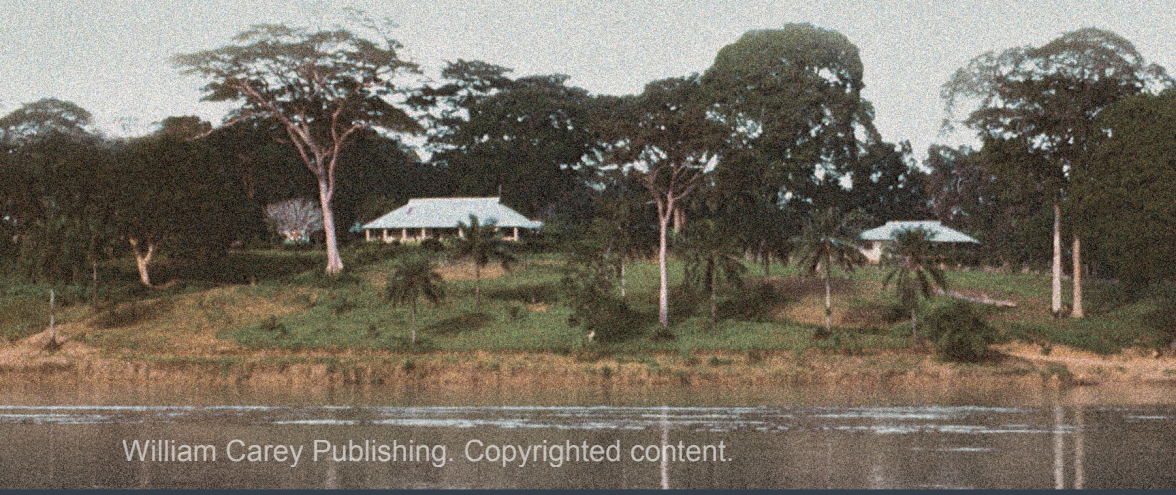
HEALTH FOR ALL

THE VANGA STORY





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The Vision

A RUDE AWAKENING

Kilamba, a three-year-old boy, lay on a bed in the pediatric ward of the Vanga Evangelical Hospital. A quick glance at his protruding abdomen gave me an immediate diagnosis: a mass of ascaris worms stuck in his small bowel. An intestinal obstruction in a small child, malnourished, somewhat anemic, and already in fluid imbalance—this was not what I wanted to see.

Kilamba lived in the village of Kimbata, a four-hour walk from Vanga, and his mother had brought him to the outpatient clinic that morning. Like most children in villages like Kimbata, he was somewhat undernourished and anemic. In addition, he had a potbelly and often would cry at night because of abdominal pain and cramps. The clinic staff examined him and correctly presumed he had intestinal worms. A stool exam confirmed this with many ascaris eggs found in the specimen. No big deal; every child in rural Congo has intestinal worms of one species or another. They gave him a worm cure—piperazine—and presumed his problem was solved. It wasn't. Within three hours his cramps increased, he began to vomit, and his abdomen grew progressively bigger. That was when they called me to see him.

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A large U-shaped mass was visible in his abdomen, and he was already somewhat dehydrated. I ordered an IV infusion, a nasal-gastric tube, and routine blood work. I decided to wait overnight before making a decision to operate. An obstruction due to worms is not complete—some fluid and gas can work their way through the mass of worms. We could therefore afford to temporize for a few hours. I desperately hoped that somehow Kilamba would begin to pass the worms during the night and so avoid a major operation that he might not survive. Our only general anesthesia was open-drop ether on a face mask, and we had no way to measure blood electrolytes. The surgical risk was therefore quite high. I instructed the staff to go home and pray that the worms would pass, and I went home and did the same. As I prayed I felt an inner assurance that God would indeed heal him if I laid my hands on his belly and prayed for his healing. As I assured the Lord I would do that, the second part of the message came—*Make sure you have a scalpel in your hand when you lay it on his abdomen*. God was saying, "I got you trained in surgery. Don't ask me to do your work for you. You do your work, and I will be with you to complete it."

Early the next morning, finding the mass unchanged, we took Kilamba to the surgical theater. The operating room was packed with staff wanting to see what would happen, for this was indeed a big deal. When I opened the abdomen of this little boy, I found a large loop of small intestine ballooned with worms—big ones. A tiny hole in the bowel allowed me to pull out the worms one by one. As I removed them, the onlookers counted. When the last worm was removed (alive and moving), the final count was 497. I closed the small hole in the bowel and then the abdominal incision. We sent him to the ward, and God was faithful to his promise to heal him. Within a week Kilamba returned home, proud as punch of his abdominal incision. This was a major surgical triumph; we were delighted and so was his mother. God was too, I believe.

Four months later Kilamba stood in front of me again in the outpatient department. I looked at him, looked at his distended abdomen, recognized the incision, saw the stool exam report showing ascaris worms, and gasped. Another bellyful of worms! A thundering question came to mind instantly—what on earth had I done for the health of this cute little boy? The answer was clear—absolutely noth-

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ing! Unless we bring about changes in health-related understanding, behavior, and conditions in communities, we can have minimal impact in improving the lives of people.

THE PROBLEM OF MEDICAL CARE ALONE

My wife, Miriam, and I had come to the Congo to heal sick people, but not to heal the same ones over and over again. We had come to establish a health service, but all we had was a medical service. Our hospital could be likened to a body and fender shop, repairing the damage of wounded people but doing nothing to prevent those wounds or illnesses or health problems. Our vision was too narrow and our approach was too constricted. We had to make major paradigm changes if we were to be effective as a physician and a nurse. We had to learn how to go beyond just healing sick persons to promoting and celebrating health.

A HEALTH SERVICE

What is a health service? A health service is based on a paradigm that focuses on health and on helping individuals and communities to be healthy. This paradigm has four operational objectives:

1. To promote the health of individuals and communities.
2. To restore health and wholeness to individuals and communities that are ill.
3. To train and empower healthcare personnel on all levels.
4. To make effective healthcare available to all individuals and communities geographically, economically, and culturally.

THE PARADIGM OF HEALTH

The health paradigm rests on five assumptions:

1. Life is unified although multidimensional. It is not compartmentalized into separate parts. Health, well-being, and transformational development involve individuals and communities. They require initiatives that are physical, social, economic, political,

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environmental, and spiritual. We must integrate all of these services together.

2. Diseases come from many sources, not just physical ones. Many illnesses come from a combination of physical, emotional, social, economic, cultural, and even spiritual causes all interacting together.
3. Health is an individual and a community issue, not just a medical program. As a physician, I can make no one healthy, nor can I make a community healthy. I must work both with individuals and communities, however, to provide information they need, motivation to stimulate them, and certain resources beyond what they have themselves. The chief resources, however, must come from them—wisdom, the knowledge of their own people and culture, and the skills and abilities God has given to them.
4. Health providers need to be cognizant of the whole picture of the life of a sick person and of the community and nation. Any given provider will, of necessity, focus on only a small area of illness, because with the accumulation of knowledge and technology, specialization is necessary. Nevertheless, specialists must be aware of the full dimensions of health and illness and be prepared to work as a team with other providers to promote health and healing in all dimensions.
5. Health personnel must be health promoters. We must multiply our knowledge and skills through training others, sharing the vision of health and wholeness with individuals and communities, and participating as team members with all who are working toward a healthier world.

MEDICAL MISSIONS

I am writing this book from the perspective of many years in the practice of intercultural healthcare. This has been my calling and my experience for more than half a century. Medical missions has a history of almost two centuries, and from the beginning has had a broader and deeper vision of healthcare than has the biomedical model from which it has come. It has pioneered healthcare in many parts of the world where medical services had not previously penetrated.

Dr. Peter Parker, an American ophthalmologist and missionary, went to China in 1834 and gained credibility among Chinese lead-

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ers for medicine and Christian missions by establishing an effective eye care service. This included the successful treatment of a serious eye disease in the nephew of the emperor of China. This deeply impressed the emperor and enabled missions and Christian physicians to begin medical services in China.

In Africa, the earliest missionary was a physician, Dr. David Livingstone. He brought simple medical care to many people and made the Western world aware of the immense health needs of that continent.

Mission medical services also penetrated into many areas of India where no modern medical services yet existed. It was a missionary surgeon working in North India, Dr. Carl Taylor, who was the first missionary allowed into the Kingdom of Nepal. The King of Nepal was aware of the health needs of his people and invited Dr. Taylor to come and make a survey. Dr. Carl Frederichs then followed to set up a mission hospital. From the beginning much of the mission work in Nepal has centered on health and community development.

FOUR PHASES OF MEDICAL MISSIONS

Medical missions has evolved through four phases:[1]

Doing Phase

Through much of the nineteenth century, medical missions was in the "doing" phase. Missionary doctors went out to "do" medicine; nurses went out to "do" nursing. Medical missionaries established hospitals and clinics, often in remote places where logistic support structures were minimal. Medical missions pioneered the development of leprosariums, and missionary physicians carried out much of the basic research and innovations on leprosy care.

Training Phase

Around the beginning of the twentieth century medical missions entered the second, or training, phase. Missionary doctors and nurses realized that the health needs of the people they served

1 David E. Van Reken, *Mission and Ministry: Christian Medical Practices in Today's Changing World Cultures* (Wheaton, IL: Billy Graham Center, 1987).

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