

HOLD MY HAND
POLICY BRIEF SERIES

Closing the protection gap:
The Case for a Maternal Support Grant
Investing in mothers, securing healthier
futures for children

■ OCTOBER 2025

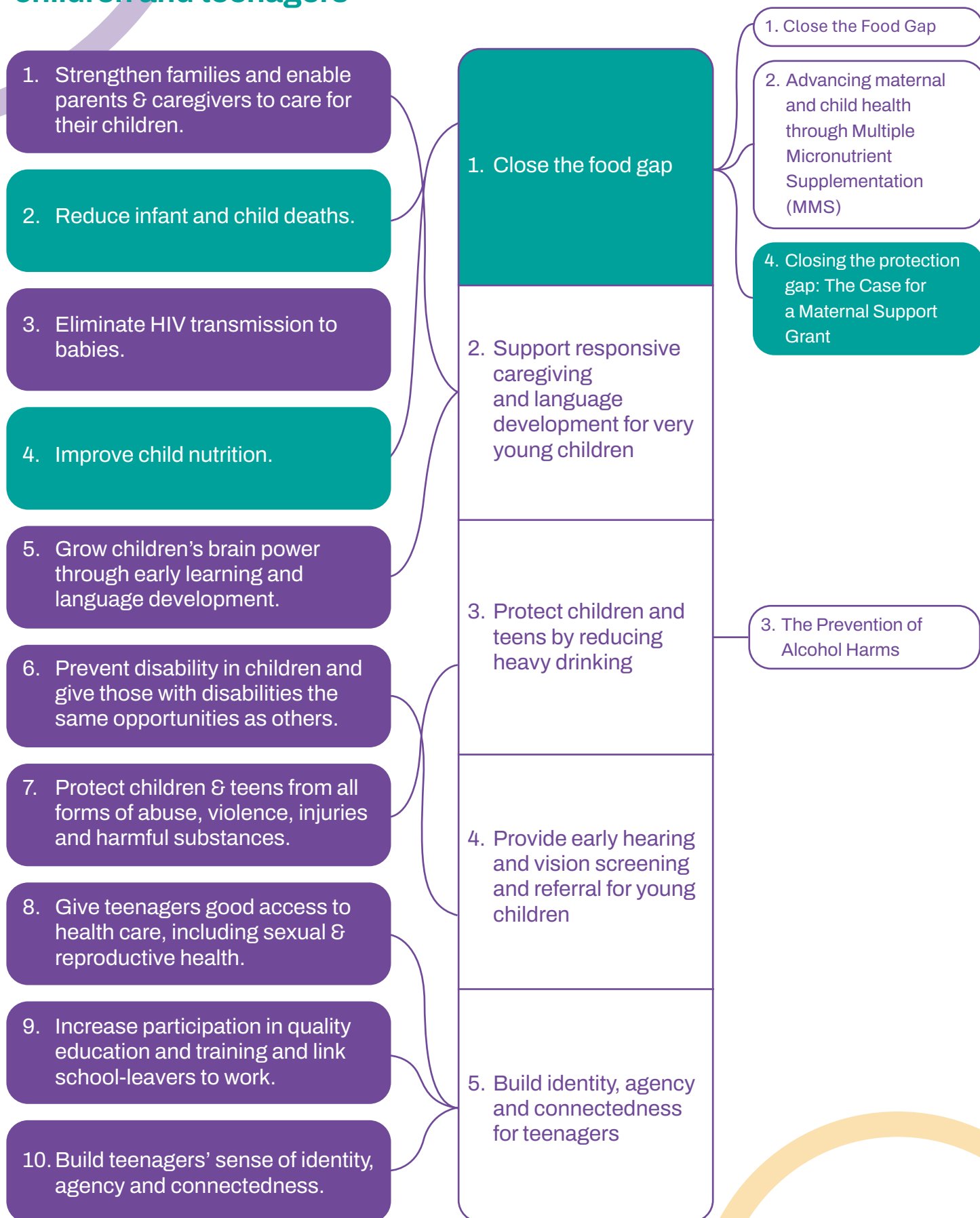


NSAAC's ten priorities to accelerate progress for children and teenagers

The Accelerators

Five Initial Strategies

Policy Briefs



Hold My Hand Accelerator

Every day, about 3 000 children are born in South Africa, 1 million every year, and their childhood experiences will shape their future and the nation's. Ensuring they thrive would unlock massive opportunities – a stronger economy and a safer, happier society. Global experience shows that progress accelerates when the President leads, society unites behind a national programme for children, and a dedicated, energetic organisation drives action. This is the logic behind the National Strategy to Accelerate Action for Children (NSAAC), led by the Presidency and the Department of Social Development. The Strategy identifies 10 key priorities and calls for broad partnerships across government, civil society, trade unions, and the private sector.

A key mechanism is the Accelerator for Children and Teens, established through a partnership between the Presidency and the DG Murray Trust. It fast-tracks critical strategies that require public-private collaboration, focusing on closing the food gap, supporting responsive caregiving and language development for very young children, protecting children and teens by reducing heavy drinking, providing early hearing and vision screenings and referrals for young children, and building identity, agency, and connectedness for teenagers.

A series of policy briefs is being developed to support this work.

POLICY BRIEF SERIES

Executive summary

South Africa faces unacceptably high rates of maternal and child malnutrition and stunting, most damaging during the first 1 000 days of life. These challenges are particularly acute for women who are poor, unemployed or working informally, many of whom live in female-headed households with little access to maternity benefits, childcare and adequate healthcare.¹

This policy brief makes the case for introducing a Maternal Support Grant (MSG) – a monthly cash transfer starting in the second trimester of pregnancy and transitioning automatically to the Child Support Grant (CSG) after birth. The grant would fill a critical gap in South Africa's social protection system, protect mothers during pregnancy, and improve child health outcomes from the earliest stages of life.

Why the MSG matters:

- **Improves birth outcomes:** Income support during pregnancy reduces low birth weight (LBW), stunting, and maternal stress, laying the foundation for healthier children.
- **Closes a protection gap:** Nearly half of infants under one are excluded from the CSG; the MSG bridges this gap by starting in pregnancy and setting the foundation for easy transition to the CSG.
- **Affordable and cost-effective:** At an additional expense of approximately R2 billion per year, the MSG could generate savings of R13.8 billion from averted health costs alone.
- **Advances equity:** Reaches women in informal work and female-headed households excluded from the Unemployment Insurance Fund (UIF) maternity benefits, reducing inequality and promoting gender equity.

While the CSG has improved child outcomes after birth, pregnant women remain without income support, leaving them vulnerable to malnutrition, stress, and poor health outcomes, which affect foetal development.²

Evidence from South Africa and globally shows that even modest income support during pregnancy improves maternal nutrition, increases antenatal care attendance, reduces the risk of LBW, and strengthens early childhood development.³

The MSG is affordable and cost-effective, with the potential to integrate into the South African Social Security Agency's (SASSA) existing systems.* The systems and evidence are in place; what is needed now is political will.

* The Social Assistance Act of 2004 and its Regulations set out the rules and procedures for accessing social grants in South Africa. To qualify, you must be a South African citizen, a permanent resident, or a recognised refugee.

Under Regulation 13(1), a caregiver applying for a child grant must provide their own ID and the child's birth certificate. These documents prove eligibility based on citizenship or legal status.

However, not all caregivers have IDs, and some children do not have birth certificates. To ensure that they are not denied access to social grants, Regulation 13(1) makes provision for an exception. If a caregiver does not have an ID, or the child does not have a birth certificate, the South African Social Security Agency (SASSA) must still accept the application. In such cases, SASSA provides the caregiver with an affidavit form to complete and sign. This affidavit is then accepted in place of the missing ID or birth certificate.

Source: UCT Children's Institute and Legal Resources Centre. 2023. *Social Grants for Children without Birth Certificates and Caregivers without identity documents*. Children's Institute. Available from: <https://ci.uct.ac.za/articles/2023-04-17-ci-and-lrc-create-resource-explaining-how-apply-child-grant-without-birth-certificate-or-caregiver>.

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The pregnancy support grant is a highly cost-effective solution for supporting expecting mothers and ensuring healthy pregnancies. With its positive impact on child health outcomes, there is a clear imperative for government to implement this grant. By investing in this program, cost savings could be leveraged. The implementation of this grant should be given high priority in public health and social policies.

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Aisha Moolla et al from the SAMRC/Wits Centre for Health Economics and Decision Science – PRICELESS.⁴

Introduction

Maternal and child health outcomes in South Africa are deeply unequal. Many women face hunger, poverty, and poor access to essential services during pregnancy.⁵ These conditions not only contribute to poor nutrition and food insecurity but also sustain South Africa's unacceptably high maternal mortality ratio, which has barely shifted in recent years (101 per 100 000 in 2022/23 to 100.6 per 100 000 in 2023/24), far off the Sustainable Development Goal (SDG) target of fewer than 70 per 100 000 by 2030.⁶

Evidence shows that food-insecure women are significantly more likely to deliver LBW babies, a key predictor of stunting and poor child development outcomes.⁷ Improving maternal nutrition and ensuring early access to antenatal care are therefore critical strategies to prevent both maternal complications and adverse birth outcomes.⁸

The first 1 000 days of life, from conception to a child's second birthday, are foundational for brain development, immunity, and long-term productivity. In this window, inadequate maternal nutrition and stress can have lasting negative effects.⁹ South African women from households reporting child hunger were about 53% more likely to deliver a low birth weight baby.¹⁰

Research from low- and middle-income countries (LMIC) shows that babies born with low birth weight are 2.5 to 3.5 times more likely to become stunted.¹¹ In South Africa, evidence indicates that the CSG helps reduce this risk: children receiving the CSG had stunting rates 31% lower than equally poor children who qualified but did not receive the grant.¹² These results are consistent with other studies in the field.

Despite this, income support through the CSG only begins after birth and often only far too late. In addition, exclusion rates are high, particularly for younger children; nearly half of children (48.3%) who are eligible for the CSG do not access it during their first year of life, when benefits can have the greatest impact.¹³

There is also substantial evidence that social grants, including the CSG, are mainly spent on essential household needs such as food, education and basic goods and services. In this way, the CSG not only alleviates income poverty and fulfils children's constitutional right to social assistance, but it is also associated with improved nutrition, health and educational outcomes.¹⁴

These benefits are most significant when children access the grant early and remain enrolled. However, barriers to access persist. These include confusion about eligibility criteria (especially the means test), lack of documentation such as identity books or birth certificates, and institutional challenges – such as the cost and time involved in reaching SASSA offices, long queues, and inadequate baby-friendly facilities.¹⁵

The MSG could serve as this crucial buffer, bridging the gap in the first months of life and ensuring that children benefit from the CSG's full potential – particularly since the nutritional, health and developmental gains are greatest when access begins as early as possible.

International evidence: what's worked elsewhere

Across Latin America and Africa, pregnancy-related income support has consistently improved maternal and child outcomes.¹⁶

Latin America: In Mexico, the Prospera programme offered conditional cash transfers tied to antenatal visits, improving maternal nutrition, clinic visits, and reducing LBW by 32%.¹⁷ Brazil's Bolsa Família linked support to routine health check-ups, improving dietary diversity, and reducing infant mortality.¹⁸ Uruguay's maternity grant reduced the incidence of LBW.¹⁹

Africa: In Kenya, the Afya programme linked transfers to antenatal care, facility delivery, and postnatal visits, increasing antenatal attendance and skilled deliveries.²⁰ In Togo, unconditional cash transfers combined with nutrition education reduced household food insecurity and LBW.²¹

These examples show that predictable income support during pregnancy improves maternal nutrition, increases antenatal care attendance, and reduces LBW. South Africa can adapt these lessons to close a critical gap in its social protection system.

The policy proposal

A 2022 Cornerstone Economic Research study estimated that a pregnancy grant could avert 59 000 disability-adjusted life years (DALYs) annually, generating significant health savings and strong economic returns relative to its cost.²² An updated 2025 study by Cornerstone evaluated the potential impact of a pregnancy grant in South Africa. It found that the MSG would reduce neonatal complications and improve birth outcomes.

Below is a detailed breakdown of the policy proposal, based on Scenario 3 in the updated 2025 study:²³

Eligibility and value:

- All pregnant women would qualify if their income is below the means test used for the CSG. In 2024, this was R62 600 per year for single applicants and R127 200 per year for married or cohabiting couples.
- The grant would apply from the second trimester through to three months post-birth, covering nine months in total. This design provides a financial bridge until the CSG is activated.
- At the 2025 CSG value of R560 per month, the total benefit per pregnancy would be R5 040.
- After birth, recipients would transition automatically to the CSG, ensuring continuity of support.

Delivery and administration:

- The MSG would be delivered through SASSA's existing infrastructure.
- Grant eligibility would be verified using the Maternity Case Record at the first antenatal visit.
- Integration of social protection and health systems is central. The Maternity Case Record, issued at the first antenatal visit, would serve as proof of pregnancy and eligibility. Linking SASSA's systems to the Department of Health's (DoH) records would enable automatic verification and encourage early antenatal booking.
- Collaboration with the Department of Home Affairs (DHA) is essential so that birth registration triggers the automatic transition to the CSG. Three-way integration – between SASSA, Health, and Home Affairs – would reduce paperwork, avoid duplicate applications, and ensure that eligible women are identified and enrolled early.

Projected reach and cost:**Design:**

- Value: R560 per month (same as the CSG).
- Duration: Nine months (six during pregnancy, three post-birth).
- Eligibility: All pregnant women below the CSG income threshold.
- Automatic transition to CSG upon registration of live birth.

Cost breakdown (Scenario 3):

Item	Amount	Notes
Gross transfers	R2.82 billion	Based on 80% take-up (800 000 women annually)
Subtract: overlap with CSG (first three months)	R878 million	Costs already budgeted under the CSG
New spending requirement	R1.92 billion	Additional cost of MSG
Administrative costs	R54–R94 million	Annual SASSA administrative cost
Administrative savings	Not applicable	About 700 000 fewer CSG applications due to automatic transition
Total estimated annual cost to government	R1.97–R2.01 billion	Net transfers and administration

How will the MSG transition to the CSG?²⁴

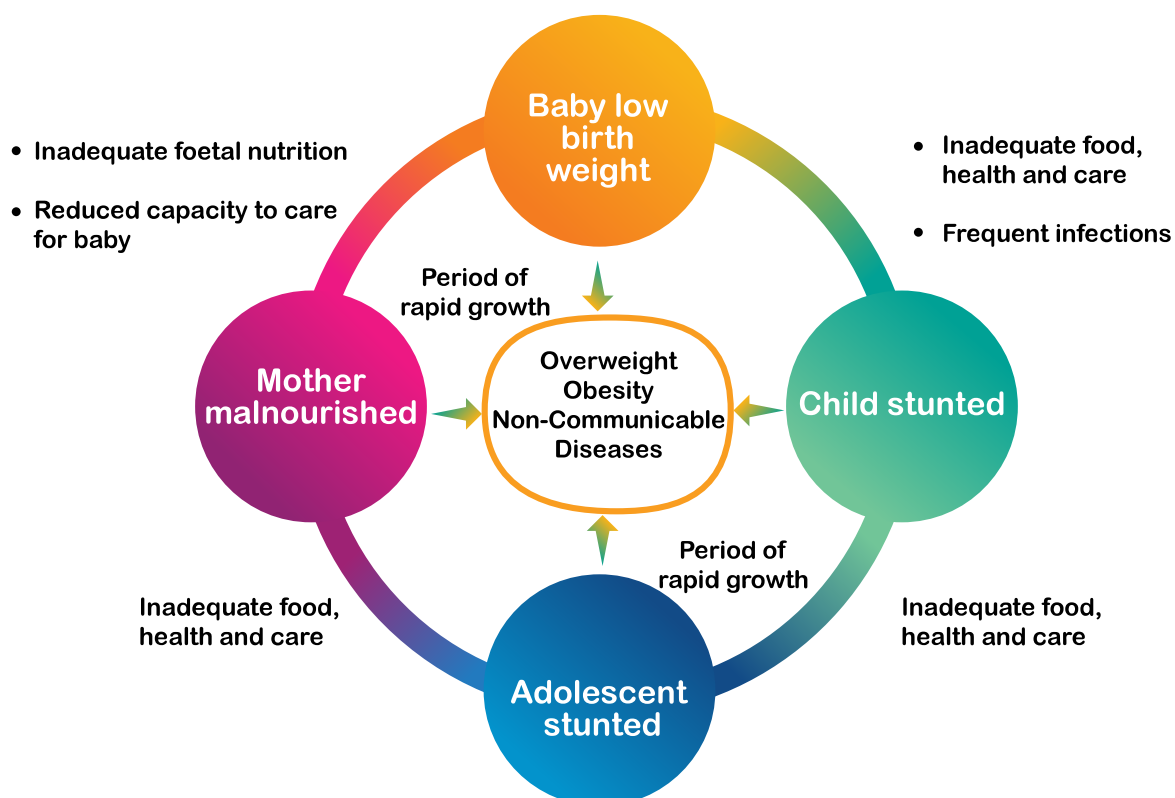
One of the strengths of the MSG design is its potential to automatically transition to the CSG. The MSG and CSG will have the same eligibility rules, meaning that all MSG recipients will also qualify for the CSG. This has the following benefits:

- **Automatic handover:** During the three post-birth months covered by the MSG, SASSA would use the mother's ID to check the Department of Home Affairs (DHA) Population Register for the newborn's birth registration. Once the child's ID is found, the MSG ends and the CSG begins – no reapplication required.
- **Reducing exclusions:** This process closes early coverage gaps.
- **Lower administrative burden:** Automatic transition would eliminate the need for around 700 000 separate CSG applications each year, saving time and resources.
- **Safety net:** If the birth is not registered within three months, MSG payments end, but families can still apply for the CSG. This encourages early birth registration.

Potential impact and benefits

Providing financial support during pregnancy improves maternal nutrition, lowers stress, and improves birth outcomes.²⁵ Research from South Africa shows that pregnant women facing food insecurity are at greater risk of delivering LBW babies, linked to later stunting, poor cognitive development, and chronic disease.²⁶

The impact of undernutrition across the life course



Source: Child Gauge, 2020²⁷

The CoCare voucher programme, implemented during the COVID-19 pandemic, provided R300 every two weeks for 16 weeks to 400 low-income women.²⁸ Despite its modest value, it improved maternal wellbeing, reduced hunger, and promoted healthier infant care. Maternal hunger decreased from 39% to 25% while maternal depression was reduced from 33% to 24%.²⁹

Economic and equity rationale

The MSG is affordable and cost-effective and delivers strong health, economic and social returns. By improving nutrition and supporting earlier access to antenatal care, the MSG lowers the risk of LBW and neonatal complications, conditions that place a heavy burden on the public healthcare system.³⁰

According to the cost-effectiveness analysis, the MSG could avert approximately 59 000 DALYs annually, reflecting improvements in survival and long-term wellbeing.³¹ Valued economically, these health gains equate to an estimated R13.8 billion – far exceeding the programme’s annual cost of approximately R2 billion.³²

At the same time, the MSG addresses major gaps in South Africa’s social protection system. Many women, especially those in informal work or unemployed, are excluded from UIF maternity benefits and often cannot afford time off for antenatal care. As a result, gender inequality is entrenched, and child health disparities worsen.³³

According to Stats SA, over 1.07 million women work informally, and 38% of households are female-headed, most of which are poorer than male-headed ones.³⁴ By reaching this group, the MSG will provide direct relief to the poorest women, reduce inequality, and promote gender equity while strengthening early child health.

Progress toward implementation

Although the MSG has been under discussion for more than a decade, it has not yet been implemented. Progress has been uneven, with early feasibility studies, moments of strong political endorsement, and ongoing fiscal concerns slowing final approval.

The timeline below highlights key milestones, from initial policy development to its current status awaiting Cabinet submission.

A timeline of relevant policy developments towards a Maternal Support Grant

2012

DSD commissioned a study, led by Dr Alex van den Heever at Wits, to explore state support for vulnerable pregnant women. This research provided key evidence on the health and economic benefits of maternal support during pregnancy.

2013

Policy brief: Dr Matthew Chersich and his team published one of the first policy briefs recommending income support for pregnant women. This brief highlighted international maternal support programmes and argued for South Africa to adopt similar measures to improve maternal and child health outcomes.

2015

The Interdepartmental Task Team (IDTT), led by DSD and the Department of Health, was formed to evaluate integrating maternal support with health services. Supported by SASSA, other government departments, and global organisations, it aimed to connect pregnancy-related services across government following a pivotal workshop.

2016

The Children's Institute's Child Gauge report, with Van den Heever's analysis, highlighted how prenatal support improves childhood outcomes and reduces poverty. Chersich further contributed with insights from 27 international pregnancy support programmes, strengthening the case for the MSG.

2018

A Reference Group led by DSD and the Department of Health released a discussion paper on maternal benefits. This paper provided the rationale for the MSG, and the need for such a grant was included in the Medium-Term Strategic Framework for 2014-2019. However, formal policy development did not immediately follow.

2020

In response to Covid-19, Grow Great launched the CoCare voucher programme, providing food vouchers to low-income pregnant women in the Western Cape. The initiative improved maternal mental health and food security, showcasing the MSG's potential impact.

2021

Debbie Budlender, commissioned by DGMT, crafted an investment case for the MSG, proposing a grant comparable to the CSG from the second trimester. Her analysis underscored potential healthcare savings and significant economic benefits.

2022 - 2023

The DSD held 27 national consultations with government bodies, civil society and beneficiaries. Feedback from the sessions refined the draft MSG policy and strengthened multi-sectoral support as a complement to the CSG.

2023

The South African Law Reform Commission (SALRC), with Cornerstone Economic Research, proposed a grant for pregnant women. Cost estimates ranged from R1.89 billion to R3.26 billion, depending on the eligibility period and number of payments. The report highlighted the health and socio-economic benefits of early parental support and recommended a phased rollout starting in 2025 for feasibility.

February 2024

Dr Aisha Moolla and colleagues' study on the cost-effectiveness of a grant for pregnant women projected savings of R13.8 billion by reducing low birth weight and improving neonatal outcomes. This research bolstered the economic case for the MSG and its inclusion in national budgets.

May/June 2024

Grow Great assisted the DSD in requesting updated MSG costing and comparative analysis from Cornerstone Economic Research. Using the latest population data, this analysis aimed to strengthen the MSG case for its final Cabinet submission.

October 2024

Grow Great officially launched the MSG Advocacy Coalition, partnering with organisations like DGMT, SAMRC/Centre for Health Economics & Decision Science – PRICELESS SA, Embrace, HEALA and Ilifa Labantwana. Their first meeting produced a strategy for public and legislative advocacy, showcasing strong, organised support for the policy.

Next Steps

The draft MSG policy document is awaiting Cabinet review, followed by public consultation. This step is crucial for final approval.



History: DSD began developing the grant in 2012, commissioning a feasibility study that led to consultations and a proposal for a conditional grant linked to antenatal care.³⁶

Presidential support: In September 2022, President Cyril Ramaphosa endorsed the 1 000 Days Campaign and announced that it would include a maternal support policy, to be finalised and presented to the relevant structures.³⁷

Policy status: Despite fiscal concerns raised by the National Treasury³⁸ and questions from parliamentarians,³⁹ DSD confirmed in September 2024 that the MSG had been adopted as an official policy initiative.⁴⁰

Next steps: In its 2024/25 Annual Performance Report, DSD reported that the draft policy was in its final stages, awaiting submission to Cabinet and subsequent public consultation.⁴¹



Provincial innovation: Western Cape pilot

Although the MSG has not yet been implemented nationally, provincial pilots provide useful lessons. The Western Cape's Khulisa Care pilot is currently generating evidence for how targeted maternal nutrition and support can be delivered through health and community systems, highlighting the feasibility and added value of a national grant.⁴²

The Western Cape Department of Health and Wellness announced Khulisa Care in April 2025 as a pilot programme to reduce stunting by addressing maternal undernutrition and low birth weight before and after birth. The programme was co-created by the Department of the Premier, the Department of Health, DG Murray Trust and Grow Great, with Shoprite coming on board as the retail partner. It has been rolled out in Breede Valley, Khayelitsha, and Mitchells Plain – areas with high maternal and child vulnerability.⁴³

Khulisa Care is not equivalent to the MSG. It is a targeted health intervention, using nutrition support, behaviour change communication and enhanced care for a defined group of pregnant women and new mothers.

The pilot started in Breede Valley in July 2025 and followed a staggered roll-out in Khayelitsha and Mitchells Plain. It targets three priority groups:

- Underweight pregnant women
- Women at risk of delivering LBW babies (under 2.5kg)
- Mothers who give birth to babies under 2.5kg⁴⁴

Its primary goal is to prevent LBW and ensure that mothers of vulnerable babies receive timely support to help their children grow and thrive in the first six months of life.⁴⁵ Participants receive monthly nutrition support for 10 protein-rich foods, redeemable at Shoprite, alongside enhanced care from community health workers, including growth monitoring, breastfeeding counselling, mental health support and maternal health education.⁴⁶

Monitoring and evaluation will assess the impact of the programme over the period of the beneficiary eligibility, which may be up to 12 months depending on enrolment date. It will also examine the potential for scale up.⁴⁷

While Khulisa Care differs from the proposed MSG, it reinforces the core argument: increased care, along with financial and nutritional support during pregnancy improves maternal and child health outcomes. A national MSG would provide universal income support, while pilots like Khulisa Care can continue as complementary, targeted interventions. Together, they point to a scalable model for reducing stunting and maternal undernutrition nationwide.

What needs to happen next?

Despite more than a decade of research, consultation, and policy drafting, the MSG has yet to be implemented. The draft policy must now be updated taking into consideration comments from the Social Protection, Community and Human Development (SPCHD) Cluster, then submitted to Cabinet and subsequent public consultation. National Treasury has raised fiscal concerns, but evidence shows the MSG is affordable, scalable and cost-effective. The main barrier is political inaction, not lack of evidence.

To move forward, five priorities must be addressed:

1. Political commitment and approval

DSD must table the MSG before Cabinet without further delay, and Parliament must begin the process of amending the 2004 Social Assistance Act to include pregnancy as a recognised category, as recommended by the SA Law Reform Commission.⁴⁸

2. Treasury buy-in

Support must be built at the level of Treasury, highlighting the grant's long-term health savings and economic returns.

3. Phased implementation

Follow a phased rollout (Cornerstone Scenario 3):⁴⁹

- Year 1 pilots in high-need provinces such as KwaZulu-Natal, Eastern Cape, and Limpopo, reaching around 20% of eligible women.
- Expand annually with national coverage achieved by year 5.
- At full scale, the grant would reach approximately 800 000 pregnant women (80% take-up rate) annually.
- Provide nine monthly payments (six during pregnancy and three post-birth), after which the grant would transition automatically to the CSG.

This design avoids payment gaps in the first months of life, reduces administrative burden through automatic transition, and ensures that the programme is affordable, with an estimated net new cost of around R2 billion per year.

4. Interdepartmental collaboration: closing system gaps

Implementation requires coordination between DSD/SASSA, the DoH, and the DHA:⁵⁰

- DSD/SASSA: administer the grant, process applications, and ensure a smooth transition to the CSG.⁵¹
- Health: verify pregnancy through the Maternity Case Record and provide grant information at clinics.
- DHA: ensure timely birth registration to trigger transition to CSG.⁵²

Current gaps – late birth registration, weak system integration, high administrative burdens, and lack of ID support for vulnerable women – must be addressed to ensure continuity of support.⁵³

5. Monitoring and accountability

- Track uptake, health outcomes, and cost-effectiveness, and use results to refine and scale.
- Position the MSG as a constitutional obligation to close the pre-birth protection gap, and strengthen the overall social protection system.

Conclusion

The evidence is clear: a Maternal Support Grant is one of the most cost-effective strategies to improve birth outcomes, reduce stunting, and strengthen South Africa's human capital. By targeting women most affected by poverty and food insecurity, the grant addresses both health and equity gaps.

The systems, pilots, and policy groundwork are already in place, and the cost-effectiveness is proven. What is missing is the political will and interdepartmental coordination to deliver. Implementing the MSG would close the pre-birth protection gap and affirm South Africa's constitutional commitment to dignity, equality, and social protection for all mothers and children.

Suggested Citation:

Closing the protection gap: the case for a Maternal Support Grant. 2025. (Hold My Hand Policy Brief 04). Cape Town: Hold My Hand. Available from: <https://holdmyhand.org.za>.

Acknowledgements: Written by Phylicia Oppelt (DGMT) with contributions from Rahima Essop and the Hold My Hand Accelerator Team. We are grateful for reviewer insights provided by Liezel Engelbrecht.

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tomorrow and the next day
and the next....
had enough love, enough food,
enough safety and brain power.

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