Hazel Bradley

Prof Richard Laing gave the Annual David Sanders Lecture at the School of Public Health, UWC on Wednesday 25 June 2014. The Annual Lecture was instituted in 2012 in celebration of Emeritus Professor David Sanders’ contribution as founding director of the School of Public Health at UWC and his influence in the field of Public Health. Prof Laing was an apposite choice as Richard and David met over 40 years ago as medical students in Zimbabwe where they were both subsequently involved in various capacities in the Zimbabwean health services. Richard spent his last three years in the country (1987-89) developing the Zimbabwean Essential Drugs Programme (ZEDAP). This set the direction for his professional career in pharmaceutical policy, notably at the World Health Organisation (WHO) from 2003-2013 and latterly back at Boston University, School of Public Health as professor of International Health. At the lecture SOPH announced that Prof Richard Laing has recently been appointed as Extraordinary Professor at the School and we look forward to ongoing collaboration in the area of pharmaceutical public health and policy.

Richard was introduced at the Annual Lecture by Bada Pharasi, Management Sciences for Health (MSH) Country Representative for South Africa, who had been a colleague in Zimbabwe during ZEDAP days. Richard drew on his vast experience to focus on critical issues influencing access to medicines. He commenced by reflecting on key moments including the first essential medicines list developed in 1977; the Nairobi conference on Rational Medicines Use which introduced a compromise by limiting the concept to the public sector; and 1998 when the compromise was broken down when 39 big PHARMA companies sued the South African government.

Over the years, many have perceived patents and patent law to be barriers to the essential medicines concept but work published by Kowalski et al (2011) quashed this assumption by showing that less than 6% of essential medicines were patent protected anywhere in the world. However, if patents are not a barrier to access to essential medicines, then pricing remains a key issue with studies showing wide variations in prices both between countries and within the public and private sectors. Ironically, even though medicines in the public or government sector may be affordable, or even free in some cases, availability is often very poor which results in patients reverting to high-priced medicines from the private sector. Affordability of medicines is a critical issue in many countries with cumulative mark-ups between manufacturers selling price and final patient price varying considerably. Studies have revealed that in some countries the cumulative mark-up can be anything up to 600 times the manufacturer’s selling price (even up to 6000 times in El Salvador).

Generic medicines have been proposed as one answer to ensuring availability and affordability of essential medicines but, again, available data show massive variations between countries in terms of use with the United States being a world leader in generic uptake by volume (almost 80%). Austria, on the other hand, is at the other end of the scale with generics standing at just over a third of the market share and brand loyalty remaining high even after the patent ends. The generics picture in South Africa falls between these two, with 2010 data showing generics at 71% market share and brand erosion in the year after the patent ends varying between 60-90%.
Richard cited recent work by Leng, Sanders and Pollock in South Africa that showed among some medicines, like metformin (an anti-diabetic medicine), the originator retains market share with a slight price premium, whilst in the case of fluoxetine (an anti-depressant) the originator slowly loses market share but price premium remains and for ciprofloxacin (an antibiotic), the first generic has the greatest market share but is under stiff pressure from other suppliers.

Richard concluded his lecture by pointing to several future hopes and challenges remaining for South Africa with respect to access to medicines, including the still to be unveiled National Health Insurance (NHI), which will hopefully include access to essential medicines in its package; reform of the Medicines Control Council to speed up drug registrations; and lastly reform of patent legislation resulting in faster access to generics. He asserted that whilst South Africa has made significant progress in extending access to medicines in the past 20 years since democracy, ‘the struggle continues’.

SOPH Winter School 2014: Two New Medicines Courses Offered

In his role as Extraordinary Professor at the SOPH, UWC we look forward to Prof Richard Laing’s contribution to our teaching and research, particularly in the area of pharmaceutical public health and policy which is an emerging focus at the School. This initiative was launched at Winter School this year with two new courses with a medicines management focus: Rational Medicines Use and Medicines Supply Management. Both courses were convened by SOPH in collaboration with several partners including Prof Laing, School of Pharmacy at UWC, Management Sciences for Health/Systems for Improved Access to Pharmaceuticals and Services (MSH/SIAPS) and with input from the department of health and a colleague from the Institute of Tropical Medicine (ITM) in Antwerp.

The **Rational Medicines Use Course** was held in the first week of Winter School and this interactive course was attended by 22 participants, mainly pharmacists but also some family physicians, from South Africa and several other SSA countries. The course focussed on the importance of the rational medicines use concept and introduced participants to a range of tools to investigate and promote rational medicines use. A highlight was the session by Prof Marc Mendelson, head of Division of Infectious Diseases & HIV Medicine at Groote Schuur Hospital, University of Cape Town on antimicrobial resistance and the principles of antimicrobial stewardship by prescribers and dispensers. This was followed by a practical session on the role of Pharmacy and Therapeutic Committees (PTCs) in rational medicines use and the course concluded with participants developing a Quality Improvement Plan for implementation on return to their setting.
The second course, **Medicines Supply Management**, engaged healthcare professionals in the key principles of medicines supply management. This course was added by 19 participants, again mostly pharmacists working in the public sector across South Africa. Whilst the majority of participants were based at district, sub-district or facility level, the course was enhanced by the attendance of several participants who worked at medical depots or at the provincial level. The course covered the key principles of procurement, quality assurance, inventory management and storage control, as well as the use of pharmaceutical and logistics management information systems for managing and monitoring medicines. In addition, the course provided participants with several key tools for managing medicines in their own setting such as quantification and financial management using ABC analysis.

We plan to run these two short courses on a regular basis at our Winter School which is held annually in June/July at the School of Public, UWC, and with continued support from ITM and the input of our collaborators we are developing these two new courses into **on-line modules** which will become elective modules in a new pharmaceuticals steam in our MPH qualification from 2015.

**Winter School 2014 Courses offered and Participation**

<table>
<thead>
<tr>
<th>Course Description</th>
<th>Participants</th>
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<tbody>
<tr>
<td>Computerised District Health Information Systems: An Intermediate Course</td>
<td>9</td>
</tr>
<tr>
<td>Using Geographical Information Systems (GIS) for Analysing and Mapping Health Care Issues</td>
<td>4</td>
</tr>
<tr>
<td>Information Systems for Human Resources for Health</td>
<td>7</td>
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<tr>
<td>Health Management</td>
<td>48</td>
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<tr>
<td>Qualitative Research Methods</td>
<td>6</td>
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<tr>
<td>Rational Medicines Use</td>
<td>22</td>
</tr>
<tr>
<td>Computerised District Health Information Systems: Advanced Course</td>
<td>6</td>
</tr>
<tr>
<td>Monitoring and Evaluation of Primary Health Care Programmes: Programme 1 (2 weeks)</td>
<td>20</td>
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<tr>
<td>Urbanisation and Health in Developing Countries</td>
<td>9</td>
</tr>
<tr>
<td>Using Health Information for Effective Management: Intermediate Course</td>
<td>20</td>
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<tr>
<td>Introduction to Complex Health Systems</td>
<td>22</td>
</tr>
<tr>
<td>Globalisation and Health: Key Aspects for Policy Makers, Managers and Practitioners</td>
<td>8</td>
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<tr>
<td>Clinical Trials and Indigenous Herbal Medicine</td>
<td>12</td>
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<tr>
<td>DHIS 2 – Web based: Foundation Course</td>
<td>31</td>
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<tr>
<td>Current Thinking and Practice in Health Promotion</td>
<td>14</td>
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<tr>
<td>Epidemiology and Control of HIV and Tuberculosis</td>
<td>9</td>
</tr>
<tr>
<td>Medicines Supply Management</td>
<td>19</td>
</tr>
</tbody>
</table>

**TOTAL NUMBER OF PARTICIPANTS:** 266
Dr Saadiq Kariem awarded the 2014 Jakes Gerwel Award in Public Health

The second Jakes Gerwel Award in Public Health by the UWC School of Public Health was made to Dr Saadiq Kariem. The award, to a graduate in Public Health of the School, is sponsored by the Mauerberger Foundation Fund, a private philanthropy with a long history of support to UWC.

Dr Kariem (MBChB, MPhil Public Health, FCPHM, EMBA) was extensively involved in the restructuring of health services in the country since 1990 at local, provincial and national levels and played a major leadership role in policy formulation in the health sector. He served as the ANC National Health Secretary (1996 to 2006) and served on the Council for Medical Schemes (2001 to 2008). He was COO and CEO of Groote Schuur Hospital (2005 to 2010). Since 2010 he is the Chief Director: General Specialist and Emergency Services in the Western Cape Department of Health.

Prof Helen Schneider, Director of the School: ‘Together with the Mauerberger Foundation Fund, with the Jakes Gerwel Award we at the UWC School of Public Health celebrate the twenty three years of our vision and promise to provide public health education based on equity and social justice. This is as relevant now as it was twenty three years ago.’

The Rector, Prof Brian O’Connell based his talk on sense-making in South Africa today, on thoughts taken from a poem by Samuel Taylor Coleridge Work without Hope: ‘Work without hope draws nectar with a sieve and hope without an object cannot live’. He developed the theme of living with an object and traced how this drove people and societies to achieve good and bad outcomes. He concluded his talk by asking whether in a democratic South Africa we know what our historical object is and if we are driven to achieving good outcomes in every sphere of social life, including overcoming the challenges we are facing on health issues.

Ms Dianna Yach spoke about the close relationship over more than three decades with the University of the Western Cape and with the Gerwel family - beginning with the sponsoring of bursaries for dental students. She renewed the commitment of the Mauerberger Foundation Fund to support the university and deepen the relationship. She reminded the audience of the foresight of Prof Jakes Gerwel in working to establish the first School of Public Health in the country. The award in public was the Mauerberger Foundation Fund’s contribution to growing future leaders in the field of public health.

Heinrich Gerwel: ‘As Vice Chancellor of UWC, my father Prof Jakes Gerwel had a personal and proud involvement in the establishment of the School of Public Health and felt that this was an area in which the university could play an important and positive role in academic scholarship that truly made a practical impact on our nation’s democracy. Even after leaving UWC in 1994 to serve President Mandela the institution always held a special place in his heart. Being involved in healthcare through his chairmanship of Lifehealth Hospital Group always gave him insight into the importance of a well established public healthcare system, to its contribution to the wellbeing of society as a whole and specifically towards the economically marginalised in our country. The important work pioneered by Prof. David Sanders and continued by Prof Uta Lehmann and now Prof Helen Schneider as Director of the School serves as testimony on the part of the University and the School to play an immensely important role in furthering human development in a holistic and socially transformative manner.’
JAKES GERWEL AWARD IN PUBLIC HEALTH

CITATION

Dr Saadiq Kariem

Dr Saadiq Kariem is one of the first graduates of the Public Health Programme at UWC, obtaining a MPhil (later renamed MPH) in 1997. Saadiq graduated in medicine from UCT in 1992, obtained the Fellowship of the College of Public Health Medicine South Africa (FCPHM) in 2002 and Executive Masters in Business Administration (EMBA) from UCT in 2009.

In the period before and during his Masters studies Saadiq spent several years working at community health centres in Crossroads and Khayelitsha as a medical officer and during the transition period served on the Strategic Management Team of the Minister of Health in the Western Cape (1996), assisting with developing priority programmes for the restructured Department of Health in the Western Cape.

Saadiq has been centrally involved in the restructuring of health services in the country at local, provincial and national levels and has played a leadership role in policy formulation in the health sector, both as the ANC National Health Secretary from 1996 to 2006 as well as serving for seven years on the Council for Medical Schemes from 2001 to 2008, in the latter years as Deputy Chairperson.

His first senior position in government was as deputy director of the HIV/AIDS programme in the Western Cape (1997–2000) where he was responsible for amongst others, implementing the first mother-to-child-transmission (MTCT) programme in South Africa despite high-level political opposition. This initiative, which has deservedly received much praise, inspired other provinces to later initiate similar programmes. Saadiq remains actively involved in community organisations and serves as the Chairperson of the National AIDS Convention of South Africa (NACOSA), an organisation focussed on building capacity amongst civil society organisations in the field of HIV/AIDS. NACOSA is the principal recipient of the Global Fund Grant to South Africa responsible for disbursing several million rands to community organisations and non-governmental organisations in South Africa.

Since 2010 Saadiq has been Chief Director: General Specialist and Emergency Services in the Western Cape Department of Health, responsible for regional hospitals, psychiatric hospitals, oral health services, emergency medical services, forensic pathology services as well as the Western Cape rehabilitation centre. During this time he has inter alia been instrumental in drafting the Interim Bilateral Agreements between the Western Cape Department of Health and the University of the Western Cape as well as between the Department of Health and the Cape Peninsula University of Technology. These agreements have now formalised the relationship between the Department of Health and these respective universities and have established governance and oversight mechanisms for ensuring the training and development of health professionals.

Dr Kariem has combined his clinical and public health training and skills with a dogged commitment to influencing politics and policy in health. His courage in initiating HIV/AIDS treatment at a time of ‘denialism’ played a critical role in influencing the evolution of this programme which is rightly hailed as one of South Africa’s great post-apartheid health successes. His role in this struggle is little known, having been attributed to others. For this alone, Dr Kariem is a worthy recipient of the Jakes Gerwel Award in Public Health.

Read by Professor David Sanders
Emeritus Professor
School of Public Health
Friday 11 July 2014
I come from a State called Chhattisgarh in India. I work with communities, specifically indigenous communities on health rights and helping community-based organisations to build their capacity in doing research and advocacy for health rights. Am associated with the People’s Health Movement (PHM) in India, and I am one of the national joint convenors. Through the PHM I met Prof David Sanders from the UWC School of Public Health (SOPH) who came to Chhattisgarh on our Community Health Workers Programme in 2008. He encouraged me to undertake a Masters in Public Health (MPH) degree at SOPH in 2010, supervised by Prof Helen Schneider. I am now doing my PhD also here at SOPH also with Prof Helen Schneider as my supervisor.

As a research focus for the PhD I will be looking at the National Health Insurance scheme which is currently being implemented in India. I will be studying issues of access and equity within social categories and poor communities. India has always had a comprehensive public health system, providing from primary to tertiary level healthcare. But there have been challenges in terms of its capacities to provide adequate and appropriate services due to issues such as human resources and under-funding.

In 2005 a new programme was initiated called the National Rural Health Mission which aimed at filling some of these gaps. So in the last nine years we do see progress in improving the capacities of the public health system. The National Insurance Scheme was introduced in 2008 and it also aimed to bring in the private sector and provide public funding to the private sector and have the service provisioning through them. As a result many challenges and problems have emerged because the government is really not strong enough to regulate the private sector which by definition is a profit making enterprise. So we are seeing increasingly cherry-picking by private sector hospitals of procedures which are more profitable to them and leaving the unprofitable illnesses and diseases to the public sector. We also see them engaging in a lot of irrational treatments. So there has been a lot of evidence around unnecessary hysterectomies performed on women who could have been treated with medication, in order to get the money. The national insurance only covers hospitalization, so a lot of the treatment which could be managed through ambulatory services are being hospitalized.

As a result the provision of health services as a result has become very skewed and our fear is that the financing is also getting skewed, something we’ve seen happening other states: more and more money is going from primary level care to secondary and tertiary level care. Which is really not a good thing because like an upside down pyramid money is moving away from primary level care.

I am here in Cape Town to attend the PhD Social Innovation in Public Health Impulse (SIPHI) capacity development programme and the SOPH Winter School course on Complex Health Systems. Just being in Cape Town and away from work and family commitments gives me the chance to concentrate on my studies and that has been very valuable to me. In terms of formulating my research questions I have had a lot of opportunity to speak to my supervisor and other academics here in the School. Attending the SIPHI classes has helped a lot in clearing the doubts; also meeting with the other PhD students sharing our trials and tribulation - has helped to build solidarity! The inputs I received from the course on Complex Health Systems has helped me very much, as I will be looking at health systems in a very comprehensive manner, and it will really help me in my future writing, research and work.

The School of Public Health is always very special to me. Over the last two weeks I have had a lot of people ask what is it about the School that brings so many people from so many places. This to me is what is unique about the School that it manages to attract people with similar pro-equity pro-poor thinking, a common global agenda, and I think that SOPH is a nodal point in the global south.

About my future: I’ve always been working in NGOs at the grassroots and at the policy level to an extent. I hope to continue with that work because it is very important to me. I also want to pursue more rigorous research which the PhD will provide me the opportunity to do. So it will be a combination!
Growth Effects of Exclusive Breastfeeding Promotion by Peer Counsellors in Sub-Saharan Africa: the Cluster-randomised PROMISE EBF Trial


Abstract

Background

In this multi-country cluster-randomized behavioural intervention trial promoting exclusive breastfeeding (EBF) in Africa, we compared growth of infants up to 6?months of age living in communities where peer counsellors promoted EBF with growth in those infants living in control communities.

Methods

A total of 82 clusters in Burkina Faso, Uganda and South Africa were randomised to either the intervention or the control arm. Feeding data and anthropometric measurements were collected at visits scheduled 3, 6, 12 and 24 weeks post-partum. We calculated weight-for-length (WLZ), length-for-age (LAZ) and weight-for-age (WAZ) z-scores. Country specific adjusted Least Squares Means with 95% confidence intervals (CI) based on a longitudinal analysis are reported. Prevalence ratios (PR) for the association between peer counselling for EBF and wasting, stunting and underweight were calculated at each data collection point.

Results

The study included a total of 2,579 children. Adjusting for socio-economic status, the mean WLZ at 24 weeks were in Burkina Faso -0.20 (95% CI -0.39 to -0.01) and in Uganda -0.23 (95% CI -0.43 to -0.03) lower in the intervention than in the control arm. In South Africa the mean WLZ at 24 weeks was 0.23 (95% CI 0.03 to 0.43) greater in the intervention than in the control arm. Differences in LAZ between the study arms were small and not statistically significant. In Uganda, infants in the intervention arm were more likely to be wasted compared to those in the control arm at 24 weeks (PR 2.36; 95% CI 1.11 to 5.00). Differences in wasting in South Africa and Burkina Faso and stunting and underweight in all three countries were small and not significantly different.

Conclusions

There were small differences in mean anthropometric indicators between the intervention and control arms in the study, but in Uganda and Burkina Faso, a tendency to slightly lower ponderal growth (weight-for-length z-scores) was found in the intervention arms. Trial registration number ClinicalTrials.gov: NCT00397150

Published: 21 June 2014
http://www.biomedcentral.com/1471-2458/14/633/abstract
Costs of Promoting Exclusive Breastfeeding at Community Level in Three Sites in South Africa

Lungiswa Leonora Nkonki, Emmanuelle Daviaud, Debra Jackson, Lumbwe Chola, Tanya Doherty, Mickey Chopra, Bjarne Robberstad, for the Promise-EBF Study Group

Abstract
Background:
Community-based peer support has been shown to be effective in improving exclusive breastfeeding rates in a variety of settings.

Methods
We conducted a cost analysis of a community cluster randomised-controlled trial (Promise-EBF), aimed at promoting exclusive infant feeding in three sites in South Africa. The costs were considered from the perspective of health service providers. Peer supporters in this trial visited women to support exclusive infant feeding, once antenatally and four times postpartum.

Results
The total economic cost of the Promise-EBF intervention was US$393,656, with average costs per woman and per visit of US$228 and US$52, respectively. The average costs per woman and visit in an operational ‘non research’ scenario were US$137 and US$32 per woman and visit, respectively. Investing in the promotion of exclusive infant feeding requires substantial financial commitment from policy makers. Extending the tasks of multi-skilled community health workers (CHWs) to include promoting exclusive infant feeding is a potential option for reducing these costs. In order to avoid efficiency losses, we recommend that the time requirements for delivering the promotion of exclusive infant feeding are considered when integrating it within the existing activities of CHWs.

Discussion
This paper focuses on interventions for exclusive infant feeding, but its findings more generally illustrate the importance of documenting and quantifying factors that affect the feasibility and sustainability of community-based interventions, which are receiving increased focus in low income settings.

Introduction
Suboptimal breastfeeding has been estimated to be responsible for 1.4 million child deaths worldwide, which represents 12% of deaths in children under 5 years of age and 44 million disability adjusted life years (DALYs). Appropriate breastfeeding can reduce the prevalence of the main causes of infant death, including diarrhoea, pneumonia and neonatal sepsis. A key element of feeding guidelines is that infants should be exclusively breastfed until they are 6 months of age.

Evidence from a systematic review suggests that Community health workers (CHW) can be effective in improving exclusive breastfeeding (EBF) rates. This international experience is confirmed in the South African context. However, the extent to which CHWs can improve EBF rates is varied. An intervention cohort study from Kwa-Zulu Natal (VTS) reported EBF rates of 76.5% and 66.7% at 5 months for HIV negative and positive women, respectively following intensive home visit support.

PROMISE-EBF a cluster randomised trial implemented in three sites (Kwa-Zulu Natal, Western Cape, and Eastern Cape) was also successful in increasing exclusive breastfeeding. However, PROMISE-EBF achieved a lower level of effectiveness than the VTS study. At 12 weeks of age, the EBF prevalence in the intervention and control arms were 10.5% and 6.2% in South Africa, with a prevalence ratio (PR) of 1.72 (95% CI 1.12-2.63). In PROMISE-EBF women received 5 visits, whereas, in the VTS study the high impact of peer support was achieved with an intensive intervention with as many as 18 visits during the antenatal
period until the infant was 6 months old. Community-based interventions and task shifting are now high on the Millennium Development Goals (MDG) policy agenda.

Large investments are being made in CHW programmes through disease specific channels; this is evidenced by the use of CHWs in HIV, TB, child health and malaria programmes. Lack of skilled health workers and recent effectiveness evidence has boosted the interest in the use of lay health workers, and many countries are again investing in national programmes. The increased interest is driven by an expectation that the inclusion of lay health workers will render health systems cost-effective by reaching large numbers of previously under-served people with high-impact basic services at low costs.

Little work has been done to estimate the cost of delivering such interventions. Economic evaluations from South Africa and Uganda have shown that stand alone individual peer support is not inexpensive. The economic evaluations from Uganda and South Africa were conducted alongside a cluster randomised trial and prospective cohort study respectively and all costs were adjusted to 2007 prices. In the Ugandan study the cost per mother counseled was US$139 and the cost per visit was US$26. The South African economic evaluation was a cost effectiveness analysis with three scenarios. First, a full scenario which was the intervention as it was implemented under research conditions. The simplified and basic scenarios had fewer visits, 6.2 and 3 visits respectively. The simplified scenario had more clinic than home visits, and the basic scenario had no home visits and was entirely clinic based. The total costs for the three scenarios were US$14 million (full scenario), US$7 million (simplified scenario) and US$2 million (basic scenario) per year in the Kwa-Zulu Natal province. The costs per month of exclusive breastfeeding for the full, simplified and basic scenarios were US$48, US$29 and US$88 respectively.

The study showed that home visits have a role in EBF promotion, and the authors recommended the simplified package. In this paper we analyse the costs of providing peer counselling through five visits at home to promote EBF up to 3 months after delivery in three South African communities. We also assessed the potential affordability of the intervention in an operational setting. This study provides evidence from an upper middle-income country in sub-Saharan Africa on costs of promoting EBF through a low intensity intervention (five visits), in a high antenatal HIV prevalence setting, where the national exclusive breast feeding prevalence is low.

doi:10.1371/journal.pone.0079784

The Lancet Correspondence...

The Child Support Grant and Adolescent Risk of HIV Infection in South Africa

Tanya Doherty, Wanga Zembe, Yanga Zembe, Natalie Leon, David Sanders

The report by Lucie Cluver and colleagues (December, 2013)1 is a welcome effort to document the effects of the child support grant in South Africa and shows the complexities of assessment of cash transfers in programmatic settings.

The Article raises several questions which would benefit from further consideration. With regard to study design, the study is described both as a case control study and as a prospective observational study. It is not clear that the same adolescents were interviewed at baseline and follow-up. It seems in table 11 as if different adolescents were interviewed, since among both sexes, from families not in receipt of the grant, there were fewer maternal and paternal orphans at follow-up and a more than 10 percentage point difference in the prevalence of both sexes living in informal housing (fewer at follow up).

This shift is fairly large over a 1 year period, which could point to other improvements in social status of these households that could affect sexual risk behaviour. The investigators conclude that this study provides evidence of feasibility and scalability of child-focused cash transfers as an HIV prevention method. We would like to add some caution to this message.
Although socioeconomic status is among the social determinants of health, it cannot realistically be expected that a small cash transfer to mothers should result, by itself, in changes in adolescent sexual risk behaviour.

There has been much discourse regarding the adequacy of the child support grant to meet even basic needs of children. At US$35, the child support grant is not likely to be used for high-value social items (e.g., clothing, hair products, mobile phones), which are known to underlie poor girls’ motivations for engaging in transactional sex. The child support grant presents immense opportunities as a policy instrument for alleviation of child poverty in South Africa, but we argue that to reach its full potential the value of the grant needs to be higher. In its current form it is not a magic bullet for HIV prevention and there is a danger in oversimplifying the complex mix of challenges of living in poverty and of solutions that might be needed to improve the health and wellbeing of vulnerable families.

We declare that we have no competing interests. Copyright © Doherty et al. Open Access article distributed under the terms of CC BY-NC-ND.

References


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