

IN THE COMPETITION COMMISSION OF SOUTH AFRICA

In the complaint submitted by:

TREATMENT ACTION CAMPAIGN

Concerning the conduct of:

MSD (PTY) LTD

MERCK & CO., INC. AND RELATED COMPANIES

AFFIDAVIT OF FATIMA HASSAN

I, the undersigned

FATIMA HASSAN

do hereby solemnly affirm:

1. I am a senior attorney at the AIDS Law Project (ALP), the legal representatives of the Treatment Action Campaign (TAC), the complainant in this matter.
2. The facts contained herein are true and correct and within my knowledge, unless the context indicates otherwise. To the extent that I rely on the information received from others, I believe that such information is true and correct.
3. I have read the statement of complaint, and insofar as it pertains to me, confirm its contents.
4. I can be contacted on 021 422 1490 or hassanf@alp.org.za should the Competition Commission (Commission) wish to obtain further information from me.

5. At the ALP I am responsible for conducting certain aspects of its formal monitoring work including collecting provincial and national data on the provision of antiretroviral (ARV) treatment in the public and private sectors, and convening the Joint Civil Society Monitoring Forum (JCSMF).
6. The JCSMF is an ad hoc monitoring body that was formed in June 2004. It is made up of several leading civil society and private sector organisations. The founding members of the JCSMF are the ALP, Health Systems Trust, Centre for Health Policy, Institute for Democracy in South Africa, Open Democracy Advice Centre, TAC, University of Cape Town (UCT) School of Public Health & Family Medicine, Public Service Accountability Monitor and Médecins Sans Frontières (MSF). It is also supported by the Southern African HIV/AIDS Clinicians Society, Anglo American, Institute for Health Care Improvement, Oxfam and the School of Public Health at the University of the Western Cape.
7. The JCSMF is dedicated to monitoring the implementation of the *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa* (Operational Plan) and the national *HIV & AIDS and STI Strategic Plan for South Africa, 2007–2011* (NSP).
8. The JCSMF has publicly issued several reports containing resolutions and recommendations for improving the pace and manner of scaling up ARV treatment in South Africa. All resolutions and minutes are publicly available at www.jcsmf.org.za.
9. Since 2004 the JCSMF has extensively monitored the availability of ARV treatment in eight provinces, in addition to paying attention to *inter alia* the following issues: nutrition, paediatric access, budget and resource allocation, private sector provision of treatment, donor funded treatment programmes, scaling up access to counselling and testing services, the NSP and the crisis in human resources for health.
10. I respectfully submit that I am by my training and experience duly qualified to express the views and opinions that I express in this affidavit.

11. This affidavit provides a brief overview of the information that the ALP and JCSMF have collected since 2004 relating to the numbers of people on ARV treatment in South Africa as well as stock-outs of efavirenz (EFV).

Numbers of people on treatment

12. Since 2004, the ALP and JCSMF have tracked patient numbers in all provinces. In South Africa the bulk of patients receiving ARV treatment are in the public sector, through which they get free access to ARV medicines at a state facility. At some of these sites, however, donors are assisting with staff training and funding of associated costs.
13. A large number of patients also receive ARV medicines in the private sector. For purposes of this affidavit the *private sector* includes the not for profit sector, workplace treatment programmes, medical schemes (private health insurance) and the unfunded private sector (people who pay out of their own pocket).
14. In workplace treatment programmes (WPTPs), larger employers and donors fund the free provision of ARV medicines in the workplace. Some of the larger companies that provide treatment for workers who cannot afford to belong to a medical scheme include Eskom, Anglo American, DaimlerChrysler, BP, Engen, Sasol, Tiger Brands, M-Tel, BMW and Unilever.
15. Many private sector programmes are administered by external disease management programmes (DMPs) such as Aid for AIDS, LifeSense, Aurum Health, QUALSA, Right to Care, Caliber Clinical Consultants, Discovery DMP, Lifeworks, Old Mutual, Prime Cure, Sizwe Yebo Life, Direct health, and Metropolitan Health.
16. Despite efforts by civil society (including the JCSMF) to collect data, information is generally not publicly or easily available. This hampers the ability of civil society to compile accurate data on patient numbers, adherence, side effects, mortality, age and gender, and inter- and intra-provincial disparities. In addition, a national monitoring and

evaluation system that collects data in the public, not-for-profit and for-profit (private) sectors is not yet fully in place. This means that no one – including the Department of Health (DoH) – has accurate information and data on the exact number of people on ARV treatment in the country at any given time.

17. In some provinces, proper clinical monitoring systems of patients are not yet fully functional. From a civil society perspective, it is therefore difficult to track important indicators such as the take up of treatment; adherence; side effects; mortality and good outcomes.
18. In addition, aside from a handful of fairly short parliamentary press briefings, neither the DoH nor the Minister of Health has, to date, compiled or publicly presented a qualitative assessment of the programme. There has never been qualitative reporting to the public, Parliament or the South African National AIDS Council (SANAC).
19. Because it is therefore difficult to access reliable data on ARV treatment in the public sector, the JCSMF relies on information submitted by health care workers at provincial facilities and community organisations working at those facilities. We also rely on experts who model or estimate the numbers of patients needing treatment, and use information gleaned from ARV sales in order to estimate the number of people on treatment versus numbers enrolled on the programme and the numbers on first- and second-line regimens.
20. On this basis, we estimate that at present about 350,000 people are accessing ARV treatment in the public sector. In the private sector, we estimate that the number could be in the region of about 110,000 – 120,000. The combined total is therefore approximately 460,000 – 470,000.

EFV stockouts

21. During 2005, approximately a year after most provinces had commenced providing ARV treatment, health care workers informed the ALP that drug shortages – mainly of EFV –

had occurred in at least three provinces. These shortages occurred in Gauteng, KwaZulu-Natal and Mpumalanga.

22. In a joint report dated June 2005, the ALP and TAC reported that they had “received a number of reports over the past few months regarding problems with drug availability in various parts of the country, in particular the supply of efavirenz (marketed by MSD as Stocrin[®]). In our view, this is largely as a result of MSD’s inability to meet demand”. A copy of the full report is available at <http://www.jcsmf.org.za/?q=node/24> entitled ‘*Let them eat cake*’ – a short assessment of provision of treatment and care 18 months after the adoption of the Operational Plan.
23. I am also in regular contact with various DMPs and medical schemes that provide treatment and related services to patients in the private sector.
24. In my dealings with them over the last few years, on several occasions, I have been alerted to drug shortages and stockouts. In particular, several DMPs and medical schemes have indicated that the second largest courier ARV pharmacy in South Africa (which serves 11,000 patients monthly) has often experienced supply problems with a number of ARV medicines, including EFV. I was also advised that EFV had been in short supply due to storms in the Caribbean a few years ago.
25. In the last few months I have requested DMPs and medical schemes to provide me with further information and detail about such shortages. However, they have now been unable or unwilling either to locate relevant records relating to the stock outs, or to make such records and information available, or to place the information on record.
26. On the basis of my extensive dealings with DMPs and medical schemes, both in my capacity as a former board member of the Council for Medical Schemes (1999 – 2001) and my monitoring work with the ALP and JCSMF, I am aware that DMPs and medical schemes are required by law to maintain qualitative data and records on every aspect of disease management, and in fact do so.

27. I submit that the most effective way to obtain such information will be for the Commission to request it. Failing that, it may have to use its powers of search, seizure and/or subpoena.

FATIMA HASSAN

**SIGNED AND AFFIRMED BEFORE ME AT _____ ON THIS THE ____
DAY OF NOVEMBER 2007, THE DEPONENT HAVING ACKNOWLEDGED THAT SHE
KNOWS AND UNDERSTANDS THE CONTENTS OF THIS AFFIDAVIT, THAT SHE HAS
CONSCIENTIOUS OBJECTIONS TO TAKING THE OATH, AND THAT SHE CONSIDERS
THE AFFIRMATION AS BINDING ON HER CONSCIENCE.**

COMMISSIONER OF OATHS