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Africa: House Calls and Health Care

BRANCACCIO: Here's a bit of magic: an uplifting story from Rwanda, the central African country that produced one of the great horrors of the late 20th century. What brought us here is a radical reinvention of healthcare: tens of thousands of village health workers devoted to helping people eat right, take the right pills, and yes, hundreds of thousands of house calls are involved. It's about making people well, making them healthy which is something more than just fixing a disease, American style, which clogs our hospitals and costs a fortune. As we debate health care reform in the U.S. it's worth getting to know the Rwanda system. William Campbell produced our report part of a series on social entrepreneurs at work that we call "Enterprising Ideas."

It's dawn in central Africa. In Rwinkwavu, a village in southeast Rwanda, Drosella Zaninka sets out to visit some neighbors. This is a place where 15 years ago an early morning knock on the door could bring terror. But today it means hope. Drosella is what is called an "accompagnateur," literally, a person who accompanies you if you are sick. She will visit three patients this morning to give them their anti-retrovirals the medicine that can keep HIV/AIDS at bay. Drosella counts out the pills, watches that her patients take the medicine right there and then, and keeps careful records. The medicine she carries in a paper bag will only work well if they are taken every single day at the same time. In the case of HIV/AIDS, this medicine has to be for the rest of the patient's life. Drosella's cell phone is passed back and forth to check the exact time and stay on schedule. The bitter pills are washed down with passion fruit. This quiet morning ritual is part of a revolutionary, health care program designed by Boston-based Partners in Health, which has had dramatic success in getting people well and preventing disease in difficult parts of the world.

FARMER: What we really want to bring to scale is not only good health and education systems, but also we want to bring the fight against poverty to scale.

BRANCACCIO: Harvard infectious disease specialist and medical anthropologist Dr. Paul Farmer is the co-founder of Partners in Health. Farmer created a rural clinic in Haiti where he developed his model to link the battles against disease and poverty, then expanded the program to Peru, Russia, and other countries. The Partners in Health approach has been called both innovative and controversial. They use global funding to train poor villagers in basic health care and then pay them to deliver long term life saving treatments to their neighbors. Call them what you will, medics-in-the-field, community health workers, accompagnateurs, in the world of international aid putting them on the payroll is a surprisingly big deal.

FARMER: Imagine that it has become a radical notion to suggest that you actually pay poor people for their labor. I mean, there's that sort of justice issue, quite aside. I mean, of course, you should pay people for their work. I have never, in 25 years, seen a project be really effective in marshalling, you know, the talents and capacities of people like the community health workers. I've never seen them be effective for long unless they're compensated in one way.

BRANCACCIO: The Partners in Health system that combines paid health workers and preventive care caught the attention of leaders in Rwanda, a country still struggling to rebuild fifteen years after an eruption of genocide and civil war killed more than a million people.

DR. AGNES BINAGWAHO: And it's the first time, I guess, this country is in peace, security and development process. So people are so grateful that we want to make it happen. We want to, everybody wants to participate in that miracle.

BRANCACCIO: Five years ago the Rwandan government invited Partners in Health to help expand their health system. First on the list, in southeast Rwanda, a hospital in the small village of Rwinkwavu had been abandoned and gutted during the genocide. And so Partners in Health, with initial backing from The Clinton Foundation, started by rebuilding the shattered husk of the hospital. Dr. Michael Rich, has been with the Rwanda project from the beginning.

RICH: When I first came here in 2005 in fact there wasn't a single doctor for the population of about 150,000 people.

BRANCACCIO: Dr. Rich is one of the world's leading experts on multi-drug resistant TB, a condition so nasty that until a few years ago it was considered simply too difficult and too expensive to treat in poor countries. Partners in Health thinks differently. Today Rwinkwavu hospital is tidy, bustling, and quite well-equipped for a rural hospital in Africa. Here they do their own CD4 counts for HIV testing and there's a lab that can check for most tropical diseases. There are a few western doctors on staff but this is a Rwandan Ministry of Health Hospital and it is run by Rwandan doctors, nurses, and support staff. Look at the well-stocked pharmacy as well, a one year treatment for HIV/AIDS now can cost as little as $150 dollars per patient, thanks in part to a campaign to allow some drugs to be produced generically in places like India. And make no mistake: Paul Farmer and his crew didn't dump this program into Rwanda like a set of shipping crates just off the cargo plane from Boston. Like their Partners name says, it's built on a partnership with the Rwandan government, which had already embraced the idea of modestly trained people delivering health care at the village level. Phase one: the Rwandan government took local people and gave them some basic medical training to treat diseases like malaria and diarrhea. But given budget realities in the country, it is a force that is all-volunteer. Partners in Health takes community health workers and trains them to deliver a higher, more intensive and crucially important level of care. It's like getting promoted from private to sergeant. These are

the Paid caregivers with the title accompagnateur and those are the ones with the training to deliver long term care for those fiendishly tough to treat diseases like HIV and TB. Every day, sometimes twice a day, they perform the kinds of duties normally performed by hospital staff.

RICH: But here he is, 9 months later...

BRANCACCIO: Dr. Rich, the country director for Partners in Health, has been tracking the program's progress.

In the case of HIV/AIDS, what do you know about how well it works?

RICH: There's a lot of components to the system that have, I think, resulted in very excellent outcomes. And in truth, some of the best outcomes in the world. Even compared to the United States and the other areas.

BRANCACCIO: So, you're not just comparing elsewhere in Africa. You're saying that—your system here has better outcomes than sometimes in the US.

RICH: It does. We've measured how many people are still on treatment after two years. And how many of them have viral load suppression. And it's about 93 percent are still on treatment with suppressed viral loads. Quite a bit higher than almost most programs in the world. I attribute a big component of that although, there are many to this accompagnateur system.

BRANCACCIO: Now, compare that to less labor intensive systems used in most treatment programs. Maybe a patient just gets sent home with a pile of pills and a list of instructions. Do it that way and only about 60% of AIDS patients are still under treatment and keeping the AIDS virus under control, after two years. Pascal Harerimana is one of this area's elected volunteer community health workers. Yes, chosen by a vote of the people he serves, there are two elected for each small village, a man and a woman. As one of the 45,000 volunteers mobilized by the Ministry of Health, Pascal's duties include offering routine health checks, again volunteer. But when Partners in Health set up shop in Rwinkavu, they hired Pascal to be one of their advanced health workers - an accompagnatuer. More training, more duties and regular pay. Now, in addition to his volunteer work, Pascal makes scheduled house calls to help people with the heavy-duty health conditions. Pascal's small salary from Partners in Health has made a big difference in his life. He has a modest farm that produces mainly sorghum grain to help support his wife and two children. With the extra funds he receives from his accompagnateur work Pascal has been able to buy new roofing for his house, some locally made furniture, and a special cabinet that he uses to keep his community health supplies under lock and key. You can see how the money he gets in wages stimulates the local economy.

During a walk with him one afternoon he told us that his job is to give his patients medicine, to remind them of the instructions from the hospital, and he helps them as he can. We joined him on his rounds, checking on children to see if anyone's got signs of malaria or maybe a stomach or respiratory infection, checkups that use standard guidelines prescribed by the Rwandan government. If there's a youngster who may not be getting enough to eat, Pascal will refer them to the local clinic. He's looking for signs a child is too thin by measuring the circumference of her upper arm. Most mothers will go to a clinic if there's one close enough, because they're covered by Rwanda's national health insurance. Yes, unlike the U.S., almost everyone in this country has insurance.

If the clinic's not enough, patients get referred to the Rwinkwavu hospital where they might be seen by Dr. Bosco Niyonzima. Dr. Bosco, the doctors here use their first names, is Chief of the Medical staff and a pediatrician. He got interested in medicine as a teen in seminary and graduated from medical school here in Rwanda. If Dr. Bosco diagnoses malnutrition, the treatment of course is feeding the child. But Rwinkwavu's system does not leave it there, and what happens next is crucial to understanding the Partner's in Health approach. If it is malnutrition, parents are also given the option of taking a short course in making their home vegetable gardens more productive. An agricultural expert on staff with the hospital shares tips on cool ways to get the most out of the little land a family might have. And the community health worker will continue to look in on the family to see if everyone stays fed. It's a way of making that trip to the hospital yield lasting benefits.

It sounds like at some level you're less interested in actually just treating, for instance, malnutrition in a baby that comes into your clinic. You want to solve the problem that caused the malnutrition.

DR. JEAN BOSCO NIYONZIMA: Absolutely. This is the way we should be doing because if we deal only with malnourished people and then today we treat one child, tomorrow another child. But when they go back to the community and if the cause is still there, the malnutrition will resume. So we have to treat the cause which is poverty.

BRANCACCIO: Treating poverty as the cause of disease needs a top to bottom approach. It means providing clean water, nutrition, education, and economic development. It's a long-term fix that's hard to accomplish with a scattershot volunteer effort. That's why the World Health Organization recently broke with tradition and clarified that while volunteers are great, community health workers should quote "receive adequate wages and/or appropriate and commensurate incentives." Farmer and his group take delight in challenging the skeptics who say their program is too expensive to be sustainable, to keep itself going in the long term. The wages that Partners in Health pays accompagnateurs in Rwanda are not much by western standards, about $30 dollars a month, but with 888 of them already on the payroll, it does add up.

Some people see it as expensive, because it requires quite a few accompagnateurs to serve everybody. Is it expensive?

FARMER: What's really expensive is to do a bad job. That's what's costly. It's very inexpensive to have accompaniment. And you know, we've done some exercises, costing exercise, I guess the term is, with the Clinton Foundation and the Rwandan government just to say, Hey, how expensive is it? What fraction of the labor costs, or the total budget is consumed by training and paying community health workers? And the answer is a very small fraction, less than 10 percent. And then when you take that, and you start demanding that the results of your intervention be really good, you're going to need community health workers for a chronic disease.

BRANCACCIO: Because there are models that should suggest, no, we really should be volunteer. We don't have the money.

FARMER: Well, you notice that those models almost always come from non-poor people. Those ideas and those models, they come from experts like me, and I think we should be a little bit suspicious when people who don't have to worry about food and shelter and you know, having enough to eat or getting their kids to school, when they are the ones arguing we shouldn't pay poor people to help us do a project, be skeptical.

BRANCACCIO: If you can extrapolate from the Rwanda experience, as much as $150 per patient to run this system, what you get is this back -of-the-envelope calculation: to bring paid accompagnateurs to each and every of the tens of millions of people with HIV/AIDS in sub-Saharan Africa would cost, per year, 3.3 billion dollars. That's about what the U.S. government paid for the few short weeks of the Cash-for-Clunkers program this summer. And if we continue with this thought experiment, if you took the money paid to bail out just the failed insurance company AIG, you could bring life-sustaining accompagnateurs to every man, woman, and child with the AIDS virus in sub-Saharan Africa for 25 years.

They say bailing out AIG was an investment in the future? Some might argue, so would be a continent of healthier people. But before the model can spread through a continent it has to take off in the country at hand. Partners in Health, with new funding from big names like The Clinton and Gates Foundations plus the United Nations, is already expanding into two more areas of Rwanda, building hospitals and clinics and hiring more accompagnateurs. To assess just how far these projects can go a trip back to the Rwandan capital, Kigali, is in order. About fourteen miles from Rwinkavu the bumpy red dirt road turns into smooth tarmac. The roads and villages now seem spotless and even plastic bags are banned in Rwanda. The president has decreed that all motorcyclists wear helmets, and they do. The government says no more bare feet, and again, remarkably universal compliance.

New schools dot the countryside. Education is now free up through the 9th grade. On the outskirts of Kigali we start to see a boom in new house construction. Thousands of Rwandan exiles are returning to start businesses and work for the civil service. One of these professionals who returned after living and training for much of her life in France is the permanent secretary at the Ministry of Health, Dr. Agnes Binagwaho. She helped spearhead the design of Rwanda's community health system, customizing some ideas that work in other countries, like these house calls, to serve the needs of Rwandans.

DR. AGNES BINAGWAHO: We try as a pretty standard strategy to keep people in their community and try to serve 80 percent of the disease burden where people are living. Because it's cheaper. No transport. No disconnection with your family. And no burden to the health facilities where people who are really sick with complications can go. So you solve the problem of human resources. You solve problem of infrastructures by keeping people at home when you can treat them at home.

BRANCACCIO: And there's another level of people who at the community level keep an eye on others who are sick, the accompagnateur.

DR. AGNES BINAGWAHO: Yes. Accompagnateur is another model that is a model of Partner in Health. But it's not a national model. Their people are paid to do a work. So it became employment.

BRANCACCIO: And that's more of a Partners in Health creation, that idea?

DR. AGNES BINAGWAHO: That idea is a Partner in Health creation. And it cannot be replicated at country level because we don't have enough money to do that for now.

BRANCACCIO: Now you heard those words "for now". Look out her window and you see more of that construction. In 15 years Rwanda has come a long way from the genocide that left the country traumatized and virtually bankrupt. Last year the country claimed an impressive 11 percent growth rate, despite the dismal global economy. President Kagame, the former rebel leader who stopped the genocide and civil war, is courting business leaders and international donors to invest in Rwanda's vision of a poverty free country by the year 2020. Financing an expanded health care system and making it sustainable is a daunting task even for a man with a lot of support from his people.

President Kagame, you've worried deeply, and actually been very outspoken about where you believe international aid has gone wrong in some cases. What's the problem?

KAGAME: If you look at the whole history, you have many decades of development aid. Yet,

as more years go by, you find there hasn't been much impact. But I'd also still argue that as we get this aid, we have also to look at the future. The future being as we get more aid, eventually we should be seeing a situation where we need less aid, or no aid at all. And that depends on how this aid money is invested.

BRANCACCIO: If Rwanda expects to stand on its own two feet and be able to make its own decisions about how it wants to raise money, to affect, for instance, public health, countries like Rwanda have to also guarantee the donors transparency and accountability.

KAGAME: Absolutely, I agree with that. And, that's in fact for us what we are doing.

BRANCACCIO: But not all governments are as disciplined as Rwanda. Transparency is a fancy word for the clear and open bookkeeping that can stop the pilfering, skimming, and corruption that fritters away international aid. Some countries that desperately need an effective health care program are notoriously un-transparent. Rwanda is different and the work in health care in southeastern Rwanda is proof that with sweat, innovation, and money, paradigms can shift for the better.

Take this husband and father, Louis Manirafasha who had a horrible case of multi drug resistant TB. He told us that he was terribly sick. He couldn't move by himself and he was coughing up blood. Two years ago he looked like this patient. Intensive treatment like this for a man with little financial resources in such a very poor part of the world used to be out of the question before the work of Partners in Health. After a year in the Rinkwavu hospital men's ward and then another year being treated at home by his accompagnateur, Lea Kawesa, Louis is utterly free of tuberculosis. With Louis at home, his family is stable and whole and he can help support his wife and children with the crops that he grows around his house. Plus, there is usually enough to sell at the local market. A man whose catastrophic illness was once a terrible drain on resources is now a productive member of society.

FARMER: What you need to do is disrupt this cycle of poverty and disease. So we're trying to intervene on several levels. Doing our job as doctors and nurses in a hospital setting. But also thinking about, does this family have access to land? Do they have access to fertilizer, to agricultural implements, good seed quality?

BRANCACCIO: That's the innovation that has the potential to guide health care across the poorest parts of the world, the understanding that making someone well takes more than medical science.

FARMER: If the goal is to break the cycle of poverty and disease, then you're going to have to take on the ranking health problems. And in some places, those are gonna be AIDS and tuberculosis and malaria. And in other places, they're going to be cancers. But to say you know,

we can't do anything about this because it's too expensive, you're not going to be able to break that cycle without investments.

BRANCACCIO: There is a lot more to tell about healthcare in Rwanda and we tried to capture even more it with our trustee Nikons. If you have a moment, check out our photo essay that we put together and explore some other cool enterprising ideas on our website.