The roll-out of Antiretroviral (ARV) treatment and the contribution of Family Medicine - let's take up the gauntlet.

On the 8th August 2003, the South African Cabinet announced their commitment to antiretroviral treatment. They expect a plan to implement antiretroviral therapy throughout the country to be ready by the end of September 2003. A national task team was given a number of issues to take into consideration: the roll out should be within the District Health System; staffing, drug supplies and laboratory services should be improved; and academic institutions should be involved1.

As family doctors we were excited about this statement. Not only did the Cabinet finally decide to make a start with ARV, but it also stated that this should be accompanied by significant investment in the existing health system. The Stellenbosch National Family Practitioners Conference ended on the 10th August with a declaration to the Minister of Health: "The 350 attendees welcome the decision on the implementation of an ARV programme and express their commitment to assist in the roll-out".

Time has come to take action. Family Medicine is the discipline par excellence to do the job. We are skilled senior clinicians who work community-based with the patient-centred method. We have a defined practice population and work as part of a health care team (whether or not full-time) within the district health system. Generalist family doctors are everywhere in the country and many are part of an academic infrastructure.

In April 2003, an active network was created between the family medicine departments at all the South African medical schools and other organisations representing family doctors in the public, private, urban and rural sectors. This network is currently in the process of developing Post-graduate Training in Family Medicine for South Africa. For this training, sites will be developed in existing health districts throughout the country, including the rural areas.

On the 24th August, the 'Family Medicine Master plan' on HIV/AIDS was launched. In this plan, family doctors/generalists play a central role in the provision of a comprehensive care package to people living with HIV/AIDS and their families, including ARV treatment, within the district health system. All existing programmes relating to HIV/AIDS (VCT, PMTCT, management of TB, STI management, home-based care, palliative care, etc) need to be incorporated in this package2,3. It would resemble the model of care required by people with any of the chronic conditions at primary care level, where nurses and doctors work together.

The post-graduate training plan set within the district health system, can provide a network of training and support for care at the clinic level. The plan links each of the eight university family medicine departments via provincial heads of family medicine with district family physicians (public and private). They in turn take care of the sub-district family physicians and the family medicine registrars who will be responsible for the care at local service area level. Each of these areas includes 4-7 clinics and the Health Centre. They will work with the teams at the local level, giving support and training and take responsibility for difficult and complicated decisions4. Alternatively the work at local service area level can be done by any other doctor who is either part-time or full-time, but contracted to work under the supervision of the sub-district family physicians following the provided guidelines and protocols for care. This can be a private doctor or a community service doctor. Good working relationships with the private sector and other role players in the field are essential to the success of the plan.

Our country has an extended system of primary health care facilities including clinics and health centres. The 46 health districts of our country are divided into approximately 250 sub districts. In these sub-districts, the almost 3000 clinics are clustered in about 750 functional units, the so-called local service areas. Thus up to 300 Family physicians and 750 registrars or other generalist doctors are needed to put this plan in place. A major effort and a more flexible immigration policy will be needed to recruit some of these family doctors within a short period of time. To enable us, as family doctors, to focus on this challenge, we may need to reflect on the priorities in our current work. We will have to consider what can be excluded, postponed or delegated in favour of this task of crucial national importance.

The 'Family Medicine Master plan' was launched on the various web-based discussion lists and sent to various interested parties. After adjustments on the basis of feedback received, we will offer it to our Minister of Health. We regard this as a once in a lifetime opportunity to respond to the desperate need of our people.

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