

SOCIALLY INCLUSIVE CITIES

Report of a Global Evidence Review

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SOCIALLY INCLUSIVE CITIES

Introduction

This report summarises initial results of a global evidence review conducted by researchers at the University of Leeds on how public services can help reduce the inequalities experienced by minority ethnic and religious groups. The report synthesises evidence from a global literature review and from a national workshop in May 2017, involving key stakeholders from public service institutions. Parallel evidence reviews and workshops are being held in India, Kenya, Nigeria and Vietnam to explore the same issues from a national perspective. The evidence from all project partners will be synthesised following an international workshop on 5th June 2017.

Methods

We reviewed published evidence from across the world on ways that public services have tried to reduce the social exclusion of people from minority ethnic and religious groups. The review was guided by 13 specific research questions, structured around four themes that aimed to improve understanding of:

1. Key drivers of ethnic and religious exclusion internationally and which populations were identified with the evidence available
2. Strategies available to address causes of social exclusion in four public service sectors (education, health, police and local government services), including evidence of their effectiveness in different contexts
3. The particular impact of social exclusion on women and young people and any inclusion strategies used by public services to particularly target these subgroups
4. Gaps in existing knowledge and agenda for future research, to inform future policy and practice to combat social inequalities

The review was conducted between January and April 2017 and covered literature available in English from 19 key academic databases covering publications in social science, criminal justice, economics, education and health (see Appendix 1). For the global report, review articles covering inclusion strategies for minority ethnic and religious groups in local government or health, education or police services were selected for review. The process included the following steps:

- systematic searching of databases using keywords agreed between all partners
- initial screening of titles and abstracts for eligibility, with at least 25% of results examined by two researchers (481 papers screened);
- selecting eligible articles from full text of screened publications (57 papers selected).
- use of a standardised template to summarise the contents of each relevant article.

Analysis of the completed summaries was guided by the research questions. Gaps in the literature were identified in relation to publications on economic interventions and police services. Further work is needed to explore what evidence is available in these areas.

PART 1: SOCIAL EXCLUSION

Which minorities are described in existing research?

Evidence from the literature indicated that the understanding of ethnicity and religious identity varies across different contexts, and is **shaped by national and cultural influences**. Where specified, 45 papers were from high income countries and two from low and middle income countries, with only three papers taking a global perspective. This partly reflects the fact that papers relating to partner countries have yet to be synthesised but may also reflect a lack of evidence on LMIC contexts.

SOCIALLY INCLUSIVE CITIES

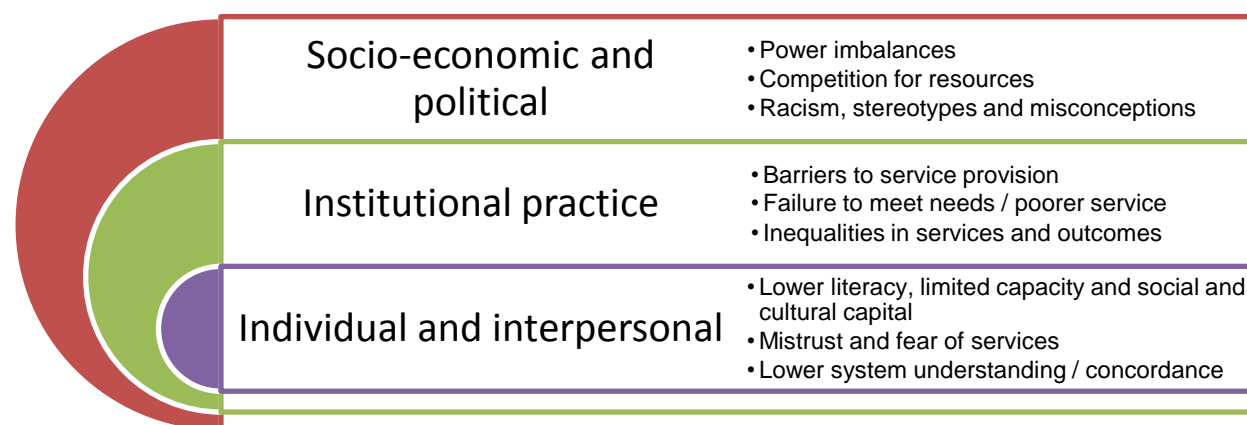
Studies on minority ethnic and religious groups often combined these populations with other socially excluded groups eg 'lower economic status', 'vulnerable' or 'disadvantaged' communities (Cyril et al 2015; Eakin et al 2002; Enard et al (2016); Gallagher and Polanin (2015); Hahn et al (2015); Legler et al 2002; Tao et al (2016)). Even when the focus was exclusively on ethnic and religious identity, broad categorisations, such as 'BME', 'North African' or 'South Asian', raised questions about whether inequalities within these large and diverse groups were being masked (Aggarwal et al 2016; Anderson et al 2003; Escriba-Aguir et al (2016); Garcia et al 2016; Kehoe et al 2016; Knopf et al., 2015; Lood et al (2015); Manuel et al (2015); Sullivan & Simonson, 2016). In some publications the experience of specific sub-groups within these broad categories was explored, eg 'BME elders', 'asylum seekers', 'Roma', 'Korean Americans', 'Muslim' (Clifford et al (2015); Davy et al (2015); Fesus et al (2012); Goodkind et al. (2010); Wolff et al (2003)). There were, however, only 9 of 57 papers on religious identity, with the vast majority focusing on exclusion in relation to ethnic identity.

Multiple layers of exclusion were considered by workshop participants to exist when additional factors such as low socio-economic status are compounded by ethnic and religious discrimination. Vulnerability is increased by, for example, mental illness, learning difficulties, disability, domestic violence and age.

Access to services and welfare benefits is reduced for the poorest as services are not tailored to those who live in poverty. For example transport systems globally are designed for commuters, middle class car users and business travellers. Government policies such as the bedroom tax and welfare benefit caps in the UK disproportionately affect minority ethnic and religious groups because they are over represented among deprived communities.

What are the key drivers of exclusion from public services?

Research evidence indicates that causes of social exclusion cover a complex web of **multiple and interrelated influences**. As shown below, these drivers cut across three broad levels: *macro* (the socio-economic and political environment), *meso* (organisational and institutional context) and *micro* (individual and inter-personal factors):



At the **systems or macro level**, for people from minority ethnic and religious groups key drivers relate to competition between different groups or sectors for resources combined with societal values and norms that tolerate racism and stereotypes. The more limited power and capacity of some social groups to challenge dominant norms results in the absence of public service policies and action that would ensure the needs of minority ethnic and religious groups are met (Fesus et al 2012; Goodkind et al. (2010); Manuel et al 2015).

SOCIALLY INCLUSIVE CITIES

At the ***institutional level***, key drivers of exclusion are influenced by this social context . Failure to recognise and address the needs of minority ethnic and religious groups creates institutional barriers to service provision, such as an absence of staff with diverse cultural and linguistic understanding. Institutional drivers of exclusion contribute to inequalities in the provision of public services, ultimately leading towards poorer outcomes e.g. lower education levels or higher mortality in these groups (Anderson et al 2003; Davy et al 2015; Kehoe et al 2016; Knopf et al 2016).

At the ***individual and community level***, the root causes include limited literacy, lower social and cultural capital, mistrust and fear of public services and limited or mis-understanding of public service systems, contributing to their limited use (Alam et al 2008; Eakin et al 2002; Kehoe et al 2016; Knopf et al 2016; Lakhanpaul et al 2014). The social and institutional contexts outlined above contribute to these individual and community level factors in social exclusion.

Overall, the evidence indicates that these various drivers interrelate within and between all three levels. This highlights the importance of identifying influences at each level that can be targeted most effectively through policy and practice interventions.

Workshop participants confirmed that ***exclusion is multifaceted*** and can affect all areas of life as well as communities and institutions such as education, health and housing services. State policies and powerful institutions such as banks operating at the macro level can use their powerful positions and influence to maintain exclusionary practices and focus on profits rather than people. Participants also highlighted that exclusion can happen within minority ethnic and religious communities as well as in wider society and public services.

The language used to describe exclusion can be politically motivated eg 'disparities' and 'discrimination' reflect different perceptions of the issues involved. Exclusion on the basis of poverty is not always recognised within anti-discrimination policy and this can lead to competition; those in the ethnic majority from deprived communities can resist acknowledging minority ethnic and religious inequalities because they feel that would put these groups at an advantage and consequently puts the majority at a disadvantage in terms of resource allocation. Education was seen as a key issue so that, in schools for example, young people can develop positive attitudes and cultural competence.

Economics was seen as a central issue for exclusion. In terms of public services, decisions made about budget allocations can be used to maintain exclusion – studies that explore budget-related rules for decision-making could help unearth these exclusionary practices. Growth is a central issue for local government and this is often linked to infrastructure such as transport systems. The flow of resource into a geographical area influences change within that area. Subsidies that enable people to be involved in 'anchor institutions' (ie non-profit institutions that play a role in local economies) are a potential means of reducing inequalities.

However, people made the point that minority ethnic and religious groups are versatile and can still have the capacity to be resilient in constrained circumstances, so should not be conceptualised simply as 'victims'. Entrepreneurism is a response to exclusion when people can not find employment, for example. It can also be a way of escaping restrictive work conditions and dependence on state services. Conceptualising people as 'potential' and searching for globally applicable solutions to exclusion is an important perspective to retain despite the multilevel nature of barriers.

SOCIALLY INCLUSIVE CITIES

What is the impact of social exclusion? How do these inequalities affect social mobility and economic development?

The key impacts of social exclusion highlighted in the review were closely linked to the key drivers outlined above and again involved interrelated impacts and overlapping areas:

1. **Constrained access to public services** was linked to the way services are structured or located or the terms on which they are provided. Examples of specific barriers to access included lower rates of referral for healthcare and lower awareness or use of services
2. **Poorer service outcomes** within each of the four sectors. Examples of these included poorer health or more disability and lower education levels, both contributing to lower employment and lower social and cultural capital,
3. **Poverty and income inequalities** are created and maintained through lower access and poorer outcomes to services and can in turn create further difficulties in access. For example, the costs of transport or childcare can limit the use of public services or ability to take up employment opportunities within them.

(Anderson et al 2003; Eakin et al 2002; Kehoe et al 2016; Wolff et al 2003; Kehoe et al 2016)

Inequalities in different public service sectors were considered by workshop participants to be **correlated and interlinked**, for example, lower education levels are associated with lower health literacy. The latter is often blamed for health problems without consideration of the social inequalities that produce lower literacy more broadly. Interdisciplinary linkages are needed to address the multiple sectors involved in people's experience of social exclusion. All the different levels of exclusion – macro, meso and micro - were considered unjust and important to address simultaneously.

What can be done jointly with communities to reduce inequalities?

Research evidence indicates that collaboration with communities is **crucial in efforts to reduce the social exclusion of minority ethnic and religious groups**, whether in service development or research projects. Collaborative relationships with disadvantaged communities can:

- a. *Disrupt and redress current power imbalances* within society by privileging the worldview and agency of excluded groups
- b. *Increase access to and strengthen institutional relationships* with minority ethnic and religious groups, so that social and institutional contexts are more integrated for people from these communities
- c. Use intercultural dialogue to *support the greater involvement of socially excluded groups* in policy development and implementation
- d. *Improve the responsiveness and accountability of public services* to the needs of people from these communities
- e. *Leverage community resources and services* (people, organisations, linguistic and cultural knowledge)

(Alam et al 2008; Anderson et al 2015; Bhui et al 2015; Cyril et al 2015; Davey et al 2016; Eakin, et al. 2002; Fesus et al 2012; Goodkind et al 2010; Haynes et al 2014; Legler, et al 2002; Knowlden & Sharma, 2013; Tsou et al 2015; Wolff et al 2003; Wilson et al 2016)

Successful collaborations with communities include, and are driven by, the following key considerations or principles:

SOCIALLY INCLUSIVE CITIES

1. Communities need to be involved at all stages of intervention or research design, planning, implementation and evaluation. This requires the involvement of linguistically and culturally-skilled staff, understanding of cultural belief systems and utilising social networks to identify and address potential obstacles.
2. Multi-agency collaboration is required. Addressing complex issues such as social inequalities requires a concerted intersectoral approach that addresses the multiple linked aspects of exclusion. In practice, this means effective communication and collaboration between education, health, police, local government and other relevant institutions.
3. Honesty and openness is needed. As with any collaboration, both parties should be willing to work together and see mutual benefits from engaging in collaborative activities. Trust is essential for such relationships.
4. Mutual learning and intercultural dialogue involves recognition that those who design and implement interventions to reduce social exclusion and affected communities have something to learn from the collaboration.
5. Constructive and longer-term relationships are key. Evidence shows that gains from short-term interventions need to be sustained in the longer term, often through continuous engagement and follow-up. The latter is only possible through long-term collaborative relationships.

(Alam et al 2008; Burns and Tomita 2015; Cyril et al 2015; Wolff et al 2003);
Pearson et al 2007; Knowlden & Sharma, 2013)

Barriers to collaboration include

- *Problems with funding* for studies involving collaboration
- *More willingness to collaborate in specialist community organisations* than in mainstream services
- *Lack of policy support* for work in this area.

(Knowlden and Sharma 2013; Davy et al 2015)

Workshop discussions revealed 'political sensitivity' linked to a risk averse culture as a further barrier. The experience of the UK team in Leeds and during the field visit to Vietnam suggested that local authorities and police services were both unwilling to work with religious groups that dissented from national government policies. Staff within these organisations feared the impacts on funding as well as the negative personal impact engagement might have for those attempting to engage.

Workshop participants discussed collaboration in terms of both collaboration practices and research methods.

Collaborative practices

Good practices that could be learnt from existing collaborative initiatives included:

- University departments that work collaboratively (e.g. when the International student office and the Inclusion office come together) to promote attention to diversity amongst both teaching staff and students on courses in the universities.
- Adopting an asset-based approach rather than a deficit approach promotes public health messages in a vast public arena. For example: to reach thousands of people simultaneously with information about bowel screening, we can learn lessons from recent collaboration between the NHS and the Leeds Islamic Centre, who worked together to use a prayer setting with a captive audience of 4,000 worshippers to provide public health information on bowel screening to the worshippers rather than waiting from the 4,000

SOCIALLY INCLUSIVE CITIES

people to individually visit GP surgeries. This was an example of working with organizations as they stand

- Adopting a participatory approach to budgeting (example from Porto Allegro, Brazil), which is a process of democratic deliberation that makes communities part of the budget process, thus facilitating mass participation in decision-making. This example promotes: i) transparency of an annual process; ii) encouraging community members to influence a process when there is something at stake, iii) responsiveness to the needs of local communities.

Bad examples of collaboration included:

- Tokenistic collaboration in the name of ticking a box e.g. during commissioning of health services
- The Cambridge guided bus route project that opted for a participatory process in 29 venues that already enjoyed ample access to transport, while excluding communities that required access to bus services.

The potential for multi-sectoral collaboration to reduce exclusion from public services is huge but requires:

- Effective leadership;
- An organized community (this might need support to become organised)
- Facilitators need to speak the language of collaborating partners. .

Examples in workforce race equality initiatives include situations whereby:

- Marginalized groups may have barriers to breaking through a glass ceiling. However, by providing research evidence that shows the burden of inequality a leader or champion can inspire change
- Framing issues of social exclusion in the context of issues that interest the leadership of an organization (e.g. accountability issues), can make leaders more likely to respond

Involving excluded groups in the research process was confirmed by workshop participants as essential to reducing inequalities. Community participation that is representative of groups experiencing exclusion, organised by staff with linguistic and cultural competency and in touch with community organisations was considered the most appropriate method for achieving this aim.

Research methods that could potentially help reduce inequalities included

Coproduction approaches were also supported with the involvement of all relevant stakeholders and particularly third sector groups that represent the interests of minority ethnic and religious communities. *Participatory Action Research Groups* can help with being reflexive about methods/design. *'Participatory visioning'* was highlighted as a particular research method that could facilitate bridging the gap between the outcomes excluded groups wanted to see and the process for how to get there.

A number of other research methods were also seen to support the aim of reducing inequalities. Examples of research that was able to successfully influence policy and be taken forward by national bodies include *routine data analysis and framing findings in terms of current policy priorities* e.g. 'patient care/experience' rather than emphasising inequalities. Methods that were accessible to people from minority ethnic and religious groups and exploratory could help ensure the focus remained on their experience. *Mapping exercises*

SOCIALLY INCLUSIVE CITIES

within communities could also help with framing research questions that are relevant to community priorities.

Evaluating alternative service models in practice was also seen as a helpful way to focus attention on service development. It was also felt important that studies in the field of inclusion robustly accounted for all relevant variables and took account of the complex relations between these. ‘Counter studies’ against poorly conducted research that failed to account for these relationships were felt to be needed. Participants also suggested drawing on evidence about inclusion for other socially excluded groups that might be more developed, such as sex equality and disability equality initiatives.

Mixed methods approaches are helpful, such as analysis of large datasets to provide a broader picture plus qualitative work to explain and understand patterns found. Qualitative studies such as focus groups of minority ethnic and religious participants are also helpful during service planning processes. An awareness of the *range of evidence across diverse public service sectors* could help inform research understanding and the development of findings. The research methods most commonly used in different disciplinary areas could reflect and potentially impact on how exclusion is conceptualised and understood. Different concepts and language may be used to explain exclusion - for example a focus on individual drivers in health sciences and more structural explanations in sociological research - with the potential for learning across disciplines.

The following **research gaps** relating to collaborative work were also highlighted:

1. What is most effective in creating understanding of exclusion and its drivers amongst the majority population?
2. What methods are effective in developing inclusive societies - how can we measure change?
3. Research that brings together micro, meso and macro inclusion strategies that also recognises the imbalance within current research - which focuses heavily on individual and community level drivers - and aims to redress this
4. Comparative analyses to highlight inequalities.

Key Challenges identified were:

1. Academic rewards and funding are not geared towards community collaboration or work on inequalities
 - a. Universities doing more to support such work
 - b. Showing the business case relating to impact on services
2. How to get impact via policymakers, politicians and media eg
 - a. Develop relationships with individuals
 - b. Links with journalists
 - c. Involve community groups in dissemination.
3. How to create ownership of research for social justice within communities eg
 - a. Feeding back evidence that exists to communities
 - b. Dissemination in accessible formats
 - c. Developing/drawing on expertise and knowledge within communities. Asset based approaches that draw on strengths within communities to address exclusion challenges rather than focusing on community deficits.
 - d. Phased research with earlier stages focused on experience of excluded groups.
 - e. Normalising research within communities and creating links between different groups.

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SOCIALLY INCLUSIVE CITIES

Appendix 1 – Databases searched

Healthcare

Cochrane Database of Systematic Reviews : Issue 1 of 12, January 2017
 Conference Proceedings Citation Index- Science (Thomson Reuters Web of Science) 1990-present
 Database of Abstracts of Reviews of Effects (DARE): Issue 2 of 4, April 2015
 Global Health (Ovid) 1910 - 2017 Week 01
 HMIC Health Management Information Consortium (Ovid) 1983 - present
 Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R) 1946 - Present
 PsycINFO (Ovid) 1806 - January Week 3 2017
 Sciences Citation Index (Thomson Reuters Web of Science) 1900-present

Social sciences

Applied Social Sciences Index and Abstracts (ASSIA) (ProQuest) 1987- present
 Conference Proceedings Citation Index- Social Science & Humanities (Thomson Reuters Web of Science) 1990-present
 International Bibliography of the Social Sciences (IBSS) (ProQuest) 1951 - present
 Sociological Abstracts (ProQuest) 1952 - present
 Social Sciences Citation Index (Thomson Reuters Web of Science) 1900-present

Arts and Humanities

Arts & Humanities Citation Index (Thomson Reuters Web of Science) 1975-present

Criminal justice

Criminal Justice Abstracts (EBSCO) 1830 - present

Economics

EconLit (EBSCO) 1886 - present

Education

Education Resources Information Center (ERIC) (EBSCO) 1966- present