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

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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 societies.

In this paper we attempt to bridge 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. 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 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.

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 operationalised. 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; disadvantage; public services

Bio

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Ghazala Mir, Sarah Salway, Joe Kai, Saffron Karlsen, Raj Bhopal, George TH Ellison, and Aziz Sheikh. 2012. "Principles for research on ethnicity and health: the Leeds Consensus Statement." *The European Journal of Public Health*, 23(3):504-510.

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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 5 and 10 focus on gender and wider societal inequities respectively. Furthermore, aspirations for universal access to essential services (e.g. health and education) and the alleviation of poverty and hunger all underline the importance of this equity agenda.

The SDGs were developed in the context of growing acknowledgement that social inequalities are intensifying within countries and globally (Sachs 2012) and that equity must be addressed in ensuring sustainable development, particularly within low- and middle-income countries (LMICs) (World Bank 2013). The inequality focus, has for the most part, centred on women and on poverty, however, and discussions of SDG 10 have paid little in-depth attention to ethnic and religious exclusion despite the overrepresentation of ethnic and religious minorities amongst the poorest communities (Ostry, Berg and Tsangarides 2014; Roser and Ortiz-Ospina 2018). Intersectionality i.e. the experience of exclusion at multiple levels, as experienced by women, young people and migrants from minority ethnic and religious groups, has similarly been neglected in studies on gender, age and migration (World Bank 2012; Shah et al. 2015).

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.[1] 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.[2]

Religious and ethnic minority groups are particularly vulnerable in many contexts, and represent the focus of this paper. Both ethnic and religious minorities typically have poorer access to services and institutions relating to healthcare[3], education[4] finance[5] and systems for justice and government (United Nations 2015; Galab et al 2008). Ethnic inequalities are often linked with religious discrimination[6] particularly in the rhetoric of nationalist groups and ruling political parties in various global contexts (Pew Research Centre 2018; Obadare E 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 i.e. the prevention of social participation, or exercise of full citizenship, operates (Gerometta et al 2005; Nambiar et al. 2016). Restricted access to job opportunities and

[1] Sachs 2012; World Bank 2012; UN-Habitat 2010; World Bank 2006

[2] World Bank 2013; Uzochukwu BSC 2012; Steinberg and Lindfield 2011; World Bank 2014; United Nations 2014

[3] Mir and Sheikh 2010: Priest et al 2013; Subramaniam 2018

[4] Xaxa 2001; Jahan 2016; Suresh and Cheeran 2015

[5] Dymski and Bagchi 2007; Dymski et al 2009; Meer 2013

[6] Meer 2013; Mir and Sheikh 2010; Mir et al 2015

the resources of public service institutions enables privileged 'insiders' within these institutions to systematically deny such opportunities to stigmatised ethnic and religious groups, thus maintaining their exclusion (Kabeer 2000). 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 criticised 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 services and employment opportunities (Pew Research Centre 2018).

The role of public services and systems in challenging social exclusion is, therefore, important. For example, engaging minority ethnic and religious groups in institutional governance is considered an essential element of inclusive activity within cities (World Bank 2015; Commonwealth Inclusive Cities Network 2016) 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 2003). Institutions also have competing priorities and exclusion can be made invisible through lack of data on socially excluded groups (Stuart. and Woodroffe 2016; Makoloo 2005). In Vietnam, for example, 53 ethnic minority populations are classified as one group to compare with the Kinh majority and there is a lack of data for specific ethnic minorities (Duong 2018).

The evidence base on underlying causes of exclusion affecting ethnic and religious minorities, and effective interventions to address exclusion across public services (such as health or education), is limited and fragmented by a focus on specific services such as maternal healthcare (Doan et al 2016; 2018) or specific aspects of education with limited attempts to generalise across different public services or even within sectors. There is thus an urgent need to synthesise 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 will 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 bridge 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 conceptualise 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 synthesise 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 summarise the outstanding gaps that should inform a future research agenda on this topic.

Methods

Between March and November 2017, we systematically searched and reviewed global evidence from literature reviews about strategies or interventions 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. 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. 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 and in relation to local government and police services, where research evidence was extremely sparse for all the reviews. 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. Electronic databases searched for the global review are listed in Table 1.

A two-step strategy was used to screen records obtained from the searches. First, titles and abstracts of records were screened for eligibility, with at least 25 percent of results examined by two researchers. Second, the full texts of eligible papers were analysed using a standardised 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 and initiatives relating specifically to gender, age and migration were also identified, to capture any initiatives aiming to reduce intersectional disadvantage. Finally, gaps in the evidence were highlighted in order to develop a future research agenda that could support the improved social inclusion of disadvantaged ethnic and religious minorities.

Table 1: Databases searched for global evidence review

Applied Social Sciences Index and Abstracts (ASSIA)) ProQuest 1987-present
Cochrane Central Register of Controlled Trials: Issue 11 of 12, November 2016
Cochrane Database of Systematic Reviews: Issue 1 of 12, January 2017
Criminal Justice Abstracts (EBSCO) 1830 -– present
Database of Abstracts of Reviews of Effects: 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
HMIC Health Management Information Consortium (Ovid) 1983 -– present
International Bibliography of the Social Sciences (IBSS) (ProQuest) 1951 -– present
Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) 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 - Thomson Reuters: •Arts & Humanities Citation Index (Thomson Reuters Web of Science) 1975-present •Conference Proceedings Citation Index- Science (Thomson Reuters Web of Science) 1990-present •Conference Proceedings Citation Index- Social Science & Humanities (Thomson Reuters Web of Science) 1990-present •Sciences Citation Index (Thomson Reuters Web of Science) 1900-present •Social Sciences Citation Index (Thomson Reuters Web of Science) 1900-present

Source: Authors.

As part of our analysis we grouped initiatives that had common 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 redressing societal power imbalances, improving service processes or outcomes, individual behaviour change or
- service sectors in which the strategies were delivered,
- the target group(s) (e.g. services, staff, service users) and
- key activities of the strategies (e.g. the provision of information or resources).

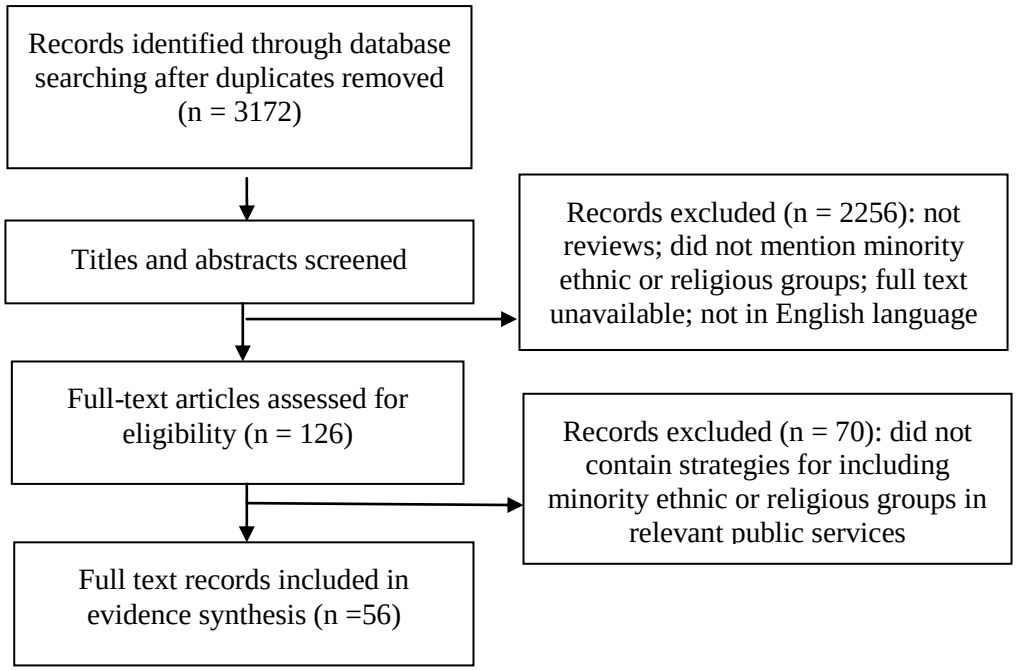
We also sought evidence from relevant policymakers, practitioners, voluntary sector organisations and academics to supplement the literature review through a series of workshops and high level research interviews in each partner country. Participants discussed the literature review findings with the 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. Country academic, NGO and policy leads met at four international workshops to pool and consolidate findings from these national and international contexts.

Results

A total of 126 full text records of the 3172 screened were selected for the global evidence review from which 56 full text records were included in the final evidence synthesis (Figure 1). These 56 papers covered initiatives relating to a wide range of minority ethnic and religious groups, 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 Tay Nguyen 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, such as the use of the term 'Asian' as a designator of East Asian (e.g. Japanese and Korean) descent individuals in the US and South Asian (e.g. Bangladeshi, Indian and Pakistani) descent individuals in the UK.

Figure 1: Modified PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) flow diagram showing the study identification and selection process



Source: Authors.

Drivers of Exclusion

The exclusion of minority ethnic and religious communities was found to be created and operationalised at three distinct but interconnected levels of society. Macro- (i.e. socio-political) level 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- (i.e. institutional) level failure to recognise and appropriately respond to the needs of these groups. This in turn produces barriers to access and inequities in service provision and outcomes[7]. 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 services and lower literacy, capacity, social and cultural capital and disempowerment among disadvantaged ethnic and religious groups[8]. Figure 2 illustrates the dynamic relationship between the various social processes that create and maintain exclusion.

[7] Anderson et al 2003; Davy et al 2016; Kehoe et al 2016

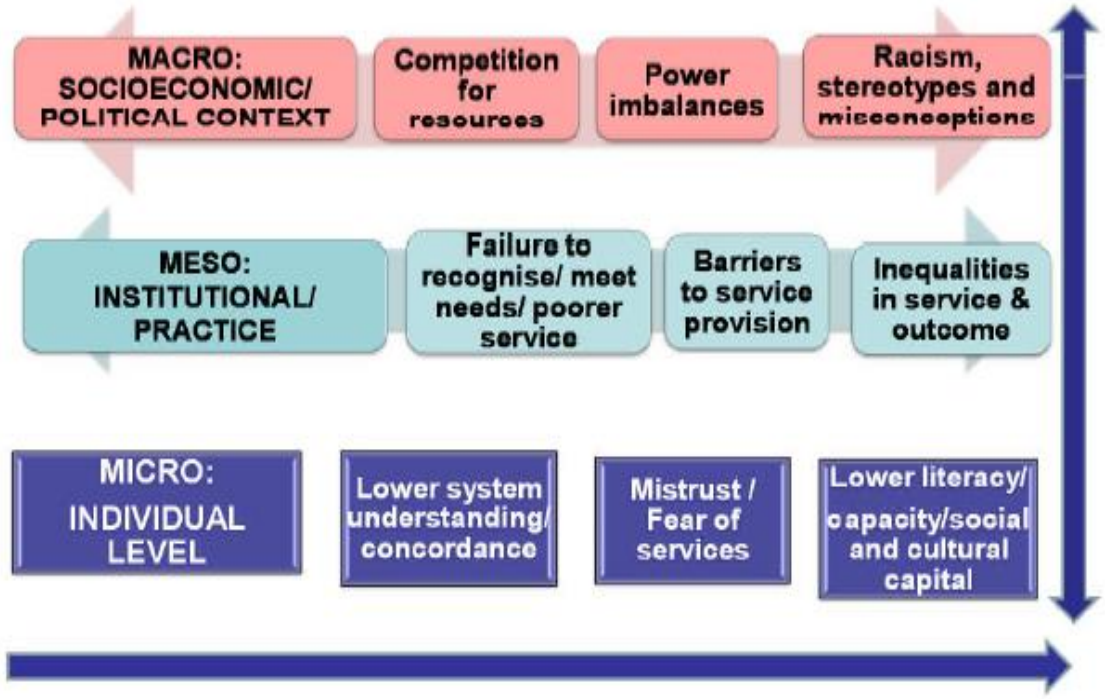
[8] Alam et al 2008; Eakin et al 2002; Lakhanpaul et al 2014

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 and the association of religious minorities with threats to security.

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 addressed through initiatives such as

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



Source: adapted from Solar and Irwin 2010

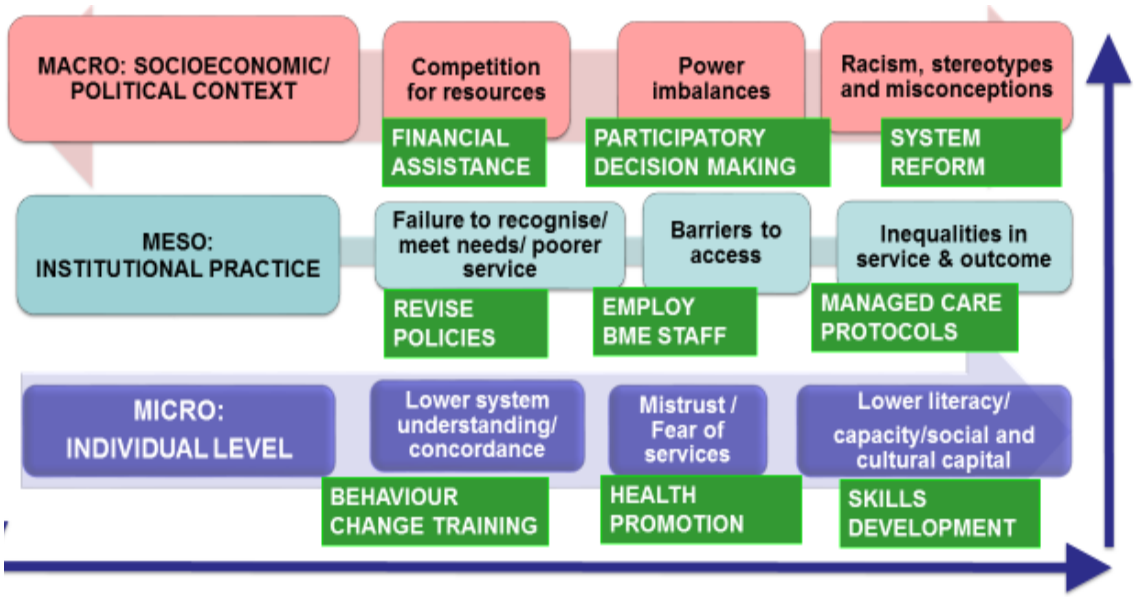
financial assistance or other incentives (Escriba-Aguir 2016), correcting power imbalances through instituting participatory decision making (Tsou et al 2015), and changing social norms through removing segregated education and targeting provision at those experiencing disadvantage (Gamoran 2012 Hahn et al 2014). 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 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 also helped ensure they were more culturally-acceptable[9]. 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 mobilisation and changes in living conditions, such

[9] Kalibatseva 2014; Zeh et al 2014; Haynes et al 2014

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, e.g. through skills development (Valla and Williams 2012), changing individual health behaviour (Anderson et al 2003) and reducing negative perceptions of services through health promotion (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, all but two of which 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 excluded minorities (Escriba-Aguir et al 2016; Sass et al 2009) and their involvement in the development of new or adapted provision (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' i.e. underperformance by those in an excluded group that is caused through fear of fulfilling a negative stereotype about underperformance in that group (Gamoran et al 2012). Providing

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



financial support for school-based health access was also effective in addressing inequities healthcare use as well as school attendance and completion for low income ethnic minorities (Knopf et al 2016). Although these findings were scientifically significant, reasons for the effectiveness of the interventions were absent from most of these reviews. The review team 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 India, where affirmative action policies mostly addressed macro and meso-level factors. Affirmative action policies linked to the Indian constitution 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 Viet Nam, 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). At meso-level, training and employing young women to provide maternal and village healthcare services has proved promising (Doan et al 2018), whereas a large-scale behaviour change campaign on hand washing had limited effectiveness (Chase and Do 2012).

Despite the preponderance of papers focused on health services, all studies that described macro-level strategies in the global review related to educational services. In India, too, macro level studies existed in education, employment and governance, where affirmative action policies are long established. Health is not similarly recognized as a fundamental right within the Indian constitution and, consequently, no policy measures specifically target ethnic and religious minorities. State-funded health insurance has more recently targeted those living in poverty and has indirectly benefitted ethnic and religious groups overrepresented among the poor (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 addressed macro, meso and micro-level factors and led to reductions in health inequalities for ethnic minorities 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 limited evidence that reservations in higher education have helped enhance targeting, admissions and educational outcomes for ethnic minorities[10]. There is also evidence of poverty reduction, and improvements in allocation of welfare budgets resulting from the reservation policy for ethnic minorities in elections[11]. 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 review. Both the Kenyan Constitution (Republic of Kenya. 2010) and the County Government Act 2012 provide clear references to inclusion and protection of 'marginalised 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). The Act directs that at least 30 percent of vacant posts at entry level are filled by

[10] Robles and Krishna 2012; Nagpurkar 2011; Bagde et al 2016

[11] Kaletski and Prakash 2016; Chin and Prakash 2010; Pande 2003

candidates who are not from the dominant ethnic community. Similarly, the Commission for Revenue Allocation has developed criteria for sharing revenue in line with the Equalization Fund provided by the Constitution. The policy also identified ethnic minority communities that need to be targeted for service provision, particularly: Elmolo, Makonde, Watta and Dorobo-Saleita/Ogiek (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 such groups struggling to access basic services and economic opportunities. 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.

There was very little discussion of the underlying theories that informed the development of initiatives to improve public service inclusion of minority ethnic and religious groups. With the exception of India, where long-standing affirmative action policies are based on acknowledgment of the historical social oppression suffered by certain groups, community-level strategies rarely targeted the wider socio-cultural environments that created and helped to maintain social exclusion and there was a lack of consideration, in particular, of the historical and social processes that produce these inequities. Inclusion initiatives were at times clearly influenced by these exclusionary processes, assuming that the reason for inequities lay in community deficiencies or cultural norms. For example, interventions focused on disadvantaged ethnic and religious communities rather than on service providers 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). 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**Error! Bookmark not defined.** (Bhui et al 2015). In Nigeria, studies included in the review could similarly position socio-cultural issues as the key cause of poorer outcomes within disadvantaged minority ethnic and religious groups, rather than the failure to accommodate these cultural norms within public services (Ayanore et al 2016; Oluyemi et al 2014). The reason for studies adopting such a focus for initiatives aiming to improve inclusion was unclear and lacked justification. Feedback at international workshops highlighted that policymakers 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 stigmatise research that tried to challenge such perspectives, creating disincentives for researchers in this field.

More collaborative approaches to development initiatives were adopted by a number of studies in order to achieve more inclusive services (Mir and Sheikh 2013). 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-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 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 would improve the effectiveness of school-based obesity interventions targeting African American and Hispanic children. 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 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 marginalised communities in, 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 action that addressed the inequities such communities experienced.

Despite the lack of explicit discussion within the review 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), internalised racism (Dancy and Jean-Marie 2014) and links between (public) sectors and effects on life-course**Error! Bookmark not defined.** (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 with 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 which provided 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 communities. These 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 a multisector programme of policy and public service development that promotes comparable access to, representation in and outcomes from public services between ethnic and religious groups has 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, currently 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.

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 suggest 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 the model should in theory increase the potential of such initiatives to improve the experience of minority ethnic and religious groups and individuals.

The 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. 2012). There has, however, been considerable resistance to such an approach despite the abundance of social science theory on structural racism (Mir et al. 2012). 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 the structural causes of inequity and this suggests a need for cross-fertilisation 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 research.

There is also a need to ensure that under-represented or ‘hardly reached’ groups, typically excluded from both research and policy, are addressed in future research studies. Solution orientated evidence can 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) with implications for the availability of research funding and the career trajectories of those conducting such studies.

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 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 recognise the need for particular attention to disadvantaged religious groups 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 studies are needed to improve our understanding of mechanisms by which effective implementation can be achieved and how to reduce implementation barriers. Robust evaluations of interventions to implement these policies would contribute valuable knowledge on the processes involved and outcomes 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 aspect of this 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. A future research agenda that fills current evidence gaps 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 to happen 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 operationalised at three distinct but interconnected social contexts: macro (the socioeconomic and political environment), meso (organisational and institutional context) and micro (individual and inter-personal) levels. 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.

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