



CATALYST

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Newsletter of Cyriac Elias Voluntary Association (CEVA), Kochi

From the Chief Editor

Everyone knew it was going to happen and that it was just a matter of time. Finally it happened. A recent UNAIDS report says that India has overtaken South Africa in terms of the number of people affected with Human Immunodeficiency Virus (HIV). According to the report, India has 5.7 million HIV positive people compared to 5.5 million in South Africa. This means that our country has the world's largest population infected with the deadly virus.

Against this backdrop, the question that arises in the mind of any concerned person is, 'Is there no light at the end of the tunnel?' Well, there are evidences to suggest that HIV does yield to determined and concerted intervention. Sustained efforts in diverse settings have helped to bring down HIV incidence among homosexuals in western countries, among young people in Uganda, among sex workers and their clients in Thailand and Cambodia and among drug users in Spain and Brazil.

In India, Southern states, despite being the worst hit initially, have emerged most successful in containing HIV spread. According to a study by *The Lancet*, rate of incidence of HIV in South India has fallen by one third in four years. These instances provide sufficient scope to be optimistic about the future. An important learning of these positive developments is that HIV prevention effort works best when they are intensive, i.e. comprehensive and long term. In other words there is no room for complacency of any sort and every concerned citizen has to contribute his/her best in spreading the awareness about HIV/AIDS.

There is no better time for the Catalyst to focus on the issue of HIV/AIDS. In this issue we have tried to put together relevant thoughts of people from varied walks of life.

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response to

HIV/AIDS

In fond remembrance...



Karl Kuebel
(1909-2006)

“How can I be of service?” that was the guiding motto of Karl Kuebel, the outstanding entrepreneur, visionary and philanthropist, who passed away on the 10th of February, 2006, peacefully at his home.

Karl Kuebel was born in Duisburg as the eighth of nine children of the master carpenter Carl Kuebel and his wife Maria on 6th September 1909. He began his apprenticeship as hardware salesman in 1923. At the age of 23 he formed his own company and over the next 40 years he built up a leading furniture producing company in Europe named 3K. The company employed 3800 employees at its peak. Karl Kuebel offered his employees an internal partnership contract since the 1950s.

Karl Kuebel’s philosophy was formed by the religiousness of his parents and his own analysis of catholic social teaching. He aimed at making his employees jointly participate in the development of his company as well as share the profits and finally build up joint ownership. During the post war years, Karl Kuebel encouraged the building of family-oriented homes and was involved in development policy matters. In the 1960s he began to support development projects in Bolivia, Afghanistan, Tanzania and India. In 1972, Karl Kuebel sold the 3K company and donated DM 72 million (appr. 36 million EUR), representing the entire proceeds of the company sale as well as most of his private fortune to his foundation, the Karl Kuebel Stiftung which he founded in the same year.

German Federal President Richard von Weizsaecker awarded Karl Kuebel the Great Order of the Federal Republic of Germany in 1988. In 1995, German Federal President Roman Herzog presented Karl Kuebel the “Medal of Merit of Foundations” of the Federal Association of German Foundations. In December 1995 the Commercial College of the district Bergstrasse was named after Karl Kuebel. Karl Kuebel was presented with the Ring of Honour of the city of Worms in June 1997 and in December of the same year with the Badge of Honour of the city of Bensheim.

Contd. on page 16...

“Bunch of Roses”

Dr. A. S. Sankaranarayanan*

NMCT (Native Medicare Charitable Trust), Coimbatore has been working in the field of HIV prevention for over a decade now, with interventions focusing on school and college students, industrial workers, male sex workers and general public. During the course of our work, we realized the need to focus on care and support systems for People Living with HIV/AIDS (PLHAs). The Periananickenpalayam block of Coimbatore, a predominantly industrial belt was identified as the geographical area for our intervention, which started in 2000. The experience in the field of delivering care and support to PLHAs have been challenging to say the least, sometimes tinged with sorrow at the loss of lives of some of the infected people, whom we had befriended along the way.

I would like to highlight specifically some of our work with children living with HIV/AIDS. These children undergo intense trauma but are unable to articulate their feelings, which increases the burden that they carry. Destitution due to loss of one or both parents, stigma and discrimination, especially in school and amongst their immediate social circle on account of their parents or their own HIV status, economic deprivation and anxiety regarding their own future are some of the crucial issues faced by the children affected by HIV/AIDS.

In our scheme of intervention, a strong network of peer educators in the community helps us to identify the affected families and through them we reach out to the children who number around 90 at present. We also receive calls from people who have heard of us through advertisements and through referrals from government hospitals and private clinics. We have established networks with these institutions for conducting tests for HIV and for treating opportunistic infections of the affected persons.

Enhanced social acceptance and support for the child, both social and economic, forms the crux of our focus. In order to increase social acceptance,

awareness programmes are organized for the community including folk presentations. A Village Development Committee (VDC) has been set up comprising Panchayati Raj representatives, self help group leaders and other influential persons in the village. Orientation programmes for school management also form part of this strategy.

In line with support groups formed for adult PLHAs, five children’s support groups have been set up. These support groups meet every month to discuss issues of concern which also serve as a forum for social contact. In addition, eight children’s clubs are functioning, the members of which include children affected by HIV/AIDS as well as those not affected. This helps in fostering bonds amongst the children and removing the feeling of alienation among the affected children. Selected members of the support group and clubs are provided leadership and life skill training. These representatives transfer the learnings to the other members under the concept of ‘child to child’ education. The training programmes serve to enhance the coping skills of the children in dealing with the pressures of life.

Representatives from the various children’s clubs have come together to initiate a children’s forum called ‘Roja Koota’ (bunch of roses). All the members of the group are encouraged to save money and their collections are deposited in a bank account jointly operated by child representatives, a community representative and a staff of NMCT.

Sponsorships are mobilized for different needs such as education, uniforms and medical care. Cash received from donors under the programme named ‘Join Hands’ is deposited into the savings account and the children prioritize its use. Coin boxes have been placed in different industries and other commercial establishments to enable small donations under the ‘Nanaya Nanbar’ (friendship through coins) scheme.

*Dr. A. S. Sankarnarayanan is the Managing Trustee of NMCT, Coimbatore

Counseling of children is undertaken once they attain a certain age and level of maturity that will help them understand the implications of HIV on their lives. We have become the confidence keepers of many a child who has faced rejection or experienced the trauma of death of his or her parents. We have also faced poignant moments, when parents in the last stages of their life have entrusted children to our care. We

strive to live up to their trust and continue with our work for these children.

Sensitivity, empathy and active support form the core principles of the strategy to deal with the children affected by HIV/AIDS. We do believe that the work of NGOs in this direction will mitigate the suffering faced by the children and help them to look forward to a life of hope.

Some Facts about HIV and AIDS

HIV is a virus. 'HIV' stands for the '**Human Immunodeficiency Virus**'. Someone who is infected with HIV is said to be HIV positive. HIV attacks the body's immune system which makes it dangerous. It is usually the immune system that protects the body from diseases. Since the immune system is affected, HIV infected persons become increasingly vulnerable to illnesses, many of which they would previously have fought off easily. As time goes by, the person is likely to become ill more and more often until, usually several years after infection, they become ill with one of a number of particularly severe illnesses. It is at this point that they are said to have AIDS- when they first become seriously ill, or when the number of immune system cells left in their body drops below a particular point. Different countries have slightly different ways of defining the point at which a person is said to have AIDS rather than HIV.

HIV is transmitted through direct contact of a mucous membrane or the bloodstream with a bodily fluid containing HIV, such as blood, semen, vaginal fluid, preseminal fluid, and breast milk. This transmission can come in the form of anal, vaginal or oral sex, blood transfusion, contaminated needles, exchange between mother and baby during pregnancy, childbirth, or breastfeeding, or other exposure to one of the above bodily fluids.

Acquired Immunodeficiency Syndrome or **Acquired Immune Deficiency Syndrome (AIDS or Aids)** is a collection of symptoms and infections in humans resulting from the specific damage to the immune system caused by infection with the Human Immunodeficiency Virus (HIV). The late stage of the condition leaves individuals prone to opportunistic infections and tumors. Although treatments for AIDS and HIV exist to slow the virus's progression, there is no known cure.

Without drug treatment, HIV infection usually progresses to AIDS in an average of ten years. This average, though, is based on a person having a reasonable diet. Someone in a resource-poor area who might not be adequately nourished may well progress to AIDS and death much more rapidly.

www.avert.org

www.wikipedia.org

Concept Note on Mobile Clinics

Dr. E. Mohamed Rafique*

Mobile clinics provide medical services on wheels. This means service delivery to the target group at their doorsteps. With medical services unavailable to a large portion of the population in India, mobile clinics are a viable option. The role of mobile clinics in the prevention of HIV/AIDS cannot be overestimated.

Why Mobile Clinics to deliver services?

Taking medical service-on-wheels means service delivery to the target group at their doorsteps. It has the advantages of mobility like reaching hard-to-reach spots and covering wide areas with the disadvantages of having fewer infrastructures, equipments and therefore a limitation in delivery of secondary and tertiary services. How best mobile clinics could be utilized is the question here.

What type of services can mobile clinics deliver?

The services that can be provided are:

Medical Services: The point to be noted here is that medical services should ideally be non-stigmatizing, gender-sensitive and cater to both general and reproductive health ailments. Ideally it would be the norm to have same-gendered health care worker as the client, as this definitely brings more health seeking behaviour.

Lab Services: For want of space it would not be feasible to provide lab services. However arrangements would have to be made for collection, labeling, storing and transport of clinical specimens that are gathered.

Counseling Services: This would have to be rendered outside the van in a nearby building or under a shady umbrella out of the earshot of the public.

Behaviour Change Communication (BCC): While medical services help in mitigating the morbidity, it is the BCC and counseling that actually contribute to

the prevention of HIV/AIDS/STIs. The use of BCC in asymptomatic infection management cannot be over emphasized.

Condom Distribution: Prior liaison with the condom franchises set up by the project with other NGOs, government primary health centres, district and taluk hospitals should help ensure a steady supply of various types of condoms required as per the preference of the target population. The team should ensure that condoms are given free or socially marketed.

What are the specifications for a Mobile Clinic?

Taking into account the fact that internal examination of patients necessitates the size of the mobile van at a minimum as big as a sixteen-seater bus. This gives comfort for the doctor to work long hours. There has to be enough space for an examination couch and a rotating stool to be placed along the length of the van. If such a vehicle is chosen it also has enough space for a person to stand. A van of smaller size could be chosen if the seat by the side of the driver is removed to take in part of the examination table. The examination table should be padded and upholstered on both sides so that it can be hinged back to the wall to act as a backrest for the long bench seat below when not in use. The partition between the driver and the rest of the bus should ensure visual and auditory privacy. A medicine cabinet, a well-mounted retractable writing slab, a fan, curtains for the windows, a washbasin and water tank are also required. A portable generator, for the public address system, TV, and other audio-visual equipment, if required, should be fixed in tamper proof boxes in the luggage carrier atop the van.

Who are the target population and the service providers?

The target population would be those people usually found in target area like brothel-based sex workers, floating sex workers, bar girls, trucking community

**Dr. E. Mohamed Rafique is the resource person and moderator for the AIDS Community of United Nations*

etc. If the mobile van is used in a medical camp setting, then others like dependents would have to be catered to. It is envisaged that the health care team manning the clinic would be the personnel staffing the van in addition to the driver.

This health care team would comprise of the doctor trained in Syndromic Method of STI Management in addition to Asymptomatic Infection Management and willing to treat minor ailments of general health nature as well. The counselor, the outreach worker and the staff nurse or clinical attendant complete the team.

When will Mobile Clinics operate?

The timings of operation should be when there is the maximum concentration of the target groups and its attendant target population. The onus of responsibility to determining and constantly monitoring the peak flow of the target groups and accompanying target population through various geographic areas would rest fairly and squarely on the implementing agency. A mutually convenient timetable of visits should be drawn up after consultation with the target groups. Contingency arrangements should be made if the vehicle has to report for maintenance.

How could Mobile Clinics be used innovatively?

The vans should carry collapsible screens and examination table for women, fabricated locally that could be used to set up areas of privacy at the temporary camp for examination of patients or for counseling of client in their workplace. In the area

of BCC, vans could carry the ubiquitous television set and a video cassette player. Local folk art troupe/street theatre performers and relevant print materials for distribution should be carried along. A generator set if electricity is not available at the checkpoint, would be essential to screen the movies/videos etc, about the implementing agency's activities, about sex work, general health, STI/HIV/AIDS etc.

Disadvantages of Mobile Clinic

The space required for parking such a vehicle may not be available in narrow and crowded streets. Some groups of sex workers and bar girls could feel that there is a stigma attached to using services of a mobile clinic. The quality of the various services offered by the clinic would be lower than the static one and this could decrease the follow-up attendance. The capital or rental costs plus the maintenance of the mobile clinic are high and cost effectiveness would therefore be low even if there is good attendance.

Possible alternative for Mobile Clinic

One of the possible alternatives for a mobile van could be a collapsible tent or pre-fabricated material, which could be transported to the area where the temporary camp has to be set up. Another option would be to periodically rent a lodge room, or a portion of a school building, community halls or wedding halls, to set up all the mobile paraphernalia. Hiring a vehicle for a long duration and using it as a mobile clinic could be a stopgap arrangement especially if the implementing agency is not sure about its sustained success.

Mode of Transmission of AIDS in India

Transmission Categories	Number of cases	%
Sexual	95,941	86%
Perinatal	4,059	4%
Blood and blood products	2,231	2%
Injecting drug users	2,672	2%
Others (not specified)	6,705	6%
Total	111,608	100%

Source: 2006 UNAIDS Report on the Global AIDS epidemic

NEWS FROM CEVA

Coordination of Projects

At present CEVA is coordinating 45 projects supported by Karl Kuebel Stiftung, Germany, many of which are co-financed by the European Commission or BMZ. One new project was sanctioned in 2006-Integrated Development Programme, Chakkupallam implemented by Voluntary Organisation for Social Action & Rural Development (VOSARD), Kumily, Kerala.

CEVA-CMI Relief Fund (for Tsunami Relief and Rehabilitation)

The fund raised by CEVA and CMI congregation for the relief and rehabilitation of tsunami victims has been distributed to three agencies- KESS, Trichur, Sahrudaya Kalamassery and Samagra Vikas, Alappuzha. They have been carrying out reconstruction work in Midalam in Tamil Nadu, Vypin Island in Ernakulam and Valiyazheekal in Alappuzha respectively. As part of this, construction of eight houses is progressing in Alappuzha. In Cherai in Vypin Island reconstruction of library cum community centre has been completed. Thirty five school children have been provided scholarship and 180 persons have been covered by medical insurance. In Midalam 23 fishing boats and engines have been distributed. The construction of houses in Midalam has been completed. The inauguration of the houses was held on 3rd May 2006. The Secretary of CEVA, Fr. Varghese Kokkadan, Moderator, Fr. Austine Kalapurackal and the Coordinating Officer, Mr. Joji Sebastian attended the ceremony.



The procession during the inauguration of houses at Midalam, Nagarcoil. The newly built houses can be seen in the background

Kavach Project

CEVA NRO is one of the partners implementing the Kavach Project supported by TCI Foundation, Gurgaon (funded by Bill & Melinda Gates Foundation), targeted on reducing the transmission of STI/HIV/AIDS among long distance truckers along national highways. CEVA works along the NH-2 on a locale called Gyani Border (Delhi-UP border), one of the busiest transshipment areas in Asia.

Child Labour Project

Three schools are being run by CEVA NRO under the child labour eradication project jointly supported by Catholic Relief Services and District Authority, Ghaziabad. The duration of the project is for three years

starting from July 2005. Each school has 50 child labourers as students and classes till fifth standard. The government has taken the responsibility of mainstreaming the children to regular school after they pass out from the schools.

SHG and Literacy Project

The project 'Strengthening of Rural Poor through Formation of Self Help Groups and Literacy' coordinated by CEVA and the Department of General Social Apostolate of CMI congregation is in the second phase of its implementation. The project with the financial assistance of Italian Bishops' Conference is being implemented in 12 provinces and in one division under the CMI Generalate. 168 SHGs and 60 literacy centres are functioning benefiting 4408 people. CEVA received the second installment of the project in June 5, 2005 and this has been distributed to the provinces for implementing the project.



Christmas Celebrations at CEVA

On 23rd December 2005, the staff of CEVA, Kochi celebrated Christmas along with the SHG members of the SHG and Literacy Project. 112 members from 20 SHGs and 50 children participated in the programme. Mr. Joshy Appicil took awareness class on the importance of SHGs. After lunch a carol singing competition was conducted for the women groups. This was followed by cultural programme by children and a formal session.

Visit of Mr. Ralf Tepel to CEVA, Kochi Office

Mr. Ralf Tepel, Executive Director of KKS, Germany visited CEVA, Kochi office on 31st January 2006 and had a detailed discussion with CEVA staff about the visit of the BMZ auditor, Mr. Sowade earlier in the month. Mr. Tepel also held discussions with some prospective project partners.

Visit of Mr. Mathias Wilkis, Foundation Council Chairman, KKS, Germany

Mr. Mathias Wilkis, Foundation Council Chairman of KKS, Germany along with some delegates from Germany visited the project, Relief and Reconstruction Programme, Helen Colony, implemented by Santhidan Nagercoil on 18th March 2006. The Secretary of CEVA, Fr. Varghese Kakkadan and the Coordinating Officer, Mr. Mathew P. Thomas went to Nagercoil to guide the project staff to make necessary arrangements for the visit.

Mr. Matthias Wilkis along with Fr. Varghese Kakkadan during his visit to Santhidan on 18th March 2006.



Visit of Auditor from BMZ

The Integrated Sustainable Development Programme, Canara implemented by Karwar Rural Women and Children Development Society, Karwar and Village Development Programme, Anthyodaya implemented by Maithri Trust, Mangalore were visited by Mr. Sowade, auditor from BMZ along with Mr. Ralf Tepel from 24th to 28th January 2006. Mr. Mathew P. Thomas from CEVA also joined them during their visit to Maithri Trust.

Visit of Delegates from Initiative against AIDS and Global Infections



Prof. Dr. Pees & Dr. Bunge along with Mr. Tepel at Amala Medical College, Thrissur

Prof. Dr. Hans Wilhelm Pees and Dr. Dietrich David Johannes Bunge from Initiative Against AIDS and Global Infections (IAAGI) along with Mr. Ralf Tepel, Executive Director of KKS, Germany and Mr. Mathew P. Thomas, the Coordinating Officer of CEVA visited KESS and Amala Medical College, Thrissur from 6th to 9th March 2006 and had detailed discussions with the authorities. Prof. Pees and Dr. Bunge also visited CEVA office on 9th March and had discussion with the Secretary and staff.

Combined Meeting of Social Workers of Provinces and General Social Apostolate

The General Social Apostolate of CMI Congregation in consultation with CEVA coordinates the social work activities of the different CMI provinces. As part of this, combined meeting of social workers of the provinces and the general social apostolate were held. Fr. Austine Kalapurackal, General Social Councilor, Fr. Varghese Kakkadan, Secretary of CEVA and Mr. Joji Sebastian, the Coordinating Officer attended the meetings, apart from the members of the provinces.

Meetings were held in the four South Indian provinces of Coimbatore (15.10.2005), Calicut (5.11.2005), Trivandrum(21.01.2206) and Kottayam (30.01.2006). A combined workshop of the social apostolates of North India was held at Bhopal on 21st and 22nd Febuary, 2006. Twenty six members representing five North Indian provinces and one region participated in the meeting.



Fr. Austine Kalapurackal, along with the members of the North Indian Provinces at Bhopal

Annual Meeting 2006 – KKS/KKID/KKF/CEVA



Mr. Ralf Tepel lighting the lamp during the Annual Meeting

The tenth annual meeting of KKS / KKID / KKF/CEVA was held at KKID, Coimbatore on 11th and 12th February 2006. The Executive Director of KKS, Mr. Ralf Tepel along with Mr. Arno Eul attended the meeting. Fr. Austine Kalapurackal, Moderator of CEVA, Mr.P. J. Ignatius President of CEVA, Fr. Varghese Kakkadan, Secretary cum Treasurer and Fr.Thomas Medackal, Regional Secretary attended the annual meeting. Apart from these dignitaries, the staff of KKF, KKID and CEVA participated in the deliberations. Parallel discussions were held between KKS&CEVA and KKF&KKID during the meeting.

Change of Office Premise

The office of CEVA, Kochi has been shifted to a new premise just opposite to the main road leading to the old office. It is now located in the building of the St. Joseph's Monastery (CMI house) at Karikkamuri. The postal address remains the same. The phone numbers and email id have changed.

The new phone numbers, fax and email id is given below:

Phone: 0484- 4070225 to 230 ; Fax: 0484- 4070225

Email: cevakoci@airtelbroadband.in, cevakoci@vsnl.com

The Red Ribbon

The red ribbon is used internationally as a symbol of the fight against AIDS which first came to prominence at the 1991 Tony Awards (An annual award celebrating achievements in live American theater, including musical theater, primarily honoring productions on Broadway in New York.). The red ribbon has been a powerful psychological component of AIDS, although it has recently declined in popularity.

The Red Ribbon was born in the style of the yellow ribbons, which were popular in the USA at the time as a symbol for awareness of those soldiers fighting in the gulf war. There is some disagreement as to the origin of the ribbon. Many attribute its creation to Frank Moore, a New York painter, who allegedly pitched the project to the New York based Visual AIDS Artists Caucus. However, others credit Paul Jabara, a singer, songwriter, and actor who died of AIDS in 1992.

The Red Ribbon Foundation describes the meaning of red ribbon as follows: The Red Ribbon is:

Red like love, as a symbol of passion and tolerance towards those affected; Red like blood, representing the pain caused by the many people that died of AIDS; Red like the anger about the helplessness by which we are facing a disease for which there is still no chance for a cure; Red as a sign of warning not to carelessly ignore one of the biggest problems of our time.

Despite the criticism that wearing the ribbon is hypocritical, the red ribbon has won recognition around the world and it has contributed to breaking the silence and raising consciousness among the general population about those living with HIV/AIDS. www.redribbon.net, www.wikipedia.org

A Positive Speaker...

Mathew P. Thomas*

When I hear about HIV/AIDS, the face of a young lady comes to my mind. I do not remember her name. But she was around 25 years old, beautiful and healthy. I met her, during a sharing session of NGOs and doctors working among people affected with HIV/AIDS, organized at Thrissur. Many eminent doctors and NGO leaders shared their experiences and findings with the participants. Many questions were raised and doubts were clarified. But the young lady was quiet. After the tea break, the Project Manager of a NGO stood up and said, “My colleague who is HIV positive will share her experience on behalf of our society.” Pin drop silence in the hall and all the eyes focused on her.

The young lady moved to the centre of the hall took the microphone and started talking. After introducing herself she narrated her story. She was born and brought up in a village in Thrissur in Kerala. She was married at the age of 18 years. Her husband also from Kerala, was working in Gujarat. After marriage she also accompanied him to Gujarat. They lived a happy life and had two kids within a few years. Gradually her husband started to become sick continuously. They came back to Kerala for

treatment. Finally a blood test confirmed that he is HIV positive. It was a big shock for her.

Doctor advised all of them to test for HIV. She tested positive. Luckily her two children were negative. She explained the struggle they had at the beginning. Family members, friends and neighbours were against them. They become isolated from the society. Her husband was too weak to go for work. Finally they decided to end their lives.

At this juncture, the project staff of the NGO, where she is at present working, came into contact with them and gave support and guidance. The moral support given by the project staff changed their life completely. A new hope arose in them. Now both husband and wife are under going regular check up and treatment. Her husband has regained strength to work and has started earning again. She joined in the project of the NGO as a positive speaker. Now she is courageous enough to motivate others to lead a normal life by narrating her own life. In her own words, the project of the NGO saved her family from death. After narrating her life this lady, an innocent victim of HIV/AIDS, went back to her seat with a smile.

More Money for HIV/AIDS

Warren Buffet, one of the richest men in the world, has agreed to hand over 80% of his \$44 billion fortune to the Bill and Melinda Gates Foundation. This was announced on 26th June 2006.

Mr Buffett, a 75-year-old financier from Omaha in the USA, told reporters at the donation ceremony that he thought Mr Gates “would do a better job of giving it away than I can,” before signing a pledge that would see a total of around \$31 billion given to the Gates Foundation in annual installments.

Since its inception, The Gates Foundation has granted over \$5.8 billion to global health programmes, \$1.1 billion of which went towards HIV and AIDS. Buffett’s gift, the largest in US history, will enable the Gates Foundation to spend nearly \$3 billion a year on overseas and US-based projects; a sum equivalent to one quarter of the entire United Nations annual budget.

www.avert.org

**Mathew P. Thomas is the Coordinating Officer of CEVA, Kochi*

HIV / AIDS: A TCIF Response

Dr. Alka Gupta*

HIV/AIDS has become one of the most serious health problems facing mankind. With more than 5 million people living with HIV/AIDS, India has the second largest number of HIV positive persons in the world in 15-49 age group. India is considered to be a “next wave” country; i.e., it stands at a critical point, with HIV poised to spread quickly, but where large-scale prevention and other interventions today can help to avert a major epidemic in the future. As the second most populous nation in the world, even a small increase in India’s HIV/AIDS prevalence rate will represent a significant growth in the world’s HIV/AIDS scenario.

The association between migration, mobility and infection with HIV has been documented since the inception of the AIDS epidemic. Truckers have been the objects of a great deal of attention as far as HIV is concerned. One reason is simply that there are so many of them. There are about 5-6 million truckers (truck drivers and crew members) in India. Among them nearly half ply on long distance routes. Studies have shown that the long distance truckers are more vulnerable (compared to their short distance counterparts) to STDs in general and to HIV/AIDS, due to their long spell of absence from home. Given an 11–16% expected prevalence levels among long distance truckers in India, there are about 0.3-0.5 million truckers living with HIV / AIDS today and based on studies it is estimated that about 20% of long distance trucking community could be HIV positive by 2005. (Source IHMR Study).

Given the gravity of the situation TCI Foundation, the social arm of Transport Corporation of India is implementing a preventive project (funded by a grant from the Bill & Melinda Gates Foundation) targeted on reducing the transmission of STI/HIV/AIDS among long distance truckers along national highways. Project “Kavach” as it is called, is implementing a comprehensive integrated package on STI treatment, which includes Behaviour Change Communications (BCC), promotion

of preventive methods, and counseling at intervention locations along the national highways.

DAYS TO REMEMBER

11 July	World Population Day
9 August	International Day of Indigenous People
12 August	International Youth Day
8 September	International Literacy Day
16 September	International Day for the Preservation of the Ozone Layer
21 September	International Day of Peace
1 October	International Day of Older Persons
1st Mon. October	World Habitat Day
5 October	World Teacher’s Day
10 October	World Mental Health Day
2nd Wed. October	International Day for Natural Disaster Reduction
16 October	World Food Day
17 October	International Day for the Eradication Poverty
24 October	World Development Information Day
10 November	World Science Day for Peace and Development
16 November	International Day for Tolerance
20 November	Universal Children’s Day
25 November	International Day for the Elimination of Violence against Women
1 December	World Aids Day (WHO)
2 December	International Day for the Abolition of Slavery
3 December	International Day of Disabled Persons
9 December	International Anti-Corruption Day
10 December	Human Rights Day
18 December	International Migrant’s Day

*Dr. Alka Gupta is the Regional Coordinator of TCI Foundation (Delhi), the social arm of TCI Group

Project Scope and Objective

“Project Kavach” is a nationwide project covering about 1.4 million long distance truckers in 15 states (about 30 % of trucking population and 60% of long distance truckers) in the course of 5 years (starting December 2003). This coverage is achieved through interventions in 38 halt points currently along the major national highways in the country. Each of these intervention centres interfaces with about 20,000-30,000 truckers a year.

The objective is to promote adoption of safe sex behaviour of truckers through BCC (Behaviour Change Communication), promote condom use, the diagnosis and treatment of STI/STD through the project clinics branded as Khushi Clinics. Supplementary services like general health services, rest and recreation facilities by way of providing

Drop-in-Centres (to avoid stigmatizing and positively influencing the number of truckers who halt and spend time at these points) are also provided.

Cooperation and Collaboration

Transportation is an economic function. Cargo road transport in India is entirely in the hands of private sector. Transport Corporation of India, Asia’s biggest company has access to million of truckers and has taken up this challenge as response to the HIV / AIDS in the trucking sector.

The business sector has a vital role to play in mitigating the impact of HIV/AIDS. TCI Foundation has played a crucial role to bring together the efforts and resources of the allied industries like Indian Oil Corporation and J.K. Tyres for supporting the clinics at highways, Apollo Tyres for infotainments and AITWA for conducting health camps.

CEVA- A Partner in Kavach Project

Dr. Shobha Mohapatra*

In the response to combat HIV/AIDS, CEVA has also contributed by implementing a project named Kavach with an objective to reduce the impact of HIV/AIDS in our country by arresting the spread of HIV among trucking community. It has initiated the project in NH-2 locale called Gyani Border, one of the busiest transshipment areas in Asia, focusing on trucking community. The major areas of intervention includes

1. Behavioural Change Communication- Under the same, one to one communication, one to group, events like street play, puppet show, magic show, film show, truckers utsav, health camps etc. were organized on regular basis
2. STI treatment- Clinic named Khushi has been introduced in two forms, one a static clinic based in border with fixed timings the other one- a satellite clinic of mobile nature occurring in premises of companies and brokers with fixed schedule of four hours per week.
3. Community Mobilization- under this, a CBO has been formed, which is actively collaborating in activities of the project. Apart from regular meetings of CBO members, meetings of brokers, peer educators, condom depot holders are also being conducted.
4. Capacity building- For smooth functioning of the project and better understanding of related concepts, various training programmes both for staff, beneficiaries and also for secondary stakeholders have been conducted from time to time.

With rigorous hard work of the project team and good understanding and support of TCIF, we are on the roads of achievement. In the year 2005 we have managed to reach out 23,104 people through BCC. 3,484 patients were treated out of which 627 were infected with STI. With a mandate to fight against this evil and make meaningful changes in the lives of the people, CEVA will continue its untiring efforts.

**Dr. Shobha Mohapatra is the Programme Officer of CEVA, NRO*

Human trafficking & HIV / AIDS: Northeast Scenario

NEDAN Foundation*

Though blessed with magnificent mountains and waterfalls, the Northeastern states of India have always been troubled by violence. Now, a study across eight states in this resource-rich, infrastructure-poor, conflict-scarred region seeks to highlight a new worry: the rising tide of human trafficking—mostly women and girls—and its potential for hastening the spread of HIV / AIDS.

India's northeast is home to 200 of the 430 odd tribal groups in the country. The region is also socially and culturally distinct from mainstream India. A seven-month long study carried out by the Nedan Foundation, an Indian NGO working in the largely isolated region, is expected to be released soon. The study was sponsored by the United Nations Development Programme (UNDP).

“Poverty and conflict are fuelling trafficking in the north eastern states. This opens up huge possibilities for the spread of HIV. It is high time that this problem is addressed”, Digambar Narzary, head of the Nedan Foundation, said “We visited 25 relief camps of internally displaced persons (IDPs) in Kokrajhar in Bodoland Territorial Council, Assam. Nearly 200,000 people are living in these camps without proper food. Traffickers carry out recruitment drives in such relief camps. They make false promises of jobs as domestic help in big cities,” he said.

An influx of migrants over the past few decades into Northeast India from neighbouring areas has sparked ethnic conflicts over land, leading to demands for secession and political autonomy. Many armed insurgent groups are active in the region and blood feuds are common. In the last few decades, violence has ravaged the states of Assam, Manipur, Nagaland, Tripura and Arunachal Pradesh. Assam, Manipur and Tripura have also witnessed massive displacement. Economic liberalization launched in the early 1990s is yet to impact the northeast in the same way that it has touched other parts of India.

Narzary noted that more than 100 young women had gone missing from the camps over the past two years. Regional analysts fear that such “missing girls” may have been sold into sexual slavery or “temporarily married”—often a euphemism for prostitution. The fear is that many have already been infected. “Young girls and women from poor, desperate families are dually vulnerable: to being trafficked into the sex trade and to catching HIV. But there are no initiatives at present to address these twin problems”, Nazary said.

With little reliable research, the trafficking problem is more widespread in the region than previously thought. Interviews by Nedan's field teams with 60 teenage sex workers at Dimapur, a border town in the north eastern state of Nagaland, revealed that many of the girls had been trafficked from the Naga countryside with false promises of sales jobs in big cities. Most of the girls were from broken families, having lost one or both parents in the region's protracted ethnic conflicts. Almost all had dropped out of school and faced a bleak future, the foundation discovered.

Sexual transmission is driving India's AIDS epidemic, according to UNAIDS. This route accounts for approximately 86 per cent of HIV infections in the world's second most populous country. The remaining 14 per cent are through blood transfusion, mother-to child-transmission and injecting drug use, particularly in northeastern states and some metropolitan cities.

Narzary hopes that the report's key findings, such as these from the eight states, will spur the Indian government, as well as NGOs, to come forward with initiatives to reduce the level of human trafficking in the region and thereby lessen the spread of HIV / AIDS in this troubled part of the country.

**NEDAN Foundation is a NGO working in the North East Region particularly in Bodoland Territorial Council, Assam*

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Karl Kuebel had strong bond with India which is still continuing by the efforts of his foundation - Karl Kuebel Stiftung (KKS). Since 1978, nearly 700 projects have been supported by Karl Kuebel Stiftung in India. Most of the projects are in rural India, supporting mainly women and children. The lives of thousands of poor people all over India have improved by the efforts of late Mr. Kuebel and his foundation.

The first development efforts of Karl Kuebel Stiftung in India is linked to its relationship with Kuriakose Elias Service Society (KESS), Trichur. In fact, the first major project of KKS in India, Integrated Rural Development Project Silwani was implemented by KESS. Mr. Kuebel was happy with the cooperation with KESS. During his visit to India in 1986 he decided to expand the activities of KKS in India by implementing more projects and wanted CMI congregation to take the responsibility of coordinating the projects in India. An agreement to this effect was signed between KKS and CEVA in 1987 and the relationship is still continuing. At present CEVA is functioning from three different offices- Kochi, Delhi and Kolkata for the effective coordination of KKS supported projects. .

“How can I be of service?” this motto of Karl Kuebel, who dedicated his life to the children and families of this world, will remain and continue beyond his death. Karl Kuebel passed away peacefully on the 10th of February, 2006, at his home in Wald-Michelbach/Odenwald, Germany.

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