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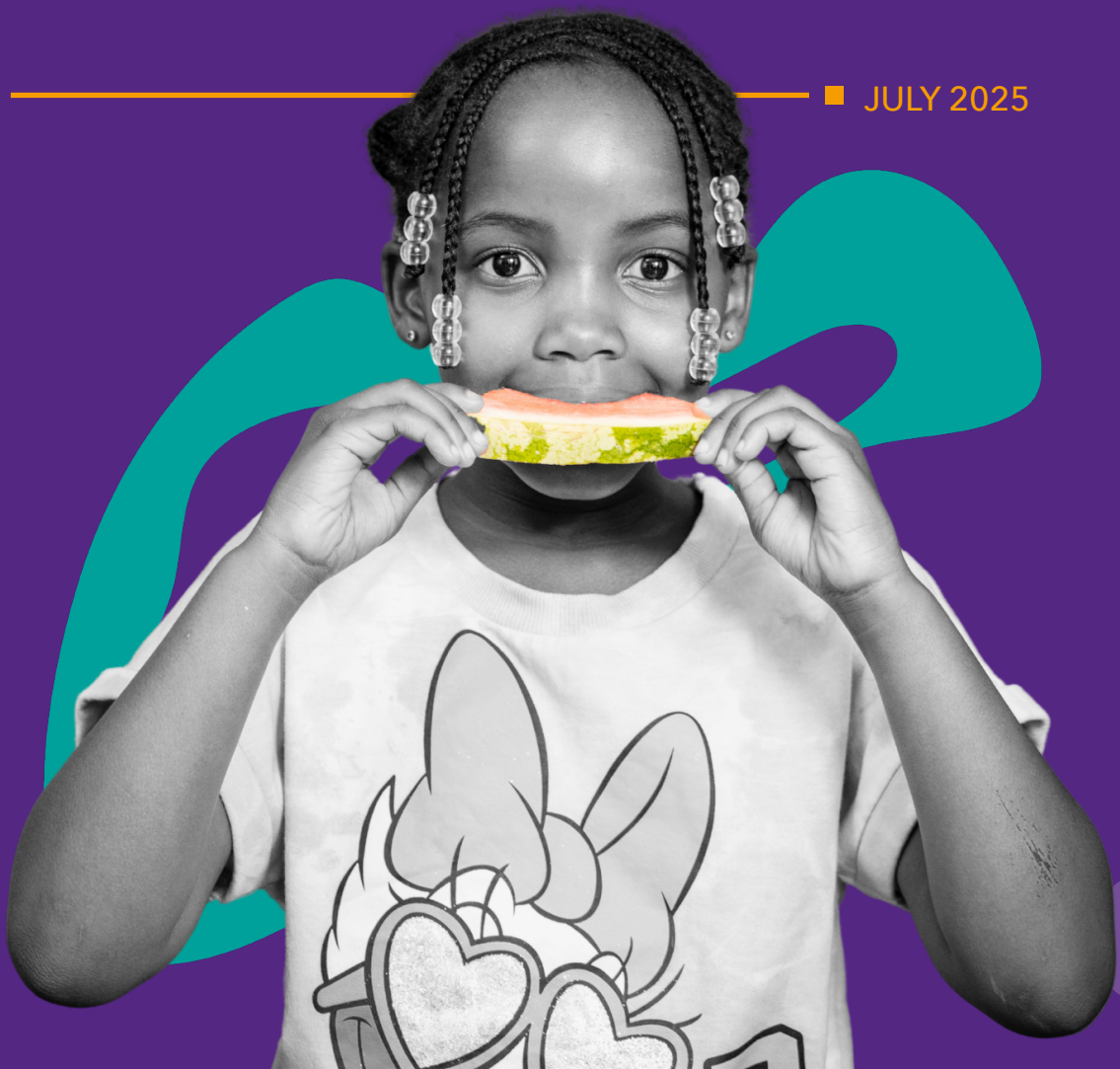
POLICY BRIEF SERIES

Closing The Food Gap

JULY 2025



01

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

1. Strengthen families and enable parents & caregivers to care for their children.
2. Reduce infant and child deaths.
3. Eliminate HIV transmission to babies.
4. Improve child nutrition.
5. Grow children's brain power through early learning and language development.
6. Prevent disability in children and give those with disabilities the same opportunities as others.
7. Protect children & teens from all forms of abuse, violence, injuries and harmful substances.
8. Give teenagers good access to health care, including sexual & reproductive health.
9. Increase participation in quality education and training and link school-leavers to work.
10. Build teenagers' sense of identity, agency and connectedness.

The Accelerators

Five Initial Strategies

1. Close the food gap
2. Support responsive caregiving and language development for very young children
3. Protect children and teens by reducing heavy drinking
4. Provide early hearing and vision screening and referral for young children
5. Build identity, agency and connectedness for teenagers

Policy Briefs

1. Close the Food Gap

Hold My Hand Accelerator

Every day, 3 000 children are born in South Africa, which equates to 1 million every year whose childhood experiences will shape both 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 Hold My Hand Accelerator for Children and Teens, established through a partnership between the Presidency and DGMT. 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, beginning with this overview of Closing the Food Gap, is being developed to support this work.

POLICY BRIEF SERIES

Introduction

Food security is the foundation of a thriving society and economy. It exists when all people, at all times, have physical, social and economic access to sufficient, safe, and nutritious food that meets their dietary needs and preferences for an active and healthy life. This definition includes four key dimensions: availability, accessibility (financial and otherwise), utilisation (by your body) and stability (of supply).[1]

Without it, South Africa cannot prosper. Despite producing enough food to feed its population, over 45% of the country's food supply goes to waste; at the same time, one in three children lives in a household unable to meet basic nutritional needs.[2] The Child Support Grant, a lifeline for millions, falls far below the food poverty line, leaving 23% of children in severe food poverty and at risk of life-threatening malnutrition.[3]

Malnutrition is South Africa's most pressing child health crisis. The incidence of severe acute malnutrition among children under five had been steadily declining – from over 10 per 1 000 children in the early 2000s to below 5 per 1 000 by 2010 and further down to 1.5 per 1 000 in 2020. However, this progress has been sharply reversed in recent years.[4]

Between 2020/2021 and 2021/2022, the incidence of severe acute malnutrition increased by 33% nationwide. By mid-2023, the Department of Health reported another 20% rise, with cases growing from two per 1 000 children in 2021/2022 to 2.4 per 1 000 in 2022/2023. In addition, the 2023 child death statistics show that of all children who died, 1 457 (7.5%) were because of moderate and severe acute malnutrition.[5]

Stunting – when a child is too short for their age – is a key indicator of chronic malnutrition and remains persistently high in South Africa, affecting more than 25% of children under five.[6] Stunting affects cognitive and physical development and puts the child at risk of chronic disease later in life. This doesn't just harm individual children – it weakens the economy. If eliminated, stunting could add R80 to R90 billion annually to the economy by enabling children to reach their full potential.[7]

Stunting begins in the womb, often driven by inadequate maternal intake of key macro- and micronutrients such as protein, iron and essential vitamins and minerals. This can result in low birth weight, a strong predictor of stunting and other adverse birth outcomes.

After birth, exclusive breastfeeding for the first six months is critical for optimal infant nutrition and to prevent risks related to breastmilk substitutes, such as hygiene-related disease, increased susceptibility to infections, loss of immunity acquired through breastmilk and suboptimal intake due to high-cost breastmilk substitutes. However, food-insecure mothers, who also have increased energy needs during lactation, are less likely to breastfeed, with contributing factors including stress and poor mental health. This raises the risk of early malnutrition which, if persistent, can lead to stunting. From six months to two years, a child must receive a diverse and nutrient-rich diet to support healthy growth and brain development. Without adequate food, even the best early stimulation efforts will fall short.[8]

With protein-rich and nutrient-dense foods often out of the financial reach of economically vulnerable people, it is no wonder micronutrient deficiencies are widespread.

For example, over 60% of children under the age of five are affected by anaemia.[9] Iron deficiency is the most common cause of anaemia. Iron, found in protein rich foods such as fish, chicken, lentils and nuts, is essential for red blood cells to deliver oxygen to the rest of the body and is necessary for brain development and growth in children. Deficiencies in other critical nutrients such as vitamin A, folate and zinc further compromise growth and immune function.[10]

Poor living conditions further compound the problem by increasing the risk of diarrhoea and gut infections, which impair the body's ability to absorb nutrients. This highlights a critical yet often overlooked dimension of food security – the body's capacity to effectively utilise the food consumed. It is estimated that up to a quarter of the global stunting burden can be linked to children experiencing five or more episodes of diarrhoea within their first 1 000 days of life, with the risk rising with each episode before 24 months.

At the same time, South Africa faces an alarming rise in child obesity, with rates reaching 22%.[11] This is fuelled by diets dominated by ultra-processed foods and refined starches, which are more affordable than nutrient-dense protein sources. The result is a dual burden of malnutrition, where undernutrition and obesity coexist, threatening the health and future potential of millions of children.

Closing this food gap, starting with children and adolescents and then expanding to the broader population, requires decisive action. Key solutions include making protein-rich and nutrient-dense foods more affordable, increasing families' purchasing power through child-centred social protection and strengthening local food production and supply chains. Collaboration across government, industry and civil society is imperative to ensure that no child in South Africa goes hungry.

The current situation

Section 28 of South Africa's Constitution guarantees every child the right to adequate nutrition. Yet, millions of children are at risk of lifelong harm due to circumstances beyond their control.

According to the Pietermaritzburg Economic Justice & Dignity Group, as of May 2025, the cost of a basic nutritious diet for a child stood at R980 per month, while the Child Support Grant is only R560.[12] This leaves families 33% below the Food Poverty Line, estimated at R840 for 2025[13] and 43% below the minimum cost of a nutritious diet.[14] Simply put, families cannot afford enough protein-rich, nutritious food for their children.

Food insecurity is rising, with households experiencing moderate to severe food insecurity. This has increased from 15.8% in 2019 to 16.2% in 2022 and 19.7% in 2023. Female-headed households are disproportionally affected, with rates climbing from 17.2% in 2019 to 21.5% in 2023.[15]

The consequences are devastating. Severe acute malnutrition, when a child is severely thin, leads to about 15 000 children being hospitalised and 1 000 deaths annually.[16] Stunting, a form of chronic malnutrition, affects over a quarter of children under five, permanently impairing their cognitive and physical development.[17]

STRATEGIES TO CLOSE THE FOOD GAP

The Accelerator proposes a set of practical, scalable sub-strategies to ensure children have access to nutritious food. These focus on three key areas:

- **Affordability**: Lowering the cost of protein-rich foods through subsidies, industry collaboration, and targeted discounts can reduce the gap between the value of the Child Support Grant and the minimum cost of a nutritious diet for a child. This can improve affordability and access for low-income households, increase dietary diversity, reduce food insecurity, and support healthy growth and development in young children.
- **Availability:** Strengthening local food production and distribution while reducing food waste through surplus food redistribution.
- **Quality**: Enhancing food fortification, monitoring and regulation, and consumer awareness to improve nutritional value.

Additionally, targeted mother-and-child initiatives aim to support the most vulnerable to reduce risk factors for cognitive and physical developmental consequences. These include:

- **Maternal Support Grant (MSG):** Providing financial assistance to pregnant women for essential nutrition and healthcare needs;
- **Multiple Micronutrient Supplementation (MMS):** Improving maternal and child health through enhanced micronutrient intake; and
- **Cash plus care model to address low birth weight (LBW) in babies:** A targeted strategy combining direct food support and high-dose community health worker visits to underweight pregnant women, women at risk for delivering LBW babies, and mothers of low birth weight babies to prevent and rehabilitate LBW babies.

1. Affordability: Double discounting protein-rich foods

The government and retailers should collaborate to make 10 protein-rich foods significantly more affordable. A targeted "double-discount" – championed by DGMT and Grow Great and contained in the Medium-Term Development Plan 2024-2029 as a strategic intervention to reduce poverty and improve livelihoods[18] – would reduce the cost of 10 nutritious foods that will make eating a balanced diet more within reach of low-income households. These include lentils, beans, fortified maize, eggs, full cream milk, amasi, soya mince, pilchards and peanut butter.

This is a cost-sharing mechanism in which both retailers and government contribute to lowering the price of key nutritious foods. Retailers and manufacturers reduce margins or forgo profits, while the government matches this effort with targeted subsidies, making healthy foods 20-25% more affordable for consumers.

The estimated cost to the National Treasury would range between R3 billion and R5 billion per year, comparable to the revenue loss from a broader VAT exemption.

This would need to be accompanied by appropriate monitoring and accountability mechanisms to ensure effective safeguards are in place.

To enable this, we must:

- develop a clear policy framework to guide funding, incentive structures and roles for both government and industry.
- establish monitoring and accountability mechanisms to track food price reductions and industry compliance.
- monitor prices to compare subsidised and non-subsidised products.
- create public awareness to promote discounted products and healthier food choices.

2. Availability:

a. Strengthening local food systems

A robust local food system is essential for ensuring nutritious food reaches all communities. Systemic barriers such as poor infrastructure, high transport costs and market inefficiencies prevent food from reaching those who need it most. Rural areas and informal settlements are particularly affected, as residents struggle to access fresh, affordable and nutrient-dense foods. Provincial and local governments, alongside civil society, must build an inclusive food system. Sustaining local food production not only requires improving local supply chains, but also stimulating demand for nutritious, locally produced food that supports health and livelihoods.

To close this gap, we must:

- invest in small-scale and community-based agriculture, particularly agroecology.
- strengthen systems-level coordination with the Department of Agriculture, Land Reform and Rural Development to ensure context-relevant support for smallholder farmers, particularly in nutrition-sensitive and agroecological practices.
- support smallholder farmers with training, finance and market access.
- support the development and scaling of agri-hubs, cooperatives and farm-to-market programmes to strengthen distribution networks.
- stimulate demand for nutritious foods through public sector procurement, community education and support for informal traders to sustain local markets for smallholder farmers.
- invest in improving cold chain infrastructure and logistics to minimise post-harvest losses.

b. Food rescue: Redirecting wasted food

South Africa wastes 10 million tonnes of edible food annually – 45% of available food – even as food insecurity rises.[19]

A 2021 study by the Council for Scientific and Industrial Research found that 68% of food losses and waste occur before food reaches consumers – with 19% lost post-harvest, 49% during processing and packaging and 18% at the consumption stage. By food type, cereals account for 50% of total losses, followed by fruit and vegetables (19%), milk (14%) and meat (9%). These inefficiencies highlight an urgent need for coordinated interventions to reduce food waste and improve access to nutritious food.

To close this gap, we must:

- scale food rescue initiatives, such as those by SA Harvest and Food Forward, to ensure safe surplus food reaches those in need.
- accelerate the finalisation of the Department of Forestry, Fisheries and the Environment's 2023 Draft Strategy for Reducing Food Waste to provide national direction and accountability.

3. Quality: Strengthening food fortification

Early childhood is a critical window for growth, requiring essential micronutrients such as zinc, iron and vitamin A. Deficiencies in these nutrients can lead to impaired brain development, weakened immunity and increased risk of illness and mortality. [20]

Fortification involves intentionally adding essential vitamins and minerals to food in order to enhance its nutritional value. This practice aims to improve the overall quality of the food supply and deliver public health benefits, especially to groups that are vulnerable to deficiencies.

Despite mandated wheat bread flour and maize meal fortification since 2003[21], compliance remains a challenge. An assessment published in 2015 of fortification coverage found that in many cases maize meal and wheat bread flour products were unfortified or inadequately fortified. This variability in fortification practices highlights the need for improved fortification monitoring and accountability to ensure fortification reaches vulnerable populations effectively.[22]

To address this, we must:

- strengthen monitoring and accountability processes to improve compliance among food producers, suppliers and retailers.
- increase consumer awareness on the importance of fortified foods through education and fortification certification displayed on product labels.

Mother and child initiatives

4. Maternal Support Grant: Investing in the first 1 000 days

Over the past decade, support has grown to extend the Child Support Grant into pregnancy. This must be treated with renewed urgency given South Africa's children are now more likely to live in poverty, suffer from food insecurity and die before their fifth birthday than they were before the Covid-19 pandemic.[23] The Department of Social Development has investigated the Maternal Support Grant (MSG) since 2012, and we are now awaiting Cabinet approval for the draft policy for public comments.

In 2023, the South African Law Reform Commission also recommended the Child Support Grant be extended into pregnancy, creating the MSG.[24] It is modelled to save approximately R13.8 billion in healthcare-related costs alone.[25]

The momentum behind the support for the MSG has been driven by several factors, including high food insecurity and poverty rates. Pregnant women are particularly vulnerable to unemployment and struggle to afford nutritious food at a time when their health and their babies' development depend on it.

Maternal nutrition is crucial for pregnancy outcomes. South Africa faces a double burden of malnutrition – high rates of obesity (41%) coexist with widespread micronutrient deficiencies, including anaemia (33%). Anaemia during pregnancy increases the risks of low birth weight, preterm birth, stillbirth and developmental issues in children.[26]

This is especially concerning, as low birth weight is a major risk factor for stunting and is closely linked to long-term health and developmental challenges.[27] Research suggests babies born with a low weight are three times more likely to experience stunting between the ages of six months and two years. [28]

These alarming trends underscore the urgent need for intervention, particularly during pregnancy when early nutrition is critical to preventing child malnutrition and stunting.

Evidence shows that income support for vulnerable pregnant women enhances food security and mental health.[29] Beyond improving maternal well-being, the MSG would also encourage early antenatal visits and follow-ups, increase facility-based births, improve maternal and child nutrition, facilitate early access to the Child Support Grant, and reduce stunting in children under two.

To close this gap the Department of Social Development must advance the MSG draft to Cabinet for consideration for public comment.

5. Multiple Micronutrient Supplementation

Increased nutritional needs make it challenging for pregnant women to meet their full requirements, particularly when healthy foods are not easily accessible and affordable. Maternal undernutrition, micronutrient deficiencies and anaemia significantly increase the risk of stillbirth, preterm delivery and impaired foetal development with lasting effects on children's growth, learning and future earning capacity. [30] South Africa's high rates of preterm birth and low birth weight contribute to maternal and child mortality and long-term developmental disabilities.

Multiple Micronutrient Supplements (MMS) offer a cost-effective solution that outperforms Iron and Folic Acid (IFA) supplementation in addressing maternal nutritional deficiencies and reducing stillbirths and low birth weight, particularly among anaemic and underweight pregnant women.[31] MMS, containing 15 essential vitamins and minerals, taken daily in pregnancy, can improve anaemia and is more effective in reducing low birth weight than IFA alone.[32]

Between 2010 and 2015, South Africa was the only low- and middle-income country providing MMS through government channels. However, public sector provision was discontinued and MMS is not currently on the national essential medicines list (EML). Potential reasons include a lack of clear WHO guidelines at the time of implementation, in addition to a lack of knowledge about its evidence base.[33]

Transitioning to MMS presents significant health and economic benefits. Though the average cost of MMS is slightly higher than IFA (US$3.27 per beneficiary for MMS vs US$2.27 for IFA), the long-term benefits outweigh the costs.[34] It is estimated MMS can prevent between 1 100 to 2 700 preterm births, 300 to 600 stillbirths, 2 600 to 6 500 cases of low birth weight and 1 500 to 3 600 cases of small for-gestational-age children in South Africa. Additionally, MMS also demonstrates a cost-effectiveness ratio of approximately US$12.17 per disability-adjusted life year being averted, leading to substantial healthcare savings.[35]

Compared to IFAs, MMS has been shown to reduce the risk of low birth weight by 12%, stillbirths by 9% and small-for-gestational-age deliveries by 8%.[36]

The reduced risks are also greater in anaemic and underweight women, with MMS showing a 21% reduction in relative risk for stillbirth and a reduced rate of under-six-month infant mortality by 29% among anaemic women.[37]

Reintroducing MMS into government channels through its inclusion on the EML and subsequently updating national maternal and perinatal care guidelines could lead to significant improvements in maternal and child health outcomes. With minimal cost differences and substantial long-term savings, MMS is a worthwhile investment that can prevent adverse birth outcomes and enhance the well-being of future generations.

To close this gap, the following steps are essential:

- Evaluate the feasibility and appropriateness of MMS. Then, include it on the National Essential Medicines List and establish clear treatment guidelines to enable the transition from IFA.
- Create awareness among healthcare professionals and communities on the benefits of MMS.
- Establish a local supply of MMS that is registered with the South African Health Products Regulatory Authority and strengthen supply chains to ensure its availability and affordability at healthcare facilities.
- Train community health workers to support and guide pregnant women.
- Implement robust data collection and analysis to track outcomes and improve adherence to respond to inefficiencies.

6. Cash plus care model to address low birth weight in babies

Low birth weight (LBW), defined as a birth weight under 2 500g, affects 14.1% of babies born in South Africa.[38] LBW is a key correlate of stunting, which can lead to long-term health and developmental challenges such as early childhood stunting, disability, and preventable mortality.[39]

The World Health Organization (WHO) emphasises the importance of economic-support strategies, like family support and involvement, to help families care for LBW infants, particularly in resource-limited settings.[40] Subsequent recommendations by the WHO guideline development group also recommends that mothers, fathers, and families receive continued support from birth in health facilities through to post-discharge – via education, counselling, and peer support – to improve outcomes such as parent-infant interaction, breastfeeding, and parental mental health. The group also issued a good practice statement calling for global expansion of parental leave policies to meet the specific needs of parents of preterm or LBW infants, including financial entitlements, despite limited evidence on the optimal form or duration of such support.[41] This aligns with the evidence that reducing financial stress on families could lower the risk of malnutrition and stunting in LBW babies.

If a baby is born LBW, breastfeeding can however mitigate its potential harmful effects. Breastfeeding not only supplies the necessary nutrients but also protects LBW infants from infections and other health complications that can exacerbate their vulnerability to stunting.[42] Meta-analyses of observational studies suggest that breastfeeding reduces the risk of obesity at school age by approximately 20% compared to formula feeding, even when adjusting for biological and sociodemographic factors.[43]

However, food insecurity presents a significant barrier to successful breastfeeding. The energy cost of breastfeeding a child between 0 and 6 months is approximately 2 500 kilojoules per day.[44] Additionally, most micronutrient needs increase during breastfeeding, and deficiencies in the mother can lower the nutrient content in breastmilk, impacting the infant's growth.[45] The Grow Great CoCare Maternal Support Study[46] found that 39% of mothers in the Western Cape reported going to bed hungry, and food insecurity was strongly linked to reduced breastfeeding rates. The CoCare study further demonstrated that digital food vouchers positively impacted maternal hunger and mental health, with maternal hunger decreasing from 36% at baseline to 24% at follow-up, and child hunger also showing a significant reduction.

Research shows that breastfeeding mothers from low-income households experience high-stress levels, which they believe reduce their ability to produce sufficient and high-quality breastmilk.[47] In 2021, 80% of the approximately 17.9 million households in South Africa reported having adequate access to food, while 15% experienced inadequate access, and 6% faced severely inadequate access.[48]

In a country-wide rapid SMS survey of over 3 000 mothers registered with Mom-Connect,[49] it was found that hungry mothers were less likely to breastfeed compared to mothers who did not report hunger.[50] Addressing food insecurity through food vouchers can thus be strategic in increasing breastfeeding rates, supporting optimal growth for LBW babies, and reducing stunting.

Community Health Workers (CHWs) play an important role in the success of maternal and child health interventions, especially in resource-limited settings. A systematic review of community-based interventions found that nutrition education in both food-secure and food-insecure populations was associated with significant improvements in child growth and increased exclusive breastfeeding practices.[51] Findings of a Cochrane review published in The Lancet's 2021 update on effective interventions to address maternal and child malnutrition found that CHW-led education significantly boosts antenatal care use, early breastfeeding initiation, and reduces newborn and perinatal mortality.[52]

Several global studies support the design of the pilot, which combines food vouchers with maternal care and counselling. Evidence shows that income support during pregnancy improves maternal nutrition, increases antenatal care attendance, and reduces the risk of LBW. In Uruguay, a maternity grant significantly reduced the incidence of low birth weight, while Mexico's Progresa programme was associated with a 32% reduction in LBW.[53, 54] In Indonesia cash transfers increased health seeking behaviour, and in Peru, cash transfers improved dietary quality and reduced maternal anaemia.[55, 56]

A global review of pregnancy support in 27 low- and middle-income countries found that financial and nutritional support during pregnancy can lead to healthier birth outcomes.[57] Another 2022 global systematic review found that cash transfers paired with nutrition counselling increased dietary diversity and animal-source food intake, both key factors in preventing LBW, while a 2021 systematic review indicated that cash-"plus" combinations outperformed cash alone, particularly when paired with food transfers and primary health care, though more research is needed to understand when and how models work best.[58, 59] These findings highlight that combining financial support with targeted health interventions can improve birth outcomes and break the early cycle of child undernutrition.

In response to this, the following steps are being piloted in the Western Cape:

- Introduce a cash plus care model by providing monthly R525 food vouchers redeemable for a curated list of protein-rich, micronutrient-dense foods such as eggs, beans, lentils, and tinned fish, aimed at improving maternal nutrition and supporting infant growth.
- Target three priority groups: underweight pregnant women (MUAC <23cm), women identified with suboptimal foetal growth, and mothers of infants born LBW.
- Deliver tailored primary care through CHWs: CHWs will provide twice-monthly home visits, offering maternal nutrition counselling, growth monitoring, breastfeeding support, mental health support, and postnatal guidance to improve infant care and support LBW prevention and/or rehabilitation.
- Establish a robust monitoring and evaluation framework to track voucher redemption, product purchases, growth indicators, breastfeeding rates, and participant adherence to inform future scale-up and integration into provincial or national health strategies.

Conclusion

Closing the food gap in South Africa is not merely an economic or social imperative – it is a moral one.

By making nutritious food more affordable, strengthening local food systems and investing in maternal and child nutrition, South Africa can end preventable child malnutrition and build a healthier, more equitable future. We call on government, industry and civil society to unite in ensuring that we close the food gap for children in South Africa. The time to act is now.

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