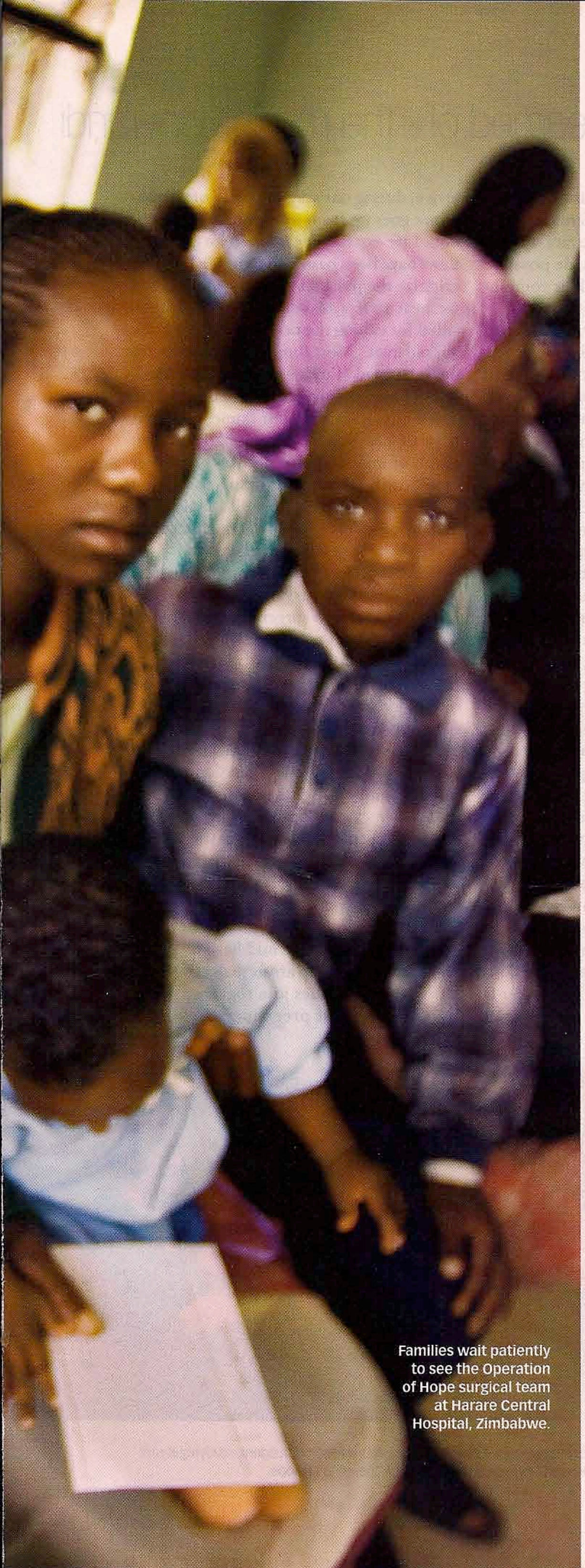


Families wait patiently to see the Operation of Hope surgical team at Harare Central Hospital, Zimbabwe.

AN OPERATION CALLED HOPE

In the desperately poor African country of Zimbabwe, an all-female team of medical miracle workers is changing (and often saving) lives by providing free reconstructive surgery to children with cleft lips and palates. Difficult? Yes. The best thing they've ever done? Without a doubt. AIMEE LEE BALL puts on her scrubs.

Photographs by VANESSA VICK

THE PEOPLE OF ZIMBABWE sometimes give their babies names that reflect the adversity of their lives in an impoverished and strife-scarred country, where grocery shelves hold little but cornmeal and a policeman earns the equivalent of about $10 a month. So when a group of American doctors and nurses arrive at the pediatric wing of Harare Central Hospital to perform free facial reconstructive surgeries, the children who are brought to be evaluated include Hard Times, No Matter, Wishes, Forget, Otherwise, Again (the ninth child in the family), and Swear to the Sky.

For several months, posters in public spaces have notified people in remote corners of this country about Operation of Hope, the brainchild of Joseph Clawson, MD, a surgeon from Longview, Washington. Dr. Joe, as he's known by patients, retired from private practice when HMOs took over the healthcare system and he realized he wasn't a 15-minute kind of physician. He began traveling to disadvantaged places in the world, starting with Chernobyl after the nuclear power plant disaster, and he kept trying to find the areas of greatest need. Learning that Zimbabwe had a large number of children with congenital defects—especially cleft lips and palates—he made plans to go in the fall of 2006. The day before his departure, the minister of health called to say, "We don't know if there will be any babies for you," and Dr. Joe said, "If there's one, I'm coming." On that trip, he had to turn away 50 children in one day and made a commitment to return twice a year. Now, for the ›

We're all performing tasks we'd never dreamed of—the modus operand

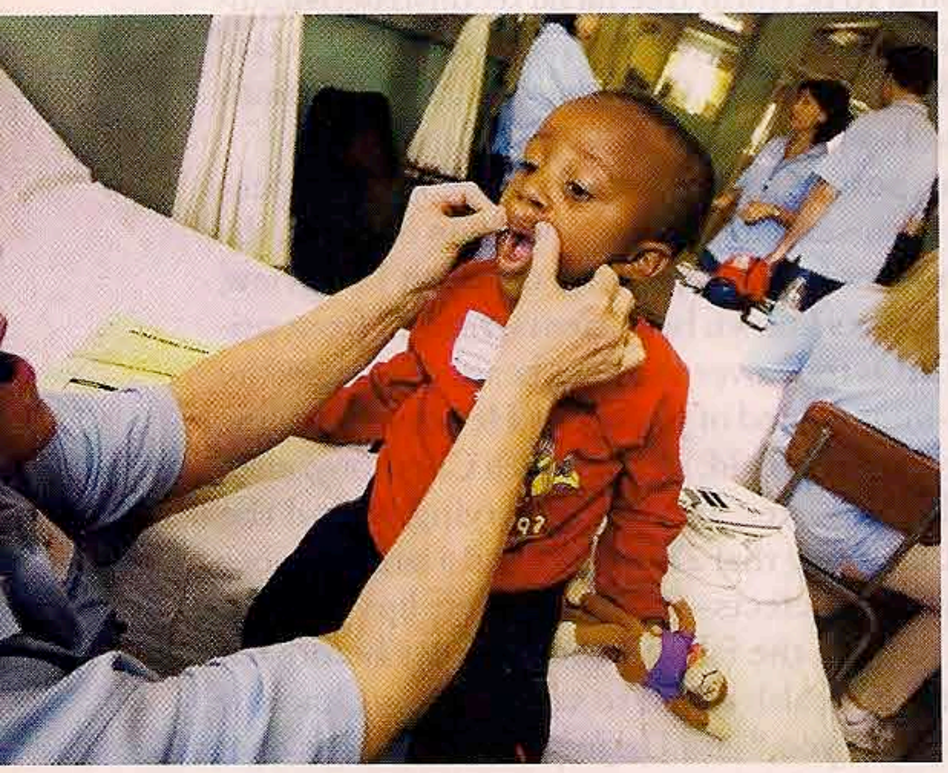
first time, his medical team—surgeon, resident, anesthesiologist, nurse anesthetist, recovery nurse, floor nurse, and scrub technician—is composed entirely of women.

And that's how I got involved: A year ago, I met Op Hope's executive director, Jennifer Trubenbach, 49, from Lake Forest, California, when she won the *O* magazine contest to join Oprah Winfrey at Miraval Resort and Spa. Most of the contest winners were deemed deserving of a spa vacation because of serious stress and calamity in their lives—the group included an Iraq-war veteran, an Iraq-war widow, and a woman whose son was killed in a drive-by shooting—but Jennifer won because her life is about helping others. She is Dr. Joe's daughter and gave up a career as a technology consultant for two Fortune 10 companies to run Op Hope. We stayed in touch by e-mail, and when the all-woman team was assembled for Zimbabwe, she called with an irresistible proposal: Come along as a volunteer.

"MANGWANANI, CHIREMBA." Everyone on the Op Hope team is wearing a bright blue scrub suit designed by Katherine Heigl of *Grey's Anatomy*. Jennifer persuaded the actress to donate this wardrobe, which seems to merit the native Shona greeting of "Good morning, Doctor" for all of us. The reason for our uniformity is not cosmetic—it's so we can recognize each other down the long, unfamiliar corridors of the hospital. A number of patients and their parents have traveled eight or ten or more hours, by bus or train or the back of a friendly farmer's truck to get here. For some, even the fare of a few dollars is an extravagance made possible only through a collection in their community. Several carry the sort of lined notebook I remember from grade school, containing their medical histories, but many have never seen a real doctor, and they've been told by a *n'anga,* the traditional village healer, that children with cleft defects should have been drowned at birth, that such afflictions are payback for some ancestral transgression. They sit on hard benches in an airless room with bars on the windows, the overflow standing in the hall, waiting to be screened by one of the Op Hope surgeons. They sit or stand without complaint or crying, certainly without Nintendos or iPods or other amusement to pass the time. Patience and civility are an ingrained part of their culture; complaining and assertiveness are considered inappropriate. Almost without exception, those who speak English smile broadly and say, "How are you? I am fine if you are fine."

We're fine, except for the palpable tension associated with traveling to a country in chaos. An election was held just a week before we got here, but Robert Mugabe (generally viewed as more despot than president) has refused to cede power, refused even to allow the release of voting results. Zimbabwe's economy is in free fall, with 80 percent unemployment and an official inflation rate of 165,000 percent—yes, all those zeros are correct. One U.S. dollar is worth 50 million Zim dollars the week we arrive; during our stay, the price of a newspaper goes up from $3 million to $20 million. Life expectancy is less than 44 years. Laws have been passed making it a crime to criticize the president and his policies, and we hear that a 16-year-old girl has been jailed for calling the octogenarian Mugabe an "old man." Most foreign journalists have been banned (I'm here under the radar), and opposition supporters have been killed. A few days before we left home, the front page of *The New York Times* had a photograph of men escaping across the border into South Africa by cutting through a barbed wire fence. We are all a little edgy, and the people here seem a little shocked to see us. But there is work to be done.

There will be two teams, each of which will perform four surgeries a day, Monday to Friday. That's 80 surgeries in two weeks. The surgeons set up a screening clinic in a ward with peeling paint the color of iceberg lettuce: The astonishingly energetic 75-year-old Dr. Joe sets the pace for Lisa Buckmiller, MD, a 41-year-old ear, nose, and throat surgeon from Arkansas Children's Hospital in Little Rock. They wear headlamps that look like miner's lights to assess the children, asking them to repeat words like *cake* and *papa* (because *k*'s and *p*'s test the palate). In the United States, Lisa explains, clefts are often recognized on a prenatal ultrasound and are routinely repaired in infancy. The human face is formed out of three plates that meet in the middle. The ridges above your upper lip are actually the scars left when the tissues join together in the first trimester of pregnancy; a cleft lip



High hopes (*from left*): Anesthesiologist Patti Kymer, MD, examining 3-year-old Kelvin Pikayoegore Nyarugwe; Carrie Francis, MD, a medical resident, studying X-rays to decide on possible treatment; Charity Rukasha, holding 2-month-old Shantal, confers with Joseph Clawson, MD, founder of Operation of Hope.

is the classic ROLL-UP-YOUR-SLEEVES motto: Do what's needed.

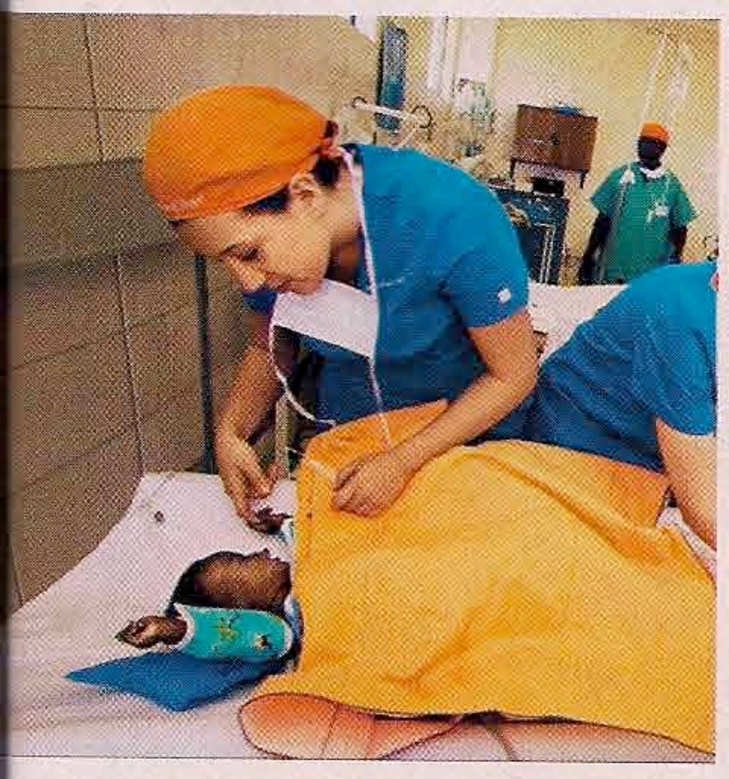
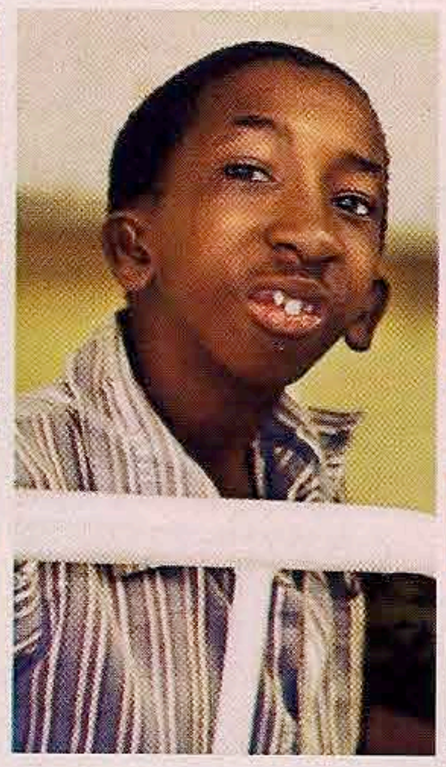
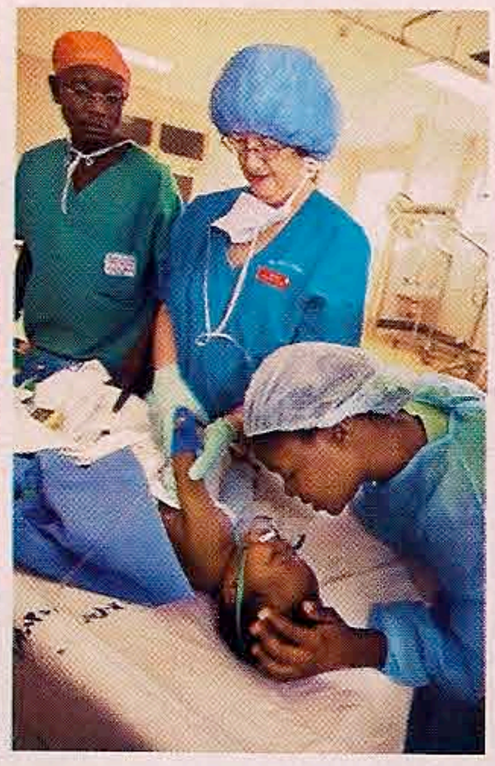
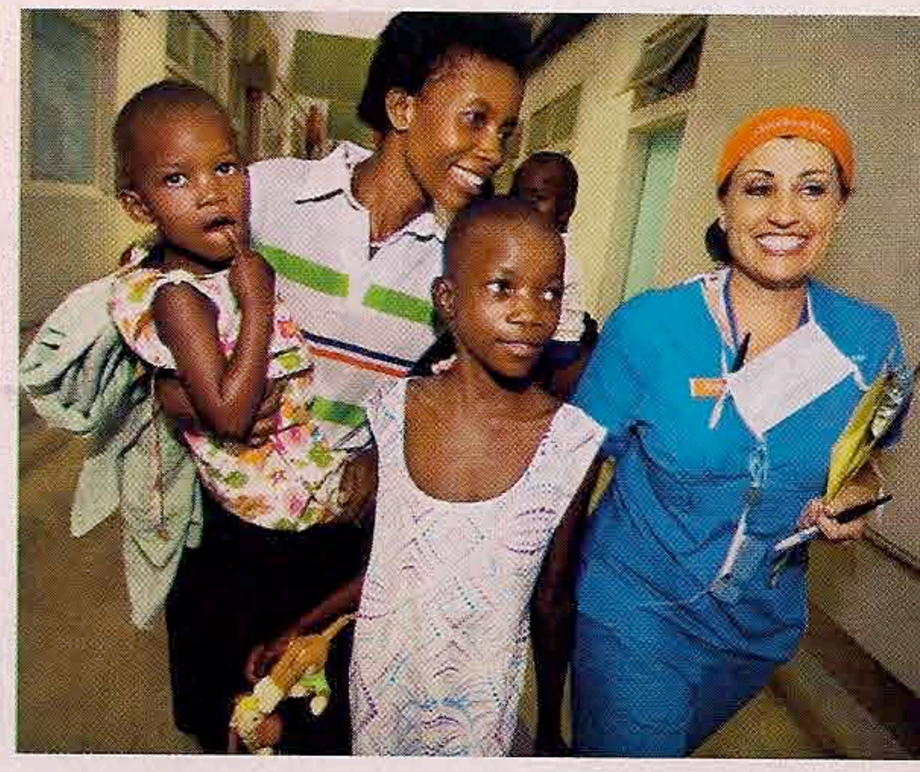
results when that fusion doesn't take place. During the same period of gestation, the tongue drops down, and the two segments of the palate "zipper up." A cleft palate is the result of a chink in that zipper. A lot of these children are older than most cleft patients in the United States but look tiny for their age—both poverty and the mechanical difficulty of swallowing has left them malnourished.

IT'S THE JOB OF 56-YEAR-OLD ANESTHEsiologist Patti Kymer, MD, to clear each child for surgery. She was a cocktail waitress in Colorado when she decided to go to medical school ("I thought I might as well do something with my good grades"), but it wasn't until she specialized in treating children that she found her calling. It's easy to see how well suited she is to caring for young patients and their nervous parents. "I'm going to make sure he's asleep and doesn't feel anything," she reassures the mother of one little boy. "We'll take good care of him, but he'll be mad when he wakes up." Sometimes the parents are crushed to learn that their child is too small or too sick for surgery. A common criterion is the "rule of ten": The child should be at least ten weeks old, weigh at least ten pounds, and have a hemoglobin (the protein in red blood cells that carries oxygen from the lungs to the body's tissues) of at least ten. Patti's got a stethoscope and a blood oxygen monitor that fits on the toe, finger, or ear. But with the limitations of language and equipment, she admits, "we're kind of winging it."

Plus she has to rely on a cadre of willing but unskilled volunteers, including two other members of Jennifer Trubenbach's family: 18-year-old daughter Mari, a high school senior, and 48-year-old sister Teryn Bonime, a real estate agent in Portland, Oregon. And then there's me—we're the amateur "info-structure" of this crew, taking histories of the potential patients, often grabbing a passerby who can translate from Shona to English. I'm rather intimidated about getting an accurate body weight since it's an important guideline for administering anesthesia and medicine. But after a while, we're all performing tasks we'd never dreamed of, like mixing powdered amoxicillin with exactly 74 milliliters of water to make a pediatric dose of antibiotics. The modus operandi is the classic role-up-your-sleeves motto: Do what's needed.

Jennifer has transported 2,000 pounds of medical supplies in military bags (and wrangled for hours with immigration officials at the airport), all of which is stocked on operating room shelves by 50-year-old scrub tech Daisy Dailey. There are syringes and thermometers, bandages and dressings, masks and gloves, acetaminophen and stainless steel surgical blades (numbers 11, 12, and 15), miles of suture (plain gut, chronic gut, and fast-absorbing gut), and "no-no's," which are post-op arm restraints. Jennifer has even brought books about sign language, knowing that several parents will show up with deaf children in the hope that surgery will correct their hearing. The ORs are dusty, and the gurneys must be tested to make sure they actually have functional wheels. There is no soap at the scrub sinks, just a watery green liquid that smells like industrial-strength floor cleaner. When the autoclave, an apparatus for sterilizing instruments, conks out, Daisy boils water. "Sterility is a relative term here," Jennifer confides. "The water to wash your hands could be worse than what you're washing off."

Nancy Crisler, 50, and Claudia Gibson, 51, are readying their respective domains: the recovery room and the post-op ward. The two women are sisters from Oregon, both of whom came to the nursing profession by circuitous routes. With a degree in community service and public affairs, Claudia went to work for a local health department, "but I had way too much energy to sit at a desk," she admits. Nancy took a summer job with the forest service in a rural community of 1,200 people and stayed to marry a man she met there. "I needed a skill that I could use while living in a small town," she says, "and I figured small towns always have schools and hospitals." The sisters were planning an indulgent trip together to celebrate Nancy's recent half-century birthday but chose to help Operation of Hope instead. "It's such a cool way to travel," says Claudia. "There's no other way you can step into another culture as quickly." The two can communicate with each other in that wordless way that siblings have, and sometimes their communication seems to convey, *What have we gotten into?* But they manage to care for their patients in strange and rudimentary surroundings. When Nancy runs out of plastic bags for her patients' [CONTINUED ON PAGE 275]

From left: Mari Trubenbach-Mora checking vital signs; 13-year-old Tinashe, everyone's favorite; local nurse Jean-Claude Ingoy and nurse anesthetist Bonnie Hilliard with a postoperative child and his mother; 11-year-old Tinevembo (*center*), an Operation of Hope success story, with her family and executive director Jennifer Trubenbach (*far right*).

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take-home meds, she packs them in the gauzy shoe covers used for the OR.

Like Dr. Joe, 27-year-old medical resident Carrie Francis, MD, originally wanted to be a vet, but a job at an animal clinic in her hometown of St. Louis revealed that she liked only horses and dogs, didn't want to touch anything else. "And I realized I loved talking to people, being a patient advocate, empowering them to take responsibility for their healthcare," she says. "I didn't like dealing with long-term diseases that aren't curable. I wanted to cut out the problem." Surgery seemed the right fit, and a mentor in medical school found her a research project in otolaryngology, the specialty that deals with the ear, nose, and throat. "It's like trying on shoes," she says. "You know once you've slipped into a comfortable pair."

For a young doctor whose training has been 21st-century high-tech, the bare-bones facilities in Zimbabwe are a shock. "In the States, we have machines to do everything for us," says Carrie, "protocols that print out as soon as a patient is brought to the floor, calculators for formulas that people used to do in their heads. It's invigorating to compensate. To actually examine the patients, take a history, and listen to them when you don't have a blood pressure cuff, it's a challenge. But it's fun to become a grassroots physician."

An experienced surgeon, Lisa admits that she has perfected the art of detaching emotionally from the inert patient on the table in front of her. But she has a real and personal connection to the value of humanitarian work: Three years ago, she operated on a little girl brought to Arkansas from an orphanage in central China with a disfiguring birthmark that had hijacked her face; a year later Lisa and her husband went to China to adopt the girl themselves, and Anna is now a thriving kindergartner, described by her mother as Miss Personality. Being in Zimbabwe gives Lisa what she calls reverse culture shock. "I feel absolutely in my element," she says, "but I'm amazed at how people hand their child over to somebody who doesn't even speak the same language. They're entrusting their baby's face to me, and I'm humbled. I have the best job in the world."

No, I have the best job. Everyone on the Op Hope team has brought a suitcase full of toys. I fill one pocket of my scrub suit with boy stuff like model cars and puzzles, another pocket with girl stuff like barrettes and bracelets, then load my arms with stuffed animals and both hands with finger puppets. I go into the ward like Santa Claus, and when the children receive a gift, they clap their hands as a thank-you.

THE HARDEST PART OF THIS TRIP IS NOT the 5 A.M. wake-up calls, the 14-hour days (mostly standing), the strange smells of this bankrupt country where hygiene is a luxury, nor the unnerving rumble of trouble from a government in collapse. (Our hotel is across the park from Parliament, the site of protests from the opposition party, and we discover in concerned e-mails from the States that politically motivated violence is a distinct possibility.) The hardest part is seeing

> "They're entrusting their baby's face to me, and I'm humbled."

a child frightened beyond my ability to comfort. And I'm not the only wimp: Patti confesses she can't cope when a child cries. So she has a bag of tricks to help. She's brought cherry-flavored anesthesia masks from home, which she puts on the children's faces while making a "yum-yum" sound, and then sings them to sleep—"Blue's Clues" and "Feliz Navidad" and "Twinkle, Twinkle, Little Star."

At 67, nurse anesthetist Bonnie Hilliard is the no-nonsense veteran of the group—this is her 15th humanitarian trip. She lives on 40 acres in rural Oregon with a menagerie of animals and works at a 20-bed hospital, where she never knows what kind of surgery will come up; it takes a lot to ruffle her. She's made considerable effort to anticipate any contingency here, in fact, bringing myriad supplies—from anesthesia drugs to tape for holding down IVs. "I try to keep myself as a unit," she says. "And since we don't have every modern convenience, it's like going back to the old days, when we had to use a more touch-and-feel approach to see how the patient was doing. It's a great chance to use all my skills." But the equipment here is a nightmare—an ancient Japanese anesthesia machine and monitors that may or may not tell her if a patient is in too light or too deep a sleep. At one point, the power goes out in the OR, and an emergency generator comes on. The power is restored in a few minutes, but later a member of the hospital staff says that sometime in the next week or so, the power will go off and it won't come back on. The surgeons will not have oxygen monitors, and they'll have to tell how the patients are doing the old-fashioned way: by looking at their fingernails. "It reminds me of the era when hospitals made you remove your nail polish before surgery," says Bonnie.

After a few days, a natural trust and camaraderie evolves between the American team and the Zimbabwean staff. Their wariness and reluctance to speak about the political situation subsides, and we start hearing what life is really like here. One nurse used to work in a clinic where rebels brought their wounded comrades and demanded treatment on pain of death. A medical student who makes $20 a month has a house payment of $250 a month, so he sold his car, took in relatives, and is now buying and selling sugar on the black market. Daisy, setting up the OR for the next day's procedures, gently teases one of the nurses who's trying to leave early; it turns out that she lives without electricity and is hoping to get home so that she can see her baby in daylight. When Daisy notices another nurse washing her underwear in a bathroom sink at the end of the day, she learns the woman has only one pair, and no running water at home. Before she leaves, Daisy gives the local nurses all the underwear and socks in her suitcase.

Jennifer brings lavender spray to freshen a small, dank space that her sister and daughter have dubbed "the mom room": It's where the parents (mostly mothers) wait for their children in surgery. Every child gets a new going-home outfit, selected from a prodigious collection provided by Jennifer's friends back in California, but they're so small for their age that Teryn has to convert their weight from kilos to pounds to figure out the appropriate size. Mari takes pictures of the moms with the "photo booth" function on her computer and conducts an impromptu art class, with drawings done on hole-punched cards that will be sewn together with yarn as a "quilt." (One card says "Thank you for the job well done in our country." Another has a stick figure and the words "This is a boy"—the girls in this culture tend to have close-cropped hair, and there's been some gender confusion.) Somehow we manage to communicate pretty well despite the language barrier, with a few comical slipups: When Jennifer tells a group of parents, "We'll take you to the floor now," everyone looks down at their feet. When the moms try to comfort their crying babies in the recovery room, ›

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they chant a soothing phrase that sounds like "so-ree, so-ree," and Nancy finally asks them to explain the Shona word, only to be told they're saying, "Sorry, sorry."

One of my jobs is helping the parents get into hospital gowns, caps, and booties, so they can walk into the OR with their children. Lisa tells one mom she can kiss her daughter before leaving, but the mom doesn't speak English, so Lisa and her whole team demonstrate with air-kissing. It's crucial that the kids not eat or drink anything within at least a couple of hours before surgery, but for Claudia, just explaining NPO (nothing per oral) orders can be challenging: One little girl has drunk something orange—is it juice? is it soda? is it a problem?—and her surgery must be postponed. The time that I fail miserably to communicate is when a woman arrives at the hospital with her 9-year-old son, too late to be put on the surgery schedule. I give her a "priority card" and, with the help of a Shona-speaking nurse, hope I've conveyed that the boy will be pushed to the front of the line when Operation of Hope returns in six months. Her face is weary and resigned as she accepts the slip of paper and thanks me.

A few crazy hours later, I notice the two of them still standing in the hall outside the doors to the operating room. Gingerly, she comes over and says, in halting and heartbreaking English, "Is there hope for him?" I haven't been credible, haven't made her believe that she'll get the help she so desperately wants for her son.

Most problems, large or small, are dumped in Jennifer's lap, and to get through the day she guzzles a vile gel from a tube called Rapid Energy Fuel that provides 50 milligrams of caffeine. Her problem-solving runs the gamut from finding diapers for babies who have only rags wrapped around them to finding an MRI for a patient whose lungs are a concern, but her bailiwick extends to our hotel, where we're being awakened by a ringing phone around midnight every night, only to find nobody on the line. We finally realize that prostitutes in the hotel bar are dialing random room numbers and hanging up if a female voice answers, so Jennifer has a little chat with the management.

There is one problem that can't be solved, not on this trip: Everyone's favorite kid is a 13-year-old named Tinashe, who endears himself with his gentle manner (and his winks when he passes one of the Op Hope women). His soft cleft palate is part of a particular kind of condition called Pierre Robin sequence: His jaw seems to be connected to his neck with almost no chin in between. He's taken into surgery, but when the doctors try to get a tube down his throat, they can't see what they're doing. It's possible that they could operate with a special lighted instrument called a flexible fiber-optic bronchoscope—not exactly standard issue in a place where even Q-tips are hard to come by—but even if such a device were acquired for Op Hope's next trip, it might not be the answer: Tinashe is close to the age when surgery alone would yield little improvement in speech. His brain is hardwired to dealing with his impairment. When he wakes up in recovery, he points to his mouth and is told the surgery didn't happen. The playful boy is gone, silent tears streaming down his cheeks. And as I'm hugging him, in a feeble attempt at comfort, I know this is a moment I'll bring home with me. If Tinashe can't have the surgery, he could still benefit from speech therapy and dental work, both real luxuries in this country. I make a vow to raise funds for him back in the States.

Working under conditions that range from impractical to primitive, Operation of Hope has performed more than 2,000 surgeries but lost only one patient, a baby with a preexisting heart condition. Jennifer still remembers going into the waiting room to tell the mother, who said simply, "I know." There's a legend in Zimbabwe about a mermaid who appears when a child dies: If the mother cries, the mermaid will take the child to the bottom of the river—not a good resting place. But if the mother doesn't cry, the mermaid will carry the child to the shore and care for it.

AMERICANS WHO DO HUMANITARIAN work in places like Africa are sometimes asked why they put their efforts into helping "foreigners" rather than those in their own country. "I get that question a lot, and I understand why people ask," says Jennifer. "But life inside the walls of this hospital is so simple, and the need is so desperate. They don't have surgeons trained to do this work. The face is a piece of art—it's different from a hip replacement—and there is a satisfaction to doing it well that is so pure. A person who's been shunned because of a birth defect will be able to get a job now."

The take-home package for everyone on the team is a profound sense of gratitude and suspension from complaining about the insignificant irritations of a privileged life. If I ever bitch again about being caught in traffic, or getting the middle seat on a

plane, or having "nothing to wear" in my closet, somebody should slap me. When anyone asks in a perfunctory way, "How are you?" I no longer answer with a mechanical "Okay." I say, "Good" or "Fine" or even "I am fine if you are fine." While we were in Zimbabwe, there was a tornado in Little Rock that devastated areas close to where Carrie lives, and a large 100-year-old tree in her yard fell, taking down electric power lines and breaking her fence. "I just took a deep breath and allowed myself to stay peaceful," Carrie reports. "There was no sense of anxiety over things I know I can replace. The line at the bank, the coffee barista taking too long—these things don't seem to be as important. The pace of life we observed, the way people seem to accept what comes, is so different from American culture. We tend to be uptight about things that don't go our way or get in our way. There's definitely been a turnaround in my everyday life." And if you happen to come across Carrie—or any of us from Op Hope—standing in those long lines at the bank or at Starbucks, you might hear us slowly repeating a mantra that sounds something like this: Zimbabwe, Zimbabwe, Zimbabwe.... ◘

To contribute or volunteer, go to operationofhope.org.

TO BANISH THE DARKNESS

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the details of hospitality; she nodded absently when Susan announced plans for a morning's adventure ("like Dora the Explorer!"). After the adults noticed the little girl was missing, search parties were sent into the woods, but Susan did not turn up. The approach of night at last persuaded the adults to call 911.

In darkness, the Maine Warden Service arrived at the scene to begin the complex process of organizing an efficient search and rescue operation. Small teams of wardens with and without K-9s went out on quick, urgent sorties to places whose proximity to the "point last seen," or whose hazards (an old well, a piece of trail that snaked along a rocky cliff) made them "high priority." But the enveloping darkness inhibited a broader, more thorough search, even as it intensified the parents' fear almost beyond enduring.

As chaplain, I reassured them constantly. "The air is warm. She's a smart kid," I repeated over and over as the long hours passed. "She won't have a comfortable night—she'll be chilly and probably scared—but she'll be all right."

In my head, I believed this, but the windows of the command post were dark squares of glass that could reveal nothing, and my heart was uneasy.

"Couldn't there at least have been a moon?" Susan's mother cried.

Human beings are creatures of light. Ours is a species that relies heavily on our vision as we scan for danger and search for food, for shelter, and for each other. A bat can maneuver through black air with astonishing quickness, relying on the data received through its ears. By a single, well-placed sniff, a dog can discern all sorts of delightful and relevant information about her loved ones' health and well-being. Humans have ears and noses, too, but when it comes to gathering the information that makes a difference between life and death, in most cases we need to see. No wonder darkness discourages and depresses us, no wonder light is the first creation of the Bible's God! Without light, there can be no life, no love, no nothing.

A bright morning sun rose, gladdening the hearts of all who searched, and rousing Susan from her makeshift bed beneath a pine tree. It didn't take long to find her once the sun was up. And after she was restored to her mother's embrace, her father took a photograph of her, surrounded by beaming wardens. Sunlight bounces off ›