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13 The Effects of COVID-19 and the Suffering of Pastors: Implications for the Provision of Pastoral Care and Counseling

Abstract

This chapter discusses pastoral care and counseling (PCC) in the context of the Coronavirus disease 2019 (COVID-19). The pandemic posed challenges towards religious practitioners in their care context. PCC provided solace towards dying or bereaved congregants. The rationale is that religion promised eternity, a concept that forces religious ministers to lose their lives without being able to avoid their dying members in both pandemic and non-pandemic contexts. PCC provides a holistic approach towards human comfort and hope for Christian sufferers and their families. In the academia, PCC contains key concepts of spiritual and psychosocial care that unites existential suffering and physical illness. This is provided for by trained religious practitioners in the service of the church and their needy members. Pastors tapped into the arena of the sacred on one hand; and psychosocially titillated the human psyche to heal human suffering. The theory and practice PCC appropriately reflects upon and implements religious resources towards care for persons facing in extreme physical, psychological, and social distress. The chapter used mobile instant messaging interviews (MIMIs) in this qualitative study. PCC is a holistic form of human care that positively affects families, health workers and patients during a health crisis like COVID-19. Religious resources provide vigilance for one to cope with highly contagious and fatal pandemics like COVID-19, and that can make a difference in the lives of sufferers.

Keywords: COVID-19; Pastoral care; Pastoral Counseling; suffering

Introduction

At the beginning of the year 2020, various presidents of African nations declared the Corona Virus disease 2019 (COVID-19) a national disaster.

COVID-19 like its precursor, Severe Acute Respiratory Syndrome – Corona Virus 1 (SARS-COV1) presented new complications that affected nations and religions alike. Christians who provided spiritual and psychosocial care through the church's pastoral care and counselling (PCC) programmes found social distancing to be a challenging requirement when providing PCC services. COVID-19 challenged how Christian pastors provided PCC services to sufferers. However, spiritual care became the third and important dimension of medical healthcare after physiological and psychological care. Spiritual care has become a key component in that it kept a holistic approach on human hope during health crises. Spiritual care assisted sufferers to find meaning in their relationships with their own bodies, other people, society, the environment and the spiritual dimensions of their lives. Religious remedies, using a wide range of spiritual resources, given by pious pastors changed circumstances for sufferers. Loving God for most COVID-19 sufferers in Zimbabwe became one of the greatest romantic practices that those who sought God went on a spiritual adventure to find their ultimate as a whole life achievement in their life history. Many pastors who became essential services providers had to attend many and bury people including other pastors who died in their call of duty. Pastors became chief mourners, burying colleagues, congregants and relatives alike. Due to the complications brought by COVID-19 and related illnesses religious practitioners were forced to attend to the dying and dead with COVID-19 related complications at greater risk to their own lives (Khosa-Nkatini 2022).

PCC affirmed the humaneness of sufferers in the era of the pandemic as pastors steadfastly delivered what is required in their professions on care-giving as they devised new ways of performing their pastoral duties in keeping with a conclave of health measures in the form of social distancing, de-socializing, masking, hand-washing and sanitizing. COVID-19 had socio-demographic and psychological characteristics as well as religious and spiritual factors to deal with the context of a seemingly untamable bug. COVID-19 brought higher levels of anxiety and depression among sufferers, which led to lower levels of psychological wellbeing. These elements led to higher levels of suffering as evidenced by qualitative MIMIs to understand the suffering of church members due to COVID-19. However, there were '[p]otential benefits of both integrating assessments of suffering into screening procedures and addressing experiences of suffering in mental health service settings' (Cowden, et al. 2021a:1).

It, therefore, became necessary for pastors to acknowledge their own pain and the need for them to change how they do their ministries. This chapter challenges pastors to look deeply into their caring and counseling during the COVID-19 pandemic with a view to take care of the caregivers in their process of caring for others. This chapter understands self-care during the COVID-19 pandemic as a change of ministry without necessarily committing suicide in their professional practices.

Theorising Suffering during the COVID-19 era

This chapter is written from the perspective of a spiritual and psychosocial care situation using the 'praxis theory of suffering' by an English-born qualitative health researcher, Dr. Janice Margaret Morse (born 1945). This is a caring intervention that measures a person's emotional response towards illness or untimely death of loved ones (Morse 2001, 2005:257, 2011; Foss & Nåden 2009). On the other hand, Finish-Swedish nurse Katie Erikson (1943-2019) developed the 'theory of caritative caring' in the nursing theory of suffering. She provided the fundamental elements of ontology when caring for sufferers (Eriksson 1997, 2007; Lindström 2013; Näsman 2020). On anthropology and science in the nursing care context, Morse (2001, 2011) focused on empirical results of suffering while Erikson (1997, 2007) focused on the ontology of suffering. They both provided useful information on the phenomenology of suffering for distressed COVID-19 sufferers to religious practitioners working in the science and art of spiritual and psychosocial care.

Researchers on suffering developed their theories by synthesizing theories from other qualitative studies making theories of suffering interventionist because of their emphasis on clinical care sciences. COVID-19 imposed scientific awareness upon the religious practitioner that spiritual and psychosocial care became transformed, with changing consequences on pastor and congregant relations. PCC focuses on helpful interactions and integrations for classified sufferers. The biggest challenge is the agony and anxiety of the caregiver who cannot operate as a disembodied professional due to the contagion of disease and suffering. To understand this challenge, Morse developed a model of physical care that had categories of ethos, care and suffering to support 'compathetic care-giving' (Morse 2011).

Eriksson on the other hand sought to synthesise similar concepts of caring sciences in the development of caritative caring. Pastors, thus, can

suppress emotions but they also need to release them as in praxis theory of suffering. 'Suffering is an emotional experience; emotion is reflected in, and evidenced in, the suffering person's behaviors' (Morse 2011:574). A sufferer usually exits the mode of suffering by reformulating their identity and dignity on life. This affects how pastors discharge their duties beyond their own experiences of suffering if they are not allowed to recover their normal selves and to learn from their suffering their God-given vocations.

Research Methodology

The study used mobile instant message interviews (MIMIs) from WhatsApp discussions to discuss issues of suffering during the COVID-19 era. The study engaged a total of ten (10) Church of Christ in Zimbabwe members, specifically four (4) pastors (RP1-4) and six (6) congregants who were engaged in a focus group (CFG1) in this study. MIMIs collected in situ data (Kaufmann, Peil & BorkHuer 2021). Questions were posed to pastors and congregants alike through WhatsApp groups. MIMIs produced data on the implications of suffering for Church of Christ pastors, of whom several pastors succumbed to the disease leaving their families struggling to make ends meet. Pastors were engaged through personal and key informant interviews while congregants were interviewed through the focus group discussions. All participants were asked to verbally consent to the study to meet the required validity and reliability concerns in trying to meet minimum ethical standards that included informed consent, confidentiality and anonymity to participants. These results may not be representative of how pastors in other denominations and religious institutions experienced during the era of the pandemic, but makes tentative suggestions that can apply to many religious entities of a similar nature such as the training and retraining of pastors and their churches on the exigencies of pandemics as well as how to protect practitioners. Data obtained was interpreted thematically.

Background to the Study

The outbreak of the Corona-Virus 2 in 2019 codenamed COVID-19 in Wuhan, China, is one of the novel Corona-Viruses that include Severe Acute Respiratory Syndrome Corona-Virus 1 (SARS-COV1), and the Middle East Respiratory Syndrome – Corona-Virus (MERS-COV). Diseases of the

respiratory nature have included various influenzas such as H1N1 and H5N1, which are subtypes of the Influenza A virus (Masengwe, forthcoming). 'The World Health Organization [WHO] also mentioned that there were cluster cases of pneumonia with unclear etiology originating from Wuhan City, Hubei Province, China' (Ngesthi, et al. 2021:789). The WHO later declared it a pandemic. COVID-19, like the different variants of other viral infections before it, caused great socioeconomic turmoil (Masengwe & Makuvaza 2021), due to political manipulation necessitated by the response to the pandemic (Masengwe, forthcoming). 'At the global level, response [to COVID-19] has taken place in the form of fiats for lockdowns, social distancing, and a new conclave of public health measures such as hand washing and sanitizing, wearing masks, and avoiding large gatherings' (Ma, Rogers & Zhou 2020:5). The recommended WHO's adaptive measures of limited physical contact that imposed travelling constraints, limited physical meetings, gatherings and events had socioeconomic consequences for most nations, especially developing countries like Zimbabwe (Masengwe & Makuvaza 2021).

When members contracted the virus, whether with chronic conditions or not, pastors were expected not to fear death but to walk the patient through the death process. The COVID-19 pandemic, however, claimed lives of both patients and pastors, disrupting the processes of PCC among other factors. The instability of the public health sector in the midst of the disease affected many patients and practitioners leading towards social isolation (Counted, et al. 2021; Daly & Robinson 2021; Twenge & Joiner 2020; VanderWeele, et al. 2021; Xiong, et al. 2020). In developing nations, besides complications caused by COVID-19 infection, there were too many stressors such as economic challenges, poor health facilities, chronic diseases and political instability that exacerbated the subjective experiences of pain and suffering. This chapter accepts the need for PCC towards sufferers of COVID-19, especially towards chronic patients, but mindful of the risks towards caregivers.

Further, the effects of COVID-19 on the global health emergency left developing nations unable to quickly and adequately respond towards disease containment and eradication due to ailing economies. Systemic global health inequalities in the face of rising global pandemics and lack of basic facilities left nations unable to invest, incentivise and support technological research and development due to lack of political will

(Masengwe, forthcoming). COVID-19 shocked economies, affected markets and depleted job opportunities. It led many institutions into indebtedness.

COVID-19 dealt away with past certainties on how to deal with health using insurances, which brought the need for religion to take centre stage through PCC during the era of the pandemic (Leduc & Liu 2020). Religious services to COVID-19 patients and the bereaved families in the midst of WHO measures raised another challenge to both the religious practitioner and the patient. This chapter seeks to investigate the suffering caused by COVID-19 upon both patients and religious practitioners in the provision of PCC to the patient and the families. This has implications for religious theory and practice in the context of pandemics. While some scholars like Damaris Parsitau (2020) thinks that religion also floundered in the face of COVID-19, it can still be argued that the pandemic gave religion a chance to assert itself in science and medicine with regards to the economics of pandemics (Ma, Rogers & Zhou 2020). Religion was affected, but remained vigilant with answers on the uncertainties of COVID-19 upon human survival and redundancy (Leduc and Liu 2020). Religious practitioners, as was with tradition, were forced to provide the care they usually provided in normal circumstances mindful that the disease was spreading among those "being susceptible, actively infected, and no longer contagious" (Ma, Rogers & Zhou 2020:2).

Due to its effect on economies, COVID-19 came at a time talks about a new recession were on the news. Many have accused governments of using COVID-19 to avert the recession by cutting back on economic activity through lockdowns and curfews. Unfortunately, decreased economic activity meant that religious practitioners could not acquire the latest equipments required to carry out PCC business as usual. Thus, ministers of religion became vulnerable as well as patients who, often than not would not be attended to as expected. The results from this study indicate that governments are called to capacitate and incentivise welfare projects, especially religious ones, which are with the people in the midst of their suffering. The following results indicate what pastors experienced during the pandemic era.

The Conception of Suffering in the Advent of Pandemics

The meaning, nature and implications of suffering during the era of COVID-19, as found in this study, indicated that it is a stage of existential

vainness caused by the sickness or death of a loved one. Study participants stated that the sickness of their relatives or their own led them to experience 'existential void', or a 'relational experience of meaninglessness' (RP2, RP4). Suffering is, therefore, a difficult concept to understand, especially for scholars of religion, but religious practitioners (RP) who have for long dealt with issues of happiness and suffering in the context of human wellbeing and flourishing is understood differently (CFG1). Religious practitioners may include scholars such as theologians, philosophers and psychologists who for long discovered the intricacies of suffering in connection to human existence. Literature indicates that existential suffering can only be stopped by death (Khosa-Nkatini 2022). Existential suffering is what 'every person trying to find meaning in illness and death' (RP1, RP3) undergoes through experiences of 'emptiness in my relationship with others' (CFG1). Suffering is a key emotion of value inferred to as one of the physical and emotional outcomes of COVID-19 (VanderWeele, et al., 2020). It is associated with pain, anxiety, depression and mental disorder in both clinical and pastoral practice.

This study has been supported by literature on suffering, which emerged to show that 'emotional and psychological stress' is one of the undesired experiences one undergoes when one loses 'personal and social goods' (RP1-RP4; CFG1). This is because suffering interferes with 'self-assertion', meaningful relations and achievement of personal goals as it threatens one's sense of self (Tate & Pearlman 2019; VanderWeele 2019; Fitzpatrick, et al. 2016; Cassell 2004). The intensity and duration of suffering (i.e. physical sickness and pain) posed by the COVID-19 pandemic maybe incomparable to the emotional and psychological turmoil endured (VanderWeele 2019). Participants reacted differently to the concept of suffering with religious practitioners stating that: 'I was dreaded by the pain of the disease' (RP2), 'My thoughts of the pain drained all energy out of me' (RP3), "I did not like COVID-19 because of the state of our hospitals' (RP1), or 'I did not like the sudden loss of my friends and relatives' (RP4). Congregants in the focus group discussion also concurred on fear of the 'incurability of the disease' and 'dreaded thoughts of incurability', or the 'locked down poor populations' or 'sudden death to people well-known to me' (CFG1). With these responses, one can state that suffering refers to the 'physical symptoms' (i.e. incurable illnesses), 'psychological crisis' (mental challenges), 'systemic problems' (i.e. poverty) and 'social losses' (for example, romantic break-down) (Cowden, et al. 2021b). Suffering

thus permeates all aspects of human life with some perceived loss of control (Cassell 2004). Participants viewed COVID-19 as something that had brought this kind of suffering, because 'the infected were distressed from fear of imminent death' (RP3, 3), while 'the affected were uncertain of the consequences of the illnesses of their relatives' (RP1, 4), and 'everyone had lost control of human wellbeing' (CFG1). All people alike were afraid, uncertain, distressed and hopeless because no one had medical or technological answers to the problem (VanderWeele 2019). Religion and spirituality however was the only institution with age-old answers to the problem of human suffering (Masvotore 2020).

Participants further indicated that suffering was conceptually and empirically different from anxiety and depression. 'Suffering is not only psychological and emotional but existential' (RP1, 3, 4), as it involved 'loss of human livelihood' (RP2). CFG1 indicated that suffering included 'psychological distress, mental sickness and physical pain due to the disease and lockdown measures' that followed it. In other words, suffering involved loss of: *health, livelihood* and *freedom* (Cassell 1999). In this way, suffering is distinctly subjective to human experience, and is highly personal (Cowden, et al. 2021b; VanderWeele 2019). Participants indicated that their sense of the self was diminished by COVID-19 leading to 'the degraded wellbeing of people' (RP1-4), and hence experienced 'lower levels of emotional and psychological health' (CFG1). This distress has been experienced by patients receiving end-of-life care from terminal illnesses like AIDS or cancer following the diagnosis of having been infected with COVID-19 (Cowden, et al. 2021a, b). This has also affected physical health as loss of hope due to negative psychological functioning affected the patient's ability to ingest food and water.

In all, all participants indicated that they received peace as soon as they surrendered, affirmed and accepted their own fate (RP1-4; CFG1). Literature supports this as one of the only available options in life, saying: "God is our ultimate goal, our ultimate meaning" (Masvotore 2020). Confused and disorientated people only received meaning by surrendering their beings to God. Meaning here is a a point of sacrifice, thoughtfulness and sensitivity towards ourselves, others and God. It calls for personal responsibility and commitment towards the grace of God. Pain and suffering however leads one towards deeper learning experiences and therefore acquiring deeper life values, personal imagination and compassion to the suffering of others (Masvotore 2020). The uniqueness of experiencing suf-

fering means suffering should not be regarded as a problem to be eradicated but a mystery to be actively accepted and affirmed by the sufferer to attain the needed holiness.

Psychological Distress from the COVID-19 pandemic

Participants further indicated that COVID-19 caused psychological distresses due to the hardships and losses people consistently suffered. Participants stated that: 'We have lost employment, our cherished religious rituals and social gatherings' (RP1-4; CFG1). Losses included physical mobility, psychological freedom, economic independence and social integration (Counted, et al. 2020; Meagher & Cheadle 2020; VanderWeele, et al. 2021; Wakam, et al. 2020). These losses threatened career development and gainful employment, spiritual resources provided by religious services and the value of connections in one's life. Participants stated that 'inconsistent public health messaging pronounced by the Minister of Information rather than the Minister of Health and Childcare, showed that we had lost control of ourselves' (RP1-4). In fact, participants stated that 'COVID-19 was intolerable as we had no hope in any foreseeable near future' CFG1). This total loss of hope was also experienced in other countries were nations had no typical coping strategies to deal with the health crisis (Rettie & Daniels 2021). Psychological suffering experiences have been measured among cancer terminal patients (Wilson, et al. 2007) in relations to mental health (Lehmann, et al. 2011; Abraham, et al. 2006; Al-Shahri, et al. 2012; Samelius, et al. 2010). COVID-19 however also dealt with physical and psychological health, suffering related to anxiety and depression (VanderWeele 2019).

This chapter addresses broader knowledge gaps on emotional and psychological suffering as patients sought for answers from difficult (esoteric) questions. Participants stated that 'COVID-19 is the will of God for fallen humanity' (CFG1), or questions like: 'How does God feel when people die in thousands?' (RP3, 4), or 'This is truly a punishment for our wrongdoing' (RP1, 2). This reiterates questions asked by scholars concerning suffering such as 'Where is God during the pandemic?' (Louw 2020:27). The cause of psychological suffering to both pastors and congregants were the increasing levels of sufferers in the midst of fears and anxieties of an incurable disease. In all, pastors in Zimbabwe thus understood the brevity and depth of this suffering with dire consequences on their own lives and families.

Spiritual Care for Members and their Limitation during COVID-19 Era

From the study results, it can be suggested that pastoral care, from Latin *curae*, and English cure, is the 'tending to the needs of the vulnerable' [pastoral], or, 'the attentive concern for the other' [care] (McClure 2012:269). The care for church members took priority during the era of the pandemic with huge adaptations on PCC services that gave primacy to safe responses towards calls for care and counseling. Care-giving in this case materially depends upon the care-receiver for effective-mutual healing and wellbeing (Klaasen 2018:6). The care-receiver informs the caregiver on sense-making and the meaning of things during the complex situation, while the caregiver accepts material proceeds from the care-receiver for devoted and effective spiritual services to the needy. Pastors began to 'back off, unless supported by full gear to attend funerals' (RP1-4), as they responded to the pandemic's effect towards their own finitude. They could state that 'we too, in a small way, can be healers of others' (Campbell 1986:41-42), if their members responded positively to the felt needs of the shepherds. Rather, many congregants 'do not produce milk to feed the shepherd' (CFG1), which 'wears away enthusiasm and excitement for serving others' (RP1-4). Such traumatic experiences have been recorded in literature as having caused suicides among pastors (Gugushe 2014). Though this contrasts the biblical image of 'a Good Shepherd who lays down his life for the sheep' (Khosa-Nkatini 2022:4), it needs to be understood that burned out pastors can lose their devotion due to illness and lack of sleep (Salari, et al. 2020). This speaks to the PCC services and the limitations thereof as COVID-19 affected allof the earth's inhabitants (Louw 2020).

PCC has for years been used in the care-giving context to routinely conduct funerals where pastors acted as front-runners, or even undertakers, in the lines of duty (Roman, et al. 2020:1). COVID-19 foiled the processes leaving members who used to rely upon religious and spiritual services of the underserved (Koenig 2009; Koronkiewicz 2009; Samuel-Hodge, et al. 2000). Dire consequences have been recorded wherein 7 of the estimated 300 pastors in the Church of Christ in Zimbabwe succumbed to the pandemic. Failure of science and medicine brought about this anxiety and uncertainty as pastors faced imminence of death in the context of COVID-19. This chapter challenges religious congregations to

devise a new culture of warm human interactions other than physical associations that care for practitioners and congregants during pandemics because 'PCC is informed by culture at every point' (Lartey 2015:61). Interactions are culturally informed processes that can be used for PCC.

Pastoral Protection and Care during COVID-19 Era

The care and protection of pastors during COVID-19 took two levels: care by members and self care. Participants noted that 'Our pastors are at the centre of our healing, but also need to be cared for' (CFG1). PCC is an important spiritual practice that also appeals to the Shona culture, and 'we cannot shortchange our members on such a service' (RP1). However, the pandemic demanded change of ministry-practice in association with prescribed WHO regulations. Pastors stated that 'We need congregants who understand the times so we can continue to provide pastoral services to Christian families' (RP2, 3, 4), because 'pastoral presence is essential in the broader context of loss of health and life' (RP1; De Backer 2021). During this time, PCC was required by those in need of essential services, or who lost livelihoods due to lockdowns and curfews, so they may not commit suicide (Khosa-Nkatini 2022). Suicidal behavior, due to emotional distress and anguish, is recorded as one of the leading causes of death and injury worldwide (Alexander 2008; Nock, et al. 2008). Distressed and anguished persons cannot fully live normal lifestyles without use of alcohol and drugs. Congregants and pastors who cannot use such substitutes could not escape suicidal tendencies. At the behest of COVID-19, most pastors experienced functional difficulties due to fear of infection. Advanced religious congregations provided physical, emotional, and psychological protection as PCC was extended to their families. Pastors lost loved ones, especially faithful congregants, making them wounded healers (Nouwen 2010 (1972/1979); Greenfield 2001). This called for congregations to extend a hand of care and protection as they carried out this difficult task of caring for people suffering from COVID-19. Most countries have called pastors to join their vital staff in providing essential services to the nations.

For pastors to receive care and protection from their members, they should be the first to acknowledge their own vulnerability (i.e. pain, fear and anxiety), before their members can provide them with their needs. Most of uncared for pastors live troubled lives (Duncan 2020; Usher, et al. 2020), yet 'we are essential for serving the least members of society'

(RP1-4; Ferrell, et al. 2020; Parkinson 2000). 'If COVID-19 kills us, our critics question our calling' (RP1-4). For this reason, congregations have devised new approaches to PCC that cannot replace 'our need for material support so we can freely, holistically and effectively give care to our members' full arc of life' (RP1-4; Vaccarino & Gerritsen 2013). Studies are replete with the enormity of work done by pastors during critical moments to their members (Roman, Mthembu & Hoosen 2020), but little on the services that must be rendered to the pastors. This leaves pastors serving their congregants with unmet needs such as burnout, stress and anxiety. This calls for pastors to take the first step in caring for themselves.

Self-care is a term used for pastors, but remains an ox moron because a burned-out pastor may not know that they are burned out, stressed or anxious. It is like asking a brain surgeon to remove a brain tumour in his own head. They may just experience 'a decline in energy, motivation and commitment' (Barnard & Curry 2011:49). This is not a sign of weakness for 'it is so easy for those who are care-givers of others to neglect their own welfare' (Horsfall 2010:52). Self-care demands that pastors distance themselves from the hurts in the people whose wounds they are mending. Pastors, who are traumatised by wounds of members, become themselves wounded that they collaterally infect other congregants (Greenfield 2001). This affects their spirituality, which is 'the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred' (Ferrell, et al. 2009:18). In fact, the most devout and committed pastors can be equipped to serve others better if their own existential and professional needs are met first (Oswald 1991; Horrex, n.d.:6). PCC, thus, becomes a prayer offered to God through the pastor for the healing of listening believers (Kelcourse 2002). Givers of this ministry thus need it for themselves first before they can give it to others (Khosa-Nkatini 2022). During the COVID-19 crisis, most pastors questioned the presence of God as they anxiously grieved for lack of balance in their own lives, yet they presided over funerals to provide essential services to their members (Khosa-Nkatini 2022).

Relevance of Pastoral Praxis in the Context of COVID-19

PCC is in the field of Practical Theology, which is a product of praxis; hence an academic study of the subject cannot be freed from its alma mater (Steyn & Masango 2011). Practical Theology thus cannot be separated from the theological convictions and phenomenon of the Christian family (Steyn &Masango 2011). Scholars and practitioners thus should influence practice in the daily living of care-receivers in their specific social settings (Miller 2015). Thus, "the subject matter of Practical Theology is identified as General Christian (or human) praxis due to the theological need to create a space for caring for different people in the church" (Maddox 2015:160). The practice of care takes place in the context of the Christian family in whose bosom are caregivers and care-receivers (Khosa-Nkatini 2022). Pastors receive the least of this care within that context; prompting this study to explore the need to equip pastors for self-care towards increased workloads in the midst of an incurable pandemic. The practice and theory of PCC bridges the gap between the caregiver and the care-receiver in their interaction within the congregation of the faithful (Ikenye 2016). Conceptually, COVID-19 challenges pastors and their congregations to adapt to new, safe and effective methods of serving, and be served by, congregants.

Church of Christ in Zimbabwe Virtual Services during Lockdowns

Virtual Services in the Church of Christ in Zimbabwe

A study on virtual services in one of the Church of Christ in Zimbabwe congregations shows that PCC is possible in many ways. The Inner City Church of Christ did not only provide counseling services, but also provided virtual services to their members in the comfort of their homes. Use of mass media technology on religious platforms to give members access to church services, funeral processions and live-streamed counseling programmes became central during the defined moment. The pastor no longer served as a minister but spiritual service provider to congregants who became clients and consumers. Technology however, cannot define or be defined by religion on what it offers in the spiritual moment. Rather technology liberated both the worshipper and the preacher by providing

greater possibilities in the worship moment. One has to guard against enslaving or being enslaved by technology rather than be used as an extension of human effort. Enslaved pastors cannot use rigid recordings because they see their own relevance in live streaming technologies. Users also must see technology as a solution to their problems. The value of technology therefore is in its functional definition to humanity, that is, usefulness to the human society only.

Most COCZ congregations broadcasted their services on Facebook and WhatsApp platforms to keep members informed of what was going on, in the church, at a funeral, home or hospital. They firstly depended on rigid recording, until later some adopted live streaming technology, and in fact many congregations remained unable to acquire live streaming technology and streaming data. Urban congregations like Inner City Church of Christ in Harare acquired a radio programme that has not fully functioned apart from recorded digital messages using Skype, Zoom and Microsoft Teams. Social media platforms, however, have remained central in the communication of the gospel (Khosa-Nkatini 2022). Some pastors in congregations that failed to embrace technology during lockdowns have succumbed to the virus. Of the seven pastors lost in the COCZ included a prominent business-pastor, an entrepreneur, and a passionate preacher. Pastors who adopted audiovisual strategies recorded their messages on video or audio and forwarded them to their church groups. This, however, did not give congregants the benefits provided for in live streaming.

Pastors eventually innovated in various ways to keep their congregants informed, especially on human vulnerability to the virus (Haußmann & Fritz 2020). At ColenBrander Avenue Church of Christ in Bulawayo, virtual meetings included forwarded audio and visual messages as well as live streamed Facebook messages for those who could afford to buy internet data. Live streamed services benefited members who could respond on the platform with prayer requests for the sick, to visit the bereaved and other needs. PCC could be done on the platform during the service. Interaction would further lead the pastor to urge members to send mobile money onto the line or into the church account to allow the pastor to serve those in need. Those pastors who could not emotionally and technologically connect with their congregants due to limitations became exhausted, anxious and afraid of their own relevance and welfare. One participant stated that 'I felt this emptiness and void in my life because I was disconnected to others' (RP3). Virtual services allowed distanced members to reconnect to each other.

'Calling one Another to Life' at Inner City Church of Christ

PCC is one of the most difficult pastoral services to be carried out virtually because it involves physical, emotional, intellectual and sensory receptors. While people can suggest many ways of providing PCC virtually, this study captures an innovation that was carried out by one of the young-senior pastors in the Church of Christ in Zimbabwe.

At Inner City Church of Christ during lockdowns, Pastor Smallmatter Zulu (senior church pastor) introduced the programme 'Calling One Another to Life'. The congregation had about 150 to 180 members. He created different platforms of accountability and communication for purposes of 'calling one another to life'. The pastor would call each of his elders and ministry leaders on a daily basis through WhatsApp call to find out how they were doing and if they had encountered any incidences that warranted attention during the day. He had to call and counsel eight senior church leaders on a daily basis. He also would call two committee members from each of the church wings: the youths, women, men and singles. In turn, each of the eight church leaders called would also call eight members of their cell group who represented households to find out how they had spend the day or if they needed help so that they could be assisted in whatever way possible. Each of the committee members for the church wings would also call at least eight people in their group to do the same. Masvotore (2020) says such an act "demonstrates the ministry of healing, compassion, and reverence". People who felt unaccepted in the church became healed as they felt wanted after their leaders called upon them for accountability. Leaders enabled followers to become concerned people as they became integrated into becoming whole by the gospel. This innovation and orthopraxis permeated into the whole congregation that even after the era of COVID-19, the congregational striving for human freedom has developed an approach that matures persons according to the design of God.

This was the strategy that allowed the pastor to worry about a few leaders under his care, while each of the leaders shared the pastor's burden to the rest of the congregation. The senior pastor indicated that he designed the strategy as a self-care approach to allow him to attend to the core of his calling: study of the word, prayer and fasting. Church leaders freed him from the daily care of the congregants. The pastor thus created a self-care programme that effectively reduced his workload, but at the same time allowed him to reflect upon his work as church leaders extended his

work through the 'Calling One Another to Life' Programme. Reports given to the senior pastor by elders and deacons encouraged this strategy; which has further cared for the welfare and needs of the pastor.

The second approach that was used in the same congregation was a public mass service. Mass services were contacted three times a week. There was a main service that was live streamed during a Sunday service only with the pastor's family in attendance. This encouraged families to cope with challenges of the moment. As families attended public mass services virtually, the pastor would attend to prayer requests, usually passed on to individuals through recorded messages or voice calls. Questions during services were attended to, with options to get hold of the pastor outside the service. A similar prayer service provided scriptural readings for each of the presenting problems during the week, including questions asked during and after the Sunday service. Lists of prayer requests from the pastor hinted on those who would have succumbed to COVID-19 needing prayers. Wednesday prayer meetings focused on praying for people and their needs, and this was live-streamed to congregants who would have fasted the whole day until after the 6 p.m. prayer sessions.

The third approach was a live-streamed discussion with experts in various fields affecting human life during the lockdowns such as medical doctors, researchers, scientists, politicians or economists, to help congregants cope with their situation. Discussions were also posted on WhatsApp platforms as audiovisual or typed questions and answers. This usually took about 45 minutes to one hour. These lively discussions were carried out after 8 p.m. as services would be live-streamed if the pastor had data for such purposes.

All these innovations in the practice of faith reached everyone including non-COCZ believers as it cared for the human person and not only a church member (Ganzevoort & Roeland 2014). For the regular Sunday services and Wednesday prayer meetings, congregants were encouraged to have a closer walk with Jesus, and hence, improved Christian life practices (Ganzevoort & Roeland 2014; Stadelman 1998). The Church of Christ in Zimbabwe, and in fact the Inner City approach, has motivated two young people to take up ministerial training because they were counseled and helped at the death of an uncle and a grandmother. Inner City focused on caring for, and putting others first, as part of loving God in doing, living and practicing one's faith (Ackermann & Bons-Storm 1998). This led the young people to restore the devastated lives of family members, and made home in the complexity of human relations (Swinton &

Mowat 2016). They practiced rather than merely verbalised their faith during the health crisis (Anderson, Jané-Llopis & Cooper 2001).

Implications for Theory and Practice

This chapter discussed the effects of COVID-19 to pastors involved in PCC in relationship to the broad concept of their suffering during the professional discharge of their duties during a public health crisis (Khosa-Nkatini 2022). Pastors who are unhealthy and unbalanced provide poor services. Despite this suffering, their administrators, elders, deacons and members regard them as incompetent yet their unmet needs are not dealt with. This calls for scholars to study suffering in the context of pandemics to translate theories into practices through empirical studies. Emphasis on practice forces church leaders to be sensitive towards subjective experiences of pastors during health crisis moments like COVID-19 because it eventually affects congregants, hence the need to further explore the etiology of anxiety, distress and burnout with regards to the pandemic. Analysis of PCC practices should go beyond surface perceptions of suffering by developing a more personalized approach to treatment. Therapies for distress during a public health crisis need to deal with subjective experiences of suffering as well as developing meaning-based focus that takes them away from their pain. Suffering and pain require patience and courage as philosophical and theological resources to promote personal growth are acquired (VanderWeele 2019). This has implications beyond clinical studies that must include socioeconomic and political inequalities, as well as material lack and poor health systems (Govender, et al. 2020). Exploring suffering in this context contributes to the refinement of context-informed treatment and intervention programmes that support COVID-19 sufferers inclusive of caregivers and care-receivers.

Conclusion

This chapter discussed PCC in the context of COVID-19 and its causal links for suffering among devout congregants and devoted pastors. The suffering of pastors in the COCZ in their call for duty was discussed as providing solace to their congregants. COVID-19 disrupted all public life settings that changed the way the life-giving warmth of PCC was done for eternity bound communities. The chapter emphasised the holistic nature of PCC to the care and comfort of members. Concern over the care of

pastors was raised as impeding with the quality of service provision to congregants. PCC is a product produced by the church but fails to serve the practitioner who is believed to tap into the arena of the sacred in healing the human psyche. The multitudinous levels of pain and suffering brought by COVID-19 increased the crisis in Zimbabwe, and herein make PCC relevant by actualizing the need to support the caregiver in their role of care-giving during the pandemic. The study encouraged an exploration of the theory and practice of PCC for the broader range of congregants as health conditions in Zimbabwe remained deplorable. The outbreak of COVID-19 could not stop PCC as churches adapted to new changes and strictly adhered to government regulations in keeping with members' dependence upon God. Interestingly, PCC is difficult to be practiced using remote contact, especially for bereaved families. While services have for the first time been held electronically, some pastors did not have relevant media technology to reach their congregants. In the Church of Christ in Zimbabwe, services have for long been streamed for both public and private viewing on Facebook, Whatsapp and compact discs. An attempt to use radio, television, Zoom and YouTube following the Inner City attempts have been affected by congregants' poor mobile networks and data costs. The pandemic, however, has forced these innovations in PCC due to workload burdens, health challenges and uncertainty associated with COVID-19. This has made the church vigilant in the face of the pandemic.

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