

**Jina Kim**  
**September 27, 2005**  
**SP.783 Writing Assignment 2**

Generic Drugs

The cost per patient for highly-active antiretroviral therapy (HAART) in Zambia is \$488, with drugs constituting 57% of that cost. Even with the production of generics, the bulk of the treatment cost for HIV/AIDS understandably derives from the drugs. In a December 2004 BBC report, Rowan Gillies, president of Medecins Sans Frontieres said “[t]here’s no way we can deal with the problem without generic drugs...There are still these five or so million people who will die in two years if they do not get the drugs they need.”

Kombe and Smith’s 2003 Partners for Health Reform *plus* report on costs of ARV treatment in Zambia projected that providing HAART to all eligible patients would cost \$50 million in the first year and increase to \$160 million by the fifth year. If the cost of drugs could be cut by half, \$14 million in the first year costs could be saved. These savings could be invested in training personnel, laboratory resources, and other infrastructure inadequacies that often hinder HIV/AIDS treatment.

Those involved in HIV/AIDS treatment have become more or less complacent about the availability of generic drugs. However, if we want to continue driving down the cost of HAART, then further reducing the cost of generic drugs should be considered. One option would be for the World Health Organization to motivate companies with non-monetary incentives to pass quality control tests. More competitors in the generics market will bring down

prices, allowing for more HIV patients to be put on medicines without greater investment in the treatment effort.

At some point in the future, foreign aid for HIV/AIDS will run out. National governments will have to take on more of the financial responsibility. The WHO can alleviate this future burden by encouraging a competitive market now for even cheaper, bioequivalent essential medicines.

### Personnel Training

Another major obstacle to scaling up HIV/AIDS treatment is the lack of trained personnel. To provide scaled-up, community-based treatment, any ARV program must recruit and train more health-care workers. Without counselors or support groups, there is a much greater chance that patients will not diligently follow the recovery regime.

The 2003 WHO report on emergency scale-up mentions training new workers at all levels of health care. And at the health center level, it recommends that patients living with HIV/AIDS are also recruited to serve as advocates for others. This latter approach seems like a highly viable solution to the staff shortage. If HIV/AIDS patients were obligated to volunteer at their local health centers in return for treatment, staffing would be sufficient as the system becomes self-sustaining. They would also be the most supportive and understanding counselors and support group members since they are living with HIV/AIDS themselves.

Furthermore, health centers should provide local benefits for their workers. Through the Ndola Catholic Diocese home-based care program,

volunteers receive food supplements at half the selling price. Nsutebu et al. (2001) found that volunteers were more involved and held greater responsibilities in the Ndola program than in the other Family Health Trust project.

As more community members become employed and seriously involved in the HIV/AIDS treatment effort, the stigma around the disease will also begin to dissolve as people come to terms with its presence. Home-based care has especially been successful in Zambia, and if it is to continue as ARV therapy scales up, the full support of every affected community will be necessary.