POLICY BRIEF

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A POOR START IN LIFE PREDICTS POOR LIFE OUTCOMES:

Investigating the potential impact of maternity and early child support in South Africa

Source:

This policy brief was compiled from a report produced for the Department of Social Development entitled "State maternity and early child support - Investigating the potential impact of maternity and early child support in South Africa: An Options Assessment"

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Introduction

Though pregnancy is a normal life occurrence, it marginalises vulnerable women and children by reducing their income-generating potential and by introducing a host of new financial needs. There is evidence that poor pregnant women are at high risk of malnutrition, which can have lifelong effects on children through disability, short stature, cognitive delay and poor academic achievement among other things. Major causes of maternal deaths and still births are low utilisation of and delay in seeking antenatal and childbirth services.

The Department of Social Development's (DSD) comprehensive social security system for the poor does not cover maternity benefits for unemployed women or those in the informal sector. Internationally, over 30 countries provide maternity and early childhood support. Mexico has seen a substantial reduction in maternal and infant mortality, with notable long-term impacts on human capacity. Experience in over 30 countries shows that maternal cash transfers are predominately spent on food. South Africa can markedly enhance human capital and avert several costs for the state by investing in early childhood development which is highly cost-effective. For example, improved maternal nutrition lowers the risk for treating costly low birth weight infants.

Recommendations:

- Appropriate maternity and early child support could give children the best possible start in life, reduce inequities stemming from pregnancy and alleviate family poverty.
- Maternity and early child support is needed for households in poverty during pregnancy and for newborns, and to promote longer-term, accumulated social and economic benefits in children and vulnerable women. This will enhance the life chances of current and future generations.
- Proactive communication must counter the invalid but widely held notion that maternity and early child support would encourage pregnancy and increase birth rates, especially among teenagers; or that funds would be misused and spent on non-essential or luxury items. There is a large body of evidence that discounts these perceptions.
- Careful messaging is required, focused on "ensuring healthy newborns", "promoting equity" and "securing maternal health". The formal sector recognises that pregnancy markedly curtails women's earning potential, yet not such benefits exist for unemployed women or those in the informal sector. The grant will acknowledge the immense, but under-appreciated social and economic value of women's role in childbearing and rearing.
- It is best to begin with a phased approach to the implementation of a comprehensive programme of interventions. The basic package could be implemented immediately. The comprehensive package is a medium- to long-term goal, within a period of 5 to 7 years.

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Better nutrition in pregnant and postpartum women would also help to promote breastfeeding, especially among HIV-infected women. State support could reduce stillbirths and infant deaths, and improve growth of children from the foetal period through the first year. Maternity support might also reduce vulnerable women's need for termination of pregnancy. The state would save costs of HIV treatment for children and reduced blood transfusions and other associated consequences of maternal anaemia. Incentives for earlier attendance at antenatal clinics would improve pregnancy outcomes, especially for the 30% of pregnant women who are HIV-infected, as early initiation of antiretroviral prophylaxis in pregnancy markedly lowers the chances of transmitting HIV to children (each additional week of antiretroviral drugs substantially reduces transmission risk). (*See Annexure 1 for a summary of benefits of maternity and early childhood support)*.

Research Methods

We held in-depth interviews with pregnant women at a public-sector antenatal clinic, key informant interviews, and focus group discussions with health workers and policy makers from national and provincial departments, including the Departments of Education, Health (DoH) and Social Development (DSD), and the South African Social Security Agency. We analysed the General Household Survey, comparing pregnant women with non-pregnant women and other population groups. After reviewing outcomes of pregnancy support in other 30 countries, we appraised and costed potential policy options and likely benefits to the DSD.

Findings

Pregnancy poses significant health, social and economic challenges for women who are already in socially vulnerable positions prior to pregnancy. This includes women who are unemployed (or informally employed), low-income earners, women who have low education levels and those who are principally responsible for supporting all dependants (adult and children) in their homes. Pregnancy introduces **financial pressures** on households through maternal inability to work; increased volume and variety of food needed for pregnancy and breastfeeding; travel costs for additional health visits; and costs of a new child and childcare. Transport to health facilities, supplies and other costs around childbirth total about R320, double in rural areas. Without state support, inequities in maternal health and early childhood outcomes continue, and progress towards health and social goals will remain slow. Participants agreed that state support for pregnant women, through food parcels, vouchers, a cash grant or a combination of these, would contribute positively to the health and broader socio-economic outcomes of pregnant women. **Nutrition outcomes** particularly would benefit both mother and child. State support would **empower women** to nurture their newborns in the first critical years, and maximise their maternal health during pregnancy. While women are pregnant for up to nine months, the health, social and economic consequences go beyond birth to the child's first years of life. Children would achieve **normal cognitive development and physical growth**.

*International studies show that as maternal nutrition improves, **attendance at health facilities rises**, with large gains in **foetal and young child growth**, and in **maternal health** and wellbeing. As with the Child Support Grant (CSG), this support would not significantly influence women's decisions about **fertility**.*

Such support is in line with DSD's priorities and related government strategies. It would extend the impact of the CSG, which currently begins too late for many children. The earlier in a child's life the CSG starts, the greater its impact on child growth, with even higher gains the earlier support begins in pregnancy. Improving maternal and child health are key health Millennium Development Goals (MDG) and an important priority for the Department of Health (DOH). Maternal grant would develop linkages between the services provided by DSD, the Department of Health (DOH) and other sectors.

Policy Options Considered

The policy framework is underpinned by three broad inputs: income support, advice and services, and the incentivised use of related health and education services.The resulting outputs are seen on two levels: empowering women and providing support to children at a pivotal point. The policy option appraisal ranges from a basic approach to more comprehensive options.

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Table 1: Summary of packages of interventions

	Interventions
Basic Package	• Cash grant for 6 months during pregnancy (pregnancy grant or PG). Cash grant for 12 months post-delivery (post-delivery grant or PDG). • Call centre support for pregnant women.
Enhanced Package (In addition to basic package)	• The increment to the PG for use of antenatal clinic services for 6 months pre-delivery. • The increment to the PDG for use of postnatal clinic services for 12 months post-delivery.
Comprehensive Package (In addition to enhanced package)	• Food parcels or vouchers replacing the cash equivalent for 6 months pre-delivery. • Food parcels or vouchers replacing the cash equivalent for a period of 12 months post-delivery. • Crèche support as a conditional cash allocation for all women in the target group for a period of 12 months post-delivery. With time, this crèche support is paid directly to the crèche for a period of 12 months, replacing the cash amount paid to the mother.
Excluded for now	• CSG increment for use of family planning services. • Schools and Higher Education Institutions (HEI) support mother's return to education. • Advice offices operating though schools, HEIs, Labour centres and SASSA.

Administratively, cash transfers are the least burdensome means of social support. They would meet the wide ranging and shifting needs of pregnant women and their unborn children. To avoid perverse incentives of falling pregnant to access the grant, payments would occur after childbirth. This would cover the gap between childbirth and the initiation of the CSG, and provide critical support for breastfeeding. Operationally, maternity and early child support could be an extension of the CSG rather than a "new" grant. The grant would be registered in the pregnant woman's name, similar to the CSG "primary caregiver notion", and convert to a CSG after birth.

Financial Implications

Potential costs of maternity and early child support vary considerably, depending on the package provided (See Figure 1).

The simplest form entails giving the present CSG value (R280) for the final 6 months of pregnancy for about 900 000 of the 1.2 million women pregnant each year. This would incur annual costs of R1.5 billion, with the grant converted into a CSG following childbirth. This assumes 100% uptake among those eligible; a 4% administrative overhead; all women apply for the grant at 3 months' pregnancy; and a CSG means test to determine eligibility. Discretionary cash support for adults is about R1 200 per month (for 6 months of pregnancy, 12 months postpartum). Together with a call centre for ongoing advice, this would cost R9.3 billion, and R4.6 billion at R600/month. The most comprehensive package requires R24.6 billion, which includes additional cash for food and transport support, increments for attending antenatal and postnatal care, and crèche support of nearly R10 billion.

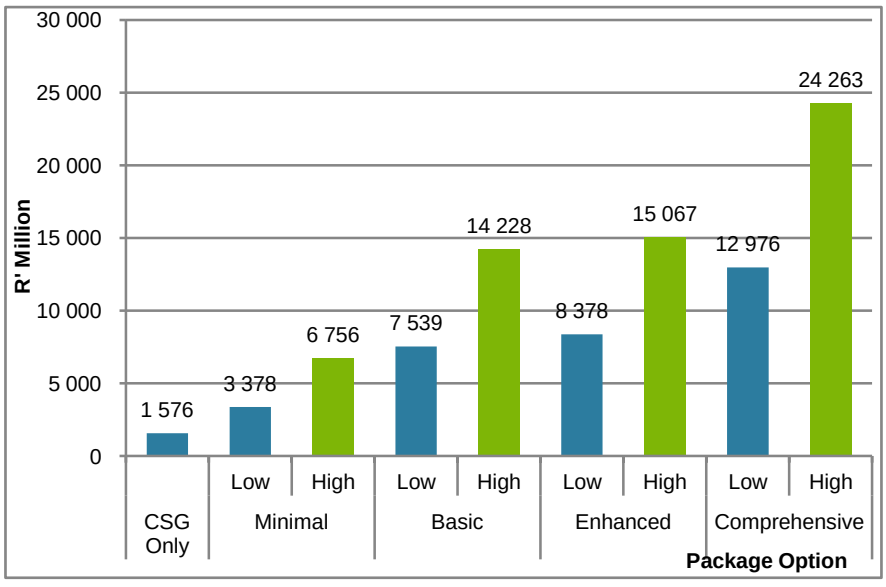

Figure 1: Headline cost estimates by package option. Low and high valuations (R' million, 2012 prices)

Summary and Conclusion

- A maternity and early child grant could reverse the adverse effects of poverty, unemployment and inadequate education among vulnerable women. It could avoid costs for the state presented by low birth weight infants and inadequate maternal nutrition.
- A multi-sectoral response is required for the multi-faceted vulnerabilities faced by poor pregnant women. The grant is fully aligned with DSD priorities and government strategies.
- A low and high valuation of the benefit framework, from a basic (start-up) to a comprehensive package, suggests a range from R7.5 (basic at low valuation) to R24.3 billion (comprehensive at high valuation) which includes crèche support of about R10 billion per annum.
- To limit inter-departmental implications, DSD should complete the proposed intervention framework for implementation through the South African Social Security Agency (SASSA). Departments that need to perform some verification (e.g. pregnancy) for a benefit entitlement include those predominantly responsible for the health and education functions.
- The intervention should begin modestly, followed by scale-up with deepening benefits within affordability constraints.

Annexure 1:

Table 2: Summary of benefits of maternity and early childhood support

Benefit category	Type of benefit	Description of impact
Maternal nutrition	Maternal weight gain and anaemia	More women gain weight necessary for healthy pregnancy, but also some rise in maternal obesity in 2 studies. Reduced maternal anaemia. Improved maternal nutrition can lower maternal anaemia by 39%.
Gender relations	Women's position within household	Increases in women's bargaining power and intra-household decision making, and reduced domestic violence. Long-term support increased marriage rates by 4%.
Equity	Targeting and impact on poor	Successfully targeted poor in most instances. Size of impacts generally higher in poor than other groups.
Health service utilization	ANC attendance	Rise in ANC attendance in 8 studies[1], ranging from 19% in a trial in Honduras[2] to 65% in Peru[3], and four-fold increase in Bolivia[4]. No or minimal change in 2 studies.
	SBA coverage	Rose in Bangladesh 3.6 fold[1] and in 4 other countries. Also improved timeliness of access to services in childbirth.
Health services quality	Quality of care	Low quality health services limits the benefits gained by higher patient demand for services. However, more empowered, informed and proactive patients, demanded higher-quality services, thus improving service quality.
Maternal health and wellbeing	Maternal mortality	Grant reduced maternal mortality by 11% in Mexico[5].
	Physical and mental stress	Women more able to rest in late pregnancy, with reduced physical and mental stress.
Child health	Stillbirth rate	Improved nutrition can reduce stillbirths 45%[6].
	Birth weight	Mexico trial showed 127 gram rise in birth weight from the grant[7]. Reduction in low birth weight (<2500 grams) varied from 5% in Mexico[7], 15% in Uruguay[8], 0-30% in USA, to 40% in black recipients in USA[9]. In Columbia, newborn weight rose in urban, but not rural areas. Improved nutrition during pregnancy can reduce low birth weight by 16%[10].
	Premature and small for gestation babies	No effects on prematurity in Uruguay, but in USA marked reductions. Also, with each 10% increase in duration of support in USA, risk of a full-term small-for-gestation baby dropped 2.5%[11]. Improved nutrition in pregnancy can reduce small-for-gestation babies by 14-32%[10].
	Infant growth	Infants in intervention arm of Mexico trial were 1.1 cm taller and had less childhood anaemia[12]. In USA, infants of grant recipients were much more likely to have normal weight and length, and 2-fold more likely to be perceived as having good health than non-recipients[13].
	Newborn and infant survival	USA grantees had lower infant mortality rate, 11% lower in Mexico. India grant lowered perinatal deaths by 3.7/1000 and neonatal deaths by 2.3/1000[14]. Improved maternal nutrition can reduce neonatal mortality by 38% and infant mortality by 22%[10].
	Child growth and development	Offspring of women receiving grant in Mexico had higher height at 24-68 months, less stunting and fewer were overweight[15]. Grants increased childhood motor and cognitive development, and receptive language abilities[16]. In Brazil, children from families who received a grant were 26% more likely to have normal height and weight[17]. In South Africa, children beginning CSG in infancy had 0.45 higher height-for-age Z score than other children[18].
	Human capital and long-term development	South African research shows height at 2 years is best predictor of human capital, and damage suffered in early life leads to permanent impairment, and affects future generations[19]. Improving child nutrition during infancy and before 3 years can raise adult income by 46% in men [20].

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