Doing Global Health Work

Approaches that Really Make a Difference

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health guides

Contents

Partnering to Meet Needs

I'll never forget every detail of the trip that inspired me to study medicine. As a college sophomore, I joined a group of doctors and students visiting underserved rural areas of Jamaica. Our team showed up in a new village each day, greeted by hundreds of smiling faces as we set up a makeshift clinic. The free care was greatly appreciated, and we felt quite needed. Patient stories of poverty and lack of medical care touched us deeply. People were suffering from easily preventable and treatable diseases. A simple antibiotic like amoxicillin could save a life, and we felt like nobody would give it if we didn't. Every day echoed with meaning and inspiration. After seeing a few hundred patients, the sun would set and we'd hold our last few consults by flashlight. Finally, we ate and then staggered off to a deep and fulfilling sleep.

Nearly every health professional I've met has been profoundly inspired by volunteer work in resource-limited countries. Almost universally, they return from a volunteer trip with a spring in their step and an uplifting refrain, proclaiming:

This is exactly why I went into medicine! I was helping the neediest and loved every minute of it! I can't wait to go back there again!

I'm also part of this club, and I've lost count of how many times I've said this. Nearly every year of my adult life, I've volunteered in at least one resource-limited country (sometimes for the entire year). These trips have been among the most meaningful experiences of my life.

I feel like I'm on top of the world when I return from a volunteer trip abroad; I feel like I've really helped and I'm overcome with a rush of empowerment. Yet this book is not about the empowerment we get as medical volunteers from North America, Europe, and other high-income places; it's about how we can support the empowerment process of people living in resource-limited countries, since that is the ultimate goal that matters. People living in the deepest poverty

throughout the world deserve to control their own health and health care; outside volunteers who keep this goal in mind and work towards it will make a much greater difference than those who simply, yet admirably, "just want to help."

After one of our clinics in Jamaica, we sat around a campfire reflecting on our work and the lessons of the day. A family medicine resident said something that I'll never forget:

"Well, it was a great day and I really enjoyed what we did. But I feel like it was more for us than for them. How did we really help in the long-term?"

At the time, I was too naive to understand how critical and insightful that question was. Yet on my second volunteer trip (to rural Mexico), I'd gotten past my global health "honeymoon period." In each village for only one day, we treated the people who showed up and then left. I started asking: Who would be there to give medical care the next day? Did we really do anything helpful, or was our work a superficial quick fix or even a health care "tease"? Why didn't we volunteer with the local medical providers? Why didn't we offer to further train people in topics they wanted to learn more about? Couldn't community providers do a better job caring for their own people, given their knowledge on local health conditions—knowledge that we lacked? Why didn't we offer to address the community's deeper public health needs? I vowed to make my next volunteer trip more meaningful. To prepare myself, I minored in public health, studied medical anthropology, and read global health books.

In rural Uganda, we rode bikes from village to village training local people to become HIV educators.

On my next two trips, both to rural Uganda, I was convinced our team was contributing in deeper ways. Community members requested that our team teach about HIV/AIDS, and we trained local people to be teachers themselves. They taught us about their clean water needs, and we organized the construction of wells. Only a small part of our program involved seeing patients, as local clinical needs were

clearly trumped by public health needs. However, our clean water programs were quite likely doomed because we had organized them rather than the Ugandans themselves. I had yet to learn the most important lesson in global health…

Local People Lead, Outsiders Follow

Medical education trains us through the study of problems so we can diagnose and treat them. We search for things that are wrong and we strive to solve them ourselves. While this may work in our own clinic or hospital, we must approach community health problems—at home but especially abroad—in an entirely different way. Community problems need to be identified and solved primarily by people of the community, or else the solutions just won't be appropriate and enduring. This is the only way for community members to achieve and retain power and control over their health and their society. It may be tempting, and our training may lead us to believe that we can solve problems for them, yet I believe that we must be humble and admit that we do not have the knowledge and ability to do this nearly as well as the community itself. In fact, we can easily cause more harm than good by implementing our own solutions in cultures that we know little about.

To keep communities in the driver's seat, only outside groups who are invited should jump on a plane. A genuine partnership is needed between foreigners and local community groups, health facilities, public health programs, Ministries of Health, and health care workers. Rather than providing foreigner-led health services, we should offer to integrate with existing health projects and health systems to assist in bolstering them in ways identified by the community. Keeping local people in charge involves seeking out community health efforts, talented leaders, and resources which are already in the community; these will be the bedrock for any enduring health improvements, not the fleeting presence of us people from faraway lands with honest intentions and strange accents.

During the civil war in El Salvador, an American health and human rights group was invited to form a long-term partnership there. When I applied to join them for six weeks, Salvadorans reviewed my application and invited me to integrate with and contribute to their preexisting health projects. Throughout the trip, I watched truly empowered local people organize their own groups and sustainable health programs. Our organization supported these efforts

A local handyperson builds a concrete latrine slab in the mountains of Honduras.

behind the scenes, while community members took the lead. We foreigners have contributed by supporting them in small ways while they organize their own programs in community-based health education, clinical care, and advanced training. These programs have thrived for decades due to the centrality of the hard-working Salvadoran protagonists to these efforts.

Next I joined a Global Health Track in Family Medicine Residency, through which we organized biannual health empowerment trips to a community in Honduras. We encouraged the community to determine its own health priorities; after doing so, it developed successful programs in community health worker training, medical care, clean water, sanitation, improved cook stoves, education, microfinance, and agriculture.

Empowering involves actively listening to a community as it identifies its health problems and further develops existing or potential solutions. Local people need to lead the process of improving their health, and outsiders can assist in this process but from the sidelines. It is the right of the community to decide what, when, and how health programs will emerge, and not surprisingly they often launch public health initiatives rather than the clinical programs in which outside health professionals may have more interest. Humble outsiders who follow such an approach are often said to be doing *health accompaniment*, where we extend solidarity to those with fewer resources in a locally-led and long-term partnership.

I refer to this generally as empowerment work since it consciously refrains from taking power away *from* community members and transferring it *to* foreigners. Outsiders do not design the health

programs or carry out the care; rather, local people remain the central deciders and implementers. When appropriate and called on to do so, outsiders can go further by assisting communities in identifying and using their existing structures, programs, personnel, and other resources to improve health. In this setting, we can help to inspire or spark local people to use their community strengths to further improve their living conditions.

In these pages, I explore the ways in which global health **empowerment** approaches differ from the voluntarism and **charity** approaches that many foreigners have been used to following—including myself. While charity does things for others and gives things to others, because it is led by outsiders it cannot help but take power and control away from the people it is serving. I believe that empowerment approaches are especially important because poverty is not simply a lack of money, but rather a multilayered state of disempowerment. This is exactly what must be transformed.

Throughout the world, power derives from various factors including race and ethnicity, class and social status, gender, education, and nationality. Many of us simply have too much power compared to those who don't have enough power to meet basic needs such as housing, clean water, and health care access. Promoting social justice involves transferring power *from* those with an abundance of it *to* those with not enough of it to meet their basic needs. This lies at the core of what I believe global health work is about. Empowerment is central to health—especially in the poorest communities in the world.

> *I went on various visits to Sierra Leone, Uganda, Burma, Dominica, Honduras, Haiti, Botswana, and Tanzania, all with the goal of implementing the health empowerment approaches outlined in the next chapter. These "empowerment trips" were by far the most meaningful trips of my life, as I saw first-hand the incredible potential of communities to expand their health, without being dependent on outsiders. Over the course of 22 visits, I've spent over five full years living, working, and volunteering in these countries. Since my first trip abroad during college, I've spent every year organizing health partnerships with resource-limited countries—even when I'm not abroad. I'm a family practice doctor, tropical medicine specialist, and HIV specialist with a master's in global public health.*
>
> *I've been a "global health nomad," working with various types of organizations while taking very different*

approaches to global health partnerships. I worked in settings of chronic poverty as well as disaster relief; I've done education, clinical, public health, and social justice work in these settings. Through each twist and turn, I've been on a personal journey of learning how to best partner with communities living in deep poverty as they work to improve their health. I'd like to take you with me on this journey through this book.

Doing Global Health Work is for health and public health professionals and students who've asked themselves or others how they can *really* make a difference in the health of a community. It's a guide to helpful global health approaches, methods, and activities as well as an explanation of why others may be less helpful. It explores ways we can facilitate the accomplishment of more and deeper results in the exercise of our time, energy, creativity, knowledge, and skills. All global health trips are not created equal, but they should be as helpful and meaningful as we can make them.

These pages will explore evidence-based approaches to improving people's health in meaningful and sustainable ways. Throughout I will reference best practices from the fields of global health, public health, sustainable development, disaster relief, facilitation, appreciative inquiry, engineering, social justice, human rights, and anthropology. In an effort to give examples and to make this book livelier, I'll jump back and forth between the literature and my own personal stories of health programs and adventures around the world.

I've refrained from using the names of organizations that I volunteered or worked with; this is because I aim to explore themes rather than to critique specific groups. Finally, the terms *outsiders* and *local people* are used throughout this book. *Outsiders* refers to people or groups from another society who visit a community living in deeper poverty, with the goal of assisting the *local people* who live there.

By reviewing the literature—and through my own experience— I've become convinced that helping the most we possibly can and empowering communities are actually one and the same goal. As local people take control of the process of improving health, they'll be far more likely to achieve long-term health improvements. There's much that adventurous and sincere outside health professionals can do to encourage the fruition of this critical goal.

Global Health Approaches

Health professionals have a variety of skills and training that combine with a wide range of personal motivations leading them to do global health work. People tend to think they can be most useful by doing what they are most used to doing, and in the past, this may have been a good way of thinking about how to make an individual contribution to global heath. The experience gained and research conducted over the past several decades have allowed us to evaluate the many accomplishments of global health volunteers as well as our shortcomings. Taking this evidence base into account allows us to categorize and discuss various approaches to doing global health work.

The seven most common, influential, and—in my view—important approaches to doing global health work will be explored here. I label the first two as traditional approaches since they have been done for a great many years and they are followed by most groups that do global health work:

1. Suitcase Medicine
2. Health Facility-Building

I'll explain more about what these are, but first would like to add five other approaches to global health work which have generated more impressive results. These other approaches have been developed over time, especially by larger and more professional global health groups. They aim to improve the health of local people while keeping them in control of the process, and I therefore label them as empowering approaches. They are:

3. Local Clinical Capacity-Building
4. Strengthening Local Health Systems
5. Professional Disaster Relief
6. Local Public Health Capacity-Building
7. Facilitating Community-Based Programs

I'll introduce them each here with a personal story, and then I'll delve much deeper in the chapters which follow.

Suitcase Medicine

We drove madly bumpy roads from the break of dawn trying not to lose our meager breakfast on the way. The line of 400 patients waiting gave me a quick, jolting hiccup as I looked back at our staff of three crammed between suitcases. Repeatedly brushing off cascades of sweat and

queues of mosquitos, I saw patient after patient with endless complaints as I kept referencing a short list of meds scribbled out under an array of thermometers and stethoscopes hastily being moved around the room. We skipped lunch and dinner, and were cutting open an abscess after dark with flashlights.

Another 80 remained lined up but we dared not turn them away since we somehow believed we were "their only hope." Since they showed superhuman patience, so would we. The spaces between my words lengthened and between patients I propped up my head with my hand. I thought to myself: "We could actually help much more by doing less work, but doing it much more deliberately."

What I call *suitcase medicine* describes what I did on my first global health trips in Jamaica and Mexico. Teams of foreign medical volunteers from wealthy lands travel for one to three weeks to a resource-limited nation and provide free patient care. Traditionally, participants carry medicines and supplies in suitcases, which become the supply cabinets from which they are distributed to patients. Makeshift clinics are set up in an empty building, church, school, or large tent, and the care offered is unrelated to the local health care system. Outsiders may stay at one health care site for a week or more, or they may spend only one or two

days at each site, touring the country like compassionate travelling salespeople with bulging suitcases.

Suitcase medicine is by far the most common global health approach. Outsiders who do it demonstrate great concern and work extremely hard, treating hundreds or thousands of patients under difficult conditions before reboarding their planes. Unfortunately, volunteer teams typically lack needed awareness of local diseases, medical systems, language, and culture. Therefore, they may inadvertently give poor quality care and cannot offer patient follow-up. They also may unknowingly compete with local care providers and curtail the community economy. The fruits of their intense engagement typically last for only a few weeks, while much more sustainable benefits could be achieved by outsiders who work to further the training of local health workers in these communities.

Local Clinical Capacity-Building

Deep brown men waded in an equally dark river, expectantly panning for diamonds which might finally give them a shot at life beyond the mud of poverty. This is where I altered the typical suitcase medicine model to try to make a bigger difference.

Our team spent two days in each village, and I insisted that both days were heavily focused on health worker capacity-building. The first day involved learning about the village and its health workers and community groups; our team did a guided village walk and organized a focus group to learn about their health resources and problems. Of course, this was the tip of the iceberg, and additional days of learning and connecting with the community would have been far more helpful. Yet it allowed us to hear about some of the community's priorities which we could then act on by providing training on delivering babies using clean birth kits, as well as resuscitating babies that don't breathe. We boosted our limited awareness, expanded local health worker capacity, and started forging a clinical care partnership for the second day.

We arrived the next morning with a stack of med and supply suitcases, but I was determined to do things differently. We would only see patients at the local public clinic and only hand-in-hand with the health workers that normally run these clinics. I insisted that none of us would

treat a patient without seeing them together with a local health worker. We used each patient visit as an opportunity to teach a local health worker, as well as to be taught by them.

At one clinic, my wife—a pediatrician—was paired with a local pharmacist and they dispensed meds together. She both taught and learned about how medicines are dispensed there. Meanwhile, the local health worker and I sat at the same desk and attended the same patients. When a patient presented with more classically "Western" issues such as diabetes and heart disease, I did more teaching than learning; when patients came with malaria and river blindness, he did more teaching than learning. We were clinical **partners**, *and the training could make a much larger ripple than the patient care.*

Training local health care workers can boost their ability to prevent, diagnose, and treat disease long after we outsiders have returned to our home countries. It can further the knowledge and skills of existing providers and be employed to train new ones, helping to reverse the critical shortage of health workers in many resource-limited nations. Capacity-building can be successful in both long-term and short-term trips abroad, and it generally makes a deeper difference than suitcase medicine's focus on individual patients.

Strengthening Local Health Systems

I volunteered in a rural African town with a struggling locally-run public hospital that was riddled with problems. The first outside medical group to approach the hospital found it so dysfunctional they decided to set up a completely independent HIV and TB care program. They gave up on working with the hospital, built their own clinic, and "did their own thing" in a way that was supposedly better. A second foreign medical group decided to construct their own clinic down the street, with minimal communication with the local hospital or the other foreign facility. They denigrated the bad care provided by the hospital and vowed they would do better. Patients could get the care they deserved from them instead of the hospital.

Then the Ebola Epidemic of 2014-15 arrived and deathly ill patients flooded the understaffed public hospital, with

limited electricity and no running water! It could do little to support Ebola victims—and neither did the two outside organizations. Despite being unprepared, the public hospital served as the only facility accepting potential Ebola patients. After all, both foreign clinics were even less prepared.

*Finally, a third outside medical group came and formed a genuine **partnership** with the public hospital. Care given by community members took center stage in this partnership. Meanwhile, outsiders were asked to provide minor assistance to the hospital through staffing, supplies, and equipment. These cross-cultural partners also focused on Ebola preparedness and restored running water to the hospital. The outside nonprofit prioritized **system strengthening** over doing patient care themselves; it supported the hospital so that local health workers could do a better job with ongoing patient care. While the other two outside groups had recruited local staff away from the hospital to work at their clinics, the third group made a positive contribution toward addressing the understaffing crisis. They participated in improving the quality of the local health care system rather than constructing an alternative to it.*

Failing health care systems develop enormous gaps, and outside volunteers may rush in to provide care and attempt to fill this void. However, doing so doesn't fill the gap with quality and sustainable care. As outsiders, we could do more by partnering with local health care leaders to address the root problems of their health systems. Helping within such a system can be far more successful, empowering, and ultimately sustainable.

Health Facility-Building

An alternative to health systems strengthening would be the traditional approach of *health facility-building.* It is laudable that outsiders want to reach beyond their volunteer trips to create a longer-term health program in the form of a new clinic or hospital, as this is hard and expensive work. However, sustaining its services presents a major challenge, and for the minority of new facilities that endure, they also pull staff, patients, funds, and confidence from struggling local health systems.

Professional Disaster Relief

   The compound consisted of one circus tent after another; you knew that you were entering a special place, but there was nothing fun or amusing inside. External fixators pierced a patient's leg from all directions, as he showed off what appeared to be a half-human and half-robot lower extremity. I was at the Haiti border in 2010, and the earthquake had crushed far too many houses, limbs, and senses of security. The main operating room table may have been hastily constructed from scrap wood, but many lives were saved on it. Before I arrived, surgeons were working without x-ray capacity, sometimes diagnosing fractures by cutting into the flesh and feeling with gloved fingers for cracks in the bone.

   In this desperate situation, surgeons did challenging and incredible work. Primary care docs like me provided emergency and orthopedic care, as well as treatment for post-operative complications. As in my previous Dominica and Burma disaster relief experiences, I had no qualms about focusing on patient care here; local health services were overwhelmed and frantic. The need was high—and importantly, our professional relief groups were partnering with communities to address critical public health needs simultaneously.

Disasters almost always overwhelm the capacity of local people to respond; therefore, outside involvement can be critical to avoid unnecessary suffering and death. We outsiders can contribute by scaling up health and other services when affected communities are overwhelmed and request such assistance. Unlike in areas of chronic poverty, local people may ask outsiders to initially provide the majority of health services following a disaster or war; constructing a temporary health facility may also be helpful during such an acute crisis. Importantly, when disaster-affected communities make these decisions and lead response efforts, then they can remain empowered even as they accept outside help.

Local Public Health Capacity-Building

Tin roofs reflected the sun from so many scattered points; the scene blinded me in its simple beauty. Medical volunteers split up on paths hugging the volcanic slopes of Honduras. Teens passed us carrying live chickens and massive teetering stacks of firewood on their heads. One volunteer was assigned to a fish farm to assess how the project was functioning. Another passed a waterfall criss-crossed by yellow birds to check in with ongoing latrine projects. Still another visited the school to meet with teachers involved in a scholarship program for the kids from the lowest income families. One of us stayed in the center of town waving to school-going kids, as their parents stopped to discuss ongoing and proposed microfinance project ideas.

Public health projects were heavily structured into the daily routine of outside health volunteers; at any given time, only a few of us were seeing patients and we would rotate positions. Much more sustainable work was being done in tandem. Most volunteers spent their days addressing root causes of poor health in the mountains, part of our partnership led by the Lenca indigenous people. Disease was prevented through community-based public health work and the clinic would therefore expect to see fewer patients in the future. Some medical students would stay here six to twelve months, getting to know the community very well rather than quickly flying in and out.

Unmet basic public health needs almost always overshadow those of medical care in resource-limited countries. Medical volunteers can help in a deeper way by preparing themselves to address such needs

in partnership, or else by inviting local and outside public health professionals to join and lead their teams. While providing clinical training serves as a very helpful and sustainable approach, public health capacity-building can make an even bigger difference.

Facilitating Community-Based Programs

Each community has its own unique location on the spectrum of developing and sustaining successful health programs. For those that have not yet identified their priority health problems and strategies for solutions, invited outsiders may be able to assist by facilitating community members to meet for this purpose. Community-based health programs can emerge from such discussions, and thousands of lives can potentially be improved or saved by local people as a result. Other times, the seeds of health projects may be sprouting or successful health programs may already have grown, yet they might encounter challenges for which a partnership with outsiders could be beneficial. There will often be some missing yet critical resources needed to achieve locally-identified goals. When requested, assistance from outsiders can be quite helpful in such scenarios.

Comparing Global Health Approaches

Table 1 compares these seven approaches to global health work in terms of their evidence-base and likely effect on local people; it summarizes data which will be presented in the chapters that follow.

Suitcase medicine and *health facility-building*—the traditional approaches—are based in sincere intentions and very hard work. Even so, they aren't rooted in an evidence-base, generally have the potential to be hurtful to resource-limited communities, and may not be helpful for such communities in the long-term. Further, these traditional approaches lead to duplicate and parallel health systems to those of local people; as such, they don't typically empower these communities or lead to sustainable health improvements. The other five approaches—the empowering ones—show much more promise.

Table 1: Approaches to Global Health Work: Evidence Base and Effects on Local People				
Approach	Evidence-Based	Potential Effect on Local People		
		Helpful	Empowering	Sustainable
Suitcase medicine				
Local clinical capacity-building	✓	✓	✓	✓
Strengthening local health systems	✓	✓	✓	✓
Health facility-building				
Professional disaster relief	✓	✓	✓	
Local public health capacity-building	✓	✓	✓	✓
Facilitating community-based programs	✓	✓	✓	✓

The Journey of This Book

This book will lead you through these different approaches to global health work, reviewing specific strategies and methods for maximizing benefits, minimizing harm, and keeping local people in control of their own health programs. This book focuses mostly on the empowering global health approaches which can make the biggest difference. Suitcase medicine and health facility-building will be mostly referenced in contrast, with more depth found in *Appendices A* and *B*.

Part I will explore the three clinical and educational empowerment approaches, and it will conclude by analyzing global health work one level deeper than the *approaches*—it will analyze the *agendas* influencing each approach. *Part II* will then review the two public health approaches, as well as related agendas. It will go on to explore the profound and determining influence on global health work of poverty and social injustice—and the struggle against them.