xuan Thoi Son Commune, Tan Xuan Junior High school and Xuan Thoi Thuong Junior and Senior High school of Hoc Mon District.

1.3 Assessment team

The assessment was jointly conducted by Save the Children UK, the Life Centre and an interviewer...
team being school children and the children in the community (considered as peers).

- Save the Children UK was responsible for (1) organising and liaising with the concerned agencies and authorities to prepare for the survey; (2) providing data collection tools; (3) supporting and supervising data collection and (4) collaborating with CPFC HCMC to train 60 interviewers collecting information on the situation and needs of infected and affected children.

- Life Centre was responsible for (1) training a team of interviewers being school children and community based children on the structured KAP questionnaire; (2) training Life Centre's interviewers on the semi-structured interview guide; (3) collecting qualitative information on the needs of infected and affected children from infected and affected children, families of infected and affected children and concerned government agencies and mass organisations; and (4) analyzing all data and information and write report of the entire assessment.

- The interviewers who are peers was responsible for conducting structured interviews with in and out-school children, infected and affected children. The Life survey team undertaken Focus Group Discussions with the infected and affected children, their families and local government bodies and relevant organisations.

1.4 Methodology of the assessment

The assessment applied a combination of qualitative and quantitative methods. Secondary sources of information were also used as references. Group interviews were conducted in a participatory manner so as to facilitate the participation of officials from the concerned agencies of the project assessment sites.

All group interviews were tape recorded and transcribed, checked and analyzed manually. Data collected from structured questionnaires were analyzed using SPSS software. The information collected from these two methods was independently analyzed. Report was compiled by Life Centre based on the analysis of this data/information.

1.5 Sampling and sample size

Infected and affected children were selected from the list of adult people living with HIV and AIDS provided by various concerned departments, organisations, charity and religious groups, Save the Children UK. A total of 229 questionnaires have been completed by the infected and affected children.

In- and out-school children were selected from the two groups: (1) Out-school children aged from 11 to 18 living in the assessment sites and (2) Children within the same age range studying in the junior and senior high schools in the same localities. The expected size for this sample was 1,000 children (approximately 10% of the total number of children in each site). The children were randomly selected from the lists of children provided by the authorities of the districts and schools. However, only 965 questionnaires were valid (properly completed). See Annex 1 for details of sampling for this group.

The actual samples in reality are presented in the below table.

**Table 1. Actual sample size and valid questionnaires for data analysis**

<table>
<thead>
<tr>
<th>Data collection techniques</th>
<th>Binh Thanh</th>
<th>Go Vap</th>
<th>Hoc Mon</th>
<th>Collected questionnaire</th>
<th>Valid questionnaires</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structured interviews of infected and affected children with questionnaires</td>
<td>111</td>
<td>72</td>
<td>26</td>
<td>229</td>
<td>194</td>
</tr>
</tbody>
</table>
### 1.6 Data collection

In this survey, data were collected by quantitative and qualitative methods. For quantitative method, a KAP structured questionnaire was used for individual interviews of two groups including (1) in and out – school children and (2) infected and affected children. All individual interviews were conducted by children from designated localities and schools with support and supervision from the CPFC’s project staffs and teachers of the respective schools. Prior to the interview, a one-day training on how to use KAP structured questionnaire was organised by the Life Centre’s assessment team for the interviewers.

Qualitative method was applied to gain insight information and perspectives from infected and affected children, their families and representatives of concerned government bodies and organisations. For collecting qualitative information, focus group discussions (FGDs) were conducted using three sets of interview guides - one set for infected and affected children, one set for families and one set for concerned bodies/organisations. Each FGD took approximately one and a half hours and were tape recorded to prevent information from missing. All the FGDs were facilitated by the Life’s survey team with the arrangement and support from Save the Children UK project staff.

### 1.7 Ethical considerations

The assessment has complied with the international code for research ethics. All respondents participated in the assessment voluntarily. All interviews, transcriptions, interview notes, codes and interview schedules have been kept in confidence. The assessment team has been committed to the principles of the Convention on the Rights of the Child and to the professional and ethical standards described in the Save the Children UK’s Child Protection Policy document.

### 1.8 Limitations of the assessment

It has been a challenge to ask and discuss such topics as HIV and AIDS, STDs, sex, sexuality which are traditionally sensitive with the children in the first meeting.

A large part of the children invited to the FGDs are in the lower range of age (11-12 years of age, Grade 6) and thus they were very shy and hesitant to share their thoughts in the above-mentioned topics. As such, the assessment team had spent more time than expected to make acquaintance to the children and make them comfortable prior to proceeding to the actual discussion.

The Life’s team failed to conduct the FGD of infected and affected children from Binh Thanh District as 11 out of 12 children are under 10 years old. The Life’s team requested to re-organize the FGD of this group but this could not be arranged.
Chapter 2. KAP in relation to HIV and AIDS of in- and out-school children

2.1. Profile of the respondents

A total of 965 KAP questionnaires were correctly completed and valid for data analysis. Specifically, there were 315 (32.64%) from Binh Thanh District, 345 (35.75%) from Go Vap and 305 (31.61%) from Hoc Mon. There were 51.92% male and 48.08% female children. There are no statistical differences in gender in all assessment sites.

Some 86.84% of the interviewed children were still going to school. Among these children, those following junior high schools in Binh Thanh and Hoc Mon account for 100% and 94.87% respectively. Particularly in Go Vap, the rate of children from senior high school over-rates the other level being 65.45%.

The interviewed children have a mean age of 14.7. The minimum age is 11 and maximum age is 19, median age and mode age are equally 14. The out-school children in Binh Thanh and Hoc Mon Districts are older than the in-school children in the same districts. The difference between the mean age and mode age of these two groups – out-school and in-school – in Binh Thanh are 2.8 and 4, and in Hoc Mon being 1.9 and 2. In Go Vap, the interviewed out-school children tend to be in the same age range as the in-school group. The children aged from 16 onwards account for 64.63% in Go Vap, while in Hoc Mon being 15.74% and Binh Thanh being 12.13%.

Some 86.94% of the interviewed children said that they have never been in contact with peer educators. In Go Vap, more out-school children reported of meeting with peer educators than in-school children. In the same district, the children under 16 years of age reported of contacting peer educators 1.81 times more than those from 16 years and above. Topics of discussions in such contacts/meetings, as shared by the interviewed children, are as follows in a descendant order:

- Discussion on HIV and AIDS prevention methods
- Advice not to use drugs
- Advice to help and to not discriminate against people living with HIV and AIDS
- Talk about sex and sexuality generally

A profile of the interviewed children is presented in Table 2.

---

1 The spectrum of age with variance of 3.6; standard deviation being 1.9 and standard error being 0.06.
2 \( \chi^2 = 265.70 \), degrees of freedom \( df = 2 \) and \( p = 0.0000 \).
3 \( \chi^2 = 18.63 \) and \( p = 0.0001 \). Odds ratio (OR) = 4.25 with 95% Confidential Interval (CI) [2.00, 9.00].
4 \( \chi^2 = 4.15 \) and \( p = 0.0000 \). OR = 1.815, 95% CI [0.98- 3.34].
Table 2. Profile of the interviewed children

<table>
<thead>
<tr>
<th></th>
<th>Binh Thanh (n = 315)</th>
<th>Go Vap (n = 345)</th>
<th>Hoc Mon (n = 305)</th>
<th>Total (n = 965)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>182</td>
<td>57.78</td>
<td>178</td>
<td>51.59</td>
</tr>
<tr>
<td>Female</td>
<td>133</td>
<td>42.22</td>
<td>167</td>
<td>48.41</td>
</tr>
<tr>
<td>Education status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-school</td>
<td>268</td>
<td>85.08</td>
<td>301</td>
<td>87.25</td>
</tr>
<tr>
<td>Out-school</td>
<td>47</td>
<td>14.92</td>
<td>44</td>
<td>12.75</td>
</tr>
<tr>
<td>Contact with peer educators</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having contacted</td>
<td>26</td>
<td>8.25</td>
<td>58</td>
<td>16.81</td>
</tr>
<tr>
<td>Having not contacted</td>
<td>289</td>
<td>91.75</td>
<td>287</td>
<td>83.19</td>
</tr>
</tbody>
</table>

2.2 HIV and AIDS

Results of all structured questionnaires showed that most of the children have heard about HIV and AIDS. Some 96.17% of the children in Binh Thanh, 98.26% in Go Vap, and 97.76% in Hoc Mon replied having heard about HIV and AIDS. There were no statistically significant differences among the districts, children in school and dropout groups, between boy and girl groups, children who have been in contact with peer educators and those who have not, nor between children under 15 and those above 16.

The surveyed children had received information on HIV and AIDS from many different sources. The most common source mentioned by children was television (76.89% of surveyed children), followed by teachers (60.93%), books/newspaper/brochure (50.4%), and relatives (44.87%). Percentage of in-school children receiving information from teachers is 0.23 times higher than that of dropouts and from relatives is 0.28 times higher than that of dropouts, at the 95% confidence interval. Information receiving from peer educators is least mentioned, at 15.85% of surveyed children. There was no statistically significant differences between information provision from peer educators to in-school children group and dropout group.

Most of the surveyed children were able to name the main routes of HIV transmission. The two main routes of sharing an injection needle and from a pregnant mother to her foetus were mentioned by an equal percentage of children (93.16%). Transmission through sexual intercourse without condom was selected by 81.96% of surveyed children. The percentages of children mentioning correctly all three transmission routes of HIV were 74.28% in Binh Thanh, 80.28% in Hoc Mon, and 77.04% in Go Vap. The average percentage was 77.31% (Figure 1). The percentage of schooling children in Hoc Mon who mentioned correctly the three transmission routes was higher than that of dropouts in the same district.6 Besides, there were no statistically significant differences among the surveyed districts, the boy and girl groups, and whether the children have been in contact with the peer educators or not, in the percentage of children correctly mentioning all three transmission routes.

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5 $X^2 = 20.54; p = 0.00000; OR = 0.21; 95\% CI$
The 03 measures for preventing HIV transmission, namely correctly using condoms for sexual intercourse, using new injection needles and boiling used needles at 100°C in 20 minutes were mentioned by 79.27%, 89.22%, and 39.07% respectively. Other incorrect preventive measures were also mentioned by 26.63% to 47.36% of children (see Figure 2).

Some 39.79% surveyed children mentioned all three prevention methods. This percentages in Binh Thanh, Hoc Mon, and Go Vap were 29.84%, 42.62%, and 46.37% respectively (Figure 3). The difference is statistically significant.\(^6\) Percentage of in-school children in Binh Thanh who did not mention correctly all three prevention methods was higher than the school dropouts\(^7\). In Go Vap, more of the children who had been contacted by peer educators could name all three methods than those

\(^6\) \(X^2 = 20.28; p = 0.0000; \text{df} = 2\)

\(^7\) \(X^2 = 5.81; p = 0.015; \text{OR} = 2.16; 95\% \text{ CI} [1.09, 4.26]\)
who have not. Other factors did not cause statistically significant differences in the ability to name all three prevention methods.

Figure 3. Percentage of children, by districts, naming correctly all three prevention methods.

Most of the surveyed children (93%) perceived that HIV and AIDS is currently one of the issues that receive most attention in their school/ward/commune. This percentages were similar in all the surveyed districts and there were no statistically significant differences among the surveyed groups. The main reasons of the perception include that:
- HIV is perceived “as the disease of the century and is a threat to man kind”.
- HIV is spreading rapidly.
- HIV and AIDS is not curable.
- HIV can be prevented.

The information source about HIV and AIDS more preferred by the surveyed children is television in the form of documentaries (66.01%). Small group and personal communication were mentioned by 28.5% and 25.08% respectively. There were no significant differences in the preference of information sources among the surveyed groups. The entertaining information sources were preferred over other sources (see Figure 4).

Figure 4. Preferred information sources on HIV and AIDS

Schooling children prefer teachers (56.44%) as their communicators while the school dropouts prefer health staff (49.61%). These two groups of communicators were most preferred by surveyed children.

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\( \chi^2 = 5.98; p = 0.014; \text{OR} = 2.05; 95\% \ CI [1.1, 3.82] \)
There were no significant differences in preference of information sources between genders. Table 3 shows children's preference of communicators.

Table 3. Children’s preference of communicators of HIV and AIDS

<table>
<thead>
<tr>
<th>Communicators</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>School</td>
</tr>
<tr>
<td>Teachers</td>
<td>44.09</td>
</tr>
<tr>
<td>Health staff</td>
<td>49.61</td>
</tr>
<tr>
<td>Parents</td>
<td>37.01</td>
</tr>
<tr>
<td>Friends</td>
<td>43.31</td>
</tr>
<tr>
<td>Social workers</td>
<td>37.01</td>
</tr>
<tr>
<td>People living with HIV/AID</td>
<td>26.77</td>
</tr>
<tr>
<td>Siblings</td>
<td>15.75</td>
</tr>
<tr>
<td>Peer educators</td>
<td>14.96</td>
</tr>
<tr>
<td>Performers/singers</td>
<td>8.66</td>
</tr>
</tbody>
</table>

About half of the surveyed children indicated that they had talked with their parents or relatives about HIV and AIDS. These percentages were 41.45% in Binh Thanh, 52.52% in Go Vap, and 43.09% in Hoc Mon (Figure 5). There were no significant differences due to gender, education level, or whether or not they have been contacted by peer educators.

Those who have talked with their parents and relatives about HIV and AIDS responded well to the survey. Results of the questionnaires showed that 86.54% children were able to raise and discuss their concerns while about 8% of children were not. Those children who have not talked to their parents and relatives about HIV and AIDS (47.73%) did not know how to begin the conversation. Some (39.25%) were afraid that their parents and relatives would have wrong perception about them. About 24.06% of children indicated that they were not used to discussing ‘sensitive’ issues with their parents and 20.12% of children were sure that their parents would not like to listen. There were no significant differences between genders or between schooling children and dropouts.

More than half of the surveyed children said they had talked with friends about HIV and AIDS. The average percentage of the 03 districts was 56.12%. The percentage in Go Vap was 63.78%, Binh Thanh 50.32%, and Hoc Mon 49.67%. Those children who had been contacted by peer educators said they had talked about the topic with the friends more often than other children did\textsuperscript{10}. There were no statistically significant differences between genders or education levels.

The topics related to HIV and AIDS that children discussed included risk of HIV infection of youth (57.5%), knowledge related to HIV and AIDS (52.94%), perception and attitude towards HIV-infected people (42.88%), and some situations/cases/stories of people suspected to be infected (35.86%).

\textsuperscript{9} \chi^2 = 13.14; df = 2 and p = 0.0014.

\textsuperscript{10} OR = 1.66; \chi^2 = 6.17; p = 0.01; 95% CI [1.09–2.55].
Among the children who reported having never talked about HIV and AIDS with friends had cited the reasons why they did not do. These reasons were relatively equal. There were no significant differences in relation to sex and education levels among those children. Most of the children said they were willing to talk about HIV and AIDS with their parents (68.60%), with siblings (66.84%), and with friends (66.11%). Results of the questionnaires showed that 38.45% of the informants agreed that a girl friend could talk with her boyfriend about sexuality and sex, and 31.09% of the children felt comfortable talking with their girl friend/boyfriend about using condom. Some 4.87% of the informants agreed with the 5 comments above. There were no significant differences in attitudes towards HIV and AIDS due to genders, level of education, nor whether or not they had been contacted by peer educators.

Inappropriate perceptions about HIV-infected people were still common in the surveyed group. Some 53.16%, 47.98%, and 34.51% of the informants thought HIV transmission was due to drug abuse, prostitution, and having sexual intercourse with prostitutes, respectively. Some 46.74% of the informants thought HIV-infected people always display an unhealthy appearance. Some 84.35% of the children said they would be willing to take care of their relatives should their relatives had been infected and 70.47% of the children said they would do the same for friends. About 44.66% of the informants said they would feel comfortable talking to infected people. There were no significant differences among the surveyed groups.

More than half (54.92%) of the surveyed children said that there were HIV-infected people in their districts. Some 53.06% thought there were HIV-infected people in their neighbourhood and 47.67% thought any one were subject to infection. 39.59% of children thought that they were at also at risk of being infected. The school dropouts in Binh Thanh and Go Vap thought they were 2.27 and 0.16 times higher risk than the schooling children in the same districts. There were no significant differences due to whether or not they have been contacted by peer educators.

Groups of children with different perception of risk are presented in the table below in the descending order.

<table>
<thead>
<tr>
<th>Reasons for feeling at risk</th>
<th>Reasons for feeling safe</th>
</tr>
</thead>
<tbody>
<tr>
<td>- HIV spares no one.</td>
<td>- Know how to prevent.</td>
</tr>
<tr>
<td>- Accidentally step on used injection needles,</td>
<td>- No drug abuse</td>
</tr>
<tr>
<td>cuts by barbers or nail technicians.</td>
<td>- No unsafe sex</td>
</tr>
<tr>
<td>- Weak self control to unsafe sex</td>
<td>- No contact with HIV and AIDS infected people</td>
</tr>
<tr>
<td>- Cannot be sure what can happen in the future</td>
<td></td>
</tr>
</tbody>
</table>
2.3 Sexual Transmitted Diseases

More than half (56.62%) of the surveyed children claimed knowing about STDs. The percentage of children claiming to know about STDs in Go Vap is higher than those in the other two districts. Besides, there were no significant differences due to level of education, whether or not they have been contacted by peer educators. The claims recorded were purely perceptions from the informants.

The suspicious signs of STDs were mentioned by less than one third of the surveyed children (Figure 6). The results were similar among the surveyed groups. 4.25% of the informants mentioned all 5 signs.

Figure 6. Knowledge of children of the suspicious signs of STDs

Some 54.61% of surveyed children thought that any one could be infected by STDs. Sex workers and playboys were also mentioned (Figure 7). Gender, level of education, localities, or whether or not the informants had been contacted by peer educators did not cause any significant differences in the response. Graph 7 below shows perceptions of children of the risk of different groups to STDs.

\[ X^2 = 48.54; \ df = 2 \text{ and } p = 0.00000. \]
STDs mentioned by surveyed children included HIV and AIDS (52.75%), syphilis (42.18%), gonorrhea (39.9%), and hepatitis B (6.84%). Approximately 34 or 3.52% of surveyed children mentioned all the above diseases. The school dropouts in Binh Thanh were able to list more diseases than the schooling children\textsuperscript{12}. Tuberculosis and diabetes were also mentioned as STDs by 5.28% and 3.73% of informants respectively. There were no statistically significant differences between the surveyed groups.

### 2.4 Gender, sexuality, and sex

On the question of whether they knew of a place in the neighbourhood that sells or gives out free condoms, one third (31.33\%) of the surveyed children responded with positive answers. More children in Go Vap (40.32\%) came up with positive answers than those in the other 02 districts.\textsuperscript{13} At the same time, more school dropouts came up with positive answers than schooling children. Those who had been contacted by peer educators were also more knowledgeable than those who had not been contacted. Gender did not cause any significant difference in the responses.

The places that sell or give out free condoms are shown in Figure 8, of which, the 03 addresses mentioned most commonly were Pharmacy (77.15\%), health service providers such as clinics (63.25\%) and the peer educators (27.15\%). Among the children who had been contacted by the peer educators, 33.33\% knew that the peer educators were selling or giving out free condoms.

\textsuperscript{12} \chi^2 = 12.09; OR = 6.39; Fisher exact p = 0.003

\textsuperscript{13} \chi^2 = 21.16; df = 2 and p = 0.00002
The average percentage of children having heard about the uses of condoms was 64.52%. This percentage was highest in Go Vap (74.7%)

14. The number of children having been contacted by peer educators and having heard of the uses of condoms was 1.87 times higher than that of children who had not been contacted by peer educators. The mentioned uses included HIV and AIDS prevention (93.57%), prevention of STDs (85.85%), and contraception (80.06%). Some 68.15% surveyed children mentioned all three uses of condoms. The number of children having been contacted by peer educators being able to mention all three uses of condoms was 1.7 times higher than that of those who had not been contacted.

Some 16.07% of surveyed children claimed to know how to use condoms. It should be noted that this is purely their own perception. There are significant differences among the groups: 27.19% children in Go Vap, 12.78% in Binh Thanh, and 6.93% in Hoc Mon who claimed to know how to use condoms

15. More boys knew how to use condoms than girls (1.84 times)

16. More school dropouts knew how to use condoms than schooling children (1.88 times) and more children having been contacted by peer educators know how to use condom than those who have not been contacted, 1.77 times

The majority (64.56%) of surveyed children thought that their peers had already experienced sex. The percentage with this perception was 74.20% in Go Vap, 61.61% in Hoc Mon and 57.14% in Binh Thanh (Figure 9). Some 75.59% of school dropouts thought that their peers had had sex experiences while 62.89% of schooling children thought so as well. More girls thought their peers had had sex than boys. Some 85.23% children from 16 and above and 54.34% children under 15 years of age responded to the question whether their peers had had sex. There were no significant differences due to whether the informants had been contacted by peer educators or not. Graph 09 illustrates the (rather crippled) correlation between the percentage of children with perception that their peers had had sex and their own skills on using condom.

14 $X^2 = 26.82; df = 2$ and $p = 0.0000015$
15 $X^2 = 52.63; df = 2$ and $p = 0.0000.$
16 $X^2 = 9.51; p = 0.002; 1.22 < OR < 1.84$
17 $X^2 = 7.82; p = 0.005; 1.17 < OR < 3.01$
18 $X^2 = 6.04; p = 0.01; 1.09 < OR < 2.80$
19 $X^2 = 23; df = 2$ and $p = 0.0000.$
20 $X^2 = 7.78; p = 0.005; 0.35 < OR < 0.86$
21 $X^2 = 5.17; p = 0.02; 0.53 < OR < 0.72$
22 $X^2 = 94.02; p = 0.00000; 0.13 < OR < 0.28$
Among the children who perceived that their peers had had sex, 50.55% thought that only a few of their peers had done so, 8.87% thought that half of their peers had had sex, and 8.56% thought that most of their peers had had sex.

Some 32.01% of children responded that they did not know. While 82.98% children said their friends used condoms for intercourse. This percentage is similar among the districts, between the boy and girl groups, between the schooling and school dropout groups, and between those having been contacted by peer educators and those without having been contacted. Some 38.96% of the informants thought that only a few of their friends used condom for sex and 15.36% thought that all of their friends used condom for sex (Figure 10).

On the discussion on at what age youth could have sex, 25.28% said they did not know and the remaining 74.72% indicated a specific age. The perceived mean age was 18.5, ranging from 10 to 32 (median=mode=18). The mean value of the perceived age for sex from the schooling group was higher than that from the school dropouts by 0.8 years and that from the boy groups was 0.9 years higher than from the girl groups. The mode values were always 18 regardless of genders or level of education.

Some 60.13% of surveyed children indicated having heard of sexuality. The percentages in Go Vap, Binh Thanh, and Hoc Mon were 69.21%, 57.52%, and 52.49%, respectively. The differences are

---

23 Variance: 7.73; standard deviation: 2.78 and standard error: 1.04.
More from the schooling group (62.14%) have heard about sexuality than the school dropout group (46.77%) and more children of the group above 16 years old (69.28%) have heard about sexuality than those of the group below 15 (55.83%).

Of the children having heard about sexuality, most (71.96%) thought that they only knew a little, not everything. Some 10.54% claimed that they knew everything and 17.50% claimed they knew nothing. There were no statistically significant differences among the groups. Some 13.81% children above 16 years old claimed to know all about sexuality while only 8.55% of the group below 15 claimed the same. Of the 126 children having been contacted by peer educators, 84% had heard about sexuality (84/126 = 66.66%), and 34 children further communicated to others the information they received from the peer educators (34/126 = 26.98%).

The number of children having heard about sexuality was 65.5%. This percentage was highest in Go Vap district at 80.29%, followed by Binh Thanh at 63.49%, and Hoc Mon at 51.15%. More children having been contacted by peer educators (74.4%) had heard about sexuality than those who had not been contacted (61.15%). More children of the group above 16 years old (78.64%) have heard about sexuality than those in the group below 15 years old (59.36%). There were no significant differences among the groups. The percentage of children receiving information on sexuality from peer educators, among those who had been contacted, was 29.37%.

More than half of the children received information on sexuality from television, newspaper, radio, books, and health staff. More than one third of the children said they received information from the unofficial sources (books, magazines, pictures) (Table 4).
Table 4. Sources of information about sexuality

<table>
<thead>
<tr>
<th>Information sources</th>
<th>Communication on sex (%)</th>
<th>Communication on sexuality (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Television, newspaper, radio, books</td>
<td>63.67</td>
<td>66.84</td>
</tr>
<tr>
<td>Teachers</td>
<td>52.29</td>
<td>75.58</td>
</tr>
<tr>
<td>Health staff</td>
<td>47.71</td>
<td>58.65</td>
</tr>
<tr>
<td>Parents</td>
<td>36.33</td>
<td>51.16</td>
</tr>
<tr>
<td>Close friends</td>
<td>38.7</td>
<td>41.89</td>
</tr>
<tr>
<td>Other books, pictures</td>
<td>34.28</td>
<td>37.08</td>
</tr>
<tr>
<td>Social workers</td>
<td>31.39</td>
<td>39.93</td>
</tr>
<tr>
<td>Internet</td>
<td>29.7</td>
<td>31.91</td>
</tr>
<tr>
<td>Siblings</td>
<td>22.43</td>
<td>29.77</td>
</tr>
<tr>
<td>Peer educators</td>
<td>16.79</td>
<td>14.82</td>
</tr>
</tbody>
</table>

On the discussion of which information channels would be appropriate and effective to provide information on gender, sex, and sexuality, the common preference was for interactive channels that combine entertaining activities. No single channel was preferred by more than 50% of the informants. Classroom was preferred for delivering information on sexuality, not for information about sex. On the other hand, movies and personal communication were preferred for sexual information. Radio, newspaper, brochures, posters, and documentary on television were not preferred. The table below shows percentages of preference of information channel on sex and sexuality of groups by their level of education and sex. The 3 sources of information selected as priorities are presented in bold and underlined figures.

Table 5. Information channels thought by children to be appropriate for delivering information on sex and sexuality

<table>
<thead>
<tr>
<th>Information sources</th>
<th>Communication on sexuality (%)</th>
<th>Communication on sex (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Drop-outs</td>
<td>In school</td>
</tr>
<tr>
<td>In class</td>
<td>40.94</td>
<td>42.00</td>
</tr>
<tr>
<td>Personal communication</td>
<td>25.20</td>
<td>36.63</td>
</tr>
<tr>
<td>Drama, plays</td>
<td>37.01</td>
<td>27.09</td>
</tr>
<tr>
<td>Movies, documentaries</td>
<td>25.98</td>
<td>22.79</td>
</tr>
<tr>
<td>Small group activities</td>
<td>30.71</td>
<td>31.38</td>
</tr>
<tr>
<td>School yard speeches</td>
<td>24.41</td>
<td>34.84</td>
</tr>
</tbody>
</table>

Some 04 groups of communicators most preferred by the surveyed children for getting information on sexuality and sex were health staff (56.58%), teachers (50.47%), parents (38.55%), and friends (32.85%). Graph 13 shows percentage of children for each group of communicators. The school dropouts tend to prefer social workers as their information sources. There were no significant differences due to sex of informants.
Figure 13. Children’s preference of communicators for information on sexuality and sex

<table>
<thead>
<tr>
<th>Communicator</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Famous singers, artists</td>
<td>14.61%</td>
</tr>
<tr>
<td>Siblings</td>
<td>19.69%</td>
</tr>
<tr>
<td>People living with HIV and AIDS</td>
<td>20.21%</td>
</tr>
<tr>
<td>Peers educators</td>
<td>20.62%</td>
</tr>
<tr>
<td>Social workers</td>
<td>29.12%</td>
</tr>
<tr>
<td>Close friends</td>
<td>32.85%</td>
</tr>
<tr>
<td>Parents</td>
<td>38.55%</td>
</tr>
<tr>
<td>Teachers</td>
<td>50.47%</td>
</tr>
<tr>
<td>Health professionals</td>
<td>56.58%</td>
</tr>
</tbody>
</table>

Places preferred by surveyed children to talk about sexuality and sex were specialized counselling centres (63.73%), school (58.55%), and hotlines (43.21%). Other places included clubs (40.41%), at home (32.37%), and at places together with friends (29.02%). School dropouts also selected school among the three appropriate places for them to talk. There were no differences between genders. There were no significant differences in the response to the question whether they should learn about sexuality issues together or separately between schooling children and school dropouts and between the children having been contacted by peer educators and those had not been contacted. More from the group above 16 prefer to learn together (63.19%) than those in the group below 15 (54.46%). This difference is statistically significant\(^{31}\). The average percentage is 55.67%. The corresponding percentages in Go Vap, Hoc Mon, and Binh Thanh were 64.81%, 55.67%, and 50.79%, respectively\(^{32}\).

The age thought by surveyed children to be appropriate to begin learning about sexuality was 14.7, with mode value of 15\(^{33}\). The mean and mode values of the data from Binh Thanh were 14.4 and 15; Go Vap 14.8 and 14; and Hoc Mon 14.9 and 15; respectively. The mode values of the girl group and the schooling children group were 15 and those of the boy group and the school dropouts were 18. The mean value of the data from the dropout was 15.4, the schooling group 14.6, boy group 15.2, the girl group 14.3.

### 2.5 Children’s rights in the context of HIV and AIDS

Most of the surveyed children (81.24%) indicated having heard of children’s rights. This percentage is similar in all districts. More schooling children (83.29%) heard about children’s rights than the school dropout group (67.72%). The difference is statistically significant\(^{34}\). Meanwhile, more children in age group below 15 (83.56%) had heard about children’s right than those in the group above 16 years old (76.38%)\(^{35}\) (see Figure 14). There was no statistically significant difference due to genders or whether they had been contacted by peer educators or not.

\(^{31}\) \(X^2 = 6.49; p = 0.01; 0.52<OR = 0.7<0.93\)

\(^{32}\) \(X^2 = 13.64; p = 0.001; df = 2\).

\(^{33}\) Variance 7.8; standard deviation: 2.79; standard error: 0.094.

\(^{34}\) \(X^2 = 17.56; p = 0.00002; OR = 2.38; 95\%CI; 1.53<OR<3.68\).

\(^{35}\) \(X^2 = 7.13; p = 0.007; OR = 1.57; 95\%CI; 1.11<OR<32.23\).
The most common source of information on rights of children and youth recorded was schools (86.86%), public media (58.29%), and family (41.96%). Friends play the least important role in providing information on children’s rights (21.3%) (see Figure 15). Out of 126 children, 49 or 38.89% received information from peer educators. Some 66.28% of dropouts received information from schools which is the highest information source. Schooling children received information from schools 0.23 times higher than school dropouts\textsuperscript{36}. There were no statistically significant differences among the districts and between the sexes of the children.

Most of the surveyed children agreed with the rights of children that were mentioned by the surveyors as examples for probing. The percentage is similar among the districts and between genders. 47.22% of surveyed children agreed to all 04 probing items. The percentage of the girl group was 53.21% while that of the boy group was 41.67%\textsuperscript{37}, the group above 16 accounting for 57.93%, and the group below 15 for 44.14%\textsuperscript{38}. There were no significant differences due to education level. Percentages of children with different responses to each item are presented in the table below. Details on the responses to the probing examples of children’s rights are presented in Table 6.

\textsuperscript{36} X^2 = 35.86; p = 0.00000; 0.14<OR<0.4.
\textsuperscript{37} X^2 = 10.8; p = 0.001; OR = 0.63; 95%CI; 0.47<OR<0.84
\textsuperscript{38} X^2 = 16; p = 0.00006; OR = 0.58; 95%CI; 0.43<OR<0.76
Table 6. Percentage of children responding to each item related to children’s right.

<table>
<thead>
<tr>
<th>Probing item</th>
<th>Agree</th>
<th>Do not agree</th>
<th>Do not know</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV and AIDS-infected children and youths have the rights to go to school and participate in other educational and training activities.</td>
<td>85.39</td>
<td>7.15</td>
<td>6.5</td>
</tr>
<tr>
<td>Children and youths have the rights to be consulted and participate in activities and programs that affect their life.</td>
<td>86.32</td>
<td>3.32</td>
<td>9.1</td>
</tr>
<tr>
<td>Children and youths have the rights to informed and educated about sexuality and sex.</td>
<td>76.27</td>
<td>10.88</td>
<td>11.9</td>
</tr>
<tr>
<td>Children and Youths have the rights to be provided with reproductive health and sexual health services.</td>
<td>66.22</td>
<td>15.44</td>
<td>17.4</td>
</tr>
</tbody>
</table>
Chapter 3. Needs of children infected and affected by HIV and AIDS

3.1 Situation of children infected and affected by HIV and AIDS

3.1.1 Situation

According to local government and mass organizations at the surveyed districts, the HIV-infected population is rapidly becoming younger and the age group that is most subject to being infected is between 15 and 22 years of age, both male and female. Young females are usually infected through unsafe sex, with some cases recorded as being students. Most of the victims did not know until there were obvious symptoms or were detected in antenatal checkups. At most of the surveyed sites, there were children infected by HIV and AIDS through their mothers.

At the surveyed sites, most of the HIV and AIDS-infected children were living in areas with many drug addicts or HIV and AIDS-infected adults. Some children said they had seen HIV/AIDS-infected people died. Information from the interviews showed that most of the HIV and AIDS-infected children are living in impoverished families, with 03 generations sharing a house. The care for HIV and AIDS-infected relatives has become a real burden for these families. Information from the interviews with the mass organizations revealed that some HIV and AIDS-infected children were sent to grandparents to be cared for because the parents were afraid of being known that they were infected.

"Both the wife and the husband were infected but they rarely stay at home for fear that people would know and gossip. They went away and rent a place to live. Only when they had no choice, they came back. The children were sent to the grandparents or aunts. The aunts cared for the children for a while until the children became weak that they brought them to the local health station. They were told that the children were infected so they sent them to the Care Centre" (a representative of a mass organization in Go Vap)

According to the surveyed children, they were receiving care and love from all of the family members. The family members are those they rely on in life’s difficult situations. “I always talk to my grandma because she loves me very much” (a HIV and AIDS-infected child in Go Vap). However, most of the issues that children share with their family’s members were everyday issues or only those related to their schooling. They rarely share other private issues with their relatives.

3.1.2 Knowledge and attitude

Many interviewed children said they had just recently heard about HIV and AIDS from the public media such as television and radio. To the school dropouts, public media and relatives are the main sources of information about HIV and AIDS. There was a significant difference in awareness about HIV between schooling children and the school dropouts. In Hoc Mon, many surveyed children answered correctly the main routes of HIV transmission, the prevention methods, as well as responded appropriately to the probing questions about their attitude towards HIV and AIDS-infected people and about rights and responsibility of infected people.

“I just learned that an HIV and AIDS-infected person can keep his/her secret but must take measures to prevent transmitting to others. They have the rights not to let others know about their infection and they have the rights to be sympathized by others. They also have the rights to go to school and to have a job. Their families are responsible for providing care and love to them and don’t have the rights to discriminate them” (an HIV and AIDS-infected/affected youth in Hoc Mon district)
Meanwhile, most of the surveyed children in Go Vap have dropped out from school and none has participated in an HIV and AIDS training or trainings on children's rights. Most of the surveyed children were able to mention all three main ways of HIV and AIDS transmission but could not respond well on the questions about prevention methods:

What to do to prevent infection? (Interviewer)

“Not eating together, not sharing clothes, not making physical contact with infected people.”

“Not using things used by HIV and AIDS-infected people.”

“Not sharing meals and not sharing clothes with HIV/AIDS-infected people.”

“Stay away from a HIV and AIDS-infected person.”

(Interview with HIV and AIDS-infected/affected children in Go Vap)

Having experience from the HIV and AIDS-infected relatives, many children said they could tell from the outside appearance if a person was an AIDS patient. The common symptoms mentioned included anorexia, peevishness, alopecia, rapid weight loss, laziness to talk, pale appearance.

3.1.3 Threats and challenges faced by HIV and AIDS-infected/affected children

According to the informants, HIV and AIDS-infected/affected children are faced with some risks

- Living with constant anxiety “I think because she has lost a relative and herself is also infected, so she is really living in fear” (an HIV and AIDS-infected/affected child in Hoc Mon).

- Lacking a guardian “I see that she has no one to care for her. All the relatives are scared” (an HIV and AIDS-infected/affected child in Hoc Mon).

- Inferior and unfortunate complex “such as this one, she is nursing an unfortunate and bitter feeling, so she gets peevish, angry at even her parents. She blames it on her parents. If you ask if she loves her parents, she would say no” (an interview with a family in Hoc Mon district).

- Fearing to be transmitted from relatives “his brothers have skin eruptions. They have taken medicine but the skin still erupts. It looks very scary. I am afraid that my children may be infected. It’s hard to guard the children all the time” (an interview with a family member in Hoc Mon).

- Lacking friends “he is 11 years old, selling lottery tickets. Getting back home after selling tickets, he would only play alone. He has no friends as every one is scared of him” (an interview with a family member in Hoc Mon).

- Being avoided by people

“People stay away from him because they think he was already infected from his parents” (an interview with a family member in Hoc Mon)

“No one attends funerals of HIV and AIDS-infected people”

“The mother of this child was a drug addict and got infected by HIV. People transmitted to her but she didn’t transmit to her children because they were grown up. When she learnt hairdressing and opened a shop here, no one dared to come. People were afraid to let her do hair dressing” (interview with a family member in Hoc Mon)

- Discrimination not only took place in the community but also in the mass organizations “the police, I do not dare to say they discriminate them but if there are HIV and AIDS-infected people in their
area, they just want to get rid of them” (Focus Group Discussion with mass organizations in Go Vap)

- Not going to school “this little girl. When her parents died, there was a big gossip about it so that the kindergarten school refused to take her in. They required test certificate from Pasteur Institute to certify that she was not infected. They also required birth certificate and household registration book. I saw that the whole community turned their back on her” (Focus Group Discussion with families in Go Vap)

3.2 Needs for support of HIV and AIDS-infected/affected children and their families

3.2.1 Needs of children

66% of the respondents in structured interviews reported that there are girls under 18 year olds living in the family of the mentioned PLWHA. Boys are reported by 64.6% of respondents. The majority of those families have one girl (71.3%) and/or one boy (64.7%). There is no significant difference in the needs of the two groups of boys and girls.

Remarkable needs of the HIV and AIDS-infected and affected children include (i) health care for children with HIV, (ii) prevention for affected children, (iii) orphans to be brought up and cared of, (iv) support for education for children who are at the age to attend primary and secondary school and (v) employment for older children and children dropping out of school.

Children’s needs identified from the qualitative information include:

- Not to be discriminated. They want to talk to people without being discriminated. They want to be cared for.

- To be provided with information on HIV

  “Infected people also need to learn more about HIV. If not, once they recover, they will continue their vices and get infected again” (Focus Group Discussion with HIV and AIDS-infected/affected children in Go Vap)

- To go to school again. Some children really want to go back to school but their families are in difficult financial circumstances. The HIV and AIDS-affected children should be exempted of tuition to enable them to back to school because most of their families are poor.

  “I suggest there should be a tuition exemption program or something like that to encourage these (infected) children to continue their education. Their family cannot afford it. The children should go back to school, here their friends stay away from them.” (FGD with a family group in Hoc Mon)

- Participating in peer club. To have joint activities for entertainment or income generation to change society’s attitude toward themselves. Most of the surveyed children wanted to participate in the group activities for HIV and AIDS prevention such as the Thao Dan and Nu Cuoi groups.

  “It is difficult for community to understand us. I think there should be peer clubs so that people who are infected but are still healthy participate and do some things appropriate to them to show that HIV and AIDS can still work in order to change attitude of people around them. This will take time and it will make people see that HIV-infected people are nothing to be scared about.” (FGD with a family group in Hoc Mon)
- **Health care.** Treatment of opportunistic infections, provision of free medicines for AIDS treatment and support for daily nutrition are the needs of health care raised by the infected children in the survey while the affected children need to prevent from infection of HIV.

  “...such as providing with free medicines and treatment. That costs a person about 300,000 dong per month for treatment but parents earn only 30,000 dong per day from. How on earth they can afford the medicines.” (FGD with a family group in Hoc Mon district)

- **Care for orphanage HIV-infected children**

  “I hope there are places that take care of HIV-infected people so that children in the families are not affected by their HIV-infected relatives.” (FGD with a family group in Binh Thanh)

### 3.2.2 Needs of families of children

- **Provide address of test places to families of HIV and AIDS-infected people so that they can take test and obtain treatment in time.**

  “The patients themselves always wish to have support, care, and attention from their families. Or else, the government should have support programs such as free medicine provision, for example.” (FGD in Hoc Mon district)

- **Be more flexible in the interventions to support infected people: bear in mind that medicine is needed by patients the most.**

  “It’s better to give them medicine than money, because if they receive money support, they will probably not spend on medicine but on drug again, thinking that they would die sooner or later anyway. I see many people think that way.” (FGD with a family group in Hoc Mon)

  “I agree with that. This little girl for example (having a mental and HIV and AIDS-infected mother) received support from an NGO. She receives 1 million per quarter but she cannot keep the money. Her family does not spend on medicine for her. I think it is better to help her mother to be cared in a mental hospital.” (FGD with a family group in Hoc Mon)

- **Provision of safety measures for families to take care of HIV and AIDS-infected people.**

- **Help them to have a job to improve income.**

- **Raise awareness of laws and apply strict punishment to those who violate the laws and regulations**

  “The policies and regulations that the government issued for the patients should be implemented. The government says discrimination is not allowed but the daughter of this woman cannot go to school if she cannot prove that she is “clean”. If a student is found infected, he/she would be dismissed from school. I am serious.” (FGD with a family group in Hoc Mon)
Chapter 4. HIV and AIDS Prevention, Care, and Support Program

4.1 Prevention program

- The interviewed representatives of local government and mass organizations said HIV and AIDS is one of the issues that receives the most attention from the local government and their organizations. The current interventions are mainly about raising awareness for prevention of HIV and AIDS transmission combined with anti-drug education.

- Educational communication through public media and the operation of the community counselling services are the main communication activities. There is a counselling service in some wards but not at all the wards. There is also counselling services in schools. There are 07 counselling services in Go Vap in the elementary, secondary, and high schools. There is a clear office schedule in each of the counselling service that students can come to if they have issues to consult.

4.2 Program for caring and supporting HIV and AIDS-infected children

Counselling activities and support in the form of diagnosis and treatment for HIV and AIDS.

- The names and addresses of the support services that were mentioned most commonly by the children were Voluntary Counselling and Testing Centre at 53 Vu Tung (Gia Dinh Hospital, Tu Du hospital). Some children, when asked, mentioned the service/support from a project by Save the Children UK, Youths Helping Each Other to Live Healthily by UNICEF, the Thao Dan club, Nu Cuoi group, or Friend-Help-Friend group. The children group in Hoc Mon also listed some services such as helping homeless children to move to ‘warm roofs’ and ‘open houses’ and helping those who dropped out early to attend universalized education classes, and provide material support to other children in especially difficult situations.

- The program that provides free diagnosis and treatment to children below 06 years old.

Care for HIV-infected people at home

- The sympathetic clubs to provide care to HIV-infected people at home.

- The trainings for families of HIV and AIDS-infected people on how to care for infected-people have proved to be useful.

“The training taught us how to eat, how to treat and care for the patients (HIV and AIDS-infected people). They taught us 02 times a month, about 02 hours each session. I see that this program is very useful for the family. The people who don’t have direct experience will only say general stuff. Only those families that have direct experience would provide careful instructions to us.” (FGD with a family group in Hoc Mon)

“I know that a family would stumble if there is an HIV and AIDS-infected member. When participating in a meeting like that, the way they talk makes us want to listen without stopping. They provide detailed instructions in a gentle way that pleases the ears.” (FGD with a family group in Hoc Mon)
Diagnosis and treatment for HIV and AIDS-infected pregnant women.

- The milk provision program supported by CRS for infants up to 06 months of HIV and AIDS-infected mothers.

- Program by Life-Gap to provide free-of-charge diagnosis and medicine to HIV and AIDS-infected pregnant women.

Support to families in difficult circumstances and orphan children.

- Some places mentioned as providing useful support for HIV and AIDS-infected children include Mai Hoa, and Support and Care Centre (Trung Tam Bao Tro). However, of the surveyed group, neither children nor families understand the regulations and the services of these centres, the paper work and procedures.

- The coordination and cooperation among the government agencies in preventing and combating HIV and AIDS have provided support to HIV and AIDS-infected/affected children and their families to some extent.

  "In general there are many organizations such as the Women Union, the Committee for the protection of mothers and children, Department of Labour, Invalids, and Social Affairs and so on. They all pay attention to help. For example, the health sector provides diagnoses and medicine. The Labour department provides jobs or loans to families in difficult situations. Children in difficult circumstances also get support from the Population, Family, and Children Committee. The education sector and the women union also provide their relevant support" (FGD with government agencies in Go Vap)

- There are currently no exclusive policies for HIV and AIDS-infected children but they are cared and protected according to the regulations by the government for children in general.

  "Within the children program there are 10 categories of children in especially difficult circumstances. HIV and AIDS-infected children are one among those 10 categories"

  "For example, DOLISA uses decree number 7 by the Prime Minister to provide support to orphaned children. If they are orphaned, then they are entitled to support as orphans, if they have guardians, then their guardians get support according to decree 38. For examples, if a child lost a parent or both and is living with their relatives, then there is a policy to support the guardians according to decree 38 by the Prime Minister. They also get additional support from the mass organizations." (FGD with mass organizations in Go Vap district)

4.3 Constraints/challenges/difficulties of the programs

The current HIV and AIDS communication programs have not met the needs for knowledge in how to care for HIV-infected people. "I think the government communication work on HIV is not effective at all. Big propaganda posters and panels saying in big words that HIV is the disease of the century, but there is no information on how to care for patients. The commune health staff just tells us a few general things"

Current communication is mainly about prevention. Care and support for HIV and AIDS-infected people is still very limited due to regulation on privacy that mass organizations cannot be provided with names of HIV and AIDS-infected or affected children. Without knowing who the infected or affected children are, it is difficult to provide support for these children.
"We are mainly working on communication for prevention, knowing that care and support are still limited because of the regulation on privacy. The health sector is not releasing information and so we don’t have the list of patients. We don’t know how to provide support to those patients and at the same time still ensure privacy." (Representative of a mass organization in Hoc Mon district)

There lacks a systematic mechanism for management and support to orphanages, HIV and AIDS-infected children, or those infected children that receive insufficient care from their families.

"Whatever support from the government should be implemented more thoroughly. The support from the commune and local government is still very superficial. They just want to get done with it, without much quality"

"Some children do not benefit at all from the support services because their parents are afraid of being known so they constantly move and do not let their children to take test" (FGD with a family group in Hoc Mon district)

There have not been any social organizations to support HIV and AIDS-affected children or any provision of instructions on how to prevent HIV and AIDS transmission.

"There seems to be no actions at all. They just explain to adults only, no one ever explained to children how to prevent HIV and AIDS. Some learn from school not until at secondary level but it is very general. The dropouts would not know anything" (FGD with a family group in Hoc Mon)

The psychological injuries of the HIV and AIDS-infected/affected children have been recorded in the surveys. However, children’s only resort is their family for consolation and support. There are very few organizations or individuals that help children to overcome psychological crises when they themselves or their family members are infected by HIV and AIDS. Even if there is a support, it is difficult for them to access because they cannot afford travelling to get support.

The challenges and difficulties of the intervention programs that provide care and support to HIV and AIDS-infected/affected children are that they cannot get hold of infected children.

"There are two difficulties. One is that we cannot get a hold of children to bring them to test for HIV. Second is that it is difficult to do birth registration or death declaration for them. For example, both the husband and the wife are infected, the child takes test 1 or 2 times without results because he/she is too young (...). They don’t accept their grand children because they know that their children were infected and died so they would guess that their grand children would also be infected. They thus would not allow them to stay and do birth registration" (FGD with mass organizations in Go Vap)
Chapter 5. Summary and Discussion

Knowledge related to HIV and AIDS of surveyed children in and outside school

Knowledge about HIV and AIDS of the surveyed children was not sufficient or appropriate. Most of the children were able to mention 03 main routes of transmission. However, less than half of them were able to answer correctly 03 prevention methods. A high percentage of them mentioned inappropriate prevention methods. The level of knowledge on STDs was low. Very few children could answer correctly the names of the diseases from the symptoms provided as examples for probing. Most of the children knew of uses of condoms in preventing HIV and STDs. There were no significant differences between the surveyed groups due to genders, level of educations, or whether or not they had been contacted by peer educators. The main information sources about HIV and AIDS that they received were mainly the public media and teachers.

In practice, the information on public media did not provide in-depth knowledge for children to understand sufficiently. Moreover, these were only one-way information sources. In school, the health and sexuality topics were integrated into other subjects responsible by biology teachers. The survey did not obtain information on the content and teaching methods of these topics. Once in a while, on the occasion of certain events, the schools invited some speakers to talk about HIV and AIDS for all students in the school yards. The impacts of such talks were not high in terms of KAP change. Some children were sent by school to contests on knowledge of HIV and AIDS and reproductive health so they were trained to take tests. There were few contests and the number of children selected was also small. The number of children having been contacted by peer educators was also very limited at 15%. The content of the discussion with peer educators was vaguely recalled by children. The survey did not obtain information on the skills of the peer educators, especially communication skills. The above reasons explain the insufficiency of knowledge of HIV and AIDS among the surveyed children in and outside school.

Attitude related to HIV and AIDS of surveyed children in and outside school

There were no significant differences in terms of attitude towards HIV and AIDS among the surveyed children due to level of education, genders, or whether or not they have been contacted by peer educators. The surveyed children held negative attitude towards those infected by HIV or having STDs. They presumed that these people were drug addicts, prostitutes, or playboys. Less than half of the surveyed children expressed that they would feel comfortable talking to HIV and AIDS-infected people. This is a result of the formal and informal communication process for a long time. Information on HIV and STDs was most of the time provided in association of immoral practices and vices. However, most of the children expressed willingness to care for their relatives or friends if they were infected. This was good news from the survey.

Most of the surveyed children said HIV and AIDS received attention from the local government. About 60% of the surveyed children said they could not be infected. The reason they believed that they could not be infected was that they already knew how to prevent. This is a dangerous thing because the survey on knowledge revealed that only half of the children provided correct answers on prevention methods. Moreover, there was no guarantee that those children who had the right knowledge would have the right supporting factors to apply appropriate prevention methods.
Practices relevant to HIV and AIDS of surveyed children in and outside school

Most (85.23%) of children above 16 and more than half (54.34%) of children below 15 thought that their peers had already had sex. Almost 40% of the children thought that only a few of their friends who had sex used condoms. The children who claimed to know how to use condom was less than 20%.

The survey did not measure the skills of children such as condom use through demonstration of models, so the information provided was purely children self-assessment. The surveyed target was children and youth, so their practical experience on sexuality and sex was still limited. The information obtained was mainly children’s guesses on behaviours of their peers.

Needs of HIV and AIDS-infected/affected children

To be treated equally was mentioned the most by HIV and AIDS-infected/affected children. Here it only means equal treatment from the community but also from the government agencies. Other less significant needs include information, guardians for those infected, and prevention for those affected. The psychological needs of HIV and AIDS-infected/affected children had not been addressed.

Those needs of children arose from the two main reasons, including (i) there lacked a management system providing support to HIV and AIDS-infected/affected children, and (ii) most of the program focused only on adult beneficiaries.

Considerations for the project in the future

The project needs to establish a management system supporting HIV and AIDS-infected/affected children in project area with the participation of the relevant local organizations with clear roles and responsibilities. This would be a demonstration to be scaled up later on to other areas.

Behaviour change communication needs to be considered as a main activity of the project. Communication methods need to be tailored appropriately for each target group, including children and community in different contexts. Communication content needs to be specific, practical, and positive. The project should also aim to provide early the life skills and sexuality knowledge for children. The network of peer educators needs to be strengthened both in terms of quantity and quality.

The project needs to address psychological needs of HIV and AIDS-infected/affected children. Children club and family clubs or other periodic events need to be promoted.

Health care and prevention support for affected children needs to be conducted with the cooperation of local health organizations.
Chapter 6. Recommendations

6.1 Recommendation concerning children in community

Many relatives of children have expressed concern that their children are living in an environment having many drug addicts. Fearing that their children might be seduced into having sex early or using drug, families wish that their children were equipped with necessary life skills to protect themselves. It is, therefore, recommended that

- Enhance communication to children for KAP changes related to HIV prevention.
- Provide life skills and sexuality knowledge early to children, starting at elementary level, using many information channels, both in and outside school.
- Provide support to the dropouts to go back to school.

6.2 Recommendations concerning HIV and AIDS-infected/affected children

Quantitative and qualitative survey results show that HIV and AIDS-infected/affected children wish to have some one to talk to without being discriminated and those who dropped out because of financial reason wish to go back to school. Besides, children have a great need to access information related to HIV and AIDS on a regular basis. It is, therefore, recommended that:

- Strengthen communication to provide infected/affected children and their families with most updated information on HIV and AIDS at the existing counselling centres in HCMC that provides psychological support and care for infected people.
- Local government and mass organizations collaborate and try out the model of club of infected/affected children to meet regularly so that children meet with other children in the same circumstances to comfort, console, and encourage each other to live positively.

- Increase communication in various forms such as small group communication in community, neighbourhood meeting, and other community events to encourage positive attitudes towards families having HIV and AIDS-infected members or children.
- The relevant government agencies ensure privacy of HIV status of children. Local government certifies poverty situation of children and provide support for them to go back to school.

- It is suggested that the local government and the responsible government agencies provide certification for orphanages infected/affected children so that they can get free support from the care centre or charity groups.
- Orphanages with HIV/AIDS-infected/affected children raised by neighbours should also receive support from the government, in line with the policy.
6.3 Recommendations concerning families of HIV-AIDS-infected children

- Be more flexible in the interventions to support infected children. Conduct a rapid assessment to update the needs of children and their families to understand the needs of each family and child.
- Provide job information and assistance to families to improve income.
- Provide information to families.
- Provide address of HIV testing places for families of HIV and AIDS-infected people so that they can take tests. Provide information on programs that provide care, support, and anti-virus treatment to families of children.
- Provide detailed instructions and safety methods to families and caretakers for caring HIV and AIDS-infected people.
- Establish Mother or Family Clubs for families having members with HIV to come and share experience.
- Raise awareness on law and regulation and apply appropriate punishments to those violating the law and regulation.

6.4 Recommendations to the local government and mass organization at the surveyed sites

One of the biggest obstacles for the local government and mass organizations to support the health sector to care for children that are infected and/or affected by HIV/AIDS is the regulation/policy on protection of privacy. To overcome this obstacle, it is recommended that:

- Health and other institutions responsible for the care and protection of children’s rights enter an agreement to build a management system to support orphan HIV and AIDS-infected children or HIV and AIDS-infected children who do not have a guardian. Privacy is a prerequisite to this agreement.

On the increasing needs to care for relatives at home, it is recommended that:

- The institutions responsible for the care and protection of children’s rights, with the technical support from the health sector, conduct training courses on care for HIV-infected people and prevention of HIV to families or guardian of infected people.
- To support post-training follow up, manuals that summarize instructions should be provided. Information for such a manual can be compiled from existing handbooks and manuals on care for HIV-infected people and modified to suit the needs.