The role of social protection in achieving equitable reduction of child mortality

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Abstract

Equity is crucially important in global and national efforts to tackle child mortality. Which children die before their fifth birthday is not random - it is the poorest and most marginalised children, in the poorest countries that are least likely to reach their fifth birthday. Promoting equitable and universal access to social services is one of the surest ways to make progress towards MDG 4[i]. Analysis shows that countries that have achieved equitable reductions in child survival addressed the structural barriers that prevent the poorest from accessing healthcare, a nutritious diet and other key determinants of child survival.

Social protection is widely acknowledged to redistribute income, tackle inequality and promote equity in access to social services. Therefore, strategies to tackle child mortality equitably must include social protection, along with universal essential healthcare services, nutrition, water and sanitation and women's empowerment. There is evidence from a number of countries of social protection contributing to reducing inequality. For example, income inequality was significantly reduced following tax-transfer schemes in a number of OECD countries[ii], and many countries in Latin America achieved reductions in inequality through targeted cash transfer schemes[iii]. Also, evidence, from a wide range of programmes, finds that cash transfers tackle many of the determinants of child mortality[iv]. However, the extent to which social protection is able to effectively reduce inequality and achieve equitable reductions in child mortality depends on the type of programme and coverage of social protection programmes.

This paper will examine the extent to which social protection programmes can reduce inequality in income and achieve equitable reductions in child mortality. The paper will identify the determinants of child mortality and will present an analysis of DHS data, which compares the mortality rates of poor and rich children in over 30 countries and categorises countries according to progress in reducing inequity in child mortality. It will then examine the social protection policies that have been introduced in these countries as well as evidence that social protection tackles some of the key determinants of child mortality, including illness, undernutrition as well as on underlying determinants of inequality poverty and women's empowerment.

1. Introduction

In 2000, the Millennium Declaration focused on the principles of equity and social justice and led to the creation of eight goals that aimed to achieve progress in key aspects of human development. Millennium Development Goal (MDG) 4, which aims to reduce under-five mortality by two-thirds by 2015, is one of the most off-track and global efforts are focused on accelerating this progress. However, as a number of recent reports[v] have shown, a number of countries that are reducing child mortality are doing so inequitably, meaning that the better off groups are more likely to benefit from improvements in health care availability and access than poorer groups. Not only does this aggravate existing inequalities and in justice, but it undermines progress in achieving MDG4. As stated by Vandemoortele "(t)he world will miss the MDG targets largely because within-country disparities have grown to the point of slowing down global progress" [vi].

Social protection is widely acknowledged to tackle inequalities in income and to improve child well-being, through improving access to health, education and nutrition. Much of the literature on social protection relies on programme evaluations, largely from Latin America, that compare the well-being of beneficiaries to a comparison group to assess the impact of the programmes. A few studies also look at the economic impacts on the community. This paper uses the evidence from programmes, in terms of impact on inequality and some of the main determinants of child mortality, to demonstrate the potential impact of social protection on equitable reduction of child mortality at a national level. In particular, the paper draws examples from Brazil and Mexico that have successfully achieved equitable reduction of child mortality and South Africa, which has achieved equity-neutral reduction of child mortality. All these countries have national scale programmes that have led to improvements in income equality and child well-being. Indonesia is another example of a country that has achieved equitable reduction of child mortality, in part as a result of a national safety net programme, and particularly the subsidised rice programme, which in spite of issues around targeting, did contribute to reduction of poverty[vii].

However, many programmes have been associated with inequitable reduction of child mortality or did not significantly contribute to equitable reduction of child mortality. This provides three main lessons; firstly, that social protection should be complemented by health services that are available and accessible for all, nutrition programmes, water and improved sanitation and policies that promote women's empowerment as well as an inclusive growth policy. Secondly, the effectiveness of social protection depends on the extent to which the policies are comprehensive, integrated and reach sufficient coverage to have an impact at the national level. Lastly, in order to promote equitable reduction of child mortality the programmes need to be well-targeted or universal, funded from progressive taxation.

2. Equity in achieving MDG4

In part through a more concerted effort and global attention around the MDGs, child mortality has fallen globally. Of the 68 Countdown to 2015 countries, 60 have reduced their child mortality rate since 1990[viii]. Moreover, the rate of reduction has accelerated since 2000, compared with the period from 1990 to 2000[ix]. Globally, the rate of reduction in child mortality in 2010 was 28 per cent in 2010,[x] which is only 40 per cent of the progress necessary to achieve MDG 4, with only five years to go before the deadline. Although most countries have reduced their child mortality rates, three quarters of countries will not reach the goal at current trends.

Which children die before their fifth birthday is not random – it is the poorest and most marginalised children, in the poorest countries, that are least likely to reach their fifth birthday. 99 per cent of child deaths happen in the developing world. Within each country, multiple and intersecting inequalities determine which children die before the age of five. Children in the poorest households are significantly more likely to suffer from malnutrition and illiteracy as shown by Demographic and Health Survey (DHS) data. However, wealth of a country is not directly linked to child mortality levels as countries exhibit very different trends in their relative economic indicators and child mortality rates. For example, countries with comparable levels of per capita income show considerable variation in child mortality rates and there is no visible relation between per capita growth and the rate of reduction of child mortality[xi]. Excluded groups are often disadvantaged and discriminated against based on race, ethnicity, caste, religion and language and there may be geographic disparities as poor households may be concentrated in disadvantaged locations.[xii] Moreover, disparities in child mortality are growing; an analysis of countries with disaggregated child mortality data confirms that the majority of them witnessed growing inequality child mortality[xiii].

While the MDGs acknowledge the multiple dimensions of poverty, they pay little attention to inequality or social justice.[xiv] Moreover, there is a concern that the focus on achieving progress

in average values in the MDGs may worsen inequalities by encouraging interventions that achieve progress among relatively easy-to-reach groups or, so-called low hanging fruit[xv]. One example may be extending the availability of health services in urban areas, to the neglect of rural services, where the poor are more likely to be concentrated. A recent report by Save the Children[xvi] highlighted the crucial importance of equity in global and national efforts to tackle child mortality. The report found that promoting equitable access to social services, by prioritising the poor, is one of the surest ways to make progress towards MDG4. The report found that many of the countries that are most successfully reducing child mortality are doing so equitably, whereas those countries making slow or no progress towards MDG4 tend to characterised by extreme disparities in life chances[xvii].

In 2010, Save the Children conducted an analysis of equitable reductions in child mortality by looking at child mortality rates between wealth quintiles. Using DHS data and based on the 35 countries for which data was available, they found five possible trends in each country's progress[1]. This data has been updated, where DHS surveys have become available and complemented by data on geographic inequalities in child mortality for a few countries that do not have recent DHS data. The categorisation is shown in the table below.

Categories	**Countries**
Equitable progress - countries making above-average progress towards MDG4, while concentrating progress among children from the poorest households (measured by a reduction in the ratio of child mortality rates between top and bottom quintiles).	Ghana, Mozambique, Niger, Egypt, Indonesia, Bolivia, Zambia, Brazil**, Mexico**
Equity-neutral progress - countries that made above average progress towards MDG4 overall without any significant change in inequity.	Bangladesh, Morocco, Eritrea, South Africa**
Inequitable progress - countries that made above-average progress towards MDG4 with an above-average increase in inequity, because progress was faster in the richest quintile.	Malawi, Nepal, Ethiopia, Madagascar, Peru, Philippines, Haiti, Rwanda*
Slow or no progress - countries that made little or no progress towards MDG4, largely combined with increases in inequity.	India, Benin, Burkina Faso, Cambodia, Guinea, Mali, Nigeria, Senegal, Tanzania, Zimbabwe, Pakistan
Reversal - Countries that experienced rising child mortality regardless of changes in inequity.	Cameroon, Chad, Kenya

* Updated data
** Based on geographical proxy

Save the Children's policy analysis found that countries that achieved equitable reduction in child survival addressed the structural barriers that prevent the poorest from accessing healthcare, a nutritious diet and other key determinants of child survival. Social protection was acknowledged as contributing to equitable reduction of child mortality.

3. Role of social protection in equitable reduction of child mortality

Child mortality is underpinned by a number of immediate, intermediate and underlying determinants. Ultimately, the direct cause of most preventable child deaths in poor countries is illness, which is closely linked to nutrition in two ways; firstly, malnourished children are more susceptible to diseases, and secondly, illness undermines the ability of children to take in and absorb necessary nutrients[xviii]. Illness and undernutrition are caused by four factors; poor

[1] The methodology and data can be found in Save the Children (2010a)

access to good-quality healthcare, limited access a nutritious diet, an unhealthy physical environment and the inability of households to care for their children. Household poverty is a key determinant of access to health services, nutrition, household environment and care for children and women; and consequently is a key driver of child mortality. Women's empowerment and gender dynamics also has key impacts on child mortality levels[xix]. Achieving MDG 4 requires addressing the determinants of child mortality, of which poverty is an important driver.

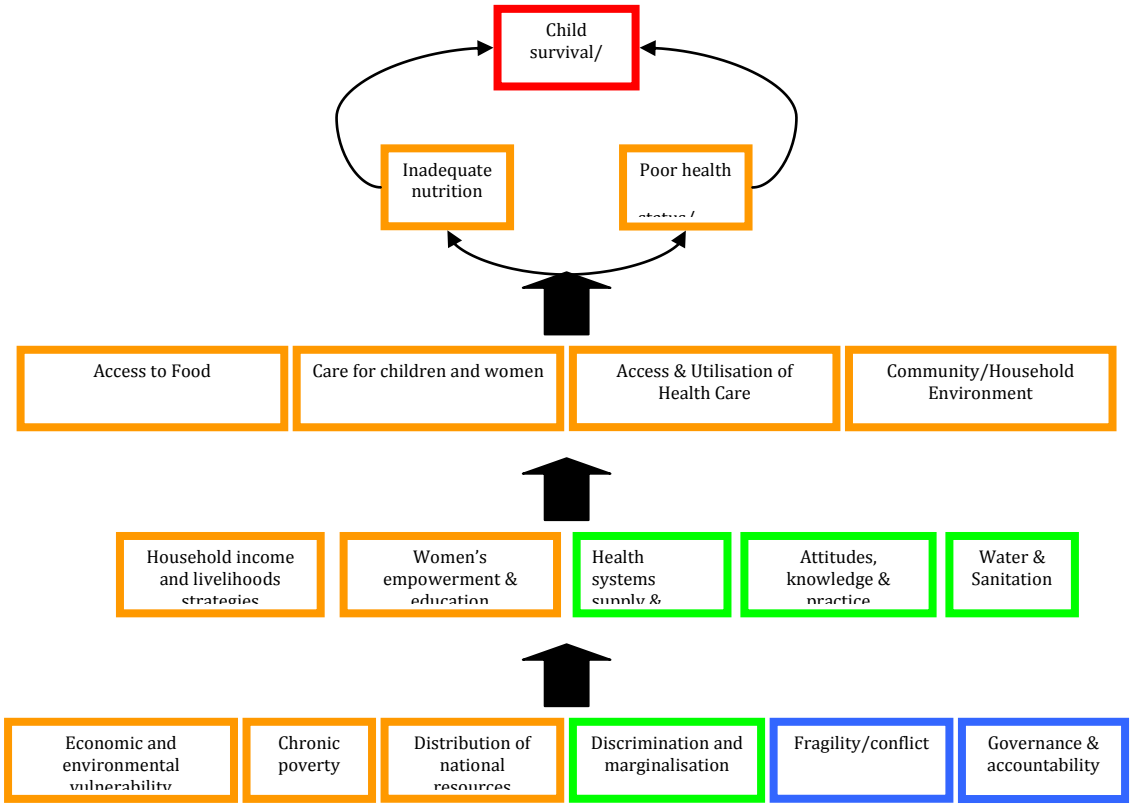

Fig 1: Main determinants of child mortality.

A consensus is emerging that social protection is not only a right, but also an indispensable instrument in supporting progress towards achieving inclusive growth and the MDGs, including MDG4. Social protection policies encompass a set of actions that enable households to counter deprivation and reduce their vulnerability. They include policies to support livelihoods and reduce risk and support human development such as social transfers (in cash and in kind), public works schemes, livelihood measures, measures to promote access to food and social insurance programmes[xx]. Social protection has emerged as a policy response to persistent poverty, inequality and to improve access to essential services. It plays a crucial role in improving child survival by addressing the financial and other barriers that prevent households from securing an adequate diet and access to social services. In addition, social protection has become a development response to the recurring crises and shocks that occur at the global, national and individual levels. In times of shocks or crisis, social protection policies reduce risk and vulnerability and, therefore, ensure these potentially catastrophic events do not have long-term impacts on a child's development chances through reducing access to services and a nutritious diet, which is key to child survival and development.

Beyond child survival, the long-term effects of protecting and promoting human capital can be substantial as children's cognitive development is improved allowing the possibility of securing higher earnings in adulthood and breaking the intergenerational transmission of poverty. Social protection is often promotive and fosters growth by protecting assets and encouraging

households to invest in riskier but higher productivity and higher return activities, and can increase social spending returns by offering poor people the means to use available services. Social protection can also be part of a strategy to empower the most vulnerable groups, tackling inequalities to make growth more inclusive.[xxi]

4. Evidence on social protection contributing to alleviating inequalities and reducing child mortality

This section looks at the contribution of social protection to alleviating inequalities and reducing child mortality equitably. It does so in three ways; firstly, by examining key social protection policies in the countries that have achieved equitable and equity-neutral reductions in child mortality. Secondly, by looking at the evidence of the impact of social protection on key direct determinants of child mortality, particularly on access to health and a nutritious diet and lastly, by focusing on the impact of social protection programmes on underlying determinants of child mortality, namely inequality, poverty and women's empowerment. Evidence shows that 'pro-poor growth has to be combined with redistributive policies if the MDGs are to benefit excluded groups'[xxii]. 'Among a range of other policies, well-designed social protection policies have helped to make development efforts, and therefore progress to the MDGs, more inclusive'[xxiii].

4.1. Social protection policies in countries that achieved equitable reduction in child mortality

The countries that have achieved equitable Ghana, Mozambique, Niger, Egypt, Indonesia Bolivia, Zambia, Brazil, Mexico; and Bangladesh, Morocco, Eritrea, South Africa achieved equity-neutral progress. Save the Children's policy analysis shows that strategies to tackle child mortality equitably must:

- 'be comprehensive, focusing on nutrition, clean water and sanitation, women's empowerment and social protection, as well as healthcare
- provide universal services, including to the poorest children and families
- ensure that the resources are distributed equitably
- include transparent and accountable budgeting and public expenditure management'[xxiv].

While acknowledging a number of other health, nutrition and economic policies that are crucial for equitable reduction of child mortality, this section describes some successful social protection policies that are likely to have contributed to the equitable reduction of child mortality outlined above. Many of the countries that succeeded in reducing child mortality equitably introduced various social protection policies. However, the likely contribution of these policies to equitable reduction of child mortality varies considerably, depending on the scale of the programmes and targeting of the schemes, largely the extent to which these programmes reached poor households. The social protection programmes with the greatest direct impact on inequity in child survival are those that sought to reduce the cost of accessing health services for the poorest families – by introducing social health insurance, for example – and those that have sought to address other key determinants of child mortality, especially nutrition. Cash transfers in some countries also contributed to equitable reduction of child mortality, particularly where the programmes were well-targeted and had a notable impact on poverty and inequality.

Brazil is considered to be one of the pioneers in the introduction of public social assistance. The Government of Brazil introduced a dedicated policy of wiping out hunger, which incorporated the largest conditional cash transfer programme in the world, Bolsa Família. The programme reaches over 12 million people[xxv], around 26 per cent of the population[xxvi]and provides mothers

of families below the poverty line with a cash transfer of between 13 and 120USD per month[xxvii], conditional on child immunisations and school attendance. Evidence later in the paper discusses the contribution of Bolsa Família to tacking income inequality, including inequality based on gender. Other important programmes in Brazil that may have contributed to this progress include the National School Meals Programme and social pensions.

In South Africa, the government committed to poverty reduction, better income distribution, low unemployment levels and better access to social assistance. Over the last decade, South Africa has developed several social protection programmes that are targeted to the poor. In total, over a third of the population of South Africa, 14 million people, receive cash transfers, including the child support grant, disability and care dependency grants and social pensions. The Child Support Grant provides 36USD each to around 10 million children every month (out of 12 million poor children). The number of children benefiting from the Child Support Grant has increased over ten-fold since 2000.

Oportunidades in Mexico has been widely regarded to be successful at reducing poverty and has been associated with better child health outcomes. Formerly known as Progresa, the programme provides an integrated approach that ensures the simultaneous provision of a basic package of health, education and nutrition[xxviii]. The programme was set up in 1997 with the dual goals of alleviating immediate suffering and breaking the intergenerational transmission of poverty by encouraging parents to invest in their children's development. Through the programme mothers in low-income households receive monthly cash transfers on the condition that children attend school and health clinics. Oportunidades reaches 40 per cent of Mexican rural households and a total of 5 million families (in 2007).

Bolivia has been moving towards a policy of universal healthcare provision since 1996. The Government initially prioritized child survival and maternal health through the National Insurance Scheme for Maternity and Childhood, which included medical assistance to mothers and children below the age of five years, maternity care and paediatric care. In 1998, this scheme evolved into the Basic Health Insurance Scheme (SBS) and was combined with an indigenous insurance scheme. The two schemes covered services for 92 health problems as well as obstetric emergency transport, newborn care, child nutrition, vaccination and care for a number of infectious diseases. In November 2002, the 'Universal Mother and Child Insurance Scheme' (SUMI) was launched covering around 500 health problems for children under the age of five. SUMI is intended to be a universal, comprehensive healthcare package, which the population can access through all public health services whatever the level, as well as through services provided by the social security system.

As a response to the financial crisis in 1997/8, Indonesia introduced a number of policies that together formed a social safety net programme. These policies included a food security programme, an employment creation programme of public works, an education programme of scholarships and block grants, a health programme, and a community empowerment programme. The food security programme, in particular, is likely to have contributed to the reduction in child mortality for poor groups. The programme enabled poor households to purchase 10kg of rice per month and reached 50 million households in 1999, including half of all poor households, In addition, the health programme provided poor households with free medical and family planning services at government health centres and nutrition supplements to pregnant women and young children. Indonesia actually experienced an increase in child mortality among the better-off, which probably highlights the negative impacts of the crisis over this time, but it is likely that policies like these allowed for a reduction in child mortality among the poor.

4.2. Social protection in improving key determinants of child mortality

Social protection, and cash transfers in particular, significantly impact on a number of the key determinants of child mortality, as is demonstrated by evidence from a number of programmes. Cash transfers have proven to be effective in reducing the overall incidence of illness in countries such as Colombia, Malawi, Zambia and Mexico. In Mexico, the Oportunidades programme has reduced maternal and infant mortality rates. The evaluations on the programme showed that children in the programme had a 4.7 per cent lower incidence of illness then children not included in the programme[xxix]. Similarly in Malawi, between 2007 and 2008, illness reduced by 23 per cent among children participating in the Mchinji programme compared to 12.5 per cent for non-participants[xxx].

Similarly, there have been consistently positive impacts on nutrition – out of ten cash transfer programmes that report on stunting, seven show positive and sizeable effects. In South Africa, children in families receiving a pension were found to have on average 5cm greater growth than children in families without a pension[xxxi]. Oportunidades in Mexico reduced the prevalence of anaemia and increased the height and weight of young children.

A World Bank study has found that conditional cash transfers have led to positive effects in the use of preventative services and have reduced the disparities in access to health between the poor and better off[xxxii]. For example, in Nicaragua, monthly health clinic visits for children under the age of two were 11 percentage points higher among children participating in the Red de Protección Social[xxxiii]. The pensions programme and Bolsa Família in Brazil as well as Oportunidades in Mexico, increased access to health services in poor households. Also, in Mexico's Oportunidades programme and in Peru's Juntos programme there were impacts on immunization rates (although there was no evidence of an increase in Colombia's Programa Familia en Acción). The Mchinji cash transfer programme in Malawi reportedly enabled more participating families to afford healthcare for children when they were ill compared to non-participating families[xxxiv].

Evidence from a wide variety of cash transfer programmes shows beneficial effects of the programme on household's access to food and dietary diversity. The Oportunidades programme improved the household diet by enabling households to buy animal products and improved children's nutrition through a nutrition supplement[xxxv]. In Ethiopia, beneficiaries of the PSNP and Save the Children's Meket cash transfer programme spent a significant proportion of their cash on food[xxxvi]. In Malawi, households participating in the Mchinji cash transfer programme ate meat or fish with their meals on 2.1 days per week compared with 0.3 days per week in similar households that did not receive the transfers[xxxvii]. Evaluations of cash transfer programmes in Mexico, Honduras and Nicaragua found that total calorie intake per person increased by 5.8 per cent, 6.9 per cent and 12.7 per cent respectively, with the effects particularly pronounced among the poorest third of eligible households.

Cash transfers have also been found to improve care for women and children as well as household environment and hygiene. There have been notable impacts on maternal health and nutrition, for example in Peru the conditional cash transfer programme reduced the number of women giving birth at home and in Mexico, maternal mortality reduced by 11 per cent among households participating in the Oportunidades programme, and the impacts were strongest in more marginalized communities[xxxviii]. In terms of hygiene, households that had been receiving a pension in South Africa tended to be more likely to have flush toilet and piped water, particularly as the household received the pension over a longer period.

4.3. Social protection in reducing inequalities and poverty and promoting female empowerment

The section above used evidence from impact evaluations to demonstrate the impact on individuals that directly benefit from the programme; irrespective of the size of the programme. However, as will be explored in section 6, the impacts on inequality and national level child mortality depend on the size of the programme and its effectiveness. As a result, evidence on the impact of inequality and poverty is limited to a small number of predominantly developed or middle-income countries.

In OECD countries, income inequality and poverty rates were significantly reduced following the implementation of tax-transfer schemes[xxxix]. The countries that provide the most comprehensive and universal social protection and health services (the socially democratic countries of Denmark, Finland, Norway and Sweden) being the most successful in producing egalitarian societies with low poverty rates. In these countries, poverty rates were reduced by 78 per cent and the Gini coefficient by 40 per cent following the implementation of tax-transfer schemes. As a general trend in OECD countries, the higher the cash transfers, the stronger the inequality reduction effect[xl].

There is good evidence from Brazil, South Africa and Mexico of the impacts of social protection on inequality and poverty. It is widely acknowledged that Brazil has achieved a significant reduction in historically-established patterns of inequality, despite moderate levels of growth because the state plays a proactive role in redistributive policies[xli]. Although Bolsa Família's transfers represent only 0.5 per cent of total Brazilian household income, they have been found to be the second most important factor in reducing inequality[xlii]. According to one study, 30 per cent of the reduction in inequality between 2001 and 2004 has been attributed exclusively to government transfers and approximately 12 to 14 per cent to Bolsa Família[xliii]. Similar impacts were found in other studies[xliv] - Bolsa Família was attributed for 21 per cent declines in inequality between 1996 and 2004 and a third of Brazil's reduction in inequality over the last decade[xlv]. Similarly, Oportunidades was attributed for 21 per cent of Mexico's decline in inequality between 1996 and 2005. In South Africa, the relatively rapid build-up of a system of social grants, alongside other policies, was an explicit attempt to address previous, largely race-based inequalities[xlvi]. Although social grants have altered the levels of inequality only marginally, they may have helped limit the growth in inequality that had been persistent in South Africa[xlvii].

The impact of these programmes on poverty, particularly on the poverty gap, has also been significant, with some impact also on poverty headcount. In Brazil, pensions contributed 26 per cent and Bolsa Família 12 per cent, of the total reduction in extreme poverty between 2001 and 2004[xlviii]. Many of South African programmes had a substantial mitigating impact on poverty, reducing both the poverty headcount and poverty gap[xlix]. In 2008, 54 per cent lived below the poverty line, compared to 56 per cent in 1993, and lower than the estimated figure without social grants of 60 per cent.[l] South Africa's social pensions have reduced the country's overall poverty gap by 21 per cent. The Child Support Grant was also effective at reducing the poverty gap and two-thirds of income to the bottom quintile now comes from mainly child grants. The grant has also proved to be effective in reducing vulnerability of households to economic shocks; it is estimated that without the Child Support Grant, the child poverty headcount ratio would have increased by 13.3 per cent and the depth of poverty by 58 per cent, when the country was hit by the recent global financial crisis.[li] In Indonesia, a household that benefited from the rice subsidy had a 4 per cent lower chance of falling below the poverty line compared to a household with similar characteristics that did not receive the benefit[lii].

Many cash transfers try to address gender-specific vulnerabilities and are found to impact on gender equality. For example, schemes may try to address inequalities in girls' education or provide free healthcare for pregnant women and breastfeeding mothers. Most cash transfers select women as the primary recipient of the transfers, based on the rationale that money spent by women tends to be focused on goods and services that are more likely to have a positive effect on children's well-being and this has been found to contribute to women's empowerment and greater role in household decision-making[liii].

The evaluation of Bolsa Família found that beneficiaries of the programme were more likely to have a higher female bargaining-power index than non-beneficiary households; although an evaluation of Familia en Acción in Colombia did not find an impact on female bargaining power[liv]. Qualitative evaluations in Brazil and Chile found that social protection had a significant impact on beneficiary women's identity and enabled women to have a stronger position in negotiating with their husbands. However, there is some concern that the programmes tend to reinforce the traditional role of women in the household, particularly of guardian of the children. Although, the evidence is mixed, suggesting the importance of programme design and context, in some countries, such as Peru there was evidence of the programme reducing intra-household tensions[lv].

Cash transfers are persistently found to have impacts on girl's education, with considerable impacts on child mortality as children whose mothers have no education are twice as likely to die before the age of five as those with at least secondary education. The Oportunidades programme is acknowledged to have contributed to the closing gender and ethnic disparities in education[lvi]. In addition, there have been positive impacts on expenditure, enrolment and retention from programmes in Colombia, Bangladesh, Nicaragua, Malawi, Zambia and Brazil.

5. Design considerations in enhancing the impact of social protection policies on equitable reduction of child mortality

Although the evidence on contribution to health and nutrition is fairly robust, there are considerable differences in the extent to which social protection policies make a notable contribution to equitable reduction of child mortality. This is for several reasons related to the social protection policies themselves and the broader social and economic policies in the country. The case studies above show that Bolsa Família and Oportunidades have been particularly successful at reducing inequality overall, and we can deduce, contributed to the equitable reduction of child mortality as shown by the reduction in geographic inequality in under-five mortality. Similarly, it is likely that the social protection programmes in South Africa contributed to equity-neutral reduction of child mortality.

The impact of social protection on poverty and inequality depends on the scale of the programme and the size of the transfer[lvii]. The reach of the social protection programmes have varied greatly - Brazil's Bolsa Família reaches 26 per cent of the population, but Nicaragua's Red Protección Social only 3 per cent. The value of benefits also varies significantly from 20 per cent of household income in Mexico, 10 per cent in Bolsa Família in Brazil and in South Africa old age pensions and the child support grant represent 175 per cent and 40 per cent of median income. In Mozambique, although there was equitable reduction of child mortality it is unlikely that social protection contributed significantly to this result. The main programme the Programa Subsídio Alimentar (PSA) was introduced in 1993 and has been expanding subsequently. Nevertheless it is characterised with low coverage and low transfer amounts, less than the 10 per cent of minimum amount as was stipulated in programme design.

The redistributive potential of social protection policies rests on their success in reaching poor and marginalised groups as well as design mechanisms to guard against leakage and high administration costs[lviii]. Bolsa Família and Oportunidades have effective targeting systems. In

Mexico, Oportunidades focuses on reaching the poorest 25 per cent of the population; the programme had effective targeting mechanisms with minimum exclusion rates and benefited indigenous groups disproportionately[lix]. Similarly, in South Africa, it is acknowledged that the impact on poverty is the result of relatively good targeting of the child support grant as the share of social assistance going to the poorest quintile was a steady 60 per cent between 1993 and 2000. The old age pension in South Africa is regarded to be the most effective social programme in reaching economically vulnerable groups and is the primary source of income for older people that would otherwise be living in poverty[lx].

However, there have been challenges with targeting even in relatively successful programmes. In spite of fairly good targeting of the Child Support Grant in South Africa, there is also notable exclusion from the programme of around 17 per cent of eligible children (2 million children). This represents children who are usually very hard to reach, very young children and adolescents that have recently become eligible due to extension of the scheme. This exclusion results from documentation requirement and a lack of capacity on reaching hard to reach groups. In Indonesia, overall targeting was not very effective across the five programmes that formed the Social Safety Net programme. Analysis finds near random targeting of the programme overall, reaching 5 to 8 per cent of the population and 5 to 10 per cent of poor households, due to substantial under-coverage of the poor and some leakage to the non-poor[lxi]. The rice subsidy, highlighted earlier, performed better than others, more than half of poor households benefited from this programme.

Lessons from a number of countries demonstrate the need for a comprehensive social policy framework with strengthened investment in complementary services, based on universal access, to improve equality of incomes and child survival chances. In terms on progress in poverty and inequality in the OECD, there are significant variations, related to the social policies in place in the country[lxii]. Similarly, lessons from early 20th century Uruguay points to the importance of broad social protection, in combination with health measures, in enabling declines in infant mortality[lxiii]. After initial impressive progress in the early 1900s, surpassing that of its industrialising counterparts at the time, reductions in infant morality stagnated. However, the introduction of the Children's Code, which enshrined child health in children's rights to welfare, education, medical care, legal protection and decent living standards, reached virtually every Uruguayan child and provided extensive coordinated services.

Of particular relevance for achieving equitable child survival is the extent to which health services are available and accessible for all. To actually reduce child mortality, social protection needs to be complemented by health services and a strong focus on giving children a head start, such as via better nutrition or preschool programs[lxiv]. Again, South Africa is a case in point where progress in reaching the poorest families with subsidies for basic services has been mixed and there are considerable challenges in health sector. Distribution and access to essential health and nutrition services are unequal across the country and large inequities also exist between the country's public and private health care systems in terms of the financial and human resources available in each sector relative to the population served[lxv]. In addition, the system remains heavily biased towards secondary and tertiary care with relatively little emphasis on primary health. The main conclusion is that inequity gaps will only be bridged if government policies deliberately focus on children left behind, delivery bottlenecks in high-child-deprivation provinces are removed, disparities in budget allocation for critical services by provinces are addressed and government and all partners keep a focused eye on ensuring that all children enjoy their rights.

6. Conclusion

There is a growing realisation that within-country inequalities have turned the MDGs into 'mission impossible' as people in the bottom quintiles have not benefited much, if at all, from social progress and economic growth in the majority of countries[lxvi]. The challenge centres on the persistence of 'spectacularly rising inequalities that are as visible as the worsening forms of social and service exclusion in large parts of the third world'[lxvii]. Most of the countries that have reduced their average child mortality over the past decade have also seen an increase in inequality among quintile-specific child mortality rates.

A selection of countries have managed to reduce child mortality equality (or in an equity neutral way), including Mozambique, Ghana, Bolivia, Indonesia, Zambia, Brazil, Mexico, Egypt, South Africa and Bangladesh. Important lessons can be drawn from the policies that were pursued in these countries. The policies tended to be comprehensive and universal, focusing on nutrition, water and sanitation and female empowerment, as well as health care. Social protection, especially social health insurance and cash transfers, was found to contribute to equitable reduction of child mortality by reducing poverty and vulnerability and increasing access to health and nutritious diet. Particular examples can be drawn from programmes in Brazil, Mexico, South Africa, Bolivia and to some extent Indonesia. Also, there is evidence from a number of programmes, from Latin America and sub-Saharan Africa of the impact of cash transfers and social protection more broadly on many of the determinants of child mortality – most immediately on illness and undernutrition, but also on the underlying causes of poverty and inequality.

The potential for social protection to contribute to the equitable reduction of child mortality depends on size of programme and transfers amounts. Programmes need to be operating at a sufficient scale, particularly in low-income countries, to effectively reach poor households. The programmes should also be well-targeted, or universal to vulnerable groups, such as the elderly and children, financed from progressive taxation. In addition, social protection needs to be complemented by strengthened investment in health, nutrition, women's empowerment and an inclusive growth policy. Many countries have introduced relatively small-scale programmes that have not reached a sufficient scale to have a sustained impact on inequalities in child survival and are not embedded into national priorities and an integrated policy framework to ensure linkages with complementary programmes. The analysis in this paper demonstrates the need for scaled up long-term, social protection programmes in order for social protection to contribute to equitable reduction of child mortality.

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