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Working Paper

Achieving SDG 10: A global review of public service inclusion strategies for ethnic and religious minorities

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Achieving SDG 10: A Global Review of Public Service Inclusion Strategies for Ethnic and Religious Minorities

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**Overcoming Inequalities in a Fractured World:
Between Elite Power and Social Mobilization**

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The United Nations Research Institute for Social Development (UNRISD) is an autonomous research institute within the UN system that undertakes interdisciplinary research and policy analysis on the social dimensions of contemporary development issues. Through our work we aim to ensure that social equity, inclusion and justice are central to development thinking, policy and practice.

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Abstract

Social inequalities are intensifying globally and widening divisions are linked to civil unrest. Disadvantaged ethnic and religious groups experience poor access to, representation in and outcomes from public services such as healthcare and education. As mechanisms for social participation and citizenship, public services are key to inclusive and sustainable societies.

In this paper we present results of a systematic review on strategies for the inclusion of minority ethnic and religious communities, often neglected populations in term of sustainable development activity. We focus on four public service areas: education, health, local government and police services and identify evidence gaps. Our overall aim is to raise awareness and provoke debate, reflection and subsequently action towards the inclusion of disadvantaged ethnic and religious minorities within public services.

Public service inclusion strategies were identified through a global evidence review and four country specific reviews conducted by the Socially Inclusive Cities Network – academics, NGOs, policy – makers and practitioners from India, Kenya, Nigeria, Vietnam and the UK. Published evidence was supplemented by country-based and international workshops involving over 230 relevant stakeholders. We specifically explored intersectional experience relating to gender, age and migration status.

56 publications were identified for the global review, mostly in health and education. Macro (social and political), meso (institutional) and micro (individual) arena were identified as three distinct but interconnected levels through which exclusion is operationalized. Three overarching frameworks appeared key to successful ethnic and religious inclusion initiatives: accounting for social context; multiple strategies for system reform; and collaboration with disadvantaged communities. Inclusion strategies that address macro, meso and micro level drivers of exclusion are needed to achieve the aspirations of SDG 10. Involving affected communities is key to their success.

Keywords

SDG 10; ethnicity; religion; inclusion; public services

Bio of lead author

Ghazala Mir is Associate Professor of Health Equity and Inclusion at Nuffield Centre for International Health and Development, University of Leeds and Director of the Inequalities Research Network at Leeds Social Sciences Institute. Ghazala leads the Socially Inclusive Cities Network,¹ which conducted the research activity on which this paper is based and which has developed a future research agenda to inform the direction of RCUK research funding.

¹ Further details of the Socially Inclusive Cities Network can be found at https://medicinehealth.leeds.ac.uk/directory_record/979/socially_inclusive_cities.

Introduction

Social exclusion is a global challenge which cuts across the 17 Sustainable Development Goals (SDGs) that have guided the global development agenda since January 2016 and that promote an agenda for more inclusive societies. Goals 1, 4, 5 and 10 focus on eradicating poverty, equitable quality education, gender equality and reduced inequalities respectively. Furthermore, aspirations for universal access to essential services (for example, health and education) and the alleviation of poverty and hunger (Goal 1) all underline the importance of equity as a key aspect of this agenda for sustainable development.

The SDGs were developed in the context of growing acknowledgement that social inequalities are intensifying within countries and globally (Sachs 2012) and that sustainable development, particularly within low- and middle-income countries (LMICs) can only be ensured through equity (Das et al. 2013). Failure to reverse inequities during periods of rapid economic growth has led to widening divisions between rich and poor and between diverse ethnic and religious populations, often leading to civil unrest.² Social sustainability is therefore a key national and international policy priority, which shapes economic sustainability through the inclusion of all population groups in development initiatives and in access to public services, regardless of gender, age, religion or ethnicity.³

Progressive universalism is a key principle of the SDGs, encapsulated in the words: “no one will be left behind...and we will endeavor to reach the furthest behind first.” The need for rigorous evidence disaggregated by “race, ethnicity, migration status...and geographic location” among other relevant characteristics has been highlighted as essential in achieving this principle (United Nations 2015a). In practice, the focus in this respect has, for the most part, centred on poverty, women and young people, however, and discussions of SDG 1 and 10 have paid little in-depth attention to ethnic and religious exclusion despite the overrepresentation of ethnic and religious minorities among the poorest communities (Ostry et al. 2014; Roser and Ortiz-Ospina 2018). Intersectionality, that is, the experience of exclusion at multiple levels, as experienced by women, young people and migrants from minority ethnic and religious groups, has received little attention in studies on gender, age and migration (World Bank 2012; Shah et al. 2015) and within the SDG monitoring framework (Sustainable Development Solutions Network 2015). Yet, it could be argued that intersectionality is a key concept for interpretations of SDG 10, given that poverty, youth and gender are specifically addressed in Goals 1, 4 and 5.

Religious and ethnic minority groups are particularly vulnerable to discrimination in many contexts. Both ethnic and religious minorities typically have poorer access to

² Sachs 2012; World Bank 2012; UN-Habitat 2010; World Bank 2005

³ World Bank 2013; Uzochukwu 2012; Steinberg and Lindfield 2011; Serageldin, M. 2016; United Nations Department of Economic and Social Affairs 2014

services, employment and institutions relating to healthcare⁴, education⁵, finance⁶ and systems for justice and government (United Nations 2015b; Galab et al. 2008). Ethnic inequalities are often linked with religious discrimination⁷ particularly in the rhetoric of nationalist groups and ruling political parties in various global contexts (Pew Research Centre 2018; Obadare 2005). This, along with indirect discrimination - such as a mismatch between work opportunities, skills and locations of people from these minority groups - results in most having low-paid, informal jobs and precarious working conditions (World Bank 2009). These widening inequities also reflect poor professional training that compounds vulnerability (Mir and Sheikh 2010, Karlsen et al. 2011).

Social relations as embedded in the formal institutions of society are thus a mechanism through which social exclusion, that is, the prevention of social participation, or exercise of full citizenship, operates (Gerometta et al. 2005; Nambiar et al. 2015). Restricted access to job opportunities and the resources of public service institutions enables “insiders” employed within these institutions to maintain privileges for some groups by systematically denying such opportunities to stigmatized ethnic and religious groups, thus maintaining their exclusion (Kabeer 2000; Kline 2014). The Nubian population of Nairobi, for example, faces both ethnic and religious discrimination in accessing identity documents such as the Kenya National Identity Card and passport. This results in their classification as “stateless” with consequent barriers to accessing government services, including health and education, and to acquiring property (Murbe and Kamudhayi 2011). Government policies can both trigger and reinforce social hostilities, as in the case of the UK PREVENT counter-terrorism policy, which has been criticized for targeting Muslim minority populations and for stereotyping and alienating Muslim communities (Awan 2012). Similar policies operate in many other parts of the world, where minority religious groups often face restrictions on their civic rights, ability to practice their religion or access to services and employment opportunities (Pew Research Centre 2018).

In order to challenge these dynamics of social exclusion, the role of public services and systems in, for example, recognising citizenship status and reducing discriminatory social practices is vital. Engaging minority ethnic and religious groups in institutional governance is considered an essential element of inclusive activity within cities (World Bank 2015), where most decision making about public services takes place, affecting the lives of both urban and rural populations. The challenge of developing inclusive public services involves negotiation of political and social contexts, particularly as competition for work and resources is a key driver of ethnic and religious conflict (Olzak 1994). This negotiation is complicated by competing institutional priorities and a lack of data on socially excluded groups, which can make their exclusion invisible (Stuart. and Woodroffe 2016; Makoloo 2005). In Vietnam, for example, 53 ethnic minority

⁴ Mir and Sheikh 2010; Priest et al. 2013; Subramaniam 2018

⁵ Xaxa 2001; Jahan 2016; Suresh and Cheeran 2015

⁶ Dymski and Bagchi 2007; Dymski 2009; Meer 2013

⁷ Meer 2013; Mir and Sheikh 2010; Mir et al. 2015

populations are classified as one group which is then compared with the Kinh majority (Doan et al. 2018). The lack of data on specific ethnic minorities is very likely to mask diverse experiences.

The evidence base on underlying causes of exclusion affecting ethnic and religious groups is further limited and fragmented by a focus on specific services such as maternal healthcare (Doan et al. 2016; 2018) or aspects of education, with limited attempts to generalize across different public services or even diverse services within these sectors. This fragmentation also applies to research on effective interventions to address the exclusion of these populations from public services. There is thus an urgent need to synthesize existing evidence on the complex and intersectional nature of discrimination faced by minority ethnic and religious groups and on strategies that have been developed to support more inclusive practice. This approach would help identify any evidence gaps and systematically identify interventions with multiagency and multidisciplinary relevance in line with best practices (Mir et al. 2013).

In this paper we attempt to synthesize current evidence and identify evidence gaps, drawing on results of a systematic review on strategies for the inclusion of minority ethnic and religious communities in four public service areas: education, health, local government and police services. Building on the work of Kabeer (2000), we conceptualize social inclusion as: equitable representation in, access to and outcomes from public services between diverse ethnic and religious groups. Our overall aim is to raise awareness and provoke debate, reflection and subsequently action towards the inclusion of disadvantaged ethnic and religious minorities within public services. Given that research and practice responses to the SDG goals have so far not sufficiently focused on the exclusion of minority ethnic and religious groups, the specific objectives of this paper are three-fold. First, we synthesize current evidence on drivers of social exclusion affecting these populations across four such services. Secondly, we identify effective strategies for addressing social exclusion within public institutions as potentially key mechanisms for stimulating social change. Finally, we summarize the outstanding gaps that should inform a future research agenda on this topic.

Methods

Between March and November 2017, we systematically searched for and reviewed global evidence from literature reviews about strategies for the social inclusion of minority ethnic or religious populations in four public service areas: education, health, police and local government. Alongside this, four country-level reviews, without limitations on type of study, were conducted for India, Kenya, Nigeria and Vietnam. Our selection of contexts allowed comparisons within and between West and East African contexts, South and East Asian contexts and also from a global perspective. The impact of colonialism was an important feature of the countries involved in the review, with development affected by ethnic and religious divisions that were historically exploited by colonisers to maintain power.

In all, 29 databases were searched in relevant areas including: social sciences, economics, education, gender and child rights, healthcare and police and criminal justice databases. Country-specific reviews drew on additional databases and also included policy documents, specific journals and websites to support the inclusion of relevant evidence and, in Vietnam, non-English language publications. The full list of databases and detailed Medline search strategy, indicating the specific focus and limits of the review, is provided in Appendix 1.

The searches were developed and carried out by ND, an Information Specialist. Database-specific indexing terms and free text terms were agreed between all partners to identify published evidence relevant to the review questions. Supplementary evidence drawn from the personal libraries of research team members was also used to fill gaps in the evidence drawn from publications, particularly in relation to: inclusion strategies on gender, age and migration; local government, where research evidence was extremely sparse for all the reviews; and police services, for which only one paper was identified by searches. Some papers on gender, age and migration that were initially excluded from the global review were drawn on to identify drivers of exclusion and policy, practice or research recommendations.

Titles and abstracts of records were screened for eligibility, with at least 25 percent of results examined by two researchers. Eligible publications described strategies (for example, interventions, policies, legislation) for the social inclusion of minority ethnic or religious populations in either health, education, local authority or police services. The global review focused on review studies and the country-specific reviews included empirical research or policy papers relating to the relevant country (Nigeria, Kenya, Vietnam or India). Studies were excluded if they did not include a focus on strategies to improve the inclusion of ethnic or religious minority groups in health, education, local government or police services.

Framework analysis⁸ was conducted on the full texts of eligible papers using a standardized template. In addition to establishing existing strategies for inclusion of minority ethnic or religious populations, the review examined the concepts, theories, methods or logic models underpinning these strategies. The quality of papers was assessed in terms of theoretical underpinnings for inclusion strategies and methodological strengths or limitations, including potential bias. Evidence regarding the success, effectiveness or sustainability of initiatives was identified to help inform future policy and practice. Initiatives relating specifically to gender, age and migration were also identified, to capture those aiming to reduce intersectional disadvantage. Finally, gaps in evidence were highlighted in order to develop a future research agenda that could support the improved social inclusion of disadvantaged ethnic and religious minorities.

⁸ Ritchie and Spencer 2002

As part of our analysis we grouped initiatives according to certain characteristics to help understand similarities and differences between the strategies described:

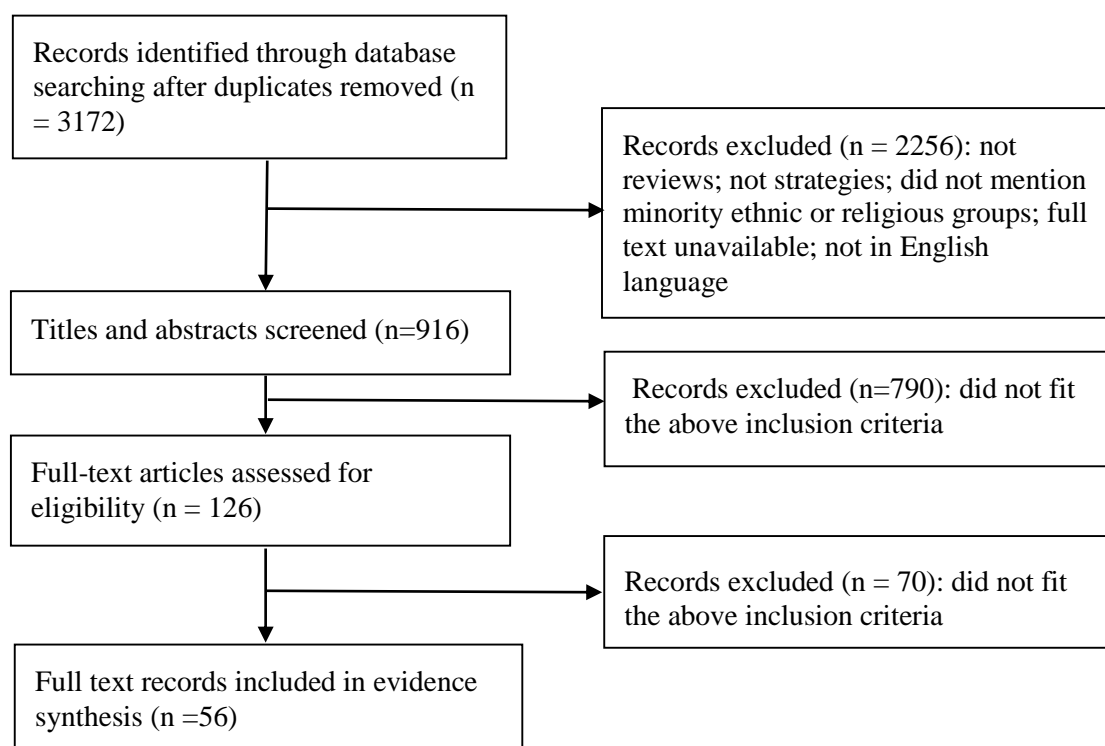
- the level(s) (macro, meso or micro) at which initiatives were targeted,
- overall objectives of identified strategies (such as involving excluded groups in the design/monitoring of interventions, improving service processes or outcomes or individual behaviour change),
- service sectors in which the strategies were delivered,
- the target group(s) (for example, services, staff, service users) and
- key activities of the strategies (for example, the provision of information or resources or community engagement).

We also sought evidence from relevant policymakers, practitioners, voluntary sector organizations and academics to supplement the literature review through a series of workshops and high-level research interviews in each partner country. Participants discussed the literature review findings with the aim of supplementing this evidence and supporting the development of a future research agenda for the social inclusion of people from disadvantaged ethnic and religious groups. Four international workshops were held for academic, NGO and policy leads from each country involved to pool and consolidate findings from these national and international contexts.

Results

A total of 126 full text records of the 3172 abstracts screened were selected for the global evidence review, of which 56 were included in the final evidence synthesis (Figure 1).

Figure 1: Modified PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses)



Source: Author

A wide range of minority ethnic and religious groups were covered by the included papers, to which country specific reviews added further populations, including indigenous communities, such as Adivasi in India and Ogiek in Kenya, along with a range of ethnic and religious minority groups: Nubians in Kenya, Fulani, Ibo and Ijaws in Nigeria and Hmong in Vietnam. At times, the review was complicated by the use of similar terms to describe groups with very different geographical backgrounds and cultural experiences.⁹

Ethnic minorities were defined within these papers in terms of population numbers, shared culture or language, or geography (see Bhojani et al. 2019). In different contexts these factors were relevant to varying degrees, highlighting the social construction of ethnicity and echoing the UN Special Rapporteur’s description of “the need for greater clarity as to who are minorities” (United Nations Human Rights Council 2019).

Drivers of exclusion

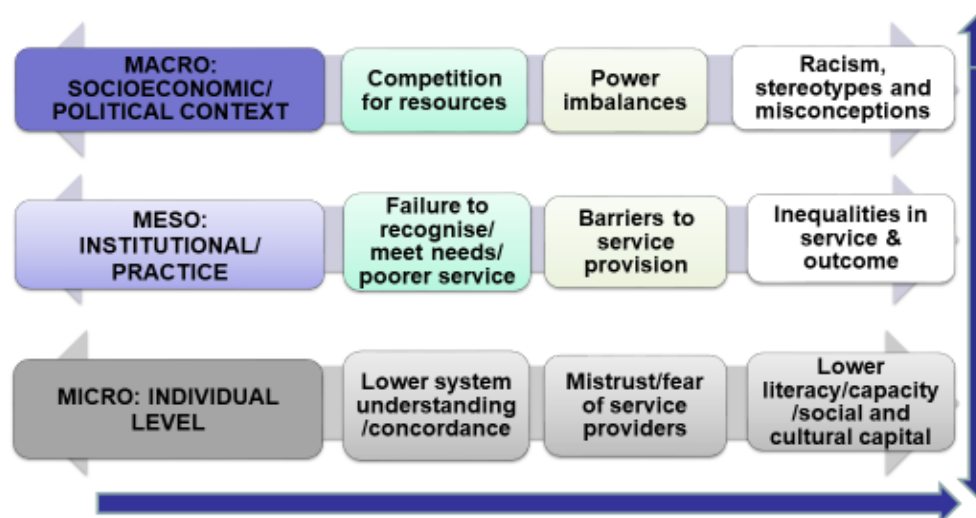
The exclusion of minority ethnic and religious communities was found to be created and operationalized at three distinct but interconnected levels of society. Macro-level (that is, sociopolitical) structural inequities, associated with competition for resources, power imbalances, racism, stereotypes and misconceptions in society more generally (Fesus et al. 2012; Goodkind et al. 2010), produce a meso-level (that is, institutional) failure to

⁹ For example, in the United States, the term “Asian” was used for individuals of East Asian (such as Japanese and Korean) descent whereas in the United Kingdom this term referred to individuals of South Asian (Bangladeshi, Indian and Pakistani) descent.

recognize and appropriately respond to the needs of these groups. This in turn produces barriers to access and inequities in service provision and outcomes¹⁰. Macro- and meso-level barriers are associated with, and reinforced by, community and micro-level factors such as poverty, lower system understanding and concordance, greater fear and mistrust of service providers, disempowerment and lower literacy, capacity, social and cultural capital among disadvantaged ethnic and religious groups.¹¹

Figure 2 illustrates the dynamic relationship between the various social processes that create and maintain exclusion. Common underlying mechanisms of exclusion were confirmed by national and international workshop participants in relation to issues such as discriminatory citizenship processes, employment practices, corruption that could limit economic and political opportunities to those within the ethnic group in government office, and the association of religious minorities with threats to security.

Figure 2: Key drivers of social exclusion for disadvantaged ethnic and religious groups



Source: adapted from Solar and Irwin (2010)

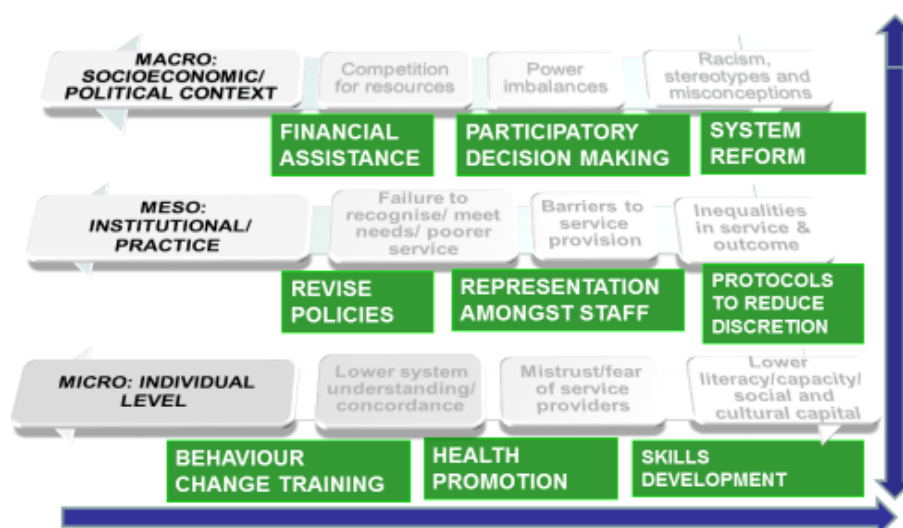
Strategies for inclusion

We mapped initiatives identified from the review to these levels in order to assess where most strategies were targeted (see Figure 3). At the macro level, socioeconomic inequalities, lack of representation in decision making and social stigma were, for example, addressed through initiatives such as financial assistance or other incentives (Escriba-Aguir et al. 2016); correcting power imbalances through instituting participatory decision making (Tsou et al. 2015); and changing social norms through removing segregated education and targeting provision at those experiencing disadvantage (Gamoran et al. 2012; Hahn et al. 2014).

¹⁰ Anderson et al. 2003; Davy et al. 2016; Kehoe et al. 2016

¹¹ Alam et al. 2008; Eakin et al. 2002; Lakhanpaul et al. 2014

Figure 3: Strategies for inclusion at macro-, meso- and micro-level



Source: Authors

Meso-level strategies aimed at ethnic and religious inclusion sought to ensure equitable service provision through targeting staff or communities. For example, “managed care protocols” (Sass et al. 2009) reduced the use of staff discretion, which might be discriminatory, by standardising best practice. Increased access to services was also anticipated through the development of a more representative service workforce (Bhattacharyya and Benbow 2013), educating and training professionals within institutions (Truong et al. 2014; Bhui et al. 2015) and actively recognising and meeting the service needs of excluded groups. Revising institutional policies (Goodkind et al. 2010; Knopf et al. 2016) and adapting or changing service practice in collaboration with excluded groups also helped ensure they were more culturally acceptable.¹² Meso-level strategies could also involve partnerships with communities to ensure the provision of services that were more responsive to their needs and to effect changes in behaviours, such as community mobilization and changes in living conditions, such as perceived neighbourhood safety (Anderson et al. 2015). Strategies to address the micro-level causes of exclusion aimed to increase individual capacity and cultural capital, for example through skills development (Valla and Williams 2012), changing individual health behaviour (Anderson et al. 2003) and reducing negative perceptions of services through health promotion that recognized the value of community engagement (Bainbridge et al. 2014). Initiatives such as behaviour change training also had the potential to improve service user understandings of systems and outcomes (Knowlden and Sharma 2013; Laws et al. 2014).

At the global level, only eight reviews presented strong evidence on effective interventions for addressing social inequality and only two of these were in the health sector. These health studies found evidence of increased service access and participation through the cultural adaptation of treatments (Bhattacharyya and Benbow 2013; Manuel et al. 2015), the use of motivational interviewing (Manuel et al. 2015), engagement with

¹² Kalibatseva 2014; Zeh et al. 2014; Haynes et al. 2014

excluded minorities (Escriba-Aguir et al. 2016; Sass et al. 2009) and their involvement in the development of new or adapted services (Anderson et al. 2003).

In the education sector, effective interventions supported the inclusion of students from ethnic and religious minorities through the provision of additional tutoring for individual students; increased parental involvement in the school; and the introduction of social-psychological interventions to address students' vulnerability to "stereotype threat", that is, underperformance by those in an excluded group caused through fear of fulfilling a negative stereotype about underperformance in that group (Gamoran et al. 2012). For low-income ethnic minority groups, providing financial support for school-based health access was also effective in addressing inequities in healthcare use as well as in improving school attendance and completion (Knopf et al. 2016).

Although these findings were scientifically significant, reasons for the effectiveness of the interventions were absent from most of these reviews. We also identified a number of methodological caveats relating to the remaining studies that were not always acknowledged by the authors of reviewed publications. These included an unclear baseline from which to measure progress (Gamoran et al. 2012), a lack of generalisability (Lood et al. 2015) and an over-reliance on self-reporting (Clifford et al. 2015). Unclear evidence on effectiveness could also be due to the diversity of social contexts covered by the studies reviewed (Tao et al. 2016), differences between intervention types or funding, outcome measures used, or type of publication reviewed (Gallagher and Polanin 2015).

Most publications included in the final selection for the global review focused on micro- and meso-level strategies, and very few on macro-level initiatives or on activities which could work across this continuum. Some divergence from this focus was found in country-specific reviews. In India, for example, affirmative action policies mostly addressed macro and meso-level factors in response to political action by excluded groups¹³. Such policies are linked to the Indian constitution and facilitate reserved spaces within state-run higher education institutions and at different levels of governments as well as within employment in public institutions for religious and linguistic minorities (National Commission for Religious and Linguistic Minorities 2007). They further support equal access to government aid for educational institutions run by and for these communities as well as reserving free private school spaces for children from disadvantaged communities, including ethnic and religious minorities (Government of India 2009). Macro-level approaches in Vietnam, including financial assistance, providing free health insurance cards (Wagstaff 2010; Nguyen 2012), exemption from educational fees (Doan et al. 2011) and micro-credit for the poor (Doan et al. 2011; Nguyen 2008), have been found effective for improving healthcare access. However, well-designed impact evaluations of such strategies remain very limited (Nguyen 2015). Macro-level policy interventions have also supported ethnic minorities to access education and training opportunities through preferential entry requirements

¹³ Jaffrelot 2006

and financial support. However, the routes into employment following course completion had not been planned resulting in low employment outcomes for graduates (CEMA/UNDP 2010). At meso level, training and employing young minority ethnic women to provide maternal and village healthcare services has proved promising (Doan et al. 2018).

Despite the preponderance of papers focused on health services, all studies that described macro-level strategies in the global review related to education services. In India, too, where legislation constituted an inclusion strategy, macro level studies existed in education, employment and governance, where affirmative action policies are long established. Unlike Vietnam, where national health targets specifically address malnutrition in deprived ethnic minority households, health is not recognized as a fundamental right in the Indian constitution; consequently no policy measures specifically target ethnic and religious minorities. State-funded health insurance has more recently targeted those living in poverty which has indirectly benefitted ethnic and religious groups overrepresented among deprived populations (La Forgia 2012). In Odisha State, a mix of strategies including expanded provision of health services, training of health workers and the introduction of cash transfer and entitlement schemes have addressed macro-, meso- and micro-level factors and led to reductions in health inequalities for ethnic minority populations and more generally. The political will of committed policy makers was a key factor in the success of this approach (Thomas et al. 2015). Other studies on affirmative action in India have produced some limited evidence that reservations in higher education have helped enhance targeting, admissions and educational outcomes for ethnic minorities.¹⁴ There is also evidence of poverty reduction and improvements in allocation of welfare budgets resulting from the reservation policy for ethnic minorities in elections.¹⁵ Feedback at Indian workshops indicated that reservations for minority ethnic and religious groups in government employment did not seem to have been implemented well, however.

Similar issues with implementation of macro-level policies were noted in the Kenyan and Vietnamese reviews (Mitullah et al. 2017; Doan and Bui 2018) and in workshop discussions in Nigeria. In Vietnam, implementation of detailed policies outlining systems to support ethnic minority groups have proved inadequate in terms of ensuring implementation.¹⁶ Similarly, both the Kenyan Constitution (Republic of Kenya 2010) and the County Government Act (Republic of Kenya 2012) provide clear references to inclusion and protection of “marginalized and minority groups from discrimination and from treatment of distinction of any kind, including language, religion, culture, national and social origin, sex, caste, birth, decent or other status” (Republic of Kenya 2012:83). The Act directs that at least 30 percent of vacant posts at entry level are filled by candidates who are not from the dominant ethnic community. Similarly, the Commission for Revenue Allocation has developed criteria for sharing revenue in line

¹⁴ Robles and Krishna 2012; Nagpurkar 2011; Bagde et al. 2016

¹⁵ Kaletski and Prakash 2016; Chin and Prakash 2011; Pande 2003

¹⁶ CEMA/UNDP 2012

with the Equalization Fund provided by the Constitution. The policy also identified ethnic minority communities that need to be targeted for service provision, particularly: Elmololo, Makonde, Watta and Dorobo Saleita/Ogiek populations (Commission on Revenue Allocation 2018). Constitutional commissions and independent offices have been established to monitor these provisions at both meso and micro levels, however, there is a dearth of academic studies in this area. Kenyan workshop participants felt that policy implementation is generally weak, leaving most disadvantaged groups struggling to access basic services and economic opportunities. Moreover, lack of infrastructure in areas where minority ethnic groups are concentrated means that allocating resources for health and education is futile when goods and materials cannot physically reach these areas.

In all the reviews we found a particular lack of research evidence in relation to inclusive policing initiatives and this was linked by workshop participants in Vietnam to poor primary data and policy development in this area. One paper in the Kenyan review provided evidence that refugees were regularly subjected to harassment, violence and systematic extortion as well as verbal or physical abuse by the Kenyan police in urban areas. Police training, legal assistance and changes to documentation requirements helped address these issues to some extent but efforts were hampered by a lack of available funding and inadequate research on refugee needs. Systematic reform of police services was recommended by the study (Pavanello et al. 2010).

There was very little discussion of the underlying theories that informed the development of public service improvement initiatives for minority ethnic and religious groups. With the exception of India, where long-standing affirmative action policies are based on acknowledgment of the historical oppression suffered by certain groups, community-level strategies rarely targeted the wider socio-cultural environments that created and helped to maintain social exclusion. There was a lack of consideration, in particular, of the historical and social processes that produced these inequities. Inclusion initiatives were at times clearly themselves influenced by these exclusionary processes, assuming that the reason for inequities lay in community deficiencies or cultural norms. For example, interventions that focused on developments in disadvantaged ethnic and religious communities, rather than within service provision or macro-level processes, provided little or no evidence of effectiveness for addressing unequal access to healthcare services or health outcomes (Anderson et al. 2003). Similarly, studies on training service users on “how to be a patient”, for example, or providing community advocates, were not found to be effective solutions, especially where these strategies were related to navigating complicated care systems (Bhui et al. 2015). In Nigeria, studies included in the review could often position socio-cultural issues as the key cause of poorer outcomes within disadvantaged minority ethnic and religious groups, rather than highlighting the failure of public services to accommodate these cultural norms (Ayanore et al. 2016; Oluyemi et al. 2014). The reason for studies adopting such a focus for inclusion initiatives was unclear and lacked justification. Feedback at international workshops highlighted that

policy makers and service providers often directed responsibility for poorer service outcomes at minority ethnic and religious groups themselves and that research institutions and funders could also stigmatize research that tried to challenge such perspectives, creating disincentives for researchers in this field.

More collaborative approaches to improvement initiatives were adopted by a number of studies in order to achieve more inclusive services. Sorensen et al. (2009) described the value of critical-dialogic models of intergroup dialogue for more positive and beneficial intergroup interactions in higher education. Tsou et al. (2015) examined a number of tools to enable more effective partnerships between Australian Aboriginal and mainstream partners, through more explicit reflection on the process and relational elements of these partnerships, and more effective transformative or iterative evaluation procedures. Knowlden and Sharma (2013) established that the effectiveness of school-based obesity interventions targeting African American and Hispanic children would be improved by: explicit operationalization of behavioural theories; incorporation of systematic process evaluation; long-term follow-up of intervention outcomes; and inclusion of the family and home environment. Enard et al. (2016) identified a need to respond to the multiple social disadvantages which impact on patients' participation in shared decision making, in this case in relation to cancer care, and the particular need to tailor patient decision aids to address them. Such collaborative approaches were rare in practice but did exist - effective multi-agency collaboration funded by international NGOs working in Vietnam, for example, has directly encouraged the involvement of marginalized communities in the implementation and evaluation of maternity service interventions (Målqvist et al. 2015).

Our analysis across the research partnership further highlighted poor acknowledgment of the intersectional nature of disadvantage, such as the additional layers of exclusion associated with gender, age, migration status, the overlap between religious and ethnic identity or geographical location. Studies rarely took account of the additional barriers experienced by women or young people from disadvantaged ethnic and religious groups, for example. These groups appeared to be consistently excluded from research and policy engagement, even within countries with policies to address these issues. In Kenya, for example, a focus on more inclusive higher education ignores the low access to higher education resulting from ethnic and religious exclusion and non-attendance at primary education level. While Indian policies targeting ethnic minorities focus on macro- and meso-level factors, these fail to take account of religious exclusion, and strategies relating to religious communities focused more on meso- and micro-level barriers (Bhojani 2018). In Vietnam, issues experienced by religious minorities were rarely researched because such research was considered too politically sensitive (Doan et al. 2018). International workshop discussions revealed that both researchers and NGO representatives could experience stigma by association with disadvantaged communities as well as political hostility when highlighting restrictive service practices or government policies. These dynamics acted as disincentives to engage with research and activities that addressed the inequities such communities experienced.

Despite the lack of explicit discussion within included papers of underlying theories that informed interventions, our analysis enabled identification of three overarching considerations that could usefully inform the development of strategies to achieve greater equity for minority ethnic and religious groups in public services:

- **the influence of social context on the production of inequities**, in relation to: how power and privilege is generated and maintained (Sass et al. 2009); internalized racism (Dancy and Jean-Marie 2014); and the effects of public services on life course (Knopf et al. 2016);
- **the need for multiple strategies to achieve system reform**, which might require a reconfiguration of existing provision across multiple sites (Knowlden and Sharma 2013); or multifaceted approaches such as targeting interventions at different stages of service provision (Aggarwal et al. 2016); and
- **the need for tailored solutions involving collaboration with affected communities** (Knowlden and Sharma 2013; Enard et al. 2016), which could include power-sharing partnerships (Cyril et al. 2015) and structured communication processes that provide guidelines for intergroup dialogue (Sorensen et al. 2009).

Discussion

Our findings indicate that ethnic and religious exclusion is a global phenomenon and that public services have the potential to act as a mechanism for social change that impacts on the life course of people from disadvantaged ethnic and religious groups. Public services are most often key employers in urban and even rural settings and, as such, can reflect and influence the social norms of a society. We suggest that multisector programmes of policy and public service development that promote comparable access to, representation in and outcomes from public services between ethnic and religious groups are needed. Such programmes would have the potential to increase social ownership of the concept of inclusion and to positively influence cultural norms within a given society. Effective inclusion strategies delivered by such services could potentially help transform the current landscape globally, in which disadvantaged ethnic and religious groups face routine and simultaneous discrimination and exclusion across multiple areas of their lives.

Evidence on strategies that could inform such development is, however, still limited and there is considerable scope for further research to fill current gaps. The evidence base is particularly restricted in terms of: research in low- and middle-income countries; studies within local government and police sectors; robust evaluation methods; multilevel and multisector strategies; as well as initiatives focused on religious minorities and on intersectional disadvantage. Such research could support action to implement recommendations by the UN Forum on Minority Issues in relation to

removing discriminatory legislation and promoting mechanisms for equal treatment and non-targeting of minorities.¹⁷

Most of the evidence reviews identified from the global search for studies were conducted by Western academics, often in Western contexts. Supplementation of this evidence through four country-specific reports allowed an assessment of parallels and differences between the global evidence and that relating to India, Kenya, Nigeria and Vietnam. Validation of the exclusion model illustrated in Figure 2 above within these diverse country contexts, by multisector and multidisciplinary workshop participants, suggests there is considerable potential to explore the transferability of effective initiatives between diverse contexts to evaluate their political, institutional and social feasibility. Mapping inclusion initiatives on to the various drivers of exclusion within our model should, in theory, increase the potential of such initiatives to improve the experience of minority ethnic and religious groups and individuals.

This model confirms the need to attend to structural disadvantage alongside institutional, community and individual factors (Bailey et al. 2017). We suggest that this multilevel approach is essential to avoid blaming disadvantaged minority ethnic and religious groups for their own exclusion and replicating social exclusion within the research process (Mir et al. 2013). There has, however, been a notable failure to adopt such an approach despite the abundance of social science theory on structural racism (Bailey et al. 2017). Within studies on health services, where the most credible evidence in our review was found, evaluation of the effectiveness of initiatives was adversely affected by a failure to address macro-level influences on inequality affecting ethnic and religious groups (Dauvrin and Lorant 2014). Studies on education were more likely to take account of these structural causes of inequity, suggesting a need for cross-fertilization of helpful approaches between disciplinary areas.

More robust empirical studies and reviews of current evidence are also needed; these could usefully draw on the stronger methodological approaches used in health research and the structural perspectives adopted in education studies. A particular gap in the literature we reviewed was the lack of interventions that specifically challenged educational curricula that portray ethnic and religious minorities as “other” or neglect their worldviews and experiences. Evaluating the quality of educational opportunities offered to such communities would support understanding of how education may need to be reframed so that Goal 10 can be operationalized effectively. Inclusion policies may fail to be transformative in effect and can have unintended consequences without this deeper attention to embedded exclusion practices. There is evidence from Liberia, for example, that police teams may become more discriminatory when they include officers from Mandingo minority groups¹⁸. This raises questions about the terms on which those recruited to existing services are valued and how much opportunity they have to shape the culture of their organizations.

¹⁷ United Nations Human Rights Council 2015

¹⁸ Blair et al. 2016

There is also a need to ensure that under-represented or “hardly reached” groups, typically excluded from both research and policy, are involved in future research studies. Solution orientated evidence can, however, be limited by social and political hostility towards ethnic, and even more so religious, minorities, in a wide range of global contexts (Pew Research Centre 2018). This context has implications for the availability of research funding and for the career trajectories of those conducting such studies. Identity-based groups gained relatively little from the progress achieved under the Millennium Development Goals and it is crucial to recognize ethnic and religious discrimination as well as intersectional inequalities if the “leave no one behind” approach is to be realized in practice (Stuart and Samman 2017).

Our reviews found that the evidence available is conceptually focused on ethnic rather than religious-group disadvantage, suggesting that this is currently a more acceptable framework in many contexts. This focus also appears to have influenced the implementation actions for SDG 10, which pay far less attention to the need for data and other indicators relating to religion than to ethnicity or gender (Stuart and Woodroffe 2016). Influential international bodies and research reports may similarly omit attention to religious discrimination. For example, the World Inequalities Report for 2018 (Alvaredo et al. 2018), compiled through collection of data on economic inequality from more than a hundred researchers located over five continents, acknowledges ethnic disadvantage but includes almost nothing about religious inequalities. This failure to recognize the need for attention to religious groups that experience disadvantage has repercussions for the type of data collected at national and local levels and the kinds of inclusion strategies that are likely to be developed. There is thus a need for future research to explore ways of legitimising knowledge production in relation to religious communities and reducing the fear and sensitivity that can surround such research.

The common failure to effectively transfer national policies into local practice indicates that more studies are needed to improve our understanding of mechanisms by which effective implementation can be achieved and implementation barriers reduced. Some existing work in this area suggests that successful implementation of inclusion policies can be prevented by non-representation, power imbalances and unequal distribution of resources between disadvantaged and socially included populations during implementation processes. Furthermore, implementation protocols and other routine instruments may favour already powerful populations and create barriers for the disadvantaged, while those responsible for implementing inclusion policies may adopt discriminatory practices towards the intended beneficiaries of these policies (Pires 2018). Robust evaluations of effective implementation processes would contribute valuable knowledge on how these processes can avoid recreating exclusion and how equitable outcomes might be achieved.

Research that more closely reflects the way in which disadvantage is experienced is also needed, involving approaches that are able to deal with exclusion holistically rather than through a fragmented, disciplinary focus on experience. Such approaches are more likely to be achieved through “all stakeholder” collaboration across sectors and disciplines and through the equal representation of community advocates from disadvantaged populations.

Our evidence synthesis has highlighted a wide range of reasons for addressing ethnic and religious group inequalities and constructive approaches to exploring how to do so. Current lack of attention to the social exclusion of ethnic and religious minorities in relation to the SDGs highlights the need for an increased focus on these populations and a future research agenda that fills current evidence gaps. Such an agenda would provide a way forward for promoting greater social ownership of “inclusive societies”. This in turn could help reduce the routine discrimination and exclusion experienced by many ethnic and religious minorities globally and transform the current landscape. There is a growing need for such transformation both in cities, where decision-making about public services most often takes place, and in other areas where those who experience such disadvantage may live.

Conclusions

The exclusion of minority ethnic and religious communities is created and operationalized in three distinct but interconnected social contexts: macro (the socioeconomic and political environment), meso (organizational and institutional context) and micro (individual and interpersonal). Existing global evidence on strategies to include minority ethnic and religious groups in public services focuses primarily on micro- and meso-level strategies. Few macro-level initiatives or multilevel strategies have been reviewed and rigorously evaluated, however, some examples of such approaches should be considered for evaluation in other contexts. From the evidence available three overarching considerations appear key to future research in this area: the influence of social context on the production of inequities, the need for multiple strategies to achieve system reform and the necessity of tailored solutions involving collaboration with affected communities.

A future research agenda that can support and influence attention to these considerations should take account of the multiple mechanisms through which minority ethnic and religious groups are excluded from public services. Such an agenda should aim to model inclusive practice and challenge dominant stereotypes to promote research that helps achieve equitable access to, representation in and outcomes from public services for all ethnic and religious communities.

Limitations of the Study

Our search for global literature was restricted to review papers that focused on inclusion strategies within public services. Country specific reviews included primary studies, policy documents and literature from relevant additional databases and national

websites. The review for Vietnam included papers in Vietnamese as well as English, however, all other reviews were restricted to English language papers. These restrictions limited the scope of our reviews and meant that academic papers were more likely to be included than other evidence sources. In particular, relevant evidence from the work of organizations such as the UN Minority Rights Group and the International Work Group on Indigenous Affairs were not identified by our database searches and may provide additional insights.

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Appendix

Databases searched for global evidence review

Applied Social Sciences Index and Abstracts (ProQuest) 1987-present
Cochrane Central Register of Controlled Trials (Wiley): Issue 11 of 12, November 2016
Cochrane Database of Systematic Reviews (Wiley): Issue 1 of 12, January 2017
Criminal Justice Abstracts (EBSCO) 1830 -- present
Database of Abstracts of Reviews of Effects (Wiley): Issue 2 of 4, April 2015
EconLit (EBSCO) 1886 -- present
ERIC Education Resources Information Center (EBSCO) 1966- present
Global Health (Ovid) 1910 - 2017 Week 01
Health Management Information Consortium (Ovid) 1983 -- present
International Bibliography of the Social Sciences (ProQuest) 1951 -- present
Ovid MEDLINE ® Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Daily and Ovid MEDLINE(R) 1946 – Present
PAIS International (ProQuest) 1972 – present
PsycINFO (Ovid) 1806 - January Week 3 2017
Sociological Abstracts (ProQuest) 1952 – present
Web of Science (Clarivate Analytics) databases: <ul style="list-style-type: none"> • Arts & Humanities Citation Index 1975-present • Conference Proceedings Citation Index- Science 1990- present • Conference Proceedings Citation Index- Social Science & 1990-present • Sciences Citation Index 1900-present • Social Sciences Citation Index 1900-present

Source: Authors.

Search Strategy for Ovid MEDLINE(R) 1946 to Present (including MEDLINE Epub Ahead of Print, MEDLINE In-Process & Other Non-Indexed Citations, MEDLINE Daily)

- 1 Ethnic Groups/ (61703)
- 2 exp Culture/ (145622)
- 3 Cultural Diversity/ (11302)
- 4 ((Ethnic* or cultural) adj (group* or minorit* or identit* or diverse or diversit*)).tw. (50077)
- 5 exp "Emigrants and Immigrants"/ (10276)
- 6 Refugees/ (8641)
- 7 Minority Groups/ (14068)
- 8 (Minority adj (group* or population* or communit*)).tw. (9303)
- 9 (Migrant* or immigrant* or refugee* or asylum seeker*).tw. (43733)
- 10 exp Religion/ (61331)
- 11 ((Religio* or faith or belief*) adj3 (minorit* or group* or identit* or diverse or diversit*)).tw. (2837)
- 12 (Adivasi or Atheis* or Buddhis* or Catholic* or Christian* or Dalit or Edo or Fulani or Hindu* or Ibibio or Islam* or Jehovah* or Jew* or Judaism or Kanuri or Moslem* or Muslim* or Moslem* or Nupe or Protestant* or Sikh* or Somali or Tiv or untouchable*).tw. (39964)

- 13 ((Backward or Scheduled or indigenous or native) adj (caste* or tribe*)).tw. (376)
- 14 or/1-13 [Ethnic or religious groups] (356848)
- 15 exp Health Services/ (2002568)
- 16 (Health adj2 (service* or provi* or practi*)).tw. (179276)
- 17 exp Education/ (717028)
- 18 (Education* or college* or school? or universit* or teach*).tw. (1083481)
- 19 (Civil adj regist*).tw. (817)
- 20 Teaching/ (48900)
- 21 Police/ (4548)
- 22 Law Enforcement/ (3417)
- 23 (Criminal justice or law enforcement or police or policing).tw. (19124)
- 24 Local Government/ (3160)
- 25 ((County or Local) adj (government or authorit*)).tw. (5697)
- 26 or/15-25 [Public service institutions] (3172291)
- 27 Inservice Training/ (20570)
- 28 Staff Development/ (9045)
- 29 Organizational Innovation/ (24689)
- 30 Organizational Policy/ (14700)
- 31 Government Programs/ (4806)
- 32 (Intervention* or strateg* or toolkit* or system* or program* or framework* or guide or guidance or training or initiative* or model? or policy or policies).ti. (1769934)
- 33 (Checklist* or legislation or regulation* or incentive* or campaign* or partnership* or collaborat* or network*).ti. (407464)
- 34 ((Staff* or tertiary or technical or organi#ational or institution*) adj2 (education or training)).tw. (11065)
- 35 or/27-34 [Interventions] (2199950)
- 36 *Social Justice/ (5334)
- 37 *Human Rights/ (8157)
- 38 *Civil Rights/ (5120)
- 39 Cultural Competency/ (4725)
- 40 *Prejudice/ (13247)
- 41 *Stereotyping/ (5127)
- 42 Racism/ (1367)
- 43 Race Relations/ (2674)
- 44 *"Discrimination (Psychology)"/ (9337)
- 45 Social Discrimination/ (736)
- 46 (Social* adj (inclusion or exclusion or justice)).ti. (1060)
- 47 (Diverse or diversit* or represented or representation).ti. (73946)
- 48 ((Human or civil or social) adj right?).ti. (4093)
- 49 (Cultural adj (competenc* or aware*)).tw. (3102)
- 50 (Service adj (improvement or development)).tw. (1628)
- 51 (Racis* or prejudice* or stereotyp*).ti. (6903)
- 52 (Antiracis* or anti-racis* or anti racis*).tw. (100)
- 53 (Marginali* or injustice or equality or inequality or equity or othering or stigma* or discriminat*).ti. (51224)
- 54 Sexism/ (940)
- 55 Saxis*.tw. (891)
- 56 Social Class/ (40658)
- 57 Social Change/ (17904)
- 58 Socioeconomic Factors/ (152550)
- 59 ((Social or socioeconomic) adj (class* or change or develop* or economic* or prosper* or cohesion)).ti. (3629)

60 ((Social* or socioeconomic) adj (mobility or mobile)).ti. (238)
61 Poverty/ (36188)
62 (Poverty or landless).tw. (22065)
63 or/36-62 [Outcomes] (402387)
64 and/14,26,35,63 (4268)
65 limit 64 to systematic reviews (236)
66 (Literature review* or systematic review* or narrative review* or critical review*
or scoping review* or synthesis or meta-analys* or "meta analysis").ti. (440104)
67 ("Search filter*" or "search strateg*" or "literature search*").tw. (50274)
68 or/66-67 (474154)
69 and/64,68 (184)
70 65 or 69 (251)