



HIV and AIDS

# A Deep Human Concern

A compilation of lectures and presentations  
from the Annual Irish Aid

Professor Father Michael Kelly Lecture Series  
2006-2015

# **HIV and AIDS**

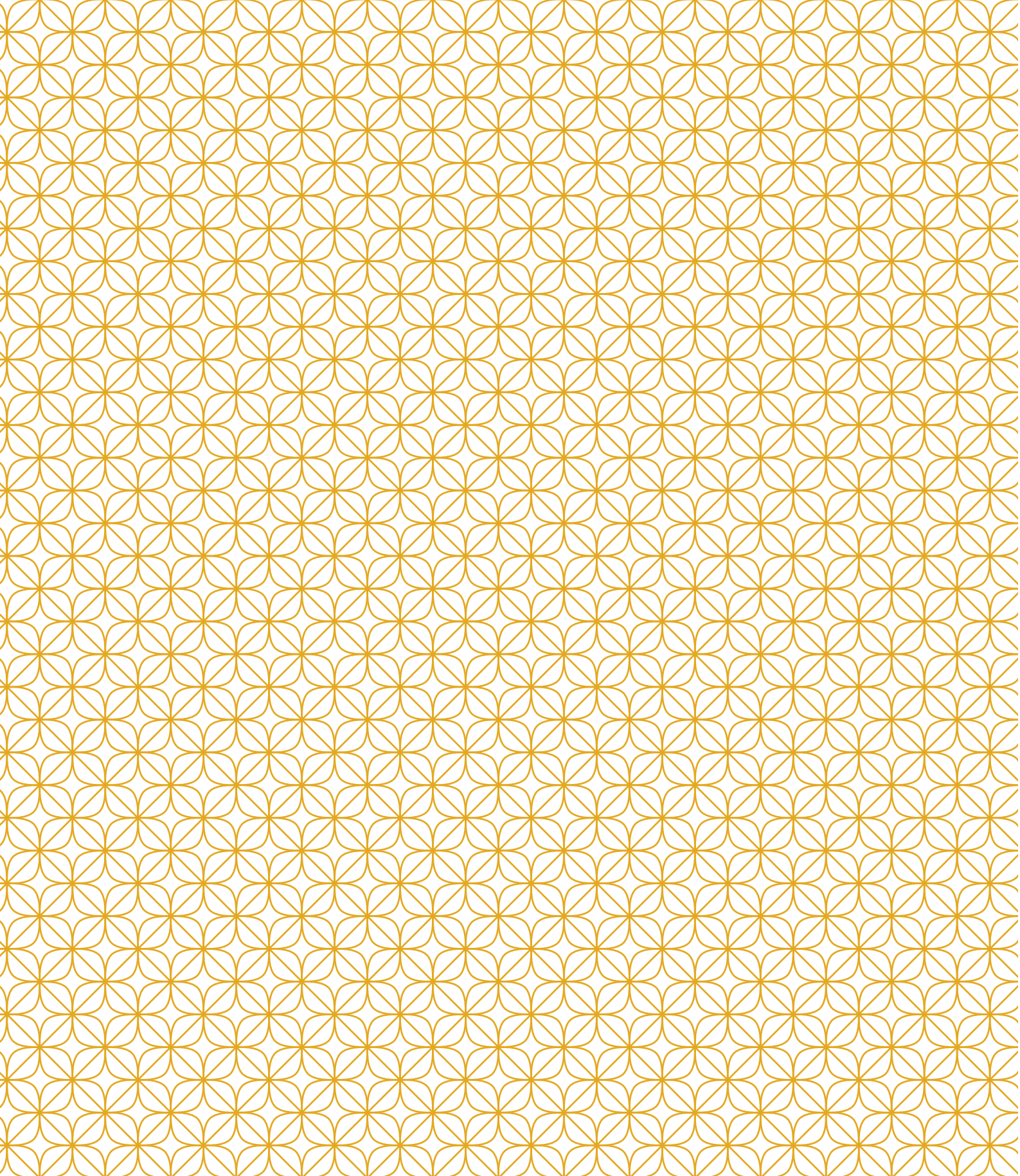
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# Introduction

This year marks a decade of World AIDS Day lectures by the inspirational Professor Fr. Michael Kelly. He is one of the world's most passionate and effective advocates for an integrated and sustained response to HIV and AIDS. Father Michael has witnessed first-hand the devastating impact of HIV and AIDS and has made a tremendous contribution to tackling HIV in Africa.

Born in Tullamore, County Offaly, in 1929, Father Michael studied at University College Dublin and was awarded a B.A in Mathematics and Mathematical Physics in 1952, both with first class honours. He went on to receive a licentiate in philosophy in 1955. He then moved to Zambia where he has lived and worked for the past 60 years, becoming a Zambian citizen. Father Michael worked for many years as headmaster of Canisius College in Chisekesi in Zambia, where he completed his PhD studies in the area of child and educational psychology in 1974. Subsequently, he became a senior lecturer and Dean of the School of Education in the University of Zambia (UNZA), where he served as Pro-Vice Chancellor and Deputy Vice Chancellor, and became Professor in 1989. Father Michael is also Professor Emeritus of Education at the University of Lusaka.

Father Michael's contribution to the complex subject of HIV and AIDS combines the highest standard of scholarship with compassion and courage. Through his extensive research and writings, he has also demonstrated the positive impact of education itself on reducing the spread of the disease – and it is not simply education about HIV, but any education at all that can make a difference. His research findings – widely distributed through meetings, articles and books – demonstrate that the more access to education is available, the less HIV is present.

The dedication of this lecture series in his name is an indication of our regard for Father Michael's contribution to the global response



to HIV and AIDS. We remember the first lecture in 2006 where he highlighted issues of stigma: then and now, he continues to remind us all never to forget the individual human beings who are affected. His subsequent annual lectures have provided leadership and insights on key issues such as the impact of HIV on Children and Women; the role of food security in reducing vulnerability to HIV; ensuring access to HIV prevention strategies especially for women; the role of men in the prevention of HIV; the need for more health workers and working with traditional healers; the role of Education in tackling the HIV pandemic; and the negative role of stigma, prejudice and certain legal measures in the response to HIV and AIDS.

Father Michael continues to astound us with his insight and we draw on him very frequently to inform the work of Irish Aid. His extraordinary insight into the complexity of HIV and AIDS coupled with his passion and deep sense of our common humanity is both an inspiration and motivation for all.

Ireland joins with Zambia and the rest of the Global HIV community in expressing our pride in celebrating the outstanding contribution of Professor Fr. Michael Kelly and his lifetime of achievement.

**November 2015**

A blue ink signature of Sean Sherlock, written in a cursive style.

**Sean Sherlock**

**Minister of State at the Department of Foreign Affairs and Trade with special responsibility for Trade Promotion, Development and North South Co-Operation**

*Father Michael's 2006 lecture came at a time of renewed commitment to the fight against HIV and AIDS, with then Taoiseach Bertie Ahern T.D. addressing the High-Level Meeting on AIDS at the United Nations General Assembly in New York in June. The Taoiseach recounted the progress that had been made since he had last addressed the UN General Assembly in 2001, and reaffirmed the Irish pledge to fund international programmes tackling HIV and AIDS.*



20  
06



## 2006 LECTURE

# STIGMA AND DISCRIMINATION

The inaugural Irish Aid Professor Father Michael Kelly Lecture on HIV and AIDS in 2006 focused on the challenges of stigma and discrimination against people living with HIV. During an inspiring rallying call against stigma in all its forms, Father Michael also made reference to the launch of the “Stamp Out Stigma” campaign<sup>1</sup>, and Taoiseach Bertie Ahern, T.D.’s address to the UN High-Level Meeting on AIDS, at the UN General Assembly in New York, in June of that year. Please visit [www.fathermichaelkellyzambia.org](http://www.fathermichaelkellyzambia.org) to read the Taoiseach’s address, as well as the full version of Father Michael’s 2006 lecture, which is abridged below.

**Michael J. Kelly, S.J.,  
Lusaka, Zambia, November 2006**

“Allow me to begin by thanking the Irish Government and the Department of Foreign Affairs for establishing this annual lecture. I am humbled and honoured that they should have recognised so generously my limited endeavours to address the scourge of HIV and AIDS, through the education sector and in other ways. But this very recognition is a challenge to redouble efforts to understand this epidemic and find how to get ahead of it.

Equally I am encouraged and heartened by the inspirational, visionary White Paper on Irish Aid<sup>2</sup> launched by the Taoiseach in September this year. The White Paper signals a massive increase in Irish spending for the benefit of those in greatest need in some of the world’s poorest countries. But it is more than that. In the words of the Taoiseach, the aid programme it embodies is a practical expression of the values that help define what it means to be Irish at the beginning of the 21st century, the way ordinary Irish people abhor injustice and their determination to

help those who are in need. It prioritises the fight against HIV as fundamental to poverty and vulnerability reduction. It commits itself to a broad-based approach in tackling this and other communicable diseases. It undertakes that Irish Aid will continue to work towards achieving universal access to HIV/AIDS prevention, treatment and care.

Above all, the White Paper is about people. It is about the inherent and inalienable dignity of every individual and giving ordinary people a fair chance in life. It is about children living happily and looking forward to a future full of possibility and hope. It is about the humanity that all peoples share in common.


HIV and AIDS are also about people, but in a very different way. The real unspeakable tragedy of the epidemic is this destruction of people through the infection, illness or death of individuals. Let us never overlook all that is going on at this individual, personal level. Behind all the mind-boggling AIDS statistics are men, women and children. No matter how much we see on television or

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<sup>1</sup> *Stamp Out Stigma* was a public awareness campaign around HIV stigma, launched by then Taoiseach Bertie Ahern in December 2006.

<sup>2</sup> *Produced in 2006, and developed following extensive public consultation, the Irish Government developed Ireland’s first policy on overseas aid.*





read in newspapers about HIV and AIDS, let us never forget the individual human beings who are affected.

## Stigma and Discrimination

We know that about 40 million people worldwide are living with HIV or AIDS. It is probably no exaggeration to say that almost every one of these, together with the further millions in their families, experience some form of AIDS-related stigma and discrimination. Even worse, it is probably just as true that hundreds of millions harbour stigmatising attitudes towards those with HIV or AIDS. Indeed, if we are honest, we may not have to look further than ourselves for evidence of this. Subconsciously and irrationally, we judge them. We put them in a box all by themselves. We separate ourselves from them.

In 1987, in an address to the United Nations General Assembly, Jonathan Mann, founder of the Global Programme on AIDS, predecessor to today's UNAIDS, noted that in HIV and AIDS we are confronted with three epidemics, not one: First there is HIV. This strikes silently and can go undetected for ten years or more. It steadily undermines and destroys the body's defence mechanisms; and it makes the person in whom it resides infectious, capable of passing the virus on to others. The second epidemic is visible AIDS or AIDS-related illnesses, with all their debilitating and life-threatening manifestations. And the third is the one we are concerned about in this lecture: the social epidemic of stigma and discrimination that grinds people down in shame, isolation and rejection.

From time immemorial, the history of contagious diseases has been a history of mistrust of the sick, avoidance measures, and exclusion, intertwined with a history of compassion and solidarity. But with HIV and AIDS, the stigma seems to be different, more universal, more comprehensive, more

bitter and soul-destroying, more stubborn to root out. It leaves no area of life untouched. Reaching deep into the lives and hearts of those affected, it cuts them off from the human family and in doing so destroys their spirit more effectively than the HIV virus destroys their bodies.

## What is Stigma?

What do we mean by stigma? Perhaps it is best to think of it as a judgemental approach to another person that arises from our values, prejudices and taboos. The person differs from us in some way that conflicts with our deep-felt values and prejudices. We react by attaching a negative social label of disgrace, shame, prejudice or rejection to the person. The person becomes significantly discredited in our eyes because of the characteristic that offends us.

Individually and communally we brand the person, rejecting and isolating him or her, but stigma also changes the way people view themselves. We refer to this as self-stigma. Pre-empting the reactions of society, the person constructs an image of self so low in self-esteem that it positively cowers before the expected comments and behaviours of others. These feelings of shame, self-doubt, guilt, and self-blame can be so powerful in a person living with HIV that they lead to the never-warranted self-judgement: "I'm getting what I deserve". That is totally wrong. Nobody deserves HIV or AIDS. Just nobody. But the self-stigmatising person does not see this.

Some things we should note about this act of stigmatizing: First, HIV and AIDS do not stigmatise; people do. It is we who do the stigmatising, not the disease. It is we who react in a hostile, antagonistic way. There is nothing rational or reasonable about our reaction. It springs from a

prejudice within us, and a prejudice is what it says — a pre-judging, a judging in advance before we have evaluated any of the evidence for our hostile judgement.

Second, the prejudice we experience is not something isolated inside us. Instead, it finds a place within a family of pre-existing social mind-sets that flourish within us. Most of us are already home to chauvinistic attitudes based on class, race, religion, sexual orientation, gender, and economic status. AIDS-related stigma is layered upon these and supported by them. So it is that when we hear of HIV or AIDS we think very easily of gay men, commercial sex workers, those who lead a liberal sex life, drug users, Africans, immigrants, the poor, women.

Third, stigma almost always means separating “them” from “us”. A strong feature of AIDS-related stigma and discrimination is the tendency to regard HIV or AIDS as a problem that belongs to someone else. We see it as a problem “out there”, belonging to others but not to ourselves. Many African countries have interpreted it as an American disease of homosexuals, while much of the world tends to see it as an African disease of promiscuous people. We all share in this unhappy tendency to “otherise” the problem, to look for the scapegoat elsewhere.

If we are being quite honest, we should ask about our own approach to HIV and AIDS. Do we see it as a problem affecting Irish society, or do we see it as something that belongs on the margins of society, to immigrant groups, largely from Eastern Europe and West Africa? How do we look on people, countries, and even regions where the disease is very



## World AIDS Day 2006

prevalent? Do we subtly blame them for bringing the disease on themselves? Do we stereotype them for what we believe are their liberal sexual or drug-injecting lifestyles? Do we place the onus for changing behaviour on them, without ever pausing to think that many millions do not have the freedoms that are needed for any other form of behaviour? Dismantling stigma and discrimination is essential for success against the epidemic. We will never overcome the medical epidemic unless we also overcome the social epidemic.

One other feature is very important. What we do not always recognise is the reality of the irrational act of stigmatizing: it makes us, the stigmatisers, lose value and become less worthy and less human — we respond to others as if they were of lesser value, and in doing so we become of lesser value ourselves.

### **Discrimination and its Manifestations**

The result of the stigma associated with HIV and AIDS is discrimination. You are treated differently, in an unfair and unjust way, because you are seen as belonging to a different group. There is no end to the

way discrimination shows itself: isolation, being shunned, taunting remarks, children being jeered at school, being spoken to in excessively unkind tones, mocking, gossiping, offensive curiosity, not letting children play together, unfriendly and uneasy attitudes, your partner dropping you, not being served in shops or banks, being made to wait until all the others have been attended to in the health centre, customers no longer buying from your stall, people refusing to share cutlery or cups, not being allowed to kiss your nieces or nephews, not being promoted, losing your job, being thrown out of your house. The list goes on and on.

About three months ago I was working with Christian Brothers<sup>3</sup> from half a dozen African countries who had gathered in Nairobi for a week of reflection and prayer on how they might best respond to the AIDS epidemic in their various districts. On one of the days, six women from different parts of Nairobi came along to talk to us about the AIDS problem as they experienced it. Each was living with HIV and some were on antiretroviral therapy.

Each woman told us how their husbands or their families had thrown them out of their homes as soon as they heard that they had HIV. Here were six young women whose only crime was that they remained faithful to their husbands and thereby became HIV-infected. And what did they get for this? They were disowned, rejected, shouted at, beaten, chased away with their children and without any belongings. And each of these six women affirmed that they were not alone, that the same thing was

happening in household after household, wherever there was HIV or AIDS.

Apart from the blatant injustice of it, you can see what this inevitably leads to. Who would want to come out into the open and acknowledge their HIV status if that is the kind of reception they can expect? Nelson Mandela once said, “many people suffering from AIDS are not killed by the disease itself; they are killed by the stigma and discrimination surrounding everybody who has HIV and AIDS”.

Stigma and discrimination kill because they stop people from coming forward for testing and life-preserving therapy. Nowhere is this so evident as in the small number of HIV-infected mothers who receive treatment for the prevention of HIV transmission from mother to child. It is a damning indictment of global policy and practice that, more than 25 years after the explosion of HIV and AIDS on the world, less than 10% of pregnant women in developing countries are accessing services to prevent the transmission of HIV to their infants.

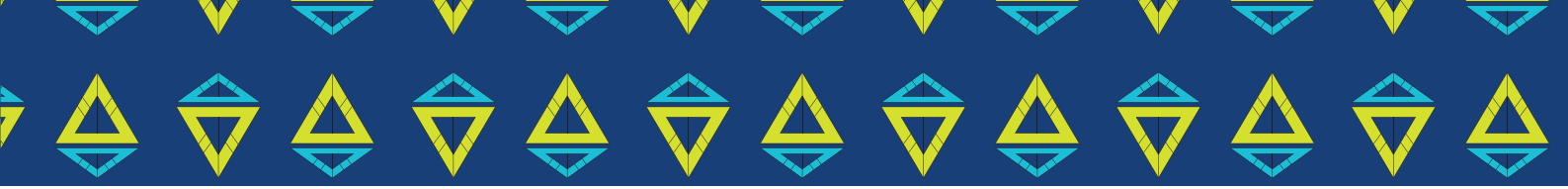
The reason is not the non-availability of services, although admittedly these need to be expanded greatly.

The reason is stigma. Mothers do not want to be tested. They do not want to know their own HIV status, because they fear the stigma they will face in their communities if they do not breastfeed their child, or if they have to take antiretroviral drugs. In a macabre way, stigma is killing mothers, leading to the premature and horrendous deaths of their infants, and making orphans of their older children.

***“The result of the stigma associated with HIV and AIDS is discrimination. You are treated differently, in an unfair and unjust way, because you are seen as belonging to a different group”.***

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3 The Congregation of Christian Brothers is a Catholic Lay Order.



Stigma kills in other ways also. Eight years ago, Gugu Dlamini<sup>4</sup>, a volunteer worker for the National Association of People Living with AIDS in South Africa<sup>5</sup>, spoke in Zulu on South African radio and television about her HIV infection. At once, her neighbours began to accuse and threaten her for bringing shame on their community. Three weeks later, a mob attacked her house, stoned her, kicked her and beat her with sticks. Within a short time she died from her injuries.

And Gugu's murder has been repeated elsewhere. Just listen to this catalogue of very recent incidents issued by the highly respected Human Rights Watch organisation:

- A Mexican AIDS activist is stabbed to death in his condom shop.
- In China, 23 people infected with the AIDS virus are put under house arrest.
- A Ugandan woman is murdered by her lover after she tells him she has the disease.
- An HIV-positive 15-year-old Kenyan boy is killed by a pitchfork wielded by his uncle as villagers, fearing infection, stand idly by.

To this we can add what happened in Taiwan in mid-October this year when, in response to complaints by local residents, a court ordered the closure of a home caring for HIV-positive children and adults. Clearly, HIV stigma is universal, and equally clearly, it is very much alive.

African philosophy has a wonderful understanding of what it means to be human: a person is a person through other persons — “umuntu ngumuntu ngabantu”<sup>6</sup>.

We need the links with other people. We cannot endure isolation from others. Our humanity is defined through our relationships with others. We develop our personality through our interactions with others. Stigma and discrimination put an end to all that. They deny the humanity and individuality of the person with HIV or AIDS. They attack the bonds that join people together. They isolate. They cut off. They do not let a person be a person through other persons. This undercutting of our common humanity gives a deeply destructive quality to AIDS-related stigma. It puts it in the category of the oppression meted out to those who differ from us on grounds of race, caste, or sexual orientation.

### **“What Medicine Can You Give Us Against Stigma?”**

At a conference in late 2005, Vicky Bam, a young Namibian woman, told us that she had been very happily married to a husband whom she greatly loved and that they had two beautiful children. One of the children fell sick, was diagnosed as having AIDS, and eventually died when still very young. This prompted Vicky and her husband to go for an HIV test. Both were found to be HIV-positive.


The HIV-status of the Bam family became common knowledge in the community, where they experienced much hostility and stigma. This became so intense that Vicky's husband, unable to stand it any longer, took his life. Stigma drove him to suicide. Having lost one of her children and the husband she loved, Vicky (who is now taking life-supporting antiretrovirals) challenged those who were present: “With ARVs we can cope with AIDS, but what medicine can you give us so that we can cope with stigma and discrimination?”

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4 Gugu Dlamini (1962-1998) was a South African woman from eastern KwaZulu-Natal province, who was murdered after publicly speaking about her HIV positive status.

5 The National Association of People Living with AIDS in South Africa is a non-governmental, not-for-profit, members' organisation which supports social and economic development for people living with HIV.

6 Originates in the Bantu languages of Southern Africa, can be translated as ‘A person is a person through other persons’, and expresses a philosophical concept of humanity towards others.



What can we do about stigma? We have our toolkits for dealing with the problem. We have our learned articles. We have our conferences devoted to understanding and responding to stigma. But it continues to elude us. It continues to flourish. And as it does so, it mounts an obscene assault on the human dignity and worth of infected individuals and their families and becomes an ever more perfectly fashioned instrument for keeping HIV and AIDS thriving but hidden.

### **Stigma and Moralising**

A major reason for the universality and depth of AIDS-related stigma is undoubtedly the way, from the start of the AIDS epidemic, we equated HIV infection with behaviour of which society did not approve — putting it bluntly, we associated HIV with sin. We identified HIV with sexual promiscuity or with a gay lifestyle or with drug-injecting use. We built up a whole series of mistaken identities: that HIV meant there had been sexual activity, almost certainly of the wrong kind; that illicit sexual activity meant sin; that sin deserved punishment. Wrong statements, every one of them, but that did not stop us from understanding HIV infection in narrowly moralising terms and thereby building up powerful justifications for a stigmatising approach.

Unfortunately, religious perceptions played a sorry role in equating HIV with moral failure. In the early days of the epidemic, many religious leaders were divided within themselves on what their response to HIV and AIDS should be. They combined boundless compassion and magnificent care for the sick with an uneasy false identification between HIV infection and immoral activity. Much of the way they reacted was a reflection of the way their communities thought about the issue. But as religious leaders they should have gone beyond being mirror images of community reactions. They should have extended their theologies of care, forgiveness, and understanding to everybody who had HIV, and not just to those who were already experiencing severe

illnesses. They should have reflected more deeply on what was occurring and worked to remove morality and sin from the discourse about HIV and AIDS. Later, almost all of them began to do so. But by then it was almost too late. Stigma, always lurking around, continued, and still continues to be enormously reinforced by this latent or express association between HIV infection and alleged moral wrongdoing.

Religious leaders have much lost ground to make up. They must be fearless and tireless in persuading people to accept the message: HIV is not a sin. AIDS is not a sin. The real sin, if we want to use that term, is stigma, and individuals and communities must spare no efforts in rooting this out.

Because HIV transmission occurs principally through sexual activity, religious leaders have the further responsibility of helping people develop a more positive attitude to sex. Even today, we still find relatively few religious authorities who dare proclaim the greatness, goodness, wonder, marvel, beauty, and godliness of sex and sexuality. This is not a limitation exclusive to the Catholic Church or to the Christian tradition. It is something that appears strongly in Islam and other world religions, including African Traditional Religions.

Religious leaders, thinkers, youth educators, parents – all have a responsibility to change this situation, to proclaim the inherent goodness of the human body and all those feelings, moods, and emotions that bring two people together in a creative intimacy of closeness and love. Every advance in this direction will help in dismantling the association between HIV and conduct that is labelled as immoral.

### **Stigma and Women**

The AIDS epidemic is savage in its onslaught on women. Almost certainly, HIV and AIDS found their way into the human community through men. It was men that spread the disease initially. It is men who continue to

spread it. But it is women who suffer, women who carry the brunt. Men may have opened the ghastly Pandora's Box of the disease. But they have been singularly successful in passing on its contents to women.

Men certainly suffer because of HIV and AIDS. There can be no doubt about that. But women suffer even more. They are blamed for bringing HIV into the family. This is so ingrained in the culture that in Malawi a sexually transmitted infection is designated in local languages as "the women's sickness". The stigma and rejection of AIDS affect women very deeply in every sphere. It is not just a matter of their reputation. There is also the question of their economic dependence on men. In many cultures, they lack property rights, ownership of assets, and access to credit. They are defined in relation to men and have no independent legal existence. In such circumstances, rejection on the grounds of AIDS is total rejection. We will never be successful in responding to the AIDS epidemic until we take robust, sustained, and specific action to reduce and ultimately eliminate the prejudice, discrimination, and unjust treatment that women experience. Every step that is taken to raise the status of women and to recognise their equal status with men is a step against the epidemic and a step against stigma.

This will never be a world fit for humanity until it confronts male dominance and acknowledges at every hand's turn the full equality of the women who constitute more than half the human race. Do you want to see an end to stigma and discrimination? Involve the participation of women. Cut out the exploitation of women. Reject attitudes and practices that offend against the dignity of women. Above all, listen courageously and carefully to the experience of women and hear what they are saying about this epidemic and the stigma that goes with it.

## Stigma and International Approaches to HIV


HIV and AIDS run into so many areas of life and activity that we should always be alert to the possibility that features of our policies or practices might be offering them unwitting support. For instance, an education ministry that requires teachers to travel to some central location at the end of every month to collect their salaries is a powerful ally of the disease, since it sets up the situation of men regularly away from family and home and with some money at their disposal — ideal circumstances for behaviour that could lead to HIV transmission. A mining company that establishes single-sex hostels for men recruited from rural areas, as is currently happening in a copper mine development in Zambia, is offering "céad míle fáilte"<sup>7</sup> to HIV infection.

Could global policies and approaches be doing something similar with stigma and discrimination? Almost from the outset, we have exceptionalised the disease to an extraordinary extent. We have hedged it around with human rights and legal concerns that we do not apply to other diseases. If I need a medical examination, the doctor will automatically prescribe a number of tests, for my cholesterol, sugar, uric acid, and other things, without asking me. But there can be no test for HIV without my prior and informed consent.

Maybe this was all right at a time when no treatment could be given for AIDS. But surely it is unacceptable today that a medical practitioner needs the express consent of a pregnant woman before testing her for HIV and possibly placing her on treatment that will protect her life and

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7 Traditional Irish greeting, translated as 'A hundred thousand welcomes'.



that of her unborn infant. Surely it is time that we moved towards normalising HIV and AIDS, making testing part of routine medical procedures. Doing this would bring several great benefits. It would increase the numbers who know their HIV status. Thereby it would increase the numbers both of those who wish to remain HIV negative and of those who want to avoid transmitting their positive condition to others. It would increase the numbers who would present themselves in good time, before it is too late, for antiretroviral treatment. And it would demystify the whole area of HIV and AIDS and thereby would make a signal contribution to reducing stigma and discrimination.

There is need also to question the global AIDS prevention policy. Despite some successes, the bottom line is that this policy has not succeeded in preventing HIV transmission. The fact of more than four million new infections in 2006 — almost 12,000 each day or eight every minute — is testimony to that. The fact that in every region of the world there were significantly more people living with HIV or AIDS in 2006 than there had been in 2004 bears witness to the failure of global HIV prevention policy.

A major reason for this failure is that the policy focuses narrowly on the virus and does not pay sufficient attention to the broader environment of poverty, hunger, poor sanitation, inadequate health care services, and gender imbalances, in which transmission occurs. Its vision is limited, its concern mostly with producing immediate results. It fails to take into account that HIV transmission is possible only if, as with every other infectious disease, the environmental conditions are supportive.

A major concern of this virus-centred global policy is to make people more responsible in their sexual and drug-using behaviour. This seems to be an unassailable approach. But the trouble with it is its unspoken assumption that different patterns of behaviour are

real possibilities for an individual. The behaviour change approach simply fails to address the social and economic factors that shape behaviour. Instead it removes sexual encounters from the domain of the passionate and impulsive, and treats the entire process as if it ran in a straight-line direction, guided always by reason and what George Bernard Shaw called “brute sanity”.

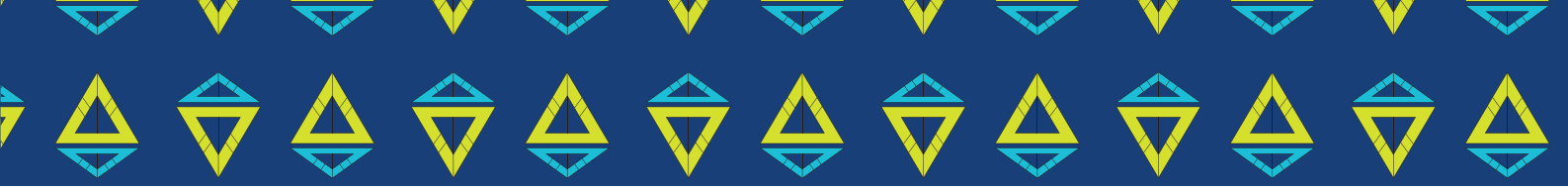
In doing so, it places responsibility for HIV transmission squarely on the shoulders of individuals and overlooks the fact that individuals are not always in full control of their choices. In terms of what finally gets to people, the message is straightforward: behave in way X and you will not contract HIV; behave in way Y and you run the risk of becoming infected — but if you do become infected, it is because of your own behaviour, your own choice. You will have only yourself to blame. And so we are back to where we started, people made to feel small, blameworthy, unworthy, because they have HIV or AIDS.

In this way, the global approach has institutionalised stigma at the heart of international policy. We have got our act about HIV prevention wrong, and we have got our act about stigma wrong. If we cannot do better, we will never overcome this HIV and AIDS epidemic.

### **The Road Ahead**

We cannot stand by while stigma and discrimination create a fertile terrain that allows the AIDS epidemic to thrive. We must bend every effort to ensure their reduction and eventual elimination. And we must be fired by the assurance that we can succeed. Stigma reduction is an achievable goal.

Pointers to a way forward come from what we have discussed already. First, there is an urgent need to demystify HIV and AIDS, turning it, as far as medical and social interventions are concerned, into a condition analogous to any other health condition. In practical terms, this implies incorporating HIV testing into routine



medical investigations, so that there is no more mystery about one's HIV status. Integral to this is the need to ensure the availability of antiretroviral treatment for every person in need. Guaranteed access on the part of every HIV infected person to life-preserving treatment is a powerful antidote against stigma. This is the human right of those who are infected. Equally it is the obligation of those who are not infected to ensure this right. Universal access means life for millions of people who are infected. It also means less stigma.

Second, the emphasis in responding to HIV and AIDS needs to be placed squarely on development. Like poverty, the epidemic is one of under-development, though again like poverty it can occur in well-developed societies. A developmental approach takes the spotlight off the individual and puts it on the joblessness, poor education and health provision, food insecurity, unsanitary conditions, and other circumstances in which the disease thrives.

Third, we need massive stress on human rights and justice, in all areas, but very especially in relation to women and to persons living with the disease in any of its stages. Governments must take steps to respect, protect, and fulfil the rights of every individual, but particularly those of the women, children, and infected persons which the stigma associated with the disease puts under such threat. This will require full and absolute adherence to the first principle of the Universal Declaration of Human Rights: all human beings are born free and equal in dignity and rights.

Because of their condition, people living with the disease have privileged access to what it is like. They know what infection means. They know what it is like to have to take drugs at a set time morning and evening

every day of their lives. They also know what it is like to be stigmatised and discriminated against. The greater involvement of people living with the disease is a cardinal principle in the global response. Those living with HIV should be our first allies in the struggle with the epidemic and in efforts to deal with stigma and discrimination.

## Conclusion

Let the last words be those of a child, Nkosi Johnson<sup>8</sup>, the little South African boy with the big eyes. Nkosi's mother was HIV positive and passed the virus on to her unborn baby in 1989. He should have been a statistic, one of the 70,000 South African children born every year with HIV. But Nkosi was a fighter. For an extraordinary twelve years he lived with HIV and then AIDS. He never knew the support of antiretroviral treatment, because at that time only the wealthy could access this. Six years ago he electrified the world by his address at the opening of the International AIDS Conference in Durban, where he took President Thabo Mbeki to task. He was eleven years old when he spoke so movingly and fearlessly at that world gathering. Less than a year later he died. Listen to his appeal:

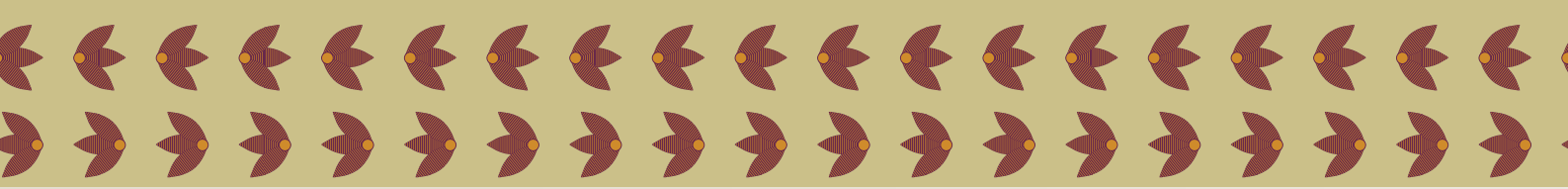
*"I want people to understand about AIDS — to be careful and respect AIDS — you cannot get AIDS if you touch, hug, kiss, hold hands with someone who is infected. Care for us and accept us — we are all human beings. We are normal. We have hands. We have feet. We can walk, we can talk, we have needs just like everyone else — do not be afraid of us— we are all the same!"*

Nkosi was absolutely right. We are all the same. There is no need to be afraid of anybody. This whole stigma and discrimination scene is utterly nonsensical. Let's make an end of it!"

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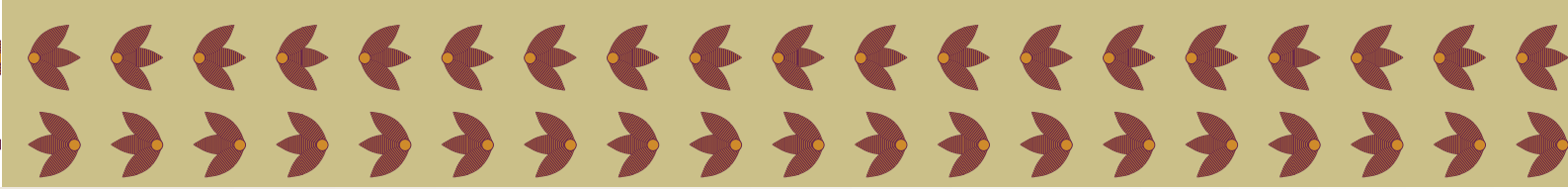
<sup>8</sup> Nkosi Johnson (1989-2001) was an 11-year old South African child living with HIV and AIDS, who was the keynote speaker at the 13th International AIDS Conference in Durban, South Africa. His advocacy had a wide-reaching impact on public perceptions of the HIV pandemic.





# 2007

*The 2007 Professor Michael Kelly Lecture on HIV and AIDS was opened then Minister of State for Overseas Development, Michael Kitt, T.D. The Honourable Professor Sheila Dinotshe Tlou, then Minister of Health of Botswana, also spoke at the event, focusing on the country's experiences in addressing HIV and AIDS among children. In "Children Affected by HIV/AIDS: The Botswana Experience", Professor Tlou outlined the progress that had been made, as well as ongoing challenges, in areas such as Prevention of Mother to Child Transmission, HIV prevention among young people, paediatric HIV and AIDS treatment and care, and protection of orphans and vulnerable children.*



## 2007 PRESENTATION

# HIV AND CHILDREN

In his 2007 address, Father Michael turned to the specific challenges encountered in caring for children affected by HIV and AIDS, and called for a renewed global commitment to addressing the well-being of children and their caregivers. At the time, children in Sub-Saharan Africa were becoming orphans due to AIDS at the rate of 2,500 each day, or over 100 per hour, and at the beginning of 2007 there were 2.3 million children under the age of 15 with HIV. A total of 15.2 Million Children under the age of 18 had lost either one or both parents to AIDS, and many more were made vulnerable by the disease. The event was opened by then Minister of State for Overseas Development, Michael Kitt, T.D., and Father Michael was introduced by Professor Sheila Dinotshe Tlou, then Minister of Health for Botswana. Father Michael's lecture in 2007 was not recorded, therefore this section contains a distillation of the messages included in the slides of his presentation. Both Father Michael's, and Professor Tlou's presentations can be downloaded from [www.fathermichaelkellyzambia.org](http://www.fathermichaelkellyzambia.org).

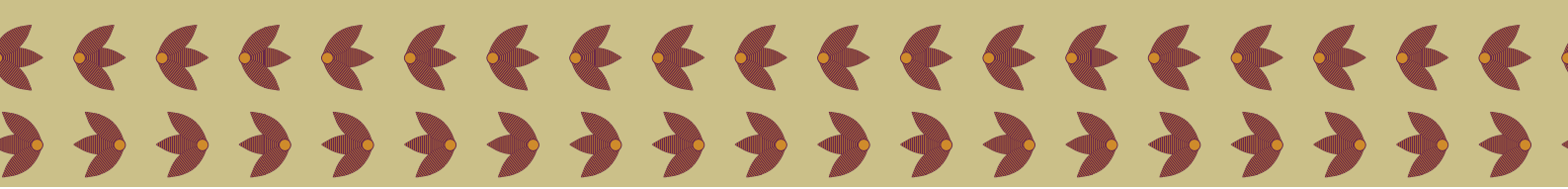
**Michael J. Kelly, S.J.,  
Royal College of Surgeons in Ireland,  
Dublin, Ireland, November 2007**

Father Michael highlighted the fact that orphanhood is a lasting state – not only for the child but for society as a whole, and called for the global community to be prepared to make long-term commitments to provide for orphans, for a period of 20 years or more.

Speaking of the wider vulnerabilities caused by HIV and AIDS, Father Michael drew attention to children whose parents were living with HIV and AIDS; those who live in households where HIV and AIDS is present, yet the parents remain healthy; those living in households where there are no adults, or where the caregivers are themselves elderly; and finally children who are themselves caring for other children or orphans. He also spoke of the circumstances where children might become vulnerable – for example if their families are no longer able to turn to relatives for assistance, or when they are exploited for labour.

Children in these circumstances face economic insecurity and difficulty meeting basic needs for food, healthcare, and education, but in addition to this, Father Michael also noted that they might suffer from emotional concerns including trauma, feelings of fear, sadness, helplessness, worry, distress, and unhappiness. Compounding this problem, parents may have reduced time and capacity to provide the support needed for their child's development. Beyond the individual level, Father Michael also spoke of the broader societal consequences for children orphaned by AIDS: stigma and discrimination, school absences, risk of exploitation, and the risk of contracting HIV themselves.

In addition to these issues, Father Michael added that in many situations, children also bear the burden of caring for parents with HIV and AIDS. Furthermore, they might be separated from siblings or re-housed to live with relatives, and can be forced into secrecy and silence about the disease, as well as facing inadequate time and supports to grieve for a deceased parent. Against this backdrop, many families are unable to cope with



the way HIV and AIDS increases poverty, or to provide for orphans: as Father Michael observed, *“The poor help the destitute by sharing what they cannot afford”*. He also noted that often the burden of caring for children orphaned by HIV and AIDS often falls upon the elderly, grandparents, and others who are in poor health themselves, yet there are few supports in place for these caregivers.

Father Michael also brought to the audience’s attention the fact that there is a disproportionate effect on school-age girls, who are too often removed from education to care for relatives and support the household. Consequently, this increases their vulnerability to HIV and denies them the better economic prospects that education can bring.

Father Michael gave a number of examples of Zambian young people who had lost parents to AIDS, from which it became clear that children share the same aspirations

and dreams everywhere, yet AIDS is depriving them of the irreplaceable parental love and emotional support that would help make those dreams a reality. While to date there has been much focus on meeting children’s physical needs, more attention is required to attend to their emotional and psychological needs. The HIV epidemic has meant that children are being forced into adulthood before their time, assuming responsibilities as caregivers and heads of households, and being deprived of their right to happiness, to rest, to leisure, and to play.

Father Michael remained adamant that the international community can halt the preventable growth in the number of orphans and help to establish a protective and stable family environment for children affected by HIV and AIDS. By helping keep children in education, it will be possible to ensure a decent life for every child, and Father Michael also noted that in 2007, the Irish government

earmarked an additional 20% in resources to support vulnerable children affected by HIV and other communicable diseases. He also praised Ireland's efforts, through government, civil society, missionary, and volunteer channels, which demonstrated the country's commitment to improvement of formal support programmes to address the needs of orphans and vulnerable children. Father Michael called upon the international community to keep children's issues high on the agenda, at all levels, through state, church, civil society, and the media, and to support the child-focused efforts of organisations such as Trócaire, Concern, Goal, Oxfam, UNICEF, Zambia Orphans of AIDS, HelpAge, VSO, and missionary bodies. He also warned

that we must never become complacent, quoting Dr. Martin Luther King: *"Our lives begin to end the day we stop talking about things that are important"*.

In summary, Father Michael's final thought for the day acted as a rallying call to all involved in contributing towards the global response to HIV and AIDS: *"Every one of us needs to maintain an unflinching devotion to doing something about the havoc the AIDS epidemic is wreaking in the lives of children, so that we can help in creating a brighter future for millions of children. Only in this way can we be true to the common humanity that binds us all together"*.





*Father Michael's 2008 lecture was accompanied by keynote speeches from Dr. Stuart Gillespie, Co-Founder and Director of the Regional Network on HIV and AIDS, Rural Livelihoods and Food Security (RENEWAL), whose speech, titled "International NGO Perspective on Transformative Roles in HIV, Nutrition and Food Security", covered HIV-focused efforts to integrate social protection and agricultural programmes with targeted nutritional and health interventions, and Connell Foley, Director of the Strategy, Advocacy, and Learning (Policy Unit) within Concern Worldwide, whose speech "International NGO Perspective on Transformative Roles in HIV, Nutrition, and Food Security" outlined some of Concern's community-based projects focusing on improving resilience and livelihoods among those affected by, and at risk of, HIV.*

2008



## 2008 PRESENTATION

# HIV AND FOOD SECURITY

In his 2008 lecture in Dublin, Father Michael spoke about the dynamic inter-relationships between food scarcity and insecurity and the epidemiology and experience of those living with HIV and AIDS. He reiterated the former Taoiseach's statement to the United Nations that: *"It is an affront to our common humanity... that 30,000 children die each day from easily preventable diseases, or that 100 million people go to bed hungry"*. Father Michael's lecture was accompanied by guest speakers Dr. Stuart Gillespie, and Connell Foley. Father Michael's 2008 lecture was not recorded, therefore this section contains a distillation of the messages contained in his presentation from that year. The full presentation, as well as those of the guest speakers, can be downloaded from [www.fathermichaelkellyzambia.org](http://www.fathermichaelkellyzambia.org).

**Michael J. Kelly, S.J.,  
Royal Irish Academy,  
Dublin, Ireland, November 2008**

Nine million people die each year, or 1,000 per hour, because of hunger and poverty. And while 10% of hunger related deaths are from acute events, like famine, 90% of those deaths are from chronic hunger and malnutrition, with the number of chronically hungry people growing by an average of four million per year. Our response must shift from just the acute cases of food shortage, to address those who lack the basic human right to food – a basic human right outlined by the World Food Summit in 1996 as: *"the right of everyone to have access to safe and nutritious food, consistent with the right to adequate food, and the fundamental right of everyone to be free from hunger"*. Food is life, and the right to food is a fundamental one without which many other rights cannot be enjoyed.

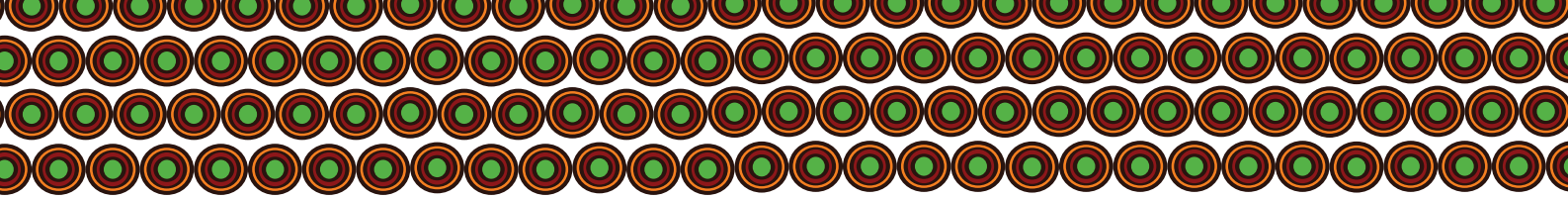
There are 240 people per hour dying from AIDS-related illnesses (2.1 million people in 2007), and 285 people per hour become newly infected with the HIV virus (2.5 million people in 2007). Every minute, a child under the age of 15 dies of an AIDS-related illness, and another child becomes infected with HIV. It is no coincidence that HIV prevalence and malnutrition coexist in many

parts of the world. The very factors that lead to hunger and malnutrition are those that are now driving the HIV/AIDS epidemic: poverty, the movement of people, conflict, and inequality. This appears very strongly in the case in Africa.

Food security exists when all people, at all times, have physical and economic access to sufficient, safe, and nutritious food to meet their dietary needs and food preferences for an active and healthy life. Food security is concerned with the availability, access, stability of supply and access, and safe and healthy use of food. By contrast, food insecurity exists when food is available but not adequate, there is not enough food for everyone, families cannot feed all the members of their households due to prices, transport, or food type, or when food reserves become inedible.

As Peter Piot, then Executive Director of UNAIDS related: *"I was in Malawi and met with a group of women living with HIV. I asked them what their highest priority was. Their answer was clear and unanimous: food. Not care, not drugs for treatment, not relief from stigma, but food"*.

Food security and HIV and AIDS are inextricably linked. From a physiological perspective, food insecurity makes it easier to become infected with, and to transmit HIV,



and it speeds the progression from infection of HIV virus to AIDS. Malnutrition and hunger can also lead to risky survival activities, like migration in search of work or food, the exchange of sex for food or money, or having to remove girls from their schooling to provide support in the home. These activities and behaviours put individuals at a further disadvantage, with greater nutritional needs but with even less access to adequate food.

At a societal level, HIV increases the need for food, reduces the food labour workforce through HIV and AIDS-related illness, and reduces the level of support from agricultural support services, impacting land use, crops, animal care, environmental protection, and community support systems, all of which increase food insecurity. Women especially are impacted negatively by food insecurity because of the major role they play in food production, and as carers for the sick and for children, including orphans, or when they themselves become ill. Whole communities relinquish assets and productive food equipment in order to support the sick, pay for medical costs, transport, and funerals.

In addition, there is a reduced investment in the next generation through health and education, diminishing the potential for passing on essential skills and knowledge, such that social capital is diminished. HIV and AIDS also complicate and magnify the scale and complexity of current global issues related to food security including rising food prices, climate change, biofuels, innovation and Genetically-Modified Organisms (GMOs), population growth and responses to poverty, and establishing comprehensive social protections for women, children, the

elderly, and other vulnerable populations.

For instance from 2006 to 2007, biofuels were responsible for the consumption of 50% of major food crops. There is now concern that the development of alternative biofuels has contributed to rising food prices, further endangering food security for the world's most vulnerable, and that the full environmental effects of biofuels are uncertain and possibly negative. The increasing use of genetically modified organisms, or GMOs, while enabling hardier, more productive crops, has been associated with too much reliance on a few biotech companies for a wide diversity of inputs, reducing biodiversity. This puts populations at risk of agricultural crop mono-reliance, as was the case in the Irish potato famine. There is also uncertainty over the potential risk to health from daily intake of genetically modified organisms, such that even food-stressed countries like Sudan, Angola, Malawi, and Zambia have rejected GM crops and imports.

One way we can intervene is by enabling comprehensive social welfare or protection programmes integrating cash transfers of five to seven euros per month and other social provisions. Even such a small amount of cash can transform the lives of severely impoverished households, allowing them to buy food, basic items, farm inputs, and to repay debts. These transfers can lead to improved nutrition, less illness, and improved school attendance. Such assistance also promotes a sense of well-being and hope.

We can replace the negative cycle linking food security and HIV and AIDS with a virtuous cycle in which, as food security and

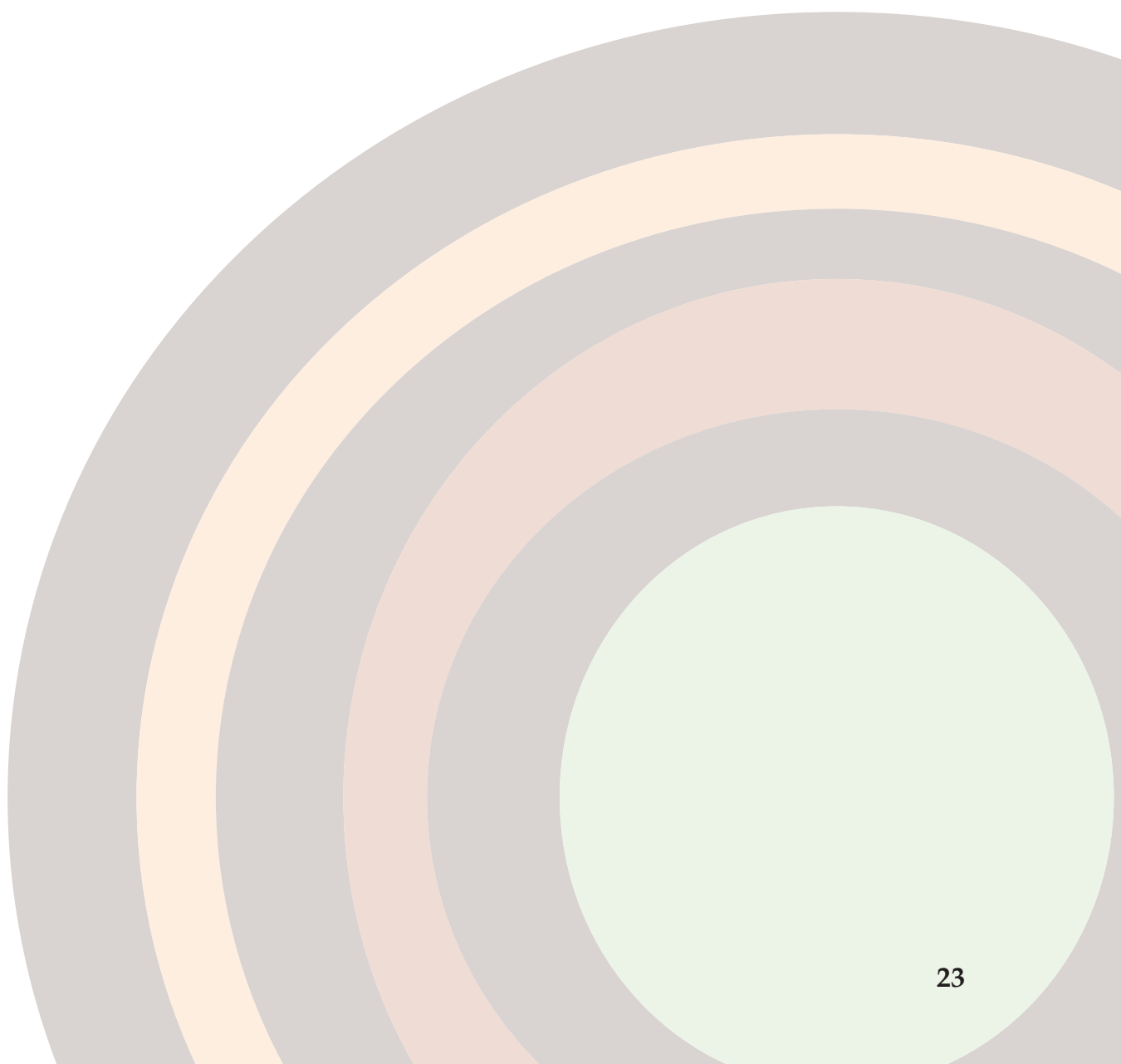
*“Where we are met  
with cynicism and  
doubt, and those  
who tell us that  
we cannot, we will  
respond with that  
timeless creed that  
sums up the spirit of  
a people:  
YES WE CAN!”*



nutritional status improve, HIV and AIDS decline, leading to further improvements in nutritional status and food security and improvements in health. We will succeed in doing this by strengthening the individual capacity of families, households, and communities and ensuring access to essential services, especially schooling for girls for as many years as possible, health care, and the prevention of HIV transmission from parent to child. We must advocate that governments protect the most vulnerable through social protection programmes, cash transfers, school-based food programmes, and similar interventions, and we must promote sustainable livelihoods in both rural and urban areas and advocate for a greater priority for food security and fair trade.

Ireland has made a commitment to respond not only to acute needs, like famines, but also to the underlying causes of hunger. To do this and successfully contribute to food security requires a range of interventions, from building livelihoods, to agricultural research, to rural development. A focus on poverty reduction is the most comprehensive way of addressing hunger. We need new and innovative ways to reduce vulnerability, provide social protection, and build productive capacity.

Where we are met with cynicism and doubt, and those who tell us that we cannot, we will respond with that timeless creed that sums up the spirit of a people: YES WE CAN!







*In 2009, the Professor Michael Kelly Lecture was opened by then Minister of State for Overseas Development, Peter Power T.D., whose speech reflected on current progress and future challenges faced in widening universal access to HIV prevention. Minister Power focused on the burden suffered by women and girls, but also drew attention to the great progress made by the biomedical sciences towards discovering an effective vaccine for HIV. Dr. Seth Berkley was an invited speaker at this event, and presented his extensive experience of working in the field of HIV and AIDS research and vaccine development. Much of Dr. Berkley's work to-date has been dedicated to developing and ensuring universal access to HIV treatment and prevention.*

2009



## 2009 ADDRESS

# MAKING UNIVERSAL ACCESS FOR HIV PREVENTION HAPPEN FOR WOMEN

The 2009 Professor Father Michael Kelly Lecture on HIV and AIDS took place at the Royal College of Surgeons in Ireland, as part of an event which centered on the work of the International AIDS Vaccine Initiative (IAVI)<sup>1</sup>. Then Minister of State for Overseas Development, Peter Power, T.D., gave the opening address to mark World AIDS Day. Father Michael was unable to attend that year, and instead delivered his address via video from Zambia, introducing guest speaker Dr. Seth Berkley, founder of the IAVI. Please visit [www.fathermichaelkellyzambia.org](http://www.fathermichaelkellyzambia.org) to view Father Michael's address, and read the full transcript of Minister Power's speech, as well as view a presentation by Dr. Berkley on strategic advancements in HIV vaccine development.

**Michael J. Kelly, S.J.,  
Lusaka, Zambia, November 2009**

"Chair, Ladies, and Gentlemen, it gives me great pleasure to speak to you from Lusaka today, welcoming you to this year's annual World AIDS Day lecture. I really regret that I cannot be with you this year, but commitments here in Lusaka make this impossible. By the time you hear this, I will have spent much of the morning on a chat-back radio programme dealing mostly, I expect, with what we can do to prevent the further transmission of HIV.

This is a very lively two-hour programme that receives almost non-stop phone-ins and text messages from a wide audience in many parts of English-speaking Africa. Then, at the very time this lecture is starting in Dublin, I will be telling a German Aid Agency audience in Lusaka about the way the AIDS

epidemic is impacting on women and girls, and stressing that the surest way to bring down the number of new HIV infections is to end the subordination of women.

Two weeks ago it was really great to hear a national HIV prevention convention in Zambia agree on establishing long-term programmes to end the second-class status of women throughout our society. If we had enough action on that, we would stop much HIV.

Then, later this evening, I hope to participate in the candlelight memorial service at the Anglican cathedral to remember the living and the dead who have been infected or affected by HIV, and to renew our commitment to moving towards an AIDS-free world. An AIDS-free world, yes, that's what we really want to see, and one of the best ways towards this lies in the development and use of an AIDS vaccine.

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<sup>1</sup> *Global not-for-profit public-private partnership which works to accelerate development of vaccines against HIV.*



And who better to talk about that than Dr. Seth Berkley, the world's leading expert in this area, whom you will be listening to in a few minutes time. For the past thirteen years, Dr. Berkley has worked dynamically and tirelessly in promoting the development of an AIDS vaccine, and in keeping this issue high on the international agenda.

Because progress is necessarily slow, it is a thankless task, but the rewards for Dr. Berkley's persistence may now be on the horizon, with encouraging recent news from Thailand showing that it is possible to develop a vaccine that would prevent HIV infection in a general adult population.

Dr. Berkley, allow me to congratulate you and all who are involved in this very significant development, and to express the hope that

this may be the harbinger of what the world is hoping for: a safe, and effective vaccine against HIV.

Also, let me say how greatly honoured I am that you are giving today's lecture. That you are giving of your time to do so is a challenge to me, and every other person in the AIDS field, never to let up, but to continue doing all we can, to roll back this epidemic which is such an affront to the dignity and humanity of millions of people worldwide.

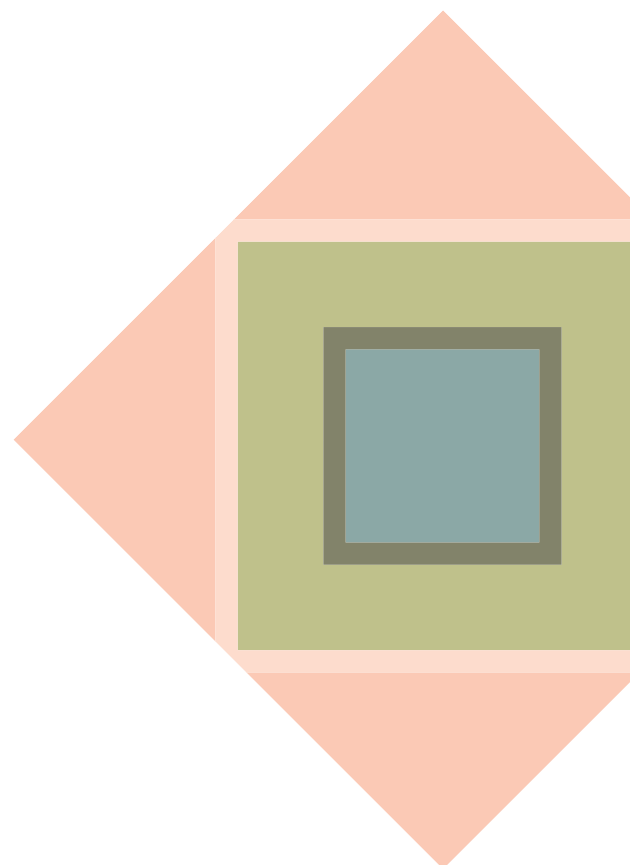
And finally, Ladies and Gentlemen, let me thank the Irish government and Irish Aid, for making this lecture an annual event and for doing me the honour of identifying it with my name. I can think of many indeed who are far more deserving of such recognition, among them, Nicola Brennan and Vinnie O'Neill



of Irish Aid, Sister Miriam Duggan and her tireless work in Uganda<sup>2</sup>, Mary Donohoe of the Rose Project<sup>3</sup>, my own namesake and fellow Jesuit Michael D. Kelly, who established Kara Counselling<sup>4</sup> here in Lusaka, Sister Kay O'Neill who runs Our Lady's Hospice<sup>5</sup>, also here in Lusaka, and James O'Connor of the Open Heart House in Dublin<sup>6</sup>.

I think also of the thousands I have known and admired, people who experienced utterly dehumanising sufferings, but who rarely complained, and never lost hope. I trust that the association of my name with this annu-

al lecture will be seen as symbolic with me as it were standing in for and representing the great body of wonderful Irish people who have spent themselves in addressing HIV and AIDS and their appalling impacts, as well as the great body of heroic people who have endured the worst ravages of the epidemic. I conclude by saluting all of these for their great resilience, their unquenchable hope, and above all, their unsurpassed human dignity. I welcome you again, and I thank you. I hope you will enjoy the lecture, and may God bless all of you".

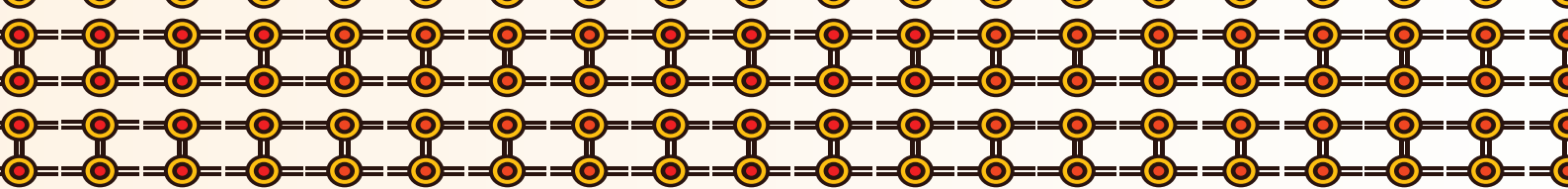


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- 2 *Sister Dr. Miriam Duggan is an Irish Obstetrician who was the Founder of Youth Alive, and in 2015 was awarded the Presidential Award for Distinguished Service for the Irish Overseas*
  - 3 *An NGO founded by Mary Donohoe, which aimed to fund programmes addressing maternal and child healthcare in Malawi.*
  - 4 *The Kara Counselling and Training Trust, founded in 1989, pioneered in the field of Voluntary Counselling and Testing (VCT) in Zambia, running VCT centres in Lusaka, and providing other activities.*
  - 5 *Hospice in Lusaka which provides care for those living with HIV, including volunteers who visit patients in surrounding communities to support medication adherence and general health.*
  - 6 *Open Heart House was a member-led organisation in Dublin which aimed to support and empower people living with HIV to lead full and productive lives.*

*The 2010 Professor Michael Kelly Lecture was accompanied by the John Kevany Memorial Lecture, which was delivered by Dr. Zeda Rosenberg, Chief Executive Officer of the International Partnership for Microbicides (IPM). Dr. Rosenberg's talk titled, "New Science, New Hope: Giving Women Power Over HIV and AIDS", explored the multiple factors that increase women and girls' vulnerability to HIV transmission, and gave insight into current achievements and collaborative efforts working to improve prevention technologies.*



# 2010



## 2010 PRESENTATION

# HIV AND AIDS: ACCOMPLISHMENTS AND ENDURING CHALLENGES

Hosted by Irish Aid with the Irish Forum for Global Health, the 2010 Professor Father Michael Kelly Lecture on HIV and AIDS was held in conjunction with the Combat Diseases of Poverty Consortium<sup>1</sup>, at the National University of Ireland, Maynooth. The event featured a keynote speech, which was delivered by Dr. Zeda Rosenberg, CEO of the International Partnership for Microbicides (IPM)<sup>2</sup>. This section contains a transcript of Father Michael's introductory address, and a distillation of the messages included in the presentation from his lecture. Audio of Dr. Rosenberg's speech can be heard, and Father Michael's slides can be downloaded, at [www.fathermichaelkellyzambia.org](http://www.fathermichaelkellyzambia.org).

**Michael J. Kelly, S.J.,  
NUI Maynooth, Ireland, November 2010**

“The effects of poverty on health are never more clearly expressed than in poorer communities of the developing world, and I think I could adapt those words to what we are talking about this evening. The effects of HIV on health are never more clearly expressed than in the female communities of the developing world. Most of the HIV that is transmitted is being transmitted heterosexually, and the most vulnerable people are the women. They are vulnerable because they have practically no say in whether to have sex, when to have sex, how to have sex, and some of what we are going to hear this evening from Dr. Rosenberg is, I think, going to help us to see that it will be possible, it is possible,



and it will be done, to equip women with an instrument, a methodology, where they can protect themselves against the unnecessary transmission of HIV from a sexual partner.

In their experience, there is a lot of infideli-

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<sup>1</sup> Initiative funded through the Programme of Strategic Cooperation between Irish Aid and Higher Education and Research Institutes, in collaboration with the Higher Education Authority.

<sup>2</sup> International partnership aiming to prevent HIV transmission by accelerating the development and affordability of safe and effective microbicides for use by women in developing countries.



ty in their partners. They have partners who refuse, because of machoism, to go for HIV testing; that that is “woman’s side”: it is not a man’s position to go for a medical test. They experience a great deal of inter-partnership violence, marital rape, and they experience a great deal of hostility to the use of a condom, a male condom, and amongst women themselves a female condom – amongst other things I hear it said, because it rustles and makes noise. A speaking condom, so to speak.

Well in that very somber climate, where now in many countries in Africa, women account for 60% of the people who are infected, and globally it has gone over 50% by now, in that sort of an atmosphere and climate, we have got to turn and look: can we get some technology that women can use to protect themselves, and we are very glad that we can, and we are so chuffed that tests and trials in the

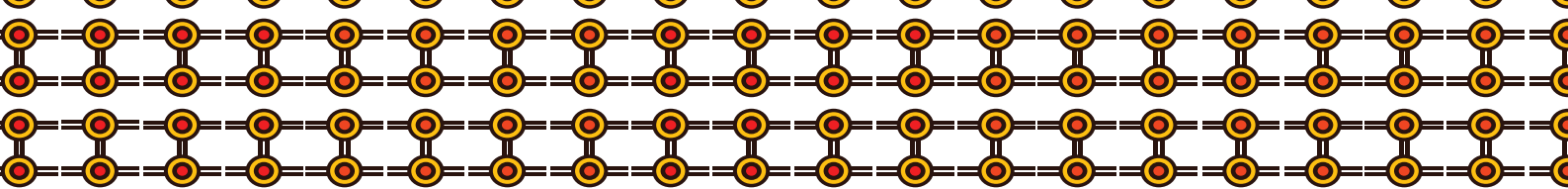
last couple of years have brought considerable success.

But none of that success would have come even this far without the resourcefulness, the ingenuity, the activism, the advocacy, and the tireless passion of Dr. Zeda Rosenberg. We are delighted that she is here with us this evening to tell us, maybe, about some of the failed early efforts. Whether it was lemon juice, because these were some of the early ideas, but to bring us forward to the CAPRISA<sup>3</sup> trials involving Tenofovir and the VOICE<sup>4</sup> trial involving Truvada, and other things that are going on, what is going on now, what is going on in the future, and giving us the promise of a safe, effective, affordable, and available microbicide prevention means that women themselves can use. So it is my great honour and pleasure to introduce to you Dr. Rosenberg, and to ask her to give us her views and her lecture”.

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3 Centre for the AIDS Programme of Research in South Africa, and AIDS research organisation based in Durban, South Africa.

4 “Vaginal and Oral Interventions to Control the Epidemic” programme which tested the safety of different HIV prevention approaches.



In his lecture, titled “HIV and AIDS: Accomplishments and Enduring Challenges”, Father Michael focused on the key challenges of maintaining access to ART for those 5.2 million people who have already accessed it, and expanding it to the 9.4 million people who the WHO estimate are still in need of treatment. He sought to highlight how we must also prepare to expand ART to those 20 million people who have HIV but who do not yet require a treatment regime. Additionally, there are 2.7 million new cases of HIV annually, adding further to the number that will require access to antiretroviral therapy.

The ART drugs themselves represent only about a third of total costs related to antiretroviral therapy. Universal access to treatment is unaffordable, and Father Michael noted that we must turn to preventive measures to eliminate new HIV infections. Vertical transmission, or mother-to-child transmission (MTCT), can be nearly eliminated, even though very often the father is the source of the infection. At the time, there were 430,000 children annually being infected with HIV from parent to child transmission, an unacceptably high figure. More than half of infected pregnant women did not have access to prevention of mother-to-child transmission (PMTCT) services, and women were often blamed for refusing testing, not returning for test results, or not taking drugs, even as they were not being offered life-saving access to ART. In speaking of widening access, Father Michael called on the international community to make better efforts to involve men, and have couples go for joint HIV testing.

At the time, there were more than two million children living with HIV, with that number increasing due to the slowing of deaths as a result of the availability of paediatric ART. However, the broader issues affecting those children’s lives also came to the fore: education, food, hazard and accident awareness, puberty and sex awareness, and school integration were all issues for those young people who were coming of age whilst living

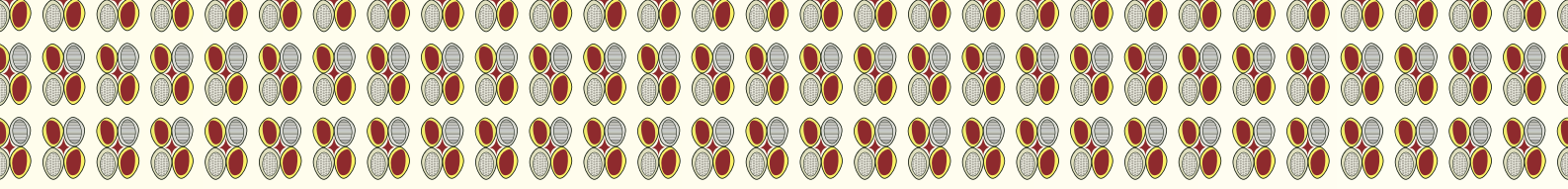
with HIV. The good news at that time was that that young people and adults were reporting more responsible sexual practices, and that HIV prevalence among young pregnant women (aged 15-24) was declining. Nonetheless, challenges remained: For every one person who began ART, two more would become newly infected, and in Zambia in 2009, for every adult who died of AIDS, two more became newly infected with HIV. The real challenge and best hope was therefore to work to prevent new HIV infections. To achieve this aim, Father Michael highlighted the need



for continued dedication, commitment of resources, partnership, and leadership.

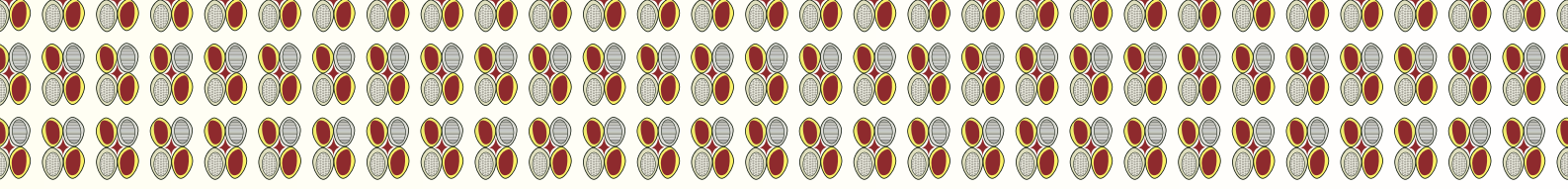
In summing up, Father Michael called on those working in HIV prevention and care to use all available and acceptable prevention measures, tackling social, cultural, and structural factors that were driving the epidemic, and to make changes through good leadership. These included socio-cultural, biomedical, behavioural, and structural justice and human rights interventions to achieve maximum impact in preventing HIV transmission. In closing, he reminded us of a core problem that continued to hamper efforts to control the spread of HIV: “The low status of women is at the heart of the AIDS epidemic”.





*The 2011 Professor Michael Kelly Lecture was opened by the Honourable Dr. Mphu Keneiloe Ramatlapeng, then Minister of Health for Lesotho, and Executive Vice President of HIV/AIDS, TB, and Health Financing, of the Clinton Health Access Initiative. Dr. Ramatlapeng spoke around Lesotho's HIV response, and highlighted the collaborations with other countries that had led to dramatic improvements in the local training of HIV-competent nurses and healthcare workers. South African Singer and Humanitarian, and UNICEF and Roll Back Malaria Goodwill Ambassador, Yvonne Chaka Chaka, was also present, and delivered a speech which focused on the great opportunity that exists to help Africa through investing in its people.*

# 2011



## 2011 LECTURE

# CHANGING LANDSCAPE OF AID AND THE HEALTH WORKFORCE

2011's Professor Father Michael Kelly Lecture on HIV and AIDS was held as a part of the Irish Forum for Global Health International Conference, "Changing Landscape of Aid and the Health Workforce", in February 2012, at the Royal College of Surgeons in Ireland. Here, Father Michael was joined by Dr. Mphu Keneiloe Ramatlapeng, then Minister of Health for Lesotho and Executive Vice President of HIV/AIDS and TB Programmes for the Clinton Health Access Initiative; and Ms. Yvonne Chaka Chaka, South African Singer and Humanitarian, UNICEF and Roll Back Malaria Goodwill Ambassador, and UN Envoy for Africa. Audio of Dr. Ramatlapeng and Ms. Chaka Chaka's addresses can be found at [www.fathermichaelkellyzambia.org](http://www.fathermichaelkellyzambia.org).

**Father Michael Kelly, S.J.,  
Royal College of Surgeons,  
Dublin, Ireland, February 2012**

"Ladies and Gentlemen, good evening. Good evening to all distinguished guests, Ministers, and Ambassadors, and our medical profession as well. I am very honoured to be able to speak here this evening. I am very grateful to Irish Aid, to the Irish government, and therefore to the Irish people, for maintaining this lecture over a number of years, even in a time of financial crisis and hardship. It is a great indication of how serious and committed the people of Ireland are, to their government, to improving the wellbeing of people who have less than the people of Ireland.

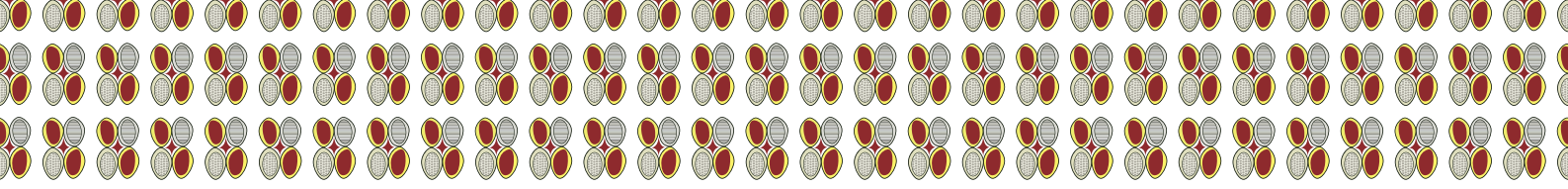
I wanted also to thank very, very much our previous speaker, Dr. Mphu Keneiloe Ramatlapeng, and our subsequent speaker, Ms. Yvonne Chaka Chaka. It's such an honour

and such a privilege to be able to share a platform with them. In the closing part of her film, Yvonne said "Africa is our home, and Africa is our hope". Well I certainly join with that also. Africa is also my home, and Africa is certainly my hope. Wonderful people. Resilient people. As the former Irish Ambassador to Zambia said when he was leaving Lusaka a couple of years ago, "*I hate going away from here, because it was from here that my ancestors came*". As I read in a much more scientific book in the last couple of months, somebody said, "*The first European was almost certainly an African*", so we are in good company, and we come from a good place.

Within the last 12 months I was asked by the World Forum on Early Care and Education for Children<sup>1</sup>, to say something at their meeting, and when I got the programme, and I looked down to Thursday the 5th of May, I found that what I was down for was: Thursday the fifth of May,

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<sup>1</sup> Biennial forum gathering professionals to share knowledge and ideas on issues impacting on delivery of services for children and families.



10.45, Michael Kelly, Zambia, AIDS and Children: Provocation. I have been asked to make presentations, to give lectures, to give opinion pieces and so forth, but it was the first time I was ever asked, deliberately, to provoke an audience of over 900 people. So I am going to continue with that this evening: I am going to provoke. Some words and ideas that might help all of us to sit up and think differently and even think better in a world with AIDS, but also a world with TB, with malaria, and so many other illnesses and sicknesses, some of them preventable, almost all of them curable.

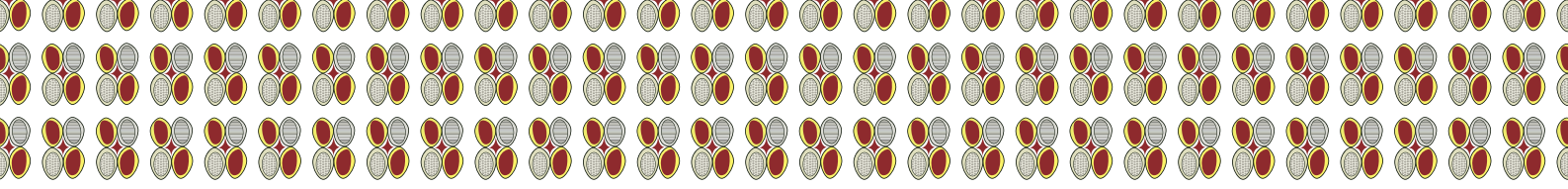
As we do so, we might be able to reflect on a few other aspects of our work. I want to go back a little bit to 2005, to the Paris Declaration<sup>2</sup>, where the big money

players in the world came together with other countries to consider what would be the best strategy to use in coordinating and harmonising the use of aid, so that foreign aid donors were not tripping over one another. They came out with what they called the “Three Ones”: that there should be one national coordinating authority, that there should be one national framework for action, and that there should be one monitoring and evaluation system. That seemed to satisfy the donors, that everything would be hunky-dory, but back in Zambia, when this was being put into practice, a number of us came together and we said there was something missing. We needed something else. We need a “Fourth One”: that there should be one coordinated and acknowledged voice from Civil Society,

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2 Paris Declaration on Aid Effectiveness, acting as a practical, action-oriented roadmap to improve the quality of aid and its impact on development.





from all of those groups that worked so relentlessly, so industriously, in the fields of health and education and so forth, but particularly here in the field of HIV and AIDS, trying to reduce the impacts of the epidemic and seeing how they can move in the areas of prevention and treatment.

We did not get very far, but I was encouraged with a document that came out from UNAIDS only within the last week. It is called: "Guidance on Collaboration with Civil Society", and it is directed not to Governments, and not to Civil Society, but to the members of UNAIDS, the World Bank, UNICEF, UNESCO and all of these United Nations organisations, and it is acknowledging publically and possibly for the first time that the response to HIV and AIDS has been very largely spearheaded at the field level, by Civil Society and by member organisations.

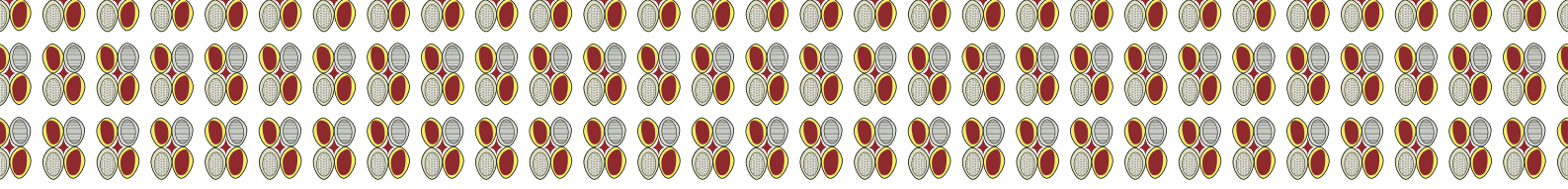
I think that is important for us, and I notice with gratification that in the abstract books that were distributed, that there's quite an amount on how to mobilise Civil Society and how to help them better. And even what the Minister from Lesotho has just been putting before us, about allowances for volunteers, and particularly for the women who are providing the home-based care, all of this is excellent and all of this is within the same radius.

Coming up more recently, UNAIDS has been speaking to us in the last two years about moving towards an AIDS-free world. In that AIDS-free world, there would be zero discrimination on the basis of HIV, zero new HIV infections, zero AIDS-related deaths, and all of that bringing us to an AIDS-free world. That came home to me here in Dublin remarkably this very morning. I was being driven outside Dublin by a taxi driver, and I mentioned that I was in the area of AIDS. He said, "Two of my brothers died of it". He went on to tell me, that they had been at a funeral, he and the two younger brothers, and after the funeral they went into a pub

to get a bit of lunch, a bite to eat, and after some time he noticed they were getting no attention, and he went up to the barman and asked, "What's the problem, we are waiting for service", and the barman said, "I have been told we cannot offer you service, there has been a complaint from some of the people having lunch in this pub".

HIV discrimination is everywhere, even here in our midst. HIV new infections are increasing in Ireland, not as dramatically as in other countries, but still increasing. AIDS-related deaths, I am not sure about them in Ireland, but certainly they are occurring where I come from in Zambia, where you might have five, six deaths every hour of every day throughout the year, attributable to AIDS conditions. So that is what UNAIDS is aiming at, that this situation should change, but as with the "Three Ones", where we suggest from Zambia the need for a "Fourth One", I feel that we need also a "Fourth Zero". We are not going to get to the other three "Zeroes", of zero discrimination, zero AIDS-related deaths, and zero new HIV infections, unless we face up to the other one. That is: zero fudging of central AIDS issues, and in an academic gathering, it's not too easy, maybe not too pleasant to have to say and have to acknowledge, that there has been considerable dodging and skirting of issues – a considerable amount of burying issues in the cupboard, not examining them, not allowing them to be examined as they require, because they are politically sensitive, or because they might conflict with previously held scientific opinions and outcomes.

I think also we have to be very careful about the out-of-this-world aspirations that are being put before us in the area of AIDS as if it was all over. It is far from all over. I will say a little bit more about that in a moment if there is the time. I think we have underestimated the challenge of reaching an AIDS-free world. Just let me give you one area where I believe there has been a lot of fudging going on: that is the



a rea of genetics. A couple of years ago at a conference there was a very prestigious professor who had done some of the major discoveries in HIV, and I asked him what about genetic implications of this disease, do genetics play a role? But he says of course and everybody knows that. I said, Professor I'm sorry, nobody knows that. That is not spoken about. That is a taboo issue.

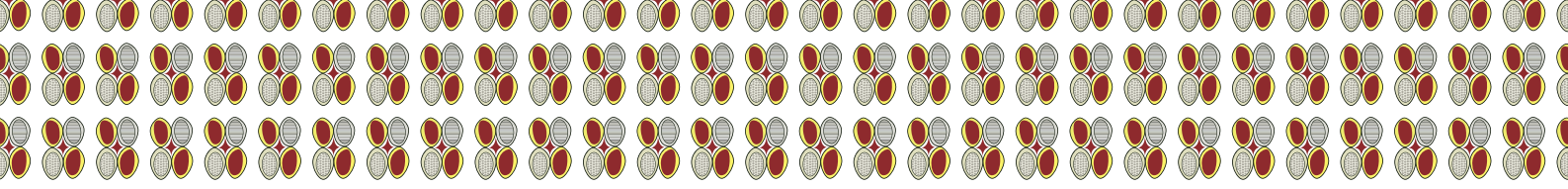
I asked a senior official why do we not look into the genetic determinants or issues that can be related here, and I was told: "Absolutely not. It is bad enough that it is in Africa and with such intensity. We do not want the slur to be cast on Africa that the people are genetically predisposed to HIV transmission or infection". Yet the genetic evidence that we seem to have at the moment is that the Northern Europeans, the Swedes, the Norse and so forth, about 15-18% of them are genetically incapable of contracting HIV. People in Southern Africa, it is said that 90% of them are carrying a gene which predisposes them to HIV infection. Now the trouble with ignoring that kind of thing in my very limited parochial book is, first of all, there are avenues there surely for further investigation for the development of vaccines that would protect. There is also room there to protect people or to prevent resources all going along the one track, that if we can solve the sexual transmission of the disease we will have solved everything. Also, there is the almost inevitable stereotyping of Africa. Africa, the Horn of Africa, Southern Africa, South Africa, Lesotho, Botswana, Mozambique, Zambia, Zimbabwe, Namibia. They are the countries where AIDS is concentrated most in the world. Emphasising strongly the sexual transmission of the disease almost inevitably casts an image of Africa as a highly sexualised continent with an unspeakable amount of sex, and sex of a strange nature.

Yet the fact is that one of the pillars of a modern approach to sexual activity, what's called multiple concurrent partnerships –

stop these, and you will stop the disease – that approach is built on a model that does not work. Apart from the model not working, it ignores the fact that international evaluations and assessments show us that in Southern and Central Africa, multiple concurrent partnerships will occur on the average for six men out of one hundred.

In Europe, it would be 10 or 12. In the United States and France, it might be 14 or 15. We are loading ourselves with something, and we might not have the answers at all. The idea is that we should not speak about it because this would be saying, well the African people are predisposed to this disease and they are at a genetic disadvantage in relation to HIV transmission. We have no inhibitions about speaking about sickle cell anaemia, a condition that only people of African descent can manifest in the numbers that are being shown, and that 80% in Sub-Saharan Africa are carrying the gene that could lead to sickle cell anaemia in their offspring.

We are inhibited and almost forbidden to speak about this in relation to HIV. I feel that that is wrong and that is something that needs to be changed. I am concerned at present about some of the reports that are coming out, the tone of the reports more than the actual content. The tone is very upbeat, as if we have conquered HIV, as if we have conquered this disease. We are hearing enthusiastically about a new treatment platform that will be a platform also for prevention. We are hearing that the goal of an AIDS-free generation is within reach. That statement, the goal of an AIDS-free generation being within reach, is what the media published of what Hillary Clinton said last year on World AIDS Day. What Hillary Clinton actually said was: the goal of an AIDS-free generation is possible. I think there is quite a difference between something being possible and something being within reach, but the spin-doctors got at it, and one is given the impression of "Mission Accomplished, we have reached the goal".



We are very far from it.

I do not think any document I have read, any speaker that I have heard, has addressed the real problem of treatment for HIV, or for AIDS. Currently – and this is a magnificent accomplishment and we must salute it as a very positive thing out of the early years of this century – almost seven million people in the lower economic countries are on treatment, and that is wonderful, and I think we should applaud.

But that is costing, with other AIDS efforts, in and around \$10-12 billion a year, money which is partly coming from the Irish economy, through its contribution to the Global Fund. That is only one aspect; getting these seven million onto AIDS treatment, and maintaining that treatment is now proving more and more difficult: in the year 2010, for the first time, resources fell for AIDS activities across the world.

What does that mean in practice? In practice it means that at a clinic in Malawi, which most years would admit 350 new

HIV patients, they cannot do that anymore. They are limited to 250. At clinics in Lusaka, where a person like the man who does my laundry, used to go every three months to get his tablets, he is now getting only one month's supply. He will have to go back every month for his supply. Now that is fair enough for him in some ways – I think I am a decent employer, so you get the day off for it, but that does not happen all over the country, and for people to get to clinics it may take two days, and take a considerable amount of their income. Now they are having to go every month instead of every three months. What does that mean? It means, of course, they are not going to go back. They are going to lose heart. They are not going to go back for the assessment they require. So maintaining the seven million on ART treatment is extremely difficult.

That's only those seven million. What about the nine million additional patients who are in need of antiretroviral therapy and are not yet receiving it. That's a WHO figure. So we have seven million getting it, a further nine million in need not receiving it, and then beyond that there are a further 20 million who are in need who have HIV, but are not yet in need. Who is going to look after them when the time comes, and beyond them again, the two to two-and-a-half million who become newly infected every year? I do not think we have sat down and done the arithmetic on this at all. There is a group called the 2031 Group, which is producing evaluations and reports on the state of the epidemic in 2031, which will be 50 years after it first came to public attention in 1981, and their projections are horrendous. They are projecting that the cost will rise from the current 10 billion or so to 35 to



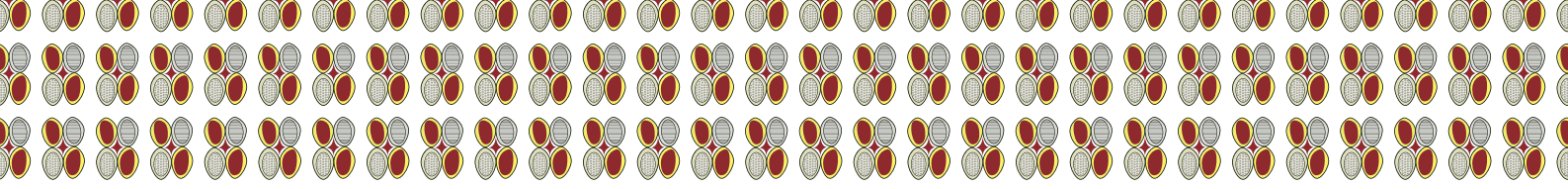
37 billion a year. Another group, the United States Institutes of Medicine, have stated bluntly that the world is rapidly losing the battle against HIV because the numbers are going to continue increasing at an alarming rate. I think with all of these wonderful aspirations and statements of intent, I do not think we are going to reach there.

One of the things that makes me ask, and this is why I said this involves obviously thinking wider than just one epidemic or a whole series of epidemics and sicknesses, is: these people who have HIV or malaria or tuberculosis, or these other diseases, do they really count in the world? The Global Fund, as I said, is not getting the increase in the contributions, in fact it is experiencing a decrease, and we are told the world is in financial crisis, economic crisis, countries cannot afford. It was in the thick of a crisis

that many of these countries were able to guarantee billions of euros to revamp their economies. We are asking here for a matter of 10-12 billion per year. And yet they can generate that money overnight in order to save economies and they keep trying to do so at these meetings in Brussels, and elsewhere, to generate money, and more money, and more money, to keep, if you do not mind my saying so, what seems to be a rotten system going.

But they do not do it in order to keep people alive. The life of people is the wealth of nations. The lives of people are the wealth of the world, and they are being jeopardised by this strange order of priorities of the world today. Coming closer to what this conference is about: human resources, not just financial resources to deal with these diseases, but the human resources that are required. According to the latest figures from the United Nations, Ireland has 31 physicians per 10,000 people. South Africa has eight. Lesotho has one. Zambia has one for every 19,000 people, and Malawi has less than one for every 20,000 people. You begin to ask, what exactly are we doing, and are we doing anything to remedy this. There are the ethical questions that arise about recruitment, about labour mobility, and some of these we may be discussing these days. There are the technical problems of training personnel, rapid training of personnel in the numbers required. There is the whole issue of task shifting, and giving additional responsibilities to less highly qualified people.

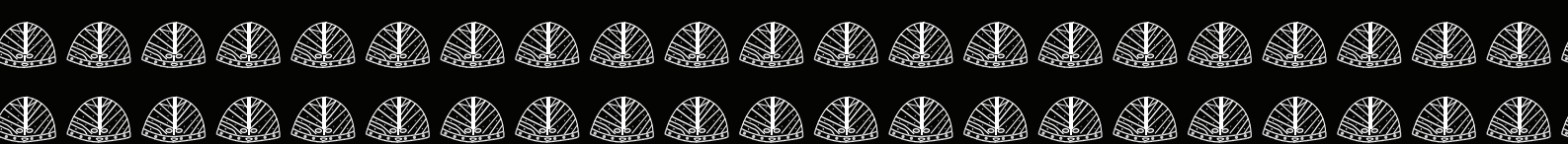
All of these are good, all of these are important, but I sometimes wonder are they necessary. I scanned through this conference's abstract book for one term, and I found extremely little about it in the book. The term was: "traditional healers". Are we making sufficient use of these people who exist in our countries, and who could be helped to respond to HIV and AIDS and to other matters? Just to put a figure on that, in Zambia, population of about



13.5 million, we have 40,000 traditional healers, and they are in an association. 25,000 of them are registered, the rest are not registered yet, but that is an enormous number compared with the 700 physicians that we have got, in spite of our university having graduated 1,500 physicians in the last decade and a half. These people, the traditional healers, they are the ones to whom nearly everybody goes in the first instance. They go to see them, and they take the remedies from them, and even if they are attending a Western type of outlet or clinic, they will still go to traditional healers to get their word on things, and to get their assistance and their advice, but I wonder are we ignoring these, and are we ignoring them not only to our own cost, but also to the costs of the people living in these countries.

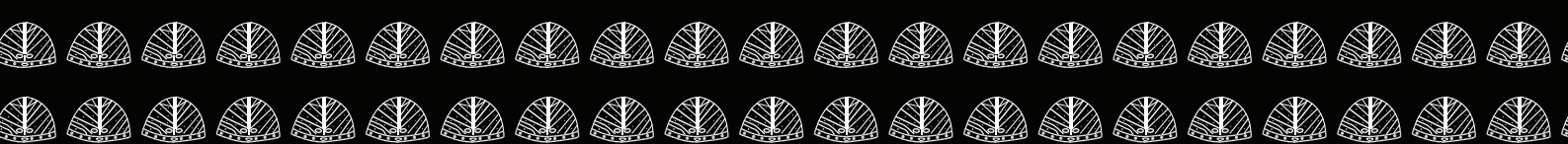
And then finally, I think this whole problem of responding to HIV, malaria, TB, the other diseases, the lack of trained personnel in the way we think of trained personnel, I think it makes us ask, are we using the correct paradigm? Not just in health. In education. In economics. In political issues. In church issues. To what extent are we in fact ignoring much of the substratum that is there in the developing countries, and instead importing what we have found satisfactory amongst ourselves here in the North or in the West. Really, I think we have to ask ourselves, whether as health professionals, as economists, as teachers, educators, as church personnel or whatever it may be: are we in fact imperialists? I said at the beginning, that I was going to provoke. I do not have an answer, but I leave it to you to answer. Thank you very much”.





# 2012

*Then Minister of State for Trade and Development, Joe Costello T.D., opened the 2012 Professor Michael Kelly Lecture with a speech which outlined the outstanding challenges, particularly in Low and Middle-Income Countries, and the progress which has been made through international collaboration. To date HIV treatment has reached an unprecedented number of people worldwide. In addition, Dr. Busi Mooka, Consultant in Infectious Diseases at Limerick Regional Hospital, spoke about the local experience of dealing with HIV stigma, testing, and perceptions of those living with HIV in Limerick. The Red Ribbon Project's Ann Mason also delivered a presentation, which discussed the changing demographics among people living with HIV in Ireland, and the trends in rates of diagnosis that year.*



## 2012 LECTURE

# EDUCATION: RESPONDING TO HIV AND AIDS

Father Michael delivered his 2012 lecture, “Education: Responding to HIV and AIDS”, followed by guest speakers, at the University of Limerick during the 2012 World AIDS Day event. The opening address was given by then Minister of State for Trade and Development, Joe Costello, T.D. Dr. Busi Mooka, Consultant in Infectious Diseases at Limerick Regional Hospital, spoke on her experiences of treating HIV in Limerick, and Ms. Ann Mason, Manager of the Red Ribbon Project<sup>1</sup>, delivered her talk on “HIV in Ireland”. Minister Costello’s address can be viewed, and Ms. Mason’s presentation can be downloaded, at [www.fathermichaelkellyzambia.org](http://www.fathermichaelkellyzambia.org).

**Michael J. Kelly, S.J.**  
**University of Limerick**  
**Ireland, November 2012**

“I want to thank the Minister very sincerely for his presence with us this evening, for the encouragement that that gives us in this struggle here in this Southwest part of Ireland, but also to what it means worldwide because today or this week is a very special one. This is the week of World AIDS Day, and it is a time when we are beginning to think about this disease a bit more.

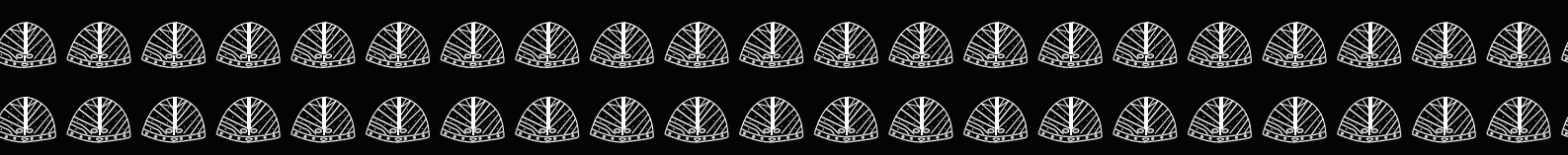
One of the difficulties, the problems, is that we may become complacent. We have had very considerable scientific success during the past decade. We have not had anything like the same success in the social sphere that Dr. Mooka was talking about, and I think we need that also. Several years ago, Martin Luther King said, “*We begin to die the day we stop talking about things that are important*”. In this epidemic, because we have had a certain measure of success in dealing with it, people are, I am afraid,

beginning to stop talking about it. It is going off the radar screen of the world, and yet it continues to be one of the most catastrophic global occurrences of our lifetime and possibly of the lifetimes of those who will follow us.

The Minister gives some of the statistics, and add into those statistics the number of families that are shattered when people are infected, or when people die, and the enormity of the epidemic becomes very, very apparent. Let me just tell you something about what it is like in Zambia, where I come from. We have approximately one million people living with HIV, out of a population of less than 14 million, so you might say one in every 14. Two years ago, new infections were occurring at the rate of 250 every day, not in a year, but every day, out of 14 million people. Deaths were occurring at the rate of 135 a day. You can see from that a huge number of people dying every day needlessly from this disease, and also because the number of new infections exceeds the number of people dying, the total number of

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<sup>1</sup> Irish organisation promoting and providing HIV testing services and advocacy.



people living with the disease is increasing with us just as it is increasing worldwide, where the number of infections outstrips very significantly the number of people who leave the scene through sickness, through death, and leaving behind them families, leaving behind them loved ones, and very often, leaving behind them orphans.

Some years ago at a conference a child addressed the group. The child was about eight-years-old, and her name was Tsepo Sitali<sup>2</sup>. She said: *“In my language, the name ‘Tsepo’ means ‘Hope’. We are turning to you grown-up people asking for hope. We are trying to reach you. We are trying to tell you something. We are trying to draw attention to how we feel. What will you do to help us to realise our dreams. We want you to bring us hope, hope for the little children of Africa, and not just of Africa, but of so many other parts of the world also”*.

Well, we have the hope of the changes, the developments over the last decade. One of the greatest hopes I think was the vast global mobilisation against this epidemic. Unprecedented in human history, the way the world came together and focused on this

and said, *“We must do something about it”*. Concern, resources, personnel, science, the whole United Nations apparatus, countries, every sector seemed to come together and say, *“What can we do to respond to this disease, to reduce its impact, and to head it off and eventually to cure it?”* I’d like to take the occasion here, to say a sincere word of thanks to Irish Aid and to the people of Ireland for their sustained and very generous commitment to dealing with this epidemic over the years. The effort from Ireland has been fantastic, and Ireland is one of the big contributors, relative to its size, to dealing with this epidemic worldwide, and we are extraordinarily grateful for it.

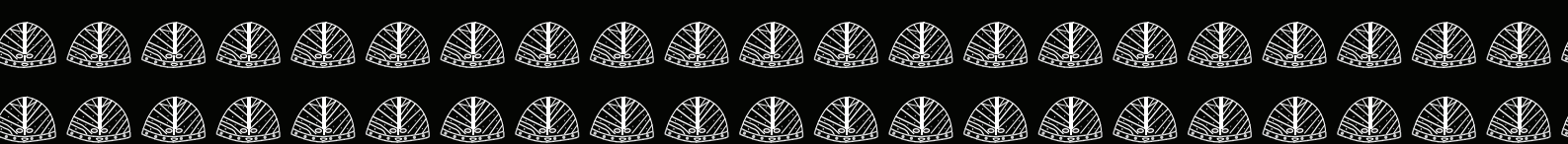
Ireland has, in Dublin, what is called Open Heart House, and this little book, “Stories from the Heart”, came from Open Heart House about a year ago, some of the people there who are HIV-infected and what they said about themselves. There are about 20-25 stories in this. I have read them all a couple of times, and what struck me was the hope that was in them. The confidence that this disease is now being tackled, and can be overcome. One of the writers, a man called Charlie, said, *“I have so much to be thankful for”*. This, remember, is a man living with HIV. *“I have so much to be thankful for, and I look forward to a brighter future full of hope and happiness”*. That is the way so many of the other stories are, and they are a wonderful tribute to those who are engaged in Open Heart House: James O’Connor and his team there, and to all who support them – I think they deserve a round of applause.

Long before the new medications were introduced, and before they were distributed more and more widely, amongst the people who are infected, long before even there was an Open Heart House, we did have something to work against this disease,



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2 Tsepo Sitali, then aged 8, addressed the 11th International Conference on AIDS and Sexually-Transmitted Diseases in Africa, in Lusaka, Zambia.

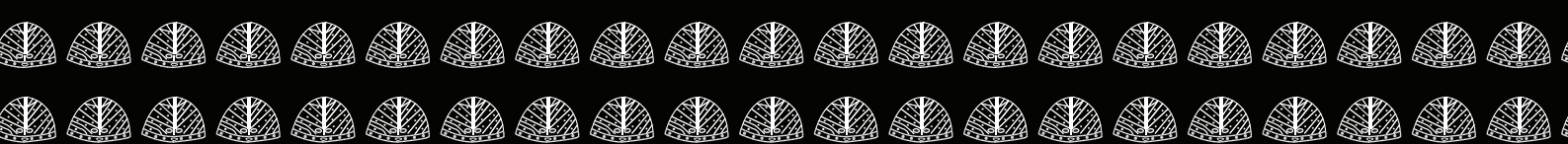


and that something was education. Not just school education, but education on all fronts. Education in every aspect: community education, community involvement, but also and very particularly, the education in schools. 12 years ago, at Dakar, at the World Education Forum, the then Director General of the United Nations programme against AIDS said, *“Education is perhaps the most powerful force of all in combatting the spread of HIV and AIDS”*. My feeling is that that was not followed up. The words were said, people accepted them, and then they went back to square one, to the status quo. Yet he had said it, and it was true. Probably the most powerful force of all in combatting the spread of HIV and AIDS.

Then even more recently, earlier this year, the current director of the UNAIDS Programme Against HIV said, *“Ending AIDS is possible, and education is key to the access”*. We will not get anywhere unless we make good use of education. We are not necessarily talking about education, about sex. We are not excluding that. We are not excluding talking or teaching about the correct use of condoms, but there is something wider than the narrow focus just on some of these preventative measures. There is something wider than the narrow focus on the medications. There is the illiteracy. There

is the poverty. There is the subjugation of women. There is the discrimination. There are the male chauvinistic attitudes, which are inbred in society. It is these things that fuel the spread of this epidemic, and education, more formal education if you will, school education, literacy, learning the mechanics of reading and writing, and in numeracy also, building up these things within our young people is now bringing a transformation.

I want to be very honest with you, and tell you that up to about 15 years ago, we could not have said that. Because up to about 15 years ago, the better educated people were the ones who had more HIV. The last survey that was done with us in Zambia was in 2007, so it is five years back, but in that survey we found what is found in so many other countries: more HIV amongst the wealthy upper classes than amongst the poorer, lower classes, and the wealthy upper classes are the ones who have received more education. But now better investigations are going into the matter, they are investigating what is it with the people up to the age of 23 or 24, and what is it with the people from 30 to 40, and what is it with the people above 40. They are finding a very radical change, with the younger people, the ones who have more recently passed through



the schools, and had their education, there is considerably less HIV infection than amongst the older ones. Education was not a vaccine, or a vaccine that was being used wrongly in the early days, whereas today it is proving its worth.

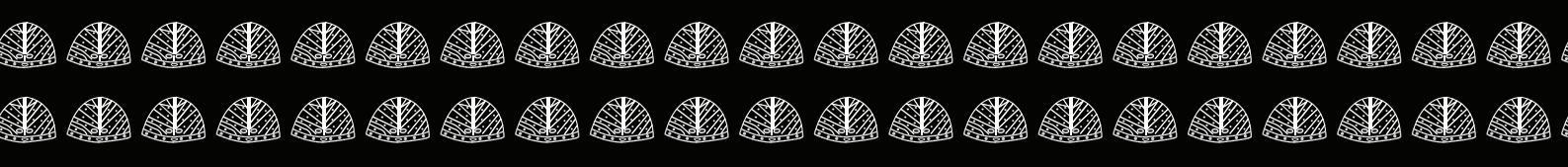
We used to say about them in the early days that the problem was the “Three M”s, and they are not the little sweets. The “Three M”s were: Men, Mobility, and Money. Put them into combination, and HIV spread very easily amongst populations in Africa and in other parts, but that dynamic or that scenario is now changing and changing for the better. Where there is money, where there is mobility, but where also there is education, there you have a chance of less HIV. There you have people who will present themselves earlier for treatment. There you will have people who will adhere to the treatment. Another speaker pointed out MSM, the men who have sex with men, but we are thinking now of MEM: men who are educated men, and that there, there will be much less of HIV. Think back to the time when we learned

how to read and write. It was not just that we were learning mechanical things on a page. We had to learn very deeply how to link the first word of the sentence with the last word. How to link the words together with their grammar, shorter sentences at first, and later longer ones that we could read and internalise.

Now that is a whole process that goes on with the individual and it seems to transform an individual, that they regard life as very different when this has happened. Also, occurring with individuals, is the ability to delay gratification, to put it off, to say, “No I cannot do that now, I have my homework to do”. The discipline that is involved in the simple things of schooling is something that stays with people, and when they know a little bit more about this epidemic, it stays with them to help them to defend themselves against it. We do not use the word discipline very much nowadays but it is something that is very, very real.

We have very strong evidence from Uganda and from some other countries of the infection rate coming down in communities for those with secondary or with primary education, and staying level much higher for those with no school education. This happened at a time when there was no sex education in schools, and when even the very quality of education was not good. Education can do more. It can do infinitely more, because the better educated know information is not knowledge, but the information has got to be there. They are able to take in the messages that are coming to them through the media all around them. Now, the social media are kicking in throughout Africa, and this is being used by the people there.

Those who are better educated know the importance of going for a test and following up on it, not just getting the test, but going back for it. Educated people know much more about nutrition and the importance of a nutritious diet, which is all tied up with HIV. You are much more susceptible to



HIV infection if your nutrition levels have gone low. Educated people have learned more about these things. They show more understanding and accepting attitudes to the people who are infected.

One of the greatest, one of the worst, curses in this area is discrimination and stigma. Treating people with HIV as if they were a race apart, we lower our esteem, negative attitudes towards them, and these negative attitudes sometimes showing, in employment, in access to a dentist, in access to medical services, in all sorts of places. I said this before – some of you have heard it – but I was in a taxi in Dublin in February of this year, and we got around to talking about this disease, and the taxi driver told me: *“Two of my brothers have died of HIV, of AIDS, and when the funeral of the first one took place, we went into the local pub with the people to have a drink and a sandwich. Nobody came to serve us, and after about 10 minutes, I went over to the bartender and I asked him why. He said ‘some of the other customers are objecting to your being here, they would prefer if you left’”*. That sort of stigma – is it there lurking

in the hearts of people? Education, there is abundant evidence, that being through school, learning what UNESCO calls one of the pillars of learning for this 21st century, learning to live together – that is also succeeding immensely in dealing with this.

So, education is doing a lot. Could it do more? Yes, if given a chance. Maybe you know the story of the man who kept going into the church and pleading, “God help me to win the lotto. God, help me to win the lotto”, and nothing was happening. He vocalised it out loud one day and he heard a voice booming, “Give me a chance: buy a ticket”. Well, I think that with education, it is a question of giving it a chance. More education, better education, more universal education especially for girls. If we can do that, we are responding to the human rights of all of our children. We are building a great barrier against possible HIV infection, or if infection occurs, we are supporting more speedy treatment that will keep the person alive. Thank you very much”.



*The 2013 Professor Father Michael Kelly Lecture took place as part of DSA Ireland and Gender ARC's joint conference, "Health and Gender Equity in a Period of Global Crisis", at the Galway Bay Hotel, in Galway. Father Michael's lecture was introduced by the Director-General of Irish Aid at the time, Brendan Rogers.*

2013

## 2013 LECTURE

# ASPECTS OF GENDER AND HIV

The 2013 Professor Father Michael Kelly Lecture on HIV and AIDS took place at the Development Studies Association of Ireland<sup>1</sup> and Gender Advanced Research Consortium<sup>2</sup> Joint Conference on “Health and Gender Equity in a Period of Global Crisis”. Then Director General of Irish Aid, Brendan Rogers, introduced the lecture, followed by Father Michael’s address, “Aspects of HIV and Gender”. In his lecture, Father Michael focused on the key issues making women and girls especially vulnerable to discrimination, and how these contribute to their risk of contracting HIV. The event also featured a photographic exhibition by Trócaire, “Facing AIDS: The Time is Now”, as well as the unveiling of a quilt created by members of the support organisation Open Heart House, which recorded in physical form messages of strength and resilience from those living with HIV. Audio of Father Michael’s lecture, his presentation slides, and images of the Trócaire photographic exhibition and the Open Heart House Quilt, can be accessed at [www.fathermichaelkellyzambia.org](http://www.fathermichaelkellyzambia.org).

**Michael J. Kelly, S.J.,  
DSAI Conference,  
Galway, Ireland, November 2013**

“We are considering something that’s very negative, and that we do not like: HIV. But I want to ask you that as we hear many of the negative aspects, we should think also of some of the positive aspects, and if you want to get them highlighted for you, I invite you to examine very closely the quilt that the members of Open Heart House have prepared.

When there are such beautiful expressions as, “I am a mother, I am a wife, I am HIV, I am happy to be who I am”, that is the spirit that is within many of the people who have HIV, and that is the spirit we admire in them. That is the spirit that encourages so many of us to try and join hands with them to overcome this ferocious disease that has struck the human race.

I’d like to thank the Irish people very warmly




for their support for HIV activities worldwide and here in Ireland, and to thank them for the continued support for this World AIDS Day event, this annual event, which even in difficult financial times is going ahead. At the same time, I would like to congratulate Ireland on an award that was made, to Ire-

*1 Irish membership-based and membership-driven organisation aiming to provide an open and participatory space for dialogue between researchers, policymakers, and practitioners working in international development.*

*2 Research network linking academics across disciplines at NUI Galway and the University of Limerick.*





land, only within the last 10 days or so, that it received an award for its commitment to addressing the challenges of international migration of highly skilled persons from the developing world. I gather that you were talking about some of this at the last meeting of the conference here that has just ended, and Ireland has shown itself, as in so many other areas, to be boxing much above its weight.

These lectures have been going on since 2006, and the first of the lectures was on Stigma and Discrimination. It got tremendous support as was said already from Bertie Ahern, and it was held at the time of the launch of the Stamp Out Stigma Campaign, and that campaign has led to great positive things. This evening we are considering another area: gender and HIV, with something on sexuality maybe. That is an area where there is a huge amount of discrimination, inequity, shameful treatment of people, mostly against women and girls, unacceptable treatment, and maybe we need now a Stamp Out Discrimination Campaign: SOD. Get rid of it now, once and for all, and get it out of our system, get it out of not just our personal system, but out of our systems, in government, in civil life, in private life, in every dimension. This problem of stigma, discrimination, inequity in the treatment of women – it comes up very strongly in the whole area of HIV and AIDS.

There has been remarkable progress, but for millions of people the disease has now been transformed so that it is no longer life threatening as it was, but a disease that is manageable – but nonetheless a disease, and therefore something that should not be with us. The great achievement has been the development of the antiretroviral drugs which have saved the lives of so many millions of people, but also the fact that such a record number of people are on these drugs: 10-10.5 million at the beginning of this year.

In my own country in Zambia, we estimate that over 90% of those who are in need of

*“Let’s never, never, never forget the suffering of the individuals. They are not statistics. They are people, and they are suffering, and we can never forget them”.*

antiretroviral therapy are now receiving it. They do not always stay on it for a variety of reasons, but about 90% or a bit more are receiving that therapy, and that is surely a wonderful achievement. But the epidemic is not yet over. It is still with us and we must bear that in mind. It’s not over for the 35 million people in the world who are HIV infected, and some of them may be in this room.

It is worthwhile noting that of those 35 million people, more than 10% now are over the age of 50. The epidemic is moving up into my age bracket. Moving up, because people are living longer who have received the drugs, and because we have failed to recognise that just because you are over 50, you do not stop being a sexual human being. That remains until five minutes after they put your lid on the coffin. So, this is something that is happening. We saw in one of the Trócaire slides that it is the leading cause of death among women of reproductive age between 15 and 44. It is the sixth leading cause of death worldwide at the moment, and because people are living longer, there are more new infections and AIDS deaths. More people are becoming infected than are dying. More are coming into the poor than are leaving it. This of course creates enormous problems and has great implications



*“There is another factor with the women that we certainly have to take into account: the social vulnerability. They are very vulnerable because of the way we have adopted certain social and cultural norms. We have double standards in society”.*

for the future. The costs, the disease burden on countries, stigma and discrimination, and the inequality and the treatment of women, and let's never, never, never forget the suffering of the individuals. They are not statistics. They are people, and they are suffering, and we can never forget them.

There are a number of developments that

we have to consider, and that causes worry. I said that we have a great achievement at present of well over 10 million people on the drugs. The objective is to get universal access, that is regarded as 80% or above on the drugs, by the year 2015, which is only two years away. We are not going to achieve that, but apart from all the logistical problems, there is the problem of money. It is estimated that between 2014 and 2016, \$87 billion will be required to respond to HIV, TB, and malaria. That money is not going to be forthcoming. Last year, 2012, less than \$20 billion was made available. In the current economic climate, that money is not going to rise any more. In fact, at present, we notice that it is flat-lined, that the graph was going up year by year but now it has gone flat, and is wobbling, a little bit down, a little bit up, but it is not going up in the way that is required.

In some of our countries, the dimensions of this epidemic are absolutely ginormous. They are like something out of science fiction. Just last night I read that in Swaziland, a small country surrounded by South Africa, currently the AIDS prevalence is 31% of the adult population. One in every three people




the year 2007-2008, there were more men than women infected. Now, worldwide, there are many more women infected than men.

Now that speaks of a gender discrimination of two kinds: against the women, and strangely, against the men. Against the women, because they are so vulnerable to this disease, and I will look at the vulnerability in a few moments, and they are at such risk of it. Against the men, because even though there are large numbers able to re-

ceive antiretroviral therapy, the number of men who present themselves is not in any way equal to the number of women. Men are macho: "I do not get sick. I do not need a doctor. I can look after myself. I do not need to be tested". They are discriminating against themselves because they are men and have to continue to portray this male image of machismo of one kind or another. In that way they are signing their own death warrant, many of them, by not going for the treatment, whereas the women are much more open to medical treatment, and will present, and it is a social occasion for them sometimes going there, whereas a man will sit grumpily by himself, hating to have to go in to a doctor, especially to talk about sensitive issues like this.

are infected, and among women between the ages of 30 and 34, the infection rate is over 53%. One asks how a country like that is going to survive even, because it is a small country with a small population. In my own country Zambia, in Lusaka, which has about two million people at present, the estimate is that it is about 25% are infected. In other words, one in every four people that you meet on the street may well be infected. When I was lecturing in university, and I would be dealing with some of these things with the students, I would ask every fourth student or sixth student to stand up, and I would say, right, that's approximately the number of people, in this part of Zambia at any rate, that are infected with this disease. Yes, there is control through the drugs and ultimately that will, we believe, bring less transmission of the disease, but currently there is still far too much transmission of it.

It is not only HIV. We know now that in settings where HIV prevalence is high, as in Sub-Saharan Africa, particularly in the Southern Cone of Africa from Guinea down to the South, TB prevalence is also very high. The rates of TB, in the 15 to 24-year-old population, is one-and-a-half to two times higher than it is in countries that do not have



HIV. There is a link between these, and one makes you more vulnerable to contracting the other. So it is far wider than just HIV, it is over TB and it is over other diseases, also.

Several years ago, I think it must be about eight or nine years ago now, two men who were very powerful in the world at the time, Stephen Lewis of the United Nations, and James Morris, of the World Food Programme, said this: “The incredible assault of the HIV and AIDS epidemic on women has no parallel in human history. The pandemic is preying on them relentlessly, threatening them in a way that the world has never yet witnessed”. That is how it is. I said that more women than men are living with HIV. Among young women, again in the age bracket 15 to 24, HIV is much higher than among young men. In South Africa for instance, 11.5% of the young women have HIV, but only 4.5% of the young men. There is a huge difference there, and why is it, what is it, that is making women so vulnerable? Making them so wide open to attack by this virus and by this disease.

Well I think of it along three different dimensions. Physiological and health problems. The physiology of the human body, of the woman’s body. More fragile, more extensive tissues in the female genital areas, infected fluids staying there longer than they would in the body of a male, larger volumes of this fluid reaching these delicate organs. There is something that HIV transmission from male to female is seven times more likely than the other way around, from female to male. I sometimes say what we are dealing with is a faulty design, and I intend when I see the maker to bring that to his attention. And I will be seeing him before many of you I promise you that.


There is that whole problem, just in the very fact of being a woman, that cannot be avoided, and it is there objectively speaking, but also we have to recognise that HIV has a woman’s face in a different dimension. It is the women who are doing the most against the disease. It is the women who are leading

an effective response. We have to think of the women in home-based care. We have to think of the many women who are involved in NGOs, and CBOs, of various kinds. We only have to look around the room here at the moment, and see that it is predominantly women who are here with us this evening. In the religious domain, I belong there, the Catholic Church is providing maybe 25% or more of the AIDS care across the world, but nearly all of that is women. We priests, we talk, they work and do it.

There is another factor with the women that we certainly have to take into account: the social vulnerability. They are very vulnerable because of the way we have adopted certain social and cultural norms. We have double standards in society. Maybe they are a little bit more smooth here than they are in less developed societies, but by and large I think we have to acknowledge that we have a society where few women can negotiate the where, the when, the how, of sex. We have a society where women are expected to show a certain amount of sexual naiveté while men are expected to show a great deal of sexual knowledge and even experience.

I remember some years ago speaking with university students in Jamaica, and the extraordinary thing there was that nearly all of them were women. Men do not go to university so much there – education is something for the women. I said to them: “how is it that since you are the more educated part of Jamaican society, and you are also getting the better jobs, the bigger jobs, how is it, or why is it, that HIV is such a problem amongst you people in Jamaica?” One of them immediately put up her hand, and she said, “You forget, once the door is closed on the bedroom, he is the boss, not me, and I have to do whatever he tells me, and if there’s HIV around, there’s nothing I can do about it in the face of him”.

Now that is a society norm; that is something that was bred into them from the time that they were younger. Let me just read these



words from a Zambian woman, and many women in other parts of Africa and I think many other parts of the world would re-echo these words:

*“Before my marriage I was counselled by elderly female relatives who emphasised that a woman should take a subordinate role within the household and should obey her husband. They even said that violence against women within the household was normal and acceptable and that a woman should remain in her marriage regardless of her husband’s behaviour”.*

Being taught from the time they were young that he is the boss and you do not question it, even if there is this deadly disease which he can so easily pick up and transmit to her. And then in our society we have a number of harmful practices: age mixing, young girls with older men, sugar daddies many of them. Not all of them, but they are paying the rent maybe, or they are paying for the children to go to school. The older men, and the girls are their partners, but he has other partners as well; she knows that and she knows the risk, but she has to keep the kids at school, she has to pay the rent, she has to get the household necessities, so she has to have sex. She may even be married and her husband may already realise that she is engaging in such activities, but he says nothing because it keeps the food on the table, or it keeps the landlord away from the door.

We have these damaging customary practices. Girls being married too early, before their bodies are fit to be the bodies of mothers, the damage that that does to the health of the girl, but also that the girl is unable to protect herself in any way against the possible onslaught of this disease. We have a practice, it’s fairly universal in Zambia, of what’s called dry sex, inserting certain herbs into the vagina so as to dry it out with the belief that this gives the men more pleasure and that the men are demanding it. I have been at groups with men and I have asked them about this, and they said, “Oh no, no

we would never do that, we would never”. They want to do it, and so they cast the blame back on the women.

Now it may not be the same practice here in the Western world, but I am sure you are aware that there are practices like this, and that you hear about them, and the way they put the women in an inferior status. If you are to sum the whole thing up apart from the examples of it, I think what we have to say is that society in general agrees in giving women an inferior status. Then we have one other thing which we have got to mention: the violence against women. The violence against women and girls. The United Nations High Commissioner for Human Rights believes that violence against women is the most pervasive and universal form of all human rights violations. We hear about many of the others, maybe because they are less common. We do not hear enough talk about this, but it is so common in societies across the world, and it is something that is living on the back of the HIV epidemic, and the HIV epidemic living on the back of the violence against women, that this is happening so universally and it is such a problem. As we know from the stories we hear or we see in the media, from so many parts of the world, systematic sexual violence, gender-based violence, seems to be part and parcel of many of the armed conflicts that are going on, used as a tool for terrorisation, used as a tool for ethnic cleansing. Not just in Africa, and not just in the Congo at the moment – we only have to throw our minds a few years back to Serbia, and to all of that part of the world and what is going on there, to Chechnya, and what is going on there, and to Syria today. This is part and parcel of life unfortunately, and it is something that is entirely, entirely, against our ideals of human rights, but it is also something that greatly increases the risk of HIV for women.

I mentioned already the stereotyped gender images. Machismo, the man, the idea that the man needs sexual activity. When this epidemic was spreading in India, at the begin-

ning of this millennium, the routes were very often the big long truck routes, and truck drivers were blamed for spreading it, and they still are blamed in many parts including in Zambia, the trucks coming up from South Africa. When the Indian drivers were confronted mostly by NGOs, to try and cool it, they replied, "Ah you do not know how it is when you have been driving a truck, when you have driven 500 miles on one of these long hard roads. You must have sex after it. You need it to cool the body".

Sad for the men, but even sadder for the women, who become infected in this way, and this perverted image that this is something that is required. Behind it all we have to ask again, is there something working on the men here that we have not taken into account. One of my friends, a man called Tony Simpson, whom some of you may have known, he's in the University of Manchester, has written a book about men and sex in Zambia, and he has a wonderful line in it where he says that the powerful gaze of the peer group is never far away. Trying to do what the peer group requires, from the group in the pub, the group at a game, the group at a village beer party – doing what others are demanding, and not doing what they feel themselves they should be doing, and what is required.

I am going to risk spending a few moments telling you a fable. It's a fable, but like all fables, there's a great truth in it. The fable is: when God created Adam and Eve, he had two parts left. He was not sure how to share them out between them so he said he'd ask them. He called them and he said, "listen guys, I have two things left, one for each of you. Do you want to hear about them", and Adam immediately said, "What are they?" "Well", God said, "the first one is a thing you attach and when you have it attached and it has become part of you, you'll be able to pass water outside you standing up". Adam immediately started jumping up and down, "Oh let me have that, I want that, that's meant for me". God looked at Eve and Eve said, "Yeah let him have it". They gave it to him, fitted it on, and Adam went around jumping with joy. He put his name on the sand. He hit every tree he could see. He went to the stones and knocked them over. He said, "This is great, now at last I am a man—I am a real man". And God and Eve looked on, smiling. Then God turned to Eve and he said, "Well I'm sorry, there's only one thing left, you have to make do with it", and Eve said "That's okay, what's it called?" And God said: "Brains".

Is there not something in it? Is there not something in it that this identification of a man with sexuality, with prowess, with lead-



ing in these areas, and the woman following, using her head alright, as much as she is allowed to use her head, but not always allowed to use it. The high expectations that she will remain faithful to her partner, responding to a man is her primary role. Yes she can have sexual pleasure, but that's not the primary thing, her primary thing so many women are taught, instructed, is to ensure that the man has sexual pleasure, and hers comes secondary to him. In other words we have built in to this whole sexual area a subordination of women to men and that is not right. That is not the way it should be, and that perspective is something that helps very much to bring the whole AIDS issue or HIV so very, very far forward.

So I think that one of the things that has got to be done in this area is that there must be a total transformation in gender norms. We have gone along too many years with them. They are dishonourable. They are disempowering for women. They are debasing and destructive for men as well as for women, and if our generation does not set about changing these things, and making them more human, then we are going to have problems.

The end of last week or earlier this week, the World Health Organisation produced a booklet: "Sixteen Ideas for Dealing with Violence Against Women". It summed them up by saying we must do something about changing and transforming our gender norms and our cultural norms. I believe this change is required not just for dealing with HIV but so that we respect women. We are not trying to bring a change around here in order to keep a disease under control. That's important –


absolutely, very important, but much, much more important is the dignity and the respect that is due to a woman as a fellow human being, and that we work for that and that we try to achieve that, and in achieving that that we do achieve something that will help us also to overcome one big aspect of the HIV epidemic.

A long time ago, 1995 I think it was, the then director of what was known as the World AIDS Programme, I think it was called, a man called Jonathan Mann, he was killed tragically in an air crash. He said, "*The low status of women is at the heart of the AIDS epidemic*". The central issue is not technological or biological, it is the inferior status and role of women. When women's human rights and dignity are not respected, society creates and favours their vulnerability to AIDS. My friends, we are living at a time when there are changes coming about in the relationship between men and women and I think what we should be trying to do is to speed up these changes, to bring

them forward more quickly, not just because of AIDS but because of human dignity, because of people, who they are. You might say that's very difficult, how are we to do that. I do not know how we are to do it, but I know that we must do it. Maybe the first part of the how is that we are committed to doing it, no matter how hard it may be. George Bernard Shaw once said, you get it on a card in some of the card shops, "Some look at things that are and ask, 'Why?' I look at things that never were and I ask, 'Why not?'"

Equality between women and men. I look at that and I ask, "Why not?" It never was. Hard to achieve, but if we do not set our hearts on

*"I have a dream that one day we shall see that there is no more exploitation of women, no more gender-based violence, no more discrimination between male and female, but that we are all one in our common humanity".*



achieving it, we will never achieve anything in that area or anything fitting our human dignity. This year, 2013, is 50 years since the great Martin Luther King gave his wonderful Dream Address, “I have a Dream”, you may know it, many of you. He had a dream of real freedom for the people of colour in the United States, and he hoped that one day the United States would stand up and live out its creed that we hold these truths to be self-evident: that all men and women are created equal.

I would be very bold, and I have taken Martin Luther King’s words, at least some of them, some of his Dream speech, and I have adjusted it to fit the Dream of Equality between men and women. If you like, when I say the words “I have a dream”, you can say them out yourselves. Say it out loud, so you are expressing a commitment to something that is worthwhile.

Dr. King began, *“I say to you today, my friends, that in spite of the difficulties and frustrations of the moment, I still have a dream, it is a dream deeply rooted in the most noble of our human dreams. I have a dream that one day our world will turn into reality its belief that women and men are fully equal in every aspect”*. I have a dream.

*“I have a dream that one day the whole world will see the countries of Asia and Africa and*

*all other countries as shining lights of freedom, justice, reconciliation, and respect between men and women on an equal footing”*. I have a dream.

*“I have a dream that those who follow us will live in a society where they will not be classified by their gender but by the quality of their character”*. I have a dream.

*“I have a dream that one day we shall see that there is no more exploitation of women, no more gender-based violence, no more discrimination between male and female, but that we are all one in our common humanity”*. I have a dream.

In King’s words again, *“Friends, let equality ring. Let equality ring from every town and every village, from every province and every city. Then we will be able to speed up that day when all of God’s children, women and men, girls and boys, will be able to join hands and triumphantly sing, ‘Equal at last! Equal at last! Thanks be to God, we are equal at last!’”*

That is our dream. That is our hope. Let us all work together to make it a reality. Thank you”.





*The 2014 Professor Michael Kelly Lecture was delivered by two long-term collaborators of Father Michael: Dr. Noerine Kaleeba, who spoke around the key issues relating to stigma and HIV, focusing particularly on her home country of Uganda, in “Building Resilience: Challenging Stigma – Lessons from Uganda”; and Nadine Ferris France, Irish HIV and AIDS Researcher and advocate, and Operations Director of the Irish Forum for Global Health and ESTHER Ireland, who highlighted in her talk, “Self-Stigma: An Unspoken World of Unspoken Things”, the pernicious issue of Self-Stigma, which affects many living with HIV, reducing treatment compliance, impacting on wellbeing, and preventing them living full and productive lives.*

# 2014



## 2014 ADDRESS

# THE NEGATIVE ROLE OF STIGMA, PREJUDICE, AND CERTAIN LEGAL MEASURES IN THE RESPONSE TO HIV AND AIDS

The 2014 Professor Father Michael Kelly Lecture on HIV and AIDS took place as part of the Irish Forum for Global Health's International Conference, "Partnerships for Health: The Role of Partnerships in Realising Health Related Development Goals", and was introduced by Dr. Douglas Hamilton, Deputy Director, Thematic and Special Programmes at Irish Aid. Father Michael was unable to attend the event in person, and instead delivered his video address from Lusaka. In his address, "The Negative Role of Stigma, Prejudice, and Certain Legal Measures in the Response to HIV and AIDS", Father Michael spoke to the ongoing struggle to confront HIV and AIDS stigma and discrimination, and introduced the event's guest speakers, Dr. Noerine Kaleeba, and Ms. Nadine Ferris-France. Videos of all of the speeches can be viewed at [www.fathermichaelkellyzambia.org](http://www.fathermichaelkellyzambia.org).

**Michael J. Kelly, S.J.,  
Luwisha House, Lusaka, Zambia,  
November 2014**

"Good Evening Chair, Ladies and Gentlemen.


It gives me really great pleasure to speak to you today from Lusaka, welcoming you to this year's annual AIDS event and lecture.

But having said that, I am also very, very sorry indeed that I cannot be with you this year and I really regret that I will not hear the presentations of our two eminent speakers and my own great personal friends, Noerine Kaleeba and Nadine Ferris France. For a long time I had been looking forward to hearing once more the passion and the wisdom of Noerine and to experiencing yet again the brilliance and the deep human concern of Nadine. But that was not to be. Instead of being with you on what I presume will be a dark, cool and possibly damp evening in Dublin, here I am speaking

from a hot and sunny Lusaka that is looking forward to the onset of the rainy season. But it would be some recompense to get a recording of all that goes on this evening, although that will not be the same thing as hearing Noerine and Nadine in person and going away humbled and concerned at what they have shared with you.

And there is reason for concern. We need to be concerned that the AIDS epidemic is far from being over. We need to be concerned that prejudice, stigma and discrimination still affront the dignity and humanity of millions of people worldwide. We need to be concerned that in so many countries in the world draconian laws that came from another era remain in force, penalising human bonding and impeding access to HIV prevention and care services.

Ladies and Gentlemen, it is only right that we should acknowledge the tremendous progress that has been made in bringing



HIV and AIDS under control. What has been accomplished during the last decade, indeed during the lifetime of this annual AIDS event, must be acknowledged as one of the world's most magnificent accomplishments – scientifically, organisationally, financially. But the fact that 37 million people across the world are infected with HIV and that more than two million new infections occur each year shows that the global struggle is not yet over. The fact that the Irish Ambassador to Zambia, Finbar O'Brien, could say to me in the past few days that he still has to attend a large number of AIDS-related funerals shows that the struggle in one heavily infected country is not yet over.

Neither are we finished with stigma, prejudice, and discrimination. The association of the disease with sex and poverty and promiscuous human relations remains. With it, there are the sly, hurtful, malicious innuendos: "It is your own fault; if you would live like a decent person this would not have happened to you". Or we can be like the Pharisee in the Lord's story, "Thank God I am not as the rest of men, especially that I'm not like this chap here who has got HIV".

And whatever about these attitudes at the personal level, surely it must blow our minds that about a quarter of all the countries in the world still have laws criminalising same-sex relationships. I have never been able to understand this.

I come from Tullamore, and I'm very proud of that, and nearly 80 years ago, Tullamore had the distinction of being the first provincial town in Ireland to have its own swimming pool. I remember going there


as a kid and sometimes hearing the bigger lads say, "Do not let the Guards catch you swimming skinny (skinny, that is, without a swimming togs), especially when the kids are around". And I used wonder, "What on earth have the Guards got to do with that?" My childhood question is almost the same today: what on Earth have the police or the legal systems got to do with people who engage in same-sex relations? But come to one of our prisons in Zambia and you will find out: desperately over-crowded conditions facilitating much unprotected same-sex

activity because making condoms available would go against the Victorian law that prohibits this kind of activity. The result: men who were free of HIV when they began their term in prison going back to their families after their prison sentence, infected with the virus and fearing to look for treatment because they have become infected through what is technically an illegal activity.

*"... the fact that 37 million people across the world are infected with HIV and that more than two million new infections occur each year shows that the global struggle is not yet over".*

Ladies and Gentlemen. Our distinguished speakers this evening, Noerine and Nadine, will undoubtedly touch on these and other matters that are crucial to ending the AIDS epidemic. They both come armed with a wealth of experience and study to enable them to do so. I expect that when they have finished you will go home tonight, beating your breasts and asking yourself: "What more can I do to end this dreadful epidemic? What can I do to reduce stigma, prejudice, and discrimination and bring about a world where the law upholds the dignity of every man, woman and child and does not assail it?"

May you have a very challenging and worthwhile evening. For me, it is a great honour that these two notable persons,



Noerine and Nadine, are presenting on this occasion. That they are giving of their time to do so is a challenge to me and every other person in the AIDS field never to let up, but to continue doing all we can to roll back this epidemic which is such an affront to the well-being and humanity of millions of people worldwide.

And finally, Ladies and Gentlemen, let me thank the Irish Government, Irish Aid, and the Irish people for making this an annual event and for doing me the honour of identifying it with my name.

I trust that this association with my name

will be seen as symbolic, with me, as it were, standing in for, and representing the great body of wonderful Irish people who have spent themselves in addressing HIV and AIDS and their appalling impacts, as well as the great body of heroic people who have endured the worst ravages of the epidemic. I conclude by saluting all of them for their great resilience, their unquenchable hope, and above all their unparalleled human dignity.

Thank you very much indeed. Have a very enriching evening, and may God bless every one of you. Thank you”.



# 2015

*2015's theme for the Professor Michael Kelly Lecture on HIV and AIDS was "Keeping HIV on the Agenda: Women's Unequal Equality". This year's guest speakers were Professor Sheila Dinotshe Tlou, Regional Director of the UNAIDS Support Team for Eastern and Southern Africa, and former Minister of Health of Botswana; and Sister Dr. Miriam Duggan, who is the Founder of Youth Alive, and a Recipient of the 2015 Presidential Distinguished Service Award for the Irish Abroad.*



## 2015 ADDRESS

# KEEPING HIV AND AIDS ON THE AGENDA

In 2015, the Professor Father Michael Kelly Lecture on HIV and AIDS took place at the Royal College of Surgeons in Ireland in Dublin. Although unable to attend in person, Father Michael gave a video address and introduction from Zambia, in which he spoke around the theme of keeping HIV high on the international agenda, to support the work being done across the globe to support those living with HIV. In particular, he cautioned against complacency, and called for renewed effort and innovation to ensure that treatment reaches all who need it. Father Michael also introduced guest speakers, Professor Sheila Dinotshe Tlou, and Sister Dr. Miriam Duggan. Video of the 2015 lecture may be viewed at [www.fathermichaelkellyzambia.org](http://www.fathermichaelkellyzambia.org).


**Michael Kelly, S.J.,  
Lusaka, Zambia, November 2015**

“Chair, Ladies and Gentlemen: Although I’m speaking from a great distance, it gives me great pleasure to welcome all of you to this year’s annual AIDS event and lecture. I am especially delighted to welcome once more Professor Sheila Tlou, the UNAIDS representative for Southern Africa. Many of you will remember Professor Tlou’s inspiring words when she spoke to us in this gathering a few years ago about HIV and women. I am sure you will be equally inspired this evening by what she will say on the AIDS epidemic, especially in the way it affects southern Africa and what needs to be done to reverse and completely overcome it.

It is also a great pleasure and honour to welcome the great AIDS activist, Sister Miriam Duggan, to whom countless people, in Uganda and elsewhere, owe it that they are still alive today. Sr. Miriam’s current focus on responding to the HIV risks and concerns of injecting-drug-users has surely equipped her to speak very knowingly and trenchantly on an issue that is of concern worldwide, including in Ireland.

Through the great generosity and foresight of the Irish people, represented by the Government and Irish Aid, this lecture series began in 2006. At that time the world was just beginning to cope with AIDS through more affordable and easier access to the drugs that keep HIV in check – the antiretrovirals or ARVs, as they are called. But things were very bad then. In fact, the highest ever annual number of AIDS-related deaths was recorded in 2005, the year before the first of these annual AIDS events. But since then the number of such deaths has fallen, the number of new infections each year is becoming less, and a person living with HIV today has a much better prospect of living a healthy and productive life than such a person would have had in 2005.

But the AIDS pandemic is far from being ended. The bright day when we may say that it is over may come by 2030 but although UNAIDS is working hard towards that, 2030 is still a long way off. And the hopes for 2030 will not materialise unless the world continues to take account of the disease and continues to keep it high on national and international agendas. And that is the theme of this evening’s gathering – keep HIV and AIDS high on the national agenda; ensure the



resources needed not only to maintain but also to expand the present level of response; make HIV testing readily available to every person; make antiretroviral drugs available to every infected person from the moment they are known to have the disease; and take realistic measures to ensure the nutritional status of those who are on these drugs.

This last is a vital point. As with so many other medicines, the AIDS drugs have to be taken with food or after food. But it is a real tragedy that so many people with HIV can access the drugs but don't have enough food to be able to absorb them and let them get on with strengthening their immune systems. Although my circle of contacts is now very limited, twice in the last week I have had people coming to me, telling me that they had not eaten for two or more days and so could not take their ARVs. Nothing could be more harmful to them.

And another good reason for keeping HIV high on the agenda was given in a documentary on young people and development in Zambia, broadcast from Dublin by Newstalk on 21st November. There, the co-founder of a student-run agency told us that in Zambia three young people between the ages of 18 and 24 become infected with HIV every hour. That adds up to more than 25,000 in a year, and that is happening today. For the sake of these and similar young people, we simply must keep HIV and AIDS on the agenda and not take it off until every country in the world has totally eliminated this abominable disease.

And let me share with you one innovative way in which Zambia is keeping HIV high on its agenda. I am speaking from Lusaka on 27th November. This coming weekend a large pop concert will be held in the Lusaka Show-grounds with many international artists. Admission to the concert is free for those who can show that they were recently tested for HIV. To facilitate this, special test-

ing facilities, with associated entertainments and something of the air of a circus, have been set up in a number of townships and are being steadily patronised by those who want to get their free admission tickets to the great musical show. A wonderfully imaginative way of increasing HIV testing and of reaching out to young people. And a great way to keep HIV high on the agendas of communities as well as of state agencies.

The Irish Government has taken steps in the same direction. When

this lecture series started in 2006, the original intention was to let it run for five years. But as the epidemic persisted, the Government decided with great foresight to keep the event going indefinitely so as to keep concern with HIV and AIDS alive in the national consciousness and, hopefully, also in the resource allocation process. This is a strong national assertion that Ireland will not turn its back on this massive humanitarian problem; that it will not sweep it under the carpet. Hopefully this strong commitment to remembering and talking about HIV and AIDS will also be matched by an equally strong commitment to channelling financial and human resources to where they can be best used in responding to what is still a devastating epidemic.

*“...twice in the last week I have had people coming to me, telling me that they had not eaten for two or more days and so could not take their ARVs. Nothing could be more harmful to them”.*



Chair, Ladies and Gentlemen, let me end by thanking all of you once more for your presence this evening, and let me beg of you to keep this disease high not only on the national agenda but also among your personal concerns. Put people first. It is human beings who are enduring the horrors of this disease – parents, academics, young people, and others like yourselves. Never forget them so long as just one person remains infected with HIV.

And now let me hand you on to our two speakers, Professor Tlou and Sr. Miriam,

whom you have come to hear. It is possible that some of their words may sadden you, but I feel sure it will also hearten you to learn that so much has been done, even though there is need for an awful lot more.

Once again I thank you for your presence tonight. With two such distinguished speakers you will surely have a very informative and inspirational evening. And when it is over, I wish each of you a safe journey home and a very happy and blessed Christmas with your loved ones. Thank you, and may God bless all of you”.





## *Featured content available online*

In honour of Father Michael's ongoing contributions to the fight against HIV and AIDS, Irish Aid and the Irish Forum for Global Health created a website documenting the Annual Professor Fr. Michael Kelly Lecture on HIV and AIDS, which can be visited at [fathermichaelkellyzambia.org](http://fathermichaelkellyzambia.org). Contents are organised by year, including Father Michael's addresses, guest speakers' lectures, and additional media including event flyers, news features, and photography. The site is an audiovisual record of Father Michael's longstanding commitment and dedication to helping end the HIV epidemic, and we hope that you will take the time to visit it. Please see below for a list of content featured, by year, at [fathermichaelkellyzambia.org](http://fathermichaelkellyzambia.org). We welcome any comments and questions about the website or any of the following resources, which can be sent to [info@globalhealth.ie](mailto:info@globalhealth.ie).

### **2015 Content**

- Video address by Father Michael
- Video and slides of guest lectures by Professor Sheila Dinotshe Tlou and Sister Dr. Miriam Duggan

### **2014 Content**

- Video of Dr. Douglas Hamilton's introduction
- Video of address by Father Michael
- Video and slides of guest lectures by Dr. Noerine Kaleeba and Nadine Ferris France

### **2013 Content**

- Audio and slides of Father Michael's lecture
- Document on Trócaire's "Facing AIDS" photo exhibition
- Pictures of the Open Heart House quilt featuring positive messages of living with HIV
- Advertising flyer for the 2013 event

### **2012 Content**

- Video of Minister Joe Costello's opening address
- Video and slides of Father Michael's lecture
- Slides of guest lecture by Ann Mason
- Advertising flyer for the 2012 event

### **2011 Content**

- Audio and slides of Dr. Mphu Keneiloe Ramatlapeng's opening address
- Audio of Father Michael's lecture
- Audio of Yvonne Chaka Chaka's address

## 2010 Content

- Audio and slides of Father Michael's lecture
- Audio and slides of guest lecture by Dr. Zeda Rosenberg
- Audio of Pat Kenny's radio interview with Father Michael and James O'Connor

## 2009 Content

- Transcript of opening address by Minister Peter Power
- Video of Father Michael's lecture
- Video of a TED Talk by Dr. Seth Berkley
- Slides of a brief update on HIV and AIDS in Ireland, produced by the HSE and Ireland's Health Protection Surveillance Centre

## 2008 Content

- Slides of Father Michael's lecture
- Slides of guest lectures by Dr. Stuart Gillespie and Connell Foley
- Special feature by Irish Aid containing information around Ireland's achievements and commitments to the fight against HIV and AIDS

## 2007 Content

- Slides of Father Michael's lecture
- Slides of guest lecture by Professor Sheila Dinotshe Tlou
- Special news feature and HIV advocacy materials from *The Irish Times*

## 2006 Content

- Taoiseach Bertie Ahern's address to the United Nations High Level Meeting on AIDS
- Slides from Father Michael's lecture
- Downloadable document, "Lifting the Veil: Shedding Light on HIV Stigma and Discrimination", produced with the support of Irish Aid, collecting a series of reports written during the 16th International AIDS Conference which took place in Toronto in August of that year



# *Image Key*

**Front Cover:** Father Michael Kelly during his 2007 lecture.

**Page 5:** Minister Sean Sherlock, T.D.

**Page 6:** Then Taoiseach Bertie Ahern, T.D., addressing the United Nations High-Level Meeting on AIDS in 2006.

**Page 16:** (L-R) Father Michael Kelly, Professor Sheila Dinotshe Tlou (then Minister of Health for Botswana), and Michael Kitt, T.D. (then Irish Minister of State for Overseas Development), at the 2007 lecture.

**Page 18:** (L-R) Nadine Ferris France (Irish Forum for Global Health), Professor Sheila Dinotshe Tlou, Father Michael Kelly, Nicola Brennan (Irish Aid), and Ian Hodgson at the 2007 lecture.

**Page 19:** Father Michael Kelly greets Professor Sheila Dinotshe Tlou at the 2007 lecture.

**Page 26:** Then Minister of State for Overseas Development, Peter Power, T.D. (Back row, left), and Dr. Seth Berkley (IAVI; Back row, right) with Royal College of Surgeons in Ireland (RCSI) medical students at the 2009 lecture. (Image courtesy of RCSI.)

**Page 28:** Dr. Zeda Rosenberg, CEO of the International Partnership for Microbicides (IPM).

**Page 29:** Father Michael's 2010 publication, HIV and AIDS: A Social Justice Perspective.

**Page 30:** Attendees to the 2010 lecture, including Professor Ruairi Brugha (RCSI; left), Breda Gahan (Concern Worldwide; centre) and James O'Connor (Open Heart House; right).

**Page 31:** Father Michael greeting an attendee of the 2010 lecture.

**Page 32:** (Left) Dr. Mphu Keneiloe Ramatlapeng (then Minister of Health for Lesotho) and (Right) Yvonne Chaka Chaka (UNICEF and Roll Back Malaria Goodwill Ambassador, and UN Envoy for Africa) at the 2011 lecture.

**Page 34:** Attendees at the 2011 lecture enjoying Ms. Yvonne Chaka Chaka's musical address, including Dr. Mphu Keneiloe Ramatlapeng, and Dr. David Weakliam (Chair of the Irish Forum for Global Health).

**Page 37:** Yvonne Chaka Chaka encourages participation of audience members at the 2011 lecture, including Dr. Douglas Hamilton (Deputy Director, Thematic and Special Programmes, at Irish Aid; left).

**Page 38:** Yvonne Chaka Chaka addressing the audience at the 2011 lecture.

**Page 40:** (Left) Then Minister of State for Trade and Development, Joe Costello, T.D., and (Right) Dr. Busi Mooka (Consultant in Infectious Diseases at Limerick Regional Hospital) at the 2012 lecture.

## *Image key (continued)*

**Page 43:** Father Michael greets Minister Joe Costello, T.D., at the 2012 lecture.

**Page 45:** Ann Mason (Manager of the Red Ribbon Project), with Father Michael at the 2012 lecture.

**Page 46:** Quilt containing messages of hope and strength, sewn by members of Open Heart House, displayed at the 2013 lecture.

**Page 47:** Close-up of one of the messages featured on the Open Heart House Quilt.

**Page 49:** Attendees to the 2013 lecture (L-R): Professor Ruairi Brugha (RCSI), Dr. David Weakliam (Irish Forum for Global Health) and Nicola Brennan (Irish Aid), with Father Michael.

**Page 50:** Breda Gahan (Concern worldwide; at centre, with microphone) addresses attendees to the 2013 lecture, with the Trócaire photographic exhibition, “Facing AIDS: The Time is Now” in the background.

**Page 53:** Father Michael and friends displaying the Open Heart House Quilt.

**Page 56:** (Left) Dr. Noerine Kaleeba (Co-Founder of The AIDS Support Organisation (TASO), and Vice-Chair of the Ugandan National Health Research Organisation), and (Right) Nadine Ferris France (Irish HIV and AIDS researcher and Operations Director of the Irish Forum for Global Health).

**Back cover image collage, top panel** (clockwise from top-left): Dr. Noerine Kaleeba and Nadine Ferris France at the 2014 lecture; Minister Peter Power, T.D., and Dr. Seth Berkley with RCSI Medical Students at the 2009 lecture; Father Michael and Professor Sheila Dinotshe Tlou at the 2007 lecture; Father Michael addresses the audience of his 2012 lecture; attendees to the 2010 lecture including Prof. Ruairi Brugha, Breda Gahan, and James O’Connor; and Yvonne Chaka Chaka with audience members, including Dr. Douglas Hamilton.

**Back cover image collage bottom panel**, (clockwise from top-left): Father Michael with key guests at the 2012 lecture, including Minister Joe Costello, T.D., and Ann Mason; Attendees to the 2013 lecture including Professor Ruairi Brugha, Dr. David Weakliam, and Nicola Brennan; Father Michael, Dr. Mphu Keneiloe Ramatlapeng, and Dr. David Weakliam at the 2011 lecture; Father Michael receives his Honorary Doctorate from the Royal College of Surgeons in Ireland in 2012; and Father Michael with Professor Sheila Dinotshe Tlou and Minister Michael Kitt, T.D., at the 2007 lecture.

# Acknowledgments

We give profound thanks to Professor Father Michael Kelly for his tireless and unwavering commitment to supporting those living with HIV around the world. In addition, we thank all of the guest speakers of the Professor Father Michael Kelly Lecture on HIV and AIDS, who have given their time and unique expert perspectives over the years, as well as collaborators from the Global Health and International Development community who have worked together to facilitate and host the annual lecture and associated events.



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## About Irish Aid

Irish Aid is the Irish Government's programme for overseas development. The programme is managed by the Development Co-operation Division of the Department of Foreign Affairs and Trade. The work we do in fighting global poverty and hunger is integral to Ireland's foreign policy.

Our priorities are outlined in "One World One Future": Ireland's Policy for International Development. Our focus is on reducing hunger and improving resilience; inclusive and sustainable economic growth; better governance, human rights and accountability. Ireland is playing its part in addressing global poverty and hunger and achieving the Sustainable Development Goals in these priority areas.

For more information, please visit [www.irishaid.ie](http://www.irishaid.ie)

## About The Irish Forum for Global Health

The Irish Forum for Global Health is a network of academics, researchers, practitioners, students, and private individuals, from across sectors, who share a common interest in the field of global health. Since 2004, the IFGH has brought together its members through conferences, seminars, and training events, and acted as a conduit for global health news, perspectives, and knowledge-sharing, both in Ireland and overseas.

For more information, please visit [www.globalhealth.ie](http://www.globalhealth.ie)



Originally hailing from Tullamore, Ireland, Professor Father Michael Kelly has spent more than 50 years living and working in Zambia, where he is now a citizen. Since 2006, the Irish Aid Professor Fr. Michael Kelly Lecture on HIV and AIDS has been held annually to honour his lifetime contributions to tackling HIV and AIDS, and to reducing their associated stigma, discrimination, and impacts on human rights. This book compiles Father Michael's Lectures and is a permanent record of the inspiration and hope which he has given to so many women, men and children – those affected by HIV as well as those working across the globe to support them. In these annual lectures, Father Michael has addressed audiences drawn from the entire spectrum of those working in politics, health, education, international development and humanitarian action.

