

Orphans, children affected by HIV/AIDS and other vulnerable children in Lao PDR



Ministry of Labour
and Social Welfare

National Committee for the
Control of AIDS Bureau

unicef 



Contents

1	Introduction	1
1.1	Background	1
1.2	Objectives of the assessment	2
1.3	Methodology	2
1.4	Limitations	3
1.5	Assessment participants	3
2	Dimensions of vulnerability	4
3	Orphans and other vulnerable children	6
3.1	Orphans	6
3.2	Children with disabilities	8
3.3	Abandoned children	9
3.4	Street children	9
3.5	Children affected by substance abuse	11
4	Children affected by AIDS	12
4.1	Context	12
4.2	Scale of the problem	16
5	Climate of care and support	19
5.1	Residential institutions	19
5.2	Family and community-based systems of care	21
5.3	Formal support mechanisms	25
5.4	Policy and legislation	27
6	Perspectives on care and protection	28
6.1	International experience and best practice	28
6.2	Local perspectives	30
7	Conclusions	31
8	Recommendations	33
9	Annexes	39

Abbreviations

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ATS	Amphetamine-type Substances
CABA	Children Affected By HIV/AIDS
CRC	United Nations Convention on the Rights of the Child
DCCA	District Committee for the Control of AIDS
HI	Handicap International
HIV	Human Immuno-deficiency Virus
HIV+	HIV Positive
LSW	Labour and Social Welfare
MoLSW	Ministry of Labour and Social Welfare
MoPH	Ministry of Public Health
MICS	Multiple Indicator Cluster Survey
NCCAB	National Committee for the Control of AIDS Bureau
NRC	National Rehabilitation Centre
PCCA	Provincial Committee for the Control of AIDS
PDR	People's Democratic Republic
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission (of HIV)
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UXO	Unexploded Ordnance

Introduction

1



1.1 Background

Lao PDR is currently experiencing a period of rapid social change associated with the transition to a market economy and closer regional integration.

This process of change has brought many new opportunities, but has simultaneously introduced new social problems that put children and young people at greater risk than ever before. A number of significant child and youth protection issues have emerged in recent years, including child trafficking, sexual exploitation and abuse, HIV/AIDS, children in conflict with the law, substance abuse and street children.

The spread of HIV/AIDS is a particular concern given the high prevalence rates in neighbouring countries and increasing cross-border and domestic population movements. Lao PDR currently has one of the lowest recorded rates of HIV infection in the region, but there are indications that HIV may have spread more widely than official statistics suggest.

While it is difficult to make accurate projections, the indications are that the number of vulnerable children in Lao PDR will increase over the next five to ten years.

In this context, it is imperative that immediate action is taken to identify effective strategies for the care and protection of vulnerable children.

The Government of Lao PDR is committed to strengthening measures to provide assistance to vulnerable children and their families. However, currently there is little documentation on existing formal and informal coping strategies. To better understand the present situation, the Ministry of Labour and Social Welfare (MoLSW) and the National Committee for the Control of AIDS Bureau (NCCAB), commissioned this assessment, with support from UNICEF Lao PDR.

This assessment explores:

- Available data on key groups of vulnerable children.
- Key issues facing these groups of children.
- Existing options of care and protection for vulnerable children.
- Knowledge and attitudes of children, adults and local authorities regarding different systems of care and protection.
- Existing policy and legislation.

The final section of this report presents recommendations on how to take forward the process of developing national policy and plans of action.

1.2 Objectives of the assessment

The objectives of this assessment, developed in collaboration with the MoLSW and the Ministry of Public Health (MoPH), are as follows:

- To estimate the number of vulnerable children in the Lao PDR.
- To better understand the situation and needs of vulnerable children and their families.
- To investigate current mechanisms for formal and informal support.
- To review the legal and policy framework for protecting the rights of vulnerable children.
- To promote the development of integrated policies and strategies for support to community-based programs of care for vulnerable children.

1.3 Methodology

This study incorporates both quantitative and qualitative information on the situation of vulnerable children and their families in the Lao PDR. While quantitative data provides information on the number of orphans, children affected by HIV/AIDS and other groups of vulnerable children, qualitative information gives an insight into community perceptions of vulnerable children and appropriate options for care and support which might otherwise be overlooked in a quantitative study.

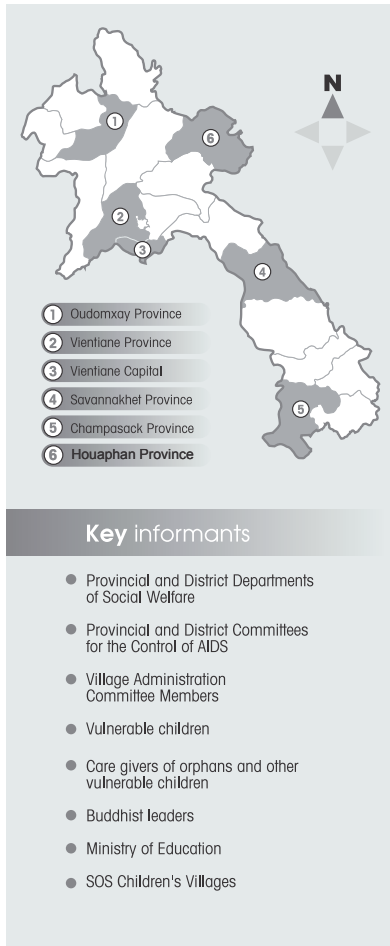
Primary research was predominantly qualitative in nature and included structured and open group discussions, in-depth interviews with key informants and the documentation of case studies. (See Annex 1 for further details on research approaches.) Since the subjects of the study are living with difficult and potentially stigmatizing conditions, the research team was careful at all times to respect the rights and privacy of vulnerable children and their families.

The assessment draws on a significant body of existing quantitative data relating to the situation of vulnerable children in the Lao PDR, including national statistics, policy documents, research reports and project documents. This secondary data not only contributed to the findings of the study but also helped define its methodology and scope. Existing data on the numbers of orphaned children in each province, for example, enabled the assessment team to identify target provinces for qualitative study. (See Annex 2 for a full list of secondary data sources.)

Field research was conducted in 6 provinces, selected according to:

- The known number of orphans, children affected by HIV/AIDS, and other vulnerable children.
- The prevalence of socio-economic conditions that contribute to vulnerability (including poverty and migration/trafficking patterns).
- The existence of established care and support initiatives for vulnerable children.
- The capacity and commitment of provincial and district staff to assist in the study.

The methodology for the assessment was developed to promote the



participation of vulnerable children, their families and local communities. It also sought to build the awareness, skills and capacity of caregivers, local authorities and policy makers. The following objectives informed the design of the research methodology:

- To collaborate with partners in data collection and assessment so that the **transfer of skills and knowledge** is an integral part of the assessment.
- To encourage relevant Ministries and mass organizations to improve systems for **planning, data collection, and strategy development**.
- To heighten awareness of the situation of vulnerable children among staff of Ministries and mass organizations so that **program resources are better focused and prioritized**.

1.4 Limitations

Data collection systems in the Lao PDR are currently weak and there is a scarcity of detailed, disaggregated, reliable and up to date statistical information on the situation of vulnerable children. Consequently, the estimated numbers of vulnerable children presented in this study should be considered as rough approximations intended to provide an indication of the situation and to spur further debate, research and analysis.

Primary research focussed on 6 provinces which, on the basis of available data, are known to have high numbers of vulnerable children. Consequently, availability of data was a necessary criterion for selection. Given the weaknesses of current data collection systems, there may be significant concentrations of vulnerable children in other provinces that were not identified by this study. In future years, as data collection systems improve, more information will become available on the situation of vulnerable children throughout the country and further insights will be possible.

While the geographical scope of this study is limited, the data from the 6 provinces targeted provides sufficient information to describe the challenges facing vulnerable children and their families nationwide and to begin the broader dialogue needed about strategies for care and protection.

1.5 Assessment participants

This assessment was led jointly by the Social Welfare Department of the Ministry of Labour and Social Welfare and the NCCAB in the MoPH. Mr Douangsy Thammavong (Technical Staff, Needy Children Assistance Section), represented the Social Welfare Department, while Dr. Phengphet Phetvisay (Trainer) represented the NCCAB.

The consulting team for the assessment included Susan Hunter, Ph.D., Sounthone Nanthavongdounsy, M.D., Masters of Public Health, and Vanphanon Sychareun, M.D., Masters of Tropical Health. UNICEF supported the design and execution of the study.



2

Dimensions of vulnerability



Given that Lao PDR is one of the poorest and least developed countries in the world, it might be possible to categorize a large proportion of Lao children as vulnerable in one way or another. High levels of infant mortality, significant rates of malnutrition, limited access to health care and low educational attainment are among a range of serious issues facing many Lao children.

Programmatically, however, it is necessary to focus initiatives on children who, in the local context, are *most* vulnerable and *most* likely to fall through the existing safety nets. Generally speaking, programmes supporting vulnerable children do not target children who face risks which are typical for most of their peers.

The most vulnerable groups of children in need of special measures for care and protection are those who, for whatever reason, face a higher risk than their peers of:

- Neglect or discrimination
- Emotional, physical or sexual abuse and violence
- Economic and sexual exploitation

Reaching the most vulnerable Lao children is not necessarily an easy task because there is a shortage of detailed, accurate, disaggregated statistical data. Available information tends to be anecdotal and qualitative, rather than quantitative, and is particularly scarce for highly sensitive issues such as sexual abuse and exploitation. However, on the basis of the evidence available it is possible to get a reasonably accurate understanding of which categories of children are most vulnerable.

For the purpose of this assessment, vulnerable children were defined as follows:

Orphans and other vulnerable children	Children affected by HIV/AIDS
Orphans	Children who are HIV+
Abandoned children	Children orphaned by AIDS
Street children	Children living with HIV+ family
Substance abusing children	Children at risk of HIV infection
Children with disabilities	

This framework offers a useful starting point for analysis, but it is a simplification of the complex range of situations and factors that contribute to child vulnerability: some children who fit neatly within these categories may enjoy the love, warmth and protection of a caring family; and some children who do not fit within this framework may none the less be vulnerable due to particular circumstances they face. Nor is vulnerability static: a child's level of vulnerability will vary throughout her life according to her own and her family's circumstances - economic status, ethnicity, size of family, age and gender, health status and family situation. Finally, there is likely to be considerable overlap between categories (some street children are also orphans; a child with a disability may live with an HIV+ family member).

Children affected by HIV/AIDS are presented somewhat separately in order to highlight the range of different ways children may be affected by HIV/AIDS. However, international programming experience suggests that measures to address the needs of children affected by HIV/AIDS should be part of broader programmes tackling the problems faced by all vulnerable children. Such an approach seeks to limit stigmatisation while recognizing that many (although not all) of the problems faced by children affected by HIV/AIDS are similar to those faced by other groups of vulnerable children.

It was not possible to include the full range of vulnerable children found in Lao PDR in this assessment. Key groups absent from this study include children who are victims of cross-border trafficking, children engaged in harmful child labour and children in conflict with the law. In each case, a major piece of research has recently been undertaken and the findings will be available soon.

Interviews with villagers, local authorities and social welfare officials during research for this assessment presented various definitions of vulnerable children, including:

- Double orphans.
- Single orphans in poor households unable to provide basic necessities.
- Adolescents, especially girls, who may be preyed on by traffickers.
- Children from very poor families.
- Children involved in substance abuse, including those who come into conflict with the law.
- Children whose parents lack time for proper care.
- Children at risk of HIV infection.

3

Orphans and other vulnerable children



ເດັກກາຳພ້າ
dek kampha
(single orphan)

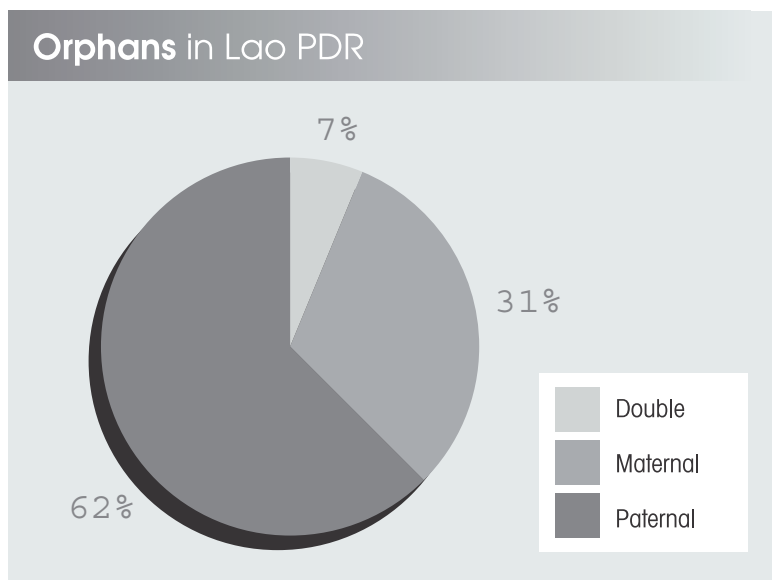
ເດັກກາຳພອຍ
dek kamphoi
(double orphan)

3.1 Orphans

The combined effect of poverty, poor nutrition, inadequate sanitation, malaria and other health problems together with limited access to quality health care services means life expectancy in Lao PDR is low, especially in rural areas.¹ Consequently, children face a considerable risk of losing their mother or father (or both) at a young age.

The number of orphans in Lao PDR is hard to determine since data collection systems are weak. There is an added terminological confusion since two Lao words ('khampa' - single orphan) and ('khamпой' - double orphan) are often used indiscriminately to describe double orphans, single orphans and children in single parent families due to divorce or separation.

This assessment has estimated the number of orphans by analysing data collected as part of a recent Multiple Indicator Cluster Survey (MICS II), which included a detailed household survey.² Analysis of this data shows about 3.5% of Lao children under the age of 15 are orphans, with one or both of their parents dead. If this proportion is applied to 2002 population estimates, **there are 85,292 orphans under 15 years old in Lao PDR.** About two-thirds of these children have lost their father (paternal orphans), about half as many have lost their mother (maternal orphans) and a small proportion have lost both parents (double orphans).



¹ Average life expectancy is just over 50 years while almost one in three Lao citizens do not survive to the age of 40. Lao PDR Human Development Report, United Nations, 2001.

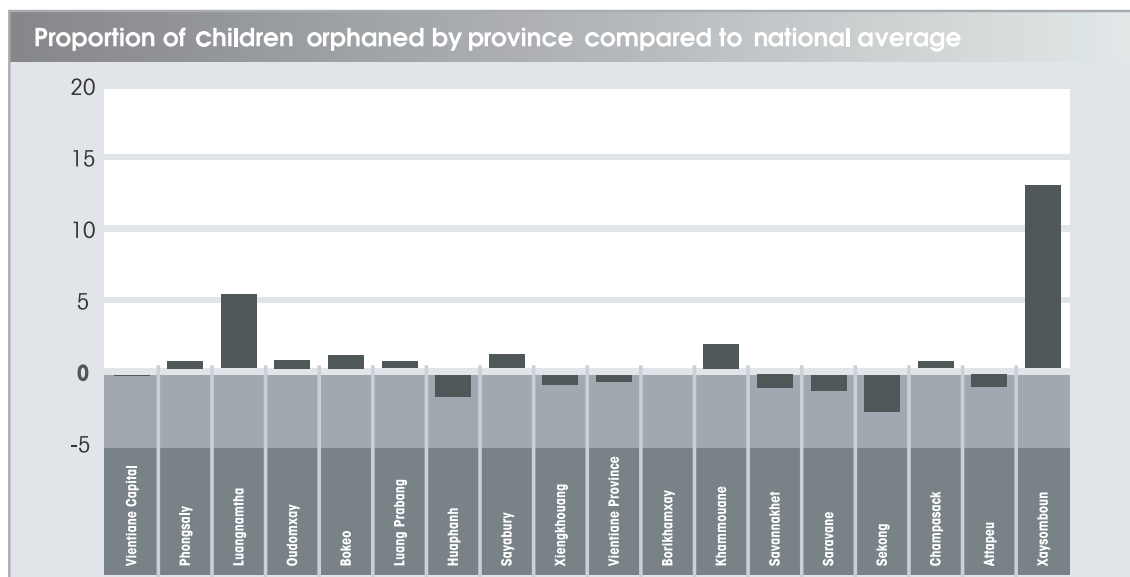
² Multiple Indicator Cluster Survey (MICS II), National Statistics Centre / National Institute of Public Health, Lao PDR, Vientiane, 2001.

It is worth noting that the figures derived from MICS II are far greater than previous official enumerations of orphans in Lao PDR. In its first report to the Committee on the Convention on the Rights of the Child (CRC), the Lao Government stated that there were 19,229 single and double orphans nationwide in 1994.³ During a 2003 training workshop for provincial and district staff from Social Welfare Offices very few orphans were reported.⁴ Similarly, in the field research conducted as part of this assessment a low number of orphans were reported by village committees, which may reflect the fact that children who have lost their parents and are taken in by another family are not always perceived as being orphans.

In the long term, the percentage of orphaned children is likely to decrease as health care provision improves and life expectancy rises. In developed countries where health care is widely available and life expectancy is greater, orphans account for only about 0.1% of children. However, such demographic changes do not come overnight and in the meantime providing care for orphans will continue to be a significant social welfare issue in Lao PDR.

³ Country Report to the Committee on the Convention of the Rights of the Child, Government of Lao PDR, 1995.

⁴ Para-professional social work training supported by UNICEF, 2003.



According to the MICS II data, two provinces have a significantly higher proportion of orphans - Luang Namtha (8.6%) and Xaysomboun Special Administrative Zone (16.7%). In the latter case, the vast majority (15.3%) are paternal orphans. Although the survey sample size was relatively small and only aimed to provide accurate analysis by region and nationally, the considerable deviation from the norm in these two provinces merits further investigation.

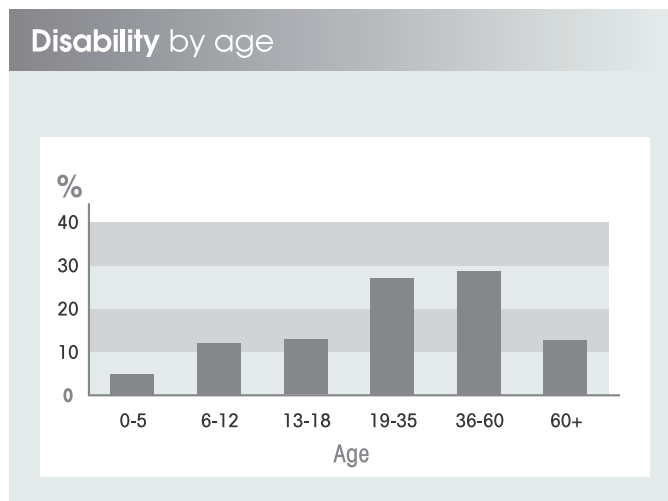
3.2 Children with disabilities

A disability is a condition where use of part of the body is so impaired that the person cannot carry out normal functions such as hearing, walking, seeing, or learning. In general, there are four major contributors to disability: congenital or prenatal disturbances (15-20%), communicable diseases (about 20%), non-communicable physical and mental conditions (40-45%) and trauma/injury (about 15%).⁵ The World Health Organisation estimates that 7-10% of the global population has a disability of some kind, while in poorer countries national estimates tend to range between 2 and 5% of the population.⁶



Lao children are particularly vulnerable to disability due to limited access to health services, wide-spread contamination by unexploded ordnance (UXO) and high levels of childhood malnutrition. UXO - a legacy of the Indochina war that ended almost 30 years ago – contaminates 25% of villages nationwide and accidents involving UXO are responsible for about 250 recorded deaths and injuries each year. Many UXO victims require amputations, suffer blindness, deafness, serious burns and paralysis. Of all UXO accidents reported in 2003, 46% of the victims were children.⁷ Child malnutrition rates in Lao PDR are among the highest in Southeast Asia and can seriously hinder normal intellectual development.

Information on Lao children living with disabilities is scarce since there is no system of routine data collection and no national studies have been undertaken. A recent study in 7 districts close to the capital city found 0.8% of the surveyed population living with a serious disability 'that presents a serious limitation on a person's daily life'. Children accounted for almost 1 in 6 of people with disabilities identified by the survey (see chart below).⁸ These figures are far lower than global country estimates and may reflect the fact that, due to limited access to quality health care services in Lao PDR, very few disabled children survive beyond the first years of life. On the other hand, none of the villages included in the survey were seriously affected by UXO, nor were they in the poorest and most remote parts of the country where childhood malnutrition is highest. It is likely that a nationwide study would identify far more children and adults living with a disability.



⁵ E. Helander, *Prejudice and Dignity - An Introduction to Community-Based Rehabilitation*, UNDP, New York, 1999, p26 cited in *Bridging the Gap - Survey of Disabled Children and Adults*, NRC/ HI/UNICEF, Lao PDR, 1999, p39.

⁶ Global estimate by WHO Director General in speech at the *Interagency Consultation on Disability, Geneva 15-16 June 1999*, www.who.int/director-general/speeches/1999/english/19990615_interagency_consultation.htm; poor country estimate from paper presented to the *Second ad hoc Meeting on a UN Disability Convention*, Rehabilitation International, Geneva, 2003 (www.disability.dk).

⁷ *Progress Report 2003*, UXO Lao, Vientiane, Lao PDR, 2003, p.2.

⁸ NRC / HI / UNICEF, op.cit., p29.

3.3 Abandoned children

The strong kinship networks underpinning Lao society serve to limit the number of abandoned children. Parents who are unable to provide care for their child are normally able to find someone in their extended family or local community who is willing to provide alternative family care.

3.4 Street children

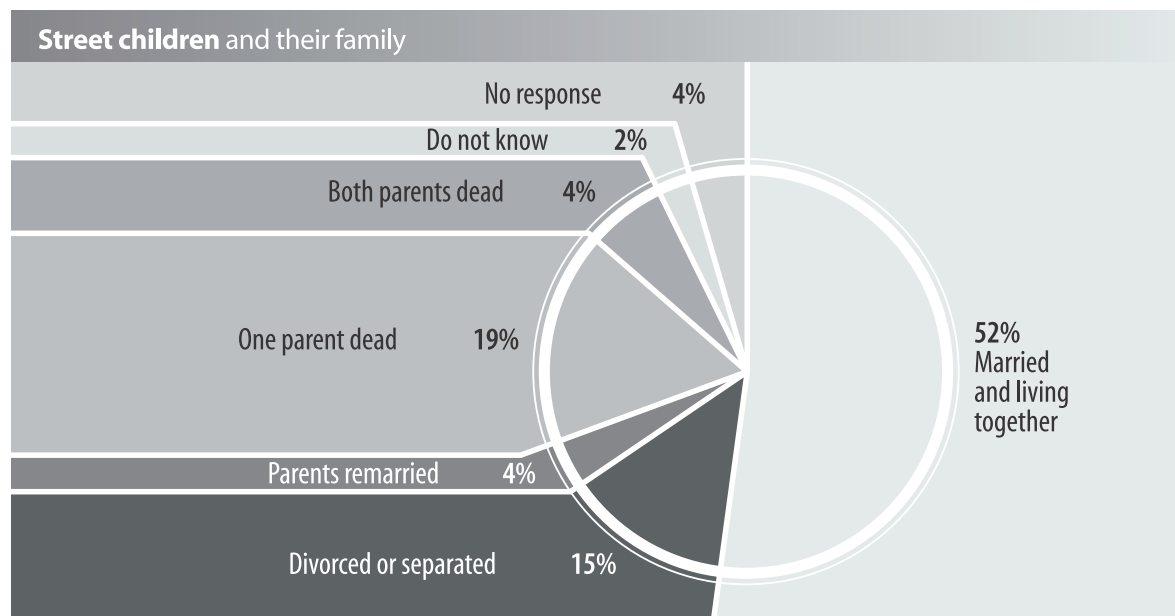
Children living, working, begging and sleeping on the streets of cities is a very recent phenomenon in the Lao PDR. While there are no national figures available, a recent survey published by the MoLSW revealed 138 children on the streets, half of them in the capital city, Vientiane.⁹

The range of contributory factors identified by this survey included poverty, increasing rural-urban inequality, dysfunctional families, substance abuse, disability and the breakdown of traditional family and community networks due to urbanization.

It is significant that most street children *do* have parents: only 5% of the children surveyed were orphaned with both parents dead, while 55% had two living married parents; 64% of children reported that their parents knew what they were doing and more than 50% of their parents knew where they were living.

Family problems were cited by many children as a reason for being on the streets. Forty-four percent of street children reported that they had been physically abused, almost always by their father. Twenty-two percent of children reported that a member of their family was abusing drugs.

⁹ *Street Children and Child Beggars*, MoLSW/UNICEF, Lao PDR, 2001.



Poverty was also a significant factor, with 24% of children reporting that they beg and work on the street to support their family, while a further 13% said they had to support themselves on the street because their family cannot afford to feed, shelter and clothe them.

Disability also appears to be a factor leading to children living and working on the streets. One in ten street children interviewed had a disability and some children reported that their parents had a disability of some kind.

As the process of urbanization gathers pace across the country, it can be expected that the number of children living and working on the streets will increase.

“Life on the street is better than being at home”

Case study: Boy aged 10 years old on the streets due to problems at home.

Kheng is 10 years old and spends most days begging on the streets of Vientiane, the capital city. He makes between 4,000 and 10,000 Kip each day (US\$0.40-US\$1), which is enough to buy food, but not much more. His parents live nearby and he maintains some contact with them. Both his mother and father work, but the family income is low. Although poverty may be one reason that Kheng has taken to a life on the streets, problems at home also appear to be an important contributory factor:

“I beg during the day and sleep in temples at night, sometimes I go home to sleep at my parents’ house, but not very often because my parents and uncle often shout and hit me. They all know that I am a beggar but they say nothing. Being a beggar during the day and sleeping at the temple at night is better than being at home. Sometimes I smoke cigarettes; my two younger brothers who live at home take amphetamines. I used to have 7 or 8 friends to play with while begging, but now I only have 2 close friends on the streets – the others don’t want to be with me. In the future I want to be a soldier.”



3.5 Children affected by substance abuse

During the 1990s, health professionals working at the Mental Health Unit of Mahosot Hospital in Vientiane, the capital city, became aware that drug abuse by young people was becoming a significant problem. Most cases related to solvent abuse, however amphetamine-type substances (ATS) emerged as a new concern with the number of users seeking treatment from the Mental Health Unit almost tripling in the space of 12 months (from 85 cases in 1999 to 220 in 2000). Most ATS users were secondary school students from the local area.¹⁰

As a new social phenomenon, there is a lack of data on the number of young people affected nationwide, however recent studies by the United Nations Office on Drugs and Crime (UNODC) in the three largest urban centres of the country showed widespread abuse of solvents, ATS, sedatives and marijuana among school age children.¹¹ The most at-risk age group was 15-19 year olds, with the proportion using illicit drugs over the previous 12 months ranging from 2.5% (in Luang Prabang) to 7.3% (in Vientiane). The proportion of adolescents who had used illicit drugs at some point in their lives was higher, ranging from 5.5% (Luang Prabang) to 15.7% (Vientiane). Prevalence is much higher among adolescent boys than girls, with 25% of adolescent males in Vientiane having used illicit drugs. Substance abuse among the youth population was highest in Vientiane, lower in Savannakhet and lowest in Luang Prabang, mirroring the level of urbanisation in each location. The situation in rural areas has not been studied in any detail, although it is believed that ATS abuse affects youth in many rural villages.

Young people surveyed reported a range of personal factors that contribute to substance abuse, including curiosity, peer pressure, depression and anxiety. However, external factors were also important with 'family problems' reported as a significant factor leading to experimentation with illicit drugs. In Luang Prabang, while only 1% reported they suffered from emotional abuse during childhood, there was a significant correlation between the use of drugs and trauma as a child. In Vientiane, there was a significant correlation between ATS abuse and family problems, including parents with psychiatric disorders and parents involved in illegal activities. A further UNODC survey on drug use among nightclub clientele noted that drug abusers often reported experiencing physical or emotional abuse during their childhood.¹²

A recent school-based survey found that 1 in 4 adolescent males in Vientiane, the capital city, had experimented with illicit drugs - mostly solvents and amphetamine-type substances. Anecdotal evidence suggests that the rate of drug abuse among out-of-school youth is higher, however no survey has yet been conducted with this population group.

¹⁰ *Drug Abuse Among Youth In Vientiane - School Survey Report*, UNODC, Lao PDR, 2000.

¹¹ *Drug Abuse Among Youth In Vientiane - School Survey Report*, UNODC, Lao PDR, 2000; *Drug Abuse Among Youth In Savannakhet - School Survey Report*, Lao PDR, UNODC, 2001; *Drug Abuse Among Youth In Luang Prabang - School Survey Report*, UNODC, Lao PDR, 2001.

¹² *Drug Abuse Among Disco Clients In Vientiane*, UNODC, Lao PDR, p19.

4

Children affected by HIV/AIDS



4.1 Context

The changing epidemic in Lao PDR

While official statistics show that Lao PDR currently has one of the lowest HIV adult prevalence rates in Asia (0.05%)¹³, there are indications that the overall infection rate might be considerably higher, especially in young people, migrants and their partners. Lao PDR may soon find itself in the middle of a much more serious and rapidly expanding epidemic once sentinel surveillance systems adequate to reflect the true extent of infection are put in place. In what follows, the most important portents of epidemic change are reviewed. Major factors shaping the future of HIV/AIDS in Lao PDR are: the changing picture of risk and vulnerability in Lao PDR; domestic and cross-border labour migration; trafficking of women, girls and boys; improving transportation networks and rapidly increasing infections among people under age 30.¹⁴

Risk and vulnerability to HIV/AIDS

Conducted in 1999 and 2001, Lao's periodic HIV/STI sentinel surveillance and monitoring surveys focused on specific population groups who were presumed to have high potential exposure to HIV (female factory workers, service women, long distance truck drivers)¹⁵. Behavioural surveillance in 2001 again focused on these groups.¹⁶ HIV rates in all of these groups were relatively low, which is surprising given the very high rates of STIs among service women.¹⁷ HIV prevalence among female service workers was 0.9% and 1.1% among service women who reported selling sex, but prevalence of STIs was 37.6%, one of the highest rates in Southeast Asia. Truck drivers also had high rates of chlamydial and gonococcal infections and related symptoms. Among female factory workers, rates of STIs were low, but significant given their relative sexual naivety. Both service women and long distance truck drivers reported inconsistent condom uses with non-regular partners.¹⁸

These surveys show that HIV has entered the Lao population and could spread rapidly given current patterns of sexual behaviour. However, the limit of the surveys to these populations has perpetuated the assumption that because prevalence is low in tested groups, HIV is not widespread.

Data on the occupation of people infected with HIV collected by HIV test centres, however, provides a completely different picture and suggests that adoption of a broader view of the nature of HIV risk and vulnerability

¹³ Adults aged 15-49 years old. *Report on the Global HIV/AIDS Epidemic*, UNAIDS, Geneva, 2002.

¹⁴ Much of the material in this section has been adapted from *HIV/AIDS Prevention Care and Support, 1996-2003, Projects and Lessons Learned*, UNICEF, Lao PDR, 2003; and Chamberlain, J., *HIV Vulnerability and Population Mobility in the Northern Provinces of the Lao PDR*, UNDP, 2003.

¹⁵ *HIV Surveillance Survey and Sexually Transmitted Infection Periodic Prevalence Survey*, Lao PDR, NCCAB and FHI, 2003.

¹⁶ *Behavioural Surveillance Survey 2000-2001*, NCCAB & FHI, Lao PDR, 2001.

¹⁷ The term service women refers to women who work in entertainment venues such as bars and nightclubs and have direct contact with patrons. In addition to serving food and beer or providing conversation to customers, some service women sell sex. HIV positive: all service women 0.9%; service women who reported selling sex 1.1%. Chlamydia positive: service women (SW) 33.4%; female factory workers (FFW) 6.6% (p<0.05). Gonorrhoea positive: SW 16.6%; FFW 0.4% (p<0.05).

¹⁸ *HIV Surveillance Survey (HSS) and Sexually Transmitted Infection Periodic Prevalence Survey (SPPS)*, NCCAB Lao PDR, 2001.

in Lao PDR would be strategic. The occupational breakdown of cumulative HIV positive cases shows that migrant workers account for 35% (384 cases out of 1,084 cases), placing them at the highest risk of all occupational categories. Manual workers comprise 9.4% of those infected (102 cases), farmers 8.7% (94 cases), and housewives 8.5% (92 cases). Service women represent 5% of all HIV positive people identified through testing, followed by government officials (4%, 44 cases), businessmen (3.2%, 35 cases), children (1.9%, 20 cases), and truck drivers (1.6%, 17 cases).

Of course, these results are not a completely accurate reflection of the actual distribution of current infections by occupational group because they include only those people who voluntarily sought testing from public facilities in Lao PDR. They also represent only those who identified their occupations - the occupations of almost one-fifth of those who have been tested is not known. Despite these constraints the occupational data from HIV testing suggests two things: that the risk groups included in the surveillance system are not an accurate reflection of the epidemic in Lao PDR, and that a more comprehensive and regular surveillance system is needed to capture a much broader range of potential vulnerable groups beyond those normally identified at risk for HIV transmission.

Unlike most of its neighbours, HIV transmission in Lao PDR appears to be primarily through heterosexual contact. NCCAB data shows that 81% of cumulative infections were through heterosexual contact. When only people with known sources of transmission are used, that proportion jumps to 97%. The next largest cause is mother to child transmission (2.3%), with bisexual contact, injecting drug use and blood transfusions playing an extremely minor role in transmission.

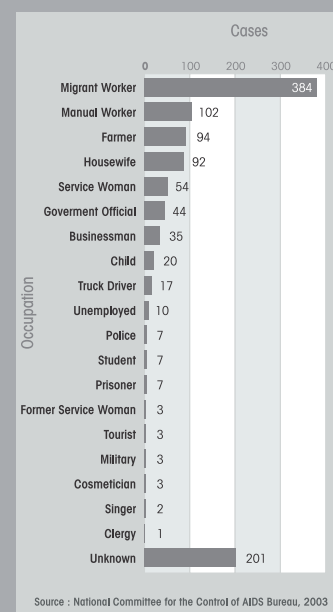
The role of migration in the epidemic

Ten Lao provinces border Thailand and Lao citizens regularly cross the border to work, trade, visit friends or relatives and attend festivals. According to a 2002 Asian Development Bank (ADB) study of migration in the Mekong region, "the exchanges between Thailand and Lao PDR are more than just looking for work. The exchanges are markets, festivals, family visits, and many other formal and informal exchanges."¹⁹

Estimates of the total number of migrants and visitors are difficult to make because the border between Lao PDR and neighbouring countries is porous and in many places people cross back and forth without going through official border checkpoints. Many Lao families are heavily dependent on the remittances from family members migrating within the country and to other countries, primarily Thailand. Officially reported remittances from migratory workers constitute a substantial percentage of income for families in central and southern provinces - 10 to 30% according to the 1997-98 Lao Expenditure and Consumption Survey (LECS).²⁰ The total might be higher than that voluntarily reported by families to official LECS interviewers.

According to HIV test data, the epidemic is concentrated in provinces that are centres for internal migration and cross-border movement of mobile and migratory populations, including Savannakhet, Vientiane, Khammouane,

Occupation breakdown of HIV positive cases from 1990 to April 2003



Mode of transmission of HIV positive cases from 1990 to April 2003

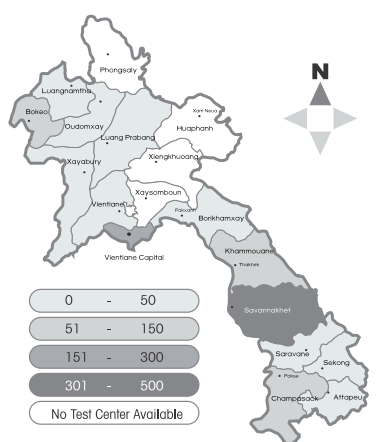
Mode of Transmission	Cases	%
Hetero-sexual contact	800	81%
Bi-sexual contact	8	1%
Injecting Drug Use	1	0%
Blood transfusion	4	0%
Mother-to-Child (Vertical)	21	2%
Sharps injury	1	0%
Unknown	174	16%
Total	1,089	100%

Source : National Committee for the Control of AIDS Bureau, 2003

¹⁹ Chantavanich, S., *Mobility and HIV/AIDS in the Greater Mekong Subregion*, ADB, 2002, p46.

²⁰ *Lao Expenditure and Consumption Survey*, National Statistics Centre, Lao PDR, 1999.

Number of HIV positives cases from 1990 to April 2003



Source : National Committee for the Control of AIDS Bureau, 2003

²¹ Chamberlain, J., 2000, HIV Vulnerability and Population Mobility in the Northern Provinces of the Lao People's Democratic Republic, South East Asia HIV and Development Project, UNDP and UNOPS, p. 1; Du Guerny, J., Chamberlain, J. and Hsu, L., from *AIDS Epidemic to an AIDS Pandemic: Is an HIV/AIDS Hub Building in South East Asia?*, UNDP and UNOPS, Bangkok, 2000.

²² Chantavanich, S., *op. cit.*, p. 42.

²³ *HIV/AIDS Prevention Care and Support, 1996-2003, Projects and Lessons Learned*, UNICEF, Lao PDR, 2003, p4.

Champassak and Bokeo. Unfortunately, this data may not be sufficiently comprehensive to document the extent of infection through migration in the other border provinces because testing facilities have not been widely available until recently.

Trafficking

The relationship between trafficking and migration is still being investigated through qualitative studies by a range of organizations. The two forms of mobility are hard to separate because some young people migrate voluntarily and then become victims of trafficking networks. It is impossible to know the numbers of children that are victims of trafficking although factors leading to vulnerability are currently being studied. What is clear is that trafficking is a very lucrative business, and that it multiplies the exposure of young people to HIV infection by exposing them to hazardous, exploitative and illegal forms of labour including domestic work and commercial sexual exploitation.

Epidemic hot spots

*"Lao PDR is about to become the hub of land transportation for the Greater Mekong Sub-region, the centre of a far-flung transportation network linking Thailand, Cambodia, China, Myanmar, Viet Nam and more distant countries... Within these opening channels of communication lies an enormous potential for the rapid spread of HIV."*²¹

Since the mid-1990s, Lao PDR's program of development has emphasized improvements in the country's transportation system which facilitates the movement of populations within its borders and to surrounding countries. While this brings many opportunities for improved livelihood, it also increases the risk of HIV/AIDS transmission.

It is clear that there are many "hot spots" for rapid expansion of the country's HIV/AIDS epidemic that the existing national surveillance system has not sufficiently documented. According to ADB's 2002 analysis of mobile populations in the Mekong Sub region, "the Hot Spots in Lao PDR are along trucking routes, which include major towns, border towns and other truck stops," and "border areas with Thailand, Yunnan and Vietnam, [which are] magnets for traders, migrant workers and others."²²

HIV test data

HIV test data provides an important indicator of HIV infection patterns in Lao PDR. However, recorded prevalence rates should be considered in light of the very limited availability of testing facilities and the low number of people who have come forward for voluntary testing. Only 80,803 people, representing less than 2% of the population have been tested.²³

There are several factors accounting for the low number of people tested for HIV in Lao PDR. First, test facilities are available in only 14 out of 18 provinces nationwide, usually in provincial hospitals, which are not easily accessible for many people. Second, although the Lao population is increasingly aware of the risks of HIV/AIDS and how to avoid infection, the personal perception of risk remains low. This not only contributes to unsafe sexual behaviour (multiple partners and low condom use) but also limits the number of people who recognise their vulnerability and see the need for testing. Third, the lack of referral and pre-test/post-test

counselling services may disincline people to seek testing. Finally, given that the cost of anti-retroviral drugs is beyond the means of most of the population, it may reasonably be assumed that many people who suspect that they might be HIV+ would prefer not to know their status. Indeed, most HIV+ cases have been identified only because the person fell ill and came to hospital for treatment.

More extensive testing would provide a more accurate picture of HIV infection and the relative vulnerability of different population groups in Lao PDR. The NCCAB is now reconceptualizing its surveillance system with a working group of experts in accordance with the Lao PDR National Strategic Plan on HIV/AIDS/STD 2002-2005. The national HIV/AIDS strategy includes a commitment to develop a strategy for reducing the vulnerability of mobile populations through cross-sectoral programming.

Summary: key epidemic factors for children and young people

While the official estimate of HIV prevalence in Lao PDR is still very low, there are many signs that the epidemic has spread more widely than official statistics show.

It appears that adolescents and young adults - male and female alike - are being hit harder than older people, who in other societies are usually the first to become infected. The high migration rates of young people, combined with high levels of ignorance about HIV/AIDS and STIs, create a substantial risk of HIV infection in people under 30 years of age.

Fear and denial

Case study: Widow of migrant worker denies her husband's death was due to AIDS.

Lay grew up in a small town on the banks of the Mekong River. By the time he was 16 he had married, had a child (who died in infancy), and separated from his wife.

For the next 10 years Lay worked in several large towns along the river; he also went to work for one year across the border in Thailand. Finally, having earned enough to buy a small riverboat, he returned home and a few years later he married for the second time. He was 29 years old. Shortly afterwards, Lay and his new wife, Oye, had a baby daughter.

Three years later Lay fell seriously ill and was advised to take an HIV test. His family suspected that he may have been infected through high-risk sexual behaviour during the many years he had spent working away from home. Lay tested positive for HIV, his condition deteriorated and he died a month later.

Oye refused to accept that her husband's death was caused by AIDS and despite the advice of local medical staff did not seek a test for herself or her young daughter. Two years later she married again. She and her daughter moved to another town to stay with her new husband and his family.

Authorities in Luang Prabang told the researchers for this assessment that all of the recent HIV positive cases were under 20 years of age and that they had become infected through seasonal off-farm work in the municipality.

HIV/AIDS threatens to become a severe economic and development problem in Lao PDR because of this pattern of infection, which will have a marked negative impact on agricultural labour and productivity, and will reduce remittances from migrant workers and increase the burden of poverty in the country. Provision of services will also be threatened, particularly health services, which will witness a heavy increase in demand toward the end of this decade.

4.2 Scale of the problem

While the warning signs are clear, assessing the scale of the problem is more difficult. There are two key challenges to accurately estimating the number of children affected by HIV/AIDS in the Lao PDR - both relate to inadequacies in existing surveillance systems.

First, the surveillance system is currently not comprehensive enough to provide a true picture of the number of children and adults living with HIV/AIDS. As of April 2003, the NCCAB had recorded 233 HIV+ children under the age of 18. However, recorded prevalence rates should be considered in light of the very limited availability of testing facilities and the low number of people who have come forward for voluntary testing. Undoubtedly, more children have already been infected with HIV than shown by official test data - but how many more is not known.

The second obstacle in assessing the number of children affected by HIV/AIDS is that too little is known about the health, marital status and fertility of HIV+ adults to give a clear idea of the number of children in their care and the impact that HIV has on their lives. Consequently, there is no reliable data on the number of children born HIV+, living with HIV+ family members or orphaned by AIDS.

The picture of HIV/AIDS in the Lao PDR will become clearer as the surveillance system improves. New national estimates of the number of children affected by HIV/AIDS will be prepared by the Government for Lao PDR's next National HIV/AIDS Strategic Plan (for the period 2006-2010). In the meantime, recorded infection rates and tentative estimates are presented here in order to help stimulate dialogue among experts within the country.²⁴

Recorded and estimated number of HIV+ infants

A cumulative total of 25 infants under five years of age were tested HIV+ between 1990 and April 2003. However, it is likely that the true figure is much higher. Based on the national adult HIV prevalence rate (0.04% between 2000 and 2002, rising to 0.05% in 2003) and an average mother-to-child transmission rate of 30%, it is likely that around 10 children have been born HIV+ in the last four years (see table on page 18 for details).

The mother-to-child transmission rate used in this estimate is based on international studies that show almost one in three children born to HIV+ mothers will also be infected with HIV at birth or through breastfeeding,

²⁴ All recorded HIV infection data and estimates of children affected by HIV/AIDS are based on NCCAB data from 1990 and April 2003.

unless programmes to prevent mother-to-child transmission (PMTCT) are in place. Although work to establish a PMTCT programme is currently underway, the programme is not yet fully operational and therefore the estimate presented in this report uses a mother-to-child transmission rate of 30%.

Recorded cases of HIV infection among children and young people

Only 17 cases of HIV infection in children between 5 and 15 years old were recorded by the NCCAB as of April 2003. In contrast, a much larger number of 15 to 25 year olds have tested HIV+ with a cumulative total in April 2003 of 198 reported cases. Significantly, *HIV infection among 15 to 25 year olds represents 18% of all recorded infections.*

Estimated number of children living with HIV+ parents, family members or guardians

It is estimated that 376 children have been born to HIV+ mothers but are not themselves infected. This estimate is based on the number of HIV+ females (344) multiplied by an age adjusted fertility rate; then the number of HIV+ children is subtracted.

While it is possible to estimate the number of children living with HIV+ mothers using female fertility rates, it is not possible to estimate the number of children living with HIV+ fathers or other family members because fertility data for men is not available and HIV test records do not include information on whether HIV+ adults have children or live in households with children.

Estimated number of children orphaned by AIDS

It is estimated that 57 children under the age of fifteen have lost their mother due to AIDS. This estimate is developed by multiplying the number of reported female deaths by the average female fertility rate. (The lack of fertility or household data for HIV+ adults makes it impossible to estimate the number of paternal orphans due to AIDS.)

Children at risk of infection

Given the current low levels of reproductive health awareness among young people, a large number of adolescent children may be at risk of infection through unprotected sex if effective prevention programs are not instituted soon. However, it is difficult to provide estimates at this stage.

Future projections

Considering the current lack of clarity regarding the situation of HIV/AIDS in Lao PDR, the future pattern of the epidemic remains uncertain. However, for now a few remarks can be made about several epidemic-related trends. First, age-related infection data suggests that HIV is accelerating rapidly among young people aged 15-24 and there is considerable danger that a large number of young people will become infected with HIV in the coming years unless effective prevention programmes are implemented immediately. Second, an effective nationwide PMTCT programme is essential in order to limit the number of infants infected with HIV. Third, major increases will be seen in the number of children living with HIV+ adults and family members as the infection rate grows in Lao PDR.

Estimates of children born HIV+

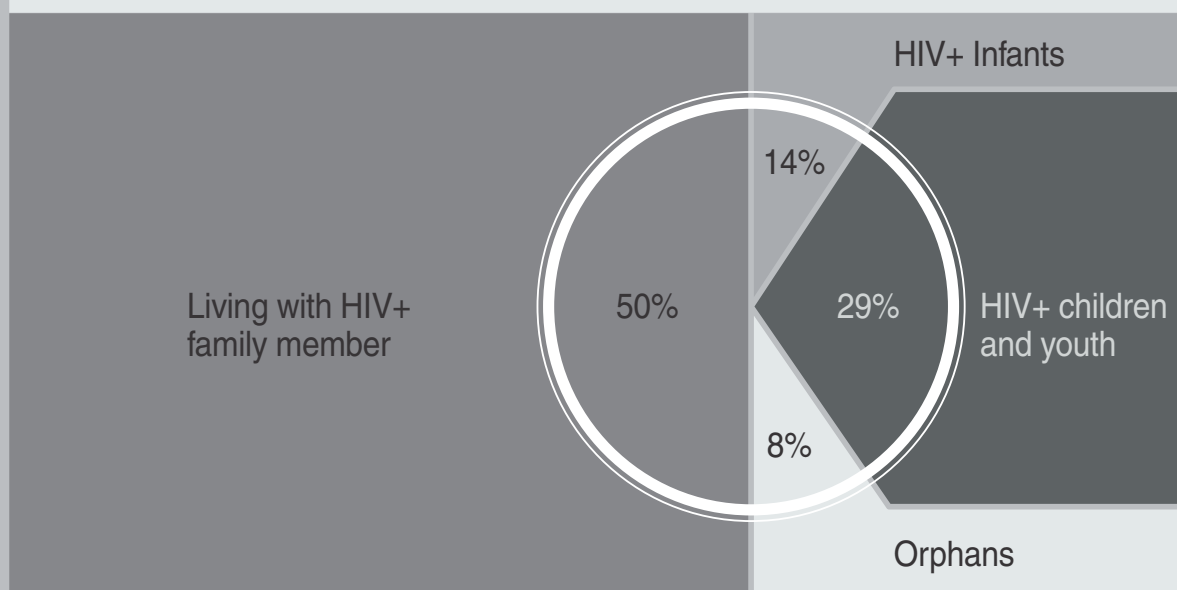
Year	# of births	Infection rate	Transmission rate	# HIV+
2003	200,000	0.05%	0.30	30
2002	200,000	0.04%	0.30	24
2001	200,000	0.04%	0.30	24
2000	200,000	0.04%	0.30	24

Total HIV+ infants in 2003	102
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Summary of Children Affected by HIV/AIDS in Lao PDR

Group	Definition	Number of children
HIV+ infants	Infants, aged 0-4 years, old infected through mother to child transmission	102 (estimate)
HIV+ children and young people under 25 years of age	Age 5-9 10 Age 10-14 7 Age 15-19 30 Age 20-24 168	215 (recorded)
Children living with HIV+ family members	Due to limited available data, this estimate includes only children living with HIV+ mothers	376 (estimate)
Children orphaned by AIDS (but not themselves HIV+)	Due to limited available data, this estimate includes only maternal orphans	57 (estimate)
Children at high risk of infection	Difficult to determine - but note that young people aged 15-24 account for almost 20% of all recorded HIV cases.	Unknown

Total children affected by HIV/AIDS in 2003	750
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The figures presented here include test data collected by NCCAB between 1990 and April 2003, and tentative estimates derived from that data. More accurate estimates and more detailed analysis will become possible as the national data collection system improves.

Climate of care and support

5



5.1 Residential institutions

Orphanages

SOS Children's Villages have been established under the supervision of the Cabinet of the Ministry of Labour and Social Welfare in four provinces (Vientiane, Champassak, Xieng Khouang and Luang Prabang); a new facility is currently being built in Houaphan. Records for the existing four sites show that together they house 243 boys and 227 girls, or 470 children in total. Children admitted to these institutions are double orphans and single orphans whose surviving parent is unable to care for them. They must be under 7 years of age or the older sibling of a child under 7 years old. SOS will not admit children with chronic diseases, including HIV/AIDS, because it creates too much of a demand on their staff. SOS operates primary and secondary schools on-site (which are open to non-residential children), three kindergartens, a small vocational training facility, and a social centre. There are also three 'youth houses', which serve as half-way houses for male orphans when they turn 15 years of age.

Ethnic minority boarding schools

There are 13 Ethnic Minority Boarding Schools in Lao PDR, administered by the Division of Ethnic Minority Schools of the Ministry of Education (MoE). Five provinces do not have ethnic minority boarding schools but the MoE has plans to open one in every province. Some of the schools were built with assistance from the Government of Vietnam and are of high physical quality, while others have older, poorer facilities. Of the 2,752 children in these schools, 52% (or 1,421 children) are double or single orphans. However, only 280 orphaned children are under 15 years of age.

The staff of Ethnic Minority Boarding Schools reported that they undertake extensive community fund-raising because their budget for operations is so low. The schools are provided with 90,000 kip per month per child from the central education budget for food. Rice is provided from government distribution networks. In addition, the schools visited during this assessment relied on extensive gardens where the children help to grow vegetables.

According to one school administrator, the MoE at the central level has not developed systematic plans for the growth of the schools, so the school attempts to supplement its budget through donations in order to add grades for older children. The schools that were visited during this assessment are gradually adding school grades to accommodate the children as they grow older, and were just starting to add senior secondary levels.

Although detailed figures are not available in Lao PDR, this assessment found that Ethnic Minority Boarding Schools receive 90,000 KIP (around US\$9 at current exchange rates) per child, per month to purchase food. This equates to over US\$100 per child over the course of the year and implies the annual food budget for all 13 boarding schools nationwide runs to almost US\$300,000 - not including salaries and general running costs.



Children are expected to return to their village of birth after completing their education, but none have yet done so. However, many children do return home during long school vacations, and this no doubt helps them to maintain close relations with their families and communities of origin.

National rehabilitation centre

The main facility in Lao PDR for disabled adults and children is located in Vientiane, the capital city. The National Rehabilitation Centre (NRC) was established in 1964 and since then has developed a range of services including medical rehabilitation, physiotherapy, orthopaedic surgery, production and assembly of orthopaedic prostheses and orthoses, vocational training, special schools for children who are deaf and for children who are blind, and a resource room for community-based rehabilitation. In addition there are also six smaller provincial prosthetic and orthotic centres around the country.

The NRC has a small residential unit for adults and children who need longer term care and rehabilitation. At the time of writing, the residential unit catered for 60 people, of which only 20 were children. Most children return home during school holidays.

Cultural school

The Ministry of Public Security operates a residential children's facility 67 kilometres from the capital city, Vientiane. While in the past this facility was described as an orphanage, today it is a boarding school for the children of civil servants and other government employees. While some of the children enrolled are orphans, are from poor families and may be vulnerable for other reasons, this assessment was not able to access data on students and their backgrounds.

Summary of institutional care in Lao PDR

Few residential institutions for vulnerable children have been established in the Lao PDR and those that do exist are able to provide care for a very small number of children.

Orphans are the largest single category of vulnerable children in residential care, although the number of children is low in absolute terms and as a proportion of all orphans. SOS Children's Villages provide care for only 470 orphans, while Ethnic Minority Boarding Schools care for no more than 280 orphans. On this basis, it appears that less than 1% of the country's estimated total of 85,000 orphans under the age of 15 are in institutional care.

Very low numbers of other vulnerable children are found in institutions. Twenty children with disabilities (out of some 20,000 nationwide) are currently resident at the NRC. A small number of adolescents with drug problems are in the care of Somsanga Treatment Centre. There are no residential institutions for street children or other groups of vulnerable children at this time.

5.2 Family and community-based systems of care

Guardianship and adoption

Lao PDR has a strong tradition of family and community care for children whose parents have died, are ill or need care for other reasons. There are two main traditional practices of alternative family care in Lao PDR – guardianship by relatives and guardianship by non-relatives.

The research conducted for this assessment found that grand parents are the most common guardians of orphans, followed by aunts and uncles. If no relatives are able to act as guardian, another individual from the community will usually offer to take care of the child. Vulnerable children are sometimes taken in by childless couples - who may or may not be members of the extended family.

It is the duty of the village chief to ensure that a proposed guardian has the capacity to provide an adequate level of care and protection and to monitor the child's well-being thereafter. However, interviews for this assessment suggest that in practice the village chief does not always play such an active role in the process, especially if the guardian is closely related to the child.

There is provision in the Lao law for adoption of children, however, in practice the care arrangement is often not formalized and it would be more accurately described as 'informal guardianship'.

“I keep her to remind me of my brother’s face.”

Case study: Double-orphan, female, 5 years old, living with her uncle in a village in the north of Lao PDR.

Nang Lieng became a double orphan before her second birthday. Her mother fell sick with chronic diarrhoea shortly after Nang Lieng was born and died within the year. Around the same time, Nang Lieng's father developed a chronic cough and by the time his wife had passed away the coughing had become so severe that he was unable to continue working. He could not look after his young daughter on his own and so he moved with Nang Lieng to stay with his brother's family. His health continued to deteriorate, he began coughing blood and died a year later.

With the death of both her parents, Nang Lieng remained in her uncle's house. Some neighbours suggested that Nang Lieng should be sent to an orphanage, but her uncle insisted that she would be better off living with him and his family. When asked why he did not want to send her to an orphanage, Nang Lieng's uncle said:

“I keep her to remind me of my brother's face. I think the best place to care for her is in my small house. Here she will receive warmth as if she were living with her parents; she is treated the same as my own two children and I will support her to study alongside them to ensure a brighter future. I just ask that Nang Lieng not be treated differently from the other children in the village; and I hope to find a way to earn more money so I can better support my three poor children.”

In certain situations, children may be temporarily placed in alternative family care. Children whose parents are seriously ill may be cared for by another family member until the situation improves; rural children are often sent to stay with relatives in urban areas in order to gain access to education and health services. Children of seasonal labour migrants are frequently left in the care of grandparents or other family members.

The number of children living in households without their biological parents (i.e. in some form of guardianship arrangement) was captured in the MICS II survey. An analysis of the MICS data shows that 36,500 (1.5%) children under 15 in Lao PDR are not living with either of their biological parents. It is worth noting that orphans account for less than half of all children under 15 cared for by guardians (approximately 30% of children in the care of guardians are single orphans and 10% double orphans). The proportion of children living with guardians is highest in urban areas and among older children aged 10-14, which may reflect temporary living arrangements designed to enable access to secondary school education.

Unfortunately, the MICS II data does not provide sufficient detail to say more about the situation of these children. Since there is no information on the relationship between the child and the family with which they live, it is not possible to tell whether guardians are members of the child's extended family. Nor is it possible to differentiate between children who have been informally adopted and children who have temporarily joined a family (to gain access to school, to work opportunities, or for other reasons). Additionally, since MICS II was a household survey, the data does not include children in institutions and children living in temples as novice monks.

Community support for vulnerable children

This assessment identified some examples of financial support to families of vulnerable children from the local community. Within the village, collections are frequently made to pay for funeral expenses and money is sometimes raised at festivals and other community social events to support families providing care to orphans. But in some villages it was reported that help was available only from relatives and friends, and that there was no wider community support. Poverty constrains the ability of community members to help each other in times of need, since when the whole community is poor there are few resources available to share. This assessment found that financial assistance was more commonly provided in the southern provinces surveyed, which are slightly less poor than those in the north.

However, financial assistance is only a small part of the picture. Far more important is the level of psycho-social support provided by both relatives and the wider community to vulnerable children and their families. Such support includes home visits when people are sick, helping out with child care, helping with the harvest and providing other labour inputs.

The level of community cohesion was found to be an important factor in determining the level of support provided by communities to vulnerable children and their families, with clear differences between rural and urban areas. In rural villages where traditional social structures remain intact, families who have known each other for many generations will readily come to each other's assistance in time of need. Community assistance

is lower in towns and cities because where communities are much more fluid as a result of rural-urban migration and population movement within the city itself.

One example of community-based support for vulnerable children and their families is **self-help groups** recently established in southern Laos with the support of the MoPH, UNICEF and the Lao Red Cross. They provide psycho-social support together with some financial and material assistance to children and families affected by HIV/AIDS in 106 villages across three provinces. Self-help groups provide four main services: counselling, including peer counselling; care and treatment; social support through community mobilization; and economic support, including income generating activities. Staff from Provincial Committees for the Control of AIDS (PCCA) and the Lao Youth Union support the groups' activities, while Village Committees for Control of AIDS also provide advice, moral support and other in-kind assistance. Self help groups have been found to strengthen the physical and mental health of members, to strengthen their family's economic coping mechanisms and to reduce stigma and discrimination faced by people living with HIV/AIDS (PLWHA).



Child-headed households

Case study: Four orphaned siblings living alone in a city in the north of Lao PDR.

Nang Boua was 15 years old when both her parents died. With no close relatives nearby she was left to look after her younger brother, Xay (12), and her two younger sisters, Keow (10) and Noy (7). Members of the local community contacted an orphanage to seek a placement for the children, which was accepted. A traditional farewell ceremony was held, however no one from the orphanage came to collect the children and they have remained for the past 2 years living on their own in their parent's house.

Nang Boua has been able to make a little money selling meat in the nearby market. She earns about 10,000 to 15,000 kip (US\$1 – US\$1.50), which is barely sufficient to buy rice and cover basic household expenses. So far, Nang Boua has been able to support her brother and 2 sisters through school, but she is not sure for how much longer.

To add to her problems, their house is built on someone else's land and the owner wants them to leave; recently someone cut their electricity and water supply.

Nang Boua, now 17 years old, is often propositioned by young men and also older men 'who want to talk about love and sometimes marriage' and she faces increasing pressure to sell sex as a way to earn enough to support her younger siblings.

Despite their difficult situation, the children have received little assistance from social welfare officers or from members of the local community.

The role of temples and monks

Temples play a pivotal role in the life of many communities in the Lao PDR, where the majority of the population is Buddhist. Apart from their important religious and cultural roles, temples also provide care and protection to a large number of boys who have ordained as novice monks. Many poor families place their sons in the care of the local temple in order to guarantee them access to food, shelter and education – and also, of course, so that they can practice spiritual development (dharma).¹ Temples also provide care for non-ordained ‘sangaree’ (temple boys) who are from poor families or families far from town. They do chores around the temple in return for food and shelter.²⁵ Temples also sometimes provide short-term care for vulnerable children. It appears that temples in Lao PDR are contributing in an important way to the care and protection of vulnerable children, especially boys. However, data on the number of children living in temples was not available for this survey and further research is required.

In interviews conducted during this assessment, most local authorities were not able to give examples of specific links between temples, monks and social welfare activities. However, in a number of provinces the potential of temples and monks to support social welfare initiatives has been harnessed in relation to HIV/AIDS prevention.

In Savannakhet, for example, monks work to support people living with HIV/AIDS (PLWHA) who have formed self-help groups. Temples assist by providing:

- Psychological and moral support, warmth and counselling
- Advocacy to reduce discrimination against PLWHA
- Disseminating *Dharma* to school children and adult community members
- Providing traditional medicine to treat opportunistic infections affecting PLWHA.

²⁵ *HIV/AIDS in Khammouane and Savannakhet – Trip Report June 2000*, UNICEF, Lao PDR, 2000.



5.3 Formal support mechanisms

Labour and social welfare departments

Labour and Social Welfare Departments (LSW) at the provincial and district level reported in interviews for this assessment that they lack the funds and other resources to provide help to vulnerable children and their families. LSW Departments receive a small budget to provide material assistance to families, but all said that it was far too small to help the number of families in need. Support to vulnerable families consists primarily of distributing material support to families in times of crisis; social welfare officers lack the resources to undertake preventative programmes.

Although there is no formal referral system for orphans and other vulnerable children, social welfare officers reported that they are normally consulted in cases of institutional placement at SOS Children's Villages and Ethnic Minority Boarding Schools. However, there is no system of monitoring or inspection to identify deficiencies or abuse.

Provincial and district social welfare staff said that their primary weaknesses were lack of funds and clear programming. They reported difficulties in implementing frequent changes in central level policy. Most Provincial Labour and Social Welfare Offices were fully staffed, but district offices reported that they faced staff shortages, which were compounded by the wide range of tasks they were expected to undertake. Besides the lack of budget, other factors identified as limiting their capacity to respond to the need of vulnerable children and families included:

- Lack of baseline data on orphans and other needy children.
- Lack of transportation and facilities (office space, equipment, furniture, computers).
- Too few staff.
- Lack of training on social work.
- Lack of managerial skills (no evidence of action plans).
- Lack of clear, detailed individual job descriptions.
- Low motivation, arising perhaps from the other constraints.

Village and local government officials

When village committees were asked about their roles and responsibilities during this assessment, they stated that their main tasks are to follow government policy, to promote village development and maintain village security. No committee members mentioned care and support of orphans or other vulnerable children. However, in interviews and group discussions, local government officials participating in this assessment showed a great deal of concern, compassion and commitment to address the needs of vulnerable children and their families. This was evident in the range of suggestions made for providing support, which included assisting poor children and orphans to access education, establishing vocational training and setting up local committees to assist vulnerable families.

In practice, the capacity of local officials to assist vulnerable children and their families is severely constrained by an acute lack of human and financial resources. However, it was reported that financial assistance is

occasionally provided. Some people living with HIV/AIDS have been able to borrow money from the village fund without interest to pay for medical treatment. Village committees also reported assisting with funeral expenses for poor families and AIDS victims and providing emergency supplies of rice and roofing materials to families caring for orphans.

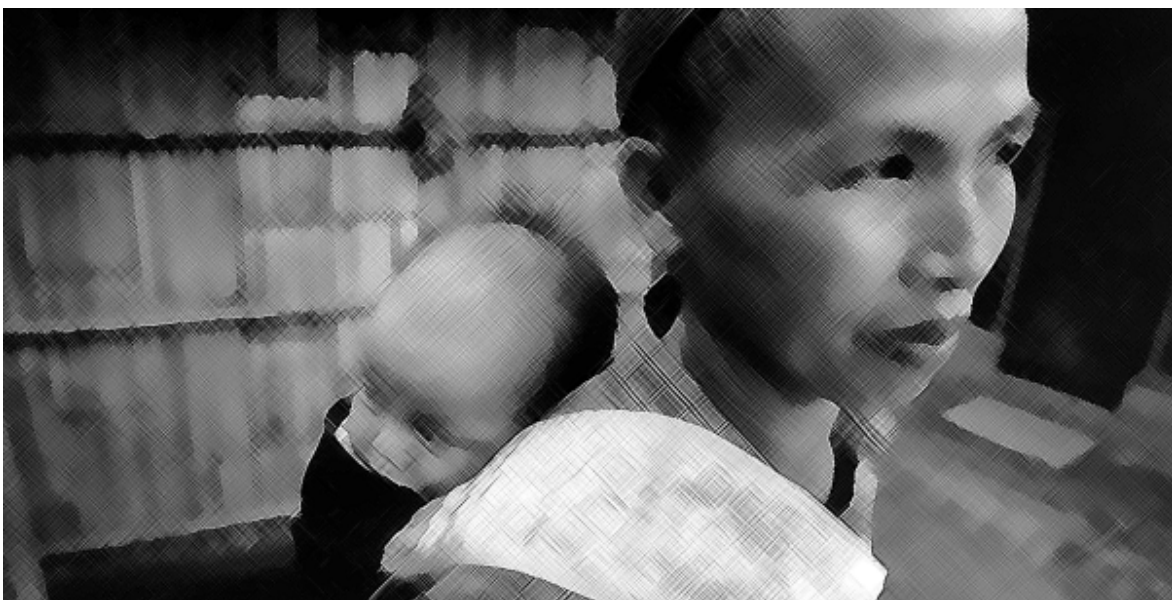
Local authorities do provide some in-kind, non-monetary assistance to vulnerable children and their families: one village committee reported allocating additional paddy land to families caring for orphans, and one district authority reported that they waived the market fee for the oldest girl in a child-headed household.

Provincial and District Committees for Control of AIDS

The NCCAB coordinates all HIV/AIDS-related activities within the country. Smaller working committees are active in each province and district. PCCAs are multi-sectoral and include social welfare officers, while many District Committees (DCCAs) do not currently include social welfare officers.

The PCCA and DCCAs within the province are actively supporting self help groups for PLWHA in Savannakhet. However, in the other provinces included in this research they had not been able to facilitate the establishment of self help groups and felt it would not be possible until treatment, counselling and income generation schemes were in place.

Both PCCAs and DCCAs suffer many of the management difficulties commonly faced by new organizations. Provincial committees complain, for example, about too much work, but do not delegate to the district or coordinate well with other government bodies. The NCCAB recognizes the problem and in 2003 undertook a management survey of the problems faced by PCCAs and DCCAs as part of an effort to improve their working relationships and efficiency.



5.4 Policy and legislation

Residential care

While there is increasing recognition among social welfare staff that institutional care should be a last resort, there is currently no national legislation or policy to determine when a child should be placed in institutional care, or when they should be returned to the community of origin. There is no system of routine inspection and the conditions within different institutions are largely unknown.

Given its mandate to work on social welfare issues, the MoLSW would be well placed to supervise referral procedures and to monitor conditions of care provided by institutions. However, the situation is complicated by the fact that three different line ministries (MoE, MoLSW and Ministry of Public Security) share responsibility for the different institutions and there is no over-all coordinating body.

In a presentation to the Stockholm Conference on Children and Residential Care in May 2003, the Lao Government highlighted the need to establish policy, guidelines and standards for monitoring and supervision of institutions, to review and revise admission criteria to ensure that children are admitted only as a last resort, and to ensure that regular inspections take place.

Adoption

The Lao law on adoption is contained within the Family Law (1991), which defines the duties of adoptive parents and local authorities with respect to adopted children; in 1994 a proposal was accepted by the National Assembly to halt inter-country adoptions. Lao adoption law was highlighted as a point of concern by the Committee on the Convention on the Rights of the Child in the Committee's response to the national progress report submitted by the Lao Government in 1995. The Committee's principle concern is that, in its current form, the Lao adoption law may not be consistent with Article 21 of the United Nations Convention on the Rights of the Child (CRC) and the principle of best interests of the child. The Lao Government proposes to develop a children's law, which may help to address this issue.

Perspectives on care and protection

6



6.1 International experience and best practice

In many countries institutional care has, until recently, been seen as an appropriate response in situations where children have lost parental care or where parents lack the capacity to provide adequate levels of care.

It is now widely recognized that institutions can cause serious and long lasting harm to the children they aim to protect. There is a significant body of evidence demonstrating that uprooting children from their community and separating them from their parents, siblings, other family and friends causes a great deal of psychological damage that can last throughout their adult lives. Moreover, certain features of the institutional environment mean that many of children's basic needs are not satisfied. Deprived of a family environment, children receive less stimulation, individual attention and love. Abuse and bullying is common, both by staff and other children. Institutional care isolates children from society at large and does not prepare them for real life and normal social interaction. After leaving closed institutions, many young adults have difficulty re-integrating into society because they lack access to the network of family and community relationships that children growing up in families take for granted. Frequently they also have problems feeling empathy towards others and building trusting relationships.

It is difficult for any institution, however well intentioned and well resourced, to meet the standard of care provided by a good family.

Not only does institutional care risk failing to provide adequately for the needs of children, it is also expensive. Closed institutions require significant financial inputs to cover construction, maintenance costs, salaries, food and basic services such as education and health. A number of studies have demonstrated that the cost per child of institutional care is many times more than the cost of equivalent community-based care. In poorer countries where state finances are limited, children in institutions may not receive adequate health care and nutrition. The high cost of operating residential institutions means that they are able to provide care for only a small percentage of vulnerable children.

Increasingly, it is accepted that growing up in a family provides the best possible environment for a child's well-being and development. The bond

'The child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding.'

United Nations Convention on the Rights of the Child

between parent and child, the continuity of care, the personal attention and the opportunities for social interaction that families and communities provide are fundamental to children's full development. This is why families have evolved as the principle structure for nurturing children.

For children deprived of family care, the best solution is one that approximates the family environment as closely as possible and causes as little disruption and dislocation as possible to the child. International experience suggests that when a child loses parental care, they should be provided care within the extended family or with another family, preferably within the same community. In circumstances where family care is not possible, institutional care may be necessary as a *temporary* measure until permanent placement in a family setting can be arranged. Placement in an institution should be a last resort and only considered when careful assessment concludes that the child cannot function in a family environment.

The United Nations Convention on the Rights of the Child

The United Nations Convention on the Rights of the Child and other human rights instruments recognize the primary role of parents in ensuring children's care and protection. The CRC states that parents, or where applicable, the extended family or legal guardians 'have the primary responsibility for the upbringing and development of the child' (Article 18:1). The state has an obligation to assist parents and guardians in this role by taking 'all appropriate legislative and administrative measures' (Article 3:2), including the provision of social security (Article 26), education (Article 28) and healthcare (Article 24). It is the state's responsibility to ensure children are protected from abuse and neglect (Article 19) and to implement appropriate measures for prevention and treatment. A child must not be placed in a residential institution simply to improve their access to health, education or other basic services. Instead, comprehensive support should be provided to a child's family in order to improve the capacity of parents to provide adequate care for their child. If, in their own best interest, a child is removed from the family environment, or if they are separated from their family for any reason, the state has an obligation to provide special care and protection, which may include guardianship within the extended family, foster care, adoption, and as a last resort, institutional care (Article 20). Children who are placed in institutional care have the right to have their placement reviewed regularly in order to ensure re-integration into their community of origin as quickly as possible (Article 25).



Residential institutions are highly valued for the educational facilities they provide. However, most families of orphans and other vulnerable children prefer to provide care themselves. “If we push them away, it will hurt them twice,” commented one grandmother caring for her daughter’s orphaned child.

6.2 Local perspectives

The field research conducted for this assessment explored the attitudes of families, communities and local officials towards care and protection strategies. Guided discussions were held with community leaders and local government officials, while in-depth interviews were conducted with children, their parents and other care-givers.

Children’s views

When orphans and other vulnerable children were asked about the best place for them to live and grow up, none talked about institutions – despite the fact that some of their caregivers had explained to them the educational opportunities available at SOS Children’s Villages and Ethnic Minority Boarding Schools. Single orphans expressed a strong need to live with their siblings and surviving parent; double orphans wanted to remain in their parent’s house or with relatives.

Parents and other adult community members

Respondents emphasized that the primary responsibility for care and protection of children rested with parents and the extended family. Some adults recognized that the child’s preference should be taken into account when deciding which relatives should provide alternative care.

While the firm preference for family and community-based care for vulnerable children undoubtedly reflects strong beliefs about the best interests of children, it may also reflect the reality that very few formal mechanisms of alternative care exist. It is worth noting that adults who had heard about the education facilities at SOS Children’s Villages were much more likely to recommend institutionalisation for orphans and other vulnerable children.

To assist vulnerable children and their families, villagers called for vocational training in order to improve livelihood skills. Some also asked for more government support to be directed at vulnerable children and their families.

Local authorities

Local government officials were most likely among respondents to recommend institutional care for orphans and other vulnerable children. Ethnic Minority Boarding Schools and especially SOS Children’s Villages were seen as a good means for children to secure access to food, shelter and education. This is reflected in the fact that some villagers reported that local officials had advised very poor caregivers of orphans to seek an institutional placement for the child.

Conclusions

7



Gaining a clear understanding about the situation of vulnerable children in Lao PDR is complicated by the scarcity of reliable information and detailed, disaggregated data. This assessment has presented very tentative estimates of the number of vulnerable children using the limited information available. Improved systems of data collection and further research are needed in order to provide more accurate enumerations of vulnerable children in Lao PDR.

Despite the gaps in existing data, it is clear that patterns of vulnerability in Lao PDR are changing and the country will be faced with increasing numbers of vulnerable children in the coming years. By far the biggest rise is likely to be associated with the ongoing process of economic and social change, which has already resulted in greater numbers of children abandoned, living on the street, involved with substance abuse and affected by HIV/AIDS.

Existing systems of care and protection are fragile. Formal support through social welfare services is limited and institutional care options are able to cater for only a tiny fraction of vulnerable children. Meanwhile, the range of community-based support mechanisms for vulnerable children is very limited: neighbours and members of the extended family often act as guardians for vulnerable children; local communities provide occasional financial and material assistance; temples provide food, shelter and access to education (for boys); and a few self help groups have been established by and for people living with HIV/AIDS.

It is imperative that immediate action is taken to identify effective strategies for the care and protection of vulnerable children. The projected rise in the number of vulnerable children in the years ahead will stretch the limited capacity of existing formal and informal systems of care and support. Indeed, emerging youth problems such as children living and working on the streets, substance abuse and commercial sexual exploitation demonstrate that children and young people are already beginning to fall through those safety nets that do exist.

There is a growing international consensus that closed institutions are not, in most cases, in the best interests of the child and can cause long term harm to the children they seek to protect.

Moreover, institutional care is an expensive means of providing basic health and education services which might equally be provided within the community. Given that residential institutions in Lao PDR currently cater for less than 1% of orphans and an even smaller fraction of other vulnerable children, it is clear that the cost of providing quality institutional care to all children on an equal basis is far beyond existing national resources.

Increasingly, community-based care initiatives are being promoted as a more efficient and more effective response to the needs of vulnerable children. One important advantage of community-based strategies of care and protection is that they are able to integrate initiatives for prevention, protection and rehabilitation of vulnerable children. In other words, community-based care is able to address both the causes and the consequences of vulnerability, whereas institutional options generally address consequences only.

In devising effective strategies for the care and protection of vulnerable children, it will be important to consider the knowledge and attitudes of different stakeholders. While orphans interviewed as part of this study expressed a strong desire to remain within their community of origin and caregivers of vulnerable children were generally committed to community-based care options, many government officials see institutional care as a valid means to provide education, food and shelter for children living in poor households.

Institutional care will undoubtedly remain necessary for a small number of children for whom family-based care is not possible, but there are strong economic, ethical and practical reasons for supporting community-based care and support for the majority of vulnerable children. For those children whose needs can best be met by institutional placement, quality of care needs to be ensured through clear policy, legislation, monitoring and supervision.





Summary of recommendations

Strengthen and expand existing systems of community care and protection for orphans, children affected by HIV/AIDS and other vulnerable children.

Conduct further research on the range and effectiveness of community-based initiatives for the care and protection of vulnerable children.

Establish clear policy on the care and protection of orphans, children affected by HIV/AIDS and other vulnerable children in line with international guidelines.

Develop regulations and standards of care for children in institutions.

Conduct regular and periodic inspections of all institutions.

Develop a national strategy on care and protection for orphans, children affected by HIV/AIDS and other vulnerable children.

Ensure the full participation of children and their families in developing new community-based initiatives.

Form coordination teams at the provincial level to facilitate strategy implementation.

Improve management systems, increase collaboration and improve the division of labour between different agencies working to support vulnerable children and their families.

Improve national data collection systems on vulnerable children.

Advocate for community-based child protection measures.

Increase funding for social welfare work.

Strengthen and expand existing systems of community care and protection for orphans, children affected by HIV/AIDS and other vulnerable children

Immediate steps should be taken to support existing systems of community-based care. A number of concrete steps should be taken, as follows:

- Increased material and moral support should be provided to vulnerable families in order to help them provide good quality child care.
- The successful model of community self-help groups should be expanded as quickly as possible to support children and families living with HIV/AIDS.
- Additional support should be provided to community-based rehabilitation programmes for children and adults with disabilities.
- Existing practices of guardianship by extended family members should be encouraged in cases where parents are unable to provide adequate care and protection.
- The role of village administrations and social welfare officers in monitoring the care of children being cared for by guardians should be strengthened.
- Plans already underway for the establishment of Child Protection Networks should be implemented as swiftly as possible. Such networks act as a referral system to help communities identify children in need of more formal forms of assistance.
- In areas where HIV/AIDS self-help groups exist, Child Protection Networks should be integrated as much as possible in order to avoid overloading the capacity of the local community and social welfare officers.

Conduct further research on the range and effectiveness of community-based initiatives for the care and protection of vulnerable children

In the time available for this assessment, it was possible to identify only a limited number of community-based mechanisms for the care and protection of vulnerable children and their families. Further research is needed to identify additional systems of community-based care already in existence and to evaluate their effectiveness in meeting the needs of vulnerable children and their families.

It would be useful to document the cost effectiveness of family and community based care in Lao PDR and to compare this to the cost of similar care provided by institutions.

Further research on the range of community-based care initiatives and their cost effectiveness would also help to build a consensus in support of community-based care among the various actors working in the field of social welfare.

Establish clear policy on the care and protection of orphans, children affected by HIV/AIDS and other vulnerable children in line with international guidelines

The MoLSW should develop an explicit national policy on family, community-based and institutional care that is consistent with the CRC and the commitments made at the United Nations General Assembly Special Session on children.

The policy should prioritise family and community-based care options, while making allowance for institutional care as a last resort when all community-based care options have been exhausted. The policy should clearly state which children need institutionalization, when, and for what purposes, and what proportion of state resources should be allocated to this form of care given that less than 1% of all orphans and other vulnerable children under 15 receive care from this source. Moreover, the policy should state that institutionalisation is, wherever possible, a temporary measure until permanent care can be found within the child's extended family or community of origin.

Develop regulations and standards of care for children in institutions

The MoLSW should develop regulations relating to residential care institutions, including Ethnic Minority Boarding Schools and SOS Children's Villages. Regulations should cover referral and admission procedures, minimum standards of care and the minimum qualifications of staff.



Conduct regular and periodic inspections of all institutions

Institutions should be inspected regularly to ensure that they provide adequate care for children in accordance with the CRC. The MoLSW is the most appropriate agency to undertake this task.

Develop a national strategy on care and protection for orphans, children affected by HIV/AIDS and other vulnerable children

A national strategic plan should be developed to assist in the implementation of national policy on the care and protection of vulnerable children. A working group within the National Commission for Mothers and Children would be a good locus for developing this strategic plan. The working group could begin with a review of this report and other research relating to vulnerable children in Lao PDR.



The national strategy should:

- Set specific goals, objectives and indicators (an international set of standard indicators has been developed for orphans and vulnerable children and can be used as the basis of a monitoring and evaluation system).
- Clearly specify the roles of the various actors in the social welfare system, including families, communities, local government, institutions, the MoLSW and other line ministries.
- Describe how the social welfare sector will make the transition in orientation from case work to community development.
- Specify how assistance will be targeted to key groups of vulnerable children.
- Set budget levels, staffing needs and training requirements to meet the specified goals.

Ensure the full participation of children and their families in developing new community-based initiatives

It is vital that vulnerable children, their families and the wider community actively participate in the development of policy on community-based care and in the design of implementation strategies. Community participation is important because it can help to identify which are the most vulnerable children within the community, and why. Moreover, community participation helps to ensure that programmes are relevant, feasible and successful.

Form coordination teams at the provincial level to facilitate strategy implementation

For the purposes of this assessment, discussion groups were convened at the provincial level to discuss issues relating to the care and protection of vulnerable children. For many participants, this was their first opportunity to share experiences with others working in the same field and several of these discussion groups indicated their intention to meet in the future in order to continue to learn from each other's experiences. It may be possible to transform these discussion groups into provincial coordination teams with responsibility for facilitating the implementation of national strategic objectives on the care and protection of vulnerable children.

Coordination teams could receive information and guidance from the MoLSW, but also learn about and document successful community initiatives and community preferences for different options.

Improve management systems, increase collaboration and improve the division of labour between different agencies working to support vulnerable children and their families

Efforts to limit the spread of HIV/AIDS in Lao PDR currently suffer from difficulties similar to those experienced in other counties during the early stage of epidemic management. The roles and responsibilities of different agencies are not as clear as they could be, leading to problems of coordination between the Department of Labour and Social Welfare, Committees for the Control of AIDS and the Department of Health at national, provincial and district levels. During this assessment, for example, Provincial and District Committees for the Control of AIDS complained about their workloads, but were failing to share tasks that might have been conducted collaboratively with other ministries.

The roles and responsibilities of staff within each agency also need to be clarified and individual job descriptions should be developed for all staff detailing specific areas of responsibility.

The internal management systems of social welfare agencies were found to be weak, particularly at the district level. NCCAB is currently improving its management systems and should continue this effort; the MoLSW should consider undertaking a similar review of management needs at the district level.

Care should be taken to avoid duplication of resources wherever possible. On the other hand, it is essential that all relevant agencies are represented in planning and implementing bodies. Currently, MoLSW officers are not included in all DCCAs and this needs to be addressed.

Improve national data collection systems on vulnerable children

Better data is needed to enable policy makers and planners to identify which children are most in need of care and protection and to develop programmes addressing their needs. Data collection systems should be improved to provide accurate, disaggregated data. However, care should be taken not to encourage enumeration of vulnerable children for its own sake or as a special project - communities soon tire of counting children without receiving benefits afterwards. Before devising new data collection systems, efforts should be made to make full use of quantitative and qualitative information that is already collected on a routine basis; the priority should be to ensure that data already collected at the village level finds its way to planners and policy makers at the district, provincial and national levels.

More accurate data on HIV/AIDS is also urgently needed. It is clear from the occupational data collected by HIV test centres that the existing model of periodic surveillance misses the most at-risk population group. Labour migrants are the largest single group of known HIV+ people in the country, yet they have not so far been included in periodic surveillance.

While the NCCAB is aware of this situation, it has concluded that for the time being surveying migrants is too difficult given the mobile nature of this population. This could prove to be an extremely dangerous delay given that the window on epidemic containment may be closing. The NCCAB should take steps to ensure that all at-risk groups are targeted by the national HIV/AIDS surveillance system.

Advocacy for community-based child protection measures

Advocacy is needed at both the national and local levels to promote and improve community-based initiatives for the care and protection of vulnerable children. During this assessment it became clear that some parents, local officials and policy makers believed institutionalisation to be an acceptable means of providing food, shelter, education and basic services to orphans and children from poor families, which runs counter to the spirit of the CRC. The MoLSW should, as a priority, seek to raise awareness regarding the limitations of institutional care arrangements and the advantages of community-based care. Advocacy can work at different levels: among national policy makers it would help to secure more financial resources for the social welfare sector; among villagers it would help to improve community solidarity and motivate individuals to be proactive in assisting vulnerable families and their children. Such advocacy work would contribute to broader strategies for poverty alleviation, since orphans and widows have been identified in this and several other studies as particularly vulnerable population groups.²⁶

Increased funding for social welfare work

Limited resources are currently available for social welfare work. The result is that social welfare officers are able to provide assistance only when a child or their family has already reached crisis point. Emergency assistance can provide short-term relief, but is rarely able to tackle long-term causes of vulnerability or offer long term solutions. The MoLSW needs to compliment emergency assistance with programmes for community development and community rehabilitation that address long term causes and deliver long term impacts. More resources should be allocated to social welfare departments in order to help them undertake this additional work.

²⁴ See for example, *Participatory Poverty Assessment: Lao PDR*, ADB, Philippines, 2001.



Annex 1: Primary data sources

The table below summarizes the main methods of information collection used during the assessment:

Guided Discussion Groups (5 to 7 per province)	Case Studies	In-depth Interviews (2 to 3 per province)	Quantitative Data
<ul style="list-style-type: none"> ● Provincial and district social welfare staff ● PCCA and DCCA members ● Village committees (males and females separate) ● Vulnerable children ● Families of vulnerable children ● HIV+ adults and their children ● Caregivers of orphans ● Buddhist leaders 	<ul style="list-style-type: none"> ● HIV+ people and their families ● Vulnerable children 	<ul style="list-style-type: none"> ● PLWHAs ● Families ● Caregivers ● Orphans and other vulnerable children ● Monks ● Ethnic Minority Boarding Schools ● SOS Children's Villages 	<ul style="list-style-type: none"> ● PCCA & DCCA data on people living with HIV/AIDS ● Provincial Labour and Social Welfare Department data on orphans and vulnerable children

Annex 2: Secondary data sources

The table below summarizes secondary sources of information that contributed to this study:

Category of information	Policy documents, special surveys and studies
Background information on vulnerable children and their families	<ul style="list-style-type: none"> ● <i>Results from the Population Census 1995</i>. National Statistics Centre, Vientiane, 1995. ● <i>Basic Statistics of the Lao PDR, 1975-2000</i>. National Statistics Centre, Vientiane, 2001. ● <i>Basic Statistics about the Socio-Economic Development in Lao PDR</i>. National Statistics Centre, Vientiane, 1998. ● <i>The Households of Lao PDR: Social and Economic Indicators - Lao Expenditure and Consumption Survey, 1997/1998</i>. National Statistics Centre, Vientiane, 1999. ● <i>Multiple Indicator Cluster Survey (MICS II)</i>. National Statistics Centre / National Institute of Public Health, Vientiane, 2001. ● <i>Health Status of the People in Lao PDR</i>. National Statistics Centre / National Institute of Public Health, Vientiane, 2001. ● <i>Participatory Poverty Assessment: Lao PDR</i>. Asian Development Bank, Philippines, 2001. ● <i>Convention on the Rights of the Child</i>. National Commission for Mothers and Children / UNICEF, Vientiane, 2002. ● <i>Report on Early Childhood Development Pilot Cohort Study</i>. UNICEF, 2000. ● <i>Traditional Child Rearing Practices</i>. UNICEF, Lao PDR, Vientiane, 1994. ● Priority problems at village level identified by UNICEF's Learning for Child and Community Development program. ● MoLSW data from selected provinces, 1996 to 2003, presented to UNICEF.

Secondary data sources (cont'd)

Category of information	Policy documents, special surveys and studies
HIV infection rates	<ul style="list-style-type: none"> ● <i>National Strategic Plan on HIV/AIDS/STD, 2002-2005</i>. MoPH/NCCAB, 2002. ● <i>Epidemiological Fact Sheet on HIV/AIDS and sexually transmitted infections in Lao PDR</i>. UNAIDS, 2002. ● <i>HIV Sentinel Surveillance and STI Periodic Prevalence Survey, Lao PDR</i>. MoPH / NCCAB, 2001. ● <i>Behavioral Surveillance Survey, Lao PDR</i>. MoPH/ NCCAB, 2001. ● <i>Community Action for Preventing HIV/AIDS in Lao PDR</i>. Asian Development Bank, Vientiane, 2003. ● <i>HIV Vulnerability Assessment Report of the Second Mekong Bridge Construction</i>. World Vision/JBIC, 2003. ● Case data from NCCAB on each province, July 2003.
Orphans (AIDS and non-AIDS)	<ul style="list-style-type: none"> ● <i>Multiple Indicator Cluster Survey (MICS II)</i>. National Statistics Centre / National Institute of Public Health, Vientiane, 2001. ● <i>Health Status of the People in Lao PDR</i>. National Statistics Centre / National Institute of Public Health, Vientiane, 2001.
Children at risk of HIV infection	<ul style="list-style-type: none"> ● <i>Adolescent Reproductive Health Survey, Sayaboury Province</i>. Lao Youth Union, Lao Women's Union, et al. 1999. ● <i>Adolescent Reproductive Health Survey, Oudomxay Province</i>. Lao Youth Union, Lao Women's Union, et al. 1999. ● <i>Lao Reproductive Health Survey 2000</i>. National Statistics Centre / UNFPA, Vientiane, 2001.
Street children	<ul style="list-style-type: none"> ● <i>Street Children and Child Beggars</i>. MoLSW, UNICEF, Vientiane, 2001 ● MoLSW data from selected provinces, 1996 to 2003, presented to UNICEF
Trafficked children	<ul style="list-style-type: none"> ● MoLSW data from selected provinces, 1996 to 2003, presented to UNICEF.
Voluntary migrants	<ul style="list-style-type: none"> ● <i>How I Got Here</i>. MoLSW/UNICEF, Vientiane, 2001. ● MoLSW data from selected provinces, 1996 to 2003, presented to UNICEF. ● Village mapping as part of UNICEF's Learning for Child and Community Development program. ● Chantavanich, S., <i>Mobility and HIV/AIDS in the Greater Mekong Subregion</i>. ADB, 2002.
Substance Abuse	<ul style="list-style-type: none"> ● <i>Drug Abuse Among Youth In Luang Prabang: School Survey Report</i>. UNODC, Vientiane, Aug 2001. ● <i>Drug Abuse Among Youth In Savannakhet: School Survey Report</i>. UNODC, Vientiane, Aug 2001. ● <i>Drug Abuse Among Youth In Vientiane: School Survey Report</i>. UNODC, Vientiane, May 2000. ● <i>Drug Abuse Among Disco Clients In Vientiane</i>. UNODC, Vientiane, 2002 ● MoLSW data from selected provinces, 1996 to 2003, presented to UNICEF.
Children with disabilities	<ul style="list-style-type: none"> ● <i>Bridging the Gap – Survey of Disabled Children and Adults</i>. National Rehabilitation Centre/ Handicap International, Vientiane, 1999.
Abandoned children	<ul style="list-style-type: none"> ● MoLSW data from selected provinces, 1996 to 2003, presented to UNICEF.
Children in institutions	<ul style="list-style-type: none"> ● <i>Addressing the Health and Education Needs of Ethnic Minorities</i>. Asian Development Bank, 2000. ● <i>Lao PDR Country Presentation</i>. Presented at the Stockholm Conference on Children and Residential Care, 12-15 May 2003.

Vientiane, 2004

Photos: UNICEF / Jim Holmes

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