



**Experience of HIV and AIDS and
UNICEF Care and Support Interventions
in Lao PDR: *A Qualitative Study***



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UNICEF, Vientiane, Lao PDR 2006

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AUGUST 2005



Abbreviations

ARV: Anti-Retroviral Therapy

CHWIV: Children with HIV

FWHIV: Family with HIV

HW: Health Worker

INGO: International Non-Governmental Organisation

MSF: Médecins Sans Frontières

MWHIV: Men with HIV

OI: Opportunistic Infection

PKS: Pakse

SVK: Savannakhet

UNICEF: United Nations Children's Fund

VCT: Volunteer Counselling and Testing

VT: Vientiane

WHIV: Women with HIV

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Introduction

Since early 2000 UNICEF has been committed to directly supporting self-help groups for people with HIV, especially in medical settings such as Savannakhet Provincial Hospital, Mahosot and Sethathirat Hospitals in Vientiane, and Pakse Provincial Hospital.

UNICEF is concerned about the lives of people living with HIV/AIDS and wants to know more about the lifestyles of these people before they became infected, including the risks they were exposed to, how they were tested, their quality of life since the test, and the services and support available to them.

This study began by recruiting HIV positive participants at the hospitals which provide care for them in Laos. As Voluntary Counselling and Testing (VCT) facilities are not yet well developed in the country, it is difficult to identify people living with HIV/AIDS outside of the formal health system. After being tested and informed of their result, people living with HIV/AIDS remain in direct contact with the medical setting where they were tested. All of the four hospitals that offer care for people living with HIV/AIDS organise a monthly day-gathering for them through a 'patients' association'. UNICEF provides financial support to the associations by funding transport and accommodation costs for these gatherings. During the monthly meetings people with HIV/AIDS are invited to share their ideas, concerns and information. However, some people living with HIV/AIDS refuse to join the associations as they consider that attending effectively discloses their sero-status to the outside community.

To provide a better understanding of the situation of people living with HIV/AIDS in the Lao PDR, the study looks into the lives of the sample of people living with HIV/AIDS, 'the participants', covering their lives before the test, experience of the test, and period between the test and the present time. The test is considered the crucial point in the life of a person living with HIV/AIDS, the moment of passage from infection to knowledge of the infection and its consequences. It is the time when persons living with HIV/AIDS must acknowledge their own or their partner's behaviour. Before the test people with HIV/AIDS are infected but neither they nor any one else is aware of their HIV status. After the test they cannot refute the evidence, especially if the counselling is well done, though one participant did disclose that he went to three different settings to be tested in order to be sure of the result.

The study analyses the individual stories and the social, family, economic and gender aspects of each participant to better understand the factors that caused their infection and the changes in their lives since the test, including their relationships within their family and community at large. Their needs and aspirations are summarised and discussed, and recommendations are made as to future interventions.

HIV/AIDS in the Lao PDR

For many years following the identification of the first HIV case in the country in 1992, the authorities and the population of the Lao PDR did not consider the HIV epidemic to be very serious. However, although Laos is a low-prevalence country compared to neighbouring countries, the number of infected people has steadily increased. This increase has necessitated more systematic provision of care and support of people infected. Following the pioneering efforts of the Savannakhet Provincial Health authority, Savannakhet Provincial Hospital initiated a project of care and support to people infected with HIV. From 2001, *Médecins Sans Frontières* (MSF-Suisse) has offered technical and financial support to Savannakhet Hospital and brought considerable improvement to the service for people living with HIV/AIDS. In September 2003, the first patients were prescribed with free ARV treatment. Now more than 250 patients from all over the country receive treatment from the Savannakhet project (cf. annexe). Many of these live in other provinces, especially Vientiane Capital.

Currently every person with HIV/AIDS in Laos who wants and needs ARV treatment, and cannot afford to buy it in Thailand, visits Savannakhet Hospital once a month for a medical check-up and to receive their monthly dosage of ARV. At the same time people with HIV/AIDS are under the care and supervision of the provincial hospital they originated from. This situation has economic consequences for the families of the infected. They need to cover the cost of hospitalisation, and are often also tempted to spend significant resources on traditional medicines.

The MSF ARV project and UNICEF cover transport fees for outpatients living with HIV/AIDS. Every month, each hospital organises a half-day meeting with volunteers and people living with HIV/AIDS who receive counselling. People living with HIV/AIDS receive travel expenses from the organization to attend the monthly-meeting.

According to Kinoy, a representative of people living with HIV/AIDS in Savannakhet province and a counsellor with the MSF project, MSF and UNICEF both support people living with HIV/AIDS who come to Savannakhet Provincial Hospital. MSF supports ARV treatment and transport of people living with HIV/AIDS from home to hospital. In the short term UNICEF also supports the transport but as UNICEF also supports income generation schemes as these improve family incomes UNICEF plans that transport assistance will be eventually discontinued. However, as the number of people living with HIV/AIDS coming to the Savannakhet consultation is increasing, - at around 500 people living with HIV/AIDS now - and due to a limited budget a new policy has been established: Support is available for transport during the first six months of ARV treatment for a person living with HIV/AIDS and after that they have to take care of themselves, if they are healthy. This policy was announced to people living with HIV/AIDS in July and comes into effect in September 2005.

Research Methodology

Three of the largest cities in Laos were selected because they gather the majority of the recorded people living with HIV/AIDS in the country: Vientiane (VT), Savannakhet (SVK) and Pakse (PKS) are the capital cities of the most populous provinces. UNICEF informed the local health authority in each city of the substance of the research.

The project recruited and trained four people living with HIV/AIDS as interviewers. Two of these were selected to carry out interviews with people living with HIV/AIDS. One research assistant interviewed the families of people living with HIV/AIDS and the care-takers of Children with HIV (CWHIV), and some people living with HIV/AIDS. Another assistant, a medical doctor, interviewed health workers who work with people living with HIV/AIDS in the hospitals. Participants were selected from the list of patients given by the head of the service taking care of people living with HIV/AIDS in each hospital. Attitudes differ in each site: one counselling service head gave the list of all registered people living with HIV/AIDS and the participants were selected at random. The interviewer then called or met the participant, reimbursed their transport fee, and interviewed them after obtaining consent. A financial incentive was provided. At the second site, the doctor in charge selected people, contacted them directly and organised the interviewing in the consultation room with the same benefits for participants. At the third site the Lao Youth Union coaches the self-help group, which randomly selected the participants and organised transport and lodging logistics, paid for by the research project.

Interviews took place in different settings, with private and quiet places chosen. The three interviewers questioned one to three people living with HIV/AIDS everyday, recording each interview with the consent of the participants - nobody declined to be recorded. The interviewers then summarised the content of the 60 to 90 minute interview and handed the tape and the summary to a research assistant for translation into English. Tapes and summary were labelled with a code to avoid confusion. Tapes and translation were stored in the computer of the principal investigator to minimise confusion and loss.

At the beginning of the epidemic in Laos, in the mid-1990s it was mostly men who were affected and recorded among people tested and attending the embryonic consultation and support groups. Now, following a high mortality rate among men with HIV (MWHIV), and improved access to testing and treatment, the number of women infected and detected has increased. To avoid a gender imbalance among participants, an equal number of women and men were selected. It soon became clear that the patterns of risk behaviour are quite different between sexes.

Description of the Sample

The breakdown of the people interviewed is as follows: 57 people living with HIV/AIDS, one person from eight families with an infected family member (FWHIV), five care-takers of children with HIV (CWHIV) and six health workers (HW) agreed to participate in interviews. A mother with HIV was included in FWHIV and people living with HIV/AIDS.

Fig 1: Gender and HIV status of people interviewed

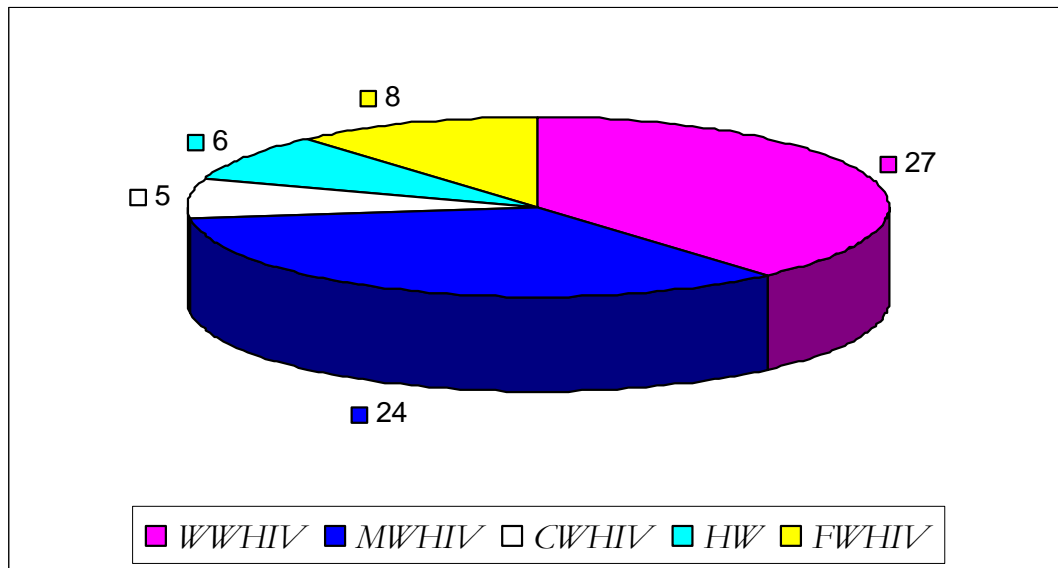


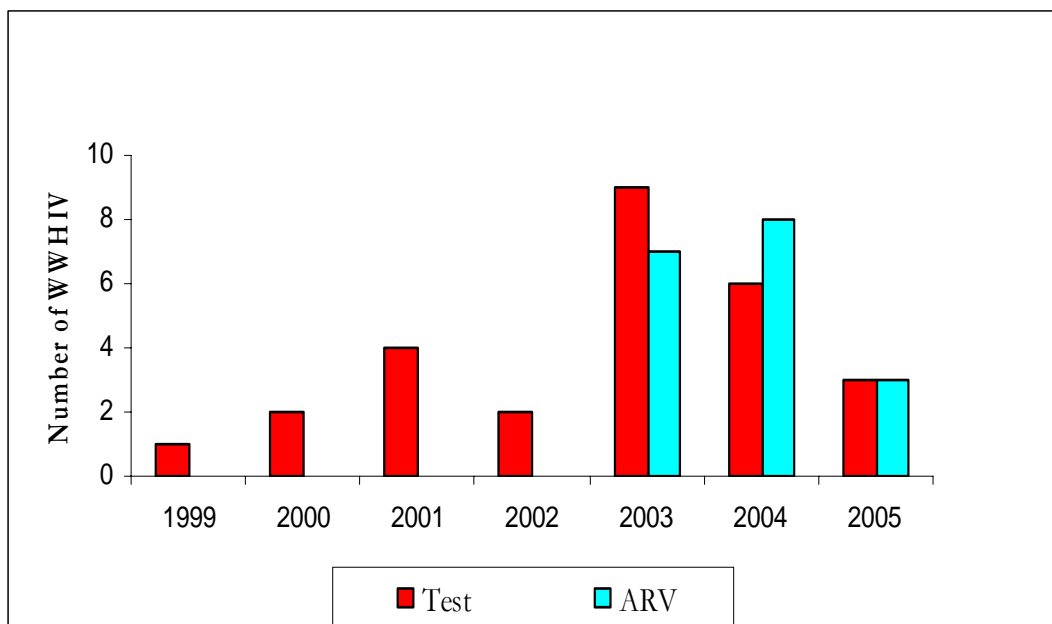
Table 1: Total Sample

	SVK	VT	PKS	Total
People living with HIV/AIDS	27	21	9	57
WWHIV	13	10	4	27
MWHIV	11	9	4	24
CWHIV	2	2	1	5
HW	2	2	2	6
FWHIV	4(1)	2	2	8 (1 WWHIV)
	32	25	13	70

Table 2: Age of Women Participants

n=27	Average	[range]	Comments
Age	34.6	[21 – 57]	Four women above 40: 46, 47, 49, 57

Fig 2: Year of HIV test and of receipt of ARV for women interviewed



The average age of the 27 WWHIV is 34.6, with a range of 21 to 57, and four women aged 40 and above. It is an average of 2.3 years since they took the test. 18 of the women (67%) are taking ARV and eight (33%) are not yet under medication because their CD4 count indicates they do not need this treatment. Nine (50%) of the WWHIV took ARV within one year of their HIV diagnosis. There is no statistical difference with the men surveyed here.

HIV is not exclusive to people aged from 15 to 49, the age range usually considered to be sexually active. One of the participants in the survey was a 50-year-old widow who married her second husband, a 30-year-old man, thirteen years after the death of her former husband. Her second husband died two years ago. *“My second husband did nothing except ask me for money and take other girls. He had worked in Thailand before, had previous wives, and injected drugs.”*

Table 3: Age of Men Participants

n=24	Average	[range]	Comments
Age	33.1	[22-42]	Two men :40, 42

Table 4: Date of Men’s Diagnosis and ARV Treatment

Year	1999	2000	2001	2002	2003	2004	2005	Total
Test	-	-	-	3	2	16	3	24
ARV	-	-	-		3	14	2	19

The average age of the 24 MWHIV is 33, with a range of 22-42 and only two men aged 40 and above. It is an average of 1.1 years since they took the test. Among the 24 MWHIV, 19 (79%) are taking ARV. 15 of the participants (79%) were prescribed with ARV within a year of their HIV test, showing that men come for testing at a later stage of the infection, when many of them are already suffering from AIDS.

ARV

Thirty-seven (73%) of the adult participants in this research are undergoing ARV treatment, while fourteen (27%) do not need to take ARV because of their CD4 count.

The MSF project is saving the lives of people who arrived ‘on time’ at Savannakhet hospital. One respondent told us that he buys his own treatment in Thailand because as a Vientiane citizen it is easier to cross the bridge to Nong Khai than to go to Savannakhet every month.

People living with HIV/AIDS who arrived at the consultation in good shape with a CD4 count of around 200 are able to maintain normal physical activities, but for those who have already suffered weeks and months of diarrhoea, fever, and multiple infections, with a CD4 count below 50, the recovery is slower and reintegration into normal life is more problematic and sometimes impossible. The treatment cannot prevent the death of such patients.

This quick description of the sample already shows some of the trends of the epidemic. The men interviewed were in contact with and infected by the HIV earlier than the women. In the Lao context of weak testing facilities, people do not have the opportunity or articulated reasons for easily getting tested. Obtaining counselling and follow up from trained and qualified people is even harder. This situation has changed somewhat with the arrival of MSF in Savannakhet and their support to free ARV for people living with HIV/AIDS. In addition, while MWHIV are diagnosed at the last stage of their infection, WWHIV mainly come for testing when their partner or new-born child is diagnosed with the virus.

Occupations

All but two of the participants were born to parents who lived by farming. Regarding the people living with HIV/AIDS themselves, many have had to change or stop their occupation after becoming sick; either because they were too weak to do the work or because they had to return to Laos from Thailand. Those who had worked over the border as sea fishermen, prawn-farmers or factory workers, and as salespersons have all had to leave their jobs. One male participant has been able to continue working as an architect in Laos, demonstrating that office jobs near home are less likely to be affected by the disease.

Women

Table 5: Female Participants Work History

Before migration n=27	%	In Thailand n=11	%	Before sickness n=27	%	Nowadays n=27	%
11 farmers	41	3 construction workers	27	12 farmers	44	10 jobless	37
4 market vendors	15	2 sex workers	18	3 market vendors	11	8 can't work	30
2 sex workers	7	2 in shrimp factories	18	2 teachers	7	7 farmers	26
2 school girls	7	1 in garment factory	9	2 beauty salon	7	1 market vendors	4
2 teachers	7	1 food processor	9	1 nursing assistant	4	1 volunteers	4
2 in beauty salons	7	1 maid	9	1 civil servant	4		
1 veterinarian nurse	4	1 harvest	9	1 sex worker	4		
1 nurse assistant	4			1 unskilled worker	4		
1 housewife	4			1 housewife	4		
1 in garment factory	4			1 in garment factory	4		
				1 maid	4		
				1 construction worker	4		

Before Migration

Eleven (41%) of the women participants were farmers previously, and four (15%) sold goods or vegetables at market. Four women (15%) had received professional training. Two were teachers, and two were nurses, one for people and one a veterinary nurse. Two of the WWHIV (7%) were already involved in prostitution in Laos and continued that trade in Thailand.

In Thailand

While in Thailand, eleven (41%), were involved in non-skilled labour, three (27%) worked as labourers in construction work, and four (36%) were employed in various shrimp, food and garment factories. Another two were involved in sex work, which both had also practised in Laos.

Before being sick

When those in Thailand came back, without symptoms, or after being tested in Thailand or being sick; twelve work at their family farm, three were selling at the market, two are still teaching, and the others are divided between beauty salons (two), a nursing assistant, a civil servant, a sex worker, an unskilled worker, a housewife, a garment factory worker, a maid, and a construction worker. By now however, the infection has taken its toll on the women's activities: 18 (67%) are either "jobless" or "cannot work".

Getting a stable income is a priority for WWHIV. The next paragraphs will show that the issue is the same for men. One of our research assistants/interviewers, a WWHIV, explained her situation: ten years ago she was a trained accountant working in a company, but after the shock of her infection and the debilitating impact of the disease - easily tired though under ARV - and the anxiety caused by her infected child and separation from her husband, she felt unable to fulfil the requirement of her previous job.

Men

Table 6: Male Participants Work History

Before n=24	%	In Thailand n=19	%	Back to Laos N=24	%	Now N=24	%
8 students	33	5 construct workers	26	8 construct workers	33	8 can't work	33
3 soldiers	13	3 fishermen	16	5 jobless	25	6 jobless	25
2 jobless	8	2 market sellers	11	3 farmers	13	2 farmers	8
2 construction workers	8	4 factory work	21	2 market sellers	8	2 vendors	8
1 architect	4	1 shrimp	5	1 photo shop	4	1 photo shop	4
1 teacher	4	1 mechanic	5	1 architect	4	1 driver	4
1 beauty salon	4	1 unskilled worker	5	1 cook	4	1 market seller	4
1 water technician	4	1 dancer	5	1 driver	4	1 office cleaner	4
1 mechanic	4	1 cook	5	1 water technician	4	1 contractor	4
1 cook	4			1 Don't know		1 architect	4
1 farmer	4						
1 driver	4						
1 waiter	4						

Among MWHIV, eight (33%) were still school boys before leaving for Thailand, three were soldiers and two were jobless. Among the few skilled or trained MWHIV, were an architect and a trained mechanic who became a truck driver. Eleven (46%) of the men worked in unskilled jobs in Thailand: five as construction workers, three fishermen, three factory workers and one in the shrimp industry. The *kathoey* was a dancer. When they came back to Laos, five were showing signs of their physical deterioration, while eight were involved in construction work. At the time of the interview 14 (58%) are either "jobless" or "cannot work" which shows their physical weakness.

Gender and HIV

Lao men interviewed for the study, due to their mobility and wandering sexual practice are more at risk than women are of encountering the virus and infecting their stable partners. Many of the male interviewees mentioned drug use and needle sharing, abuse of *yabaa* (methamphetamine), and alcohol intoxication. Many were looking for short-term and opportunistic relationships with women. In addition, their understanding of HIV and its dangers was very vague. A male construction worker said that he had no clue what a condom was when he started having sex in Thailand in the late 1980s. Among those who knew about condoms, many said “*I wanted to use them but I was too drunk to do it*”.

The women who participated in the study were more stable, with less travelling, fewer job changes, and fewer partners. They claimed to be looking for a steady and supportive partner for a long-term relationship, but were rather ignorant about the risk of infection and the fact that their own attitude was encouraging their infection. Women conscious of the behaviour of their partners, have little leeway to make them change. Many of the female participants said “*I have had only one sexual partner; my husband, and now I am infected*”. One said that she thought that people at risk of infection were those “*going out at night, drinking and looking for pleasure*” She did not include herself, as a faithful wife and loving mother, among them.

Another female participant trusted her husband, who had been faithful all through their marital life. However, when he started to show symptoms that she recognised from the Thai TV as AIDS, she asked him to get tested. He refused until three days before he died, when he told her about his work as fisherman and the group sex he had had with three team mates and one Thai woman. All the friends had died already. Her husband refused to get tested because he feared he had the same disease as his dead friends.

One risk factor behind the negligent attitude of some couples appears to be the submissive position of the women. Many women participants were trapped in relationships with partners who gave them too little space to protect themselves. Many of the female participants have had only one partner, their husband. Others have had two or three experiences with men. This woman of 30 said “*I had sex with my first lover when I was 15. We lived with each other for three years and then separated because he was a playboy and I couldn't stand what he did. Three years afterwards I got married with a Lao man. He was 42 and I was 21. He had already been married twice. The first time he got separated and his second wife died. He was also a playboy but after we got married he never had sex with other women*”. Her husband and daughter are not infected but in a country where the test is not widely available, marriage with a spouse who has had other partners could be a lottery with a lot of unlucky draws.

Many women suffered from STIs, but nothing in Lao society gave them the bravery to challenge the attitude of their partner. Although divorce or separation is a way to escape from an unfaithful husband, many have escaped one cheating husband only to marry another who was also a danger for their health. Women have more difficulties in changing partners if they have children.

Level of Education

On average the women and men interviewed have completed the same number of years at school. Unusually for a rural Lao sample, more women (four) than men (two) have received education equal to or above ten years.

Table 7: Schooling

Gender	Average years of education	Range	Comments
Women	6	[0-14]	-Four WWHIV: 14 years, one: 10 -Four no school, three less than 2 years
Men	6.3	[1-15]	-Two: 14 and 15 years -Five less than 3 years

One male participant, aged 31, said, *“I decided to leave school at grade 6 when I was 19. I was ashamed because I was older than my friends. My father divorced my mother and left my mother with seven children. I decided to help my family to survive because we had rice shortage for five months of the year”*.

Another male of 24 years said, *“I decided to leave school when I was 20 years and in grade 9, I did not want to continue because my friends who went to work in Thailand had a lot of money, and were sending it back to their parents. They had not even finished grade 6 of primary school but they could work in Thailand, so I decided to join them”*.

A 36-year-old man said, *“I left upper secondary school because my father and mother wanted me to sell clothes at the market. At that time they asked me to go regularly to Thailand and back.”*

Family History

Participants originate from families of 4-12 people. 40% of all participants have one parent who has died already, 5% have lost both parents, 27% have living parents who are divorced or separated, and 28% still have both parents living together. Thus, 72% of the participants can be said to come from disrupted families. When they were at a young age, poverty and lack of food subsistence affected family life for the great majority of participants.

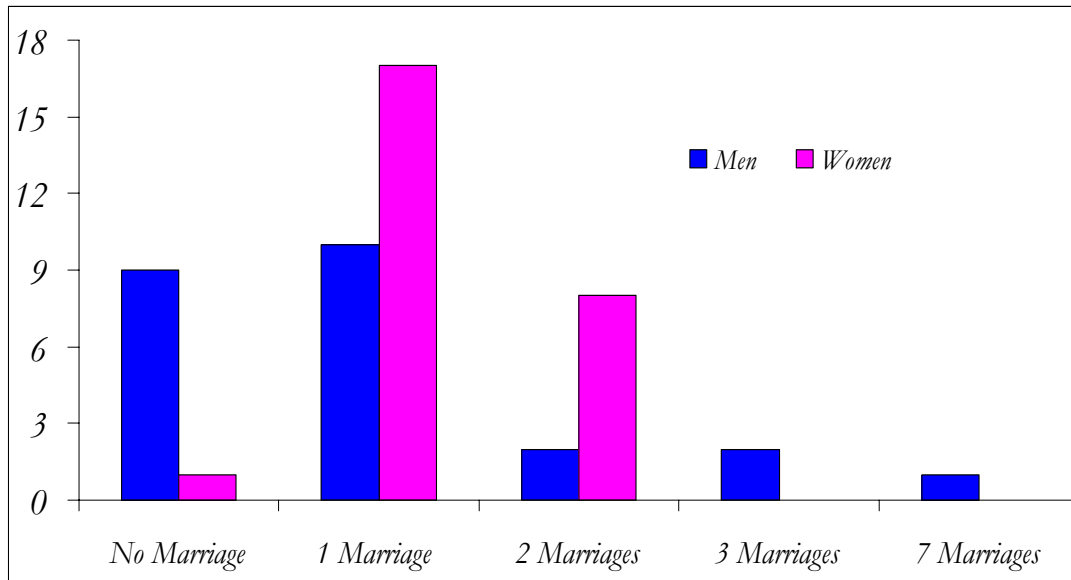
Table 8: First Sexual Experience of Women

n=27	Average age	[range]	Comments
First sexual contact	20.6	[15 – 32]	12 women 19 or under (44%)

Table 9: Movement and Marriage among Women

	Living where born	Marriage(2)	Marriage (1)	Marriage (0)
n=27	19	8	17	1
%	70	33	63	4

Fig 3: Number of Marriages for man and women interviewed



70% of the women participants now live in the place where they were born, coming back to their native village after migrating from Thailand, with their husband or alone. Eight (31%) have been married twice before being tested, 17 (65%) once and only one woman had not been married before the test. After the test, two women remarried, one with an MWHIV and one with a non-infected person. The research did not delve into the forms of marriage. It seems there are two kinds of link between husband and wife: the official wedding ceremony with an administrative registration and the communal ceremony sanctioned by a *Baci* with a few relatives as witness. This is easier to dissolve when both partners want to terminate the relationship.

Table 10: Number of Children per Woman

Women	Child(0)	Child(1)	Children(2)	Children(7)	Children(8)	Total
n=27	6	8	10	1	2	51
%	22	30	37	4	8	

The women interviewed during this research have a total number of 51 children, only three of whom have tested positive for HIV. Many of the children were born after the mother was infected.

Table 11: First Sexual Experience of Men

n=24	Average age	[range]	Comments
First sexual contact	19.6	[14-25]	13 men 19 or under (54%)

Of the people in our sample group, the men entered sexual life slightly earlier than the women. Attitudes to marriage and sex may be significant here: in the group, nine men are not married compared to only one woman. Most of the women state that their sexual relationships developed only under the 'marriage' relationship, while men admit having sex with casual partners, paid or unpaid, in Laos or abroad.

Table 12: Movement and Marriage among Men

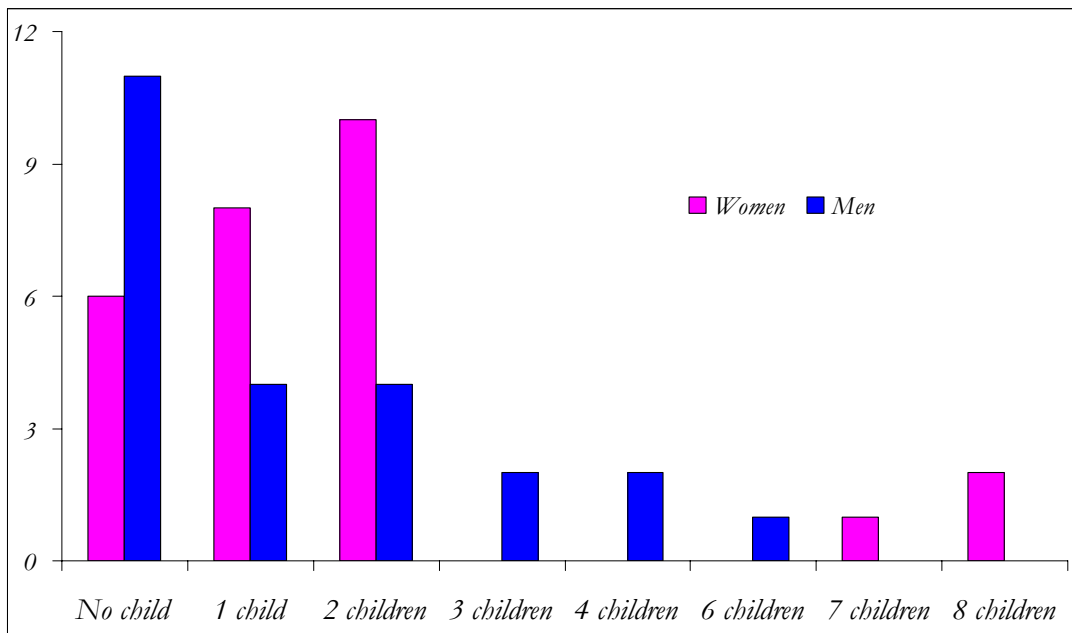
	Same birth place	Marriage(0)	Marriage (1)	Marriage (2)	Marriage (3)	Marriage (7)
n=24	16	9	10	2	2	1
%	67	38	42	8	8	4

Table 13: Number of Children per Man

Men	Child(0)	Child(1)	Children(2)	Children(3)	Children(4)	Children(6)	Total
n=24	11	4	4	2	2	1	32
%	35	13	13	6	6	3	

Nine of the men in the study have remained single, including two *kathoey*, though these have had long-term relationships. One man acknowledges seven marriages, but knows the blood status of only the last wife, who is infected. These 24 men admit to 32 children, none of whom are infected, though one man has a child of less than 18 months who has not yet been tested but is showing AIDS-like symptoms.

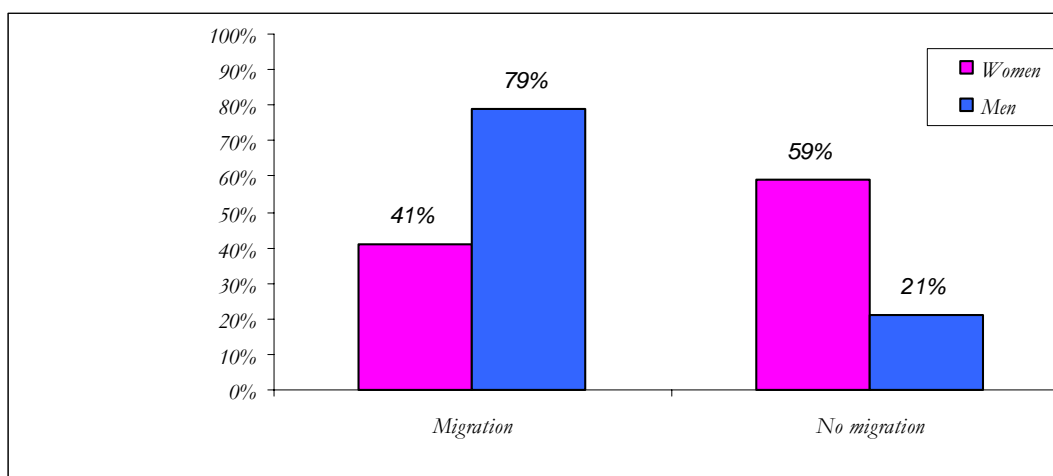
Fig 4: Number of children of men and women interviewed



Migration

Migration seems to be a common factor among the majority of the men and women participating in the research: interviewees were either migrants themselves or had relationships with partners who migrated at some time in their life.

Figure 5: Participants who have at some point migrated to Thailand



From the young age of 14-16 years old, male teens may move from their village environment to a society of which they know nothing, except for what they have picked up through media images and local conversation. They leave their community for mainly economic reasons: Laos does not provide enough opportunities to people with low education from rural areas. Many stipulated that they had to leave school because of the remoteness of the school building and the poverty of the family. At a young age, they were requested to participate in the maintenance of the whole family. Another less clear reason is the social attraction of life in Thailand. Rural areas in Laos do not match Thailand in terms of services and glamour, and young people are attracted by the prospect of a more exciting life. Many of the interviewees described their harsh working conditions in Thailand as the price they had to pay to reach economic benefits and an increase in their living standard especially in the increase in cash benefit.

Migration also seems to be linked to an increased likelihood of risky behaviour and infection with HIV. Male participants of the study worked as fishermen on sea boats, as shrimp cultivators, in factories, as waiters, construction workers, or salesmen. Income increased with age and experience, with the younger getting nothing but food and accommodation and the older men earning bonuses because of experience, hard work and the trust of the employer. Fishermen acknowledge that they were paid at the end of the fishing season, and that when they were on the ground the boat owner provided food and hired sexual services for the crew. One participant recalled that *“after one month on the boat, the owner gave us money to sleep with girls in the port.”* All the men in the survey acknowledged relationships with sex workers in Thailand or/and Laos, except the two *kathoey*, who had large numbers of male sexual partners without being able to say how many. The younger workers lived in dormitories and were subject to peer pressure that influenced them towards drinking habits, paid sexual practice, and the use of *yabaa* or injected drugs. Commercial sex is readily available to migrant workers: *“In front of our factory there were two night clubs where women provided sex for money. I went there and sometimes had sex. I had heard of STIs but did not know about HIV. I had sex twice a month, for 100-200 Baht a time, and remembered I got twice STIs in 1989 and 1992.”*

Most of the migrants to Thailand were working there illegally, crossing the borders without proper documents and one acknowledged being involved in illegal activities. This man recounted, *“then I decided to go back to Bangkok. I worked at smuggling goods including amphetamines and heroin. I got 12,000 Baht per month and other additional tips from my boss. At that time, I began to have sex with whomever I wanted. I took amphetamines, and never sent money to my family. I don’t remember how often I had sex per day, because when I took ‘yabaa’, I really needed to have sex. I think sometimes I was having sex five or six times per day. I spent my time like that for four years. At that time I thought my life was the most beautiful in the world.”*

Male participants were engaged in sexual peregrination during their migration, limited only by money and STIs. Changing partners was as easy as changing professional activity, with men indulging in occasional to short-term relationships with Lao and Thai women, working in the sex industry or not. Some men admit having steady relationships with Lao women who were involved in the Thai sex industry as a professional activity. Two men acknowledge marrying women in Laos who had been involved in sex work. One said, *“In 1991, I got married with a girl in my village when she came back from Thailand after three years working as a massage girl (prostitute) in Pattani province. She was enticed to work in Thailand as a prostitute. Another girl from her village had experience working in Thailand and lured her saying “in Thailand there is work with good salary”. When she arrived in Thailand the girl sold her to a massage parlour. Three years later her father founded the place where she was working and used money to bring her back to Laos.”* This man thinks he was infected by his wife, though he has also admitted visiting sex workers when he was working in Thailand himself.

Migrating men had more sexual partners than the migrating women did, but some of the women were involved in providing sexual services to men for money, taking financial advantage of the men’s mobility and increased income. Some of the males had many sexual partners in Thailand, often while they had a ‘wife’ at home in Laos. The notion of ‘husband’ ‘wife’ and ‘marriage’ seems quite elastic for these men and women. Such relationships are often not legally registered and those involved can simply move on to new partners. There are histories of many marriages, separations and divorces in the lives of the participants before they were tested for HIV. Male participants acknowledge the service of prostitutes but also had relationships with ‘normal’ girls, meaning liaisons based not only on sex and money. Sometimes they met Lao women also engaged in migration. Starting often with a paid sexual service, the relationship stabilises and they become a couple for a period of time. This pattern has quite dramatic consequences: when sexual services are sought by men, women are more prone to use condoms, but when the relationship becomes non-commercial the idea of risk fades away. Women keen to establish a long-term relationship with a man tend to move off condom use as a signal of a more intimate bond between the couple.

One male participant was introduced to a female partner in Thailand by friends. The new couple lived together in Bangkok and after few days they have moved into an apartment, he discovered that she has been working as a massage girl, and noticed skin diseases on her body. Another one, a salesman, had four concomitant ‘girlfriends’, young women living with their parents. He visited them when working in their cities during his four years in Thailand. His comfortable income allowed selection of women of his choice, and it seems his consumption of female partners had few limits.

While most of the participants who migrated did so to Thailand and or within Laos, some also went to Cambodia and Vietnam. One man remembered that *“in 1989, when I was a boat pilot, I had sex with a 40-year-old widow and with prostitutes in Savannakhet. In 1990, in Thailand, I had sex with prostitutes and got an STI, which I got treatment for and then cured. In 1993, I worked in Cambodia for 6 months and had sex with prostitutes. When I went to Vietnam for three months, I had sex with Vietnamese prostitutes.”*

Another man talked about having sex with a girl he met in the early 1990s during a stopover on a bus journey: *“In 1991, when I was 19, I had sex for the first time, while travelling by bus from Vientiane to Saravane”*. This shows that sexual encounters can happen on any occasion and in any location. He paid a small fee to the woman, who was a sex worker heading home to visit her parents.

One woman recounted that she spent four months in Thailand after her first divorce. During this time she had a Thai boyfriend, injected drugs with him, and had sexual intercourse with many other men. Sharing needles and not using condoms were the rule. She got STIs. Finally she went back to Laos and married a new husband, whom she divorced after a few years because of his drinking. A similar story came from another woman who divorced her husband and went to Thailand and found Thai boyfriends. She realises now that she *“was an at risk person, because I liked to have sex with Thai people before my second marriage”* and she contracted STIs four times. Now she, her second husband, and their seven-year-old daughter are all infected. She was so conscious of her risk she decided to go voluntarily for an HIV test. These two women, plus two more who openly admitted being involved in sexual services for money, are in the minority. More typical is the following attitude: *“He transmitted this virus and then he threw me away. Even though we have lived together for more than four years, he doesn’t care---I had sex only with him”*.

Other Transmission Factors

Sexually Transmitted Infections

Table 14: Participants who have had an STI

	Number	%
Women	17	65
Men	10	42

Male participants did not associate multiple sexual encounters with risk, except when they became infected with genital warts or other STIs, which they treated themselves with medicines bought over the counter or with traditional medicines. Many women and men participating in the study had experienced STIs, with some having more than one episode and episodes which lasted many months, due to un-adapted treatment or re-infection. A female participant relied on her mother’s knowledge to get treated. *“In the year 2002 I had vaginal discharge but I didn’t go to hospital. My mother told me to boil a traditional medicine and bathe with it. After a few days it was finished but my husband got genital warts and they took months to remove.”* Many women said that they started to get vaginal discharge just after marrying their husbands. Whether STIs are an aggravating factor in HIV infection is not known from the interviews.

The fact that female participants acknowledged a higher rate of STIs may be caused by three reasons: female and male interviewers did not ask questions about this matter with the same skill leading to a difference in the quality of the answer. Secondly, male participants may have lied about their episodes or *‘forgotten’* what happened in the past. Thirdly, women may have mistakenly considered any vaginal discharge to be a sexually transmitted infection, which is not always the case. The research team considers the WWHIV rate of STI to be dangerously high, and the MWHIV one as unable to show the reality of the risks taken by men.

Blood Transmission

There is no notion of infection due to untested blood transfusion among the participants. However, while none of the participants claim blood transfusion as the cause of their infection, the mother of two infected adults points the finger at blood transfused to her daughter during childbirth in 1995 in Savannakhet Province as the mode of transmission. Her daughter died, leaving an infected husband and two negative children. It is difficult to ascertain such a claim but similar cases have been reported in the past. It seems that improvement in blood safety in Lao hospitals has reduced the risk of such transmissions.

One of the male participants claimed that his sexual behaviour was not the cause of his infection as he had never had sex with service of women without using condoms. As his wife is HIV-negative he thinks that the extensive tattoo on his body was the mode of transmission of the virus. He remembered that *“in the tattoo parlour there were a lot of girls being tattooed and the needles were not cleaned between clients”*.

Intravenous drug use (IDU) is still relatively rare in Laos compared with other countries in the region such as Vietnam and Thailand, which have already a high concentration of people living with HIV/AIDS infected through needle-sharing. Only one interviewee acknowledged this mode of contamination. This woman used drugs extensively in Thailand, sharing needles and heroin with six to ten other injectors, some of whom are known to have died already. The father of one of the CWHIV was also known as an IDU in the past. This practice is still limited in Laos, but other countries in the region such as Vietnam and Thailand have already a high concentration of people living with HIV/AIDS infected through needles sharing.

Heterosexual/Homosexual Transmission

If most of the male participants recognise the mode of infection as being heterosexual, two of the male participants are evidently transgender and call themselves *“kathoey”*. *Kathoey* in Laos and Thailand are men who choose to live as a woman. In Laos, this group of people is quite visible. Their sexual practices are similar to those of homosexuals and include oral and anal sex. In addition, to the *kathoey*; there are also two male participants who reported having sexual encounters with *kathoey*. These men do not identify themselves as ‘gay’ or Men who have Sex with Men (MSM); they are married and are fathers.

Two of men interviewed are *kathoey*. In Laos, there is no specific recorded data on HIV infection among this group, but these interviewees acknowledged such sexual practices and belonging to this gender minority. In addition, two other MWHIV had sexual relationships with *kathoey* as well as with female sex workers. Both *kathoey* in the survey revealed a high turnover of sexual partners, Lao nationals and foreigners. They got some financial reward from their relationships but did not consider themselves as sex workers. They were involved in long-term relationships with foreigners that included financial advantages and short-term sexual contact with Lao men for small payments, but money did not seem to be their primary interest in their relations with other men.

One *kathoey* of 22 years said, *“I first had sex when I was 17 with a Lao male student. We were in love for two to three months. I prefer to have sex with men, not with women. On average I had sex twice per week. When I had sex with Lao men, I asked them to use condoms and they did. But when I had sex with foreigners, they did not need to use condoms. My partners were Lao students and also one Lao lawyer and were between 17 to 50 years old. At first I mainly had sex with young men and after that with those over 20 years old. I got paid about 500 to 1,000 Baht for each time with foreigners, two Germans working in Laos. Sometimes, they came to my apartment and I went to their home about three to four times per week. When I had sex with Lao men I usually didn’t get paid but it didn’t matter because I loved them. We loved each*

other. I remember one time I got 50,000 Kip when I slept with a Lao man. I remember sleeping with about 20 foreigners in four years, and with about 30-40 Lao people. I last had sex with a foreigner when I was 20. For two years I have not had sex with anybody because I knew I had HIV.”

Another male kathoey of 31 years said: “I worked in Thailand for more than 13 years singing and dancing at a night show. In the day time I worked at a beauty salon. I first had sex with a Lao man when I was in Laos. At that time I was 16. I slept with many men from different countries when I was in Thailand. I do not remember how many, but many. But I remember I lived with four ‘Falang’ men over about two or three years. I do not like women, I like men.”

Knowledge of HIV Before Testing

Before they were tested, the participants’ knowledge of HIV and its modes of transmission was minimal. The risks were far from being understood, even among participants who had contracted STIs. HIV infection was a surprise for many, even when it followed long periods of chronic fever, diarrhoea or skin disease.

Testing Positive

For many, knowing their sero-status made them think that they were going to die soon, but counselling and support group meetings helped alleviate this fear. Before being infected many of people thought that AIDS equated immediate death and were unaware of the difference between HIV infection and AIDS.

Many of the people interviewed only decided to test for HIV when they were suffering sickness which necessitated the consultation of medical personnel. Fewer of the men were surprised by their positive tests, but still they were worried by the news. Although ignorant about HIV, they had already a feeling that their behaviour put them at risk of being infected with the virus. Most of them initially thought that a positive HIV test was a death sentence that would be rapidly fulfilled, but had never received a clear explanation of “why” and “how”.

Most of women were even less informed than their male counterparts. They believed that their behaviour had never been risky, and they experienced shock and disbelief after testing. Suicidal thoughts are more common among the women than men, and the negative consequences of the infection for family, especially the children, are always on their mind.

A majority of the men (20) said that while they were waiting for their test results, they had not felt too anxious. It seems that they were able to accept whatever would happen because they had already realised that they were at risk of infection during their past lives. Only a few spoke of their anxiety at that time; not being able to sleep, feeling afraid and contemplating suicide.

A male participant of 33 said, “I knew I was at risk of infection because I had been having sex around two or three times per months with service women in Thailand. However, I was upset, very sad, and felt hopeless about life when I was told of the infection. Sometimes I thought of committing suicide and it took around a month before I could accept my situation. I used to stay inside the house, refusing to go outside. Now, after joining the support group, my life has changed and I am happy with the group and with my wife. I often go to the temple to meditate”.

Another MWHIV thought many times about suicide, but did not attempt it because of good counselling. This 38-year-old participant said: *“I went back and forth between Laos and Thailand for more than four years. I worked as an unskilled worker, and then selling food and illegal items like ‘yaaba’. I married one Thai woman and four Lao women but divorced all of them. I had sex with many service women, and sometimes with ‘kathoeys’. I rarely used condoms. At the end of my fourth year in Thailand, I became sick and went back to Laos - my mother brought me back to treat my sickness. In February 2004, after a blood test, I was told I was positive. I did not feel anxious because I realised I had done many bad things in my life, but I was ashamed before God that I had not done the right things. I decided many times to commit suicide but after receiving counselling and meeting with other people with HIV in the Group, I felt more comfortable.”*

Another 35-year-old male said *“I have married seven times, with two Thai and five Lao women. I divorced five times, and one wife died. Now I stay with my present wife. I went to the hospital because my relative, a doctor, told me to go for a test after seeing my big ganglion.”*

It seems that access to the test is improving in Savannakhet Province and Vientiane Capital, but still men usually only come for tests after they have been suffering from recurrent diseases, after long months of treatment with no recovery. Fifteen of the MWHIV (79%) were prescribed ARV within one year of their test, compared to nine WWHIV (50%) who obtained treatment the same year of the test. The women were in general tested a bit earlier after infection, with a higher rate of CD4. A mobile team, which visits the spouses of people who died of AIDS and offers them counselling and testing, has increased access to VCT, especially in Savannakhet.

Until recently confidentiality was an issue. In 2003 one woman received her positive result through the village chief who publicly read out the letter. In 2000, a different woman was not informed personally but got her result through her sister. Another complained that in 2004, the medical staff in charge of people living with HIV/AIDS at the hospital loudly and carelessly informed the medical staff and other patients during her delivery. The situation has improved, but indiscretion still occurs and gives people living with HIV/AIDS a feeling of discrimination.

Life Since the Test

After monthly meetings with the self-support group, these men and women are able to identify their risk factors and understand the course of their infection. Monthly checking in their respective hospitals also gave them hope. People living with HIV/AIDS have been travelling to Savannakhet and receive extensive information on CD4 and ARV treatment. Nobody has complained of the strict discipline required when taking ARVs, as everybody has noticed the benefits of this free treatment.

The first months after the test are crucial, when people living with HIV/AIDS are under the scrutiny of others when they openly informed the household, especially family, neighbours and the community at large. Family, mothers, fathers, and siblings may show compassion, but many fear transmission of the virus during daily contact, as if the test result was contemporaneous with the infection. They did not understand that they had already been living with somebody infected with HIV without knowing it for quite some time. Isolation during meals and family activities are almost immediate for many, adding to the stress of the people infected. The people interviewed greatly thanked the medical teams and volunteers who explained to the community the lack of risk in living with infected people. A few weeks after the result, a medical team from the provincial hospital visits the family and community at the wish of the people living with HIV/AIDS, and explains about the risk of being infected in the normal activities of the daily. After a few months, the situation reverts to normal and people living with HIV/AIDS recover their place and role in the family.

Some people living with HIV/AIDS still maintain secrecy about their sero-status. They do not want to divulge their result especially to the neighbours and community. In addition, it seems people living with HIV/AIDS, especially women, have difficulty returning to a normal life. The repercussions of the infection seem as much psychological as physical. Contact with others seems determined by the status of the people they meet. Guilt and shame are common feelings among WWHIV.

For many women, the result of the test is often a shock and an open revelation of their husband's behaviour and some wives decided to terminate a relationship that was already chaotic. Feelings expressed included disbelief and hate of the man they consider responsible for their infection. Often they took care of him at the final stage of his disease and their own infection was only revealed on his death. Some learned of their status because their child was diagnosed. One told us that she got her test result and decided to terminate the relationship with their husband. She refused to inform her husband of his infection, though she knew he was infected and responsible for the family's condition. The fact that her husband married a new woman did not move her to notify anybody.

Children with HIV

Children of parents infected with HIV are grouped into two categories: children infected with HIV (CWHIV) and children affected by HIV. The latter category refers to children not infected but whose parents are infected. Children affected may suffer discrimination, economic loss and depression from their parents' situation. This research recorded only three infected children among the families of the participants. Some of the affected children are already adults, and the consequences for them are dramatically different than they are for young children.

Among the 51 children reported, 20 are under five years of age, four are under 24 months and only 2 of the later category are aware of their sero-status. The three infected children are above five years with one being 12. Among the three infected, two children receive ARV in SVK and go to school. The 12-year old boy had to stop schooling a year ago because of his medical condition. Next September, he will resume, and his grandmother does not know how he will react. In 2004, when his father died, his mother took him and his sibling to be tested in Vientiane. His younger brother is not infected. His mother spent 10,000 Baht on traditional medicine. After he failed to recover, they consulted a doctor at the 103 Hospital who advised them to send him to Savannakhet. Since he was diagnosed as infected he has been rejected and stigmatised by his friends, and only recently have two friends come to see him and shown the normal friendly attitude of children. He wants to play with other children, and says *"I don't want to be infected with HIV"*. Sometime he complains to his uncle, saying that *"why didn't you tell my father not to go with women and bring HIV to me."*

Table 15: Women: number of children by WWHIV

Women	Child(0)	Child(1)	Children(2)	Children(7)	Children(8)	Total
n=27	6	8	10	1	2	51
%	22	30	37	4	8	

Table 16: Men: number of children by MWHIV

Men	Child(0)	Child(1)	Children(2)	Children(3)	Children(4)	Children(6)	Total
n=24	11	4	4	2	2	1	32
%	35	13	13	6	6	3	

The research also interviewed the guardians of five specific children infected with HIV. Two are girls and three are boys, with an average age of six years (range three to eleven). Four are under ARV treatment, while the fifth still has a high enough CD4 rate to not need the drugs. The caretaker of one is his infected mother, and two grandmothers and two grandfathers take care of the others. The mother is 33, and the grandparents are aged between 49 and 67. Two are farmers, the mother does handicrafts, and the others work in government offices. Income depends on the family. Every child's father has died of AIDS while three of the mothers are still living. One is still with her child, one migrated to Thailand to make her family's living, while the third is weak and cannot take care of her child.

Five of the fathers of the eight children included in the survey worked in Thailand. Two were fishermen, one a truck driver, and two more were construction workers. Another father is recorded as having been a soldier in Laos. The activities of the mothers were recorded as housekeeper (in Thailand), farmer, garment factory worker, sex worker, and customs officer. Seven of the fathers and two mothers have passed away - therefore two children have lost both parents.

Family members describe their initial fear of having someone infected among them, and recall how they avoided any contact with the infected child or adult. After visits from volunteers or a health team the family members understand they cannot be infected through breathing or sharing daily utensils. One grandmother was afraid when she learnt that her daughter was infected and even more so when she knew that her grandson was also infected. She continued to care for her daughter and granddaughter but refused to breathe directly in front of them. She was relieved when doctors and nurses from Savannakhet hospital explained the actual risks to her, though it took three explanations before she fully understood.

Four of the families informed the village authorities about the child's infection and only one reported a negative reaction from village head, who in 2003 requested the child's family to move from the village. The villagers and the chief wanted the family with the child to hide themselves in the forest. The family refused to leave the village because the mother of the son was very sick. They explained that there was no risk of transmission and the chief did not enforce their departure. However, the villagers still discriminated against the family, refusing to have contact and avoiding any relationship. This situation lasted at least one year, until evident lack of infection through normal contact with people living with HIV/AIDS reassured the villagers.

Another grandmother recounted that her infected son and grand-daughter were discriminated against by villagers, not by the chief. After her daughter-in-law died in 1996, the woman's family complained against and blamed the grandmother's family, accusing her son of giving the disease to their daughter. The grandmother's family hit back by saying the daughter had performed sex work in Thailand, and that as the first to die of AIDS it was certainly her who had brought the virus to the husband and child. Soon the whole village was aware of the situation. The villagers refused to socialise with the grandmother's family because there were people living with HIV/AIDS living in the house. After sometime, the arguing stopped between both families - basically because they were tired of feuding with each other, but the social discrimination continued. In 2003, the headmaster of the child's school was informed of her condition and agreed to accept her at school. However, the parents of other pupils did not want their children to study with an infected child and asked for the infected girl to leave the school.

The headmaster explained the risks to the parents and children and eventually only a few parents refused to have their child share a class with the little HIV-positive girl.

There can be difficulties for children taking ARV treatment. The guardian and care taker needs to understand the regimen fully, as he/she is responsible for ensuring the child maintains strict compliance with the dosage. High motivation is required and there can be challenges. For example, one grandmother living in Vientiane complains that when her grand-daughter has to go for treatment and medicine in Savannakhet, the child has to miss school. It seems to be difficult to get this child to take her treatment, and at 67 the grandmother is quite forgetful. She fears that her grand-daughter often skips her treatment.

These children are subject to usual childhood ailments, and when they occur these worry the care-takers. One said *"It is more demanding to take care of a child, with sickness...with HIV it is worse."* In addition, bruises and scratches on the children scare the care-takers, who must pay special attention to the risk of transmission from the child to his/her companion during daily life.

Families with HIV

Eight members of families with one person living with HIV/AIDS were also interviewed. The story of the following couple is not common but could indicate the future emergence of a pattern already seen in African countries where AIDS has hit hard.

A 53-year-old woman, Mrs D, was interviewed. Her husband, 59, is head of his village and they have six children, two of whom became infected with HIV. One son was infected by his wife, who allegedly caught the disease from a blood transfusion occurring after delivery. She passed away, leaving her husband and two non-infected children.

One of Mrs D's daughters was infected by her husband, a truck driver who died in September 2004. The daughter sold her motorbike and borrowed 25,000 Baht to treat her husband before he died, not knowing he had HIV. Her child is also infected and has been taking ARV in Savannakhet since 2004.

Though infected, the daughter is still in good health and has migrated to Bangkok to make her living and pay back her debt. She is a waitress in a restaurant, earning 3,000 Baht per month and coming home twice a year. The extended family makes their living farming, and a younger daughter sells lottery tickets for additional income. Remittance from the infected daughter in Bangkok also helps. Their economic situation is not as good as it was before the illness, but they can manage. The villagers are not aware of their condition: the family wanted to keep their secret because they worry about the consequences for their father's position as Village Chief. The infected child is due to begin school next year.

Mrs D has received counselling sessions from hospital staff on how to care for people with HIV/AIDS and prevent family transmission. She knows that more attention must be paid to an infected child, especially concerning wounds and scratches when playing with other kids. She was advised to use gloves to tend any wounds of her infected grand-son to avoid infection. Mrs D supervises the ARV treatment of her young grandson. Mrs D worries about her daughter going to Bangkok and not taking her treatment. During her visits to the self-help group with her grandson she witnessed the improving health situation of people living with HIV/AIDS. She would like her daughter to take advantage of this project, but the daughter seems depressed and refuses to treat herself.

For another mother of 61, the situation is less positive. “My infected daughter was selling food and I had a coffee shop; after the villagers heard some news about my daughter and my son-in-law’s health, they started gossiping; they stopped buying things from her and me, so she had to give up her business. Now I alone sell soap and candy to the children. My neighbours used to invite us to go to the temple and ceremonies together, but now nobody invites us or talks to us like before”.

Health Workers’ Report

The first specific project on HIV and care of AIDS in Laos was initiated in Savannakhet Hospital by Dr Khamphang with the support of the Provincial Health Department and the Provincial Hospital Authority. With support from MSF staff at the hospital were trained and the quality of the services provided increased to include counselling and testing, consultation, and hospitalisation of people living with HIV/AIDS with debilitating symptoms. OI treatment has been provided since 2001 and ARV since September 2003, with lab equipment allowing blood HIV diagnosis and determination of CD4 counts. Savannakhet is the only body offering such services in the country and there is a close relationship between patients and health staff at the hospital. Since the beginning of treatment at the hospital, there has been a People Living With HIV/AIDS association fighting against the epidemic through a support group. To date 175 people living with HIV/AIDS are members of the Savannakhet group, which gathers once a month under the umbrella of the Lao Youth Union. Members have participated in training offered to health staff and been trained as counsellors for other people living with HIV/AIDS attending the hospital.

Savannakhet has good experience of working in partnership with people living with HIV/AIDS and other provinces are in the process of learning how to work efficiently with their associations. This situation is being paralleled in Mahosot and Sethathirath Hospitals in Vientiane and at Pakse Provincial Hospital, where people living with HIV/AIDS regularly meet. From these locations they travel to Savannakhet Hospital for check ups, blood tests and ARV treatment.

HWs caring for people living with HIV/AIDS seem comfortable with the patients and there is no notion of fear in their daily work. The HW are highly motivated and voice their concern about the distance that people living with HIV/AIDSs travel to get their monthly treatment. They are also apprehensive about MSF ending their ARV programme and what will happen afterwards.

People living with HIV/AIDS Groups

Each hospital has an organised group of people living with HIV/AIDS, meeting once a month with each other under the auspice of this group: Savannakhet: 175; Pakse: 22; Sethathirath: 85; Mahosot: 23. UNICEF was providing financial support to the participants thus encouraging the attendance. All but two of the people interviewed are or have been members of people living with HIV/AIDS associations. One of the two is a shop owner, who collects his ARV drugs in Nong Khai (Thailand); he does not want to meet people and be identified as infected. In addition, going to Savannakhet takes time and is not compatible with his work. The second is newly infected and is still too shy to attend the support-group. Another woman attended a couple of support group meetings but has stopped because of her professional activities.

The support group brings a lot of satisfaction for people living with HIV/AIDS, especially increased psychological strength by breaking isolation. The people living with HIV/AIDS meet others with the same ailments and they can share information and questions about their life with the virus. The support group pools knowledge about HIV and AIDS and compliance with ARV treatment. Family members can also attend the support group monthly meeting. Members of the support group received training on ARV, counselling, Information Education Communication mobilisation, and group management. Some members have participated in a regional conference in Thailand with other people living with HIV/AIDS and are trying to set up a people living with HIV/AIDS network.

The support group is also a mediator between people living with HIV/AIDS and medical personnel. In Savannakhet, some of the people living with HIV/AIDS have become involved in counselling and advocacy for the entire group of people living with HIV/AIDS in Laos.

At the end of each monthly meeting, people living with HIV/AIDS receive a transport fee, designed to encourage them to participate. Providing the transport allowance dramatically increases the role of people living with HIV/AIDS in the management of their own infection. If the person living with HIV/AIDS has to attend a consultation in between monthly meetings he/she receives another transport fee.

People living with HIV/AIDS attending the Sethathirath group's monthly meetings get financial support from UNICEF to the value of 40,000 - 70,000 Kip for transport and 20,000 Kip as a per diem.

The Mahosot group gets support from the Lao Red Cross (LRC), a private individual donor and the Khop Chai Deu restaurant. The Pakse group gets an average of 100,000 Kip/person for transport and *per diem* from UNICEF.

In Savannakhet, people living with HIV/AIDS can go for a medical check-up and ARV treatment twice a month if necessary. They get free treatment and help for transport. If in an emergency people are required to stay in the hospital; they will get one meal per day.

After discussion with people living with HIV/AIDS about the support they receive, we interviewed one member of LYAP who gave us the following information. He told us *“from August 2005 people living with HIV/AIDS who get support should be a Child with HIV, or a person with HIV/AIDS who can't help themselves (can't work or is isolated with no support), or people living with HIV/AIDS who do activities for community or society. At present LYAP is supporting 15 people living with HIV/AIDS”*.

With the increasing number of people living with HIV/AIDS attending consultation in Vientiane hospitals and requiring ARV and follow up, means selection of people living with HIV/AIDS in need is underway. Discussions are also in progress between MSF and the MOH on opening an ARV programme in Vientiane.

Religion and people living with HIV/AIDS

One female participant was happily surprised to hear that there is a project run by Buddhist monks for people living with HIV/AIDS. She thought the role of monks did not include working with people living with HIV/AIDS, especially those infected through sexual contact. She felt happy after attending a session run by monks. People who participated in meditation sessions organised by monks in Savannakhet were satisfied by the peace of mind they felt after the sessions. One man said that the three sessions he had attended were not enough for people who suffer the chronic sadness that comes with infection. He wanted more.

It seems that only a few participants attend temple activities more after the test than before and that those who do go to the temple only participate on the regular Buddhist holy days. One admits withdrawing from temple activities because of her infection: she was a sinner, and her infection is the result, therefore going to the temple has become impossible. Women go to the temple more than the men, because they miss their deceased husbands. Sometime they worry and think that Buddhist monks can make them feel calmer.

Half a dozen WWHIV said that, *“when we go to temple we have to buy some food or some materials for the monks, but with the infection we do not have much money to do that so we do not go anymore”*. One added that, *“I am afraid people in my village people will talk about my infection and say that giving food to monks is not suitable because people living with HIV/AIDS are bad persons: they should not go to the temple.”* One woman does not go to the temple anymore because it reminds her of the death of her husband and her own impending death.

In Vientiane, five sessions were organised by monks to support people living with HIV/AIDS. Some people living with HIV/AIDS recognise a need to meet monks at any time, not only during planned activities. But five women complained that going to the designated sessions in one particular place is time-consuming and awkward for women who have to care for children and earn their living.

In conclusion of the Buddhist support; it seems their activities in the communities of the people living with HIV/AIDS are needed, and should coincide with people living with HIV/AIDS meeting periods. Meditation and Buddhist teaching are welcomed by PLWHIV, and also in the community: Working closely with the community will give strength to Buddhist monks and people living with HIV/AIDS.

Beside Buddhist followers there is one who is Christian who says that *“Before, I did not like to go to Church, even though I was a Christian. Now I go to church every Sunday. I like to say to God that I did many bad things in the past and now I will be a good person until the end of my life”*.

Fears and concerns of people living with HIV/AIDS

A great number of participants question the fact that the organisation providing ARV, MSF, has committed itself to the project only until 2008. As a long-term treatment, ARV needs sustainability and regularity. The people living with HIV/AIDS have signed a contract with the service in order to improve compliance. Compliance is quite high and those that abandon ARV treatment are mainly people living with HIV/AIDS with much deteriorated health and a very weak immune system.

ARV medicines are subject to global controversy: the production of generic treatment by Indian manufacturers has dramatically improved the access to treatment otherwise unaffordable for

people in poor countries. However, the fact that India has to comply with WTO regulations by 2006 raises doubt over the prospects of continued access to affordable ARV. At the moment MSF procures ARV for the whole country, and these are available only in Savannakhet. *“The estimated cost for treatment of people living with HIV/AIDS is about US\$300 per year/person. But if we include transport costs, OI treatment, and lab costs it will be \$500 per year/person”* said Dr. Khamphang, head of the Virus Unit in Savannakhet and pioneer of support to people living with HIV/AIDS in Laos. Without external support, it is doubtful that Laos could maintain such services and provide ARV treatment for the increasing number of infected people.

MSF must consider finishing the work that it has voluntarily started with great success for people living with HIV/AIDS in Laos. This means setting up sustainable access for quality and affordable ARV for people living with HIV/AIDS across the country.

UNICEF Action for people living with HIV/AIDS

Self-Help Groups

Self-help groups have given hope and support to many people living with HIV/AIDS in Laos, helping them discover that they were not alone in their distress and providing information about the disease during monthly meetings. Self-help groups break the anonymity of their members, but they provide human support to people living with HIV/AIDS, who face discrimination within their families and communities. One man said, *“I would have committed suicide without the group. I am alive because of other people living with HIV/AIDS”*. In these groups, people living with HIV/AIDS themselves play a key role in coordinating monthly activities. Parents of people living with HIV/AIDS are also encouraged to participate actively in self-help group meetings in order to share experience and learn. One mother, fearing she could not talk clearly about the infection, happily invited two self-help group members to visit her family and help inform them.

The self-help groups have broken the isolation of people living with HIV/AIDS. Groups in Pakse, Vientiane and Savannakhet are meeting and working together. One happy outcome of their activities is people living with HIV/AIDS who have decided to re-marry. Since 2004, five couples have celebrated their union. Three of these marriages have been between partners who are both infected. One non-infected man has married an infected woman and one non-infected woman married an infected man. These people expressed a feeling that the hope given by ARV treatment and the positive support they received aided their social recovery. UNICEF provides transport fees and per diems for those attending meetings and as such has contributed to the cohesion.

Transport

In 2003, UNICEF started helping self-help groups to organise themselves. One of the main obstacles to people living with HIV/AIDS attending such important activities was transport from home to the meeting venue and back. Then when MSF started the ARV programme in Savannakhet, transport to and from medical check ups and treatment was again beyond many patients. UNICEF has been covering these funds for people living with HIV/AIDS, a service that beneficiaries have found to be invaluable. This support to transport has played an important role in the activities of self-help groups and improved compliance to ARV treatment. However, due to budget restrictions, it seems that people living with HIV/AIDS will receive less transport allowance in the future. Before people living with HIV/AIDS from Vientiane received 160,000 Kip when going to Savannakhet for treatment, but now they get only 110,000 Kip, and only for the first 6 months of treatment. Only people who fail to recover and are still too poor to cover their cost will get this support for longer.

Capacity Building

Since 2002 UNICEF has supported the training of people living with HIV/AIDS in various fields at provincial level, in Vientiane, or in Thailand. 130 people living with HIV/AIDS have received training at provincial level in Public Speaking. Eight people living with HIV/AIDS were trained in Vientiane and six in Thailand in this subject. Now 17 people living with HIV/AIDS are involved in community information activities in Pakse, Vientiane and Savannakhet with LYAP, the Lao Youth Union, the Pakse Provincial Control Committee on AIDS and the Lao Red Cross. In addition three people living with HIV/AIDS work providing counselling service as part of the health staff in Pakse and Savannakhet hospitals. Three people living with HIV/AIDS have attended conferences and six participated in a study visit to Thailand as part of UNICEF efforts to boost the participation of people living with HIV/AIDS in Lao society. Such training and activities give confidence to people living with HIV/AIDS, break isolation and rebuild assurance. Two of the research assistants working on this survey were selected from people living with HIV/AIDS who attended this education.

In conclusion, UNICEF's efforts in building the capacity of people living with HIV/AIDS are proving to be effective. This strategy should be maintained and strengthened in the long term to increase the dignity of people living with HIV/AIDS and to enlist their contribution in the fight against the epidemic. The per diems and income received from these training and counselling activities are not only a welcome source of revenue for the people living with HIV/AIDS but give them a sense of worth that can help kick start their efforts to lead productive lives once more.

Income Generating Activities

A reduction of income and the inability to sustain normal daily activities have been the fate of the majority of people living with HIV/AIDS in Laos. Many migrant workers have been forced by the disease to come back to Laos, and debilitating chronic infections have prevented them from providing for themselves and their family. In addition, before being diagnosed many spent large sums of money on useless but costly medicine.

UNICEF has provided training and financial support to many people living with HIV/AIDS to help them increase their income. Thirty five people living with HIV/AIDS were provided with loans to create their business. In 2003, the first loan of 500,000 Kip (\$50) was granted in Savannakhet. In 2005 1,000,000 Kip loans were made to seven people living with HIV/AIDS in Pakse, and 2,000,000 Kip loans were approved for eight people living with HIV/AIDS in Vientiane. A total of 35 people living with HIV/AIDS have so far received loans.

Success in this programme seems to depend on the circumstances of each individual. At the start of the programme, when 20 loans were made in Savannakhet, the recipients were often unable to generate business due to discrimination from the surrounding community. This was also at the time before ARV were unavailable, and several of those who took loans were simply too sick to manage any business venture. Sometimes therefore the money was used for immediate consumption and the borrowers were unable to repay. The initial loans were therefore written off as grants. Skilled management of money is still a challenge to this part of the programme, and the Self-Help Groups are working on ensuring that members full understand the concept of the fund, and receive some support in setting up and managing their investments.

Mrs N, 43, is the wife of a village head and has 11 children: *Her life is difficult with her five children at home. After the death of her husband of AIDS in 2003, two older children went to work outside the village: until now she has had no news from them. Three others got married. She gave one of her children to her older sister. Now she lives with five children. Three are still at primary school and the two youngest are at home. She has no money to buy uniforms for her children. In 2003 she received from UNICEF one uniform and equipment for one child only. In 2005 she had to pay about 300,000 Kip for uniforms, equipment and school fees. She got a loan*

from UNICEF in 2003 when her husband was still living and she used the money to invest in chicken and pigs. Then her husband died and she had to sell pigs.

Mrs B, 32, from Vientiane: a loan beneficiary, living with her husband (both are infected) with two non- infected daughters. In June 2005, they got a 2,000,000 Kip loan for farming. She thinks this is very useful because now she can hire a helper to help her family continue farming, and can also invest in fertilizer. She predicts she will get a good rice crop in the next four months and will be able to repay the loan on time. In her opinion 2,000,000 Kip is a lot and nobody else would give her such a loan and with a low interest rate. She expressed her thanks to UNICEF.

The following statement was reported by the Lao Youth of Savannakhet in 2004 *"From current experience of income generation activities, 75 % of grants receivers were used to generate extra income successfully. But the success or failure in the use of the funds depends very much on how the recipients of the funds had the understanding of the concept of the funds. Some lessons learned from the implementation of the funds in the past two years were the funds released for the weaving activities; animal raising and growing vegetables were successful but not useful for the small trading because they could not sell their food or goods due to discrimination. The skilled management of money is very important factor for the success. "*

School Support

In 2003 to 2004, 100 families received uniforms, satchels and other equipment for CWHIV and children living with people living with HIV/AIDS. One WWHIV said of the support to her son's education equipment, *"without it I would have had to withdraw my son from school..."*

Discussion

This study has gathered differences and common factors among individual participants and between the sexes in terms of their knowledge, behaviour and attitudes both before and after HIV infection. While the sample is limited in size, and many observations might apply to single participants or small sub-groups, the team has emerged from the study with a number of conclusions:

- Migration, which can bring positive economic results to individuals, also has serious pitfalls. It seems linked to an increased likelihood of risky behaviour and infection with HIV.

The life of Lao migrant evolves during their stay in Thailand: they are often able to arrive as young, unskilled and underpaid labourers and then find their way up in the market economy. One subject became an entrepreneur in Laos after learning his craft from the bottom of the ladder in Thailand. He now runs a construction business. However, while they can reach a level of financial comfort, many of the men translate this into sexual consumption. Most admitted that they did not often remit money to their family in Laos. Some were able to marry Thai nationals. One even pretended he was a local until his Thai wife discovered the lie. When they become seriously ill, the migrant men tend to know that 'the game is up': most returned to Laos to take their HIV test.

- Access to ARV treatment and quality health services has had a dramatic impact on the lives of people living with HIV/AIDS. The mobilisation of health personnel has de-dramatised the fear of HIV in families and communities.

- ARV is a lifeline for people living with HIV/AIDS and considerably improves their lives. However the beneficiaries of the service are dependent on external factors such as INGOs' strategy, donors' agendas, political commitment, and community support. Their future is not in their own hands.

- Support groups provide indispensable help to people living with HIV/AIDS's before and after they have access to ARV treatment.

These associations help mobilise tolerance and understanding. They restore dignity to people living with HIV/AIDSs and improve the knowledge of people infected and affected by HIV. However, the majority of WWHIV and some MWHIV need special attention beyond access to ARV therapy and the support group. Their reintegration into society is still an issue. Discrimination has receded, thanks to the work of visiting health personnel and volunteer organisations, but the psychological trauma of infection is still present even if a person's health might be recovering.

- People living with HIV/AIDS in Laos are learning a lot about their disease and infection.

As support groups raise their knowledge and consciousness of HIV and AIDS, people living with HIV/AIDS are becoming aware of the fact that beyond 2008, nothing is sure about their treatment, and thus their survival. A core group of activists have gained knowledge from regional meetings about their rights about treatment. This mobilisation may be crucial for their survival.

- Many people living with HIV/AIDS remain depressed by the infection, especially women who were cheated on by their partners. They feel that their ability to conduct a normal life has diminished.

Many cannot go back to a normal way of earning their living, either because they have lost strength, or because the opportunistic infections they suffered for many months before access to ARV renders reintegration difficult. Many feel morally and psychologically stained by the virus, and are hesitant to get in contact with 'normal' people. They are especially reluctant to get married or have a steady relationship.

- WWHIV fear for their future more than the men.

They are especially troubled by their child's access to treatment or schooling, and the difficulty in finding a stable partner who can accept their infection. If discrimination and stigma recede within family and community, time is needed for people living with HIV/AIDS to get back to a normal life.

- Most MWHIV have understood that their own careless practices led to their infection, which they then spread to their sexual partners and families.

The number of men blaming their partner as the cause of their infection is minimal. The challenge is to project this realisation onto health behaviour among people who have not yet contracted diseases.

- HIV infection is a financial issue for all affected families.

Many participants acknowledge that when they were suffering from the disease but had not yet been tested, they spent large sums of money on traditional medicine and divination rituals. Many borrowed money and sold land or assets to meet the financial challenge of HIV infection.

Projects that provide quality free medicines can help families and patients avoid overspending their meagre income on vain quests for a cure. However, counselling is also needed to convince people living with HIV/AIDS and families of the scientific facts: one male participant admitted

taking herbal medicine for a few months while on he was on ARV because he had doubts about the efficacy of the 'foreign medicine'.

The economic situation can be a matter of survival for Lao people living with HIV/AIDS. The budget restrictions now affecting transport allowance for patients visiting Savannakhet Hospital to get checks and monthly ARV dosages may have a detrimental impact on the compliance to ARV treatment. The success of ARV treatment is based on the regularity of the medical follow up and the strict obedience to drug regimen. Patients who have recovered their CD4 level and a healthy physical aspect are still in need of income generating activities.

- The number of people living with HIV/AIDS stranded in the categories 'jobless' and 'cannot work' is a matter of concern.

These people need to go back to a normal life, to be able to work and provide a decent income for their family. This should be one of the main objectives of associations working with people living with HIV/AIDS.

Loss of Confidence

ARV therapy helps people living with HIV/AIDS to recover their self-confidence as well as their health and strength. But even with treatment, many participants are worried all the time: it seems that HIV/AIDS will be their bad friend forever.

One woman said *"I never forget about HIV. It is in my body when I get up every day, here, inside me. It worries me all the time"*.

Though discrimination seems uncommon and is reducing over time, people living with HIV/AIDS are still afraid of the community and strangers learning their status. Women more than men have difficulty regaining self-confidence and it takes more time for them to accept their own situation. Men recover quicker from the psychological shock of being diagnosed with HIV, probably because most of them knew that their own risky behaviour was responsible of their infection.

Marrying a partner with HIV is a way to break isolation after the death of a spouse and rejection by former friends. Such an event exists and this survey recorded two occasions of non-infected people marrying, knowingly, a person living with HIV/AIDS: a non infected man with an infected woman, and a non-infected woman with an infected man. With thorough counselling such couples should be able to lead normal lives without much risk for either partner.

Wider Implications for Lao Society

This paper shows that in Laos HIV is not chiefly transmitted through sex work, but because of unsafe behaviour. Women who use condoms during paid sex feel safe when having unprotected sex with a steady partner. A faithful and trusting wife does not feel concerned about HIV, but her husband may be having random sex with or without condoms, for money or not.

The people living with HIV/AIDS in this study were infected 7 to 15 years ago. Most of them were leading the normal life of typical Lao people. Unknowingly they became infected with the HIV. What has changed in the last five years to prevent young Lao people becoming infected during their migration to Thailand and then transmitting this to their partners at home.

Lao society is changing very fast and the choices now available to young people could have dramatic consequences as far as HIV is concerned. Commercially available sexual services seem to have increased over the last 15 years. Service women and *kathoey* are more visible, meeting an increasing demand. Mobility is also increasing, with roads being built and transport becoming more convenient.

The virus takes advantage of changes which are not corroborated with safer behaviour and increased knowledge. The campaign on 100% Condom Use Project is targeting paid sexual acts but this barely covers the typical people of our sample - migrant workers and their partners.

When the people who participated in this research were infected, many Lao people were ignorant about risks and were practicing dangerous behaviour. We feel that more people than are recorded are infected and ignorant of it.

Annexe I

Number of people living with HIV/AIDS receiving ARV by province, as of July 2005:

1.	Savannakhet:	136	53%
2.	Vientiane:	54	21%
3.	Khammouane:	23	9%
4.	Champasak:	22	9%
5.	Saravane:	7	3%
6.	Sayaboury:	6	2%
7.	Bolikhamxay:	4	2%
8.	Luang Prabang:	3	1%
9.	Sekong:	1	0%

Total: 256

Number of people living with HIV/AIDS receiving ARV by age group

Age	Males	%	Females	%	Total	%
< 5	10	6.7%	8	7.5%	18	7.0%
20-29	45	30.2%	41	38.3%	86	33.6%
30-39	73	49.0%	38	35.5%	111	43.4%
> 40	21	14.1%	20	18.7%	41	16.0%
Total	149		107		256	

There is a clear statistical difference between men and women receiving ARV in the age group 30-39: MWHIV get their treatment later than women in that age group.

Data provided by Savannakhet Hospital.2005



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