Achieving behaviour change: three generations of HIV/AIDS programming and jargon in Thailand

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NGOs have played an important role worldwide in the fight to prevent the spread of HIV/AIDS through achieving behaviour change. NGOs have often been at the forefront of innovative changes, influencing government and international programming activities. This paper identifies and analyses the evolution of the HIV/AIDS programmes of one NGO in Thailand over a period of ten years. Three generations of programming are identified both through distinct approaches to this area of work and through the changing jargon used to describe the people the programmes are aimed at.

Introduction

Despite more than a decade of interventions, the incidence of HIV/AIDS continues to increase throughout the world. It is estimated that 19 million people have died as a result of the virus and that more than 34 million people worldwide are currently infected (UNAIDS 2000). While the prevalence rates in Asia are lower than those in sub-Saharan Africa, the high population densities in that region result in a large number of people with the virus. In addition, Asia now accounts for more than half of new HIV infections each year. Thailand has been particularly affected, with estimations that up to 9 per cent of Thailand’s GDP will be lost as a direct result of the epidemic (Baker 1997).

Within social environments that are constructed primarily through public policy, NGOs have played an important role worldwide in trying to prevent the spread of HIV/AIDS through achieving behaviour change. World Vision Australia and World Vision Foundation of Thailand have been working in partnership since 1991, with the support of AusAID, to reduce the incidence of HIV/AIDS. During this time, however, both the incidence and prevalence rates of the disease have increased significantly, not only in Thailand but also throughout Asia. Over the past decade, World Vision1 has seen drastic changes in its HIV/AIDS programming, including changes in the jargon used to describe programme beneficiaries in its 11 projects. It is now an appropriate time to step back momentarily and look at these changes made in ‘the heat of the battle’.
Matthew Clarke

HIV is transmitted through the exchange of bodily fluids. This occurs generally through sexual intercourse, the sharing needles containing infected blood, incorrect dressing of infected wounds, and, from mother to child, across the placenta or while breastfeeding. Since it is widely believed that behaviour change can eliminate all these modes of transmission (with the exception of intra-uterine transmission), World Vision, like all other interested parties, has sought to bring about such change over the past decade. Upon examining these attempts, we can identify three generations of programming. Each generation reflects a distinct attempt to achieve sustainable behaviour change in response to changing epidemiology, transmission patterns, and lessons learned over time. These new paradigms of how to achieve behaviour change are also succinctly captured in the changes to the jargon used to describe programme beneficiaries.

Underlying all generations of programming has been the assumption that changing people’s behaviour is the key to reducing the incidence of HIV/AIDS. The first generation of programmes focused on simple information dissemination. The second targeted more specific groups and sought to provide information and counselling for those with the virus. The third generation focused on establishing an environment that would enable people to change their behaviour.

The change in jargon simultaneously reflected and affected these new generations. Underpinning each of these ‘generational changes’ was a new understanding of the epidemic and of how the virus was being transmitted. As a powerful tool to communicate ideas, language plays an important role in supporting responses to various situations. ‘The way people communicate about their lives and the epidemic is an integral part of their understanding, which in turn is the basis of the action they take’ (Parnell et al. 1996:63). The terms in which communities and aid programmers discuss the epidemic affect their responses and actions.

Jargon can express complex concepts in a simple manner. Parnell et al. (1996) identified the use of HIV/AIDS jargon in Zambia, the Philippines, Senegal, and Mexico targeted to make very complex concepts more easily understood and explained. Five distinct types of jargon (including metaphors) were identified: social engineering, war, farming, building, and family.

The social engineering metaphor focuses on experts and interventions. War jargon focuses on targets, enemies, and victims. The farming image focuses on planting and growing. The building approach uses concepts such as solidarity, mutuality, and belonging, while family metaphors focus on supporting one another and working together.

Within World Vision’s HIV/AIDS programmes, the first two (social engineering and war) were used primarily by programmers, while the remainder were used by the affected communities (Chiang Mai I 1991; Mae Sai II 1993; Thai–Burma Border AIDS Project 1996).

As the epidemic evolved and programmes became increasingly sophisticated, the choice of jargon (though remaining in the sphere of social engineering and war) also reflected the distinct types of programme generations. The evolution across programme generations was an unplanned phenomenon not explicitly identified at the design stage. The simultaneous shifts in terminology both reflected and informed the changes in programming. By studying these evolving programme approaches and the changes in terminology used, it is possible to map the changing paradigms of HIV/AIDS programmers over time. The changing paradigms in turn reflect the changing epidemiology of the virus.

Thus, the jargon used to identify programme beneficiaries is more than just a shorthand term to describe a person’s health. It describes a complete approach to HIV/AIDS programming. New jargon was necessary not only to capture programme interventions and activities, but also
to influence those changes. For example, the expression ‘people affected by AIDS’ provides implicit permission to target those who were HIV negative as well as those who were HIV positive.

While the constant emphasis on behaviour change is valid, it has been an elusive goal. Three generations of programmes have tried and failed. How many more generations of programming and shifts in terminology must occur before we achieve real and lasting behaviour changes that lead to reduced incidence and prevalence of HIV/AIDS?

This paper addresses the significant limitation of NGO-specific evaluations of HIV/AIDS programmes within the current literature (see Pisalsarakit 2000; Parnell et al. 1996 for rare exceptions). The paper specifically focuses on the work of World Vision in Thailand and traces how its HIV/AIDS programmes have evolved from handing out pamphlets to providing cross-border health clinics, and from a focus on victims to a more inclusive approach that incorporates all those infected or affected by HIV/AIDS. While beyond the scope of this paper, it would also be interesting to compare and contrast the evolution of World Vision’s HIV/AIDS programmes with those of other NGOs working in similar areas.

World Vision’s projects were located all over Thailand, including Chiang Mai, Ranong, Mae Sai, Mae Sot, Songkhla, and Hat Yai. Due to the loose coordination among NGOs in the field, no other NGOs worked with the same communities as World Vision. However, organisations such as the Red Cross, Population and Community Development Association, and other local NGOs were working in neighbouring communities. A major limitation of World Vision’s programmes was a lack of interaction with other NGOs. While World Vision collaborated with local Ministry of Public Health (MOPH) officials, such collaboration with other NGOs did not exist.

Despite this lack of NGO collaboration, World Vision’s programmes occurred within a positive public policy environment throughout Thailand. The Thai government first acknowledged the existence of HIV/AIDS in 1991 and soon began implementing public communication campaigns. These campaigns (see Lyttleton 2000 and Limanonda et al. 1995 for succinct summaries) focused on public education and promotion of condom use. In addition, the government began undertaking testing and surveillance in order to develop and maintain accurate records of the epidemic. While World Vision’s programmes evolved significantly over the decade, public policy remained anchored primarily in public education campaigns, testing, and surveillance (Packard-Winkler 2000). However, such an environment proved helpful to the establishment and evolution of World Vision’s programmes.

Pre-programming

Prior to the first HIV/AIDS programmes undertaken by World Vision in Thailand, those with HIV/AIDS were simply referred to as ‘victims of AIDS’ or ‘AIDS victims’. This terminology implied that the HIV-positive person was powerless and passive. ‘Victim’ denotes someone who finds him/herself in his/her position because of the actions of someone or something more powerful. Thus, being an AIDS victim implies being powerless and at the mercy of others, and it also reflects a lack of choice. The consequences of people’s behaviour are not taken into account. Victims are not only disempowered but also blameless, innocent third parties who should be pitied. There is little that can be done to reduce one’s own risk of becoming a victim because one cannot control the behaviour of the perpetrator.

In trying to design a programme for HIV-positive people, labelling various groups as victims is not an effective strategy to help them. Victims cannot help themselves and so any project activities would lack sustainability. Programmes focusing on victims are characterised by subservience and domination.
Matthew Clarke

The evolution from this position to the first generation of HIV/AIDS programmes (and later to subsequent generations) was organic in the sense that these changes were reactions to internal activities and lessons learnt. The changes were not brought about by a grand exogenous plan but rather by exogenous factors that were revealed through monitoring and evaluation. These occurred in isolation from other NGOs and soon began to deviate from public policy. Indeed, such an evolution is not consistent among other World Vision programmes in neighbouring countries such as Vietnam (see National Highway One 1996).

The first generation—information dissemination

The shift in terminology away from ‘AIDS victims’ came at the beginning of the first generation of HIV/AIDS programming. The new terminology to explain the paradigm of programming was ‘People with AIDS’ (PWAs). This new term no longer defined people who suffered from AIDS as ‘victims’, and therefore did not see them as powerless. They were simply people who were HIV positive and who continued to live their lives as best they could. This terminology was linked closely to Generation One programme interventions, which consisted of education campaigns, capacity building of local public health officials, and the expansion of HIV testing (Chiang Mai I 1991). Information was needed to stop people from becoming ‘people with AIDS’, local public health officials had to be trained to treat ‘people with AIDS’, and more testing had to be undertaken to identify ‘people with AIDS’.

Starting in the north of Thailand in 1991, the Chiang Mai I HIV/AIDS project was the first of this generation. (Two similar projects began soon after in Mae Sai and Ranong.) The prime focus for this project was the use of information, education, and communication (IEC) materials to inform people about the virus and about the ways in which they could protect themselves from infection.

Complementing the larger public awareness campaign to change public policy (Packard-Winkler 2000), the major focus of the IEC materials was on high-risk groups and their behaviour. This group included commercial sex workers (CSWs) and their clients. Intravenous drug use and homosexual sex were not considered high-risk activities, as the incidence of transmission through such behaviour was low. Drug users and homosexuals were therefore not considered a specific target group. It was expected that behaviour change would lead to less unprotected sex with CSWs and to an overall reduction in the number of visits to CSWs.

The project had a number of planned outcomes. First, that the target group of CSWs and their clients would gain greater awareness of the danger of HIV and knowledge of how to prevent its transmission. The final evaluation of the project found that knowledge of the disease, spread through community educators, was quite high (educators received information training and then trained their communities). However, there were some misunderstandings about prevention. While it was understood that condoms should be used in high-risk behaviour (sex with CSWs), it wasn’t fully appreciated that condoms should also be used with all sexual partners, including wives and partners if unprotected sex had previously been undertaken with CSWs or other partners (Chiang Mai III 1993).

A second planned outcome was a more positive attitude towards PWAs. Because there had been some misinformation regarding the transmission of HIV/AIDS prior to the project, many communities ostracised people with AIDS. As a result, there was great reluctance among infected people to share their virus status with neighbours and even family. The final evaluation found that this goal had been achieved. This was evidenced by a growing number of HIV-positive people and people with AIDS participating in community life. There was also a greater number of people attending funerals of those who had died of AIDS. This is a
reflection of both the success of the mass education campaign and of the fact that HIV/AIDS became more widespread in the general community.

The project also aimed to improve MOPH capacity in surveillance and care of HIV-positive people. The accepted thinking at this time was that the responsibility for caring for PWAs lay with the MOPH. Home care was not yet considered possible. The other important lesson was the increasing need to find strategies for the care of PWAs and their families. As the incidence of HIV/AIDS was not decreasing, there was an increasing demand on the resources of the MOPH, which was not sustainable. Thus, community acceptance of PWAs was no longer enough. A more proactive role in caring for the families and the people affected by HIV/AIDS became increasingly important: in the future, it would be necessary to provide home care for those with HIV/AIDS.

The overall aim of reducing the incidence of HIV/AIDS was not achieved in this generational phase of the programme. However, the final evaluation noted that the key to achieving this goal still remained behaviour change. The project initially sought to change behaviour by providing the community (and particularly those engaged in high-risk behaviour) with information about the dangers of the virus and how to prevent its transmission. But by the end of the project it was clear that information would not change people's behaviour:

*Behaviour change requires much more than knowledge and awareness of HIV/AIDS. The major strategy of the project was to increase the knowledge and awareness about HIV in the five districts, which is not enough to lead to behaviour change. Secondly, behaviour change often occurs over longer periods of time than the life of the project, so it is perhaps unrealistic to expect reduction in the incidence of HIV in two years. (Chiang Mai III 1993)*

Despite all this, project interventions were not yet centred on those affected by AIDS. The emphasis was on those who did not have AIDS to help them avoid becoming 'people with AIDS'. Stigmatisation still existed (Chiang Mai III 1993) and, despite great improvements, 'people with AIDS' were often excluded from community activities. Under Generation One programmes, ‘people with AIDS’ were still a passive group, in the background, and certainly pitied.
The second generation—specific information

Phase Two of the Chiang Mai AIDS project (1993–1995) was based on the lessons learned and the recommendations made in the Project Completion Report of the first phase of the project (Chiang Mai II 1993).

Responding to the increasing numbers of people becoming HIV positive, World Vision’s programmes in Thailand began to reflect a changing priority. The new terminology became ‘People Living with AIDS’ (PLWA) or ‘People Living with HIV/AIDS’ (PLWHA). People living with AIDS were capable of participating in project activities, and project interventions were increasingly aimed at them as their numbers grew. Those who had HIV/AIDS became increasingly centrally to Generation Two projects, rather than marginal, as was the case with the earlier mass education campaigns. Paradigms of programming shifted to recognise the need to offer care and support to PLWAs, and this was reflected in a change in the jargon.

Behaviour change continued to be the goal and education remained the primary tool with which to achieve it. However, this second generation project differed from the first in that the education was to be specifically targeted and used in conjunction with back-up services and counselling for those with HIV/AIDS, and care was to be provided to those with HIV/AIDS. Based on previous experience, the target groups were widened to include, in addition to CSWs and their clients, teachers, students, monks, undertakers, traditional healers, local leaders, and factory workers. Target groups were also extended geographically to cover five more rural areas in addition to the five urban districts covered in the previous phase of the programme. The intended behaviour change was also extended from avoiding transmission of the virus to changing how those with HIV/AIDS were cared for and treated.

More specific IEC materials were used in Generation Two programmes. Pamphlets and newsletters were used as well as flipcharts, stickers, leaflets, and posters. The project also began to develop local dialect audio tapes that could be used over community public address systems as well as video tapes that could be shown at community meetings. The use of local dialects was innovative and brought the messages closer to the target groups. There was also an increased effort to tailor the IEC materials to specific audiences. It was realised that primary school children and men frequenting brothels needed different information!

As the number of PLWAs grew, the need for a support mechanism for them and their families became increasingly important. Clubs for PLWAs, known as ‘Thursday Clubs’, after the day on which they originally met, were established. These clubs provided the opportunity for members to come together with others facing similar concerns to talk and offer each other moral support. Activities ranging from nutrition to artificial flower arranging were planned each month.

Assistance was also given to families affected by HIV/AIDS in the form of financial and moral support. The reality was that families were often left to care for their sick. The increase of illness among PLWAs was putting great strain on the resources of the MOPH. Many patients couldn’t obtain the level of care they needed through the Ministry and so their families were left to look after them. These family members had no training or resources available to them and often used unsafe caring techniques. For instance, they often did not know about the proper disposal of contaminated dressings, or about the nutritional needs of those infected with AIDS, or about the care of AIDS-related conditions (ARCs) and secondary illnesses. Peer trainers were trained in some home care techniques but only towards the end of the project (Chiang Mai II 1993).

The emphasis of other Generation Two projects was also on achieving behaviour change among high-risk groups (CSWs, fishermen, and illegal migrants from Burma) through the
dissemination of information via IEC materials (Ranong II 1993; Mae Sai II 1993). For example, in Mae Sai it was found that many CSWs spoke neither Thai nor Burmese but rather a local language in which they were also illiterate. Therefore the IEC materials used had to be visual or oral.

It was also recommended that the materials for all target groups be broadened to include more than messages regarding HIV or the care of PLWAs, as this could well have negative effects on those infected. In addition, it was recognised that the virus was no longer of importance only to certain high-risk groups but to the community at large. The lesson learned was similar to the concept of the ‘enabling environment’ put forward by Parnell and Benton (1999). The final evaluation emphasised that a broader approach was needed for health interventions so as not to focus solely on HIV/AIDS care but rather on community health in general:

Perhaps the major lesson learned over the past two years is that HIV/AIDS interventions need to be part of a greater whole. This has already been demonstrated in Ranong with the development of a Primary Health Care project with the Burmese communities in Ranong. Both projects have become interdependent and from them a new intervention with Burmese and Thai street children has been developed. It is through helping communities address their most pressing needs that HIV interventions can be most effectively channelled. (Ranong II 1993)

Given the importance of cross-border activities, it also became clear that working on one side of the border was not sufficient. Both Ranong and Mae Sai were busy border crossings with heavy traffic moving in both directions. In Mae Sai, many Burmese CSWs with the virus were travelling back to their communities. Conversely, there were many young women (some only girls) from Myanmar/Burma who were crossing the border to begin commercial sex work in Thailand. A growing number were from hill tribes, did not speak Thai, and were unaware of HIV/AIDS prevention measures. At each crossing point a coordinated HIV/AIDS programme had to be in place for the HIV/AIDS interventions to be effective (Ranong II 1993; Mae Sai II 1993).
The third generation—enabling environment

By the mid–1990s there was a high general awareness of HIV/AIDS, its transmission, and high-risk behaviour throughout the Thai community as a result of World Vision’s work, the work of other NGOs, and the widespread public policy campaign coordinated by the National AIDS Committee. Concurrently, however, the incidence of HIV/AIDS was also increasing. Not only had the two previous methods of achieving sustainable behaviour change failed, but the demand on the Thai MOPH to provide care was also beyond its resources. Generation Three projects recognised the need to develop a strategy of home care, support, and networking to provide an environment supportive of sustainable behaviour change. While this was beyond the scope of official public policy (Packard-Winkler 2000), no limitations were placed on World Vision to initiate programmes in this area:

...the aim of this project was to enhance the healing process for the patient, both mentally and physically. By working together, the project staff, patients, and family designed an appropriate home health care plan, which was responsive to the particular needs of the individual patient. By taking the resources away from the hospital and (putting them) into the home, this innovative pilot programme paved the way for new health care strategies for HIV positive patients not only in Chiang Mai but also in Thailand generally. (Chiang Mai III 1996)

Home care was a more effective method of taking advantage of MOPH resources. Instead of having patients seeking treatment at the hospital and occupying hospital beds, patients were encouraged to stay at home for as long as possible and receive care from their families with regular visits from the hospital staff. Not only did patients receive more attention at home, but also the familiar environment was more conducive to improved health.

This project was the first of its kind in Thailand, and therefore had to develop the processes to operate the outpatient care programme. A special patient register was produced which listed all pertinent information, including address, episodes of illness, medication, family members, and general health indicators checked regularly such as blood pressure, temperature, etc. It was important to build relationships between hospital staff and family members so that the latter would be comfortable with home visits. One member of the project team was a psychologist who was available to the patients and their family if they needed counselling. This was an innovative addition to normal staffing levels.

Hospital staff were now able to provide ongoing treatment to the patients as well as advice to the care takers on the administration of medicines, nutrition, and home nursing, including the disposal of contaminated dressings. The pilot project highlighted the importance of keeping PLWAs at home whenever possible. Home visits meant that the person’s mental and physical state was taken into account and the condition of the carer was also checked. It was easier to discuss issues related to home care at the patient’s home than at a clinic. This was a significant improvement on the use of limited MOPH resources (Chiang Mai III 1996).

It was also important to recognise that enabling environments are different in each community. Acknowledging the increase in migration and the fact that the transmission of HIV/AIDS was now spreading beyond the traditional high-risk groups through high-risk behaviour, World Vision undertook a three-site project aimed at coordinating the HIV/AIDS interventions at the Thai–Burmese border points. The interventions undertaken in the Thai–Burma Border AIDS Project (1996—an extension of the Mae Sai and Ranong projects with the addition of the western border town of Mae Sot) differed from the Chiang Mai Phase III project, even though both are Generation Three projects.
It was realised that HIV/AIDS was no longer only a problem facing high-risk groups undertaking high-risk activities and that information could not on its own change behaviour. It was at last accepted that behaviour change was not predicated solely on information or education but rather that change occurred within an enabling environment. People change for different reasons and at different times. Change cannot be forced upon them. Change is best achieved if people are able to create their own enabling environment (Parnell and Benton 1999):

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\ldots\text{fundamental to each component project is the assumption that HIV/AIDS }\ldots\text{ information, though still vital for some target communities, is not, in itself, sufficient to influence the control of HIV transmission through behaviour change or promote the concept of community care. (Thai–Burma Border AIDS Project 1996)}
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 Paramount to the enabling environment to the Burmese populations of Ranong was income generation and the development and maintenance of effective and comprehensive health services. The border project assumed partial responsibility for a primary healthcare programme that had been run independently by World Vision. By the end of the project, the MOPH was providing health services to the wider illegal migrant population. Therefore, not only is general healthcare being provided but it is being provided in conjunction with counselling for HIV positive people without any ostracism. In addition, income-generating activities were implemented to allow not only those with HIV/AIDS or their families, but the community at large, to make a better living. This was in response to the recognition that HIV/AIDS is linked closely to poverty.

Thus, rather than having an output focusing on IEC materials for target groups, this programme’s objective was to foster behaviour change strategies developed and implemented within a broader community, which facilitates the emergence of an enabling environment. It also focused on community groups that have HIV/AIDS as only one part of its activities. It took an integrated approach to working with community groups to make HIV/AIDS only one part of a broader health programme.

The most common method of transmission of the HIV/AIDS virus also changed in this period. Intravenous drug use and the sharing of needles became the dominant pattern. Project activities needed to respond to this change in an appropriate way, given the illegal nature of this activity and the difficulty of receiving permission to distribute syringes to drug users.

Due to the frequent cross-border movement of people, a coordination of project activities on both sides of the border became increasingly necessary. Although World Vision was working on both the Thai and Burmese sides of the border, formal coordination was still difficult.
While the term ‘people living with AIDS’ highlighted the ability of people with HIV/AIDS to continue to live their lives, the terminology did not adequately capture the wider community and the impact of the epidemic on it. In an attempt to correct this bias, anybody who was HIV positive, had AIDS or AIDS-related conditions, was a family member or care taker, or anybody in the community who was touched by the disease (which could be considered everyone—if for no other reasons than economic reasons) came to be described as fitting under the category ‘People Affected by AIDS’ (PABA). The change to PABA not only reflected the change in emphasis of the Generation Three programmes, but also informed the shifting of activities by making it easier to justify these to key stakeholders. In addition, the movement to the new acronym PABA incorporated a gendered perspective of the HIV/AIDS problem: since women are the primary carers and also lack power within marital and commercial sex work relationships, they are a very high-risk group as a whole and carry a particularly heavy burden in Thai society with regard to HIV/AIDS.

Conclusion—fourth generation and the end of acronyms

HIV/AIDS programming has changed dramatically over the last decade. Achieving sustained behaviour change has remained the constant aim, but how to achieve it has been a more fluid question. Over this period, the situation of HIV/AIDS in Thailand has undergone significant transformation. Behaviour change is not linked to simple information dissemination. While IEC materials are useful, in themselves they are not enough to produce behaviour change. In addition IEC materials which can include visual, audio, or other aids in local dialects have to be tightly targeted to specific communities and be as accessible as possible. There is now a generally high awareness level of HIV/AIDS and its transmission and prevention throughout Thai society as a result of the use of IEC materials in conjunction with an effective health promotion programme.

Enabling environments must now be established and supported in order for change to take root and become sustainable (Parnell and Benton 1999). This will require a much greater integration of HIV/AIDS programmes within general community development programmes. It also means that there is no single blueprint for establishing a good HIV/AIDS programme, with needs differing from one community to another and even within communities. Responding to these different needs requires the use of participatory action research by project and community health staff in the future. For some communities, it may include an emphasis on primary healthcare; in others it may be poverty alleviation, or literacy and numerical skills. The virus is no longer transmitted mainly through participation in illegal activities, such as commercial sex work or intravenous drug use. Nowadays, all sexual activities must be considered as high risk.

The fourth generation programmes are only now beginning to be designed. They will need to focus on issues of migration and sub-regional transmission. Removed from traditional support mechanisms, mobile populations are more likely to behave in unsafe ways. Target groups now encompass whole populations from a number of countries.

Hence, country-based programmes are less effective for these mobile populations, and capacities to work with them effectively must be developed by key stakeholders. This may include providing care and support within their original or host communities.

The terminology is also expanding. To make it clear that HIV/AIDS is dealing with those who can be HIV positive and HIV negative alike, the word ‘infected’ has to be included, and hence ‘people affected and infected by AIDS’ is now the term being used. These new projects incorporate the understanding that the result of mobile populations is a wide-ranging target group often including nearly all of the host and original communities. In addition, while the
interventions required by those ‘infected’ will be different from those needed by those ‘affected’, successful programmes must incorporate all of these different interventions into one project.

The future of HIV/AIDS programming will continue to be centred on trying to achieve behaviour change. As HIV/AIDS is closely related to poverty, general community development must also be a priority.

The evolution of HIV/AIDS programmes mirrors the evolution of the changing epidemiology and transmission modes of HIV/AIDS in Thailand. Jargon can become a historical marker denoting changes in HIV/AIDS programming. While not foolproof, its use can reveal much about an HIV/AIDS programme, its interventions, its target groups, and the paradigm upon which it was developed. World Vision has been innovative in its approach to programming, and, while the epidemic is far from over, many lives have been saved through the interventions of World Vision as well as many other NGOs working in Thailand. In order to continue to address the HIV/AIDS problem in ever more innovative and successful ways, the sharing of experiences and lessons learned among NGOs needs to be documented and widely discussed.

Acknowledgements

The author would like to thank Eileen Darby, Tim O’Shaughnessy, Karl Dorning, and Bruce Parnell for their assistance, discussions, and comments during the preparation of this paper.

Note

1 World Vision in this paper refers to the bilateral partnership between World Vision Australia and World Vision Foundation of Thailand. It is understood that other HIV/AIDS projects may have been undertaken by other World Vision entities.

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