

One World, One Health Podcast
Episode 24, Season 1- Transcript
Guest: Kirk Scirto

Suitcase Medicine –When good intentions aren’t enough in global health

Maggie Fox (0:01)

Hello and welcome to One World, One Health, with the latest ideas to improve the health of our planet and its people. I'm Maggie Fox.

Planet Earth faces pollution, climate change and new and reemerging infectious diseases, and they are all linked. This podcast is brought to you by the One Health Trust with bite-sized insights into ways to help.

In this episode, we're talking to someone who spent a whole lot of time directly helping people: Dr. Kirk Scirto, a family doctor in Buffalo, New York, who spent more than 20 years sharing his medical skills in 11 other countries across four continents. He's worked with groups such as Doctors for Global Health in Uganda. Kirk, thanks so much for taking the time to chat with us.

Kirk Scirto (0:48)

Thank you so much for having me.

Maggie Fox (0:49)

So, how does a family doctor from upstate New York end up traveling the world to practice medicine?

Kirk Scirto (0:55)

In college, I was very excited by doing home healthcare work and I was drawn to the field of medicine. But at the same time, I was very involved with social justice movements and public health initiatives. I couldn't decide which of these two fields to go into. It was a trip to rural Jamaica that really inspired me and I felt very appreciated. I saw [that] there was deep poverty, there were deep needs. I really loved the work and when I came back to Rochester, I sat in this dusty old library and I thought to myself, "Which of these two paths should I choose?" I realized that by doing global health work, I could really serve in the medical field as well as the public health field. So all along, I was drawn to both areas basically, then over the course of these trips to many different nations, I learned so much from people and wanted to contribute to their empowerment to this work.

Maggie Fox (1:43)

Can you tell us a little bit about some of the projects you've both started yourself and worked with over these years?

Kirk Scirto (1:48)

I began with what I call these suitcase medicine trips that were inspiring to me at the time, but in retrospect, were not very helpful at all to the people living in these communities. The first was to rural Jamaica and the second one was to villages in Mexico. The suitcase medicine concept is essentially coming in as an outsider group to places with minimal medical care, bringing all these medical supplies and medicines in your suitcases, and essentially opening them up and providing these free care, makeshift clinics. It feels very good to the people providing the care, but it's typically done parallel to the local healthcare system and actually draws confidence away from it, it draws funding away from it, it draws attention away from it, and ends up building dependence, and not really help in the long run.

On the second trip, I really came to see the many deficiencies of this model, which is the most common model for doing global health work, while I was studying public health. I went on to develop a partnership in rural Uganda, basing it on the models that had already been successful in Ghana and Kenya. And essentially, the idea was to listen to local health authorities and village leaders and just everyday people in the villages and hear what they were struggling with, what they envisioned for their own health and what type of projects they would like to partner on in a partnership that they actually led solely.

So this was an initiative that was inspiring to me, and I was involved for three years. It took up a great deal of my time and it offered me a lot more fulfillment. Since then, I have joined a lot of other very professional organizations, including, like you mentioned, Doctors for Global Health, Baylor College of Medicine, the International Pediatric AIDS Initiative and a number of other initiatives doing public health work, and system strengthening and training health workers.

Maggie Fox (3:33)

So what you're describing is kind of a way of getting away from what's been so highly criticized now, [which is] people from wealthy, white-majority nations showing up in a developing nation and saying, "Hi, here's how you do things. And we're not only going to show you how to do it, we're gonna do it ourselves because we're better at it."

Kirk Scirto (3:50)

Yes, it's a very good way to put it. A lot of people feel they're experts in their own fields. They've been trained in the United States. For example, they have knowledge that they can apply and can easily figure out the solutions and help in these villages that appear to have no functioning healthcare system. But on deeper inspection, essentially all these places have functioning health systems. Even if they don't have a hospital or a clinic, they may have community health workers doing home visits and traditional healers. In many lower income countries, it's the

pharmacists that are actually doing malaria tests and are providing care, asking about symptoms.

I think we can learn a lot from medical anthropologists and really take a grassroots approach and acknowledge that there is a lot of care there and that the care that is going on is far better than the care that we can offer. We're coming in essentially blindfolded. We don't understand the local culture and the language. We don't know the health systems or what kind of problems they have. Even if we study tropical medicine, essentially we know the local context and where to refer folks and more importantly, how to strengthen the care that's already going on. I think it's so important for us to be humble and to come in and say "Look, we don't know what to do here, we have these sincere intentions, we want to help you. But please teach us how we can partner and how you can lead that partnership so that we can help fulfill your healthcare goals in some small way with you leading the effort."

So I think bidirectional teaching and training is so important, where we can admit our lack of knowledge to local health workers and say, "Look, can you please teach me about topics that you would like to teach about, and I would love to do the same topics that you that you pick out." In this way, it's not a top-down process of coming in with all the answers, but rather learning from these very wise, local health workers.

Maggie Fox (5:32)

Who was the professional who was taking care of this man with river blindness, and what were some of the treatments that he or she was using?

Kirk Scirto (5:40)

It was a local health officer. They were doing skin snips, these biopsies to basically determine whether the worm was present. They were doing public health campaigns, doing these treatments with medicine for everyone in the village, actually. And if it wasn't successful, then bring them back for future treatments.

Maggie Fox (5:58)

What were you able to add to the equation? What did you bring to the table that helped?

Kirk Scirto (6:04)

So, this particular health worker was interested in learning more about diabetes, more about heart disease, and those are conditions we have more commonly in the United States, and I was happy to prepare some lessons for him on this. He was very excited to do a lesson on river blindness and some other conditions for me. So this is one model of training that can kind of take away that top-down power imbalance, doing a "train the trainer" session, essentially teaching people to be teachers. Whether it be resuscitating newborns that don't breathe or using clean birth kits to cut down on deaths of newborns. So essentially, we can come in as

outsiders with strange accents, doing lectures, and it can go over the heads of local folks not understanding us. But it's a much better way for people from the culture itself to do the teaching and for us to teach the teachers what they would like to learn about.

There's a massive, massive shortage of healthcare workers all around the world. So in Africa alone, it's 4.2 million, which is projected to increase in 2030 to 6.1 million. So these small groups, over 500 in the US, are coming over, staying for less than two weeks and treating as many patients as they possibly can. It's just a drop in the bucket compared with the level of need. And of course, the health workers will do a much better job than we ever could treating them. So helping to build up the health system, furthering the training and looking at other ways that it could function better, can really be far, far more help.

Maggie Fox (7:29)

You're using the term social justice a lot. Can you tell us a little bit what you mean about that?

Kirk Scirto (7:34)

I was a political science major in college, and then I went on and got my Master's in global public health. In both fields, we really conceptualize the world in terms of power, who has it and who doesn't have it and who's abusing it. So I essentially define social justice as transferring power from those with an abundance of it to those with not enough of it to meet their basic needs, including housing, education, healthcare access. These are the social determinants of health, which basically allow us to obtain our state of health far more than what diseases we have and other factors in our health system. So essentially, ill health around the world can nearly always be traced to major abuses of power. And in this way, empowerment for people in low resource countries, I think is really the key to countering this social justice issue.

Maggie Fox (8:23)

One great example you give is people living in El Salvador and how they had a completely different idea of what they deserved and what they could achieve.

Kirk Scirto (8:33)

It was a very inspiring community that this helping human rights organization partnered with. So the community left, they fled as refugees during the Civil War. and they all came back en masse to join their community once again. They had learned so many lessons and they came together and identified their health goals. They developed this Alcoholics Anonymous group and a peer-led HIV education group that were both very successful. They started up a higher education program to get folks to college to become the future village leaders, and they were organizing a nonprofit as well as the human rights radio show. So they're a very empowered community that were deeply aware of their needs and they were doing quite a bit about it. And as outsiders coming in, we were simply following their lead, which is what really I think outsiders should

always do while doing global health initiatives, to partner on the sidelines and just encourage the fruition of their goals.

What are they lacking? It differs in every community, and sometimes they have some ideas, but they've lost inspiration. We can help to co-facilitate groups to rehash these ideas and try to help them develop sustainable community programs. At other times, it's not at all needed because these programs are already ongoing, but they've identified a few resources that they're lacking. We can come in and provide a small amount of resources, loans, but most of it's coming from the community. So it's not becoming dependent on folks from the outside.

Maggie Fox (9:58)

You also work with indigenous populations in the states where you live now most of the time. Can you tell us a little bit about that work?

Kirk Scirto (10:06)

I currently serve the Tonawanda Seneca Nation. I'm the family doctor providing care out there. I love working across different cultures, whether it be on other continents or breathing here in North America. They're a really tremendous group that are following a lot of traditional ways and they have different concepts of health and illness.

Again, just as I would in lower income countries, I really like to follow their lead, and some say, "Look, I have diabetes, but I refuse Western medicine. I'm very interested in making diet changes and changing my lifestyle and doing exercise to improve this condition rather than using medicines." And so I meet them where they're at and try to further their level of knowledge and their kind of control of their own health and their health status.

Maggie Fox (10:48)

So have you learned anything from the Seneca Nation and working with them?

Kirk Scirto (10:51)

Yes, I learned a great deal. I'm extremely impressed with how close they are to the environment and they've done a tremendous job setting up environmental health initiatives and trying to gain more power and control over the environment that really is theirs to begin with. We're settlers here taking over their territory, basically, in New York state and throughout the country for that matter. And they're fighting against many challenges, but have done a very good job.

Maggie Fox (11:19)

And Kirk, you've got a book out about all of these points you've been making.

Kirk Scirto (11:23)

I've seen seven major approaches to global health work and most of them, most groups that do global health work, they're following this traditional model that's very top-down and is charity-based. It's outsiders coming in and superimposing their own ideas with very good intentions. But these solutions are not evidence-based, they're not sustainable, and they don't really inspire people to keep the improvements going. [With] suitcase medicine as I described earlier, folks coming in and doing this free medical care in makeshift clinics really can very well be more harmful than helpful. Also building health facilities, especially when it's a parallel system, often can disempower folks and hurt the local economy. So these are really common solutions outsiders have traditionally done, and they're not so helpful.

I've written a book called "Doing Global Health Work: Approaches that Really Make a Difference" with Hesperian Health Guides. This book is really critiquing these two common models and going into five other models that are more empowering and sustainable and are really taking the drive of local people. You're involving clinical capacity building, public health capacity building, strengthening the local health system, professional disaster relief, where you're not simply rushing in with clinical care but taking a public health approach and really helping in an evidence-based way, and also building these community-based health programs from the ground up from the folks themselves and us just partnering on the sidelines.

I really do analyze dramatically our agendas as outsiders. So again, it's usually sincere intentions when outsiders are going abroad to try to contribute to health and healthcare. But many times we're following the agenda of our organization. Maybe there's a religious agenda to convert people to a certain religion, or the US government or the military are promoting security or foreign relations and goals. Companies might be trying to improve their image or to market their products. Many donors are very interested in one particular area. Maybe it's malaria, maybe it's Ebola, but maybe it's not the most important health issue affecting the community. Even if it is the most important issue, they're all geared up to do something different. And really, we should be following their lead and not taking our own agendas.

I've also analyzed seven work agendas. These agendas include things like charity care and charity service that aim to help others but actually ends up helping us more, or at least making us feel better about what we're doing. So building up a local capacity, strengthening the health system and empowering, these are agendas that can do so much more. I think we can take our training and inspiration and intentions and really partner with folks in such a more productive way, as long as a partnership is locally led and we're just on the sidelines.

Maggie Fox (14:00)

Kirk, thanks so much for joining us and chatting about this.

Kirk Scirto (14:03)

Thank you so much.

Maggie Fox (14:05)

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