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# Neglecting religious health assets in responding to hiv and aids

## An assessment of the response of the free methodist church of southern africa to hiv and aids

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**Abstract**

This paper is an assessment of the response of the Free Methodist Church of Southern Africa (FMCSA) to HIV and AIDS. It shows that this church is neglecting a crucial religious health asset – the Wesleyan Health Care Ministry – in responding to HIV and AIDS. While this church is rooted in John Wesley's theology and practice, the findings show that it is not using appropriately the insights that his ministry offers for addressing the pandemic. The content of the article was obtained through interviewing church leaders and caregivers, and conducting focus group discussions with ordinary church members in the FMCSA, Southern KwaZulu-Natal.

**Key Words:** Religious Health Assets, Wesleyan Health Care Ministry, Wesley, Free Methodist.

## 1. Introduction

This paper constitutes a critical study of the response of the Free Methodist Church of Southern Africa (FMCSA) to HIV and AIDS. Literature on HIV and AIDS has shown that a multifaceted approach is needed if communities are to meaningfully respond to the challenges of HIV and AIDS (Barnett and Whiteside 2006:362; Remme, Mukonoweshuro, and Stloukal 2010:191-192). For Barnett and Whiteside (2006:347-348; 362), countries which have succeeded in responding to the pandemic have mainly considered at least two aspects in their response. They went beyond the medical model of the response and involved people from all the levels of their society. Remme, Mukonoweshuro, and Stloukal (2010:191) also observe that by the end of the 1990s, it was clear that HIV is more than a health matter. Response to it involved other sectors of the economy such as education, defence, information, youth and women (:192).

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Religion was identified as one of these multifaceted approaches through which the pandemic must be addressed (Barnett and Whiteside 2006:362). As Olivier and Peterson (2011:26) observe, one of the signs of the recognition of religion's role in health was the alliance between the World Health Organisation (WHO) and the Christian Medical Commission of the World Council of Churches (WCC). This resulted in the 1978 Alma Ata Conference and the birth of the Primary Health Care (PHC) movement (:26). According to Olivier and Peterson (2011:26), the Alma Ata Conference was followed by an increase in understanding of the need for a holistic response to health.

According to Oliver (2011:87), "Literature on religious organisations and their involvement in HIV and AIDS was missing not only in the public health arena but it appeared that the religious sector was also lacking knowledge of its own responses and resources." Therefore in order to cover this gap, theologians have been engaging the ways in which theologies can be both an asset and a liability in the effort to address HIV and AIDS (Olivier and Peterson 2011:26; Olivier 2011:87). Their endeavour has resulted in suggestions of various theologies such as a theology of life (Dibeela 2007; Ruele 2003), theology of compassion (Dube 2007), theology of healing (Hadebe 2007), and theology of body and sexuality (Materu 2011) as potential tools for responding to the pandemic.

Furthermore, scholars within the African Religious Health Assets Programme (ARHAP) have been interested in identifying and valuing religious assets for addressing health matters. Since the inception of ARHAP in 2002, these scholars have been guided by six assumptions (ARHAP 2005:2). The first two assumptions read: "[1] Faith based entities are widely present on the ground in many contexts where health crises are most urgent. [2] No matter how impoverished, under-resourced or isolated such faith based entities might be, they nevertheless represent or contribute major assets to health in their contexts" (:2)[2]. Therefore, in identifying these assets, these scholars also focus on how to strengthen them through existing potentials and how to use them properly (:2).

In this regard, ARHAP (2004:5-6) has generated a typology of phenomena which have been linked with tangible and intangible religious health assets. These phenomena have direct or indirect impact when used to address health issues (Cochrane 2005:12). Among others, they include infrastructures, funding agencies, and healers (tangible with direct impact); prayer, health seeking behaviour

[2] Other assumptions are: [3] these assets are both tangible and intangible; [4] they have a public impact on health; [5] they need to be understood in relation to each other, as part of a complex and significant social reality; and [6] properly assessing, appreciating and enhancing their potential will produce better alignment between public health interventions and the religious structures with which they might partner.

and relationship for care (intangible with direct impact); choirs, rituals, and leadership skills (tangible with indirect impact), and faith, time, and power (intangible with indirect impact) (see also Olivier and Peterson 2011:35; Olivier 2011:87-88; Chitando 2007:8; Parry 2008:16). In the study conducted by ARHAP in Mali, Uganda, and Zambia (Schmid, Thomas, Olivier, and Cochrane 2008:11), it has been recommended that religious entities contributing to health be mapped widely in order to establish a comprehensive database.

This paper was conceived with this same aim of mapping and valuing religious health assets. I specifically point to the key religious health asset possessed by the Free Methodist Church of Southern Africa which is being neglected in responding to HIV and AIDS. This asset consists of the health care ministry initiated by John Wesley, the founder of Methodism. Its key features will be outlined later. The questions that this paper is responding to are: What has been the response of the FMCSA to HIV and AIDS? To what extent has the FMCSA taken the WHCM into account in responding to HIV and AIDS? In developing this paper, I first present an overview of the FMCSA. Then I introduce the Wesleyan Health Care Ministry (WHCM) and demonstrate how it is an asset for addressing HIV and AIDS. This is followed by a description of the process of data collection and analysis. Finally I provide the results of the analysis of the FMCSA's use of WHCM in responding to HIV and AIDS.

## 2. Overview of the free methodist church of southern africa

In this section, I present the missional development of the FMCSA, the situation of HIV and AIDS in its social context, and some aspects of its doctrine capable of influencing the response to HIV and AIDS.

### 2.1 The Missional Development of the FMCSA

The Free Methodist Church was founded by a group of laymen and ministers from Methodist Episcopal Church in New York on August 23, 1860. In loyalty, the founders committed to preserve characters of early Church as portrayed in the book of Acts and Christian life as taught and lived by John Wesley (Lamson 1960:14-15). Missionaries who initiated this church in South Africa arrived in 1885 (Lamson 1951:119-120). They started the mission in 1891 in Fairview, South Coast and expanded it into neighbouring areas (Lamson 1951:119; Burritt [n.d.]:44). In 1897, another missionary started the mission in Transvaal (current Gauteng) which has also expanded into its neighbouring areas (Brodhead 1908:29; Lamson 1951:131).

From these two points, the FMCSA currently comprises five Annual Conferences (operation areas), namely, Goldfield (Gauteng), Mpumalanga, Northern KwaZulu-Natal, Southern KwaZulu-Natal, and Eastern Cape (FMCSA 2012). In 2010, it had eighty pastors, of whom sixty-seven were ordained ministers, seven were ministerial

candidates and six were supply pastors. It registered 6,465 lay members, of whom 3,282 were full members, 1,475 were preparatory members, and 1,708 were junior members (between 9 and 15 years old) (FMCSA 2012). As it reads here, this church already ministers to communities from four out of nine provinces of South Africa.

### **2.2** Situation of HIV in the FMCSA's Socio-ecclesial Context

UNAIDS (2010:28) reports that South Africa has the highest number of people living with HIV globally.[3] According to Gouws and Karim (2010:62-64), a high prevalence of HIV in South Africa is identified in the KwaZulu-Natal province (the whole eastern part, especially Durban and Hlabisa) in which the present study focuses. Other provinces with high prevalence of HIV are Gauteng (Johannesburg, Carletonville and Klerksdorp), and the Eastern Cape (Port Elizabeth, East London). Kleinschmidt *et al* (2010:1165) also locate a high prevalence of HIV in the north-western parts of KwaZulu-Natal, in southern Mpumalanga and the eastern Free State. It is important to note that all the provinces in which the FMCSA operates appear at the top of these classifications.

In addition, the Human Science Research Council (HSRC)'s national population-based survey, conducted in 2005 (Gouws and Karim 2010:70), shows that HIV prevalence among adults (15-49 years old) was 19.9% among black Africans, 3.2% among coloureds, 1.0% among Indians and 0.5% among whites. Msweli (2012) and Shembe (2012), church leaders in the FMCSA, affirm that currently, only black Africans are members of this church. These figures indicate that communities in which the FMCSA operates are highly challenged by HIV and AIDS. Sound strategies are therefore needed in order to address the pandemic in these communities. The question that must be posed is: To what extent has the FMCSA responded to this problem? In the next section, I critique the church's doctrines to identify some issues that may positively or negatively influence the response to HIV and AIDS.

### **2.3** Elements of the FMC's Doctrine Capable of Influencing the Response to HIV and AIDS

Five elements are explored here. The first element concerns the understanding of divine healing. Free Methodists believe that God is the ultimate source of all kinds of healing, being healing of body, mind or spirit. In the process of healing, "He [God] (sic) may heal by the mediation of surgery, medication, change of environment, counselling, corrected attitudes, or through the restorative process of nature

[3] 5.6 million people living with HIV were estimated in South Africa in 2009, with the prevalence of 17.8% among adults aged between 15 and 49 year old (UNAIDS 2010:28, 181).

itself. He may heal through one or more of the above in combination with prayer, or He may heal by direct intervention in response to prayer" (FMCNA 2000:42). Therefore, for Free Methodists, there is God's validation and intervention in all forms of healing, being through prayer or not. This accommodation of various kinds of healing may be supportive to the multifaceted response to HIV and AIDS as presented earlier.

The second element regards the understanding of human suffering. Free Methodists believe that in spite of God's love of human beings, God does not protect them from suffering (FMCNA 2000:46). Rather, "God meets us in our suffering, to comfort us, to shape a Christ-like character within, and to make us instruments of his healing" (:46). This understanding of God's presence and companionship during suffering may constitute a redemptive means to accommodate HIV positive people, unlike the retribution theology according to which the suffering is the result of the sufferer's sin or disobedience (West 2011:135-138). The other important insight here relates to the agents of healing. The above quote mentions God and the sufferer. In addition, the *Book of Discipline* of this church stipulates that God

> ministers to us personally and through the healing environment of Christian community ....through scripture, prayer, godly counsel and the work of the Holy Spirit. As we are comforted, we are called to extend God's comfort to those who suffer (:47).

This means that all church members are called to be concerned about the suffering of others, including the suffering resulting from HIV and AIDS, and to engage in addressing it.

The third element relates to the use and misuse of drugs. Free Methodist doctrine prevents members from using or selling alcoholic beverages and other kinds of drugs such as tobacco, marijuana, cocaine, and heroin (FMCNA 2000:49-50). To a certain extent, this doctrine may constitute a way of reducing the spread of HIV since research has shown that abusive use of alcohol and drugs increases the risk of HIV infection (Tegang *et al.* 2010; Leggett 2010). The only issue is to know how to translate this doctrine into practice because strategies such as needle and syringe exchange, which have been proven useful in addressing HIV and AIDS, have been resisted by stakeholders believing that they instead encourage abusive drug use (Leggett 2010:246-247).

The fourth element consists of issues of marriage and sexuality. For Free Methodist doctrine, "marriage is the only proper setting for sexual intimacy" while homosexuality is a deviation and "perversion of God's created order" (FMCNA 2000:53, 56). This doctrine raises doubts as to whether HIV positive homosexuals can be enthusiastically assisted in this church since they are already considered as

deviant. Another issue in marriage regards separation and divorce among couples. Free Methodists do not support domestic violence; they rather always encourage reconciliation. In extreme conditions, separation can be accepted. Divorce is only recognised in cases of infidelity (:53-56). This understanding provides a space in which people who live with unfaithful spouses can have recourse to divorce (if able to survive out of this union) as way to prevent HIV infection.

The last element regards the attitude towards reproductive health support. Free Methodists are not totally against the use of reproductive health support. For them, the guiding principle is that "all human life must be valued, respected and protected throughout all its stage" (FMCNA 2000:46). In this way, the principle of preserving human life serves as a touchstone to know what reproductive health support to apply. However, they warn that in addition to being legally accepted and leading to preserving human life, the health support must be "morally accepted" (FMCNA 2000:46). This addition seems to create a dilemma in the present time where condoms and microbicides (gel) are used for reproduction control and prevention of HIV infection (Myer 2010; Karim and Baxter 2010). With regard to the FMCSA, such dilemma and possible controversies are likely to be observed. This is because until the time of this study it has no specified (written) policy regarding reproductive health apart from the *Book of Discipline* of the Free Methodist Church North America (FMCNA 2000) which does not mention anything about HIV and AIDS or condoms.

It is visible through these lines that the FMCSA possesses elements capable of both hindering and promoting the response to HIV and AIDS, depending on how they are used. Other elements can be traced in the history of this church, its mission, its leadership, and its social context. Given the scope of this paper, I explore only one element from this church's history, the WHCM. Its main features are briefly described in the next section.

## 3. Wesleyan health care ministry

The title "Wesleyan Health Care Ministry" is used in this paper to identify various services of prevention, health care and treatment that John Wesley (1703-1791), the founder of Methodism, offered to the community during the eighteenth century (Hill 1958; Davies 1963:34-35; Wesley 1988:7). These services are distinguished by their motivation and their practice.

Hill (1958), Guy (1988), and Wesley (2004) show that a double motivation, social and theological, led him to engage in health care. Concerning social motivation, Wesley was concerned about the pitiable living conditions of the poor who were of a great number and starving in England (Guy 1988:119; Marquardt 1992:27-33). The majority of the rich who had dispossessed them in rural areas by introducing

modern agriculture were apathetic about them, considering their conditions as their own fault and divine punishment (Marquardt 1992:20-23). The poor were exposed to many sources of disease, including "the overcrowded, insanitary dwelling-houses, the open sewers, the packed, disease-ridden prisons, the degrading gin-drinking, the neglect of the poor, the indifference to the welfare of children, the general brutality" (Hill 1958:4). In addition, there was a scarcity of physicians and the available health care services were very expensive (:2-5; Wesley 2004:iii-iv).

Wesley was also motivated by his theology of health. Four features characterise this theology. First, Wesley (2004:i) understood sickness as a result of human sin. For him, the human being was meant to eternally live peacefully. It is because of the fall of Adam that this plan has changed and now the whole universe, including weather, animals, and viruses, is contributing, through diseases and death, to the realisation of God's curse against the human being, of returning to the dust (:i).

Second, Wesley (2004:i-2) believed that God wills and is involved in lessening the suffering. For him, God's willingness to soften the suffering resides within the phrase pronouncing the curses; "In the sweat of thy face shalt thou eat bread, 'till thou return to the ground'" (:i). Wesley finds here the power to preserve and restore life, especially for those who control their diet (:i). Wesley also suggests that God provides and reveals medicines, and thus is the Great Physician (Maddox 2007:12) and supreme healer (Maddocks 1988:143-144).

Third, Wesley believed that healing is part of the holistic process of salvation. According to Maddox (1994:145), Wesley's understanding of salvation includes the spiritual (inner holiness), emotional and physical (the recovery of actual moral righteousness in our outward lives) life. Atkins (2011:48) extends this conviction to all Wesleyans and Methodists when he expresses:

> A Methodist and Wesleyan understanding of healing is deep and wide. Healing holiness, wholeness and salvation are for us all of a piece: indissoluble; the sum being more significant than the parts [...]. Our understanding of healing involves us as able to be renewed and changed. Body. Mind. Spirit. Each is important, but incomplete in itself and unable to be fully healed without reference to the others [...] it's not like changing the batteries or the hard drive!

With this conviction therefore, physical life is considered to be as important as social, emotional, and spiritual life.

Fourth, Wesley considered that all kinds of afflictions - spiritual, emotional, and physical – are interrelated and need a holistic remedy. In the preface of his book, *Primitive Physic,* Wesley inserts some rules for maintaining life, borrowed from Dr. Cheyne (Wesley, 2004:vi). These rules recognise the influence of passions on

the physical life. In interpreting this, Maddox (2007:14) argues that the concept "passion" includes both psychological dynamics and the spiritual dimension, thus joining together emotional, physical and spiritual dimensions of sickness (see also Gadsby, 1998). For Maddox (1994:147), in the same way that the body can be disordered by the mind, the reverse relation is also possible. As to Health and Healing (2001:7), it is such interrelation that explains the current understanding of psychosomatic illness. It is because of this interrelation that according to Maddox (1994:146-147; 2007:6-7), Health and Healing (2001:8), and Wesley (n.d.:120), a holistic response to diseases is also needed and that in some settings, a spiritual response can heal emotional or physical disorders and vice versa.

Last, Wesley believed that participating in healing is respecting God's commandment of love of God and the neighbour. Hulley (1988:77) elucidates that for Wesley, Christians love God because God loved them first and their love extends to their neighbours, seeking both their physical and spiritual health care. This understanding is also expressed in Wesley's sermons in which he warns his audience that if they lose the love of the neighbours they lose all (Wesley [n.d.]:12), that if their faith does not work by love, they are on the way to destruction (Wesley [n.d.]:56), and that giving without love does not profit anything (Wesley [n.d.]:495). According to Wesley, all is done for God, which means that we love God for God's own and the neighbour for God's sake (:495). Therefore it is in respect of this order to love that Wesley felt compelled to engage in health care ministry, especially for the benefit of the poor.

Besides Wesley's motivation to engage in health care, his ministry can be recognised through its concrete practice. Three key features are noteworthy. First, Wesley sought solutions to health problems. According to Cracknell and White (2005:35), health care started after November 1729 when Wesley joined and began to lead the Holy Club at Oxford University. Other activities of the Club included prayer meetings, Bible study, and assistance to the poor and prisoners. But the Holy Club was dissolved when Wesley went to Georgia as a missionary from 1735 to 1738 (Gadsby 1998). Gadsby (1998) mentions that when he returned he was shocked by the suffering of the poor. It was that shock that motivated him to create dispensaries in London, Bristol and Newcastle and furthered his knowledge in health care in order to better respond to the health needs of the community (Hill 1958:54-82).

Second, Wesley's health ministry involved holistic solutions. It comprised prevention of illnesses, care and treatment of the sick, community empowerment, and advocacy (Hill 1958:1-13). As an example of advocacy, in his sermon, "On Visiting the Sick" he admonished his audience to visit the sick (Wesley [n.d.]: 117-127, 119). According to him, sending money or other assistance to the sick cannot be recognised as a pretext for not visiting them (:119). Wesley also scolded the rich

for having little sympathy for the poor (:119). He attributed their unsympathetic behaviour to their failure to visit the poor. He asserted that the rich do not know the poor because they do not care to know them and they preserve the way of ignoring them, and concealing their hardness of heart (:119). Wesley also encouraged other preachers to read books on spiritual and physical health and to leave some in parishes so that parishioners may use them. He was moreover collaborating with specialist physicians, referring to them acute and difficult cases of illnesses (Maddox 2007:8-10). Wesley's other actions to sustain human life include visits and prayer for the sick (Maddox 2007:15-17), assistance to people, with in-kind donations, poverty alleviation, opposition to slavery and gender inequality (Marquardt 1992:29, 67-75, 134; Wesley, J. [n.d.]:125-16), education promotion (Marquardt 1992:49-66), and care for prisoners (:77-86). His services were extended to all people, Methodists and non-Methodists (Marquardt 1992:29; Hill 1958:12).

Finally, Wesley adapted his ministry to the conditions and resources of the community assisted. During his time, physicians were scarce and their services expensive (Hill 1958:2-3; Wesley 2004: iii-iv). Wesley provided poor communities with cheap and easy-to-use remedies (Malony 1995; Maddox 1994:146, 148). He developed an easy way of curing diseases (Wesley 2004:iv). He valued and promoted the best medical advice and the rule of the six "non-natural" categories of factors known to be determinants of health or disease, depending on how they are used or abused (Gadsby 1998). For Gadsby (1998), these factors are the [1] air; [2] food and drink; [3] sleeping and waking; [4] motion and rest; [5] evacuation and repletion/retention; and [6] the passions of the mind/soul. In Wesley's preventive advice and curative methods, he prescribed simple and natural recipes such as air, water, milk, whey, honey, treacle, salt, vinegar, some common English herbs as well as a few foreign, cheap, safe and common medicines (Hill 1958:10-11); what was called "Cool Regimen" (Maddox 2007:17-19). He also used electrical shock as well as pharmaceutical treatments when the natural one was not available (Gadsby 1998). He also published a book on easy ways of curing 288 afflictions that he distributed to the poor for self help if need arises (Maddox 2007:27; Wesley 2004).

This overview of WHCM suggests that it contains insights which can be used in addressing the challenges that HIV and AIDS pose to the South African society.

## 4. Wesleyan health care ministry as an asset for addressing hiv and aids

In order to assess the usefulness of the WHCM in addressing HIV and AIDS, I use the SAVE strategy proposed to churches by the African Network of Religious Leaders living with or personally affected by HIV and AIDS (ANERELA) (Heath 2009:71-73; PACSA [n.d.]:12). According to Heath (2009:71), the letter **S** stands for *safer*

*practice.* This means that addressing HIV and AIDS has to include all HIV preventive measures such as Prevention of Mother-To-Child Transmission, Pre- and Post-Exposure Prevention, Abstinence, Male Circumcision, Vaginal Microbicides, Condom use, Sterile Implements in public health institutions and as used by traditional healers. In WHCM, this component can be sustained by Wesley's advices about several kinds of prevention strategies, especially through controlling the six non-natural factors (Gadsby 1998).

The letter **A** in the *SAVE* strategy stands for *available medical interventions.* This implies that the response to HIV and AIDS has to consider using medical products and services already proven to be useful in addressing the pandemic. These include antiretroviral treatment, treatment of opportunistic infections and sexually transmitted infections, good nutrition and blood tests (Heath 2009:72). This component can be related to Wesley's use of orthodox and natural recipes to heal afflictions, including the use of electricity (Hill 1958:11-13).

Likewise, the letter **V** stands for *Voluntary Counselling and Testing (VCT).* This is a requirement to always check one's HIV status in order to develop right responses in the right time (Heath, 2009:72). I was not able to find literature, if it even exists, which shows that Wesley was doing blood tests in his health care ministry. However, he was diagnosing diseases and discussing with his patients about their sicknesses (Hill, 1958:12). He was also doing counselling (Maddox, 2007:7-9; Maddocks, 1988:141). And the fact that people were continuously coming to seek care from him, revealing their sicknesses and accepting his advice shows that he was encouraging people to know their health status and to deal with it accordingly.

The last letter of the *SAVE* strategy, **E**, stands for *empowerment.* This component suggests that addressing HIV and AIDS includes dealing with factors which promote HIV infection or may hinder adequate response. These factors may be religious and cultural factors, gender inequality, poverty and economic imbalance, illiteracy, marginalisation, conflicts and violence, migration, and racism (Heath, 2009:72-73). In WHCM, it goes together with Wesley's effort to address social problems which were hindering people's healthy life and access to health services. Wesley took initiative to assist people with in-kind donations or to alleviate poverty (Marquardt, 1992:29) and to oppose slavery (:67-75, 134). He opposed gender inequality (Wesley, n.d.:125-126), promoted education (:49-66), had concern for prisoners (:77-86), and encouraged the rich to help the poor (Wesley, n.d.:1-15).

It is noteworthy that SAVE strategy is in line with South African policy for addressing HIV and AIDS. This is observed in the four objectives of the five year strategic plan 2012-2016 of South African National AIDS Council (SANAC). The first objective is to address social and structural drivers of HIV, STI, and TB prevention, care and impact. This objective focuses on behavioural determinants, sexual debut and so-

cial and structural determinants which comprise elements of *"safer practice"* and *"empowerment"* in SAVE strategy. The second objective is to prevent new HIV, STI and TB infections. Its focus is the screening and healthcare enrolment, mother to child transmission, voluntary medical male circumcision immunisation, sex workers and men who have sex with men, which include elements of *"safer practice"* and *"voluntary counselling and testing"* in SAFE strategy. The third objective is to sustain health and wellness, that is, reducing HIV and AIDS impact through treatment, which correspond to *"available medical interventions"* of SAVE strategy. The last objective is to ensure the protection of human rights and improve access to justice, which covers the element of *"empowerment"* in SAVE strategy. (SANAC, 2014: 42-73).

It thus appears that WHCM contains insights which can be used to support strategies for churches to address HIV and AIDS in line with South African policy. Therefore the WHCM constitutes a religious health asset that the Wesleyan and Methodist churches, being heirs of this legacy, can utilise in addressing the pandemic, especially in South Africa.

However, it would be meaningless to expect that this ministry developed in the 18th century can automatically be applied in the 21st century. In the next paragraphs, I underline three aspects of Wesley's theology and practice of health care, which, if not taken carefully, may hinder the response to HIV and AIDS. First, Wesley linked the sickness with the sin. Though the sin referred to is not the sufferer's sin but that of Adam (Wesley 2004:i), uninformed persons may confuse this link with retribution theology according to which people suffering from AIDS are living the consequences of their own sins (West 2011:135-138).

Second, Wesley opposed the abusive combination of medicines. For him, this combination unnecessarily increases the cost of health care while destroying life (Wesley 2004). Using his words,

> Experience shows, that one thing will cure most disorders, at least as well as twenty put together. Then why do you add other nineteen? Only to swell the apothecary's bill... How often, by compounding medicines of opposite qualities, is the virtue of both utterly destroyed? Nay, how often do those joined together destroy life, which singly, might have preserved it? (:iv).

As an alternative, he promoted natural and cheap medicine that the poor could afford and which could have the same effect as pharmaceutical medicine (Hill 1958:11-13). Of concern is the possibility that uninformed persons may confuse this opposition with the refusal or denial of antiretroviral therapy which uses combined drugs in order to delay or prevent the development of AIDS (Wood 2011:529-530).

Finally, Wesley practiced medicine without licence as a physician (Hill 1958:32). During the 16th and 17th century, basic medicine was taught to Anglican clergy candidates (Maddox 2007:5). Until the 18th century, educated land owners and clergymen were the ones providing medical care to people in the remote countryside of England (Hill 1958:29). This means that Wesley had the benefit of medical skills learned from the experience of both his paternal and maternal grandfathers and his own father who were clergy (Maddox 2007:5). In addition, he had invested himself in reading medical treaties, anatomy and physics between 1724 and 1732 at Oxford University and in 1736 when he was a missionary in Georgia (Maddox 2007:5; Hill 1958:19). What he learned during this time was not very different from what physicians were learning (Hill 1958:18-19). For this reason, Hill (1958:32) recognises him as one of the great amateur physicians of 18th century. Even so, it would be unwise today to venture into the orthodox medical profession without fulfilling all the formal requirements.

Therefore, one should be cautious in the appropriation Wesley's ministry in the contemporary context, especially as it relates to how the FMCSA has used it in dealing with HIV and AIDS. In the next section the process followed in collecting and analysing data is explained.

## 5. Process of data collection and analysis

The data gathering for this study was based on a mixture of empirical and non-empirical qualitative materials. I also used existing literature and qualitative data collected in five circuits of The Free Methodist Church, Southern KwaZulu-Natal in 2011 and 2012. The study covered three communities of Pietermaritzburg, Durban and Port Shepstone. Participants included church leaders (clergy and lay leaders), caregivers (church members directly involved in caring for PLWHA), and ordinary members. The field data collection used semi-structured interview guides adapted to the leaders and caregivers on the one hand, and ordinary members on the other.

The sample comprised 17 church leaders and 15 caregivers interviewed individually as well as 8 focus group discussions (FGD) of which 4 were with adults and 4 with the youth. In choosing participants, purposive sampling (William 2006), snowball sampling (Hall and Hall 1996), and convenience sampling methods (Hall and Hall 1996) were used.

Ethical clearance for the research was received from the University of KwaZulu-Natal; the FMCSA's leadership provided authorized access, and the participants signed their informed consent. Interviews were conducted in English.

## 6. Analysis of the response of the fmcsa to hiv and aids

The participants were asked two questions. The first requested them to express how the church should respond to HIV and AIDS and to explain the reasons for

their church's involvement or non-involvement. The other question asked whether their church has ever developed programmes or initiated action to address HIV and AIDS. Responses to these questions allowed identifying four key issues: the lack of theological rationale with regard to HIV and AIDS; the silence about HIV and AIDS; mismanagement of potential human resources; and the dependency to external donors while neglecting local assets.

### **6.1** Lack of Theological Rationale

In all sessions of interviews and focus groups, participants expressed that the church should respond positively to HIV and AIDS. Most (61.5%) of the participants stated that the Church should respond because HIV and AIDS constitute a threat to everybody, including church members. One third (28.2%) pointed out that the church should be engaged because it has a responsibility to care for the sufferer and to stand up for the weak in society. Less frequent explanations stipulate that the church should respond because people need its support (15.4%), the church is a right place for support because there are people who are willing (5.1%), and that HIV and AIDS are like any other issues that the church is concerned about (5.1%).

Surprisingly, the participants generally did not link the church's response to any theological imperatives. Only one participant, CG7:1[4], who was a caregiver, referred to the Bible, quoting Isaiah 58 and to what Jesus said in the Gospel:

> I think the Church should respond to the problem of HIV [...] because we are commended in the Bible that we should stand in for those who are weak, and we should also serve justice where there is no justice. That's our call. Our God is calling us to do that. Even if you read the book of Isaiah 58, the proper fast that God is calling us to [...] Jesus said we are the salt of the earth. And the people right now need salt.

In this local context no church leader directly linked the reasons for the church's involvement in responding to HIV and AIDS with religious belief.

This view is somewhat inconsistent with the views of theologians (Richardson 2009; Richardson 2006; Demissie 2008). They identify two main reasons for the church's involvement in responding to HIV and AIDS; the social and theological. Since the social reason was widely expressed by participants, I will highlight the theological one which was scarcely indicated. For Richardson (2009), the church has to respond to HIV and AIDS because of what it is: "The claim is that the first task of the church is neither to fight for justice nor to fight against HIV and AIDS but that the first task of the church is to be the church" (:143).

[4] Names of participants are not given but are identified by codes because of ethical reasons.

Richardson elucidates that being the church implies being a Christian faith community that remembers and embodies the story of Jesus (:143-144). He insists on a church which is faithful to Jesus' instructions pronounced to his followers the few hours before his execution, that they should remember him through breaking bread and drinking wine together, that is, through practicing the Eucharist (:145). In Richardson's understanding, the true follower of Jesus and true practitioner of the Eucharist is the one who, because of that instruction, does as Jesus was doing. Richardson (2006:48-49) uses the term "theological rationale" to name this framework of theological understanding that engages the church in any action. He explains that because Jesus had compassion on those who were suffering during his days and that he touched them and engaged with them, any church not prepared to engage in addressing HIV and AIDS will thereby "compromise its essential nature" (Richardson 2009:143; Richardson, 2006:41-45).

Wesley also engaged in health care for both social and theological reasons. He initiated his ministry not only because people were suffering but also because it is the will of God and it is respecting God's commandment to love of the neighbour (Wesley, 2004:i-ii). This conviction of taking health care as an action dedicated to God motivated him to commit all his energy, knowledge, strength, authority and wealth to health ministry and to extend his services to Methodists and non-Methodists. The responses shared by the participants suggest that they failed to comprehend the missional implications for the church and this has had a negative impact on the response to HIV and AIDS.

### **6.2** Silence about HIV and AIDS

Participants explained that the FMCSA has not developed any programme or action with the intention to respond to HIV and AIDS. This inaction constituted an embarrassment to participants like the caregiver CG26:2 who stated,

> [T]o be honest with you we do not have a formal structure that is set up to cater for these people affected with HIV and AIDS [...] [Silence] Ehhh!! Not really. [Laughter] You know, I am ashamed because I am also a member but I can't [.....]; you know, I like to say "this is what we have done, this is what we have done" but I can't.

This caregiver is surprised that he cannot find any single action that his circuit has done with respect to HIV and AIDS while he is normally proud to enumerate achievements of the Church. In his narrative, he further places responsibility on the Superintendent who is the overseer of the church in Southern KwaZulu-Natal and who did not initiate such actions.

Most respondents throughout the circuits failed to identify any engagement of the Church in addressing HIV and AIDS. This perspective was expressed by 73.3% of caregivers, 50% of church leaders, 50% of FGDs with the youth and 25% of FGD with ordinary church members.

However, participants' views of the reasons for this non-engagement differ. Caregiver CG7:12 thinks that the government is doing everything for the population, including responding to HIV and AIDS, and this hinders the Church from engaging because it feels unconcerned. As to the church leader CL13:7-8, the response to the pandemic is not a priority because "their own" people from their families or circuits are not affected. He uttered that,

> It's not that people are silent about it. [It is] because they see no need to go to programmes like HIV and AIDS. There are quite a lot of other things that we need to achieve as a Church before we go to HIV. We need to go to our priority straight. But if we say maybe over a period of three years [...] maybe four people died of HIV and AIDS, it becomes an issue. Then the Church must say "what do we do?" Can you see? That's why when you ask these questions, you will find a lot of people being evasive, not giving you direct answers.

This church leader observed that the Church is not addressing HIV and AIDS because in their small circle of membership they do not see those who are dying of this pandemic. And like him, other participants claim that the Church is not responding to HIV and AIDS because there are no HIV positive people in their midst. This view raises two concerns. First, this means that some church leaders and members are less worried about the suffering of people outside the Church, a sign of lack of love for "others". Second, it is visible that they believe that there are no PLWHA in their midst. I argue that this is an illusion because there has never been collective disclosure of HIV status. Besides, the interview with another church leader, CL19:2 revealed that her daughter was HIV+ and was rejected by the family.

Theologians who have reflected on the way the church should respond to HIV and AIDS disagree with the above behaviour. For Parry (2008:79), "We need to be compassionate in what we do and to accompany, in solidarity, those amongst us who suffer from the effect of HIV". She explains that compassion reclaimed means to engage in responding and to make sure that people affected are served in the best way. But also, the question posed by Njoroge (2008:180) can fit in this context. She asks, "What kind of leadership do we have in the church and in society that rolls merrily along as the children of God perish? Are these not the 'stiff-necked people, uncircumcised in heart and ears' that Stephen preached about in Acts 7:51?" It is visible that not one of these scholars supports the Church's silence about HIV and AIDS under any pretext.

To such a context of apathy, the WHCM could equip and empower the FMCSA to offer a relevant contextual response. This model of health care ministry should encourage the FMCSA to respond to the poor health conditions of the community and take decisions like Wesley did when he saw sickness among the poor and responded to their inaccessibility to health care (Gadsby, 1998). Their failure to engage with the sickness because of their perception that their close relatives, colleagues or friends were not infected or affected meant that the Church did not bear witness of love of others, compassion and suffering with the sufferer. Conversely, Wesley extended his services to all the people, Methodists and non-Methodists (Hill 1958:12). Likewise, by pretending that there are no people infected by HIV in the Church, FMCSA failed to know the sufferer in their midst (Wesley [n.d.]:119).

Another issue in FMCSA's behaviour towards HIV and AIDS is their inaction because of the claim that the government is already involved. Parry's (2008:76) reaction to this point is that "Faith communities are not islands". Her argument is that churches have to collaborate with other key players in order to maximise resources and services. I would specify that even the South African government has sought collaboration with churches in taking care of the sick, especially those admitted in health institutions such as hospitals and clinics (Mkhize 2011). However, FMCSA did not respond to this invitation and therefore isolated itself. In displaying this behaviour, the Church failed to work complementarily with others, unlike Wesley who referred acute and difficult sicknesses to specialist physicians and learned from other physicians how to cure various diseases (Wesley 2004:v-vi).

### **6.3** Mismanagement of Potential Human Resources

The general consensus of the participants that the church failed to address the challenges of HIV and AIDS can be contrasted with the views of some participants that a few individuals within the church have made some contributions. Three categories of people are mentioned. First, in some isolated cases, professional nurses at the same time members of this church working in clinics or hospitals provide church members with advice in general issues regarding health (CL38:2; FGD17:9). Second, some church leaders are employed as staff of hospitals or clinics, and as part of their daily duties they deal with HIV and AIDS (CL20:1-11; CL21:10; CG27:1-11). The last category comprises people who, by their own initiative, went to the hospitals or clinics to assist the sick spiritually and were recognised by these institutions and given authorization to assist in all the wards while also receiving financial incentive (CL21:6-7; CG39:6). This group has also sought and obtained support of the superintendent for this initiative.

One pastor, CL11:5, criticises the second group. According to him, they do not represent the Church because "they are attracted by money rather than love of peo-

ple". What this pastor says can arguably be accepted as true since, according to the results of the present study, not one of these pastors in the second and third groups has organised such a thing in the context of the Church. They rather remain limited to health institutions where they get a monthly wage.

Another observation is that there is no Church's monitoring, coordination or reporting of these apparent activities. This invisibility of leadership in church members' activities regarding HIV and AIDS not only confirms that there is no institutional involvement of the Church in responding to the pandemic; it could also be argued that the institutional Church has no plan or vision to respond to this urgent missional challenge. The paradox is that there are competent professionals within the church who could provide the necessary resources to respond to the challenge if the church were able to develop a strategic plan.

According to Njoroge (2008:193) the church has to nurture and empower its leaders and members in order to respond in synergy to HIV and AIDS and other social challenges. However the FMCSA is failing in this regard. It seems to lack the missional vision and commitment to inspire and mobilise its membership for an intentional response to the life denying threat of the community. This is unlike Wesley who involved preachers, parishioners and the whole community in taking part in healing themselves and healing each other by providing them with books on health and requiring them to read and to use them.

### **6.4** Dependency on External Resources

The FMCSA had developed an HIV and AIDS project that should have started in 2005 and operated for a period of two years in four district municipalities of KwaZulu-Natal Province. Planned activities included workshops and trips for church leaders; training and conferences for various church groups at different hierarchical levels; income generating activities, and support and care for PLWHA and orphans; as well as vocational training for the youth. The budget was estimated at one million two hundred ninety thousand and one hundred and ten American dollars ($1,290,110) (FMCSA 2005). According to the overseer of the Church in the whole of Southern Africa, this was the only formal programme ever planned in the whole FMCSA. However it was not adequately funded and thus failed to be implemented (Shembe 2012).

This project proposal raised two concerns. First, it seems that the church planned a project that required a large amount of money that it was unable to afford. Second, the church was unable to attract external donors and therefore failed to identify and harness its own local financial resources to address HIV and AIDS. It could be argued that this failed project proposal dis-empowered the church from taking bold action and nurtured a culture of apathy and fear in addressing the pan-

demic. This absence of internal or external donors since 2005 is used as an excuse for inaction, yet it is arguable that a contextual response to the pandemic by the church may not necessarily need a huge amount of money as I will elucidate below.

Chitando (2007:34-35) and Le Roux (2011:80) observed that mainline churches have manifested irresponsibility because of their past experience with Western missionaries. Le Roux (2011:80) uses the comment from Roland Allen in which he argues that indigenous leaders were developed in a way that they depended on missionaries and were dis-empowered from taking any initiative without the missionary's guidance, and this resulted in them being unable to undertake any plan. Chitando (2007:34-35) states that unlike African Initiated Churches and African Pentecostal Churches, mainline churches continue to depend on resources from Western countries for their projects. He warns that depending on external countries prevents them from maximising local resources in responding to HIV and AIDS. He also observes that successful projects addressing HIV are not necessarily those using "big money" but that modest money can help achieving important objectives.

Referring to this non-funded project proposal, the FMCSA has fallen into this trap of mainline churches. It was not able to use available resources for a valuable purpose and therefore missed Wesley's missional challenge. For Wesley, water, air, exercise, electricity, herbs, prayer, and other natural or simple and financially cheap means were used as a recipe for prevention or healing. He also helped people to alleviate poverty with simple means so that they may be able to pay for pharmaceutical treatment and physician's bills if needed. Wesley was not waiting for or expecting big amounts of money in order to start responding to health challenges. If the FMCSA took the missional risk to engage in responding to the pandemic using already available resources, it would involve actions such as visiting, counselling, preaching, or material support. It would also engage human resources such as nurses, experienced ministers, and volunteers. There are also partners such as government's departments, NGOs, other churches and religious networks; as well as infrastructures and properties comprising land, halls and equipment that the FMCSA could embrace to achieve its missional objective. In addition, South African nature also provides resources such as healing herbs which can be useful in responding to the pandemic (Gennrich 2007:175-177).

Furthermore, the church has failed to use its own money, unlike what John Wesley did in setting an example for others to follow. The FMCSA has more than enough human and material resources to respond effectively to the challenge. The problem is not a lack of resources but lack of missional passion, commitment and energy to identify and act on the challenge as a ministry and mission priority.

## 7. Conclusion

The objective of his paper was to respond to the questions: What has been the response of the FMCSA to HIV and AIDS? To what extent has the FMCSA taken the WHCM into account in its response to HIV and AIDS? Because the FMCSA works with communities challenged by HIV and AIDS, I have demonstrated that WHCM constitutes a useful religious health asset for responding to this pandemic. I have suggested that WHCM be utilised as a useful resource to equip and empower Wesleyan and Methodist churches in responding to health crises, including HIV and AIDS.

However, the study has shown that in Southern KwaZulu-Natal, the FMCSA has failed to respond to HIV and AIDS and to value insights from WHCM in a time of health crisis. Features of this failure include the lack of theological rationale regarding HIV and AIDS, the general silence about HIV and AIDS, insensibility to the "others"' suffering, self-isolation from other key players, invisibility of leadership in potential initiatives, and dependency on external intervention and huge amounts of money.

Insights from WHCM identified as being neglected by this church include considering health care as an action offered to God, the concern about the poor health conditions of the community; extension of love to all the people within and outside the church and family; collaboration with other stakeholders in addressing the problem; and encouragement of the involvement of all, especially church members, in addressing health challenges. They also include the recognition and coordination of all the potentials and initiatives of the church members and the use of available resources.

However, studies are yet to elucidate why some pastors who are experienced in addressing HIV and AIDS are dealing with this pandemic in all other places, except in the context of the church.

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