



Scaling Up the Response
for Children

RAPID ASSESSMENT
Most-At-Risk
Adolescents and
Young People to
HIV in Lao PDR



unicef 
unite for children



Scaling Up the Response
for Children

RAPID ASSESSMENT
Most-At-Risk
Adolescents and
Young People to
HIV in Lao PDR



unicef 
unite for children

A Rapid Assessment Most-At-Risk Adolescents and Young People to HIV in Lao PDR

Published by UNICEF Lao PDR in partnership with the Ministry of Health (MoH)

Technical support for this document provided by UNICEF APSSC and UNICEF Lao PDR

This report was prepared by the AIDS Projects Management Group for UNICEF Lao PDR and UNICEF Asia and Pacific Shared Services Center (APSSC) in Bangkok. It was written by Scott Berry, Lindsay Rogers and Dave Burrows.

All photographs are courtesy of UNICEF Lao PDR and UNICEF New York Photography website (www.photos.org).

© UNICEF Asia-Pacific Shared Services Center (APSSC) and East Asia and Pacific Regional Office (EAPRO), June 2011

Any part of this document may be freely reproduced with appropriate acknowledgement

Design and layout: Keen Media (Thailand) Co., Ltd.

UNICEF East Asia and Pacific Regional Office
19 Phra Atit Road
Bangkok 10200 Thailand
Tel: (66 2) 356-9499
Fax: (66 2) 280-3563
www.unicef.org/eapro

ISBN: 978-974-685-130-5

Contents

Acknowledgements	4
Acronyms	5
1. Introduction	6
2. National context	7
3. Background and methods	8
4. Resilience in MARA and MARYP	10
5. What we know about MARP, MARYP and MARA in Lao PDR	12
5.1 Service work/site-based female sex workers	12
5.2 Injecting drug users and illicit drug use	13
5.3 Men who have sex with men/transgender people	14
6. Findings and recommendations	15
6.1 From poverty to opportunities: Realizing hopes for the future	15
6.2 From social isolation to stronger connections with services, other people and society	17
6.3 HIV risk, knowledge, HIV disclosure and negotiation	21
6.4 Views about service provision	23
7. Conclusion	26
8. Priority for recommendations	27
Annexes	29
Annex 1	29
Annex 2	32
References	33

Acknowledgements

This report was prepared by the AIDS Projects Management Group for UNICEF Lao PDR and UNICEF Asia and Pacific Shared Services Center (APSSC) in Bangkok. It was written by Scott Berry, Lindsay Rogers and Dave Burrows. English and Lao translation while in Lao PDR was provided by Mr. Inpeng Rasprasith, HIV/AIDS Officer, UNICEF Vientiane. In-country coordination of the research programme was undertaken by Ms. Verity Rushton, Chief, Children and HIV/AIDS Section, UNICEF Vientiane.

Special thanks are due to the Lao PDR Government, especially its Centre for HIV/AIDS and STIs and the Lao Youth Union. Thanks also to key local civil-society organizations including the Lao Youth and AIDS Project, the Population Education Development Association and the Provincial Committee for the Control of AIDS, as well as international non-government organizations: the Burnet Institute, Family Health International and Population Services International. United Nations partners that provided valuable assistance and advice throughout this research include UNAIDS Vientiane, United Nations Population Fund Vientiane, World Health Organization and United Nations Office on Drugs and Crime Vientiane.

Acronyms

AIDS	acquired immune deficiency syndrome
APMG	AIDS Projects Management Group
APSSC	Asia-Pacific Shared Services Center
ATS	amphetamine-type stimulants
CHAS	Centre for HIV/AIDS and STIs
CBO	community-based organization
EVA	especially vulnerable adolescents
FHI	Family Health International
GFTAM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GLBT	gay, lesbian, bisexual, transgender
HIV	human immunodeficiency syndrome
IBBS	Integrated Behaviour Biological Survey (in Lao PDR)
IDU	injecting drug use/injecting drug user
INGO	international non-government organization
Lao PDR	Lao Peoples' Democratic Republic
LYAP	Lao Youth and AIDS Project
MARA	most-at-risk adolescents
MARP	most-at-risk population
MARYP	most-at-risk young people
MDG(s)	Millennium Development Goal(s)
MSM	men who have sex with men
NGO	non-government organization
PCCA	Provincial Committee for the Control of AIDS
PEDA	Population Education Development Association
PSI	Population Services International
SP	service provider
STI	sexually transmitted infection
SW	sex worker/service worker/service women
TG	transgender
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
VCT	voluntary counselling and testing
WHO	World Health Organization



© UNICEF Lao PDR/Tom Greenwood/2009



© UNICEF Lao PDR/Tom Greenwood/2009

The Lao People's Democratic Republic (Lao PDR) has a 'latent' HIV epidemic¹, with rates of HIV estimated at just 0.2 per cent of the total population aged between 15-49 years of age². However, because of its location in the heart of the Mekong, surrounded by countries with high rates of HIV in concentrated epidemics³, Lao PDR is believed to be "in danger of an expanding epidemic"⁴. More than 50 per cent of the population of Lao PDR is below the age of 20 and adolescents and young people engaged in high-risk behaviour for HIV are an emerging priority across Asia and the Pacific^{5,6}. In order to contribute to an understanding of how to effectively include adolescents and young people at risk of HIV into the National Strategic Plan on HIV/AIDS, STI 2011-2015 UNICEF Lao PDR, with the support of the Lao Youth Union and the Centre for HIV/AIDS, STI and UNICEF Asia and Pacific Shared Services Center (APSSC) commissioned this preliminary investigation which summarizes what was found in relation to the behaviours, attitudes and social characteristics of adolescents and young people engaged in high-risk behaviour for HIV in Lao PDR.

The findings of this report are a testament to the history and commitment of the Lao PDR Government and its partners to responding to HIV. The Lao PDR Government formally mobilized a response to HIV in 1993. It now has a National Strategic Plan on HIV/AIDS, STI for 2006-2010 and a National Committee for the Control of AIDS with representatives of key Government Ministries. The National Strategic Plan includes targets for universal access to treatment, care and support with international donors, through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), contributing substantially to this goal. The Lao PDR Government has a '100% Condom Use' policy as well as targeted interventions for those most at risk of HIV. There are international non-government organizations (INGOs) and a range of international donors and UN agencies present in Lao PDR and Provincial Committees for the Control of AIDS (PCCA) responsible for delivering local services aligned to the priorities of the National Strategic Plan on HIV/AIDS and STI⁷.

Adolescents and young people at risk of HIV in Lao PDR include young sex workers, injecting drug users (IDUs), young gay men, other young men who have sex with men (MSM) and transgender people (TG). This report summarizes key issues to be considered in programme design and implementation for most-at-risk adolescents (MARA) and most-at-risk young people (MARYP), and proposes new areas of research on MARA/MARYPⁱ. These recommendations support the Lao PDR government and its partners in their continuing response to HIV and formulating the new National Strategic Plan on HIV/AIDS, STI 2011-2015.

ⁱ While the document raises key issues, the sample size of the assessment was not nationally representative

Lao PDR is a low HIV prevalence country, with an HIV prevalence of 0.2 per cent for those between 15-49 years of age⁸. Lao PDR's HIV burden, while relatively small, is concentrated in sex workers and their clients, MSM and transgender people. Lao PDR's Integrated Behaviour Biological Survey (IBBS) Report, published in 2008, found that the STI and HIV prevalence rate among commercial sex workers was as low as 1.1 per cent but as high as 3.9 per cent in regional HIV 'hotspots' such as Vientiane, Bokeo, Luangprabang, Savannakhet and Champasak⁹. The rate of STIs including chlamydia (28 per cent prevalence), gonorrhoea (7 per cent prevalence) and syphilis in IBBS surveillance reports of sex workers was extremely high making them vulnerable to HIV exposure¹⁰. Among men who have sex with men (MSM) in Lao PDR the overall HIV prevalence is estimated to be 6 per cent¹¹. Among IDUs, the HIV prevalence rate is considered low although there are, as yet, no in-depth studies that provide definitive evidence one way or the other¹².

Lao PDR is experiencing rapid economic growth and social change characterized by increasing levels of trade, new international projects and major road and highway construction programmes¹³. In spite of this, Lao PDR remains the second poorest country in the Mekong, and a widening gap in levels of financial inequality within Lao PDR, especially disparity between urban and rural populations, is emerging¹⁴. Twenty-seven per cent of the Lao population live on less than US\$1 per day while a significant number live on close to it. New technologies such as mobile phones, the internet and even Thai television are believed to be increasingly influencing Lao young people and Laotians generally¹⁵ toward higher levels of both domestic and cross-border migration as Lao people attempt to take advantage of potential new livelihood opportunities in urban areas¹⁶.

This document provides an assessment of MARA and MARYP gathered through a series of rigorous qualitative tools, as well as the professional insights of key informants and leaders in the Lao PDR government, especially the Centre for HIV/AIDS and STIs, and the Lao Youth Union. Key local organizations participating in the assessment included the Laos Youth and AIDS Project (LYAP), Population Education Development Association (PEDA) Institute and PCCA's. Local INGOs include Burnet Institute, Family Health International (FHI) and Population Services International (PSI). UN partners included UNAIDS, UNICEF, WHO, UNFPA and UNODC.

Definitions

1. MARP – most-at-risk populations for HIV refers to those of any age engaged in behaviours known to be high risk for HIV infection, including multiple unprotected commercial sex (unprotected sex while sex working), unprotected anal sex, injecting drug use with non-sterile equipment and sex with multiple partners.
2. MARA – most-at-risk adolescents refers to those aged between 10-19 years engaged in behaviours known to be high risk for HIV transmission.
3. MARYP – most-at-risk young people refers to those aged between 15-24 years engaged in behaviours known to be high risk for HIV transmission.
4. EVA – especially vulnerable adolescents refers to those aged between 10-19 years who might engage in high-risk behaviour for HIV because of homelessness, poverty, coercion, trafficking and disconnection from family and community.

Background

This UNICEF initiative was undertaken over a two-month period between 1 February 2010 and 31 March 2010. AIDS Projects Management Group (APMG) was commissioned by UNICEF to investigate HIV risk and vulnerability for most-at-risk adolescents and young people in Lao PDR. This involved undertaking a summary review of available quantitative and qualitative data on HIV in Lao PDR; in-country consultations with professionals, as well as individual and group interviews with adolescents and young people at risk of HIV infection. Between the 15 and 24 February, Lindsay Rogers worked in Lao PDR within the UNICEF Country Team in Vientiane undertaking field research. Scott Berry, APMG Asia Pacific Coordinator worked in Lao PDR between the 21 and 24 February to synthesize the research findings and facilitate presentation of preliminary findings to UNICEF country partners and the Lao PDR government.

Objectives

The investigation was conducted in order to:

1. Demonstrate the need for specific MARA- and MARYP-based programming in Lao PDR and stimulate a discussion and dialogue on what may be considered traditionally taboo subjects towards programme design and implementation, to inform the National Strategic Plan on HIV/AIDS, STI 2011-2015;
2. Provide recommendations for the design and implementation of services targeting MARA and MARYP in Lao PDR; and
3. Demonstrate the need for further research and gathering of evidence on risk of HIV infection among adolescents and young people in the country, and the inclusion of age-disaggregated data in HIV and STI epidemiological and other surveillance or behavioural research.

Steps in the in-country investigation

1. Introductory consultation (15 February 2010) – a preliminary meeting with key stakeholders and UN Partners, chaired by representatives of the Centre for HIV/AIDS and STI (CHAS), Ministry of Health and the Lao Youth Union;
2. Interviews and group sessions with adolescents and young people at Burnet Institute, FHI and PSI in Vientiane;
3. Interviews and group sessions with adolescents and young people at LYAP in Vientiane Province;
4. Interviews and group sessions with adolescents and young people at PCCA, PSI, PEDDA and LYAP in Khammoune Province;
5. Group interviews with young people in drug rehabilitation through Samsanga drug rehabilitation and treatment centre;
6. Focus group discussions, individual interviews and observation at entertainment-site visits, including outreach activities with Burnet, PSI, PEDDA and LYAP;
7. Concluding consultation (24 February 2010) – a presentation and discussion of the preliminary findings with key stakeholders and UN partners, chaired by representatives from the Lao Youth Union and CHAS; and

- The validation of the findings of the rapid assessment (12 August 2010) by government, UN and key stakeholders.

Study sample

A total of 72 individual adolescents and young people at risk of HIV were interviewed during this investigationⁱⁱ. Seven focus groups were undertaken and, subsequent to these, 13 individual interviews. Forty-two per cent (n=29) of the total participants came from gay, lesbian, bisexual and transgender (GLBT) organizations or projects. Twenty-one per cent (n=15) of the total participants were sourced through sex work organizations or projects. Nineteen per cent (n=14) of the total participants were sourced through IDU or drug-related services. Nine per cent (n=7) of the total interviews occurred with service providers and 9 per cent (n=7) were sourced through sites where observation was undertaken.

Participants



At every site except the IDU/Drug Service site, focus group participants were peer educators engaged in MARP service delivery. Peer educators were aged between 20-44 years of age with the mean age being 25 years. All individual interviews were with MARA and MARYP who were not engaged as peer educators. MARA and MARYP in this group were aged between 15-24 years with the mean age being 19 years.

Study design

The investigation was designed and delivered in collaboration with UNICEF, CHAS, the Lao Youth Union, UN partners and other implementing partners. A literature review was undertaken before and after the in-country field investigation. The method of inquiry was primarily qualitative including individual and group interviews using open-ended questions, field observation and consultation with key stakeholders (see Annex 2). A written survey was distributed to professional collaborators and partners. Of these surveys, four were returned (see Annex 2).

Both the interviews and focus groups used a semi-structured topic guide that provided an introduction, description of the assessment and oral informed consent material. A tape recorder and notebook were used to document the discussions. A Lao male from the UNICEF Lao PDR Country Office was the interpreter. Focus groups, which lasted 60-90 minutes, were held in semi-private meeting rooms at programme sites or outdoors during the day at relatively quiet entertainment venues. Representatives from UNICEF, the Lao PDR Government and local implementing partners observed all of the focus group discussions. Individual interviews, which lasted 30-60 minutes, had only Lindsay Rogers and the interpreter present. Some interviews were held in semi-private rooms at programme sites, three interviews were held outdoors at entertainment venues and one was held in a small, busy beer shop where the respondent worked.

Grounded theory was the analytic method used to interrogate the data collected¹⁸. Comparative analysis, which was used to determine the broad themes emerging, was refined to determine conclusions emerging from the views and thoughts of adolescents and young people interviewed. In addition, key ideas emerged from both the introductory and concluding consultations with key professional stakeholders, and these ideas have been incorporated into the findings presented.

ⁱⁱ The assessment acknowledges that its informants were not the hard to reach – many of the assessment informants were already accessing services of some kind but to prompt or recommend additional research on MARA/MARY that are hard to reach and hidden.

4

Resilience in MARA and MARYP



© UNICEF Lao PDR/Tom Greenwood/2009



© UNICEF Lao PDR/Tom Greenwood/2009

In recent years, the promotion of *resilience* has become a core strategy in the fields of child development and adolescent health¹⁹. Resilience has been applied to issues such as child protection²⁰, the prevention of youth suicide²¹ and to preventing and/or treating drug dependence in young people²², among other social and health issues. Resilience, therefore, represents a useful construct with which to analyse the data collected in this investigation because:

- it is well understood in the fields of child development and young people's welfare; and
- it provides a salient method for understanding both the risks in the lives of adolescents and young people to HIV (and other health dangers) and the protective factors that can mitigate those risks.

Resilience refers to the capacity of an individual to cope with stress and catastrophe, to return to a state of equilibrium after a period of difficulty by drawing upon both inner resources and the resources available in their social systems. *Risk* refers to the dangers inherent in the external environment as well as the lack of inner resources that can threaten the capacity of an individual to cope with stress and change, to adapt, survive and thrive, to move toward their 'highest good'²³.

Resilience interventions build upon 'protective factors' in the lives of children and young people (such as emotional and physical resources, family or community, making it easy to access these resources, knowledge and ways to improve skills) in order to minimize the impact of 'risk factors' (such as emotional disequilibrium, isolation from peers, family or community, making it harder to access resources, knowledge and ways to develop skills). Resilience works with both psychological and sociological phenomena (and the 'inner' world of the child or young person and their 'outer' world). It aims to build individual skills and capacity on one hand, while building an environment that supports survival, resourcefulness and endurance on the other²⁴.

Risk and resilience are valuable concepts for understanding how to build effective HIV programmes that interrupt the transmission of HIV among most-at-risk adolescents and young people. These concepts also help in the promoting of health and wellbeing among those already living with HIV and affected by AIDS. But resilience strategies for most-at-risk adolescents and young people diverge significantly from those applied in other areas of health and wellbeing for children and young people.

Young people in their social roles as youths, friends, students, workers, citizens and family members seek support and guidance from people around them to learn and thrive in these roles – these roles are not stigmatized or illegal. The social roles described are valued by those around them, therefore openly communicating about them is possible. But this is not the case for adolescents and young people engaged in at-risk behaviour for HIV. The social stigma and discrimination associated with sex work, illicit drug use, sex between men or living as a transgender person results in a dramatic contraction of the support available in the environment as MARA and MARYP. This in itself leads to ‘self-censorship’ and refraining from disclosing their at-risk behaviour because of actual or perceived judgement or because the behaviour is illegal. In the face of social hostility, increased feelings of shame and self-loathing can also limit the psychological resources available to adolescents and young people at risk of HIV.

Discrimination and stigma are well-documented barriers to successfully preventing the transmission of HIV and supporting those living with HIV²⁵. For example, in Lao PDR, sex work and the possession or selling of illicit drugs remains illegal and compulsory drug rehabilitation and detention are the core of the drug policy in the country. HIV experts argue that punitive laws encourage the transmission of HIV because they force MARPs underground and make them difficult to find, to support and to educate²⁶. Punitive responses encourage discrimination, harassment and stigma. The Report of the Commission on AIDS in Asia describes how “harassment not only makes it difficult to supply these groups with HIV services... it often precipitates the risk behaviour itself”²⁷. Sex between men is highly stigmatized across the region²⁸. As in a number of countries in South East Asia, Lao PDR has some MSM and transgender people who live openly and the culture provides a limited pathway to do so. But many who live openly still face harassment and are prevented from full participation in society²⁹. Basically, MARPs hide their at-risk behaviour and so they are difficult to find and educate.

Adolescents and young people at risk of HIV operate outside the dominant systems that most young people use for support and reassurance (in relation to the behaviour that puts them at risk of HIV and STIs). As with at-risk populations generally, they employ strategies aimed to protect their anonymity and prevent harassment and discrimination. Paradoxically, these strategies, which are protective against discrimination, increase their risk to HIV infection as well as the risk of exploitation, trafficking and abuse.

A fact that distinguishes adolescents and young people at risk of HIV from the most-at-risk adults they may engage with is that young people will usually have little power or ‘agency’, either individually or collectively, to advocate for themselves and each other. They may not understand the social mechanisms available to them; will be unable to form groups to advocate for better health and treatment (without help from organizations and adults) and will not, in the main, have the skills which develop from years of lived experience. Of particular concern is the sub-set of very young adolescents engaged in these activities who have usually been ‘sexualized’ by an adult and/or coerced into sex work by family, other adults or age peers. This makes these adolescents and young people particularly vulnerable to exploitation by others and it makes isolation in these adolescents and young people deeply concerning.

Against this background of risk and vulnerability for MARA and MARYP in Lao PDR, this research project was initiated in order to demonstrate the need for specific MARA- and MARYP-based programming in Lao PDR, to stimulate debate, to point the way toward further research and evidence gathering, and to provide specific recommendations for the design and implementation of services targeting MARA and MARYP in the country.

5

What we know about MARP, MARYP and MARA in Lao PDR

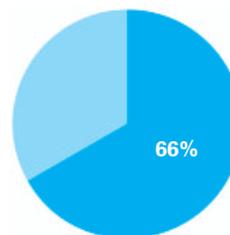
5.1 Service work/site-based female sex workers

The term 'service women' is used to describe female sex workers in Lao PDR, and a large proportion of service women are believed to be adolescents and young people. Themes that emerge from the literature review of sex workers in Lao PDR, which are further explored in this report, note:

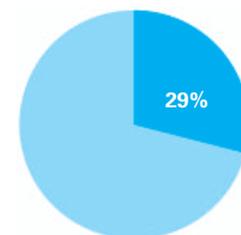
1. A significant proportion of service women in Lao PDR are adolescents and young people: the mean age of service women in the IBBS 2008 sample was 20.8 years; half of the sample were adolescents³⁰. 16.8 years was the mean age of sexual debut and 25 per cent of the sample reported selling sex at sexual initiation (at first sexual experience)³¹ while 22 per cent reported forced sex within the previous year³².
2. Service workers tend to come from a diverse range of ethnic, linguistic and regional locations across Laos and their domestic migration pattern tends to be characterized by short stays in locations, often less than six months³³. The majority are unmarried: the number of clients per service worker is estimated at as little as 12 clients per month³⁴ and as many as 60 per month³⁵.
3. STI rates are extremely high among service women, making them more vulnerable to acquiring HIV. High rates of STIs, including gonorrhoea (7 per cent prevalence) and chlamydia (28 per cent prevalence), have been reported among sex workers in Lao PDR³⁶.
4. Knowledge about condom use remains low and misconceptions about condoms, menstruation and douching before and after sex appear high. Sex during menstruation was believed by some to be high risk to the female sex worker

(10 per cent) and douching as an HIV precaution post-sex was reported by nearly 100 per cent of the sample³⁷. IBBS 2008 data showed that just over one third had ever been pregnant and, of those, 71 per cent reported ever having had a pregnancy terminated³⁸.

5. Service women are inconsistent in their condom use with intimate, casual partners and the majority do not use condoms at all with their intimate, regular partners. IBBS 2008 found that a high proportion of service women reported condom use at last sex with a regular or casual client and most had heard of HIV (higher than 90 per cent on both issues)³⁹. Condom use with intimate partners (non-transactional sex) was much less likely among service women; with casual partners the IBBS sample reported 66 per cent condom use while with regular partners only 29 per cent reported regular condom use⁴⁰. Reported condom breakage at last sex was 30 per cent, while using two condoms at once because there is a belief this will provide added protection was 25 per cent of the sample.



Condom use with casual partners



Condom use with regular partners,

6. Commercial sex work remains a criminal offence in Lao PDR. There are no official 'red light' districts in cities or towns. Instead, sex work occurs through

hospitality and entertainment establishments such as hotels (motels), beer clubs and karaoke bars and through 'on-call' (through mobile phones), street-based sex work and opportunistic and occasional sex work. Factories and other sites have also been cited as venues where commercial sex work occurs⁴¹.

7. Very little is known about 'on-call' and street-based sex workers in Lao PDR. There is scant evidence related to their

access to the means to prevent HIV and STI, their knowledge of HIV and STIs and their knowledge of, or willingness, to attend local treatment services. There is an absence of any discussion related to HIV-positive sex workers in literature published to date. There would appear to be no analysis and no planning for the support of HIV-positive sex workers in Lao PDR and further work in this area is recommended and discussed later in the report.

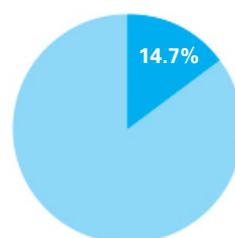
5.2 Injecting drug users and illicit drug use

Themes that emerge from the literature review of drug use and injecting drug users in Lao PDR include:

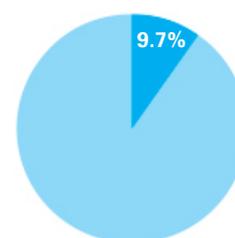
1. The trend toward urbanization in Lao PDR is bringing with it an increase in drug use and poly-drug use⁴². Across Asia, drug use among young people predominantly involves⁴³ amphetamine-type stimulants (ATS), which are mostly taken in tablet form or inhaled, confirmed in the recent UNODC World Drug Report of 2009⁴⁴. This regional trend is evident in Lao PDR as ATS overtakes heroin and opium as the drug class of choice. Studies conclude that ATS, in tablet or inhalable form, are the most popular illicit drugs in Lao PDR and injecting drugs would appear to be uncommon. UNODC's Lao PDR Country Office estimates there are approximately 1.4 million young people between the ages of 15-19 years who may be at risk of ATS use and abuse⁴⁵. The mean age of ATS use in one UNODC study was 16 years and poly-drug use was common for 98.2 per cent within the same sample. The report concluded that there is a worrying increase in poly-drug use with subsequent presentations of physical and mental health problems as a result⁴⁶.
2. If young people are at risk of HIV from drug-use, it is related to unprotected sex during drug use and less so from injecting – but there is a threat that this pattern will change if prevention and voluntary treatment options are not strengthened. Right now, the risk for HIV infection is in the sex that may occur during and after drug administration with

research showing that sexual risk taking and rates of unprotected sex are higher in ATS users⁴⁷. However, UNODC argues that increased injecting drug use in the future is likely and with it the risk of increased HIV transmission rates among drug users in Lao PDR⁴⁸.

3. The literature is silent on intravenous and other drug users living with HIV. A study by the Burnet Institute and Chiang Mai University (with a sample size of 65, mostly young, respondents) found that 14.7 per cent of the sample had ever watched drugs being injected, while 9.7 per cent had asked to be or offered to inject others. Only 1.4 per cent had injected and only one of these admitted to ever sharing needles⁴⁹. The literature is silent on the needs of people living with HIV who are drug users or ex-users, including young people are taken into account, documented and acted upon.
4. Piercing and penile enhancement is popular among some young people in Lao PDR and poses a risk for HIV. A number of studies have found inadequate universal precautions or



Watched drugs being injected



Asked to be or offered to inject others

sterile practices in tattooing, cosmetic surgery and penile enhancements which can occur outside the clinical setting by non-clinical personnel. Penile enhancement and tattooing in particular can occur in jail, rehabilitation settings or

in the homes of friends.

5. Knowledge about HIV is low and misconceptions about HIV transmission high among drug users.

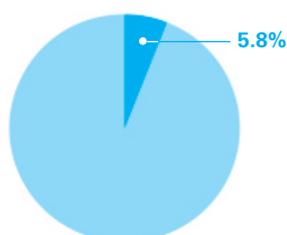
5.3 Men who have sex with men/transgender people

Themes that emerge from the literature review of MSM and TG in Lao PDR conclude that:

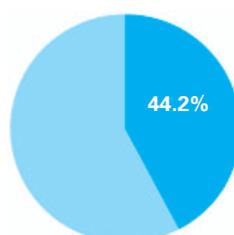
1. There are large numbers of MSM and TG who report STI symptoms in 'HIV hotspots' in Lao PDR – increasing their risk of acquiring HIV.
2. MSM and TG are over-represented among HIV positive people in Lao PDR: A 2007 Burnet Institute study of MSM in Vientiane found 5.8 per cent of the sampled population was living with HIV. MSM self-reporting STI symptoms was 42.2 per cent of the sample, while 6.3 per cent of the total respondents had never been tested for HIV⁵⁰.
3. Multiple sex partners are common among MSM and TG in Lao PDR's major urban settings and longer-term coupling between men remains uncommon⁵¹. This, combined with low rates of condom use, may suggest a high degree of HIV transmission. The Burnet Institute study found that condom use at last anal sex was 73.9 per cent; consistent condom use with intimate, longer-term partners was significantly lower in another study, where MSM reported rates of regular condom use as low as 14.4 per cent and with casual partners as low as 24.1 per cent. While there remains very little evidence available of condom use patterns and HIV knowledge among

male sex workers, this study found self-reported rates of regular condom use with commercial sex clients as low as 33.8 per cent.

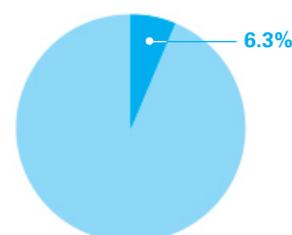
4. Consistent condom use among TG with all partners is low. More than half of transgender people in one study reported using condoms during last anal sex (51.7 per cent) but only 5.3 per cent of TG and 3.7 per cent of their partners reported using condoms with all their partners⁵². Knowledge about HIV and about risk for HIV remains low for both MSM and TG groups⁵³.
5. Knowledge of HIV and of HIV risk and prevention among MSM and TG is low. 18.5 per cent of men in a survey recently conducted in Vientiane reported having sex with other men and almost 8 per cent reported sex with both men and women. The average age of men in that study was 21 years and one third of them expressed an exclusive attraction to other men⁵⁴. Oral sex was most often practiced (69.1 per cent) but over half of the respondents reported having anal sex as well⁵⁵. Another study found that coercion of boys and young men, including forced sex, was reported in 28 per cent of the sample and anal sex was commonly practiced by 83.7 per cent⁵⁶.



Study of MSM in Vientiane, per cent of sampled population living with HIV



Study of MSM in Vientiane, per cent of sampled population self-reporting STI symptoms



Study of MSM in Vientiane, per cent of sampled population never tested for HIV

Findings and recommendations

6

6.1 From poverty to opportunities: Realizing hopes for the future

This section explores the themes of 'poverty', 'employment opportunities' and 'hopes for the future' as expressed by the adolescents and young people interviewed in this study. HIV risk and the risk of abuse and exploitation are exacerbated through a lack of employment and education prospects. However, MARA and MARYP expressed dreams for their futures that, if realized, would mitigate their risk for HIV and their overall vulnerability.

6.1.1 HIV risk is exacerbated in MARA and MARYP by a lack of employment and educational prospects.

Poverty... I decided to come here and make money [to] support [my] younger sister, but my parents don't know I am here. I volunteered.

Service women respondent

The majority of adolescents and young people interviewed for this study described a lack of options in education, employment and sustainable opportunities to generate income. They were either unemployed, engaged in informal income generation, illegal income generation or in work they described as difficult and/or dangerous and poorly paid (such as working on construction sites). Poverty was an underlying theme in all individual interviews and group sessions. All participants had migrated to their current location to find work and send money back to their families in rural village communities. They had insufficient financial resources to cover the cost of daily living including food, rent, clothes and basic medical costs. They expressed a desire for a better way of life, for a standard of living they saw on Thai television, but that could not be generated through the formal and legal employment options available. If they were to have any chance of generating incomes that could sustain them in the present, meet their hopes and dreams for the future and support their families, these participants felt there were few choices but to engage in informal or illegal income generation. The majority of young people in Lao PDR that watch television dream of having a better quality of life with enough food to eat, good clothes and money to give to their loved ones. A key unanswered question is what makes a young person more likely to engage in drug use or sex work to generate a better income or a better quality of life?



© UNICEF Lao PDR/Tom Greenwood/2009



© UNICEF LAO2009-5477/Jim Holmes

The challenge is I don't want to work in this setting, but because I came from a poor family... I have low education. I just finished primary year two and my family has no money to support my young sister and brother, so I do this work.

Service women respondent

Peer educators and adult workers spoke of the negative consequences that 'modern' or foreign values were having on Lao culture. Some expressed concern for the effect that 'materialism' and 'individualism' were having on young people's personal values and attitudes. This appears to be a generational tension in which young Lao people are highly

motivated and excited by the possibility of living a better and different life, while older Lao are concerned about a potential rejection by young Lao of the values and the way of life of their parents and grandparents. Engagement in sex work, drug use and dealing more openly with men and boys having sex with men, or living as TG were seen by older Lao as evidence of this growing generational gap. It is difficult to determine the truth of these views and to determine what this pattern really means for vulnerability to HIV among young people, in particular whether some young people are more vulnerable in this scenario to engaging in at-risk behaviours than other young people.

6.1.2 MARA and MARYP express dreams for their futures that, if realized, would mitigate their risk for HIV and their overall vulnerability

The boss [at a company] always says 'why you always speak like a women and not like a man?' and I say 'I have since birth' and he talks with other people in the company and this [is] discrimination – because even if we are successful in work we cannot be promoted... it's possible, sometimes we like a job, but have to consider the place as well. We [would] like jobs in entertainment, beauty salon [and] store.

Transgender respondent

In spite of the few opportunities available to them, almost all the adolescents and young people in this study described hopes and dreams for their futures that, if realized, would also minimize their risk of HIV infection and their overall vulnerability. They talked of "just starting out" and were optimistic they would be able to improve their current circumstances. Having enough money for basic needs, sending money home to their extended families in the country, having enough for themselves and also having money for friends and partners were some of the hopes expressed by respondents. Informal and formal education was expressed as an important resource to learn new skills, find new ways to generate income as well as meet others in similar circumstances and share experiences with each other.

For the young respondents in this research, they spoke of their desire for more trusting and loving relationships with friends, partners and families, for being able to create and sustain environments in which they were cared for but could also care for others.

I [am] just starting out... [want to] stop drugs and get married... to make my life better with [a] good job.

IDU respondent

Young drug users and ex-users (all young men in this study) spoke of a desire to stop using drugs for a better life, maybe getting married and having children. Other respondents spoke of getting good jobs in government, as teachers, working in or owning their own small businesses where they were less likely to face discrimination. Young transgender people engaged in sex work spoke of learning beauty skills and setting up their own beauty salons in current towns or cities, or back in their rural villages.

During... [means: in the past] they didn't know where to go, there was not many entertainment [venues] or restaurants or discotheques. Now you see younger and younger teenagers go to have drinks and see others and then after drinking they are thinking about sex.

6.1.3 Recommendations

Develop and strengthen interventions which provide a pathway to skilled work for MARA and MARYP and strengthen interventions which offer social alternatives for MARA and MARYP. For example, there are a range of HIV services and programmes delivered in current

hotspots for HIV in Lao PDR. Scale up these models and ensure that they focus on the delivery of social alternatives for age-appropriate peer support and education programmes and the targeting of adolescents and young people at risk of HIV.

6.2 From social isolation to stronger connections with services, other people and society

In this section, social isolation and its impact upon risk and vulnerability in MARA and MARYP are explored. HIV risk and the risk of abuse and exploitation are exacerbated by the social isolation that adolescents and young people experience. Little is known about the

situation of young people engaged in 'on-call' and street sex work. It was clear in this study that connection to HIV services, civil society organizations and peer-based programmes was a predictor for better informed, more articulate and confident respondents.

6.2.1 Social isolation is common for MARA and MARYP and it increases their risk of HIV and their vulnerability to exploitation and abuse

...when one friend grew up his father wanted him to get married and he got married twice, but after he got married, he still like to have sex with men. His father knew ...he kicked him out. Now he dresses like a woman and he goes out with men. The STI and the problem started with his family because he was not accepted by them as a transgender.

GLBT respondent

The social and familial circumstances across MARA and MARYP sub-populations vary widely. Young sex workers in this study often had not disclosed their sex work to family or to anyone in their village communities. Instead, they fabricated stories of formal work at restaurants or hotels in which the tips were exceptionally good. Young sex workers said their families, desperate for the income they provided, did not question them further in many cases. A smaller number said their families knew they were engaged in sex work and did not prevent it because few other options existed for income. Young drug users had difficult relationships with their families where their drug use was known. Young MSM and TG interviewed were more likely to describe families who knew they were having sex with men and/or living as transgender. A smaller number of young MSM and TG had not disclosed to their parents or had been rejected by parents because of sex with men/living as a woman.

From the discussions, a typical scenario for those interviewed was as follows: Predicated

by migration from rural communities to urbanized centres, MARA/MARYP, once separated from their communities and families, find that sex work, drug use and drug dealing are perhaps the only way to make a good enough living to support themselves and send money home. Young MSM and TG migrate to cities and towns so they can live openly or at least more freely. All these young people are separated from their families geographically. But they are, in many cases, separated psychologically because they must 'self-censor', choosing not to disclose the manner in which they are generating income, the sex they are having, the drugs they are taking and/or that they are transgender.

(In response to a question about watching out for one's health and safety, a teenage sex worker interviewed at a hotel responds) "...[it's] myself... just only myself. I don't even talk to the manager [of the venue]."

Service women respondent

Away from home, without the long-term care of adult family members, mentors and close friends, MARA/MARYP begin to rely on the new people around them who are not related and who may not share the same concern for them as their family or trusted friends would. Young sex workers, for example, described clients, managers, bosses and other sex workers as the people who have the most influence in their lives. Some also had peers in their lives, often other most-at-risk individuals of varying ages, with whom they a felt strong connection.

In the absence of community-based services to provide good information and assistance, what remains are adults who are either clients of the young sex worker or managers of their hotel, bar or club. Young people in these circumstances were more likely to describe the strong influences these adults had on risk taking and the 'pull' of extra money for abandoning condoms in sex work.

a. Little is known of the situation for young people engaged in on-call and street-based sex work in Lao PDR including their HIV-risk behaviours and knowledge of HIV.

...Our friend asks to use condom and the client refused to pay and the client hit our friend and says 'if you ask me to use a condom like this it's better for me to go have sex with my wife.'

Service women respondent

On-call sex workers are contacted by interested clients over the phone. Sex workers then arrange to meet with clients at hotels, bars and clubs before going to their homes or to a short-time hotel or having sex in cars or

discreet public places. Street-based sex workers operate in parks, streets and laneways where clients usually drive by and pick them up after negotiating a price. These MARA and MARYP are particularly isolated. They are not attached to a site that can provide the camaraderie and support that can be available in fixed sites. While work environments at fixed sites were variable in their supportiveness, there were usually adults and other young people available to provide at least a small measure of help. Some fixed sites provided condoms, assisted with health checks and took measures to prevent violence toward their staff.

b. Some adolescents, while not currently at risk of HIV, are especially vulnerable

Some adolescents and young people, while not currently at risk of HIV, are especially vulnerable to engaging in at-risk behaviour in Lao PDR. Vulnerability factors include extreme poverty, language barriers, educational barriers, alienation and lack of access to the health and welfare services.

This investigation found that children of migrants and children of domestically migrating Lao people are vulnerable. They may not speak the dominant form of Lao and they and their parents may not read or write the dominant form of Lao. Cross-border migrants and their children will not have rights to education and health care. These young people may be left unsupervised for long periods of time, often engaging in selling goods on the street without the supervision of an adult, and they and their families are often living in extreme poverty. Thus these young people are vulnerable to at-risk behaviour for exposure to HIV.

6.2.2 Peer-based social systems can encourage unhealthy as well as healthy choices in MARA and MARYP

For some young people in the village or community, they are unemployed and they don't have work to do and if they come together they share drugs and then they have sex.

GLBT respondent

Those who lived with or in close proximity to other MARA and MARYP spoke of these relationships as important for making healthier choices. However, a number also experienced peer pressure to engage in risky behaviour, especially where this was about being "one

of the group" where participants engaged in risk behaviours to be like their friends, to feel included and avoid rejection. Using drugs, engaging in sex work, having sex without condoms or with multiple partners were discussed as things that had occurred in the

context where adolescents and young people were bored, unemployed and had few options in their environments. Influencing these social relationships through peer-based

education and support programmes can assist adolescents and young people at risk to make healthier choices.

6.2.3 MARPs as peer mentors for MARA and MARP

There are two kinds of people: the kind people who tell you [that you] have to protect yourself when you have sex and the bad who tell you not to worry about it, just have sex – because they want to destroy us.

GLBT respondent

In the absence of family and childhood friends, participants in this study attempted to develop alternative communities of care through new friendships, peers, partners, and older people from MARP or other influential adults they had met. Respondents spoke of the negative influences that older MARP can have on risk taking but also spoke of “kind” and “gentle” older people in their networks who encouraged them to use condoms, to stop using drugs, to stop engaging in sex work, encouraged them to continue education and/or encouraged them to seek alternative forms of employment. This suggests that most-at-

risk adults in these key populations are a potential source of assistance and mentoring to adolescents and young people.

Programmes that encourage older MARPs to consider the care of younger people they engage with can be particularly effective in enhancing a more protective environment for adolescents and young people. Models exist that support this sort of practice. These models operate internationally and in the Asia Pacific region, and can provide useful insights into opportunities to be introduced/built upon in Lao PDR.

6.2.4 Connection with HIV services and civil-society organizations was a predictor of improved knowledge of HIV risk, prevention and symptoms of infection

Before coming to New House, some of our clients would offer us more money to not use condoms, but after coming to New House we ask them to take care of life and then when the client asks for sex without protection we say ‘no we can’t’ even if they offer a lot of money. We tell clients about HIV and we teach them and say if you get HIV you die.

Service women respondent

Those participants engaged with community health organizations and involved as peer leaders and educators were much more accurately able to describe risk behaviour for HIV, prevention strategies and symptoms of HIV than young people not connected to health services. They were also more likely to have age-based peers as friends who were members of most-at-risk populations and whom they could rely on for help and support. They were more likely to have what respondents called “friendly adults” in their lives that knew about their at-risk behaviour and encouraged and supported them in taking precautions and better care of their health. They were more likely to describe

relationships in their local environment as “loving”, “caring” and “supportive” than young people without these service and community-based organization (CBO) connections.

I meet with different people, have fun and we enjoy. We come from different provinces and we live together and we get along and we are happy to get along even though we are from different provinces... we are happy together. When we are living with close friends even when we cannot make money we are happy to be together and live together.

Service women respondent

Having friends and spending free time with age-appropriate peers was rated as one of the most important assets by all participants in this study. Where participants were able to spend time with friends they rated them as essential to helping them meet and cope with the challenges in their immediate environments. Those respondents engaged in both informal and formal outreach education through peer-based HIV programmes expressed higher levels of self-esteem, satisfaction and pride in their achievements. Where respondents had received information and support about HIV, this support had come directly from civil-society organizations that used age-appropriate peers to provide it. Services included the provision of condoms, HIV and STI information, risk-reduction techniques such as non-penetrative sex options and negotiation-skills training. Services also included helping MARA and MARYP to get to sexual health facilities by providing transport

and accompanying them to health services. Respondents spoke of these peers as like having “an older sister or brother” and said it made the organization “like a friend”.

Adolescents and young people interviewed, especially where they were engaged with a local civil-society organization, said that both teachers and monks could play increased roles as educators about HIV, sexuality and sexual health in the future. If these adult figures could be sensitized to the issues affecting most-at-risk adolescents and young people then they could be important sources of support and information.

Adolescents and young people are resourceful, thoughtful, resilient, self-reliant and motivated to take advantage of opportunities to participate in making their lives better. Their own optimism is a resource for better health.

6.2.5 Recommendations

<ul style="list-style-type: none"> • Develop a multi-lateral Participation Plan for MARA and MARYP in the development, implementation and evaluation of programmes in HIV hotspots in Lao PDR.
<ul style="list-style-type: none"> • Disaggregate epidemiological data for age in Lao PDR’s national HIV-surveillance system.
<ul style="list-style-type: none"> • Develop interventions which interrupt the social isolation that MARA and MARYP experience, for example: <ul style="list-style-type: none"> ◦ Age-appropriate peer-outreach interventions – programmes which use age-appropriate peers to deliver condoms, lubricant and clean injecting equipment, and to provide information about HIV, access to health services and support ◦ <i>Big Brother/Big Sister</i> programmes – that have been successful in a range of other contexts – which train an older peer who is then placed in relationship with a younger person, providing them with social and emotional support, facilitating their access to social networks and activities, and to health services and other social resources. ◦ Mobilize and sensitize teachers and monks to address the issues faced by MARYP and MARA and build their capacity to provide risk reduction advice.
<ul style="list-style-type: none"> • Develop interventions that target ‘fixed sites’ for sex work and their managers, shopkeepers and ‘Mama sans’: <ul style="list-style-type: none"> ◦ Support the Lao PDR Government to implement an appropriate 100 per cent condom programme in these venues, learning from the problems and successes revealed in evaluations of programmes in neighbouring countries such as Thailand and Cambodia. ◦ Develop educational resources, posters and pamphlets for these venues that remind patrons of the risk of HIV and encourage 100 per cent condom use. ◦ Facilitate access to health and social services for all sex workers in fixed sites with an emphasis on youth services for sex workers under 25 years of age.
<ul style="list-style-type: none"> • Develop a comprehensive, coordinated outreach education plan in ‘HIV hotspots’ in Lao PDR: <ul style="list-style-type: none"> ◦ Build programmes that target support and education to ‘on-call’ and ‘street-based’ sex workers, using a variety of methods and outreach workers. ◦ Develop a programme of HIV Road Show activities, outreach programmes and mobile clinics in ‘HIV hotspots’. ◦ Develop a research agenda for MARA and MARYP including investigating ‘on-call’ and street-based sex work as well as the protective factors associated with stronger connection between MARA/MARYP and social services.

6.3 HIV risk, knowledge, HIV disclosure and negotiation

In this section, knowledge of HIV and HIV risk among respondents as well as issues of HIV disclosure and condom negotiation during sex are explored. Not surprisingly, this assessment found that it is sexual partners (both partners and clients) that have the most influence on protection and risk behaviours during sex for MARA and MARYP. Some respondents view sex and drug-use as exciting, fun and as potentially providing new opportunities.

A key finding, as explained by the respondents, is that condoms are often very uncomfortable for young people in Lao PDR because they are

not the right size. Sex without condoms is therefore considered better sex than sex with condoms. Younger and less experienced sex workers were described as more at risk of coercion to not use condoms than their older peers. HIV risk and the risk of abuse and exploitation are exacerbated by the social isolation that adolescents and young people at risk of HIV infection experience. In sex with intimate partners, “love” was often a reason to abandon condoms. Introducing condoms into loving partnerships was viewed as a sign of not loving your partner and not trusting them.

6.3.1 Attitudes to sex and drugs

What we are doing when we are doing outreach activity is [to] tell them to use the condom. But we cannot tell them to reduce the partners. It's not possible.

Peer outreach LGBT respondent

Attitudes to sex and drugs were discussed in detail with respondents. Both sex and drugs were described as enjoyable, exciting and fun. In addition, sex was viewed as an activity that could provide new opportunities for the future, which included meeting new attractive partners or partners who could provide financial support and/or opportunities that would otherwise not be available. ATS use was identified as a causal factor for sex without condoms. For some young men in most-at-risk groups, sex with many partners was desirable and sex with just one partner was described as “not possible” simply because they desired many different partners and because their sex drives were high.

-
1. *[It's] double the money for no condom.*
 2. *It's about money. Most of our friends have to accept sex without condoms... [they] need the money for living.*

Service women respondents

Protecting oneself from HIV through condom use or through regular check-ups at services was viewed as rife with economic and opportunity costs – for example, less money for sex with condoms versus sex without

condoms and having to pay for health services. Sex without condoms was almost always described as more enjoyable and pleasurable than with a condom.

a. Access to and discomfort of condoms

Limited access to and discomfort of condoms were common themes described by respondents. Condoms are usually unavailable in rural communities or in the often-isolated places that MARA and MARYP have sex. For others, paying for condoms is prohibitive, as it can be the difference between choosing to buy a condom or to buy food. Condom size was raised as a comfort issue. The size of condoms available were big for most of the young people we interviewed and this created several difficult and embarrassing situations for young people during intercourse. Examples of problems included: the condom comes off during intercourse, the condom breaks or the condom is so uncomfortable that both parties agree not to use one. The lack of mechanisms and national guidelines for regulating the condom industry in terms of quality control, storage and distribution of condoms appears to be a factor that needs to be addressed in the immediate future.

6.3.2 Younger and inexperienced sex workers were described as vulnerable to coercion and intimidated into abandoning condoms

There was one case of first sex where the manager is like a broker and the manager says to the girl: the client will pay one million, but in fact the client gave two million, but the manager kept one million, and after a certain period after having sex, the girl had non-stop bleeding and the girl discuss with the friend and the friend recommend the girl come to [this organization]... and we recommend the girl see the doctor in the clinic and the parents they didn't know the situation.

Service worker respondent.

Young people may be totally unaware of either the HIV or STI risks associated with sex work, sex between men or injecting drug use. They may be impressionable and easily misled with incorrect information. The single largest determinant of unprotected sex in sex work was when clients offered to pay more for unprotected sex. Respondents in sex work spoke of extra payment for not using condoms as a regular occurrence. A smaller number described intimidation and violence if they insisted on condom use. Respondents described older male clients, who can leverage more power through coercion, promising to pay more or threatening not to pay at all.

Others provided misinformation about HIV to the young sex worker. One respondent described a young female sex worker with a client who did not wish to use a condom: "the client said 'Believe me [I] don't go around and have sex with anyone. I am clean... look at me, do I look sick?'" Particular risks were described for 'first-time sex' where the young sex worker has absolutely no experience with sex and where the stakes are very high because the client will pay much more for a worker who they believe to be a virgin. It is clearly particularly difficult, if not impossible, for young sex workers in these circumstances to negotiate condom use.

6.3.3 "Love" means not using condoms and trusting your partner

I have some friend[s], both died already because they shared the virus because they loved each other. Those who don't want to use condoms; they don't because they love each other and trust each other, even [when] one carries the virus – we can die together because we love each other – and they died already both.

GLBT respondent

Sexual partners had the most immediate influence on safer sex practice among most-at-risk adolescents and young people. A common reason for not using condoms (outside of sex work) was "love" and "trust" in relationships. Using a condom or insisting

on condom use in a relationship in which love was expressed was viewed as demonstrating a lack of trust and belief in the other partner. One respondent described it this way: "...with a boyfriend if you use a condom it's like you don't trust each other."

6.3.4 Living with HIV

AIDS cannot be cured and when other people know we are infected other people don't want to talk to us; it's an issue of discrimination.

Service women respondent

The experience of living with HIV was discussed by a number of respondents in this investigation. The death of friends from HIV was described, as was the social rejection of

people known to be living with HIV in the friendship networks of respondents. However, in the literature reviewed as part of the assessment, there was no discussion of HIV-

positive sex workers or drug users, and only limited data on MSM and TG diagnosed with HIV in Lao PDR.

Respondents described how friends were fearful of attending services when they knew they were HIV positive and consequently waited until they had symptoms of HIV and were 'forced' by their symptoms to attend clinics or hospital services.

...so when they go to hospital they are afraid it will come out with positive result and other people will know that they are people with HIV and this is also an issue of discrimination.

Service women respondent

6.3.5 Recommendations

- | |
|---|
| <ul style="list-style-type: none">• Develop a Standard of HIV and STI Care for MARA and MARYP that considers the known barriers to healthcare access as well as the harm-reduction approach to be taken for MARA between 10-14 years of age (see section 4.3). |
| <ul style="list-style-type: none">• Develop national condom regulations or guidelines for the manufacture, distribution, quality control and storage of condoms. |
| <ul style="list-style-type: none">• Develop social marketing and health promotion campaigns that encourage a connection between condom use and love and care between partners. These campaigns should target HIV hotspots as well as be developed by and for most-at-risk-populations for HIV. Social marketing and health education needs to incorporate strategies for making safe sex 'cool' and modern. Also develop these campaigns to address safer drug use that is based on harm reduction among adolescents and young people at risk of HIV infection. |
| <ul style="list-style-type: none">• Develop peer-based individual and group interventions for newcomers to sex work and young MSM and TG in HIV hotspots. Research is needed on how adolescents and young people in Lao PDR manage being diagnosed with HIV and how their networks cope with them and support them. |
| <ul style="list-style-type: none">• Support and education are needed to assist MARA and MARYP who are living with HIV to understand and manage their HIV-positive status in their sexual lives. |

6.4 Views about service provision

In this section we explore the views that respondents in the study had about service providers and service provision related to their at-risk behaviour. Participants mostly preferred attending stand-alone clinics and integrated programmes in mainstream clinics, as well as multi-purpose youth centres with a focus on HIV and STIs. Barriers to service access include location of sites, costs, 'self-censorship', fear of invasive procedures and concerns about

confidentiality. Further, coordination, referral pathways and cooperation between HIV and STI services needs to be dramatically improved. While the quality of services observed was high, the young people interviewed were usually only aware of, and had ever accessed, the particular service they were affiliated with and/or their local district/provincial hospital and clinic.

6.4.1 The services young people at risk prefer

I think this project set up is quite friendly for the group and for the young people because here we get a lot of information about HIV and treatment also we have the treatment of STI, but we also would like the treatment of other diseases because when we feel uneasy or have fever we don't want to go to the hospital because when we go to the hospital, the doctor says 'Oh you MSM or transgender'. There is still discrimination in the hospital and this is why we don't want to go there and we prefer to go to the clinic where it is friendly to us and we like would like to have more available here not only for STI Providers [but] provide a centre.

LGBT respondent

The services young people at risk prefer include stand-alone clinics for “people like me”, integrated programmes in mainstream hospitals and clinics, and multi-purpose youth centres. Barriers to service were discussed in detail with young people interviewed. Stand-alone clinics were generally preferred because participants felt more confident about their capacity and commitment to maintain their confidentiality. They also felt these services focused on “symptoms”, “the problem” and not the individual so they felt they were not judged by staff. They liked services where the staff spoke to them “as equals”. Integrated services in mainstream hospitals and clinics were sometimes preferred because participants felt more confident about the clinical expertise of the providers. Multi-purpose HIV and STI Youth centres were “friendly” and there was “a lot of information about HIV and treatment”. Others said these centres had “games, activities and it's quite fun” and, among young service women interviewed, there was a strong preference for multi-purpose centres as they felt distrustful of the hospital system and of openly disclosing their sex work to hospital staff.

We prefer to be accompanied by peer educators [because we] don't know where to go in the hospital... too many people.”

Service women respondent

A significant learning from this study was that participants said they would be most comfortable accessing health services and programmes where they had the help of a friend or a kind and influential adult to accompany them. Many indicated they would not go on their own. Many said they did not have these sorts of friends available to accompany them to services at the moment.

a. Barriers to access

Barriers to access included ‘self-censorship’, issues regarding confidentiality, cost, location and the fear of surgical and invasive procedures. A major barrier for access to general youth services was that MARA and MARYP participants felt embarrassed to be among “good kids” who were not engaged in at-risk behaviour for HIV. A list of stated barriers included:

- ‘Self-censorship’ being the most common and being “shy” about attending the available services for HIV and STIs.
- Cost was a significant barrier to service access, especially where respondents reported not having symptoms of any kind. Being motivated to attend a service for general health check-ups was low due to cost.
- The protection of one’s identity and the degree of confidentiality of a service provider (whether real or imagined) was noted by respondents as a serious barrier to services. When MARA and MARYP are asked to sign-in at front desks to receive a service or show identification, they report feeling very uncomfortable about whether the service will protect their confidentiality. For others, attending generic services brought with it the fear that service providers would contact families, disclosing personal and sensitive information, including test results. This issue was particularly highlighted for MARA/MARYP living with HIV who regularly resist attending mainstream and government clinics for fear that their confidentiality will be breached. As MARPs are small groups of people, connected to each other in networks in which stories and ‘word-of-mouth’ play an important role. Where

one individual in a network experiences a difficulty with a health service, that story circulates across many networks and is retold. In this study we heard similar stories across young sex workers, MSM, TG and drug users and these stories affect the willingness of those in these networks to attend the services being criticized.

- The location of services and the distances – respondents said they needed to travel to access these services. Many described needing transport to reach these sites.
- Service hours were of concern to participants who said that after hours programmes were needed to meet their needs. Waiting long periods of time was described as a barrier to access and many participants preferred instead to go to pharmacies and Alternative Medicine Clinics because they were closer, provided immediate service and were generally more convenient.
- A number of participants spoke of the painfulness of physical examinations undertaken in clinics by healthcare professionals. They spoke of instruments that were too big for adolescents and young people and procedures that were

too invasive. They wanted the health system to reconsider less invasive procedures, if possible, and questioned the regular use of invasive physical examinations.

b. Developing a harm-reduction model for 10-14 year old MARA can help to effectively case manage HIV risk along with protection and abuse vulnerabilities

A key challenge in the delivery of services to adolescents and young people at risk of HIV is managing the rights of the child. The rights of the child include ensuring protection of the child. One factor to be addressed is determining who should decide what is in the best interest of adolescents and young people engaged in sex work and/or drug use or boys and men engaged in sex with other boys and men. MARA and MARYP are relatively new concepts in the field of HIV health. Resources need to be developed advising on how to engage in harm reduction for MARA aged between 10-14 years of age and how to ensure services are safe and accessible for them while protecting them from exploitation and abuse. For example, the legal age of consent in Lao PDR is 15 – what then would services need to consider or reconsider alongside their responsibilities to deliver services to MARA and MARYP?

6.4.2 Recommendation

Develop a comprehensive outreach programme of clinics and services at the places where MARA and MARYP meet (or close to these places) that is open at hours that are convenient to them. Examples for consideration:

- | |
|--|
| <ul style="list-style-type: none"> • Mobile clinics or after hours clinics have successfully reached young people in low- and middle-income countries. Reconsider costs of services in the light of poverty with services provided at reduced cost or, if possible, at no cost. |
| <ul style="list-style-type: none"> • Government programmes, including hospitals and clinics, need to become more sensitized to the needs of MARA and MARYP and understand that they should not discriminate against anybody in the delivery of services. Establish formal and resourced relationships between civil society organizations and government services to ensure that sites delivering services to MARA/MARYP are accessible and safe for at-risk populations. |
| <ul style="list-style-type: none"> • Develop a programme to recruit MARPs, including MARA and MARYP, as volunteers or even as intake and assessment staff in government and private services. |
| <ul style="list-style-type: none"> • Develop a strategy for strengthening cooperation, knowledge sharing and stronger referral pathways between services responding to MARA and MARYP. |
| <ul style="list-style-type: none"> • Establish a national multilateral working group to develop a position on harm reduction for 10-14 year olds engaged in at-risk behaviour for HIV. |

This report has provided an in-depth analysis of MARA and MARYP gathered through a series of rigorous qualitative tools as well as the professional insights of key leaders in Lao PDR. The research was commissioned by UNICEF Lao PDR and UNICEF to contribute to the development of the Lao PDR's new National Strategic Plan on HIV/AIDS, STI 2011-2015.

Key analysis includes:

- MARA and MARYP described dreams for their futures that, if realized, would mitigate their risk for HIV and their overall vulnerability.
- Connection to HIV services, civil-society organizations and peer-based programmes was a predictor for better informed, more articulate and confident respondents.
- Sexual partners (both partners and clients) have the most influence on protection and risk behaviours during sex for MARA and MARYP in this study.
- Condoms are often very uncomfortable for young people in Lao PDR and sex without condoms is considered better sex.
- Younger and less experienced sex workers are at greater risk of coercion to abandon condoms than their older peers.
- In sex with intimate partners, "love" was often a reason to abandon condoms. Introducing condoms into loving partnerships was viewed as a sign of not loving your partner and not trusting them.
- Participants mostly preferred attending stand-alone clinics and integrated programmes in mainstream clinics as well as multi-purpose youth centres with a focus on HIV and STIs.
- Barriers to service access include location of sites, costs, 'self-censorship', fear of invasive procedures and concerns about confidentiality.
- There is a need for dramatically improved coordination, referral pathways and cooperation between HIV and STI services.

Priority for recommendations

8

Evidence-based interventions and programmes with the participation of MARA/MARYP

- Disaggregate epidemiological data for age in Lao PDR's national HIV surveillance system.
- Develop a multilateral participation plan for MARA and MARYP in the development, implementation and evaluation of programmes in HIV hotspots in Lao PDR.
- Research the ways adolescents and young people, including sex workers and drug users, in Lao PDR manage being diagnosed with HIV and how their networks cope with and support them.
- Develop a research agenda for MARA and MARYP including investigating 'on-call' and street-based sex work as well as the protective factors associated with stronger connections between MARA/MARYP and social services.
- Create enabling environments for MARA/MARYP: Develop and strengthen interventions that provide a pathway to skilled work for MARA and MARYP; develop and strengthen interventions that offer social alternatives for MARA and MARYP.

Deliver services to MARA and MARYP that meets their needs, protects confidentiality, and is affordable, convenient and accessible:

- Develop a strategy for strengthening cooperation, knowledge sharing and stronger referral pathways between services responding to MARA and MARYP.
- Reconsider costs of services in the light of the poverty issues described in this report. Services should be provided at reduced cost or, where possible, at no cost.
- Develop a programme to recruit MARPs, including MARA and MARYP, as volunteers or even as intake and assessment staff in government and private services.
- Develop a comprehensive outreach programme of clinics and services at the places where MARA and MARYP meet (or close to these places) that are open at hours that are convenient to them.
- Facilitate access to health and social services for all sex workers in fixed sites with an emphasis on youth services for sex workers under 25 years of age.

Promote safer sex and harm-reduction models for MARA and MARP that ensure their right to protection from violence, exploitation and abuse

- Establish a national multilateral working group to develop a position on harm reduction for 10-14 year olds engaged in at-risk behaviour for HIV.
- Develop a Standard of HIV and STI Care for MARA and MARYP that considers the barriers to access as well as the harm-reduction approach to be taken for MARA aged between 10-14 years of age.
- Develop social marketing and health promotion campaigns based on harm reduction that encourage safer drug use among adolescents and young people at risk of HIV infection.
- Develop national condom regulations or guidelines for the manufacture, distribution, quality control and storage of condoms.

Behaviour-change communication interventions for MARA and MARYP with traditional and non-traditional partners

- Develop interventions that interrupt the social isolation that MARA and MARYP experience, including age-appropriate peer outreach interventions.
- Develop interventions that target 'fixed sites' for sex work and their managers, shopkeepers and 'Mama sans'. Develop peer-based individual and group interventions for newcomers to sex work and young MSM and TG in HIV hotspots.
- Support the Lao PDR Government to implement an appropriate 100 per cent condom programme in hot spot venues, learning from the problems and successes revealed in evaluations of programmes in neighbouring countries such as Thailand and Cambodia
- Support and educate MARA and MARYP who are living with HIV to negotiate HIV in their sexual lives.
- Develop a comprehensive, coordinated (across all partners) outreach education plan in HIV hotspots in Lao PDR.
- Sensitization of teachers and monks to the issues faced by MARYP and MARA and training in providing risk-reduction advice – an extension of the current programme delivered by the Lao PDR government.
- Develop social marketing and health promotion campaigns that encourage a connection between condom-use and love and care between partners. These campaigns should target HIV hotspots as well as be developed by, and for, most-at-risk populations for HIV in Lao PDR. Social marketing and health education needs to incorporate strategies for making safe sex 'cool' and modern.
- Develop educational resources, posters and pamphlets for venues where sex services are provided that remind patrons of the risk of HIV and encourage 100 per cent condom use.

Annexes

Annex 1: Draft Topic Guide for MARA/MARYP Peer Educator Focus Groups and Individual Interviews with MARA/MARYP

Pre-focus group activities:

Introductory protocol

Refreshment

Initial explanation of the project

Oral Informed Consent

Introduction by Facilitator:

1. Restate the purpose of the focus group (HIV, risk taking, services and young people) as and why the participants were invited.
2. The discussion will be focused on adolescents and young people in Lao PDR or specific areas within Lao PDR. Explain that there are no right or wrong answers; the participants are the experts.
3. Re-emphasize the idea of consent and explain the protection of privacy of participants is essential to the research.
4. Participants should speak from personal experiences, but they are welcome to use "my friend..." when talking about themselves or their friends.
5. Explain to the participants the FGD is being audio taped for transcription and later review/analysis of responses. Privacy and confidentiality will be respected and the recordings will not be shared with anyone other than the research team and will be destroyed after the data analysis is complete. Introduce facilitator defined terms.
6. Ask if the participants have any rules or expectations they would like to add to make the discussion more comfortable

Ice-breaker: Go around the circle and ask everyone to state their first name (or what they would like to be called) where they are from and their favourite spare-time activity.

N.B. Substitute peer group or peer with your friends when speaking with peer educators

Section 1: General information about MARA/MARYP in Lao PDR

1. To begin please tell me a little about yourself and this group.

Probing questions: 1) Please tell me a bit about your peer group? 2) People usually have some aspects of their lives that are "going well" strengths and some challenges and areas that are more difficult. What are the "good aspects" of your lives? 3) What are some of the biggest challenges your friends face? 4) Where do your peers find support with addressing these challenges?

Section 2: Risk Behaviour and Health Concerns

1. I will come back to the issue of support a bit more a little later, but now we are going to shift the focus a little bit. Now I would like to know more about your friends' experiences with health concerns. What are the major health concerns for young people like you?

Probing questions: 1) *How important would you say health issues are for you or your friends? 2) What kinds of health issues do young people worry about? 3) How would you say these health concerns differ from the concerns of other people in your neighbourhood? 4) Why do you think that is? (age, stigma, gender, etc.)*

2. Some young people consider HIV/AIDS a health concern; for others it is not really an issue that is considered important. How important would you say health concerns like HIV/AIDS are for your friends?

Probing Question: 1) *Could you tell me more about why you feel HIV/AIDS is/is not a concern that your friends think about? 2) Where do young people hear about HIV? What kinds of things do they hear from society? 3) How does this impact young people's risk behaviours/perception of risk?*

3. What do you think are the HIV-related risks for you and your friends?

Probing Question: 1) *What are activities and situations that your friends engage in that you consider the most risky? 2) Why would you consider these situations risky? 3) In what ways are HIV risks different for young people than for other parts of the population? 4) Do all young people have the same risks? 5) What do young people do to avoid these risks? 6) How much control or choice do you think your friends have with their risk taking behaviour? 7) Why do they take these risks? 8) What are the benefits of these risky behaviours? 9) For some young people who consider HIV/AIDS an important issue, there are things they do to try to avoid the risks of HIV/AIDS. If your friends considered HIV/AIDS an important issue, what would they do?*

4. Now I would like to know a little about how young people's relationships with other people influence their behaviour. Who encourages or forces your friends to take more risks? Who is looking out for your friends' health and safety?

Probing questions: 1) *Please tell me more about the influence that friends have on each other's behaviour. 2) What role does young people's relationships with their important adults (family/religious leaders/social services/other influential) play? 3) What are young people's relationships with law enforcement? 4) How do you think your elders view your peers and other young people? 5) How does this reputation affect friend's behaviour or their ability to take care of their health? 6) How have power relationships/negotiation between MARYP and MARP affected risk-taking?*

Section 3: HIV-Related Service Utilization and Gap Analysis

For the last section on I would like to know more about the local health services and outreach programmes and how to better address young people's needs.

1. If you had a friend who was worried about HIV/AIDS or other similar health risk and needed information, prevention methods or health care, where would you recommend s/he should go for help?

Probing Questions: 1) *Why would you make this recommendation? 2) What other types of HIV-related health services and programmes exist? (including VCCT and specific services for IDUs, MSM, CWs such as drop-in centres, harm reduction, etc) 3) What kinds of information/services do you think you or your friends might like to have?*

2. Sometimes people have difficulties and run into barriers when they attend health programmes and services. What difficulties or barriers have your friends experienced when they try to seek health care or try to attend health related programmes?

Probing Questions: *1) What role does your friends' age, gender, sexual orientation have on how they are treated? 2) What would help your friends to better access health services? 3) How could these programmes be more effective at addressing the needs of your friends and other young people? 6) How could young people be involved in planning and evaluating programmes in the future?*

3. When you have a concern about programmes or services in your city, what are your options for making that concern known/heard (what actions do you think you could take)?

Probing questions: *1) Previously, have you ever made your voice heard about HIV/AIDS-related programmes or other health services? 2) What was that experience like? What happened as a result? Were there repercussions, or did you feel things changed for the better? 3) Would you do it again? If not (or for those participants who haven't taken such an action before), what would you think of doing now, in a situation where you had a problem with health programmes or services in services in your city? 4) How have young people been involved in the programming planning and evaluation?*

Conclusion

Are there other things you would like to discuss?

Annex 2: Questionnaire with Service Providers and Outreach Staff

Service provider name: _____

Service delivery point location: _____

How many years location has been operating: _____

1. What is your organization's mission statement and vision?
2. What HIV-related services does your organization provide?
3. Every agency has some aspects of their HIV programmes that are very successful and other areas that face challenges and even prove unsuccessful.
 - a. What do you feel have been your organization's recent successes?
 - b. What have been some of the challenges?
 - c. What have been your lessons learnt?
4. Who are the main clients for your services?
 - a. What are the estimated number of clients that have been reached by your HIV programme in the last year?
 - b. What percentage of your clients are estimated to be below the age of 25?
 - c. How many clients visit the programme on a typical day?
5. In your opinion, are these services meeting the needs of the target population in this area? What could you do to improve the programme's ability to better meet those needs through existing services? What other services are needed to meet their needs?
6. What experience does your programme have with working with young people?
7. How do young people's needs differ from those of your other clients?
8. How could the quality of HIV services for young people be improved in your organization?
9. If a client had feedback or suggestions for how to improve the programme, who would they talk to and what would happen? Would this be different for a client under the age of 24?
10. Considering the situation of the most at risk people and HIV, what areas do you think require further research and programming?

Additional information: (as required).

References

- 1 Redefining AIDS in Asia – Crafting an Effective Response. Report of the Commission on AIDS in Asia. UNAIDS Asia and the Pacific. Oxford University Press. New Delhi. 2008:54. “Latent: low but slowly increasing prevalence.”
- 2 UNAIDS Epidemiological Fact Sheets 2008.
Go to: http://www.data.unaids.org/Publications/Fact-Sheets01/Laos_en.pdf
www.data.unaids.org/Publications/Fact-Sheets01/Laos_en.pdf
- 3 Definition: ‘Concentrated’ epidemics are epidemics in which the routes of HIV transmission include unprotected anal and vaginal sex in sex work, unprotected anal sex generally, injecting drug use with non-sterile equipment. Most at risk populations for HIV therefore include sex workers and their clients, injecting drug users (IDU) and their partners, men who have sex with men (MSM) and transgender people (TG).
- 4 USAID HIV/AIDS Health Profile: Lao PDR. September 2008.
Go to: http://www.usaid.gov/our_work/global_health/aids/Countries/asia/laos_profile.pdf
http://www.usaid.gov/our_work/global_health/aids/Countries/asia/laos_profile.pdf
- 5 UNODC Lao PDR. (2010). Lao PDR Overview: Drugs Demand Reduction and HIV/AIDS. United Nations Office on Drugs and Crime. Go to: http://www.unodc.org/laopdr/en/Overview/Health-and-Development/Drug-demand-reduction_and_HIV-AIDS.html http://www.unodc.org/laopdr/en/Overview/Health-and-Development/Drug-demand-reduction_and_HIV-AIDS.html
- 6 APMG. 2010. Most at Risk Young People to HIV in East and South Asia. UNICEF/UNFPA. Pre-final draft report 15 February 2010.
- 7 Ibid. USAID 2008.
- 8 APMG (2010). Most At Risk Young People (MARYP) To HIV/AIDS in East and South Asia: a desk review of strategic information on MARYP from 17 countries. UNICEF and UNFPA; p24.
- 9 Lao PDR Ministry of Health (2009). Integrated Behaviour Biological Surveillance (IBBS) 2008. Vientiane, Ministry of Health Centre for HIV/AIDS and STI. p.18.
- 10 Ibid. IBBS 2008; p 18.
- 11 WHO (2009). Towards Universal Access Scaling Up Priority HIV Interventions in the Health Sector Progress Report. WHO. UNAIDS. UNICEF; p 35. Go to: <http://www.who.int/hiv/pub/2009progressreport/en/> <http://www.who.int/hiv/pub/2009progressreport/en/>
- 12 Shaw G. 2006. Report on the WHO, UNODC, UNAIDS consultative meeting with the Government of the Lao PDR on harm reduction needs in the country. In APMG. (2010). Most at Risk Young People to HIV in East and South Asia. UNICEF/UNFPA. Pre-final draft report; p 25.
- 13 Lao PDR’s Rapid Growth Brings New Development Challenges. Asia Development Bank. News Release. 8 September 2009.
Go to: <http://www.adb.org/Media/Articles/2009/12976-laosian-developments-challenges/>
<http://www.adb.org/Media/Articles/2009/12976-laosian-developments-challenges/>
- 14 AusAID. (2009). Laos Country Overview. Australian Government.
Go to: <http://www.ausaid.gov.au/country/country.cfm?CountryId=35>
<http://www.ausaid.gov.au/country/country.cfm?CountryId=35>
- 15 Ibid. AusAID. (2009).
- 16 Laos – Infrastructure, power and communications. Encyclopaedia of the Nations. 2005.
Go to: <http://www.nationsencyclopedia.com/economies/Asia-and-the-Pacific/Laos-INFRASTRUCTURE-POWER-AND-COMMUNICATIONS.html>
<http://www.nationsencyclopedia.com/economies/Asia-and-the-Pacific/Laos-INFRASTRUCTURE-POWER-AND-COMMUNICATIONS.html>

- 17 Paitoonpong, Sawooth. Thailand's Cross-border Trade in the Greater Mekong Sub region: Selected Social Issues. Thailand Development Research Institute. 2007.
Go to: <http://www1.doshisha.ac.jp/~ccas/eng/Epublications/eWP9srawooth.pdf>
<http://www1.doshisha.ac.jp/~ccas/eng/Epublications/eWP9srawooth.pdf>
- 18 Huberman, A and Miles M (eds). (2002). *The Qualitative Researcher's Companion*. Sage Publications. Thousand Oaks, CA, USA; p 15.
- 19 The Open University. *Young People's Wellbeing – The Resilience Model*. 2009.
Go to: <http://openlearn.open.ac.uk/mod/resource/view.php?id=284235>
<http://openlearn.open.ac.uk/mod/resource/view.php?id=284235>
- 20 Blackstock, Cindy; Trocme, Nico. Community-based child welfare for Aboriginal children: supporting resilience through structural change. *Social Policy Journal of New Zealand* no.24 Mar 2005: pp 12-33.
- 21 Fullagar, S and Sandwith, G. (2003). Researching youth suicide: Discourses of leisure, mental health and well-being. In Colyer, S and Lobo, F. (Eds.) *Leisure Futures, Leisure Cultures*. Perth: Praxis Education. pp. 117-124.
- 22 Home Office of the British Government. (2007) Risk, protective factors and resilience to drug use: identifying resilient young people and learning from their experiences. National Centre for Social Research. Go to: <http://www.homeoffice.gov.uk/rds/pdfs07/rdsolr0407.pdf>
<http://www.homeoffice.gov.uk/rds/pdfs07/rdsolr0407.pdf>
- 23 Masten, A. S. (2009). Ordinary Magic: Lessons from research on resilience in human development. *Education Canada*, 49(3): 28-32.
- 24 Luthar, S. S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development*, 71(3), 543-562.
- 25 Report of the Commission on AIDS in Asia (2008). *Redefining AIDS in Asia: Crafting an Effective Response*. UNAIDS. Oxford University Press. New Delhi, India; p111.
- 26 Hamblin, Julie. (1992). The role of the law in HIV/AIDS policy. Issue Paper No 11. UNDP.
Go to: <http://www.undp.org/hiv/publications/issues/english/issue11e.htm>
<http://www.undp.org/hiv/publications/issues/english/issue11e.htm>
- 27 Ibid. UNAIDS. (2008). Oxford University Press. New Delhi, India; p112.
- 28 Ibid. (2008); p112.
- 29 Berry, Scott. Inquiry in to community care and support for MSM and TG with HIV in Bangkok, Thailand. 2009. *Pact Thailand*; p16.
- 30 MOH (2009). *Integrated Behavior Biological Surveillance 2008*. Vientiane, Ministry of Health Centre for HIV/AIDS and STI; p 10.
- 31 Ibid. MOH (2009); p 12.
- 32 Ibid. MOH (2009); p 19.
- 33 MOH (2009). *Integrated Behaviour Biological Surveillance 2008*. Vientiane, Ministry of Health Centre for HIV/AIDS and STI. pp. 10-13.
- 34 Ibid. MOH (2009). p.14. The IBBS 2008 found female service women averaged between 1.6-3.9 clients per week.
- 35 Keobounphanh, I. and M. Toole (2008). *Young Women's Sexual Behavior Study Vientiane Capital, Lao PDR*. Vientiane, Burnet Institute. p.18. The Young Women's Sexual Behavior Study found client estimates range between 8-60 clients per month.
- 36 Ibid (2009); p 12.
- 37 Ibid (2009); pp 18-20.
- 38 Ibid (2009); p 10.
- 39 Ibid (2009); p 17.
- 40 Ibid (2009); p 17.

- 41 Keobounphanh, I. and M. Toole (2008). Young Women's Sexual Behavior Study Vientiane Capital, Lao PDR. Vientiane, Burnet Institute. p.17.
- 42 Fujiwara, T. Takano, T and Nakamura K. (2005). The spread of drug abuse in rapidly urbanizing communities in Vientiane, Lao People's Democratic Republic. Health Promotion/International Health, Division of Public Health, Graduate School of Tokyo Medical and Dental University, Japan. Health Promotion International, Vol. 20 No. 1. 24 January; p 61. Oxford University Press. Go to: <http://heapro.oxfordjournals.org/cgi/reprint/20/1/61> <http://heapro.oxfordjournals.org/cgi/reprint/20/1/61>
- 43 In, APMG (2010). Most At Risk Young People (MARYP) To HIV/AIDS In the East and South Asia: A desk review of Strategic Information on MARYP from 17 Countries. A. P. M. Group, UNICEF & UNFPA. p.25.
- 44 UNODC World Drug Report. United Nations Office on Drugs and Crime. Go to: <http://www.unodc.org/unodc/en/data-and-analysis/WDR-2009.html> <http://www.unodc.org/unodc/en/data-and-analysis/WDR-2009.html>
- 45 UNODC Lao PDR. (2010). Lao PDR Overview: Drugs Demand Reduction and HIV/AIDS. United Nations Office on Drugs and Crime. Go to: http://www.unodc.org/laopdr/en/Overview/Health-and-Development/Drug-demand-reduction_and_HIV-AIDS.html http://www.unodc.org/laopdr/en/Overview/Health-and-Development/Drug-demand-reduction_and_HIV-AIDS.html
- 46 Ibid. UNODC (2010).
- 47 Australian Government. (2008). National Amphetamine-Type Stimulant Strategy Background Paper: Monograph Series No. 69. National Drug Strategy. Go to: <http://www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/mono69-l~mono69-l-ch3~mono69-l-ch3.5> <http://www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/mono69-l~mono69-l-ch3~mono69-l-ch3.5>
- 48 UNODC (2009). Patterns and Trends of ATS and other drugs in East and South East Asia; p76. Go to: http://www.unodc.org/documents/eastasiaandpacific/2009/11/ats-report/2009_Patterns_and_Trends.pdf http://www.unodc.org/documents/eastasiaandpacific/2009/11/ats-report/2009_Patterns_and_Trends.pdf
- 49 Phimphachanh, C., S. Menorath, et al. (2009). Amphetamine Type Substance Use and Sexually Transmitted Infection Risk among Young People in Vientiane Capital and Vientiane Province, Lao PDR. Vientiane, Centre for HIV/AIDS and STIs, University of Health Sciences, Burnet Institute, Chiang Mai University. p. 20.
- 50 Ibid. Sheridan, S., C. Phimphachanh, et al. (2007); p 9.
- 51 Ibid. APMG (2010); p 25.
- 52 Phimphachanh, C., K. Chounramany, et al. (2008). Assessment of Condom Programming in Lao PDR. Vientiane, Ministry of Health Center for HIV, AIDS, & STI; UFPA. p.16.
- 53 Ibid. Sheridan, S., C. Phimphachanh, et al. (2007); p 9.
- 54 Toole, M., B. Coghlan, et al. (2005). Study of young men's sexual behaviour. Vientiane, Lao People's Democratic Republic. August – November 2004. Vientiane, Lao PDR, Burnet Institute p.14.
- 55 Ibid. Toole, M. Coghlan, B, et al. (2005); p 14.
- 56 Sheridan, S., C. Phimphachanh, et al. (2007). HIV prevalence & risk behaviors among men who have sex with men in Vientiane Capital, Lao PDR. Vientiane, Burnet Institute. p.8.

UNICEF East Asia and Pacific Regional Office

19 Phra Atit Road
Bangkok 10200, Thailand

Tel: (66 2) 356-9499

Fax: (66 2) 280-3563

www.unicef.org/eapro