CAN YOU DRINK THE CUP THAT I WILL DRINK?

HIV/AIDS: MEETING THE CHALLENGES, EXPLORING THE QUESTIONS[1]

Margaret A. Farley RSM
Gilbert L. Stark Professor of Christian Ethics,
Yale Divinity School, Yale University USA

with a response by

Robert Kaggwa M. Afr.
Chaplain, Roehampton University

We are here because we have sisters and brothers everywhere, especially in sub-Saharan Africa, who are threatened with grave illness, or who are already sick unto death. Lives are disrupted; families are devastated; and ordinary hopes are challenged in every way. Despite some significant progress in the struggle against the dread HIV infection, it continues to outrun us. Insofar as women and men and children who are infected and affected by HIV and AIDS share in our faith traditions, they have a special claim on us. Even if they stand outside of our communities of faith, they have a claim on us. I want to consider these claims and possible responses to them.

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[1]The first two sections of this paper were delivered at a symposium held at Digby Stuart College, Roehampton University, London, 20 April 2009. In order to respect the timing of the many rich presentations during this symposium, the third section was not included. The whole paper, however, including section 3, was presented later in a lecture given at Westminster Cathedral Hall, 21 April 2009. All three sections are included in this written version.

Although I will be speaking from the perspective of what we call the All-Africa Conference: Sister to Sister (AACSS) organization in sub-Saharan Africa, I look forward to your own sharing of your experience in each of your contexts. I suspect we have much in common, though each context is also unique.

In my brief time, I will try to speak (1) about the situation in sub-Saharan regions and countries, (2) about the guiding principles that have shaped the work of Sister to Sister, and (3) to say something about the sources of hope that sustain the women in African with whom we work.

I. The Situation

Because of your own long and hard work in response to the HIV and AIDS pandemic, I do not have to tell you much about the dire situation that, despite important progress, remains on-the-ground. As you know, of the 33.2 million people estimated to be living with HIV and AIDS, approximately 22.5 million live in the regions of sub-Saharan Africa.

Of the 2.5 million people newly infected worldwide only a little more than a year ago, 1.7 million live in the sub-Sahara. Of the 2.1 million who died in 2007, 1.6 million of them were in the sub-Sahara. Whole generations in these areas have been wiped out: parents, teachers, doctors, nurses. In some villages it is still possible to find no one alive over the age of 14. A few countries in these regions have shown recent declines in HIV prevalence–for example, Kenya. But the experience on-the-ground has not seemed to Kenyans to have really changed. A Kenyan woman with whom I worked shook her head in puzzlement over the reported decline in numbers infected in her country, and said simply, "It may be because we all have already died."

But in the last seven years, some things have improved: The silence that surrounded AIDS has to some extent been broken–by the media, by new African governmental strategies, and by groups

(many of them faith-based) dedicated to providing education and care. Anti-retroviral medicines are now available at lower prices, so that about 30 percent of those who need treatment do receive it, although this varies considerably from country to country.[3] Yet in countless villages and in many, many families, as well as parishes and mosques, silence still prevails. And while there are numerous stories of return to basic health among individuals infected in southern Africa–through treatment with ARVs–still, there remain millions who are without access to treatment. And the pandemic goes on.

Almost everything I have just said about the "situation" in the sub-Sahara represents not just difficult problems but **issues of justice**.[4] The first major justice issue is, of course, the ongoing **poverty** of people living in sub-Saharan Africa. The relationship between poverty and lack of education and medical care is everywhere visible. And deficiencies in nutrition, safe water, control of diseases such as malaria and tuberculosis, render people vulnerable to HIV infection and a quick conversion to AIDS. Moreover, AIDS itself exacerbates poverty, as when, for example, farm workers are no longer strong enough to cultivate the land. But the poverty of Africa is an international problem, whose causes have much to do with the consequences of past colonialism, international debt structures, present exploitation of Africa's rich resources, and unfair trade practices.

Poverty and its causes are not the only justice issues, however. **Gender bias** is central to the pandemic, and this, too, is an issue of justice. It is now widely recognized (as it was not yet in 2002 when AACSS began its work) that women bear a disproportionate share of the burden of the pandemic–as primary caregivers for the sick and dying, but also as more vulnerable to infection and death; and although women are increasingly at the center of community, village, city, district, and national responses to HIV and AIDS, yet their lack of economic, social, and political power remains a constraint, particularly in efforts to prevent the spread of HIV and AIDS. A significant proportion of new cases of HIV infection results

from domestic violence or violence in the workplace. In situations of military conflict, women are systematically targeted for sexual abuse, and hence made vulnerable to HIV transmission. The United Nations has declared international years of women. The African Union has articulated women's rights that should be respected and secured. Particular countries have introduced measures to protect women from abuse and to assist them with their children. But there remain blatant exclusions of women from leadership and decision-making roles in civil government, and in churches, temples, and mosques. Patterns of gender discrimination are perpetuated through social and religious reinforcement of economic dependence, and passive rather than active roles for women in both the public and private spheres.

As powerful as women may be in some aspects of their familial lives, they are often powerless in persuading male spouses or partners to engage in safe sex, or in refusing sex when it is demanded on traditional religious and cultural grounds. Without power in society, or in their own sexual lives, women who might hold the key to the stopping of the pandemic are all too often thwarted in their efforts. Practices differ from country to country, region to region, tribe to tribe, in Africa. Yet it is not uncommon that, for example, young girls and women are coerced into marriage, and into marital sexual relations, even though their husbands carry HIV. Women are subject to greater stigma than are men, although 80 percent of women carrying HIV were infected by their spouses or partners. African traditional sexual practices, which in another era served the good of the community, now put women at risk for sickness and death–practices such as "widow cleansing," ritual initiation of adolescent girls into sexual activity, etc. Even educated women are at risk, but the vulnerability of women increases exponentially when they live in small villages and rural areas without access to medical or general education.

What accounts for all of this? Many factors are involved (such as women's greater anatomical and physiological vulnerability to the

transmission of HIV), but most come down to the ways in which African women and girls are socially subordinate to, and dependent upon, men–not a completely different story from any other part of the world. As a partial explanation, South African theologian Isabel Apawo Phiri notes: "Girls learn from their mothers that they are created to serve their brothers. Boys also grow up believing that they were born to be served by girls and women."[5]

There are also justice issues that belong in particular to the **churches**. There is no doubt that churches have been in the forefront of responses to HIV and AIDS. Indeed, recent statistics indicate that in some countries faith-based organizations provide 40 percent or more of the care of the sick and dying, and that in the last five years important progress has been made through education and the many ways in which churches provide counseling and multiple other forms of support for those affected and infected by AIDS. And yet more is needed–specifically from religious traditions. For example, if there ever was a situation in which the principle of preferential option for the poor and disadvantaged was relevant and crucial, here it is. Preferential option is clearly operative in much of the work of Christian churches with the poor and with orphans, but it appears not to reach to the needs of women as a group or to individuals whose sexual behavior is judged not in accord with certain stipulated norms.

As growing voices of African women theologians are saying: their traditions must find better ways to address problems of stigma,

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[5]Isabel Apawo Phiri, "African Women of Faith Speak Out in an HIV/AIDS Era," in *African Women, HIV/AIDS, and Faith Communities*, ed. Isabel Apawo Phiri and Beverly Haddad (Pietermaritzburg, South Africa: Cluster Publications, 2004), 9. See also my consideration of these factors in *Just Love: A Framework for Christian Sexual Ethics* (New York: Continuum, 2006).

discrimination, and gender bias. The favored response of many religious leaders has all too often been to reiterate strong moral rules that may guard people against risks from sexual behaviors. Ironically, the simple repetition of traditional moral rules has frequently served only to heighten the shame and stigma associated with AIDS, and to promote misplaced judgments on individuals and groups. The perpetuation of a predominately taboo morality reinforces the sort of divine punishment motif that the book of Job was against, and it ignores the genuine requirements of justice and truth in sexual relationships. Even in response to their own personnel, some representatives and members of churches have been as likely to stigmatize those infected with HIV or sick with AIDS, as they are to deny their urgent needs.

Further, the AIDS crisis presents a clear situation in which faith traditions must address the gender bias that remains deep within their teachings and practices. It would be naive to think that cultural patterns that make women vulnerable to AIDS are not influenced by world religions whose presence is longstanding in their countries. Fundamentalism takes varied forms, but many of them are dangerous to the health of women. Questions must be pressed about the role of patriarchal religions in making women invisible–even though women's responsibilities are massive, and their agency can be crucial and strong.

I have learned from African women that there are many layers of life and influence in which Africans live: the layer of traditional indigenous culture and religion; the layer of Christian (or Muslim) beliefs and practices; the layer of colonialist imposition of gendered practices–reinforced by missionaries; the layer of modern (largely Western) cultural forces; the layer of growing post colonialist critique. An understanding of these layers of influence is necessary in order to discern accurate responses and wise strategies directly related to struggles with the AIDS pandemic. The work being done by African women religious scholars (e.g., Musa Dube, Mercy Oduyoye, Isabel Phiri, Anne Nasimyu, in books such as *Grant Me Justice*; *African Women, HIV/AIDS and Faith Communities*;

Daughters of Anowa; etc.) is crucial now as potentially formative of the work of the churches.

II. All-Africa Conference: Sister to Sister

The All-Africa Conference: Sister to Sister is but one response to all of this (hereafter referred to as either AACSS or as simply Sister to Sister). Its goal is to facilitate the coming together of African women religious throughout the sub-Sahara, in order that they may share with one another their experiences of HIV and AIDS–experiences in their families, villages, religious communities, parishes, and ministries–and thereby empower one another to address the pandemic. (There are copies of flyers for AACSS, as well as a paper on the goals, history, and dynamics of AACSS, available to you here, so I need not go into great detail now.[6]) Begun in 2002, AACSS has sponsored three regional conferences (in southeastern, southern, and southwestern Africa), as well as national conferences (multiple in Nigeria and in Cameroon, as well as one in Uganda and one in Zambia/Malawi). Conferences are planned and implemented by a local Coordinating Committee, which shapes the agenda, invites speakers and participants, secures a site, provides facilitators, etc. Sessions address not only medical and demographic information regarding HIV and AIDS, but questions of sexuality, gender, culture, faith, ethics, etc. Prime time is given throughout the conferences for small group sharing, where a principle of confidentiality is adopted in order to provide "safe space" for the telling and hearing of personal experiences and stories about the pandemic. Approximately 100 sisters participate in each week-long conference. The final two days are dedicated to training the participants in the identification and design of action plans, which they commit themselves to carry out

[6]For those wanting future access to these materials, or more information on the AACSS website, the email address is: AACSS@att.net and the website is: www.allafrica-sistertosister.org.

with their own constituencies. Currently there are more than 900 sisters and lay co-workers implementing such plans in 21 sub-Saharan countries.

The structure of AACSS as an organization includes two Co-Directors (who live in the U.S. but remain in continual contact with the Sisters in the sub-Sahara, and who travel extensively within Africa to be present at conferences, facilitate follow-ups from action plans, etc.) a U.S.-based Advisory Committee of African women religious who are working or studying in the U.S. There is also a large international advisory group. The major work of AACSS is done in Africa by African women religious. A Coordinating Committee (of local African women religious) makes decisions regarding conferences and agendas, and implements these decisions as described above. Following conferences, Coordinating Committees become Standing Committees which help in the initiation of and networking between action plans. National AACSS Coordinators are in place or in process of being identified in many individual sub-Saharan countries. AACSS works also with national and regional organizations of women religious in the sub-Sahara, as well as with Catholic charitable organizations.

Funding for AACSS comes primarily from women religious in the U.S. and Europe, but also from major Catholic foundations.

When AACSS was begun at the request of African Sisters, certain "guiding principles" shaped its work. I will describe four of these briefly. The first was the recognition and decision that **women are key** if the AIDS pandemic is ever to be stopped. This does not mean that no significant responses should be addressed primarily to men; indeed all responses should in some way take account of women, men, and children. But AACSS was born out of profound experiences of the power that is unleashed when women come together to share their experiences of HIV and AIDS, the power whereby women empower one another. Women who before had no safe place to share these experiences–not in their families, communities, parishes, villages–broke the silence among

themselves and discovered paths along which they could together be committed to go. They could rise up not only among themselves–African women religious and their lay co-workers–but through AACSS with women across the world.

Given a perceived and articulated (by African Catholic women) need to involve Roman Catholic women in responding to HIV and AIDS in the sub-Sahara, the further decision was made to work most directly with Catholic women religious, since they are already part of organizations (orders), and they have means in place for networking. In addition, they work in their ministries with many, many Catholic lay women. Moreover, they and their colleagues are trusted by the people in villages, cities, and towns, and in schools and clinics. Finally, they already have achieved a bonding among one another, so that their commitments can be shared, and their ways of mutual support provide a strong foundation for responses to HIV and AIDS.

Second, the work of AACSS is not work done by one individual or one group, but in **partnership**. For example, the Sister to Sister project is not a "missionary" project. It is not those in the U.S. (or anywhere in the West) who interpret African women's experience; nor is it Sisters from one culture who plan strategies for others. Partnership with African women religious means that AACSS as a whole is committed to pursuing partnered construction of the project's agendas, giving primary voice and responsibility in the ongoing shaping and implementation of agendas to those who are most affected by it–that is, to African partners (women religious), primarily those working directly with the people. We have gradually learned from them, however, that we can not only provide space for African women to speak with one another and to act together, but that all of us must participate in shared active dialogue and action.

Third, but closely connected to the above: the work of AACSS is by its very nature **cross-cultural**. This kind of work has always been difficult, and so very many mistakes have been made in

attempting it in the past. Our only way of bridging the boundaries between cultures is through the sustaining of our partnerships. At least in part, differences have been recognized and respected, and they have not yielded insurmountable obstacles. We have discovered that we can, across borders, experience awe before one another; we can laugh together, weep together, and labor for common goals. And we have learned that (a) it is not possible simply to transplant the beliefs and practices of one culture into another; (b) we ought not stand in general judgment of other cultures; (c) yet none of us can unconditionally respect every cultural practice–whether our own or another's; (d) we can stand in solidarity with those who critique, in their own culture or in ours, practices from which people die; (e) we have responsibilities, each for the other; and hopes, each for the other and for all.

A fourth element that characterizes and guides the work of Sister to Sister is the recognition that particular kinds of actions are required based on our understandings of Christianity as **"world church."** Probably most people who hear the term "world church" understand it to mean that the Christian gospel has been taken to the far corners of the world. But ours is a time when the concept of "world church" can be given a different content.[7] Now we recognize that the Christian gospel was never meant to be only or even primarily a Western European or North American gospel exported like the rest of Western culture to other parts of the world. Rather, God's self-revelation can not only be *received* in every language and culture, but *given*, *spoken out of*, every language and culture. We stifle its possibilities when any one culture claims nearly total control over its forms.

One consequence of this understanding of "world church" is the conviction that we are–all of us, whether in the U.S. or Europe or China or Africa–*all equal* sharers in the one life of the church. We are therefore all called to bear the burdens of one another when the church in one part of the world is in dire need. It is often said in this regard that the church has AIDS; the Body of Christ has AIDS; for Christians are not spared this devastation–neither the

faithful nor their priests and religious, nor their bishops. Insofar as this is a problem for the church of Africa (or of Ireland or Australia or East and South Asia), it is a problem for us all. We who stand in the tradition of our church cannot look upon such situations as "their" problem, not ours.[8] The gospel comes to us and is received by us–all together across the world; and it calls us not just to assist one another but to stand in solidarity with all, especially those who suffer the most. Now when AIDS is a challenge for the whole world, it is surely a challenge to the whole of the church. This is, for us, a matter of justice and identity.

III. Sources of Hope

Every major religious tradition has had something to say in response to the large questions of people's lives–questions about God, about human destiny, and about how to make sense of human suffering. Insofar as those who are involved in Sister to Sister stand in the tradition of Jesus Christ, we remind one another of what God has revealed and promised to us in the face of suffering–that of others and our own. If religious traditions have anything at all to say about situations like the pandemic as it is experienced in the sub-Sahara, they must speak of God and of human responsibility to one another in relation to God. Underneath the claim to our compassion, our partnerships, and our actions, are a claim to our hope–hope in God for us all. To sustain this hope among ourselves and share it with others, means that we must probe, again and again, the question that every Christian affected by the AIDS pandemic must face: **Where is God in the midst of HIV and AIDS?** We cannot answer this question until we ask a deeper one: **What sort of God is it in whom we believe? What sort of God is it in whom we stake our ultimate hope?**

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[8]And of course the problem *is in* just about every country, although the point I am making here is that wherever it is, it must be shared.

The God of Job, the God of Jesus Christ, the God of our faith and hope, is *not a punishing God*. God is not present as judge and punisher. It would be, we have come to understand, a contradiction to think that God as God could want for any of God's people the pain of this pandemic. The punishment would, for one thing, exceed any reasonable proportion to whatever crimes or sins we may have chosen. If there is any judgment made–by ourselves or by God–of sin in this situation, it is made not about an infection or an illness, but about stigma, discrimination, and negligence regarding those who are infected and sick.

But we understand more than this. We have looked for clues in particular biblical texts–such as Luke 23:27-31, where Jesus on his way to Calvary speaks to the women mourners who accompany him: "Weep not for me but for yourselves and your children." We have pondered our experiences of two kinds of tears–tears of desolation, which, when they have all been shed, leave the well dry, and leave our hearts empty of strength, without a capacity to love But there are also tears that water our hearts all the way to the river of action, and that give us strength and peace in real union with Jesus Christ and one another.

But here I will not pursue this text further, but select another one that has perhaps meant the most to all of us. It is Mark 10:35-40. We are all familiar with this story: The disciples are walking along with Jesus, when James and John come forward and ask Jesus to do for them whatever they ask. (In Matthew's version, their mother asks for them.) Jesus responds by inquiring about what they want him to do for them. They say they want to sit at his right and left hands when he comes in glory. Instead of answering their question directly, then, Jesus asks them another: "Can you drink the cup that I will drink?" They answer, "We can." They, of course, did not understand Jesus' question to them; nor would they understand it until the final terrible day of Jesus' life, and even then, perhaps not until his resurrection.

Looking back, we recognize the mistake made by James and John, but we sometimes have difficulties ourselves in understanding what Jesus meant. We know the "cup" to be a symbol of the cross. It symbolizes the suffering that Jesus was to undergo. But what does it mean for any of *us* to drink this cup, or to be called to this cross? And what does it mean for us in a time of AIDS?

Jesus does *not mean* that it is good for us to suffer–that suffering as such holds intrinsic merit. He also does *not mean* that suffering is a test of our love for God. Jesus, and the God whom Jesus revealed, did *not mean* that we are to be passive in the face of suffering–simply to bear it, endure it, expecting relief only in another world. In the face of the AIDS pandemic, we do not find Jesus suggesting to us that we must think of ourselves as victims–however we are affected or infected by HIV and AIDS. But if these are *not* the meanings of this text for us today, what *does* "Can you drink the cup?" mean?

We have learned that the "cup" means, symbolizes, at least four things: (1) Surely it symbolizes our *own suffering*. We are to bear it, but also to try to resist it, remedy it, insofar as possible. Bear it while we try to remedy it, and when we can do no more, bear it then, too. But the cup symbolizes something more: (2) What Jesus tried to reveal to his first disciples, and through them to us, was not only that they must be willing to suffer, to endure suffering that might be *like* his own; but rather: "Can you drink the *cup that I will drink*?" The cup to be shared was and is *the cup of Jesus Christ*. And perhaps, then, we know even more about this cup. (3) We know that it is the *cup of the suffering of all persons*. For Jesus took upon himself the afflictions of us all, the pain and the burden, the loss and the being bereft, of all persons from one generation to another. If we are to drink this cup, we are to partake in the sufferings of everyone else. Finally (4), given the context and the nature of the final sufferings of Jesus, we cannot fail to see that central to the symbol is suffering that *does not have to be*. Yes, it signifies all kinds of human suffering–suffering in the forms of sickness and tragic accident, human limitation, natural

disasters of drought and flood, earthquakes and storms, catastrophes great and small. Yet something in particular characterizes some of the sufferings pointed to by the symbol. In the context of the cross, central to the sufferings of Jesus is suffering that is the *consequence of injustice*. Hence, it is suffering that does not have to be–suffering that results from exploitation and poverty, violence and abuse, human indifference and false judgment, cruelty and abandonment. In the cross and cup of Jesus, and in the pandemic of HIV and AIDS, is suffering that cries out for an end not in death but in *change.*

We know even more about this cup. The cup that Jesus drinks is first of all a cup of love, a cup of covenant that seals the promise of a God who drinks, too, of human suffering, in order finally to transform it. This cup signifies the relationship between God and Jesus Christ; and–in Jesus–the relationship between God and all human persons; and finally the relationships among human persons, held in the embrace of God. The meaning of the cup is that a relationship holds–and this relationship makes it possible for other relationships to hold, no matter what the forces of evil try to do to break them. There *is* a love stronger than death, and it is a love that holds every suffering in its embrace until it is all transformed into a fountain of Life.

The meaning of Jesus' question to James and John and to all of us, then, is a call to love and to bear all things for love. It is not a call to passivity in the face of suffering. Like Jesus, we may ultimately experience a suffering and surely a death to which we must finally surrender. But like Jesus, we must oppose suffering and pain as long as we can, alleviate it in others as far as we are able, resist the forces of injustice until we can do no more. We must not surrender prematurely, before it is time. And when the time for surrender arrives, then we surrender not to disease, not even to death itself, but into the embrace of God. Our final dying can be experienced as our entry into eternal communion. This is what we believe. In this lies our hope.

Now what can happen if all women religious stand in solidarity, Sister to Sister, strengthened by hope and this kind of love? This is the question that AACSS asks. It also asks what might happen if all women around the world arose to share the labors of the women in Africa? And what would happen if the whole church arose to struggle with the pandemic of AIDS? What indeed.

Response to Prof Margaret Farley

Robert Kaggwa M. Afr.
Chaplain - Roehampton University

I am privileged and honoured to give this brief response to Prof Margaret Farley's lecture: HIV/AIDS: MEETING CHALLENGES – EXPLORING QUESTIONS. I must say that I am twice lucky to listen to Prof Margaret. I was present at Roehampton University as she delivered her key-note address on the same topic. I was particularly struck when she insisted that HIV affects everyone. Nobody should remain indifferent in today's global community.

Prof Margaret has highlighted how AIDS is the most globalised epidemic in history and how it thus requires both global and local solutions. She knows this from experience as she has been at the origin of the 'All Africa Sister to Sister Conference'. HIV/AIDS is now recognised as a pandemic that largely involves [poor people especially] women and dependent children in developing countries with Africa the most affected.

What Prof Margaret said about Sub Saharan Africa is also echoed by prominent Africans. For example, Sam Kobia (from Kenya), Secretary General of the World Council of Churches has observed that "No other calamity since the slave trade has depopulated Africa as AIDS has." It is a plague of genocidal proportions. But after nearly three decades since AIDS appeared we must ask

ourselves why the situation has become even worse. Earlier responses to HIV and AIDS seem to have ignored a proper social analysis of the context in which people are infected with HIV. Cultural, political, economic and religious dimensions of societies have revealed a patriarchal bias that ignored the issue of gender inequality as one of the major root causes of the pandemic. Prof Margaret has highlighted how AIDS represents injustice and this is manifested in particularly three areas: poverty, gender bias and Church (and/or religious) practices which deeply affect women and their dependent children in Sub Saharan Africa. The fact that women can come together to listen, share and empower one another is a major step towards combating these injustices and the AIDS pandemic itself.

Faith communities need to rethink their attitudes towards HIV/AIDS and to understand how to address the central issues of sexuality, status of women and the interconnection of gender, race and poverty. I think it is important to appreciate Professor Margaret's focus on the women of Africa. This is not to ignore other people living with AIDS (heterosexual men in Africa, gay people here in the UK and everywhere and other men and women in different contexts) but it is rather to acknowledge the importance of context in combating HIV and AIDS. I am sure we can all learn from Prof Margaret's analysis and testimony from the All Africa Sister to Sister Conference and see how other groups can ask questions that arise from their own contexts. She is a powerful witness as she herself was at the origin of this empowerment of African women through the 'Sister to Sister' Conference.

In a face of a situation that seems so uneven and unjust and in order to avoid remaining abstract we must continue to attend to the various contexts of vulnerability and stigma in society: women (and children), gay people, and all people who are victims of various forms of exclusion and discrimination. In a globalised culture that is characterised by an unequal-opportunity disease, we should really look at *varied faith reflections (theologies)* springing from the different contexts of suffering. We should structure our

common listening to hear the varied strains of divine and human suffering as an essential step toward their alleviation and eradication.

Prof Margaret has also pointed out how despite the care that the Churches provide for the sick, the dying and the orphans much of the responses of the Churches to AIDS have perpetuated a predominantly taboo morality that has created fear of divine punishment similar to that which the book of Job was against. This makes it all the more important to stress the justice issues in relation to the AIDS pandemic. We cannot exclude a global, systemic analysis of the conditions that are the source of the pandemic. We have to move away from a privatised analysis of a person infected with HIV/AIDS to a social analysis of a disease in a society that has proved a welcome host for the infection of its most vulnerable people. In brief we must move away from concentrating on 'individual or personal sin' to ***structural sin.*** We must look carefully for the unjust structures that make HIV and AIDS possible. We need to combat the racist, sexist, homophobic, 'classist', self-righteous, colonialist and economic unjust system. A lot of energy is lost by faith traditions when they fail to address these issues and focus exclusively on sexual morality. It is time to move away from such attitudes that increase discrimination and stigma and embrace a responsible sexual ethics that puts social justice at its centre in the fight against HIV and AIDS.

Maybe we will need to consider a few other things as well. I am thinking that today the language of human rights has taken centre stage and justice issues would need to be seen as human rights issues as well. For example, sex education and access to reproductive choice should be seen as basic human rights that are important in the fight against HIV and AIDS. I would also look at the role of dialogue with other disciplines – not only social sciences but also natural sciences (biology and medicine, for example) as essential in combating the disease. A dialogue between religious people and scientists would be seen as a dialogue of hope and solidarity in transforming the plight of all who live with HIV and

AIDS.

Professor Margaret Farley's final part is particularly and highly inspiring as it points to ***hope*** – hope not seen as promising liberation in an unknown future but hope that invites us all to make an effort to *change* the present suffering through love that is stronger than death. Her analysis of Mk 10:35-40 and its symbolism of the Cup that Jesus had to drink is particularly empowering in our response to HIV and AIDS. She invites us to recognise that this suffering '*does not have to be'* because it is a suffering caused by injustice. It is a suffering that calls out to an end, not in death but in a *change.* This is certainly a fresh new look at this passage – one that is empowering, one that points to LOVE and Relationships. The Cup of love is God's embrace for us, our embrace for one another, all of us held in God's embrace. As she puts it this is stronger than death and is a call to love that opposes suffering and alleviates it in others.

Robert Kaggwa M. Afr.