

Healing Ministry of the Church: An Investigation into the Engagement and/or Disengagement of the Methodist Church in Zimbabwe (MCZ) on HIV and AIDS

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Abstract

Churches have a unique role to play in responding to HIV and AIDS. No other institution has the reach into society, the continued presence nor the higher reach to respond like the church (Parry 2008:82). In response to the above statement, this article will argue that, healing has always been the unique call of the Methodist Church and it also formed its theology. Its founder John Wesley's priority was the physical and spiritual health of the poor of his time (Health and Healing 2001:47). His visiting preachers were instructed when visiting the sick to inquire about the needs of both body and the spirit. Wesley is argued to be one of the key drivers of the healing ministry of the eighteenth century in England. In contrast, the Methodist Church in Zimbabwe (MCZ) living in the same socioeconomic crisis like that of John Wesley is argued to have only engaged in HIV and AIDS programmes 'partially' as evidenced by the conference reports. This article will further investigate the extent to which the MCZ has engaged and/or disengaged from its theology of caring for the vulnerable that form the body of Christ in the twenty first century Zimbabwe. The paper will conclude by challenging the MCZ to revise its theology of the needy as emphasized by its founder John Wesley.

Keywords: Healing Ministry, Methodist Church in Zimbabwe, HIV and AIDS

Introduction

The church by its nature, as the body of Christ has a major role to play in response to the HIV and AIDS epidemic. According Parry, no other organization or government has the reach into the society, the continued presence nor the higher reach to respond like the church (2008:82). In response to the above statement, this article argues that, healing has always been the unique call of the Methodist Church and it also formed its theology. Its founder John Wesley's priority was the physical and spiritual health of the poor of his time. However, Methodist Church in Zimbabwe (MCZ) living in almost the same socioeconomic environment of John Wesley, the MCZ has only engaged in HIV and AIDS programmes 'partially'. Although the church made some attempts to respond to HIV and AIDS, its involvement eventually became compromised. The writer further investigated the extent to which the church has engaged and/or disengaged from its theology of caring for the vulnerable that forms the body of Christ in the twenty first century MCZ.

John Wesley's Understanding of Healing Ministry

The founder of Methodism, John Wesley wrote strongly on how to be health (Thornton & Collie 2004: iv). There are three motivating factors of Wesley's engagement to the healing ministry. First, Wesley inherited a medical involvement from his paternal and maternal lineages both as religious and medical practitioners (Schmidt 2007:13-15; see also Maddox 2007:5-8). For example, Maddox stresses that, Bartholomew Wesley (Wesley's grandfather) had refused to sign the Act of Conformity to the Church of England and was ejected. He later became a physician as an alternative career. Likewise, Dr Samuel Annesley (father of Susanna, John Wesley's mother) had a library which had over twenty volumes on medical references (Maddox 2007:5-8).

The second motivating point grew in John Wesley during his Oxford days where he developed an interest in health care thereby reading the anatomy of physic. According to Huges (2007:5), Wesley began his theological studies in the midst of dramatic shifts in science and in a society surrounded by sickness. It was a custom of the 17th and 18th century clergy candidates in England to study basic medicine in order to be able to offer simple medical care in the remote smaller villages in which they served (Maddox 2007:7). In an effort to enhance his medical skills, Wesley continued to read medical works

extensively throughout his life time (Hudges 2007: 6). Maddox (2007:5) confirms that, when Wesley was serving as a missionary priest in Georgia, his diary show continued reading of medical texts including one by John Tennet listing medicinal herbs that were available on the continent. Wesley's passion for health and healing was a central dimension of his ministry and the mission of the early Methodism (Maddox 2007)

The third stimulating point for Wesley to take healing seriously developed as a result of the plight of the poor in England during his time. According to Guy (1988), there were a large number of starving, unemployed and poor people in England. The majority of the rich had dispossessed the poor in the rural areas by introducing modern agricultural methods. These rich were not concerned about the social well-being of these poor (Gadsby 1988). The rich viewed the conditions of the poor as their own making and as a divine punishment (Gadsby 1988; Maquardt 1992:20). The entire community including its leaders were corrupt and bore some attitudes towards the poor. When these deprived people tried to organize demonstrations in order to make their voices heard, military forces intervened and imposed severe punishments on the initiators (Maquardt 1992).

According to Hudges (2007:8) and Maddox (1994: 146) in Wesleyan theology, spiritual healing contributed to physical health. Both spiritual and physical health are tangibly related and therefore both needs intentional care through not only religious practices, but also through medical care. The two Wesleyan scholars further comments that Wesley's holistic soteriology included not only integrated approach to physical and spiritual health, but also the desire for the wellbeing of the entire community particularly the poor and those without access to health care (Hudges 2007; see also Maddox 1994). Hiatt (2008:4), comments that, healing for Wesley covered the multidimensional aspects of physical, spiritual and relational. Hiatt adds that, Wesley often spoke and wrote about salvation in therapeutic healing terms. Therefore, salvation and healing cannot be separated in Wesley's theology (Hiatt 2008:6). Wesley believed that salvation is healing and healing expressed the transformation of full salvation (Hiatt 2008). In line with healing as salvation, one of Wesley's sympathizers, Maddox, maintains that, Wesley resisted suggestions to refrain from offering medical guidance, leaving it to those certified by the college. But his motive for resisting was grounded in his holistic understanding of salvation (Maddox 2007)

In view of Wesley's passion for the wellbeing of the poor of his time,

he is argued to be one of the key drivers of the healing ministry of the eighteenth century in England (Maddox 2007). Hiatt (2008:13) remarks that, over lifetime, Wesley demonstrated concern for healing as a holistic sense covering physical, emotional, psychological, spiritual, relational and even theological issues in his practical theology. Wesley understood healing theologically and he taught it because healing demonstrated the outward work of the holiness of the community of faith (Haith 2008). Hiatt further avers that, in Wesley's views, healing terminology and metaphors expressed good news as a full-bodied salvation and healing in Wesleyan theology is the most appropriate way of expressing God's loving, restorative, salvific work and throughout the fallen creation order (2008:23).

The Condition of Health Systems during the Time of Wesley

Health systems during the time of Wesley was very bad with the health services not accessible to the poor. Madden (2007) contemplates that, many diseases resulted from overcrowded insanitary dwelling houses among other challenges that includes the health institutions that were subjected to filthy conditions. Hospitals and infirmaries were filled with offensive smells. Beds were covered with straw mattresses and dirty linen and were breeding-grounds for the lethal typhus fever usually referred to as hospital fever (Maquardt 1992:21). England during the time of Wesley was also hit by the scarcity of physicians (Maquardt 1992:21). Added to this scarcity, was what Wesley defined as 'the approach used to study medicine' (Maddox 2007). For Wesley the type of training was resulting in incompetent healthcare physicians as the medical students were spending time in philosophical theories of diseases while neglecting anatomy and psychology and factual causes of diseases which was also affecting the kind of drugs distributed by the pharmacopoeia (Health and Healing 2001). Moreover, the drugs were also expensive or named in complicated terms that the unlearned poor could not interpret.

Amidst these living conditions, Wesley was one of the first not only to see the poor as recipients of alms and objects of charitable care, but also to set forth the genuinely Christian duty to eliminate their wretchedness (Health and Healing 2001). In view of his concern for the poor, Wesley undertook various measures to relieve them. His concern was to inquire if those who were ill were warm enough, well fed and clean (Health and Healing 2001:50). He enquired about the help and support that was available from the local hospitals. When

his researches found little was on offer to the poor, Wesley wrote that:

I will prepare and give the poor physic myself I took into my assistance an apothecary and an experienced surgeon, resolving at the same time not to go deep into my assistance, but leave all difficult and complicated cases to such physicians as the patience should choose I gave notice of this to the society telling them that all who were ill with chronic distempers ... might if they are pleased come to me at such time and I would give them the best advice I could and the best medicine I had (Wesley 264).

In dealing with the physical healing of the poor people of his day, in 1746, Wesley founded a dispensary for the less privileged of London (Wesley 1746: 11). According to Marquardt (1992), this medical center has been claimed to be the first free medical dispensary in England. In 1747 Wesley, published the *Primitive Physic, or an Easy and Natural Method of curing Most Disease* (Hill 1988; see also Maddox 2007). According to Madden (2007:11) Wesley's aim of publishing the *Primitive Physic* was to make health care remedies available to the poor through simple recipes which used household products. The book also contained simplified natural methods of healing for the poor. Maddox (2007 :22-23) comments that *Primitive Physic* relates one account in which Wesley prescribed two hundred and twenty five treatments of which one hundred and eighty four were from plants, seventeen from animals, twenty four from minerals. It is against this background that Madden concludes that *Primitive Physic* was the most popular medical volume published in the eighteenth century England and twenty three editions went on print during his life time and the last and thirty seventh edition was published in 1859 (Madden 2007:12). Madden maintains that; *Primitive Physic* combined the simple traditional medicine with the best scientific discoveries of Wesley's day because healing was central in his theology (Madden 2007:20). For Malony (1995), Wesley's healing methods included electrotherapy which he called 'a thousand machines in one'. Malony, adds that given the manner in which Wesley was experimenting with the electric machine for healing, he deserves to be classified among the four best known electrotherapists (Malony 1995).

Marquardt (1992) notes that although Wesley faced sharp criticism from the physicians in London concerning his health plea, he however did not

allow himself to be intimidated. Wesley remarks that just after creation, humanity knew no sin, no pain, no sickness, weakness or bodily disorder (Thornton & Collie 2004: iv). In view of this theological understanding of healing, Wesley argues that God is involved in lessening any suffering that humanity will go through by reducing the pain. In addition, he highlights that God also provides and reveals medicines to treat the diseases (Maddocks 1988:141-143). Wesley further argues that, Christ as the Great Physician heals our woundedness and semi-diseased souls, Latin (*salvus*) which means healing and wholeness of mind, body and spirit (Maddocks 1988:141-143).

Wesley's healing methods face a lot of criticism from the medical fraternity as they argue that he published books on medicine while he was not a licensed physician (Malony 1995; Gadsby 1998). Marquardt (1992:29), comments that although Wesley's knowledge and passion for healing implied him be an amateur physician. However part of his ministry's expansion carried out three steps to ensure the usefulness of healing ministry among the poor. Wesley offered free medical care not only to the Methodists, but also to the community (Marquardt 1992:29), he distributed his book, the *Primitive Physic* to the poor in England as little or no cost in order to help them not always to seek a physician, whenever there was an affliction that was costly (Maddox 2007:27) and lastly Wesley financially empowered the poor in order to help them maintain a healthy life style and pay the physician's bills. At this point, he gave them interest free loans and helped them find and create jobs (Marquardt 1992:29). According to Maddox (1988:142-143, 2007:9-10), upon Wesley's death his ministry was known throughout in England as were his curing methods applied by himself, families and the communities. Maddox (1994: 147) observes that participating in healing is respecting God's commandment to love God and to love the neighbours. Wesley's belief of healing was part of the whole process of salvation.

The Missionaries' Concept of Healing in the Methodist Church in Zimbabwe

Methodism in Zimbabwe was introduced by the missionaries. Although these missionaries regarded the ministry of the MCZ as threefold; preaching, teaching and healing as suggested by (Zvobgo 1991:71), however, Wesley's concept of healing was never transplanted in the African soil. The missionaries used healing as a token of preaching. This point was buttressed by Methodist Medi-

cal missionary Dr L.G Parson in 1910, who argues that: ‘Medical missions constituted an excellent object lesson in Christianity. If by skillful treatment, a sick native is relieved of pain, or cured of his disease , he must wonder why it has been done, and is far more prepared to receive and respond to the gospel than if this is presented him with pain unrelieved’ (Zvobgo 1991:71).

This understanding of healing ministry made the missionaries to ignore the healing understanding of their gospel recipients and concentrate on their own understanding of healing which was a western scientific. Although Shoko (2007:1) believes that illnesses and diseases of the serious and complex nature in Africa are attributed to *vadzimu* (ancestors) who are the deceased parents, grandparents or great grandparents, Makoti raises a contrasting point that the missionaries did not believe that illness could be caused by ancestors or magic convocations of an enemy (Makoti 2012:14). Such complex illnesses could be classified in the family of HIV and AIDS today.

In making sure that physical healing was attended to, the missionaries opened dispensaries. Makoti alludes that, the medical missions were an effort to wean Africans from their uncivilized beliefs (Makoti 2012). According to Zvobgo (1991:78), the missionaries boasted of these medical missions. He cites Rev H.J Baker, in Kwenda Circuit in 1914 who said: When a missionary toured the mission station, the most important item he should take with him was not the Bible or the hymnbook, but dental forceps for pulling out teeth. The missionary might forget his bible, books, wife and even food but if he forgets his forceps, he would not be easily forgiven (Zvobgo 1991:78).

The need for physical healing led to the building of Kwenda hospital in 1913. Nonetheless, the hospital only lasted to 1916 and Makoti concludes that these medical missions failed to cure many illnesses since many sicknesses for Africans were medical (Makoti 2012). One of the reasons for failure was that, the missionaries’ approach concentrated on the physical healing only and overlooked the African spirituality. In 1977, the MCZ inherited the healing ministry that was physically oriented with the answer only found in the hospitals

Steps Taken by MCZ to Engage and Disengage from HIV and AIDS Programmes

During the period of post-independence euphoria from 1980-1985, Zimbabwe

witnessed a silent HIV and AIDS epidemic, whereas the first case was identified and acknowledged in 1985 (Mboma 2002:1). Upon this identification of the first HIV case, both the government and the church entered into a state of denial (Hove 2013:7). According to Pastor Maxwell Kapachawo (the first pastor to declare himself to be living with HIV in Zimbabwe), the church has been spending more time burying its members than baptizing them because of its silence on HIV and AIDS (Mlambo and RelZim Staff 2012). Tanyanyiwa¹ says the response of the MCZ has been slow and reactionary. Tanyanyiwa (2011) adds that, when HIV and AIDS was publicized, the church was never perturbed and it paid a blind eye and a deaf ear to the epidemic. Tanyanyiwa (2011) bemoans that, it was only after one and a half decades later, when HIV was now an epidemic and had caused a lot of untold suffering that the MCZ decided to respond. The response by the MCZ was handicapped as there was lack of resources and appropriate effort from the leadership (Tanyanyiwa 2011).

The MCZ established the HIV and AIDS unit in 2000 to promote peer education, conduct training on HIV and AIDS, and Home Based Care programmes (Tanyanyiwa 2011). The MCZ joined hands with Centers for Disease control, Africare, World Vision, Hospaz and many government and UN agencies (Tanyanyiwa 2011). The church put structures in all MCZ districts, circuits and societies that would be working with the MCZ National HIV and AIDS Coordinator. In addition, the MCZ engaged in the training of its ministers on HIV and AIDS programmes. According to the Uniting World report through Methodist Development and Relief Agency website, all the 116 ordained ministers in the Connexion were trained in 2010. The other drastic step taken by MCZ was constituting the Health and Social Services Committee at its connexional level (national), district, circuit and society Deed of Church Order and Standing Orders (2007:70). Among the members of this committee is the Presiding Bishop (Head of the Church) and Mission Director (2007:70) who are key people in the daily running of the MCZ.

Apart from coordinating HIV and AIDS programmes, the coordinator was then given other responsibilities to monitor all health issues in the church, thereby renaming the coordinator, Health and Social Services Coordinator (Tanyanyiwa 2011). According to Tanyanyiwa, MCZ has four functional

¹ Tichapiwa Elton Tanyanyiwa was the Health and Social Services Coordinator with the Methodist Church who resigned in 2012.

clinics. The services provided there range from primary health care, HIV testing and counselling, maternity and Mother to child health (Tanyanyiwa 2011). From 2012, the MCZ disengaged on the HIV and AIDS programmes following the resignation of the Health and Social Services Coordinator. Two years after the resignation, the MCZ continues to bemoan the end of the donor community to support her HIV and AIDS programmes. The MCZ Minutes of Conference (2014:41) demonstrate how the church disengaged on HIV and AIDS programmes practically. The Mission Director of the MCZ reports on HIV and AIDS saying that, though there seems to be a dead-end on the thrust of HIV and AIDS within the donor community, as a church we continue to attach great zeal and enthusiasm to this mission focus. As such we have assigned MeDRA to take over the issue of HIV and AIDS for the purposes of both planning and execution (MCZ Minutes of Conference 2014:41). The same minutes indicate that HIV and AIDS programmes are no longer part of the health and social services (MCZ Minutes of Conference 2014:42). An analysis of the phrase, ‘take over the issue of HIV and AIDS’ is an indication that HIV and AIDS has ceased to be a programme but one of the ‘issues’. Unfortunately, in the 2015 Conference both the Mission Director’s report and MeDRA were quite on HIV and AIDS programmes. In the 2016 MCZ agenda for the conference had nothing on HIV and AIDS both as an issue and as a programme. These developments show that HIV and AIDS is no longer a priority in the MCZ.

What Could Have Led MCZ to Disengage on HIV and AIDS Programmes?

It is not clear as to what exactly would be the reason for the MCZ’s disengaged from its theology of healing the sick. In fact there has been a lot of theoretical engagement with HIV and AIDS on reports because of the economic situation of Zimbabwe which negatively affected the economy of the MCZ from the year 2000. The ministry and mission of the MCZ was also compromised because the same members of the churches were heavily affected by the economy which affected the financial income of the church. According to Mangena and Mandizha (2013:134), Zimbabweans having been reckoned as highly religious, sought solace in Pentecostal persuasion. Zimunya and Gwara (2013:190) maintains that , in such a scenario of poverty and uncertain events,

Pentecostal Churches sprouted and offered a much needed solace especially on the spiritual healing of all ailments. These ailments would include HIV and AIDS. The drive to Mega-Pentecostal Churches that were born during this period was necessitated by their promise to provide answers to the healing needs of Zimbabwean. This situation saw Methodist members practicing dual membership or completely transferring their faith to these churches (Mukonyora 2007).

The Impact of the Methodist Church in Zimbabwe's Disengagement from HIV and AIDS Programmes

The theological analysis of the Zimbabwean situation above leaves MCZ with deep-seated experiences of HIV and AIDS. According to Moyo (2015:148) a church that understands Jesus will label itself as HIV positive. In view of this point, the disengagement of MCZ from HIV and AIDS programmes demonstrates that the denomination proclaims Christ who always associated with the health and rich people only, which is a theological fallacy.

Chitando (2007:1), remarks that African churches need friendly feet to journey with individuals and communities living with HIV, warm heart to demonstrate compassion and anointed hands for healing. These characteristics of the church no longer apply to MCZ, but to the time of John Wesley. Maddocks (1981:60-61) argues that Jesus in his healing mission addressed the sick, touched them, smeared their bodies with oil, applied saliva and mud poultices to the diseased part of the body, addressed the individual's faith and their prayer for thanksgiving and for the forgiveness of sins. In contrast MCZ reports demonstrates that the denomination is no longer humble to be either like Jesus, or Wesley in dealing with people living with HIV and AIDS. The act of disengagement on HIV and AIDS by MCZ contradicts the point raised by Kalu that healing is the heartbeat of liturgy and the entire religious life. Healing brings the community of suffering together, it ushers supernatural power into the gathered community and enables all to bask together in its warmth. Healing releases the energy for participatory worship that integrates the body, soul and the spirit (Kalu 2008:253).

World Council of Churches (2005: 100) contemplates that remembering the suffering servant (Isaiah 42:1-9, 49:1-7, 50:4-11, 52:13-53:12), the church is called upon to share the suffering of persons living with

HIV and opening ourselves in this encounter to our own vulnerability and mortality. For the WCC (2005: 101), this action is a walk with Christ and as Christ has gone before us through death to glory, we are called to receive the sure and certain hope of the resurrection. In buttressing this point, Happonen, Jarvinen and Virtanen (n.d.: 5), note that the church should be the first to bring liberation to all people, empower them and erase the stigma which is associated with HIV and AIDS. Instead of causing stigma, the church has to function actively and purposefully to take the side of the infected and affected. The World Council of Churches further argues that, '...when the church properly responds to people living with HIV and AIDS both ministering to them and learning from their suffering, its relationship to them will indeed make a difference and thus become growth producing' (WCC 2005:79). The points raised are what is expected from the church and the MCZ is no exception. The MCZ is being challenged to be an HIV and AIDS competent church which should work towards the transformation of death dealing practices while strengthening life enhancing practices (Chitando 2007:1).

People Living with HIV and AIDS: An Amputated Part of the Body of Christ in the MCZ?

According to the Deed of Order of the Methodist Church in Zimbabwe, 'MCZ cherishes its place in the Holy Catholic Church which is the body of Christ...the church ever remembers that in the providence of God, Methodism was raised to spread Scriptural Holiness' (MCZ 2007:2). However, the mission and mandate of the church has been compromised by its position on HIV and AIDS. People living with HIV in the MCZ are like an artificial leg on the sportsman. Whereas the WCC (2005) thinks that the Church is a communion of one body with many members that are distinct to each other (1 Cor. 12:24b-27), however, the fact with MCZ is that people living with HIV 'no longer exist'. The MCZ is now a limping church with an amputated leg which formed the community of the people living with HIV. There are a number of reasons that have caused a part of the body to be amputated.

However, amputation does not stop life. For life to continue, some people are given artificial legs whereas some would use the clutches to balance up. Although it might not be clear as to what the position of MCZ is on the 'amputated leg', what remains a fact is that the church still carries a mark of

the abandoned community. Parry (2013:3) cites one speaker at the Evangelical Conference in 2008, who comments that, 'if your church does not address HIV and AIDS, your ministry is of little relevance today'. The Bishop of the Methodist Church in Harare West District Rev T Sungai (2016), bemoans that MCZ abandoned its theology by neglecting the plight of the people living with HIV. Ignoring HIV and AIDS by the church and concentrating on other facets of the ministry is as good as leaving the child to die when one has all the capacity to serve that child (Sungai 2016). The church is the only institution that meets hundreds of people each week at a very personal level.

Parry, mentions that, in HIV and AIDS ministry, the church faces the biggest combined social, cultural, economic, medical and political issues and at the same time , she deals with individual persons one by one, those affected by HIV and AIDS and their families much affected by it (Parry 2013:17). The response of the church to HIV and AIDS needs to be as extensive, broad and deep as the mission of the church itself (Parry 2013). The vision of the MCZ is to be an, 'an oasis of life, peace, justice and hope' (MCZ Minutes of Conference 2015: ii). A critique of this vision statement exposes MCZ to a denomination that is preaching Christ without the hardship of the cross. The Dictionary.com defines an oasis as spring of fresh water surrounded by fertile region of vegetation in a desert. By disengaging the HIV and AIDS programmes, MCZ can be viewed to be an oasis that is letting people living with HIV to move from the oasis to the desert where there is no life.

The church cannot ignore the theology of the 'one body of Christ' propounded by Chitando (2009) and Moyo (2015). These scholars who are also HIV and AIDS activists challenge the church on what it means to be 'one body of Christ' when some members of the body are infected and/or affected by HIV? How can the church claim to be the body of Christ when some of its members have to endure stigma and discrimination within the same body of Christ? The church must have a clearly theological defined response to the HIV and AIDS epidemic (Chitando 2009:155; see also Moyo 2015). By disengaging on HIV and AIDS, MCZ has off-routed from its theological mandate. According to the WCC (2005: 100), the church's response to the challenge of HIV and AIDS comes from its deepest theological convictions about the nature of the body of Christ and the reality of the Christian hope in which case MCZ is found wanting.

For Sue Parry, there are no reasons as to why the church should disengage from HIV and AIDS. Parry (2013:7), gave seven reasons why the

church should be involved in mainstreaming HIV and AIDS. This is the challenge that this paper is posing to MCZ. The first reason is that, people living with HIV are in the church thus the church should not disengage from its call to the infected and affected. The point raised by Parry does not give MCZ a choice of disengaging with HIV and AIDS, but to tie itself to the call of the people who form its membership and whose status most of whom the church is not aware of, but some of these members are tithers and key contributors to the life of the church. According to Moyo (2015:49) church members (some) are infected by HIV but it is very difficult to disclose. The word 'some' used by Moyo is subject to interrogation. If 'some' church members are infected and cannot express themselves, it might mean that there is a reasonable number of infected and a very big number of those affected by HIV and AIDS which leaves MCZ in a compromising position of wanting to split its members between those affected and infected and those who still enjoy HIV free life which might not be an easy thing. However, this might prove impossible because HIV is a visitor that is common in most families (Mujinga 2012:100)

Secondly, HIV is hurting people by destroying relationships. It has divided some families and communities (Parry 2013:7). Parry adds that HIV has created generations of largely disadvantaged orphans and children whose lives are severely compromised due to the insidious and avert impact of HIV on household's ability to survive. She further argues that, HIV is unlike other challenges faced by the church because it strikes at the very core of relationships and its impact is chronically deadly (Parry 2008:82). For Parry, the response of a HIV competent church to the epidemic should be characterized both in the life of the church and in the lives of those who serve in this field, by the fruits of the spirit, love, joy, peace, patience, kindness, goodness, gentleness, fruitfulness and self-control. If one has to go by the points raised by Parry, it remains critical as to what MCZ could be preaching if it has disengaged from HIV and AIDS programs which has become the center of conflict among the church members.

Thirdly, Parry comments that, the church should be involved in HIV and AIDS because the church has a comparative advantage to secular interventions. This point was buttressed by Garland and Blyth (2005: 278), who argue that the church in Africa is in a uniquely key position to address most of the aspects of the HIV and AIDS epidemic. The two scholars hold that the church has an extensive reach and its influence filters through most African

communities. Garland and Blyth also believe that the church has a massive yet often untapped potential to successfully reverse the causes of the epidemic. Its core values of love, care, support and justice have produced a nurturing and development of strong church run care and support programmes in many communities (2005:278). Failure to engage on HIV and AIDS issues renders MCZ an irrelevant church in the communities it found itself.

The fourth point states that; the church is already involved in development and humanitarian programmes and the linkage between HIV and AIDS are development gaps which the church should well recognize (Parry 2013:7). Chitando supports this point by suggesting that, the church in Africa is undoubtedly a significant presence in the spiritual, social and political economic lives of the people. It is thus strategically placed to make a difference in the context of HIV and AIDS (Chitando 2007: 5). The writer agrees with Chitando that, just like the church in Africa which is a sleeping giant, by being HIV incompetence. MCZ is not an exception. However, there is room for the church to wake up from its slumber by welcoming and reintroducing the HIV and AIDS programmes. Chitando uses the word compassion to describe an HIV and AIDS competent church. In his definition of compassion, Chitando argues that the church should feel pity for people in different circumstances. However, compassion in HIV and AIDS does not mean that the church should feel pit for people living with HIV, but stand in solidarity with them. The MCZ by abandoning HIV and AIDS programmes, has truncated part of its body. Chitando concludes that compassion compels the church in Africa to such indifferences in the face of HIV and AIDS. 'Business as usual' becomes impossible when the churches are moved with compassion, which is also a call to MCZ to translate compassion into concrete action that seek to mitigate and eventually remove the pain caused by HIV and AIDS.

The fifth reason cited by Parry is the church's theological mandate to fulfill the teachings of Jesus in (Matthew 25:31-46) which teaches that, '*whatever you do to the least of these, you do it unto me*' (:7). In this teaching, Chitando adds that Jesus was challenging his society to be more compassionate not by promising the vulnerable that their reward is in heaven, but by acting decisively to restore the full human dignity in this life (Chitando 2007:54). The disengagement of MCZ on HIV and AIDS is sad news because the church has many widows, vulnerable children and orphans and yet the church does not feel compassion for them. For Chitando, efforts to reach these vulnerable groups of people is living up to the idea of religion (Chitando 2007:54). In

reference to MCZ, taking this move is a step towards being a ‘movement’ and not a ‘monument’ as a church.

In the sixth point Parry grapples with the fact that the church is not an island but a community in a community. Parry laments that, if we ourselves are not directly affected by HIV and AIDS, we certainly all are indirectly affected if one of the body suffers (Parry 2013). Moyo (2015:149) holds that what affects the community invariably affects the church. For Parry, the church should be involved in HIV and AIDS because it has disturbed our comfort zone and our conventional theologies have been challenged, making us face inadequacies and our prejudices in the light of the Lord’s transforming love (2013:7). Parry further argues that the HIV and AIDS era has been and remains a Kairos moment for the church to be church to humanity and to bring transforming love, health, healing and restoration of hope and dignity to each other and everyone regardless of HIV status, colour, culture, creed, ethnicity or sexual orientation (2013:7).

Parry concludes the seven point on the church’s involvement in HIV and AIDS by pointing out that, for every humanity, life is created in the image of God and is sacred and is worth of that promise of abundance (2013:7). In buttressing the points raised by Parry, WCC comments that the church’s involvement in HIV and AIDS is affirmation that the church as the body of Christ is to be a place where God’s healing love is experienced and shown forth. As the body of Christ, the church is bound to enter into the suffering of others to stand with them against all rejection and despair (WCC 2005: 101).

The disengagement of MCZ automatically disqualified the church as a sanctuary that remains a safe place and space for healing. WCC (2005:79) notes that for healing, people need a place where they can be comforted in sharing their pain. If one analyses the role of the church as the body of Christ, it shows that Happonen, Jarvinen and Virtanen (n.d.: 5) are right to conclude that an HIV competent church understands healing holistically. The various activities of the church on HIV and AIDS create a supportive environment for healing in which case MCZ has short comings. Happonen, Jarvinen and Virtanen (n.d.: 5) comments that in many African communities, people do not have access to a counsellor, psychologist, family planning counsellor or a medical professional, in such circumstances, they turn to the church. However, MCZ in this case has not proved to be a shelter of hope. WCC (2005:77) observes that the church needs to have an open and acceptance heart. The WCC cites St Basil the Great who taught that, ‘it is upon those in leadership position

in the church to create an environment, an ethos, a disposition for the cultivation of the goodness and love of the community' (WCC 2005:79). St Basil further taught that, creating a safe space for healing one's own story within our church communities is therefore a practical step through which congregations can become healing communities (WCC 2005:79). In our view, in contemporary Zimbabwe, there is no way a church can be a healing community when it is quiet about HIV and AIDS.

The WCC argues that, the church which is built upon and shaped around the master story of the gospel, can offer a forum where those who are afflicted can in trust and acceptance let down their guards and share their stories (WCC 2005:80). The MCZ is currently a community of 117 713 members and 238 ministers (MCZ Agenda of Conference 2016:R52). The membership constitute a big number of people who could not just remain quite on HIV and AIDS. Everyone needs healing, however, WCC (2005:80) sets the ground of healing as a platform where care becomes more possible, as one shares the story within an atmosphere of acceptance, love and continuing concern. WCC challenges clergy who form part of their membership stating that, the task of those in ordained ministry of the church is to leave space in their own hearts and allow their own egos to die in order that this potential source of healing can flourish and bear fruits. They conclude that, this is the only way to create an atmosphere of acceptance in which stories can be said, and this healing need to happen among the people of the church (WCC:2005:81).

Conclusion

It was noted in this paper that the MCZ has side stepped from her definition of being the body of Christ and from the theology of John Wesley on the poor. The disengagement of the MCZ on HIV and AIDS programmes is an indication that the church has somehow concluded that HIV and AIDS is no longer an issue to talk about. This could be as a result of financial challenges to support HIV and AIDS programmes or it could be a socio-theological position that HIV and AIDS is no longer an issue in Zimbabwe. It can also be possible that the MCZ is affected by the general fatigue on HIV and AIDS which affecting mainly the donor community which is fuelled by the lull offered by ARVs. It is an undeniable fact that among the membership of both the clergy and the

laity in the MCZ, there are people that are either infected or/and affected by HIV and/or AIDS. These people need to share their stories, however, since the church has disengaged from HIV and AIDS programmes they find no residence in the place where they are supposed to have the first place in view of Jesus' concept of the love for the wretched of the society. The people living with HIV are struggling and they are teaching and they are learning and they want all of us to enter into a new way of understanding life in the community. The silent message of the people living with HIV and AIDS in the MCZ is a reminder to the church that everyone in the church is vulnerable and in need of healing. The 'us' and 'them' syndrome on HIV and AIDS should be curtailed (Moyo 2015). As the body of Christ, MCZ is compelled to be an agent of both social and theological cohesion otherwise HIV and AIDS will devastate communities under the care of the church which has a healing potential. In order for the healing ministry to have impact in the MCZ, the denomination needs to provide a sense of welcome and inclusiveness. It is only at this point that the church can be relevant. By being a safe place for all infected and affected by HIV, there is an opportunity for healing, reconciliation and the restoration of hope which is the vision statement of MCZ. The Methodism that was founded by John Wesley had the priority of the poor and MCZ is called upon to support, empower, accompany, advocate for, reward and save people living with HIV. It is through this action that the disengaged church can be reengaged and walk with the suffering.

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