TSHEPANG — A COMPREHENSIVE APPROACH TO THE MANAGEMENT OF HIV AND AIDS, INCLUDING THE PROVISION OF ANTIRETROVIRALS

In May 2004 President Mbeki, in his state of the nation address, reiterated the government's intention to treat 53 000 HIV-positive patients by March 2005. According to the Health Systems Trust (HST), at least 500 000 HIV-positive people need treatment right now. The biggest barrier to treatment, according to the HST, is no longer the cost of treatment, but the lack of infrastructure and trained personnel to deliver that treatment. This is where the Tshepang Trust, also known as Tshepang comes in. An initiative of the South African Medical Association (SAMA) and supported by the Nelson Mandela Foundation, Tshepang intends to act as a facilitator to ensure that patients who need antiretrovirals (ARVs) receive them through a network of general practitioners (GPs) trained in the clinical management of HIV and AIDS, who can treat at public treatment sites through sessions and who can also treat in the privacy of their own rooms. The Trust offers a comprehensive approach by including an Information Education and Communication (IEC) component to provide a mechanism that will curb the spread of HIV and AIDS and eradicate stigma through HIV awareness ambassadors.

Tshepang's vision is to ensure that every GP becomes available to treat, care for and support HIV and AIDS patients and also becomes a conduit for destigmatisation and prevention. The Trust intends to do this by developing the capacity of the private sector (comprising about 70% of South African doctors) to support comprehensive care to public sector-dependent patients. Their mission is to ensure that every patient eligible for ARV treatment receives it through public-private partnerships — effectively public health facilities working in co-operation with private GPs. Tshepang emphasises the need for its doctors to become part of a network of providers involved in HIV management, including pre-treatment and adherence counselling, care and support through community-based programmes.

The Trust also has an IEC component that aims to promote behaviour modification. Using the analogy of Einstein's theory of relativity, $E = MC^2$, the focus of this component is on the empowerment (E) of women from male dominance, male rehabilitation (M), and accellerating efforts (C^2) on prevention through sexual abstinence and faithfulness, safe sexual practices, management and control of sexually transmitted diseases, management of unsafe medical and health practices, etc. Included in this component is stigma eradication through awareness campaigns and ongoing educational programmes by doctors, prominent persona within communities and ordinary people living with HIV and AIDS, also known as HIV ambassadors. A major advantage of this approach is that doctors are an authoritative voice for the medical profession and are trusted by their patients.

Tshepang's objectives are:

- to act as a mechanism that facilitates public-private partnerships through a comprehensive disease management programme that involves treatment, monitoring and evaluation of patients dependent on public sector health care using GPs
- to ensure that every GP is skilled and equipped to treat HIV cases so that they are available to treat patients in need of treatment
- to provide treatment in accordance with national protocols
- to spread IEC messages using these GP networks and plugging into existing organisations and NGOs involved in HIV/AIDS information, education and communication campaigns
- to de-stigmatise HIV and AIDS through awareness campaigns, using prominent persona and ordinary people living with HIV and AIDS
- to provide voluntary counselling and testing (VCT) at the GP level, using trained VCT counsellors.

How is Tshepang doing this? The first phase of the Trust's strategy is to enlist private GPs to assist in public sector facilities through sessions. The second phase is to ensure that every GP practice becomes an accredited site for treatment of HIV. This means that GPs who are already trained in HIV and AIDS management would be able to treat public patients from their consulting rooms to help alleviate the burden of treatment at public facilities, and to provide comprehensive quality care and support. This would also allow the government funding of ARVs to concentrate on treatment and not on infrastructure

and would hopefully increase VCT uptake, because when patients are part of a queue of patients in a GP practice, the stigma attached to HIV and AIDS becomes an non-issue as no-one knows why they are consulting with the doctor. The basis for this approach is that HIV infection should be viewed as a chronic medical condition similar to hypertension and diabetes and should be managed by GPs rather than specialists, although specialist back up is an integral part of the process.

Key elements of this intervention:

- Access to HIV-trained medical practitioners. The Foundation for Professional Development, in conjunction with the Southern African HIV Clinicians Society, has successfully trained at least 5 000 primary caregivers in basic HIV care in the past 3 years. This trained group will form the basis for the provision of ARV treatment.
- Access to specialist back-up. All providers of treatment will have access to a centralised specialist HIV/AIDS knowledge pool using a remote medicine network, through the Southern African HIV Clinicians Society and a network of specialists in treatment centres that the Trust is in partnership with.
- Treatment protocols that are the same as those used by the Department of Health and are backed up by the Southern African HIV Clinicians Society, WHO, UNAIDS and leading academic institutions.
- Standardised laboratory testing based on the national protocol.
- Drug delivery mechanisms to be developed, to provide safe and cost-effective drug distribution, using a preferred distribution company and state pharmacies.
- IEC campaigns in collaboration with existing organisations, to help curb the spread of the virus.
- Programme monitoring, evaluation and reporting, i.e. tracking the efficacy of the programme on a confidential, case-management basis.

To be part of the Tshepang GP network involves:

- Training of self-employed medical practitioners through the Foundation for Professional Development in conjunction with the Southern African HIV Clinicians Society's HIV clinical management programme.
- Within this training period, Tshepang will also present a separate module that deals with how the Tshepang programme will work:
  - Workshops on monitoring, evaluation and reporting that will be run to ensure that patients on treatment are properly managed.
  - Regular updates on the latest development in treatment.
  - Signing of a memorandum of understanding between the GP and the Trust.

How will all this be paid for? Tshepang's public-private partnership strategy is based on signed co-operative agreements with government. The agreements are based on government to provide the ARVs and related costs for all patients needing treatment. Tshepang is committed to facilitate treatment through contractual agreements with the state by paying for GPs' consultation fees for a set period of time, after which the state will take over to make the programme sustainable. In some cases where treatment is not yet a reality, Tshepang is prepared to kick-start the funding for all facets of treatment, including ARVs, until the state is in a position to take over. A partnership of this nature already exists in the Western Cape's, GF Jooste Hospital, Manenberg on the Cape Flats, where there are 200 patients to date on treatment through the Trust. Through this partnership, the Trust is in the process of equipping a group of doctors who, in addition to the Foundation for Professional Development course, are undergoing sessional training at the hospital, after which they will see patients on a sessional basis paid for by Tshepang, at satellite clinics linked to the hospital.

Monitoring and evaluation are key to the success of this programme and will operate to ensure maximum compliance with protocols and criteria set by the programme and facilitate reliable and sustainable long-term data collection. Mechanisms whereby the success of the various elements of the programme can be monitored are being set up, including quarterly reporting on a de-personalised, case-by-case basis. This will provide information on which to base further interventions and the future strategic direction of the programme.

Tshepang is realistic about its role in this enormous challenge, acknowledging that 'no single initiative, no matter how well thought through and planned, can provide the ultimate solution.'

If you are interested in joining this network, and I would urge you to do so, you can contact Tshepang through Pumla Kobus, Head: Project Management, the Tshepang Trust, tel (012) 481-2064, fax (012) 481-2118, cell 082 652 6101, email **pumlak@samedical.org**

Bridget Farham