Modern Missionaries


It is morning at Kibuye Hope Hospital deep in rural Burundi, a country that sits three degrees south of the Equator. Goats and cows wander the red hills covered in banana, coffee, and eucalyptus trees. The power is out, which isn't unusual, leaving some doctors to do exams in dim rooms. An American pediatrician is walking the dirt path from his house to the hospital carrying a box of prosthetic eyeballs.

It is the start of a week where the staff of American and Burundian doctors in this rural outpost will preside over a birth, a death, and hundreds of medical procedures lying between those extremes. With its 11 million citizens, Burundi is one of the most densely populated countries in the world (just after Korea and India), and it is one of the poorest. Unlike India and Korea, there's very little development here, so as you traverse the country you have an odd feeling of seeing lots of people but very few buildings or other elements of modernity.

Medical care is one of the scarcest commodities of all in the country. Basic supplies and medications are unavailable, and outside of the capital there is only one hospital in the entire country with a surgeon. This is it. In addition to the goats and cows and banana trees and non-working power, Kibuye Hospital is home to 40-year-old Dr. Jason Fader, an American medical missionary.

Fader is the only surgeon for 2 to 4 million people. Patients come to him from as far as Tanzania and Congo—by motorbike, on foot, carried by stretcher, or in vehicles. Here, a broken leg can mean months of missed work. A simple wound can lead to deadly infections. A man arrived recently unable to walk after a burn on his leg healed wrong. Fader calls Burundi one of the most surgically desolate places on earth.

Fader operates on babies and old men, on brains and femurs. When he doesn't know what to do on a specialized case, he does research during the few hours when he's not at the hospital, or calls friends who are neurosurgeons or plastic surgeons for advice. Compounding the size of his task, patients often come from other hospitals whose poorly trained staff have made their situation worse.

This 205-bed hospital is affiliated with the Burundian Free Methodist Church. A house of worship with broken window panes sits just outside the hospital grounds. When it rains during

**Emily Belz is a reporter for World magazine. For more of her reporting on the Gersons and Dr. Fielder, see bit.ly/2pMcmQ9. To view Mark Gerson’s interview at the last Annual Meeting of The Philanthropy Roundtable, go to bit.ly/2IaQrIX.**
a service, everyone in the church moves to one side because of the leaking roof. One of the pastors is a nurse-in-training.

This hospital sees about 30,000 patients a year. Its big project these days is training a cohort of Burundian doctors who can relieve Fader’s caseload. Until that bears fruit, he does six to ten surgeries a day, and sees dozens of other patients outside the operating theater, leaving his family early in the morning, and coming home late, the cuffs of his pants often soaked in blood.

“Is it better to do 80 things pretty well as opposed to 50 things really well?” he asks himself at the end of a long day of surgery. “Or is it better to do 200 things poorly but at least you’re doing 200 things?” Should he spend his time scouring the world for another surgeon with the knowledge and aptitude to serve in a poor rural hospital, or should he just focus on saving lives in the operating room? He is tired.

Help is on the way
Fader found unlikely support 7,000 miles away in New York City. Jewish businessman Mark Gerson and his wife Rabbi Erica Gerson live on the Upper West Side with their four children. Mark is a serial entrepreneur; his main venture is his 1,400-employee Gerson Lehrman Group that supplies technical expertise to businesses. The Gersons are an endlessly friendly, interested, generous family who like to host a wide variety of people at Friday Shabbat dinners in their home. And they are serious about putting their faith into action, and their money to work.

Gerson stumbled into the world of Christian medical missions through his close college friend Jon Fielder, a Christian. In four years at Williams College they bonded tightly, sharing interests in national policy, American history, and philosophy. (At one point Gerson interned at Policy Review under Philanthropy Roundtable president Adam Meyerson.) “We were nerds,” says Fielder. “That drew us together.” Gerson speaks of Fielder as “the most morally serious person I’d ever known.”

After graduation they stayed in touch. Gerson went to teach history at a largely minority Catholic school in Jersey City. He eventually attended Yale Law School, then started his business ventures.

Mark Gerson says “there’s nothing sentimental” about his giving to Christian mission hospitals. “These are the most effective people I’ve ever met.”
Fielder entered medical school at Baylor. Halfway through his schooling he took a year off to work in Calcutta at one of Mother Teresa’s clinics. After finishing his residency, he decided to go work as an HIV doctor in Kenya and Malawi.

Fielder and Gerson exchanged letters during the doctor’s time in Calcutta, and Gerson was moved to help when Fielder later set his sights on Kenya. He donated money to provide Fielder’s hospital with antiretroviral drugs. He got his brother and others to give to the fund.

With Gerson’s support, Fielder and missionary doctor Nate Smith got a pioneering HIV clinic off the ground at a time when treatment of AIDS was just beginning in Africa. By the time the U.S. began investing billions in Africa to slow the disease, their clinic was well established and one of the first to garner support from the emergency American program. It now serves 5,000 patients annually, and is a major teaching center.

“One of the things about Mark: Even though he doesn’t live in Africa and he doesn’t do this work himself, he has this ability to feel it as a palpable urgency,” says Fielder. Gerson had never traveled to Africa until 2016; he is close enough to Fielder that he doesn’t feel he needs to. They talk every day.

“I trust Jon as much as I trust anybody in the world,” Gerson says. “Aristotle in his Politics talks about three kinds of friendship: friendships of pleasure, friendships of use—doing things together—and friendships of the good. This is the rare friendship that I think is all three.”

The Gersons have so far given more than $6 million to Christian

Rabbi Erica Gerson and her husband, Mark, with their children at their weekly Shabbat dinner.
mission hospitals in Africa. For him, it’s simple logic: Christian mission hospitals are saving and improving more lives on slender investments than any comparable institutions in the world. “There’s nothing sentimental about it,” he says in his extremely rapid delivery. “These are the most effective people I’ve ever met. I don’t know anybody who is more effective in his or her job than these missionaries are at theirs.”

Gerson first convinced his extended family to give money to mission hospitals. Then in 2010, the Gersons and Fielder formed the African Mission Healthcare Foundation. AMHF provides steady support to mission hospitals in Africa—buying medical equipment and supplies, funding the training of African doctors and nurses, sending an engineer to fix a power issue. Fielder and his staff in Kenya provide consultation to doctors and hospitals across the continent. Gerson recruits donors, sometimes flying to Texas or Silicon Valley to share his enthusiasm for the heroic, efficient, extremely rapid delivery. “These are the most effective people I’ve ever met. I don’t know anybody who is more effective in his or her job than these missionaries are at theirs.”

A Jewish businessman pouring heart and soul and wallet into Christian missions isn’t something you see every day. To Gerson, though, it makes all the practical sense in the world. AMHF estimates that at least a third of all the health care provided in Africa today comes from faith-based institutions; others put it even higher. In Uganda, the majority of hospital beds are in faith-based hospitals.

Judged by quality, the faith-based sector is even more important—

**A Surgeon Talks About Medical Missions**

Paul Osteen was a highly trained vascular surgeon in the midst of a successful medical career when his father—the pastor who founded Lakewood Church in Houston—passed away. “Driving home from my dad’s memorial service, I felt this overwhelming impression that I was supposed to give up my practice, move to Houston, and help with the church, however I was needed.” His younger brother Joel took over pastoral leadership of Lakewood, which is now one of the largest congregations in the U.S., with average weekly attendance of over 50,000 worshippers. Paul ended up becoming a medical missionary, bringing his surgical skills, and his wife and four children, to some of the poorest parts of the world for up to half a year, as a substitute for mission doctors in need of respite. Then in 2016, he and his wife Jennifer started the Mobilizing Medical Missions (“M3”) conference, held annually at Lakewood to connect U.S. medical practitioners with Christian missions that could use their help. Philanthropy asked Osteen about the need for trained medical professionals abroad.

**Q:** Tell me about the impetus for the M3 conference.

**A:** For about 11 years, I’ve spent four to five months annually in remote parts of the world working in small mission hospitals. These hospitals have been around for 50 or 100 years, and very often they are the only safe, affordable health care available in their area.

One year I was out in western Zambia near the Zambezi River—not far from Angola and Congo. For three or four months of the year people arrive in canoes, because the river floods. When they come on land, they generally take oxcarts. At the hospital, I saw everything from crocodile bites to malaria to endemic schistosomiasis.

At the end of my time there, one of the local doctors said to me, “Paul, do you realize that for the last four months you’ve been the only qualified surgeon in an area the size of Louisiana?” Under those conditions, all it takes is a simple obstructed labor to turn a pregnancy into a mother’s death. Because no one can do a C-section.

As I returned home and descended into Houston, I looked out the airplane window and saw the Texas Medical Center—the largest conglomeration of medical talent in the world. We have 12,500 physicians at that center. I thought, “Goodness, I’m flying from where there’s such a need, to a place where there’s so many health-care workers.” So my wife and I dreamed up a medical-missions conference to mobilize health-care providers who have a heart to serve those with desperate needs.

I’m not bringing in speakers who have esoteric theories. Most of our participants are knee-deep in the field. I’m talking 35-year missionaries, people who are doing tremendous medical work that can inspire any practitioner of health care. Yet hardly anyone knows about these amazing missionaries.

We try to give exposure to their organizations. For instance, we had the Samaritan’s Purse emergency field hospital set up outside of the arena, so people could walk through the tent and see the services offered. This year we had 75 active mission organizations present at our conference, all with a need for people to help them.

**Q:** What do service opportunities in medical missions look like?

**A:** It depends on the organization and how much time the volunteer has available. I’m retired from my practice so I can take several months and go. If you’re a surgeon,
you can make a huge difference in a mission hospital by relieving a person of your same specialty in that way. Other people can’t go that long, so there’s opportunity for shorter-term trips, too. It’s good to just get your feet wet, even if it’s a short trip.

I can dispense vaccines or medicines. But even more valuable in the long run is teaching residents so Africans can take care of Africans. We need to train local people for health care.

But think about it: if you’re a newly trained surgeon in Zambia, you probably don’t want to raise your family in the bush. There are no schools. There’s corruption. Tribalism. Many dangers. It takes people who have a real call to go to these areas.

So one of the most valuable things mission doctors like me can bring to the table at these rural hospitals is our ability to do surgery ourselves. Surgery expertise is invaluable in these parts of the world. An obstetrician in rural Africa is priceless.

These mission hospitals have been functioning for a long time. They are capable. They are resourced. They usually have very good doctors. But they are an overlooked part of American Christianity. Churches started them many years ago, but in the 1960s and ’70s, many mainline churches shrunk or withdrew their support. Now these mission hospitals are out there on their own, needing help, exposure, advocacy, manpower, resources, money, and friends. I see it as a great opportunity.

Q: What kind of medical care is needed?
A: It’s very often low-lying fruit. Can you provide good obstetric care? Can you keep moms and babies from dying in childbirth? Taking care of malaria, doing simple surgery for abscesses, treating infections, appendicitis. Run-of-the-mill surgery. You have to remember that there are no pharmacies. These mission hospitals are critical for things we take for granted.

Here’s a statistic for you: Out of 7 billion people on the planet, 5 billion do not have easy access to safe, affordable surgery. That’s from a study published two years ago. So you don’t have to do complex operations—you can just do simple surgery and make a huge difference.

Q: What’s your advice for donors interested in supporting health care abroad?
A: You need to be careful when you give your money to anywhere in Africa—you want to give to something that’s credible and sustainable. I’ve seen people build beautiful clinics and hospitals, but nobody’s thought through who will run them. Nobody’s thought about how to resource them over many years. It ends with a great hospital building that’s abandoned, with nobody using it.

But mission hospitals are credible, and for many, many years they’ve been sustainable. Where they need help is capital and expansion, like building new operating rooms or new wings. There’s virtually no money in any mission hospital that I’ve ever been to for routine things like maintenance and repair. So as a result, things wear out and get torn down. I take $20,000 every time I go, and I paint and retile and refurbish and do maintenance. There are so many opportunities for capital improvements, to build things, fix things, buy equipment.

And there are opportunities in particular subspecialties. For example, there is no heart surgery available for most of sub-Saharan Africa. I was sitting in Tenwek Hospital in Kenya and there were six pine benches about six or seven feet long—30 little kids four to six years old were sitting on the benches. Every one of them had heart disease, and we could only choose five to operate on. The rest of them, statistically, were going to go home and die. That’s just one small sample.

I could operate on a 70-year old man with a hernia and lengthen his life five or ten years. If I do heart surgery on a child I could give him 60 or 70 years. At Tenwek, my friend Dr. Russell White is building capacity to perform simple surgery and to train residents so that Africans can do heart surgery in Africa. They already have several million dollars invested, and I think the cost will end up between $20 and $40 million.

But don’t forget that there are also these little hospitals all over Africa that equally need help. They don’t need $20 million. They need $14,000 for a piece of equipment.

At Lakewood Church, we just gave $100,000 to the heart-center project. I myself give around $100,000 a year to mission hospitals. I’m always advocating and recruiting and raising money. And I do work myself when I’m over there.

“Christians are willing to go the last mile.”

Q: What is the role of faith in this?
A: We’re unashamedly Christian, but we take care of anybody who comes through the doors. We’re able to pray and comfort. But we don’t force anything on anybody. We’re there to be the hands and feet of Jesus. As Franciscans sometimes say, “Preach a sermon; use words if necessary.” Very often, we don’t need words. If you take care of a mom’s child and keep that child from dying of malaria or malnutrition, that’s a sermon.

About five years ago, I met with the representative of a large government organization, who told me something surprising: “Paul, if we want to get care to the people who live in the urban areas, that’s easy—we give it to the NGOs. But if we want to get care to the people in the most needy areas, in the remote parts of the world, we give it to Christians, because Christians are willing to go the last mile.”

Everywhere I go in the world, I find this to be true. What you find is that Christian mission organizations have been in these remote places for decades. Because they are people willing to go the last mile.
patients and doctors-in-training seek out mission hospitals because of their excellent and compassionate care. The Christian devotion Africans and Americans bring to difficult tasks together allows remarkable accomplishments. Kibuye Hospital internist Eric McLaughlin says that missionary medical work allows him to feel and express “God’s renewal and redemption…new creation breaking into the world around us.”

In 2017, Kenya’s hospitals were on strike for much of the year, so the bulk of health care that year fell to mission hospitals. Maua Methodist Hospital in rural Kenya was a vital bulwark during the strike and AMHF had already funded the surgical training of Congolese surgeon Tony Mwenyemali, as well as an anesthetist there. To date, AMHF has provided more than 100 similar medical-training scholarships.

The vice president of programs for AMHF, Jonathan Mwiindi, was born in the rural mission hospital in Kenya where Fielder does the clinical work that he mixes with his AMHF organizing. Mwiindi worked in the HIV clinic with Fielder when they first dispensed antiretroviral drugs (funded by Gerson) at the height of the AIDS epidemic. He says Fielder and other Christian doctors inspire “high-performing people” to stay at these remote institutions because they can learn from the highly skilled and devoted medical missionaries.

Mission multiplier: teaching

Over the last 15 years or so mission hospitals have taken on a major new commitment: In addition to providing crucial care, many of them are making great efforts to become teaching hospitals so they can increase the supply of indigenous medical talent that is currently so dangerously thin. This “capacity building,” through small scrappy institutions, has drawn Gerson in further. Supporting and expanding institutions that will allow a larger volume of good work to be done in the future appeals strongly to him. Without improved medical capacity, the child mortality rate in Africa is projected to rise by 2030.

The Gersons are also concerned about another problem: the mainline U.S. church denominations that established and have supported many of these mission hospitals are in decline. Missionaries are therefore having a harder time maintaining their charitable support. Christian doctors are much too humble to attract the donors they deserve, Mark observes. So he and Erica came up with a plan to galvanize attention around medical missionaries and attract funding from new sources.

One example: Recently, Erica noticed that the head of the Christian Broadcasting Network Gordon Robertson was speaking at a local synagogue, and she mentioned it to her husband. Mark reached out to set up a meeting with Robertson, and the two hit it off. Immediately Mark suggested a project: the Gersons would put up another $1 million for African mission hospitals, if CBN’s audience would match it. Robertson readily agreed. The funds will be distributed between eight mission hospitals across Africa for various projects. Fielder, the man with ground knowledge, has helped oversee the hospital and project selection.

In 2016 the Gersons began a $500,000 annual prize, called the L’Chaim Prize, to highlight remarkable medical missionaries. In addition to sending a half-million dollars immediately to the winner’s hospital or clinic, the hope is that the prize will attract additional support by more widely publicizing the humanitarian accomplishments of these people and institutions. That widening of recognition and support has already begun: At the latest prize announcement, Franklin Graham, head
of Samaritan’s Purse, the large evangelical foreign-aid charity, announced that his group was donating $4 million to get a cardiothoracic surgery program off the ground at Tenwek Hospital in Kenya, where 2017 prizewinner Dr. Russell White, a cardiothoracic surgeon, works. (For more on Dr. White, see the sidebar on the following page.)

Kenya and other African countries have a high rate of rheumatic heart disease that stems from untreated strep infections in childhood. The Gersons’ money will go toward screening and antibiotics for schoolchildren to head off those simple infections before they do heart damage. And, more dramatically, it will establish the first program in sub-Saharan Africa to train cardiothoracic surgeons, so they will be able to correct cases where damage has been done.

The prize recipient is chosen by a committee of African health-care professionals and experts, with no input from the Gersons, who say they lack the expertise. The first winner in 2016 was Jason Fader. When Dr. Fader arrived at the Gersons’ house for the prize dinner, Mark introduced his son to the physician by telling the boy, “This is one of the most important people you will ever meet.” The L’Chaim Prize money will allow Kibuye Hospital to soon welcome Burundi’s first medical resident.

Kibuye Hospital is already an ambitious teaching hospital. Every four months, a new group of 40 students pursuing medical studies at Hope Africa University in the capital of Bujumbura come here for clinical training. They rotate through every department. Even after their classroom studies they have a lot to learn.

A rural teaching hospital is unusual. It takes effort, internist McLaughlin points out, to assemble the necessary investment and personnel in a remote place. But the valuable upside is that it trains Burundian doctors in a context where a majority of the country’s patients are.

And more trained professionals is what African health care needs most desperately. “It’s the same math as compound interest,” says Gerson. “If you train ten people really well, and then they train ten people, it grows very fast.”

Improvising solutions
A pronounced caffeine habit is something Mark Gerson and Jason Fader share. At 5:20 in the morning, the doctor is up and making the first of his many daily mugs of “cowboy coffee.” To save time, he pours hot water directly over grounds in the cup, then sips carefully as they settle to the bottom. This baffles his fellow doctors, but keeps Fader going through long, demanding days.

At the hospital, a short walk from his house, staff members gather for devotions and then consultation about cases. After that, Fader rounds the surgery ward—which is a new building, thanks to the L’Chaim Prize. Time to “lay into the medical students for their inadequacies overnight,” he says half seriously.

One baby in the surgery ward has an incision that isn’t healing. She is very sick, but they have no intensive care unit. Lack of post-surgical care is a common problem in African hospitals, and this infant, he tells me later, has a high chance of dying.

Two young patients left the surgery ward just as I arrived. The boys showed up at the hospital each missing a hand. Someone had roughly sawed them off for allegedly stealing avocados—an unusual form of mob justice in Burundi. One of the boys was unconscious and almost dead from blood loss when he arrived. Fader did surgery to repair the remaining tissues and bones, and the hospital used its small but workable blood bank to overcome the blood loss. They both survived.

Rounds complete, the hospital’s two small operating rooms begin buzzing

With mainline churches in decline, mission hospitals have dwindling charitable funding. So the Gersons are at work to galvanize support.
Mini Missions

Is there any value in very short-term missions? This was the devil’s-advocate question posed to long-term medical missionary Dr. Russell White—2017 winner of the L’Chaim Prize—at the latest M3 conference. His remarks are adapted below.

I work at a place called Tenwek Hospital, which was established in 1937 in western Kenya. Some people call it the Mayo Clinic of Africa. I’ve been there for over 20 years.

There are many doctors and nurses who would like to give of their time and talents but aren’t prepared to make the leap to full-time missions work. The question is, can someone who comes over to a place like my hospital for just a week or two be effective?

Tenwek is one of the largest facilities that receives doctors from World Medical Mission. We host about 130 visiting doctors per year. So we have a lot of experience with short-term visitors, specifically surgeons. And many of them do a lot of good.

There’s potential for any skilled medical professional to care for large numbers of patients in a short period of time at our base in Tenwek. And we reach out far beyond our immediate region. Ben Roberts, our ophthalmologist, goes off three or four times a year to more desolate areas of Kenya where there’s no medical care at all. Ben will take a team and fix 100 cataracts in a week. So short-term bursts like these can meet the needs of many people despite the brief period of time.

Short mission visits can also potentially advance long-term partnerships. The most effective short-term missionaries are the ones that come back repeatedly to the same place, over and over and over, as opposed to visiting 40 different mission hospitals over 40 years. If you pick an institution and keep going back, you can be very useful. Each time you go back you become relatively more helpful and less of a burden, because you understand the institution, and you adapt.
It's very important to have reasonable goals and objectives. Some teams will come with a goal like "We want to cure all cleft lips in Africa in a week." That's not a reachable, objective goal for a one-week trip. When heart teams come to Tenwek we might say, "This week, we hope to do 12 cases." We'll also screen about 200 patients to determine future care. We also emphasize training local health-care providers, and short-term teams can help with that. It can be hard for Americans to adjust their expectations.

And it takes dedication. You may be exposed to malaria. Your GI tract may get a little off and make it hard for you to stand on rounds for too long. You'll find there's no good toilet in the hospital that you're working in, there's a pit hole.

From a dollars and cents perspective, we sometimes ask if it's worth it to fly 25 people over and do only a dozen cases. Maybe it's better to just send that much money to the mission. But just sending money doesn't build relationships, it doesn't change anyone's outlook on life.

There are challenges. Somebody may have a lot of modern knowledge but scant contextual understanding. Without that local context a surgeon might say, "Let's put the patient on subcutaneous heparin, then he'll switch to Coumadin, and he'll get his INR checked once a week." Well, none of that is going to happen, absolutely zero, because there's no infrastructure to make that possible. A visiting doctor or nurse has to work with the local team and ask, "What's achievable? What's a reasonable goal?"

For instance, we put many of our patients who would be on high-dose Coumadin in the U.S. on aspirin instead. For us, it's what we have to do. We're following the outcomes for those patients and will present statistical results next year.

Some of the companies that make heart valves are actually very interested in our efforts to find simpler, lower-cost alternatives that are effective. Some of the things we learn could change the game in the Western world if we can show that it's safe.

There's always the potential that visiting volunteers could overwhelm the capacity of the existing infrastructure. A visiting doctor might come and say, "I'm here for one week. I want to work all day and all night, and take care of as many patients as I can." A generous impulse, but our support staff are here week in and week out, and they need a regular schedule. They need to go home at night. This is their whole life, it's not a one week burst out of a year, so we have to be sensitive to that. The institution will continue after the volunteers leave. Volunteers should work to harmonize their objectives with those of the long-term institution.

Volunteers will also need an open mind. One guideline from a well-intentioned report on short-term medical trips advises the missionary to "Never perform an operation abroad that one would not perform at home." Well, yes, if you're a pediatric oncologist you shouldn't go to Africa and do heart surgery. But we need to acknowledge the elephant in the room—which is that there are elephants in the room!

I once got a call from the hospital at 2:30 in the morning. The resident starts telling me about an "entry and exit wound." I say, "So you're talking about a gunshot injury?" And he replies, "No, no, no. It's an elephant injury."

I wasn't expecting a goring, because elephants usually just stamp on you and break your ribs and your pelvis and long bones. They usually don't gore you. But this man was picked up 20 feet off the ground and then tossed by an elephant that rammed a tusk through his chest. How many American doctors have done that operation before? In the field, you don't have the luxury to say, "I've never done that. I'll refer you to the elephant specialist." There has to be some flexibility to say, "I'm willing to stretch myself within the right limits." I'm not asking a pediatrician to take out a thyroid cancer. That's not appropriate. But people may have to stretch.

I also caution volunteers not to try to make sweeping reforms from on high. I can't count the number of people who have come and said, "Do you realize you could be more effective in your turnaround time in the OR—as if we had never thought of that. We know we could improve, and we do, piece by piece. But we have to take little steps and not outrun our staff and financial capacities. Outside volunteers may have some good ideas, but they're probably not going to get them instituted in one week. They should talk to the long-term leader and offer their thoughts respectfully.

Last, if you want to volunteer for a short-term mission, you need to think about motivations. We have had thousands of doctors and nurses visit Tenwek, and 99.99 percent of them do wonderful work. They're there as humble servants for the Lord. But every now and again, like everywhere else in life, you get something different.

One visitor told me, "Honestly, I'm better than anyone else, and I feel like I should share that with the world." Another said, "I want to feel better about myself, and I think this trip might be therapeutic for me."

God does speak to the teams that come, and changes people's hearts. If you're coming for one week, that may be the biggest result. With the right motivation, goals, and vulnerability, God can use even very short-term mission trips to bring about good for the world.
He delicately begins the surgery, and Sund works feverishly to keep the newborn breathing under anesthesia. The combination of backed up waste and overloading with fluids has left the infant with little lung volume. As her abdomen is opened I watch the pressure release out of her; her skin relaxes and loses its overstretched shine. Fader carefully makes an opening in the tiny colon and sutures it to her stomach, so she has a way to excrete that bypasses her rectal malformation. The surgery is a success, and the baby survives. She is returned to her mother with instructions on caring for the colostomy.

In a few months Fader will need to conduct another operation on the girl to give her a working anus. He is making efforts to inform regional doctors that he can do this operation, hoping that word will spread and these cases, which are not uncommon, will consistently be referred to Kibuye. At present, many parents are told they must go to a place like India for a surgery of this type—something hardly any Burundian families can afford.

A few days later, Dr. Jon Fielder shows up at Kibuye for a short visit. He greets Fader with the familial warmth of the small world of medical missionaries. He has just come from visiting three other East African mission hospitals for AMHF. Over coffee and cookies he talks with the hospital’s engineering team about AMHF’s potential to help them improve their physical plant. They gather around a laptop to look over a plan for a renovation that would create two more operating rooms and an intensive-care unit in the hospital, a morgue, and a solar project to solve the hospital’s power issues.

And if the hospital wants to retain quality Burundian staff in a remote place like Kibuye, it needs places for them to live. The hospital was hoping to hire ten nurses, but they would have to spend a big part of their income on transportation to the hospital every day. If the hospital could offer staff houses, Fader suggests, staff will be likelier to stay with the hospital even if it falls on hard times. Fielder likes the idea of building staff housing.

More than a third of mission hospitals applying for the L’Chaim Prize have asked AMHF for help with housing their staff members. Gerson is enthusiastic about supporting unglamorous but practical needs like this. “You’re never going to fund housing, or hospital engineers, if you’re emotionally driven. But if you’re faith driven and intellectually driven then you will fund housing and engineers.”

Fader and Fielder walk the grounds of the hospital so Fielder can for the first time see the surgery ward built with the L’Chaim Prize funds. The old surgery ward was a cramped building with low
in a day, operating in conditions of extreme poverty often without access to electricity or water. Costs total just $25, all in, for each life-changing surgery. And this new method is as safe and successful as it is cheap and easy. An outside study showed a 98 percent success rate at six months, comparable to the best hospitals in the U.S.

Named the Himalayan Cataract Project, the charity has now spread beyond the mountains to several regions of Asia and sub-Saharan Africa. With support from the Conrad Hilton Foundation, Nancy Allison Perkins Foundation, and many others, the project has directly fixed more than 600,000 cataracts, while Ruit’s method is used in over 60 countries and taught at leading medical schools.

But the need is still enormous. More than half of the 39 million blind people in the world have cataracts to blame for their condition. Hundreds of millions of others struggle with low vision due to the same cause. This is Tabin’s greatest mountain yet to climb. In 2017, the Himalayan Cataract Project was named a semifinalist (out of more than 7,000 applicants) in the MacArthur Foundation’s competition for a $100 million grant to solve a single problem. While the prize went to another nonprofit, the increased attention boosted HCP’s visibility and stature.

This is a highly economic corner of medicine, for ending blindness brings financial as well as human payoffs. A blind person in an impoverished country is unable to work, go to school, care for his or her family, or contribute much in any way. Indeed, sighted family members who could be learning or working themselves must instead become caretakers. This ten-minute surgery turns around all of those lives at once—and transforms the afflicted into the productive.

—Caitrin Keiper

Suddenly I See

Geoff Tabin never met a mountain that he didn’t want to scale. He became the fourth person ever to reach all of the “seven summits,” the tallest peak on each continent. On one of his extreme adventures, he co-invented bungee jumping. But it was on his trip up Mount Everest that he glimpsed the true challenge of his life: conquering blindness.

A Dutch medical team was removing cataracts in one of the remote villages Tabin passed through. The young man was stunned by the transformative power of this simple operation.

Inspired, Tabin completed a medical degree, acquired a bit of funding, then in 1994 teamed up with Dr. Sanduk Ruit, a Nepalese ophthalmologist who had developed a low-cost method for carrying out cataract surgery on a large scale. Using a $4 plastic lens that Ruit had invented, surgeons were able to replace hundreds of diseased lenses...
a foster baby. They plan to be here at least another 20 years.

And Jason’s brother Caleb and his family also moved to Kibuye. He’s an engineer, and has overseen many of the hospital’s physical improvements. The Fader brothers grew up in Kenya, where their father was a doctor for almost 20 years at Kijabe, another mission hospital.

An engineer, Mark Gerson points out, is one of the most important people at an African hospital. Caleb helped Jason set up a well and plumbing system that gave the facility clean water. He took the shipping containers that medical supplies arrived in at the hospital and turned them into useful buildings. The brothers designed thermostat-controlled boxes heated with light bulbs to keep premature babies warm. Their newborn unit has since had babies as young as 28 weeks survive.

The newborn unit, like each hospital department, has an American mission doctor from Serge (the only mission agency in Burundi) paired with a national doctor. The Americans say they couldn’t do their work successfully without the Burundian staff and their cultural knowledge.

“There are certain realities here in Burundi that no one in the United States can know,” says Gilbert Kibinakanwa, the Burundian medical director of the hospital and an internal doctor, speaking in French.

This sunny morning in Kibuye, Caleb is in the surgery department trying to fix a power flaw in the x-ray illuminator so his brother will be able to examine images. Behind the ward, workers are washing the hospital’s sidewalks, trimming hedges, and stoking cooking fires. Jason, running on coffee fumes, is in the middle of surgeries.

He begins work on a hip fracture, where he uses screws that he bought with L’Chaim Prize money. Before starting, he reviews the book Surgical Exposures in Orthopedics, because he wants to try a new incision location that will be more efficient. At the end of a bloody operation that involves a lot of drilling, he isn’t happy with the placement of the screws. In the United States, surgeons have equipment to see exactly where the screws are going in. Fader has to do it blind.

One of his gloves has ripped on a bone fragment, and he has the patient’s blood on his hand. Surgeons in the United States have thicker gloves. He tries to be careful, knowing that some local patients carry HIV.

Then the next patient rolls in, his father trailing behind and stopping at the curtains that mark off the operating room. The young man has a ruptured bowel and hasn’t excreted in ten days. Sund, the anesthesiologist, begins anesthesia with some difficulty. The man’s blood pressure is low, which indicates to Sund that he might have bacteria from his bowel in the bloodstream. A very bad sign. They don’t have the right drugs to get his blood pressure up.

Fader makes an incision down the man’s abdomen and pulls out his guts as a medical student assists. The student, overwhelmed by the bowel contents, has to step out. Fader finds the problem in the bowel, cuts a section out, then sews the intestine back together. They flush stool contaminants out of the man’s abdomen. Blood pools on the floor.

Fader puts everything back inside the abdomen and sews up. As Sund worriedly stands by the bed monitoring blood pressure, the patient begins vomiting stool. Over and over again, the smell suffocates the room. The patient’s eyes go vacant.

Fader, who has moved on to another operation, steps back into the room, quietly watching for a moment. Sund begins feeding a tube into the man’s nose, planning to suction out the stool from his stomach so he won’t continue vomiting. The stool in the man’s mouth is probably making him nauseous.

Just then the power goes out. The suction will have to wait. The chaplain comes and speaks with the man in Kirundi; the patient prays with him and prepares for death.

Then the lights flicker back on. Sund inserts the tube, turning on the suction machine. The contents go into a bucket. He still doesn’t think the man is going to survive the night.

Death is a regular part of the work at Kibuye. A makeshift morgue sits behind the new surgery facility. The hospital sees about 23 deaths a month, most of those in the pediatric department. Later that night, in fact, a nine-year-old dies after surgery.

One of Fader’s biggest tasks is training students to talk to patients about death. Culturally, he said, “it’s a lot of hush-hush” when it comes to terminal diagnoses. “I’ll tell a student, ‘This is a person who is going to die probably in a couple months, so why don’t you talk to them about that?’” The student looks at Fader blankly so he says, “All right, I’ll do it this time, and you do it next time.” He will tell the patient that other places may promise treatment for the condition, but they’re just trying to get money—the patient should save his funds and energy and

You’re never going to fund housing, or engineers, if you’re emotionally driven. But if you’re faith driven and intellectually driven, you will.
spend his remaining time with his family, not searching for treatment.

“Palliative care—we can do that well. Unfortunately we have to do a lot of it.” The hospital is currently trying to develop one form of palliative care into treatment.

Retinoblastoma is a cancer of the eye affecting mostly children. In the U.S., RB is treatable, but in Burundi it typically means an excruciating death for the child who contracts it. Kibuye now has Burundi’s only chemotherapy program, for patients with RB. The program is at least palliative—instead of dying painfully from cancer in the eye, the cancer will go into the brain, which usually means a mercifully quick stroke.

And now the hospital is seeing if it can cure some of the RB patients with its chemo regimen. The first round of patients are in advanced stages of cancer, so it has few success stories so far. But the team is learning.

That evening Fader walks home for dinner. But before he can sit down to his meal a call comes in. A nine-month-old baby has arrived at the hospital with a blocked windpipe. Fader rushes back to the OR. As the anesthetist tries to put an IV in, Fader can see the baby is dying. He pulls a bronchoscope that has just been donated out of its packaging to find the blockage. The baby becomes unresponsive and his heart is slowing. Just then Fader finds and pulls out the barrier: a slippery orange seed.

“By God’s grace,” he says. But the moment has stressed him. He has a hard time sleeping that evening.

The next day, though, the baby is nursing and playing. And the young man with the ruptured bowel, who had been near death when the power went out, has also turned a corner. Two days later, Fader says while making rounds that he expects the man to live. The patient’s father stands beside his bed as the medical students pass by. “My son,” he says, smiling proudly.