

JUDAH TRUST

DIRECTORS' REPORT Annual Report of the Council of Management

The Directors and Council of Management of Judah Trust have pleasure in submitting the thirteenth Annual Report and Accounts for Judah Trust for the year ended 31st March 2010

STRATEGIC OVERVIEW

Part of our role in Judah Trust is to challenge what is perceived to be 'normal', to shine a light on what is deemed to be 'acceptable', to offer alternatives that are valid and to endeavour to create an environment where truth prevails in contrast to deception either inadvertent or deliberate. The difficulty in doing this is, of course, the famous question of Pontius Pilate, 'What is truth?'

In previous ages, we have had a near 'digital' age approach to ethics, morals, and standards of living. There was right way and a wrong way. At the same time an 'analogue' approach was reserved for equipment and technology, analogue that represented graduations from one state to another.

Today in 2010, we have a near reversal of these approaches with the 'digital' approach of absolutes and extremes reserved for technology such as the computer on which I am typing this review. To date it is difficult to see anything fundamentally wrong with a digital approach within technology.

However, the converse is alarming. In ethics, morals, and standards of living we no longer see a role for, nor do we accept anymore, absolute standards, rather, we have replaced them with analogue scales of greater or lesser good rather than absolute good; greater or lesser evil rather than absolute evil.

To date, the consequences of this shift have become increasingly destructive of the fabric of society and humanity itself.

This shift from digital to analogue regarding our ethics, morals, and standards of living, has gone largely unnoticed and un-commented on, because we have now new generations for whom this shifted world, is their normal world. But the world as we see it, is not necessarily the world as it is meant to be, or should be. (Note that this is a statement requiring the existence of absolutes).

If we look at HIV/AIDS today, 25 years on since the beginning of the explosion of the pandemic, we find an understandable, but growing lack of concern because we now have a generation who have known no other world but a world in which HIV/AIDS is endemic. HIV/AIDS is seen as part of the background of life itself, regrettable perhaps, but normal.

And the behaviour that generates the maintenance and spread of HIV/AIDS is now normal, no longer abnormal, no longer 'digitally' absolutely wrong but 'analogically' your choice as to the risk that your behaviour represents towards yourself and society itself.

There is a parallel in our daily life that makes the point, we seem to accept a certain level of road deaths as 'normal' when they are a direct consequence of deciding not to obey absolutes such as speed limits. Is any level of road deaths acceptable to the person being killed / maimed and their family and loved ones? To the people concerned, probably no. To our society, probably yes!

So it is with HIV/AIDS. **Any** death from HIV/AIDS is unacceptable and two million deaths per annum (the present rate) is not acceptable. Totally avoidable death in these circumstances is not just a tragedy (the usual analogical 'cop out' statement) but is totally unacceptable.

Can we live with such an absolute statement? And if so, what are it's implications regarding our behaviour? **Are we prepared to bring absolutes back into human behaviour?**

Today, and on into the future, three things are critical in the battle against HIV/AIDS.

The **first** is to reveal once again, that a world with HIV/AIDS is not an acceptable world in which to live. This will require an awakening of a will to eradicate HIV/AIDS, not to accept it. Let us focus the issue by personalising it. Have you thought about or considered how you would feel on being told that your son or daughter, or grandchild is HIV positive - would you find this acceptable?

The **second** critical area is to see clearly, and having seen, to act, against all forms of behaviour that lead to the spread of HIV/AIDS, to make those forms of behaviour once again socially unacceptable - promiscuity, male led demand for prostitution, and all aspects of poverty, would tend to be high on the list.

The **third** critical area is to see clearly and having seen, to act, in the wholesale provision of compassionate caring supported by the global panoply of medication to counter both the virus itself and the resulting opportunistic infections. The present double standards on quality of medication and provision based on economic status, need to be seen in the absolute standard of unacceptable.

Pilate made only one mistake in his question 'What is truth?'. He should have asked 'Who is truth?' and then looked at the man in front of him.

Judah Trust reaches out to the one who is truth.

JUDAH TRUST

DIRECTORS' REPORT Annual Report of the Council of Management

The Directors and Council of Management of Judah Trust have pleasure in submitting the twelfth Annual Report and Accounts for Judah Trust for the year ended 31st March 2009

STRATEGIC OVERVIEW

The HIV/AIDS global pandemic continues to grow, with new infections exceeding deaths from HIV/AIDS year after year. Treatment and care for those who are HIV positive rightly has a high priority in communities worldwide and universal access to treatment and antiretroviral therapy is a global goal.

Policies to prevent the spread of HIV, 'prevention', have a theme of behaviour change running through them and the behaviours referred to include many related to preventing those presently HIV negative from coming into contact with the virus. These include delayed sexual debut, limited numbers of sexual partners, faithfulness to one partner and use of measures to make human sexuality safer with regard to HIV, such as condoms.

The thrust of prevention is predominantly on reaching those who are HIV negative and endeavouring to ensure that they remain that way. This is, of course, a vital part of any prevention effort and it is the thrust of the teaching on Kingdom Living, that is the approach of Judah Trust - living in a manner that minimises the risk of becoming HIV positive.

But reaching those presently HIV negative relates to some six billion people. Even narrowing the six billion down to those who are sexually active, one is left with a total of several billions of people. We must try to do this, for all sorts of reasons, but we must also be realistic and see that it is an immense and diffuse task.

It is however, the less important part of prevention, and from observations over the decades so far, the less effective part of prevention, notwithstanding Uganda's remarkable and praiseworthy turnaround a few years ago.

There is however, no getting away from the fact that, whatever the sociological / economic / cultural reasons, the main driver fuelling the pandemic is sexual activity by those who are already HIV positive.

Unfortunately, this fact is political dynamite.

1. It relates to people who are coping with having a terminal illness, for whom we are caring and pouring in resource to help them;
2. It is a, if not the, major underpinning for stigma and ostracism; and
3. In the developed world, relates to a highly articulate and politically organised part of society.

But the fact remains - HIV spreads through sexual intercourse with HIV positive partners.

Prevention efforts that do not address this part of the HIV question are inadequate.

At present the global estimate for those who are HIV positive is of the order of 33 million. Of those who are positive, many will be in a stable relationship with a single partner; many will be already ill and abstinent through the trials of illness. It is possible therefore, that the number of people driving the epidemic is significantly less than 33 million.

Can a case be made for a tightly focussed preventative campaign directed towards those who are HIV positive and presently leading an active sexual life outside of a single partner stable relationship?

The answer to the question is probably yes, a case can be made for such a programme.

However there is a related question and that is 'should such a case be made?' and should such a programme be advocated given the risks of rampant stigma and ostracism?

Elements that would need to be considered include things such as:-

1. Universal testing for HIV, a highly contentious issue in its own right;
2. Determining who has the right to know one's HIV status, again a highly contentious issue in a world of stigma, not to mention freedom of the individual;
3. Incentives and encouragements to join such a program, again dynamite when one looks at the converse.

These are all complex issues that can cause appalling personal hardship if mishandled, but they are also issues that need to be looked at; need to be discussed and for which those holding the responsibility for a society's moral and ethical fabric, need to be willing to think about, discuss and advise the governments upon.

Without this open recognition of the drivers fuelling the epidemic, we will not see the discussion and openness arising that will defeat the growing issue of stigma. Nor will we see an end to the epidemic (already 25 years old) in our lifetimes.

And **Judah Trust?** - we will endeavour to see that even the hard issues are brought into the light, so that there is opportunity for wise and compassionate discussion and decisions to take place, towards caring for the ill and defeating the pandemic.

JUDAH TRUST

DIRECTORS' REPORT Annual Report of the Council of Management

The Directors and Council of Management of Judah Trust have pleasure in submitting the eleventh Annual Report and Accounts for Judah Trust for the year ended 31st March 2008.

STRATEGIC OVERVIEW

In December 1999, when asked by a senior Ugandan Bishop whether HIV/AIDS was an 'African disease' it was possible to answer robustly that 'it was **not** an African disease but merely a global pandemic that had manifested first in sub Saharan Africa'.

However, recent science, and recent pronouncements from senior HIV/AIDS officials, are pointing to a particular set of sociological and possibly genetic factors, that are apparently prevalent in sub Saharan Africa, as justification for localising the heterosexual pandemic to sub Saharan Africa only.

Judah Trust categorically refutes this conclusion that the heterosexual epidemic is local to sub Saharan Africa. Such a conclusion is not supported by what we have seen and see on the ground outside of sub Saharan Africa.

Turning to the **first** of the factors which relates to multiple, concurrent sexual partners in relatively stable, comprehensive sexual networks. The work is based on recent exhaustive studies on Likoma Island in Malawi. Subsequent intensive modelling of such networks showed that they enable HIV to spread explosively.

The study itself does **not** say that such networks are unique to sub Saharan Africa. The Likoma evidence is overwhelming and conclusive for that place and is invaluable for explaining one of the drivers of the epidemic. However, do similar stable, concurrent partner, sexual networks exist elsewhere in the world? Until this question is answered, it is not possible to say that this is a sub Saharan Africa distinctive.

The **second** factor relates to male circumcision, or rather the absence of it. In recent years, clinical studies in several nations in Africa have proven conclusively that circumcision makes a significant reduction in the ability to acquire HIV. We support this and Judah Trust has contributed financially to the programme in Kenya.

Today, sub Saharan African culture largely foregoes the previous centuries old practice of male circumcision, unlike Saharan Africa. But the West has also largely given up on circumcision, so the issue of circumcision, or not, does not appear to be a distinctly African issue.

The **third factor** is based on a long term study including Afro-American soldiers in the US Army relating to a genetic issue that seems to facilitate protection against some forms of malaria. Perversely it appears to enable HIV to be more easily taken up by the immune system. The extrapolation of this study to

cover sub Saharan Africa appears rather heroic.

Our concern about the genetic issue is that the genetic difference was isolated with respect to Afro-Americans, but the study does not appear to address the issue that it might be found in other races where there is or has been, epidemics of malaria - eg the Far East? Thus, the genetic issue could be a function of response to a threatening disease (malaria) rather than a function of race, so it is unclear that it is an African distinctive.

The recent **pronouncements** from senior officials are saying that we will not see elsewhere in the world, the explosive heterosexual epidemics seen in sub Saharan Africa. They are saying that the West, India and China are all expected to have epidemics associated with homosexuality, injecting drug usage and blood products but not generalised heterosexual epidemics.

Whilst this could seem to be the case in Europe and America at the present time, such a view does not accord with what we are seeing in India and are hearing from those on the ground in China.

We question whether there is there a sufficient body of evidence available to prove that the localised epidemics associated with men who have sex with men, and with injecting drug usage, do not and will not cross over into the heterosexual population.

Until these issues are resolved it is most unwise to localise the HIV/AIDS heterosexual epidemic to sub Saharan Africa and relax ones efforts elsewhere in the world. Judah Trust will continue its efforts globally.

It is clear from the UNAIDS Annual Report for 2007, that there is an ongoing need for the foreseeable future for HIV/AIDS prevention and for the caring for those who are already HIV positive. Peter Piot, UNAIDS Executive Director, makes the following statement in his Foreword to the Annual Report of UNAIDS -

'If the supply of affordable HIV drugs dries up, if there is any slowing down on prevention of mother to child transmission of HIV, or if there is the slightest hint of complacency over HIV prevention in general, we will fail in our mission.'

Judah Trust is concerned that recent pronouncements from officials, are fostering the very complacency that Peter Piot is referring to, as is shown by recent articles in influential journals such as 'The Economist'.

Judah Trust will not let up on its teaching of 'Knowing Your Epidemic' and 'Kingdom Living'.

JUDAH TRUST

DIRECTORS' REPORT Annual Report of the Council of Management

The Directors and Council of Management of Judah Trust have pleasure in submitting the tenth Annual Report and Accounts for Judah Trust for the year ended 31st March 2007.

STRATEGIC OVERVIEW

It was exactly twenty years ago that we first became involved in HIV/AIDS, firstly as a call to intercede and to raise a prayer awareness of the impact of this new disease that was striking the homosexual community within the western nations with devastating effect. This was followed by the disaster within the haemophiliac community who were given HIV positive 'factor eight' and resulted in the almost total demise of this community within the United Kingdom.

Very soon the global community began to wake up to the reality of what was really happening, that, instead of a limited disease affecting the homosexual community, we had a global pandemic that was heterosexual, and was totally out of control in Africa.

Under the umbrella of the then Wellspring Trust, we responded by mobilising a global intercession effort and then created a London based home care team for terminally ill HIV patients. Ten years later in 1997, we became Judah Trust and have taught, trained and interceded all over the world into the pandemic which is now in every country in the world. It is not abating and has spread out of control into India and China, whilst it continues to kill millions of people in Africa.

Twenty years on, we had hoped to see the demise of this disease in sight. The end is still not in sight - indeed, if anything, HIV is becoming more embedded into society.

Science has worked miracles in the development of anti retro viral drugs. Need has overcome greed in the cost of their provision and supply to many groups unable to afford the basics of life, let alone anti retro viral drugs.

The pandemic has led to study and analysis on an unprecedented scale and for the first time in the history of the United Nations, a disease, HIV/AIDS, has been officially recognised as a threat to global security. Prevention has been recognised as essential in the absence of a vaccine or cure. The answer to prevention hinges on human sexual behaviour and to our disgrace, this has generated more acrimony and discord than any other topic over the past twenty years.

Because sexuality is the key mode of transmission, the human history of stigma relating to sexual matters has burgeoned, hampering discussion, teaching and training in prevention. Of all the issues that carry stigma today, HIV/AIDS has been the most potent.

Whether we like it or not, Christian principles, consistently applied, meet all the key prevention criteria, and this ranges from virginity, abstinence,

permanence of marital/sexual relationships through to circumcision, sanctity of life and caring for one another.

Sound science, globally recognised, supports the prevention benefits of each of the principles mentioned above. But there is real cause for concern arising from the development of new stigma and a new confusion where apparently unpalatable facts get deleted from even international agencies reporting systems.

A new stigma is arising, and is already becoming noticeable. Parts of Africa are already complaining that the growing western stigmatisation of virginity is harming its prevention efforts.

Virginity relates to a delay in sexual debut. The officially approved UN position on prevention stresses delay in sexual debut as a fundamental plank in a prevention strategy, yet virginity is now stigmatised.

A new stigma is arising, and is already very noticeable. The West is having problems arising from the breakdown of families but continues to foster policies that stigmatise marriage.

Marriage relates to sexual faithfulness and one sexual partner or mutual fidelity. Again, the UN policy on prevention stresses fidelity as a plank in its prevention strategy yet marriage is being stigmatised.

The official policies see a key role for faith based organisations and acknowledge their unique qualities in helping to mobilise global prevention and caring strategies. In the main, the term 'faith based organisations' is an euphemism for Christianity, by far the leading player in the global response to HIV/AIDS.

A 'new' stigma is arising and is hampering the development of an effective response to HIV/AIDS. Christianity as a faith based organisation today carries even greater stigma along with real persecution.

Judah Trust is concerned that the growth of the HIV/AIDS pandemic is being encouraged by the development and spread of these new stigma against virginity, against marriage and against Christianity.

Or to put it in United Nations language, we remain concerned at the stigmas arising against 'delay in sexual debut', against encouragement in 'mutual fidelity' and against the 'faith based organisations'.

The UN General Assembly adopted the Declaration of Commitment on HIV/AIDS. Clause 13 notes that
'stigma ... must also be addressed.'
We concur.

JUDAH TRUST

DIRECTORS' REPORT Annual Report of the Council of Management

The Directors and Council of Management of Judah Trust have pleasure in submitting the ninth Annual Report and Accounts for Judah Trust for the year ended 31st March 2006.

STRATEGIC OVERVIEW

Prevention and Caring

Once contracted, HIV follows a predictable course of progressive destruction of the immune system. With a weakened, and weakening immune system, the body falls prey to opportunistic infections which, over time, gradually destroy the body and death results. This progression is a reality for all but a very few people.

The use of antiretroviral drugs delays the destruction of the immune system for a time, often many years, but in the end, the virus eventually destroys the immune system and the opportunistic infections eventually destroy the person.

In this setting of the onset of illness, which destroys ones income earning capacity through ill health, comes the response of the carers and helpers to love and look after the person and their dependents. The response, at family and community levels all over the world, is nothing short of a miracle. Caring, especially for little children, is something that touches our hearts deeply. Even so, the need for more carers is immense. We need to pray for more carers. We need to pray for their work. We need to pray for the resources with which to care.

We need also, to be looking at the issues which enable the virus to spread. We need to pay attention to prevention programmes of all kinds. But, unlike the response of caring, the response to the need for prevention is for behaviour change in all sorts of areas by all sorts of people.

Behaviour change is difficult to achieve at the best of times, as anyone dieting or trying to give up smoking or drinking is aware of. Part of what makes behaviour change so difficult, is that it has, always, to precede the anticipated disaster - the disaster has not yet happened personally, whereas in caring, the disaster has happened and is right in front of you.

The most common method of spreading HIV is by sexual activity. Prevention programmes and messages therefore have to address the issue of sexual behaviour change. How does one do this? Is this a message that will be taken notice of? Is this a message that will be popular? Is this a message that will impinge on the exercise of freewill?

In the UK, now many years ago, a Government prevention programme was launched that was effective. Behaviour did change. The programme used a powerful tool, that of fear, to get its life changing message across - tombstones featured a lot in the programme. But now the morality of using fear based programmes is under question. This is something we need to think and pray about as a lot of behaviour changing practices in the

Scriptures are quite openly fear based - do this and live - do that and die.

Somehow, we have to get across a message that says 'we will continue to live **only** if we are prepared to make lifestyle changes'. This is not a popular message, advocating sexual and other related behaviour changes, whether on secular grounds or on religious grounds; yet, without this message, without the resulting behaviour change, the HIV/AIDS epidemic will continue to spread and grow.

Unlike the global response to caring, which has been miraculous, the response to advocating and teaching prevention has been nothing short of a disaster, except in one or two of the African countries.

We need to pray for all those who are willing to speak out the messages of prevention. We need to pray for pastors, priests, ministers, and all spiritual leaders to be willing to speak out about the ways of Kingdom Sexuality in the context of Kingdom Living. We need to pray for a much more vital, life giving message and life changing message, to come from our spiritual and secular leaders.

We need also, to recognise the fine balance between turning HIV into a long term manageable disease, and defeating the virus as the world has done with other diseases. To put this into focus, how many individuals, organisations and businesses are now dependent upon the continuation of HIV as a long term manageable disease?

How many careers are now dependent upon the continuation of HIV? How many dividends are dependent upon the continuation of HIV? Prevention, and HIV as a long term manageable disease, are just not comfortable partners.

We need to pray for economic decisions, at corporate, national and international levels, to be made on the basis of prevention, which at first sight will look like economic madness, whilst also providing the resources needed for the caring of those already HIV positive and the consequences arising from that.

The issue of prevention is complex and difficult, yet, it would seem that it is an issue that has the heart of God behind it. It would seem that this is something God wants us to do; to preach, live and teach Kingdom Sexuality in a context of Kingdom Living. Please pray for us all, as we, in Judah Trust, seek to do our part in this piece of Kingdom work.

JUDAH TRUST

DIRECTORS' REPORT Annual Report of the Council of Management

The Directors and Council of Management of Judah Trust have pleasure in submitting the eighth Annual Report and Accounts for Judah Trust for the year ended 31st March 2005.

STRATEGIC OVERVIEW

"The global AIDS epidemic has reached a particularly alarming stage. It is both globalising and expanding at an accelerating pace while its impact increasingly depletes severely affected countries of the human, financial and institutional resources needed to curb its spread." UNAIDS Report of the Executive Director 2004-2005.

Peter Piot, the Executive Director of UNAIDS throws out two challenges to the international community in presenting the above report.

"The first challenge ... is to include now a long term horizon in our action on AIDS. Just consider, how will we assure antiretroviral therapy for decades! A second major challenge I want to bring to your attention is the need for a full scale comprehensive response to AIDS. Because of this epidemic's complexity, the response has to be comprehensive."

HIV prevention is critical because nearly 5 million people acquire HIV every year.

HIV treatment is critical because over 3 million people a year are dying of AIDS.

HIV impact alleviation is critical because this epidemic is orphaning millions of children and reversing development gains."

A number of issues arise from this clear analysis.

The first is that the fight to turn the tide of HIV/AIDS is a long haul fight that is due to continue for many decades ahead and thus all those working in this field today have a strategic decision to take - viz are we willing to plan for a decades long involvement in HIV/AIDS and what do we need to do in order to plan for such a lengthy involvement? Is Judah Trust in this battle for the long haul?

If the answer is 'yes', then this has impacts upon staffing, financing, structural and procedural decisions at the individual organisational level. For example, what are we doing about staff succession plans?

The second issue is where are we, as an organisation, placed in the three fold response required? What is the skill mix and resource availability that enables us to operate in one or more of the three categories of prevention, treatment, and alleviation?

Historically, Judah Trust, Wellspring Homecare Team and AIDS Intercessors have together been strong in all three areas. At present, Judah Trust is not directly involved in the treatment arena. Should this change?

Your Board & Council of Management will be considering these issues over the coming months.

There is also a hierarchy in the responses of prevention, treatment and alleviation. If prevention is successful, there will then be an end in sight to the need for treatment and then an end in sight to the need to alleviate the impact of HIV/AIDS. Thus, without belittling the need for treatment and alleviation, the key factor in halting the epidemic is successful prevention.

Treatment and alleviation have their own particular thorny problems, but the issues around prevention are in a totally different category in that they impact directly upon how humanity expresses its sexuality. This raises moral and ethical questions relating to the meaning of 'human rights' at the individual and population levels.

For example, is the 'right to control one's own sexuality, free of coercion, discrimination and violence' compatible with individual actions that lead to knowingly passing on the virus to other unsuspecting sexual partners?

Should programmes that include 'accurate and explicit information on safer sex' be adopted in all situations, particularly where there is risk of the reduction of innocence in the very young?

Multiple partners, early sexual debut, promiscuous life styles, etc have all been proven to enhance the speed at which HIV spreads. But each of these has factors affecting them eg coercion, economic necessity, lack of respect for the women etc. Life styles are not merely the untrammelled expression of an individual's will.

A core part of prevention is reaching an understanding of the purposes of human sexuality - procreation and recreation. Focus, not on an ethos of 'do not', but upon an ethos of understanding and enjoyment of the gift of sexuality and gender that each one of us has available.

Judah Trust is a Christian organisation that has beliefs and modes of operation based on acceptance of the life and teachings of Jesus Christ, as the only God, Lord and Saviour.

This means that Judah Trust, along with all other Christian organisations, has ethical and moral answers and responses to each of the issues arising in prevention, treatment and alleviation. These answers and responses have a successful track record proven over several thousands of years of practice and they directly address the issues raised in the global pandemic of HIV/AIDS.

Strategically, is the Christian world, and Judah Trust, prepared to promote these answers and responses?

JUDAH TRUST

DIRECTORS' REPORT Annual Report of the Council of Management

The Directors and Council of Management of Judah Trust have pleasure in submitting the seventh Annual Report and Accounts for Judah Trust for the year ended 31st March 2004.

STRATEGIC OVERVIEW

The global epidemic continues to grow. Because of difficulties with capturing proper data on the scale of the epidemic, confusion is arising as to its seriousness. The confusion arises because the key statistic being used is the number of people who are alive and HIV positive. Whilst important, this is only a residual between cumulative infections and cumulative deaths. As the dying rate accelerates, it depresses the number who are alive and positive and gives an impression that the epidemic is stabilising. It is not. It is out of control.

Human Sexual Behaviour Change

The answer to the epidemic is clearly acknowledged to be a shift in human behaviour, but the global debate is only looking for a small shift in behaviour, ie by making limited changes in how one practices sexuality - safer sex - use of condoms etc, rather than looking at a more challenging but overall more effective measure, which is to reduce the amount of multi partner sex.

The response to the epidemic has become muddled by putting emotion into terms used to limit multiple sexual activity in order to limit the spread of HIV/AIDS. Terms such as 'abstinence' and 'chastity' have resulted in unscientific and irrational responses because they carry faith based connotations. For example, the recent World AIDS Conference in Bangkok was characterised by extraordinary, irrational behaviour from eminent authorities condemning behaviour change that works. When national and global leaders such as President Museveni of Uganda and President Bush of the United States of America and their representatives are publically vilified for encouraging behaviour changes that work one, has to ask whether efforts to turn around this pandemic of HIV/AIDS will succeed.

Needle Exchange & Injecting Drug Use

Inconsistencies in the response to the epidemic are arising. For example, there is the whole issue of needle exchange (or more particularly injecting equipment exchange - the syringe becomes contaminated as well as the needle). The use of 'one time' syringes is being advised for use in immunisation. Such a simple device makes it impossible to re-use injecting equipment. 'One time' syringes could immediately limit the spread of HIV via injecting drug use. But what is being done about it? Why are multi use syringes still being sold? There is a great weight of responsibility for the spread of HIV resting on the shoulders of those who continue to manufacture the old style syringes.

Circumcision

Another area of concern is the topic of circumcision as practised within tribal areas of Africa. Sound science (accepted by UNAIDS WHO etc) makes clear that the uptake of HIV, for biological reasons, is greater in

uncircumcised, rather than circumcised males. The tribal practice has an impact in reducing the spread of HIV. However this is offset by two other aspects of the practice of circumcision. One is the hygiene of the knife / scalpel used and the second is the consequent custom that once a boy of 13 -14 is circumcised, he is now defined as a man and is expected to move into a sexually active lifestyle. These two practices encourage the spread of HIV. Active measures are being taken relating to proper hygiene - proper sterilisation of the knife / scalpel between individual circumcisions and encouragement is being given to delaying the start of an active sexual lifestyle.

Again, science has become bogged down in the use of emotive words such as 'circumcision' and the implication that a particular faith based practice is being encouraged for purposes of the faith, rather than purposes of survival. Again, normally rational leaders, scientists, and politicians are actually contributing to the spread of HIV by denying the reality of the biology and good medical hygiene. Report after report appearing in world class medical journals is letting 'political correctness' contribute to the spread of HIV.

Funding - Grass Roots or Administration

The scale of the epidemic is leading to the provision of large sums of money to cope with prevention and care. There has been an explosion of new staff positions being created in NGO's around the world to gain access to HIV/AIDS funding. There has been a massive production of literature informing the West about the scale of the epidemic, telling the stories of the poverty, deprivation and de-humanising that HIV/AIDS brings to tens of millions of people. There is less evidence of the funds reaching the grass roots to alleviate that deprivation.

Faith Based Responsibility

The faith based groups carry a heavy responsibility for encouraging and endorsing behaviour that leads to the spread of HIV and this is nowhere more prevalent than in the western based side of Christianity. The level of dying affecting individuals, families and the creation of orphans by their millions, may well be laid at the door of the churches for not teaching and practising life that is in accord with the roots of the faith they profess.

Our Concern

We are concerned at what we are seeing and what we are not seeing regarding the HIV/AIDS epidemic. Perhaps we are taking a simplistic view but there are questions that need to be asked about why good science is being ignored; why effective measures are being vilified; and about why the world seems to be encouraging the spread of the HIV/AIDS epidemic.

JUDAH TRUST

DIRECTORS' REPORT Annual Report of the Council of Management

The Directors and Council of Management of Judah Trust have pleasure in submitting the sixth Annual Report and Accounts for Judah Trust for the year ended 31st March 2003.

STRATEGIC ISSUES

Last year we indicated that it was possible for the HIV pandemic to produce over one billion HIV positive people. Later in 2002, the same indication was being given for 2025 by an expert in the field, given no significant change in behaviour and in the continuing absence of an effective vaccine.

The pandemic is spreading at an alarming rate and it is having consequences that the world is slow to comprehend and even slower to plan for.

Persian Gulf

For example, some half million troops are based in the Persian Gulf area, close to and in, several of the HIV 'hot spots'. The question must be asked as to what is being done to reduce the risk of HIV amongst the troops? Similarly, what is being done to reduce the risk of a widely disseminated spread of heterosexual HIV across Europe and the United States upon the return of the troops to their wives and girlfriends?

India

A series of changes are coming together in India that has profound implications for global business and national and international economies. The first change is the recent loosening of the censorship restrictions in 'Bollywood' and the more western approach to promiscuity that is now arising amongst the young, educated, middle classes, in the main conurbations of India. (The relaxation of restraint was a key aspect of the epidemic in Russia and in particular, in Moscow). The second is the growing trend within Europe and North America to make key parts of their economies dependent upon low cost but highly skilled jobs in India. The group providing these skills is the well educated, young, middle classes in the conurbations; the group now most at risk from HIV.

Corporations need to give very careful thought to the wider implications and planning of such job transfers. Issues range from the morality of choosing cheap labour, to the physical infrastructure of facilities that is encouraging social patterns to develop that will foster promiscuity and the spread of HIV. Similarly, the vulnerability of key segments of European and North American economies to an outbreak of HIV amongst the call and software centres in India needs to be considered by investors and governments.

China

It is of course, unfair to focus a common problem upon one country, but the sheer scale of population relocations that are being undertaken in China make China a special case. Major movements of people, whether from war or civil unrest or major construction projects have implications for the spread of HIV.

Accepted social structures break down and normal social restraints become forgotten or inappropriate in the setting of family and community upheaval. One such project in China, the Three Gorges Dam and its associated works, has led to the relocation of millions of people and the erosion of community structures. It is a moot point as to whether planning has considered the potential for an explosive spread of HIV into the areas of re-location.

A Manageable Disease?

Once someone is HIV positive, there are two main areas of treatment. The first relates to fighting the virus and includes all the antiviral therapies. The second area relates to the provision of medication to fight and treat the opportunistic infections. Broadly speaking, fight the virus and fight the infections.

Over the past 20 years, significant advances have been made in each of these two areas, such that a very dangerous myth is now prevalent, particularly in the West, that HIV/AIDS, whilst very serious, is now a manageable disease. The existence of the myth that HIV/AIDS is a manageable disease is affecting the effectiveness of prevention programmes on the one hand, and, leading to HIV/AIDS immigration to the West (where it is believed that the disease can be cured) on the other hand.

The existence of the myth that HIV/AIDS is a manageable disease is affecting the effectiveness of prevention programmes

As can be seen, the pandemic is complex and is affecting major elements of our global society in unexpected ways.

We remain concerned at the low level of knowledge about the HIV/AIDS pandemic.

We remain concerned that whilst there is agreement that the fight against HIV is dependent upon behaviour change, there is a lack of appreciation that it is human sexual behaviour that has to change - probably the most difficult of all human behaviour to alter.

Judah Trust

The teaching programme of Judah Trust is directed towards meeting these two key concerns and to increase understanding about the HIV strategic issues.

JUDAH TRUST

DIRECTORS' REPORT Annual Report of the Council of Management

The Directors and Council of Management of Judah Trust have pleasure in submitting the fifth Annual Report and Accounts for Judah Trust for the year ended 31st March 2002.

GLOBAL OVERVIEW AND STRATEGIC DIRECTION

The world population as at the end of 2001 was 6.119 billion people. Of these, the adult population aged between 15 and 49 totalled 3.198 billion. At the end of 2001, the global estimate for those living with HIV is 40 million or a mere 1.2% of the global adult population.

But sub-Saharan Africa has an adult prevalence rate of 9% and Botswana, the worst hit country in the world, has an adult prevalence rate of 38.8%.

If we apply the sub-Saharan adult prevalence rate to the global total, then there is a possibility that the global level of HIV infection could be as high as 287 million people. To put this figure into context, it is equivalent to the entire population of the United States of America.

If we use the Botswanan prevalence rate of 38.8%, then the global total becomes 1.224 billion people which is almost the entire population of China.

UNAIDS is making absolutely clear that, even after 20 years of the pandemic, it is still in its early stages. The epidemic is primarily one of heterosexual behaviour, involving normal human sexual behaviour.

There is global agreement that the answer to the pandemic is behaviour change on a massive scale. What is not often spelled out is that it is human sexual behaviour that has to change. This is not a simple change to bring about because it involves deeply ingrained customs and patterns of behaviour

The dilemma that the world faces is even deeper than attempting global changes in sexual behaviour. HIV/AIDS is a killer without a cure, and thus concern about HIV/AIDS is tempered by individual and cultural norms as to the value placed upon human life and the quality of that life. In some cultures HIV/AIDS may not be of the concern that we in the western world might place upon it.

Thus HIV/AIDS cannot be approached without also looking seriously at the underlying moral and ethical issues relating to what is appropriate human sexual behaviour and what is an appropriate understanding of the value of a human life. Different countries, cultures and races have quite different answers to these two issues.

It is because of these complexities that we are more inclined to believe that the epidemic is going to get very much worse before there is any adequate solution. Whilst there are some glimmerings of hope

that sexual behaviour may be able to be changed (Uganda for example) it is not enough.

We remain concerned that there is no significantly discernable change in sexual behaviour to prevent the world's two largest populations (India and China) from following the sub-Saharan pattern of infection.

India has an adult population of 0.534 billion. Sub-Saharan levels of infection point to 48 million infections and Botswanan levels point to 207 million infections. Parts of India are already at 30% levels of infection even though the country as a whole is presently at 0.8% or 4 million living with HIV. China has an adult population of 0.726 billion. For China, sub-Saharan levels produce 65 million and Botswanan levels produce 282 million.

The numbers that we have been using are beyond comprehension. It is only when you see four little children together who are HIV positive and realise that when you come back again all four will be dead or when you see young adults in agonising pain that the enormity of HIV/AIDS comes home to one.

This is not a time for moral judgement of individuals, but it is a time for moral and ethical understanding of what is the way of living and the approach to life that will minimise the risk of becoming HIV positive.

In our practical experience with HIV/AIDS, we have been confronted by the realities of fellow humans committing suicide through lack of hope. We have had to help in situations of attempted murder because of the anger that an HIV positive result has triggered in a person.

We have had to help and guide HIV positive girls who see abortion as the better solution to a 30% risk of bearing an HIV positive baby (3% risk if drugs are available) and we have had to give guidance to team members who have been asked by well meaning relatives to practice euthanasia. These are all big moral and ethical issues. HIV/AIDS forces us to confront them.

This is what Judah Trust is about and why it exists. To ascertain the realities of HIV/AIDS and to endeavour to make a difference in individual lives and ultimately to make a difference in communities and nations.

JUDAH TRUST

DIRECTORS' REPORT Annual Report of the Council of Management

The Directors and Council of Management of Judah Trust have pleasure in submitting the fourth Annual Report and Accounts for Judah Trust for the year ended 31st March 2001.

GLOBAL OVERVIEW AND STRATEGIC DIRECTION

Individual nations are now facing the very real possibility that they will go out of existence as a result of a disease that is wholly preventable.

HIV/AIDS is now the fourth largest killer of human beings globally and, in sub Saharan Africa, it is the main cause of death, according to the United Nations.

HIV/AIDS is predominantly a sexually transmitted disease, though once present in a community, transmission also occurs through blood to blood contact and through mother to child transmission.

To date, over twenty two million people have died from the global epidemic of HIV/AIDS. A minimum of a further thirty six million people are HIV positive. Rates of infection amongst the adult population are as high as 42% in some countries.

Of the cumulative total of adult infections (52.2 million) 17.5 million or 33.5% have already died. Infection amongst children totals 5.7 million of whom 4.3 million or 75.4% are already dead.

Whilst well over two thirds of the current infections are in sub Saharan Africa, the disease is spreading out of control in the Indian sub continent, the Far East and in China. It is present to some extent in every country in the world.

The global outlook remains dismal with no potential cure even on the horizon, and with treatments that delay the onset of illness proving to have side effects that limit their effectiveness.

The characteristics of the pandemic and its underlying causes, consequences, and responses, involve the provision of health and spiritual care for those already infected and directly affected by HIV/AIDS.

Informed education is required at every level, from prevention through to community solutions to the problems of massive numbers of deaths and the impact that this is having on whole communities in terms of lower expectations, apathy and a general loss of hope.

Judah Trust, and its predecessor organisation, Wellspring Trust, were formed in response to these needs and the work undertaken today by Judah Trust continues to be so directed. The 'objects' of Judah Trust are shown on the adjacent page.

Judah Trust has acquired a unique body of experience relating to infection by HIV since early 1988. This

experience arises from caring for over 360 patients through to dying and through the accumulated experience of meeting spiritual and physical needs of people across the globe.

The current strategic response of Judah Trust to the HIV/AIDS pandemic, consistent with its 'objects' is:-

1. to help to meet the needs of those infected by HIV/AIDS through the provision of:-

crisis and self help funding; training of carers and homecare teams; pastoral care of carers and those affected by HIV/AIDS; and the passing on of the experience gained and being gained, re holistic care of HIV patients.

2. to help strengthen individuals, families and communities affected by HIV/AIDS by providing:-

spiritual resources to counter stigma, apathy and hopelessness; ethical and moral models to foster lifestyles that will minimise the risk of becoming HIV positive; and to strengthen and mobilise informed Christian prayer and intercession across the world in support of those infected and affected by HIV / AIDS.

3. to help to raise awareness of the impact of the effects of HIV / AIDS within local and global situations, and within organisations who are in a position to 'make a difference' in prevention and caring, through:-

HIV awareness seminars; dissemination of educational materials; training trainers; and the contributing to HIV / AIDS Schools.

Judah Trust is giving effect to the above by:-

accessing funds to help make grants to meet critical needs, such as food for children;

creating and presenting awareness seminars and training courses across the world;

maintaining a 'clearing house' of information about the needs of many small grass roots ministries across the world; and publishing a monthly newsletter and prayer diary.