PARTNERSHIPS FOR EQUITY AND INCLUSION

REDUCING SOCIAL EXCLUSION IN PUBLIC SERVICES

A REPORT ON SEVEN PILOT PROJECTS IN ASIA AND AFRICA

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This report describes the activities of the Partnership for Equity and Inclusion (PEI), a collaboration of international research networks aiming to support equitable practice in public service institutions. Seven pilot projects were conducted in Africa and Asia across healthcare, education, peacekeeping, local government and other public service sectors. Findings from these pilot projects are synthesised to inform policy and practice decision-making and to provide a lever to advocacy groups and others seeking to improve public service access, outcomes and representation for socially excluded populations.

Research team members included academics, staff from Non Governmental Organisations (NGOs) as well as policymakers in Africa, Asia and Europe. Pilot reports on which this synthesis of findings is based were led by the following members of the Partnership:

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CONTENTS PAGE

Contents

EXECUTIVE SUMMARY

This report brings together evidence from seven pilot studies exploring how public services in the Global South could be more inclusive of groups that experience inequities linked to social exclusion. Our research was conducted in healthcare, education and local government settings as key institutions in which social inequities are created and maintained. Commonly used private service providers were also included in some of the studies we conducted.

Changing the culture within these services to help reduce inequity is essential for sustainable development and social stability that leaves 'no-one behind'[1]. Failure to address inequity in society, such as unfair allocation of resources and discriminatory practices, has led to widening divisions between rich and poor, men and women and diverse ethnic, religious and other social groups. This in turn is linked to civil unrest, conflict and humanitarian crisis[2] as well as to losses in national productivity and economic development[3] .

The research was carried out by teams in Bangladesh, Kazakhstan, Kenya, Myanmar, Nepal, Nigeria and Vietnam and focused on a range of social groups that experience disadvantage: women and young people, especially those from deprived and rural backgrounds, ethnic and religious minorities and migrant workers. The studies were supported by an international multisector partnership of academic, policy and non-government organisations. The pilot projects engaged with over 385 key stakeholders using robust research methods, including participatory research, policy reviews and in-depth interviews. More details of the Partnerships for Equity and Inclusion collaboration and full reports for all pilot studies can be found on the University of Leeds website here[4].

FINDINGS

The policy context

Data systems for health (HMIS) in Nepal and for health, education and urban planning in Vietnam did not record certain key social group categories so could not identify inequalities in access or outcomes for these groups. The need for such data was rejected by policymakers in Vietnam and even when collected at local level in Nepal was not used in municipal planning. The health needs of groups that experienced disadvantage were similarly not considered in other contexts; for example, risk guidance on COVID-19 was inaccessible to indigenous communities in Bangladesh

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[1] UN Department of Economic and Social Affairs 2015 *UN Sustainable Development Goals* United Nations

[2] Mir et al 2020 *Partnerships for Equity and Inclusion: Evidence Synthesis* University of Leeds

[3] "World Bank. 2013. Inclusion Matters: The Foundation for Shared Prosperity. New Frontiers of Social Policy;. Washington

[4] https://medicinehealth.leeds.ac.uk/directory_record/1366/partnerships_for_equity_and_inclusion

and was impossible to follow in overcrowded urban slums that lacked sanitation facilities in Bangladesh and Kenya.

Representation in decision-making

Collaborative decision-making with disadvantaged populations was identified as a key gap in service planning across the diverse studies.   The lack of staff from these populations and lack of involvement in public service decision-making meant that the needs of these groups were routinely overlooked and there was no challenge to power imbalances or demand for change at local, regional or national levels. Where policies existed to involve such groups in participatory planning processes, these did not function in practice.

In Nepal, though policies on social inclusion and gender equity were well developed, these did not drive change and in none of the study contexts was there effective accountability for reducing the inequities that existed. Women in most study contexts experienced exclusion from decision-making that affected their lives at policy, institutional and community levels.

Power and resources

Exclusion from policies and institutions that affected their daily lives had economic, physical and psychological impacts on people from disadvantaged communities. In Kenya, Nigeria and Myanmar findings showed that social exclusion and physical violence were closely linked, particularly for women and young people. Participants also reported structural neglect and coercive policies and practices, including financial and other restrictions on their ability to access public services. Healthcare and education institutions were often of poor quality in rural or deprived areas in Nigeria and Kenya and too expensive for many to access. Living costs added further pressure and young Nigerian women sometimes turned to prostitution to continue their education beyond primary level. COVID-19 exacerbated these existing income and resource inequalities, particularly in deprived and rural areas. Rural and slum residents in Bangladesh and Kenya and migrant workers in Vietnam suffered financially as disruption particularly affected those in insecure employment. The non-availability or use of data on disadvantaged groups in these contexts, as well as in Nepal, meant that public resources were not allocated to meet their needs. In Kenya, prostitution could be seen by some as unavoidable in order to make ends meet.

The transition to online technology in healthcare and education during the pandemic was very difficult or impossible for many in deprived areas, due to poor planning, non-access to equipment or energy supply and lower capacity to adapt, especially for women with young children. In Bangladesh, Kazakhstan and Kenya, negative impacts of the pandemic on health and learning increased pressure to self-finance healthcare, education and digital equipment.

Teacher training and distribution of digital equipment in Kazakhstan and 'Kazi Mtaani', a youth employment programme in Kenya, were examples of positive initiatives that helped mitigate inequities by targeting support at vulnerable young people during the Covid-19 pandemic. The need to maintain and increase such initiatives was promoted by multi-stakeholder workshops in all contexts, which identified key recommendations across the diverse contexts and population groups involved.

KEY RECOMMENDATIONS

Revise policies that maintain inequity:

- **Pay specific attention to gender, age, ethnicity, religious identity, disability and migrant status in policy and practice** for healthcare, education, water and sanitation, housing, criminal justice systems, employment initiatives and the impact of COVID-19.
- **Target support at excluded groups** and address systemic discrimination and the structural and physical abuse and violence that these groups experience through public services.
- **Gather and use data on current service use and outcomes and on needs** within excluded populations to inform policy development. Disaggregated data should be gained from complementary sources, including robust monitoring mechanisms and feedback from excluded communities and organisations that represent their interests.
- **Recognise** the **intersectional disadvantage** of those who experience multiple layers of exclusion, such as adolescent girls from minority groups, especially in rural areas or informal settlements.
- **Build capacity and leadership** at individual, community, institutional, policy and societal levels to achieve the systemic reforms needed.

Ensure participation in decision-making:

- **Employ people from populations that experience disadvantage** in service planning roles at local, regional and national levels, including at senior levels, to ensure their needs and context are understood during decision-making processes.
- **Develop community partnerships** with policymakers and practitioners and participatory planning to challenge current power imbalances and lack of accountability.
- **Build capacity and support for excluded groups to engage** in partnerships and to ensure that their aspirations are implemented in practice.

Redistribute resources:

- **A systemic restructuring of public services** is needed to address current injustices through, for example, service relocation, targeted provision and transparent systems that monitor and report resource distribution.
- **Invest in deprived areas** to increase access to good quality public services, provide employment opportunities and enable digital inclusion.
- **Provide financial assistance and incentives** to mitigate inequities, particularly for young people living in informal settlements and rural areas.

Scale up equity interventions:

- **Develop strong leadership** to implement evidence-based interventions at local, regional and national levels. Address political, economic, and sociocultural injustices as well as historic tensions and grievances.
- **Gather robust and stratified data** for health, education and other services, including relevant private institutions via trained staff.
- **Evaluate implementation of equity interventions** to generate further refinements and inform new initiatives that meet the needs of excluded groups.

INTRODUCTION

Why is Equity Important?

Failure to address inequity in society has led to widening divisions globally between rich and poor and between diverse ethnic, religious and other social groups that, in turn, is linked to civil unrest, conflict and humanitarian crisis (Sachs 2012; Bliesemann et al 2019; Wilkinson and Pickett 2010). Not only does this affect individuals and social groups but discrimination based on poverty, gender, ethnic or religious identity, age and intersectional disadvantage is known to significantly influence social as well as economic sustainability and development (Steinberg, et al. 2011; World Bank 2014; United Nations 2014).

Competition for resources is a key driver of social conflict (United Nations 2014; Inclusive Cities Network 2016) and public services such as healthcare, education, local government and policing can often act as a mechanism through which dominant groups maintain privilege through unfair resource allocation and discriminatory practices towards others in society (Gerometta et al 2005; Mir et al 2020; World Bank. 2009). Changing the culture within these services to help reduce inequity is, therefore, essential for social stability and cohesion as well as for equitable development that leaves 'no-one behind' (Armendaris 2015; Olzak S 2003; Mir et al 2013, 2020; UNRISD 2016).

Our pilot studies

Members of the Partnership for Equity and Inclusion initially conducted an evidence synthesis of their existing research findings on inclusive practice to identify research gaps in relation to equitable public services (PEI 2021). This highlighted the need for more evidence about innovative interventions to support public service development and robust evaluation of existing interventions. Attention to the '4 Rs' within such initiatives was highlighted: Redistribution of resources, Recognition of social context, Representation of excluded populations and Reconciliation to address historical grievances and tensions. The need to capture a holistic picture of the challenges that influence the way people from such populations act and respond was emphasised, drawing on knowledge that was based on their everyday experiences to help develop inclusive public services.

Recommendations from the evidence synthesis were used to develop seven pilot studies involving collaboration with disadvantaged populations, public service practitioners, policymakers and NGOs in Bangladesh, Kazakhstan, Kenya, Myanmar, Nepal, Nigeria and Vietnam. Projects explored how to develop more inclusive services across diverse sectors: healthcare, education, local government and peacekeeping. Each of these sectors is influential in determining health outcomes (Mir et al 2021; Gerommeta et al 2005) and pilot projects explored the mechanisms of exclusion and inclusion at a number of levels: policy and societal (macro-level), institutional (meso-level) and individual or community (micro-level) as well as across different sectors. This report highlights common themes across the different pilot studies, in order to determine the kind of interventions that could be most helpful across diverse contexts and population groups.

Below we describe the relevant country contexts for these pilot studies, including social norms and public service policies or practices that heped to create, maintain or reduce disadvantage.

Macro- (policy and societal) level context

Societal norms and public service policies

Social norms, reflected in public service policies, were a key influence on the existence of inequalities that we explored within our pilot studies. The excluded populations with which pilot studies engaged all experienced discriminatory social attitudes that were often reflected in public service policies and practice. For example, gender inequalities adversely affecting women were reported in all contexts, with fewer opportunities for education or employment available to women compared to men and vulnerability to gender based violence a feature of most contexts. In Nigeria, for example, the likelihood of early or forced marriage combined with reduced access to public services was a key reason for the vulnerability of women to abuse and domestic violence (UNICEF 2016).

The persistence of cultural norms that reduced women's roles in non-domestic spheres could undermine social and economic reforms that aimed to support women's development. For example, in Kazakhstan there has been little change in gender equality either in terms of the domestic sphere, public institutions, or political participation despite a number of initiatives promoting this. Nationalist narratives emphasising women's domestic roles have countered these efforts and influenced the concentration of women's employment within education and health services, where average wages are lower than other sectors – even though women have higher educational outcomes compared to their male counterparts (Palandjian et al., 2018). Despite high literacy rates in Kazakhstan, the social acceptance of intimate partner violence among both women (64%) and men (74%) is high (UNDP, 2020).

In Bangladesh – deprivation and school drop out could put children at risk of child marriage (Sakib, 2021). This was also a significant issue for adolescent girls in Nigeria, where over half of the girls in North West Nigeria are married by age 15 and over 80% are married by age 18, increasing their vulnerability to physical abuse and domestic violence (Bello 2007; UNICEF 2016).

Gender-based violence was also a factor in Myanmar; the military coup, which ousted State Counsellor Aung San Suu Kyi in 2021, represented a significant setback to women rights, creating a direct threat to their physical safety from an unaccountable military with a history of violence against women (Onello and Radhakrishnan 2021).

Such inequities could remain invisible in public service systems that failed to collect or disaggregate population group data. In both Nepal and Vietnam. health and urban planning information systems either did not collect or did not disaggregate data to reveal inequalities in access and outcomes between social groups. As a result planning of health and other public services neglected the inequities that these groups experienced, preventing programme managers and decision makers from examining service delivery, treatment, and health outcomes for diverse social groups (Mandal, Cannon and Nondi, 2016; Brittany S Iskarpatyoti and Cannon, 2017). The new fragmented federal structure of Nepal has affected healthcare in particular as one of the most decentralized sectors, where delivery of basic health services falls under the exclusive functions of local government (Ghimire, 2019; Thapa et al., 2019). This structure could have an adverse effect on the quality of national data planning for health systems, in which accurate, complete and disaggregated information is essential for measuring health system performance and for planning interventions to address inequities between social groups or geographic locations (MoHP, 2014). Urban planning in Vietnam, in contrast, is a centralised primarily top-down system, but the failure to require data on vulnerable populations, such as rural-to-urban migrants, means that urban plans at district and provincial levels are still unable to effectively meet the needs of such groups (Mirzoev et al 2019).

Power differentials

Power differences between ethnic and religious groups were a further key feature of the social and political context in many pilot study settings. In Kenya, for example, there was evidence that inequality in political representation is driven by ethno-regional patronage and the use of historical grievances to maintain elite capture of public policy through political exclusion and violence, resulting in significant socioeconomic inequalities between ethnic groups (Owiti 2014). In Kazakhstan, policy recognition of ethnic diversity in theory accommodates trilingual education in schools but the resources to support effective implementation of this policy were not equitably distributed across institutions. Indeed, deliberate inequality in resource allocation is built into the education system in this context: while education is provided mainly by free public schools, a small network of highly resourced schools for the gifted - the Nazarbayev Intellectual Schools (NIS) - have considerably higher funding and autonomy. NIS enrol only 0.4% of all Kazakhstani students but at a unit cost of more than three times the national average (OECD, 2015; cited in Karabassova, 2021). Unsurprisingly, NIS students outperform their public school peers by the equivalent of almost three years of schooling, with regional differences between these schools equating to four years of schooling (Marteau, 2020). In contrast, almost 60% of public primary and secondary schools teach different age groups together in one class because of low student numbers and these schools are predominantly located in rural areas (OECD, 2014, cited in Gimranova, 2021). The regional differences in education outcomes are also linked to income inequalities, with income being four times higher in regions with high performing schools compared to regions with low performance. (Marteau, 2020; Gimranova et al., 2021).

Poverty

Deprived populations, in which ethnic and religious minorities were overrepresented, were a specific focus of our pilot studies in Bangladesh, Nigeria, and Kenya. In Bangladesh, around a fifth of the urban population live in poverty (Household Income and Expenditure Survey, 2019). Many of these residents live in informal settlements - defined as areas in which less than 50% of households have adequate drinking water or sanitation facilities, with insecure and overcrowded housing conditions and located on or near hazards such as polluted or unprotected high-risk zones (UN Habitat 2003). In sections of Kibera, an informal settlement which was the context for our pilot study in Kenya, up to 83% of households live in poverty (Desgroppes and Taupin 2011). The inadequacy of public services in these informal settlements, as well as in rural areas of Bangladesh, Kazakhstan, Nigeria or Vietnam, was maintained by lower resource allocation to facilities such as healthcare, education and sanitation. This inequity contributed to a generational cycle of poverty, for example, the lack of government investment in local education facilities in Kibera has resulted in young people in the settlement having low literacy levels compared to other parts of the country:

> *'The manner in which educational policy has been designed and resources distributed over time exhibits a tendency towards marginalizing children in urban informal settlements in terms of access to quality education compared to their counterparts elsewhere.'*
>
> *(World Bank, 2020)*

Decisions to restrict resources in these areas were made despite existing evidence that effective schooling could help counter the immediate impacts of poverty through, for example, provision of regular meals, health checks and a less stressful environment (Armitage and Nellums, 2020).

Poverty has also been linked to income inequalities and could exacerbate gender-based violence. As in Kazakhstan, women in Kenya, were generally likely to earn less than their male counterparts, with more limited educational and economic opportunities (Kiriti and Tisdall 2003). In deprived Kibera, 85% of women had experienced some form of violence during their lives, which was associated with poor physical and mental health (Winter et al 2020).

Perhaps most dismayingly, many of the disadvantaged groups in the pilot studies experienced a 'poverty penalty' (IDRC 2016) that involved their paying more for basic necessities or services than affluent social groups. Inequitable resource allocation was a key factor forcing already deprived communities to pay for services that were free in wealthier neighbourhoods. Although the government is the main provider of education in Kenya, for example, the lack of government investment in local education facilities has resulted in over 81% of students in the informal settlement of Kibera attending private schools with only 27% attending government schools (Government of Kenya 2019). Similarly, private companies have made waste collection a business in Kibera because of the lack of sanitation facilities (Nthambi M., 2014). In Nigeria, low investment in schools within the North of the country, where almost 80% of poor households are found, has resulted in significant costs for families wishing to educate their children and particularly negative impacts on girls' education beyond junior secondary schooling (World Bank 2020)

Informal settlements occupy around 6% of the land used for residential purposes in Nairobi but house 55 per cent of the city's population with the remaining 45% of residents using two-thirds of the land. The unequal allocation of land is a key political issue in Kenya and has its roots in colonial policies of dispossession and racial segregation. This geography of spatial injustice contributes to increased population pressure in Kibera (Ren et al 2020).

Policies that restricted access to public services in deprived areas were often developed in the context of low levels of public service expenditure in general. In Bangladesh, for example, only around 2% of Gross Domestic Product (GDP) is spent on healthcare and around 1% on education (World Bank 2018; 2019).

Policy implementation

As with gender and ethnic equity, public service policies in relation to young people could be progressive in theory but not implemented in practice. In Nigeria, for example, the Child Rights Act of 2003 includes the right of those below the age of 18 years to live with dignity and to receive health and health services, parental care, protection and maintenance as well as free, compulsory and universal basic education. Further legal provisions at the national level aimed at protecting adolescent girls include the Trafficking in Persons (Prohibition) Law Enforcement and Administration Act 2003 and Violence against Persons (Prohibition) Act, 2015. Individual states have also enacted legislation on the rights of children such as: the Ebonyi State Law on the abolition of Harmful Traditional Practices Against Children and Women, 2001; Edo state Female Genital Mutilation (Prohibition) Law 2002; Bauchi State Hawking by Children (Prohibition) Edict of 1985 and Cross River State Girl Child Marriages and Female Circumcision (Prohibition) Law 2000 (Federal Ministry of Women Affairs, Abuja, 2004). These numerous legal and policy frameworks have had very little impact on adolescent girls' welfare, however, as there is no budget to implement these programmes (World Health Organization 2018). The federal nature of Nigeria has also been a major impediment to implementation as only 24 of 36 states in the country have adopted the Child Rights Act of 2003 (Akinwumi 2010).

The COVID-19 pandemic

Some pilot studies also explored policies relating to management of COVID-19, which directly affected all the public services areas on which our research focused as well as the general context in which studies were conducted. The pandemic was not just a global health crisis but also a social and economic crisis, impacting on the most vulnerable people in society (Latinovic 2020; Lee 2020; Thirumalaisamy et al 2020). Globally, the pandemic led to most public services being severely affected; as with previous pandemics, COVID-19 exacerbated livelihood and health inequalities for vulnerable people through lockdown and containment activities, threats of job losses, food insecurity, loss of family income, school closures and difficulties in access to healthcare. Almost 1.6 billion workers in the global informal economy suffered from a sharp decline in working hours, with immediate risks to their livelihoods (ibid; International Labour Organisation 2020a).

In Bangladesh, an already burdened healthcare sector with 1800 intensive care beds for a population of 160 million and only one registered doctor for every 1,581 people was unable to cater to the healthcare needs of millions of people (Abdullah, 2021; Khatun and Saadat, 2021). Apart from COVID-19 patients, significantly reduced healthcare particularly affected maternal and child health and non-communicable disease outcomes, with huge impacts on the most vulnerable: for example, a nationwide immunization campaign for children was postponed due to the scarcity of healthcare resources and child mortality rates in Bangladesh subsequently increased during the pandemic (Ahmmed, Babu and Ferdosy, 2021).

Similarly, schools across 79 countries were closed for over a year, either fully or with much reduced timetables (UNESCO 2021). The move to online education again had most impact on children from excluded populations, such as those with physical or cognitive disabilities who were already experiencing inequities in educational access and outcomes, (UNICEF, 2020).

The short and long term impacts of the pandemic on public service provision and outcomes were explored in Bangladesh and Vietnam, where public service policies appeared to neglect many social inequities and Kazakhstan, where education policies appeared to deliberately create and maintain these inequities.

Meso- (institutional) level context

Unfair resource allocations created a context where poor access to public services institutions and facilities, including sanitation, housing, education, and healthcare services, was a common experience for many of the excluded populations involved in our pilot studies. There was evidence of such exclusion for those living in urban informal settlements in Bangladesh and Kenya, migrant workers in Vietnam as well as those living in rural or coastal areas of Bangladesh and Kazakhstan (Ober, 2020; Onyango and Tostensen 2015). In Kibera, for example, almost half of households had no direct access to adequate sanitation, including toilets and waste disposal, exposing residents to infections and even the risk of sexual abuse in shared facilities (Onyango and Tostensen 2015). Migrant workers in Vietnam faced similar issues of limited access to social security and housing support (ILO 2020; Government of Vietnam 2020).

Although 90% of the land in Kibera is reportedly owned by the government, the residents of this population live in 12 x 12 ft houses known as 'shacks' owned by absentee landlords with the walls of around half consisting of temporary materials such as mud or cow dung, iron

sheets, cardboard, timber, uncovered nylon or cartons. These often house eight or more family members, many of whom sleep on the floor. In contrast, around 90% of housing in central Nairobi outside the informal settlement has brick or stone walls (Government of Kenya, 2019).

As highlighted earlier, inequitable access to essential health services for already disadvantaged groups was exacerbated by the COVID-19 context; sharp reductions in these services at the onset of the pandemic particularly affected ethnic indigenous groups and those living in rural areas in Bangladesh, for example (Wangmo et al 2021).

Even before the pandemic, almost one-third of the world's young people were already digitally excluded, mirroring broader social inequalities both across and within countries (OECD 2015; UNESCO, 2020c). The move to online education meant that only 16% of young people in informal settlements and rural areas of Bangladesh were able to access education because of digital exclusion linked to poverty (Ahmed 2020; BRAC Institute of Governance and Development 2020). In Kazakhstan, Marteau (2020) suggests the loss of learning resulting from school closures due to the COVID-19 pandemic was similarly expected to have most impact on children from rural and marginalised backgrounds, who were already educationally vulnerable. In these contexts, access to technology and distance learning was limited, as were opportunities for learning outside schools (USAID, 2020).

Parents with limited education, time and learning resources could struggle to home-school their children and the education of children with disabilities could become completely invisible during the pandemic, with little consideration for this already marginalised group of students (Wijesinghe, 2020). Loss of one-to-one teacher support or services such as speech and other therapies particularly affected such children (Montacute, 2020; Kovyazina, Boranbay, and Beysembayev's 2020). Refugee and internally displaced children and those living in detention and situations of active conflict were also especially vulnerable to digital exclusion (UNESCO, 2020c). While internet access is a common element of city life, this is not the case in rural locations, where evidence indicates internet access is slow and poor to the point of being a hindrance to learning rather than an advantage (Kurmangaliyev, 2019).

Migrant workers in Vietnam were also particularly affected by the economic impacts of the pandemic (Bhopal 2020; Wilkinson 2020). In Bangladesh, geography also exposed some populations to additional natural disasters at this time, such as cyclone Amphan and the monsoon flood which significantly affected coastal communities (Ober, 2020).

Micro- (community and individual) level context

The structural discrimination outlined above could be exacerbated and reinforced by dynamics within excluded groups. The worse outcomes they experienced from public services and associated poverty could combine with cultural norms within communities themselves that caused further disadvantage, particularly for women and young people.

A vicious cycle of exclusion caused by restricted resources reinforcing more limited capacity within disadvantaged populations could play a role in maintaining their exclusion from public services. For example, in Kazakhstan, parents with lower incomes and those who lacked sufficient knowledge were less likely to feel they could support their children's online learning during lockdown, whereas those with higher incomes had more capacity to do so and were more satisfied with online education (Bokayev et al., 2021). As highlighted earlier, public service resources were more likely to be i targeted at those with higher incomes thus maintaining these social inequities.

Poverty and poor access to services could also be linked to criminal activities within communities; factors that expose women to greater risk of violence, for example, include high levels of stress caused by lack of housing, education and employment (Winters et al 2020). In Kibera, tapping electricity directly from electric posts or neighbours has been linked to the fact that residents have no access to powerlines or stable housing (Cheseto 2013)

Cultural norms often reinforced the unequal status of women and young people in wider society and could normalise violence within excluded populations. In Kenya, for example, gender-based violence could be influenced by cultural beliefs and attitudes, childhood experiences, mental health issues and drug or alcohol abuse (Winters et al 2020), resulting in a cycle of violence that combined discrimination and abuse from both outside and within excluded communities. Children without access to education were also deprived of a safe haven from dysfunctional or difficult family lives (Armitage and Nellums 2020). Social norms could also contribute barriers to implementing progressive policies that aimed to advance women's status, such as those introduced in Kazakhstan (Almukhambetova and Kuzhabekova, 2020).

Targeted interventions

Some targeted interventions were identified by partners that aimed to reduce the social exclusion of populations covered by our pilot studies. The World Bank AGILE project and Coca-Cola company ENGINE initiative in Nigeria, for example, aimed to support the social inclusion of girls from marginalised groups in education, through confidence-building, skills in financial management and leadership and influencing community gender norms; by 2017 the latter programme had reached 21,000 girls (World Bank 2020a; Coca Cola 2015). What is notable about these programmes, however, is the lack of attention to institutional and policy or societal factors affecting social exclusion of adolescent girls. Whilst capacity building and skills development can be helpful, focusing solely on micro-level factors affecting exclusion implies that community deficits are the key factor to target when addressing social exclusion. It is clear from this Introduction that much larger forces are at work that constrain the opportunities and choices open to people within excluded populations and that these must simultaneously be addressed if social inclusion is to be achieved (Mir et al 2020).

The pilot studies

In response to the context outlined above, our pilot studies were developed by multisector groups, including academics, non-government organisations and policymakers. Studies were conducted in the following contexts and research areas:

Bangladesh: Equity in health and education services during COVID-19: challenges and the way forward

Kazakhstan: Education, gender and family relationships during COVID-19

Kenya: Impact of COVID-19 and inequalities in the informal settlement of Kibera, Nairobi

Myanmar: Expanding opportunities to deepen women's participation in decision making processes and initiatives for peace and reconciliation

Nepal: Generation and use of gender and social stratifiers: Health Management Information Systems

Nigeria: Adolescent girls and development

Vietnam: Migrant workers and urban planning

METHODS

A diverse range of research methods, involving document and policy analysis, stakeholder interviews and participatory approaches were used to explore specific research questions within the overarching aim of the project. This section describes the diverse study settings, research samples, data collection methods, analysis and validation processes across the seven different studies conducted by the PEI Network members. Further details about each of the individual studies on which findings are based can be found at the project website[5].

Setting and context

All pilot studies were conducted within a period of six to twelve months during the COVID-19 global pandemic, with social distancing and lockdown measures in place in each context for most of this period and closures affecting many public service functions. These conditions constrained researchers' ability in some contexts to reach out to particular stakeholders. In Kazakshtan, for example, access to the most marginalised populations in remote rural villages was constrained by digital exclusion issues, although a substantial proportion of stakeholders from rural and semi-urban areas were accessed within the three largest cities. In Nepal, access to a number of key policymakers was significantly restricted because of the widespread impact of the pandemic and the priority that was necessarily given to its management. To add to the difficulties in conducting research during the pandemic various political upheavals disrupted fieldwork in Nepal and Kenya, due to election cycles, and Myanmar, where a military coup took place in 2021.

Despite these constraints research teams in each context managed remarkably well to access a wide range of policymakers, public service practitioners and members of socially excluded communities to gather data for their pilot studies (see Table 1).

Sample

For this synthesis of findings, the seven pilot study reports constituted sources of data. In all settings members of excluded groups were involved as key stakeholders, whose voices were often unrepresented in research, in either collecting fieldwork data as peer researchers or contributing as research participants. Policymakers and NGOs were also involved in all studies, including as research leads, along with public service practitioners and managers to ensure that recommendations would be feasible in practice. Private healthcare providers were included in interview samples in Bangladesh and Nepal, where they were perceived as significant stakeholders alongside public health service practitioners (see Table 1). The range of stakeholders involved in each sample was intended to gain a range of perspectives on the social exclusion of particular social groups from public services. Workshops at the end of most projects involved a similar range of participants to identify feasible and priority interventions that would help address the issues raised by members of these groups.

Data collection and analysis

The majority of studies used qualitative methods to gather data, including semi-structured interviews, focus group discussions and reflective fieldwork diaries. Participatory research methods in Myanmar, Kenya, Nigeria and Vietnam were a key means of ensuring that research questions and findings adequately represented the views of excluded groups in each context. Training and support was provided to peer researchers to develop research

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[5] https://medicinehealth.leeds.ac.uk/directory_record/1366/partnerships_for_equity_and_inclusion

questions, gather data and analyse this. In Kenya poems, photo stories and personal accounts were compiled by peer researchers to reflect their experiences and views on how the exclusion they experienced should be addressed. Training and fieldwork was conducted online, face-to-face and over the telephone as Covid-19 restrictions at each site allowed.

A document analysis was additionally conducted in Nepal and a formal literature review undertaken in Bangladesh. All projects were led by those with expertise in the research topic and interpretation of data was grounded in their existing knowledge of the literature. A combination of thematic analysis, framework analysis and quantitative demographic analysis was conducted across studies to develop findings and recommendations (see Table 1).

For this report of findings across pilot projects we followed best practice guidance on qualitative evidence synthesis (Booth et al 2015). This involved using themes derived from an initial evidence briefing that had informed the development of pilot studies (Mir et al 2021) as a framework for analysis. Coding of data under these themes supported identification of common issues across the pilots which were then validated with pilot leads and other research teams members of pilot studies and overall project. We adopted principles for presenting evidence that would enhance policy take up of findings (Donnelly et al 2018).

Stakeholder workshops

Following the development of findings for each pilot project, stakeholder workshops were arranged with people from excluded communities, policymakers and other key professional stakeholders to validate and discuss feasible solutions to the issues identified. In Myanmar, where a recent military coup prevented such an event from being organised, recommendations were discussed with local public service leads and contacts in international peacekeeping organisations (see Appendix). Findings were presented and validated at these workshops and facilitated discussions were held about mitigation strategies that had been developed from research data or suggested by participants.

In Bangladesh and Kenya, additional workshops were held with members from disadvantaged groups to ensure final recommendations reflected community views and to determine the focus of future research areas. Proposed solutions were synthesised from those considered acceptable to the wide range of stakeholders involved in pilot projects. These were also aligned with the priorities of excluded communities themselves, who are expected to be the key beneficiaries. In participatory projects these communities led on the development of proposed solutions which were then discussed at multistakeholder events.

Table 1: Pilot study methods

Site	Setting	Research Focus	Research Methods	Research Sample (total = 385)	Workshop attendees
BANGLADESH	Four deprived rural, coastal, hill-tract and urban areas; one affluent urban comparison area.	Impact of COVID-19 on healthcare and education outcomes for excluded groups (rural, coastal, informal settlements, ethnic minorities)	Literature review to inform topic guides. In-depth semi structured interviews and focus group discussions in Bengali. Thematic analysis using 'constant comparative' method. Stakeholder validation	Patients with children attending school or college (40) Government, private and NGO healthcare staff (doctors, nurses, health assistants (16)). Government, private and religious education providers (15)	Government health and education policymakers, NGOs, specialists in public health, early childhood and equity (10)
KAZAKHSTAN	Three large cities including deprived semi-urban and rural areas	Impact of COVID-19 on education and mental health outcomes for excluded groups (rural, semi-urban, urban, ethnic minorities)	In-depth semi structured interviews and focus group discussions in Kazakh or Russian. Reflective fieldwork diaries Quantitative demographic analysis. Thematic qualitative analysis. Stakeholder validation	Teachers (30) Parents (30) Students (28)	World Bank and government representatives, parent/child NGO, teachers and school leaders (7)
KENYA	Five wards in the deprived informal settlement of Kibera, Nairobi.	Impact of COVID-19 on public services for young people in Kibera (ethnic and religious minority, gender, deprivation).	Trained peer researchers produced stories, poems and narrative accounts of their experience. Training and support to conduct thematic analysis by experienced academic researchers and NGO mentors. Thematic analysis by peer researchers, supported by pilot study leads. Stakeholder validation.	24 Peer Researchers aged 18-35 living in Kibera, including disabled young people	Two workshops with local government, health and education policymakers, NGOs, academics and peer researchers (10 + 36)

MYANMAR	Chin and Kachin districts (ethnic minority populations)	Strategies to women to develop leadership skills and positions (gender, ethnicity and age)	Trained peer researchers conducted semi-structured interviews in Burmese. Thematic analysis involving peer researchers, supported by pilot study leads.	Key Informants with expertise in relevant areas (104)	Informal communication with local leaders to develop evidence-based strategies
NIGERIA	Six area councils in Federal Capital Territory, Abuja	Adolescents girls and the national development agenda (gender, ethnic and religious minorities, rural areas)	Trained peer researchers formulated research questions. Semi structured interviews and focus groups in a range of languages	Six peer researchers Adolescent girls aged 9-18 (66) Key Informants - traditional rulers and community members with relevant expertise (12)	NGOs, peer researchers, academics, government policymakers, community representatives (10)
NEPAL	Two municipalities in Kathmandu	Inclusion in Health Management Information data collection and analysis (gender, ethnicity, age, religion, socioeconomic position)	Document review – HMIS policy and guidance documents. Semi structured interviews with Key Informants (service providers, managers, health planners at two health facilities (public and private) in each municipality	Public health facility staff (4); Private health facility staff (3); Data managers (3)	Findings presented at and fed into Ministry of Health policy meetings (3)
VIETNAM	Industrial zone in Ninh Binh province	Impact of COVID-19 on migrant workers and their families	Semi structured interviews and focus groups with migrant workers and Key Informants (Zone manager; provincial and district Labour and Health Bureau officers; Labour Union and Women's Union representatives	Migrant workers (14); Key Informants (7)	Migrant workers; Department of Health, Department of Labour – Invalids and Social Affair, Labour Unions, Management Board of the Industrialised Zone (14)

FINDINGS

Despite the diversity between pilot study contexts and between the diverse disadvantaged social groups with which the research engaged, significant common themes and dynamics were found between studies. These are presented in relation to macro (policy and societal), meso (institutional) and micro (community and individual) level factors that created and maintained the inequities experienced by deprived populations, women, young people, ethnic and religious minorities, migrant workers and rural communities. Intersectional disadvantage, involving compounded layers of inequity, is also highlighted for those whose identities fell into more than one socially excluded group, such as young women from ethnic and religious minorities.

Policy and societal factors

The political and legal context for each pilot study reflected wider social norms, with public service policymakers and practitioners rarely being representative of diverse and disadvantaged social groups. This context adversely affected public service decision-making so that people from excluded groups could be overlooked during policy development and in data gathering that informed allocation of resources. At the same time such groups could be deliberately targeted in discriminatory ways that demonstrated a link between structural and physical exclusion and even violence that could be committed or tolerated by those in public services.

Need for policy development

Policies were often not well developed in relation to equitable public service provision. For example, disadvantaged communities were often invisible in terms of unmet needs as no data was collected about them. In Nepal, very few policies about health management information specifically mentioned the importance of collecting data on gender or other categories of social exclusion. Current guidance for overall health systems in this context similarly omitted attention to data gathering in relation to equitable access, despite a stated aim to ensure such access and to strengthen health information systems (Ministry of Health and Population (MOHP), Nepal 2018). A disconnect was found between this overarching mainstream policy and other guidance that highlighted the need to disaggregate data and to train staff to gather and analyse health information (MoHP 2007; 2018; MOHP/NHSSP 2017). As a result routine health systems did not capture such data and there was a reliance on large national surveys to provide information, which was often still inadequate. Disaggregated data that, nevertheless, had been collected by local health facilities was submitted but not used by municipality-level planners, who made decisions about resource allocation. A similar top-down approach that ignored the need for data-informed health planning was found to affect migrant workers in Vietnam, who were viewed as requiring policy attention only in relation to management of migration flows. This raises concerns about the reliability of population denominators and the effectiveness of health planning systems in both contexts. The need for qualitative data about the lived experiences of people from disadvantaged groups was also raised in both these contexts.

High levels of unemployment among people from informal settlements, where ethnic and religious minorities were overrepresented, and in rural areas, were rarely addressed in public policy. In Kibera, an informal settlement in Kenya, peer researchers linked poor opportunities for employment with crime as people from excluded groups often had few other options to afford food and shelter for themselves and their families. Combined with the lack of educational facilities, deprivation made young people particularly vulnerable to criminal activities such as theft, drug dealing and violence, both as victims and perpetrators. Social attitudes that characterised people from such populations as aggressive and dishonest

meant that even the most menial jobs were difficult for them to obtain and their resultant poverty was linked to further social stigma as well as to routine police profiling and brutality, targeting young people from informal settlements.

Crime and violence were described as ''normal' occurrences' and drug or alcohol abuse was used by many as a means of escaping these stressful living conditions, reinforcing the negative social attitudes they faced.

Failure to address social exclusion in policies relating to housing resulted in extremely high and often unaffordable rents for scarce but poor quality housing in this informal settlement, which contributed to overcrowding and linked gender-based violence (see sections below on Community and Intersectional Disadvantage). Forced evictions by landlords were reported by a number of peer researchers in this context and these were compounded by urban planning processes that also forced evictions while failing to take account of the impact of new developments on existing local businesses and residents.

> "There is a cyclical relationship between unemployment and crime. Most youth who are not employed find themselves trapped in drug abuse and other crimes. At the same time, once convicted, youths cannot be employed in some jobs especially in government. […] some youth decided to sell their bodies in order to get food on the table under the COVID-19 constraints."
>
> Musa et al (2022) Kenya Pilot Report

A similar failure in policies to address the negative impact of COVID-19 were reported in Bangladesh, Kazakhstan, Kenya, Nigeria and Vitenam. These negative impacts were unevenly distributed and widened existing inequalities for already disadvantaged groups. For example, loss of work as a result of lockdown restrictions disproportionately affected those living in informal settlements in Kenya and Bangladesh and migrant workers in Vietnam. In Bangladesh, urban slum dwellers are reported to have experienced around 80% drop in daily income during the lockdown period (Basher, 2020). The impact of the pandemic could be devastating for communities, particularly in rural areas where community bonds were strong. People in these groups were already in insecure employment with low pay and were very likely to lose their income during the pandemic. However, they often were not covered by or did not have the required documentation or skills to access government support that would have mitigated the severe impact of COVID-19 on their lives. Migrant workers in Vietnam, for example, were often employed in areas that were ineligible for COVID-19 related initiatives such as monetary allowances, reductions to union fees, reduced lending rates and debt rescheduling. A deliberate rationale of keeping the same policies for all workers adversely affected migrants, who were more likely to live in poverty and had less access than other employees to housing, healthcare and education support. This example made clear that equal treatment for all workers was not equitable treatment when some faced more barriers to accessing public services and support and had more difficult living conditions than others.

> "The companies have the same policies for all workers and no special treatment for migrant workers. […] there was no special assistance for migrant workers during COVID-19 [although] many migrant workers had a lower salary but stayed throughout all the holidays and the Tet festival in their rented house as they were afraid of getting or transmitting diseases to their family members when they came home"
>
> Migrant worker, Vietnam

In healthcare and education, the lack of policy attention to inclusion meant that the transition to online interactions was easiest for those in urban non-deprived areas. Elite government-sponsored schools in Kazakhstan were the best equipped to make this transition smoothly and quickly because of meticulous planning, prompt teacher capacity development, quick distribution of digital devices, and extensive IT support for students and teachers.

Mainstream schools, in contrast, took much longer to develop staff capacity as a result of lower resourcing and support and less skilled staff. Difficulties with accessing online education were sometimes insurmountable for low-income families, parents with limited education, single mothers and parents in rural areas, reinforcing existing inequalities. Those who could access online classes often felt it necessary to pay for additional tuition because of the perceived low quality of mainstream education. Although schools and educational authorities distributed devices and pre-paid internet cards to low income families, distribution was inequitable across locations, particularly affecting those in rural areas. A significant impact was also found on the education of adolescent girls, who were often expected to contribute to household chores during the school day.

In Kenya, legal restrictions relating to lockdown were used as a means of legitimising and increasing physical violence by police against those living in Kibera. People from this settlement as well as those in overcrowded and deprived areas in Bangladesh and Vietnam were also unable to follow government advice relating to social distance and handwashing because of overcrowding and lack of free sanitation facilities or masks, which were not addressed by policymakers. In rural areas of Bangladesh and indigenous tea garden regions, awareness of pandemic risk was low and language barriers could also prevent health messages circulated via the media from being understood.

Inequitable resource allocation

The absence of inclusive policies adversely affected public service resource allocation for migrant workers and people in deprived areas, particularly informal settlements, locations where ethnic or religious minorities were concentrated and rural areas. An absence of health and education facilities was highlighted by ethnic minorities in Bangladesh, migrant workers in Vietnam, and young ethnic and religious minority women in Myanmar and rural areas of Nigeria. Residents in the informal settlements of Kibera, Kenya complained that all public services were inadequate, particularly waste management, despite services being provided in other areas. The lack of adequate sanitation facilities caused significant health and daily practical problems for inhabitants, many of whom were unable to access even basic toilets and washing facilities without paying for these. In parts of the settlement where water was available to residents, sewage lines could pass through residential areas and access to sanitation facilities such as toilets was described as 'very poor'[6].

Most Kibera residents relied on water through standpipes and water vendors, for which they could pay over four times more per unit of water consumed than those living in wealthier areas with city county water meters. The inability to practice frequent hand washing during the pandemic had obvious public health risks not just for residents of such deprived settlements but for the country as a whole. Consequently, most villages in the informal settlement were littered with refuse and contaminated with rotting waste.

As highlighted above, in Kazakhstan a higher level of resource was deliberately allocated to elite public schools compared to mainstream schools, where the majority of disadvantaged pupils were educated. Teachers in these less resourced schools were expected to use their own money to spend on stationery that was not provided by their institution. Similarly in Kenya and Nigeria, a lack of secondary school facilities in informal settlements and rural areas constrained choices for young people, forcing many to drop out of school because of the costs associated with travel or accommodation outside their local areas coupled with the financial strains experienced by their parents. Other inequities in relation to provision of housing were highlighted in Vietnam, where migrant workers were ineligible for housing

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[6] Peer Researcher, Kibera, Kenya

assistance because they did not have the required amount of savings. In Kenya, residents of the informal settlement in Kibera, complained that corrupt practices in allocation of land for housing reinforced inequalities as only those with additional money to pay officials were able to purchase this. As in other examples above, inequity in resource allocation thus created higher costs for those with least resources.

Need for policy implementation

Laws and policies that did exist on equitable treatment of vulnerable groups were often not implemented effectively. For example, our findings confirm that the Nigerian Child Rights Act 2003 continues to fail in preventing the exploitative labour of children (Akinwumi 2010) in the rural and minority communities that engaged with our pilot study. In Nepal, the Fifteenth Plan (NPC 2019) for 2016-17 aimed to mainstream gender equity and social inclusion and ensure equal participation in social and economic opportunities for all populations. However, though participatory approaches for developing locally tailored health programmes were published (Justice and Rights Institute 2020), these were not functioning in the sites involved in our research and there was a disconnect between local, district and provincial planning processes. Despite the reporting mechanisms that existed between these different levels, health planning and budget allocations did not take account of local recommendations.

In Myanmar, while women could in theory access national statutory protections instead of regional ethnic customary law, national law was difficult to access because of cost, delays, language barriers, lack of support to deal with the complex processes involved and mistrust of government institutions. Customary law was inexpensive and accessible but often failed to protect women in cases of domestic violence, divorce and child custody, inheritance and access to employment, education or financial resources. This meant that women were often denied legal rights and forced to continue in situations that maintained and reinforced the inequalities they experienced.

Political and social instability could similarly reduce or remove the legal rights and protections of vulnerable groups. The military coup in Myanmar in February 2021 restricted social gatherings, communication and travel, preventing peer researchers in our study from engaging with women in their own communities. The formal structures of the peace process in Myanmar were disbanded so that routes for findings from the pilot study to influence policy and practice were much more restricted than previously. Even prior to the coup, few women were able to participate in the national peace process, which was dominated by male negotiators as sociocultural norms prevented women playing a part in leadership roles, despite the disproportionate impact of ethnic violence on women and children.

Similarly, social tensions in India, resulting from divisive government policies affecting religious minorities, impacted on the research process so that even obtaining ethical approval for a pilot study on addressing exclusion in that context proved impossible and we were unable to proceed with the planned research. Although our NGO partners in Myanmar were at risk of being targeted for supporting minority rights, they persevered with the project as a result of their close links with affected communities. In contrast, our partners in India had closer links with the government, from which their

> "As I do not know how to speak well, I don't want to solve problems with government laws. The village elders only practice customary laws. I do not dare to go to government offices. I am not fluent in the Burmese language".
>
> "There are not any rights for women in my village. Women's jobs are to give birth and do household chores. Women do not have any opportunity to manage financial matters. When the husband dies, they lose the custody of their children. So, I want to change this law and want to get equal rights with men".
>
> Ethnic minority women from Paletwa, Myanmar

organisation received funding, and the political risks of involvement, as well as apparent support from within the organisation for government policies, appeared to be factors in their withdrawal from the project.

Participation and representation

The absence of effective policies to address social exclusion was maintained through a lack of representation of people from disadvantaged backgrounds in positions of power. Women, those from deprived or rural areas, young people, ethnic and religious minorities and migrant workers were routinely excluded from decision-making processes that affected their lives. In Nepal, programmes at municipality level that aimed to target disadvantaged groups failed to follow detailed guidance on addressing community health issues (JURI Nepal 2020) or to reach out to the groups themselves, replicating the exclusion they experienced even within activity meant to benefit them. In Vietnam migrant workers faced difficulties in becoming involved with the Labour and Women's Unions that could influence working conditions because of the need to move around in search of employment. The Labour Union representatives were also employees of the company and unwilling to advocate for migrant workers; acting simply as a means of passing on comments and complaints to managers.

Women and young people faced additional exclusion from within their own communities as well as in wider society, compounding their disadvantage. This lack of social status constricted their opportunities in multiple ways that was not effectively addressed by relevant public service policy or practice. For example, in Nigeria, Kenya and Myanmar, young people and women from ethnic and religious minorities were often unable to access education or support because of poverty and the absence of appropriate institutions in their communities. In Nigerian rural settings, families could also give lower priority to funding girls' education compared to that of boys and could fear that their cultural values would be undermined in school settings, where the staff did not reflect local student populations, particularly in relation to adolescent girls.

In Myanmar, education for women could be seen as unnecessary by some community members who stereotyped women as naïve and lacking intelligence. Those who were supported through our research to take on leadership roles in peace-making could face pressure from their families, including other women, not to become involved in community affairs and could lack support with household and caring responsibilities. The education and support that could help develop capacity for leadership roles was thus restricted at community, institutional and policy levels. The lack of policy attention to addressing these issues prevented women and young people from minority backgrounds from challenging the structures that discriminated against them within their own communities and in the wider society.

Exploitative practices

The lack of policy in relation to the above issues meant that those in positions of power could exploit the disadvantage of people within excluded communities to create further benefits for themselves. Young people in Kibera described a regular cycle of being employed by politicians during each election to harass and commit physical violence against political opponents. Many who had no other income felt forced to commit such crimes and could themselves be injured, arrested or even killed in the

> "Even when extrajudicial killings are covered by international reputable organizations like Amnesty International […] no police officer is held to account for the identified crimes. The youth also mentioned that politicians manipulate them to perpetrate violence against political opponents but politicians are not held accountable for this act. […] the person who shall suffer at the end is the youth in the slum and not the police nor the politician."
>
> Peer researcher, Kenya

process, while others were drawn into drug abuse as a coping mechanism. Whilst politicians were not called to account for their use of gang violence, extra judicial killings by the police and enforced disappearances were described as part of the human rights violations to which the community were subjected on a regular basis, with no protection from abuse of power.

Child labour was common in many of the study settings; for example, adolescent girls in Nigeria reported being employed for nominal wages, carrying heavy loads of building materials in order to support their families. Migrant workers in Vietnam w ere similarly employed on low wages with little or no government protections for their health or family welfare with urban planners concerned mainly with managing the availability of this workforce rather than the welfare of those within it. In all cases, these opportunities were seen as the only options for employment and income that were available to the disadvantaged communities involved.

These issues highlighted political and societal acceptance of the restrictions and violence to which members of excluded groups were subjected. The lack of policy to change social norms affecting these groups resulted in individuals being constrained to choose between severe deprivation and undertaking criminal activity such as prostitution, forced to give up education, were placed in positions,

Organisation-level factors

Within public service institutions disadvantage was created for the groups with which we engaged through inadequate access to services, as a result of neglect or unfair resource allocation, and non-representation of people from excluded groups amongst staff employed within these services. These issues link to the policy-level neglect and indeed reinforcement of inequities outlined above.

Access to public services

As noted above, constraints to accessing public services could be reinforced at multiple levels and involved a variety of factors. Non-representation of those from disadvantaged groups in positions of influence or within decision-making processes meant that they often faced discrimination through public organisations meant to support them. Public service staff did not reflect the communities they served and the groups with which we engaged complained of discriminatory practices by staff. In Bangladesh this affected access to healthcare for those in informal settlements, forcing them to rely on NGOs active in the settlements, which were unable to deal with critical medical conditions. Young ethnic and religious minority people from an informal settlement in Kenya complained about being profiled and beaten by the police because of their residence and clothing. Discrimination and even violence by healthcare staff towards women from these settlements was reported during antenatal care and labour as a further disincentive to seeking help in addition to the distant location of these facilities from where they lived.

Enforced curfews during lockdown could compound such discrimination as residents of informal settlements

> "Anytime we saw a police vehicle we used to run, not because we had or have anything to hide but simply because they threatened us that they 'will come for us' without any explanation about our wrongdoing."
>
> Peer researcher, Kenya

> "The doctors slap you if you do not cooperate. The midwives are ill intentioned. The sanitation facilities are too dirty. If you do not guard your baby well, it can be exchanged or even taken away. Some women just give birth on the floor as the nurses look on without offering any help."
>
> Vivien, Peer researcher, Kenya

reported being delayed en route to healthcare facilities during childbirth or beaten by police, with their earnings stolen on returning from workplaces located at a distance from the settlement.

In Vietnam, exclusion from support by the Labour Union, which was intended to represent workers, involved officials employed by the company, who often protected company interests rather than workers' rights. The Union made no allowances for the poverty experienced by migrant workers in their housing support scheme, eligibility for which required proof of ownership of existing land estate. Similarly the Women's Union restricted support for migrant women to obtain a loan to start their own businesses by requiring permanent registration documents. These same Unions gave charitable donations or gifts to migrant workers, who they recognised as having "difficult lives"[7], during national festivals and some companies provided travel or housing costs over the holiday period on proof of original residence. Rather than advocating for migrant workers to have better long-term conditions and more access to support, the Labour Union thus helped to maintain the disadvantage they experienced.

High out-of-pocket expenses relating to travel, loss of work or internet costs were an additional barrier to accessing public healthcare facilities for migrant workers in Vietnam and for all excluded groups in Bangladesh, where the better quality services from private healthcare providers were not affordable for groups experiencing exclusion. Access to primary care and essential services such as maternal and child health and immunisation provision were all affected by these issues; further restrictions relating to the pandemic exponentially increased access problems as excluded groups had little alternative to public healthcare, particularly for acute care needs. In Vietnam, fears about health risk during the pandemic further reduced access

> "Getting treatment is always tough for us. We need to buy our own medicine due to lack of supply in the health centres. It is a burden for us. The situation is the same both before and during Corona."
>
> Indigenous respondent, Bangladesh

to healthcare and led to additional housing costs as migrant workers stayed in rented accommodation rather than travelling home during public holidays, to reduce the risk of transmitting the virus to their families.

Despite the high levels of deprivation they experienced, migrant parents were often obliged to use private schools with higher fees for their children as they could not access public education without household registration documents, which required long-term residency. Children's education was also restricted by their parents' mobility in seeking employment opportunities at new locations (UNICEF 2020). No provision was made by education providers or employing companies to address this deficit.

Deprivation and digital exclusion was common amongst all the excluded groups with which we engaged and the pandemic created further difficulties through the need for equipment and a stable internet connection to access online education and healthcare. In Kazakhstan, both teachers and students could be affected, severely disrupting children's progress, particularly in rural areas. Some parents were consequently forced to send children to live with relatives in urban locations so that they had the opportunity to study.   The digital divide also affected access to healthcare and health education materials on COVID-19 in Vietnam as well as in the informal settlements, ethnic minority locations, coastal and rural areas of Bangladesh, where provision was already traditionally low, exacerbating existing inequities.

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[7] Labour Union representative, Vietnam

The impact of school closures in Bangladesh disproportionately affected those from lower socioeconomic backgrounds, who were overrepresented amongst excluded populations. Whereas urban affluent families reported access to digital and interactive forms of education, children from excluded groups were limited to lessons via television broadcast or self-learning methods with very high rates of dropout from any form of education.

In Nigeria, ethnic and religious minority adolescent girls in rural areas were unable to access secondary-level education without incurring costs for travel and accommodation in locations distant from their families. Their lack of capacity to cover these costs could often drive them to prostitution or dependence on men who could help them financially. This reinforced negative attitudes about educating girls within their communities so that it was difficult for girls access education and for communities to feel that this was possible in a safe environment that valued their cultural norms.

> "Those who cannot afford resort to the use of what is commonly termed as flying toilets or use open drainages at night. This poses a lot of health risks […] we pay to use a toilet which is expensive for me considering I live with a lot of people.
>
> That wasn't the only frustration, we could no longer get an income. This meant, no food on the table, unpaid bills, multiple debts and homelessness for some"
>
> Respondent from Kibera, Kenya

Most of the above issues constraining access were not visible through the reporting mechanisms used to monitor healthcare services. In Nepal, standard reporting formats for from both public and private providers at local levels did not report population differences apart from gender. Sometimes even this category was absent in private facilities, where data was often incomplete. More detailed data, such as patient ethnicity and education level that might be collected by local public facilities was not reported to municipalities and there was no evidence of data on socioeconomic status being collected. Data collection and analysis for management of health systems was further constrained by limited capacity to input and analyse data and a lack of internet access or dedicated staff for this purpose. This was consequently a superficial exercise, with reduced amounts of data at higher levels, that had little to no impact on equitable health planning or budget allocation processes. At national level in Nepal, data was only disaggregated by province with few exceptions.

> "Responsibility [for data input and analysis] is not assigned. When I came here, there was no one who knew how to use computers."
>
> Local healthcare provider, Nepal

Service outcomes

Similarly lower resource allocation for mainstream public schools in Kazakhstan, had an impact both on the quality of teaching compared to selected elite schools and on the capacity of teachers to adjust to online teaching. Many, particularly older staff members and those living in rural areas, had less capacity, guidance and training to adjust to online education during the COVID-19 pandemic than those in better resourced institutions. Parents often felt compelled or were encouraged by teachers to pay for private tuition to make up for the low quality of education that was being delivered online, increasing financial pressures in low income families. In Bangladesh, similar problems with school infrastructure and supplies as well as staff capacity were highlighted as affected education during the pandemic, particularly affecting disadvantaged groups.

Underfunding and inadequate priority for healthcare services was also reported in Bangladesh and Nepal. Workers from primary care and tertiary level hospitals reported historic challenges due to a lack of human resources, with mental healthcare being almost non-existent. Public hospitals consequently struggled with the large influx of COVID-19

patients and the limited number of doctors and other healthcare personnel to treat them. Lack of availability of Covid-19 protective equipment was linked to this context of underfunding.

Community/individual-level outcomes

Study participants described their experiences of living in deprivation and disadvantage and how poor access to education, healthcare, sanitation and other public services created a self-reinforcing cycle of exclusion from positions of influence that could help change their lives. As at the macro and meso levels, the Covid-19 pandemic exacerbated existing dynamics of exclusion within the communities with which we engaged. Already high levels of unemployment and exclusion in deprived communities, in which ethnic and religious minorities are overrepresented, increased during lockdown as many individuals lost their jobs when businesses closed down or interactions moved online.

Deprivation

Peer researchers in Kenya wrote about their experiences of growing up and living in poverty and their efforts to remain resilient and resourceful despite lack of food or clothing and footwear. People with dependents, including young people who were carers for elderly relatives, often lived "a life of hand to mouth"[8]. Many tried to sell small-scale services and goods to make a living but others could find themselves

> "As artists we could no longer recite our poems, sing our songs or dance to our tunes"
>
> Peer researcher, Kibera, Kenya

forced to join local gangs as the only source of income on which to survive. At the same time, housing could be very expensive, with eviction being a constant threat, and those living in the informal settlement could even have to pay for basic sanitation such as toilet facilities. In this context the pressure to earn income from any available source could be immense. Even those in work were often unable to fully cover their daily living costs, let alone save for future needs.

Participants felt they were excluded or forgotten by policymakers on issues such as housing and education but were deliberately targeted by law enforcement services who regularly threatened or committed violence against them for no explained reason. Overall the peer researchers conveyed a sense of wasted potential and a daily struggle to survive.

Oscar, a peer researcher in Kibera, described how he became a voluntary football coach to young boys and girls using a football pitch that was affected by the lack of sanitation facilities. One corner of the pitch was used as a waste dump and the whole area became a health hazard when a sewage pipe close by burst, spreading waste on most of the pitch and resulting in two thirds of the children falling ill. The restricted opportunities for education and social activity this situation exemplified were linked to young people becoming involved in crime.

Similar reports of the impact of deprivation were received from adolescent girls in rural areas of Nigeria and migrant workers in Vietnam. Deprived populations were exposed to more health risks as a result of strenuous and unhealthy working conditions and struggled to pay for healthcare where this was not free, resulting in reliance on herbal remedies rather than formal healthcare services.

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[8] Musa et al 2022

Access to education was prevented by unaffordable school fees or lack of educational facilities in Kibera, rural areas of Nigeria and for migrant workers in Vietnam. Children's education could often not be prioritised and the need for basic necessities such as food and shelter was linked to child labour in these populations. Young people in Kenya and Nigeria often mentioned family income needs as a reason for seeking work and giving up education.

Access to secondary education in rural areas of Nigeria involved attending schools located at a distance that required accommodation and living expenses, so that deprived communities had to spend *more* to access education than their less deprived urban counterparts. Adolescent girls from rural areas whose families supported them to attend these schools often found themselves in financial difficulties and either dropping out of school or "meet[ing] boys for money"[9] in order to continue their education and cover rent and food expenses. This in turn could lead to unwanted pregnancies that reinforced communities' unwillingness to educate girls beyond primary school.

Studies that focused on the impact of the pandemic in Bangladesh, Kenya, Nigeria and Vietnam all noted that study participants were less able to observe social distancing or isolation as a result of overcrowded accommodation or employment conditions. This increased their exposure to the risk of contracting and dying from Coronavirus.

In informal settlements and rural areas, many participants felt devastated by the destruction of lives and livelihoods. The fear of catching the illness and seeing neighbours and relatives die of COVID-19 greatly impacted psychological and mental wellbeing of study participants in Kazakhstan, for example, as well as their children. Most respondents from Kibera had lost their jobs during the pandemic, causing considerable financial and mental hardship. Participants in this context also reported that some residents had lost employment as a result of not being able to afford COVID-19 tests, which cost double their monthly salary. This contributed to a domino effect of other stressful consequences, such as forced evictions, overcrowded homes and inability to pay for adequate food or essential commodities such as sanitary towels.

In Vietnam, anxieties expressed by migrant workers about the impact of the pandemic are likely to have been compounded by restrictions imposed after the pilot study ended, when migrant workers were forced to remain on company premises throughout the

"I joined a small group of young men who made me feel that I belong to the street I lived in and protected me from other boys whenever fights began. To fit in, I had to put on dreadlocks, put on a tattoo and wear casual clothing. In order to commit some of the heinous acts without feeling guilty, most of the youth started abusing drugs. Unfortunately, these young people were injured, some died in the process and others were arrested."

Francis, Peer Researcher, Kenya.

'Oh, so many people died in our village due to this pandemic. At that time, people were terribly stressed'

Teacher in Almaty, Kazakhstan

"in our [rural] area there are parents with extremely low social status; the whole family lives in one room. It was exceedingly difficult for them as they eat, sleep, and live in the same room. And those parents have an average level of education; it was too difficult for them to work with the computer."

Female teacher, Kazakhstan

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[9] Respondent from Bwari, Nigeria

lockdown period and unable to travel home. Prior to this, the financial consequences had involved adaptations to daily spending such as skipping or reducing meals, prioritizing children's food or selling assets to provide additional income. The confined living arrangements that affected those living in deprivation during lockdown created tensions in relationships and over resources. In Kazakhstan, for example, although lockdown reduced spending on travel and uniforms, families with multiple children could struggle to manage the various needs for computer access. In Kenya an increase in domestic abuse during lockdown was reported by some study participants (see Intersectional Disadvantage below).

Capacity and skills within communities

In addition to lack of funds for equipment and data, lower capacity to adapt to the greater reliance on technology also disproportionately affected access to healthcare, education and employment in disadvantaged groups. Migrants in Vietnam reduced their support-seeking for health during the pandemic, which could have life-threatening consequences. Despite experiencing symptoms, some people avoided contact with the health system by choosing to remain at home or take medicine without prescriptions. In some cases, symptoms deteriorated, and patients were rushed to hospital emergency units that could result in a higher economic burden for both patients and the health system and require longer treatment times (UNICEF 2020).

Education providers in Bangladesh and Kazakhstan reported that students from low-socioeconomic backgrounds and rural areas suffered more as a result of the pandemic's consequences than other students and in Bangladesh a significant number of these students were forced to drop out of school, increasing the number of child marriages and perpetuating the vicious cycle of low employment in their communities. In Kenya, the pandemic made worse an already severe situation in which 43% of girls and 29% of boys in Kibera have not attended school at all (Government of Kenya, 2019). Similarly migrant workers in Vietnam reported that they stopped sending their children to school during the pandemic because of reduced incomes.

Parental involvement was pivotal for the effectiveness of online education in primary school students and it was clear that parents found this extremely stressful. Those who could not afford private tuition had to learn subjects such as mathematics themselves in order to support the learning of their children. Without the sustained support of parents, primarily mothers, ensuring children's progress through effective online teaching was challenging, if not impossible. Students whose parents needed to be at work or lacked either subject matter knowledge, teaching or digital skills were likely to fall further behind students who had access to better resources.

Although mechanisms sometimes existed for study participants to complain about the issues they faced, these were often not used because of unfamiliarity with the processes involved. For example, migrant workers lacked the knowledge and skills to participate in planning processes via the Labour Union and Provincial People's Committee, which in turn appeared to think it was migrant workers' own responsibility to initiate action. As highlighted earlier, these organisations made no effort to reach out to this group, despite being aware of the difficulties they faced and their specific remit to advocate for workers.

"In my opinion, the role of migrant workers is important and they should know their rights and how they should act to fully access their rights. But they themselves do not have enough knowledge and they do not understand their rights or have the skills to raise their voice. If you do not cry, your mother will not feed you."

Labour Union representative, Vietnam

Intersectional disadvantage

Within the communities involved in our studies social exclusion had additional impacts to those described above on population subgroups that experienced multiple layers of discrimination. Women and girls, young people and members of ethnic or religious minorities experienced high levels of exclusion and many participants fell into a number of these groups, compounding the adversity to which they were subjected. Dynamics at macro, meso and micro levels of society further constrained the ability of those within these groups to access public services on a just footing, escape from deprivation and violence or even challenge the status quo that created and maintained the social exclusion they experienced.

Gender and age

Gender-based violence (GBV) was reported in many of the pilot study contexts and this was linked to a number of factors: social acceptance of GBV and lack of GBV policy or implementation; overcrowded housing; financial pressures; substance abuse and child marriage. These factors often accumulated and could be linked to mental health problems in excluded populations that increased the high rates of risk of domestic violence and rape for women. Unwillingness by parents to report crimes where close relatives were involved, along with the costs and delays involved in legal action and threats from perpetrators to survivors, compounded the lack of action on GBV. The risk to mental health in young people who witnessed or were subjected to such abuse and the heightened risks to children of online abuse during the pandemic were also highlighted as key issues to be addressed. In Myanmar, women who were involved in activism relating to this issue complained of being targeted by the military junta and excluded from peacebuilding activities that could help change the social norms that perpetuated GBV.

The federal nature of Nigeria was seen as a major impediment to the implementation of laws that could prevent violence and social exclusion of women and children, as legal protections that existed at the national level were not adopted by many states within the country. This included provisions such as the Trafficking in Persons (Prohibition) Law Enforcement and Administration Act 2003 and the Violence Against Persons (Prohibition) Act, 2015. Various states in Nigeria have put in place legislative measures to secure the rights of women and children such as the Ebonyi State Law on the Abolition of Harmful Traditional Practices Against Children and Women, 2001, Edo State Female Genital Mutilation (Prohibition) Law 2002, Bauchi State Hawking by Children (Prohibition) Edict of 1985 and the Cross River State Girl Child Marriages and Female Circumcision (Prohibition) Law 2000 (Federal Ministry of Women Affairs 2004). As highlighted above, the existence of parallel legal frameworks that could fail to protect women in relation to GBV, inheritance rights and child custody was also reported in Myanmar in relation to customary and state laws. A coup in 2021, by an unaccountable military with a history of GBV was seen by peer researchers as threatening to women's rights and to the organisations that documented GBV.

> "The customary laws for Khu Mi Chin women make women to suffer and they do not have any rights. Women are nothing. I faced domestic violence many times and my parents didn't do anything about that for me because of the bride price they took when I married. My husband is having an affair though I cannot ask for punishment because I am afraid that I will not get guardianship to my children and I cannot live away from my children. I am suffering domestic abuse".
>
> Research participant, Myanmar

The existence of policy on GBV and gender equality in Nepal, was similarly not routinely implemented. For example, although hospital outpatient registers collected data on patients who had experienced GBV, this was not reported to those responsible for health planning

and service development. Women were more likely than men to have caring responsibilities and those living in poverty were under considerable pressure to provide an income, especially if they were single mothers, sometimes going without meals themselves in order to feed their children or elderly relatives. Children brought up in such conditions were often forced to work to help raise money for basic needs, particularly if healthcare costs needed to be covered.

Where education involved costs, deprived families could prioritise boys' schooling over that of girls, who were expected to move away from their families for marriage and be less able to contribute to family income as a result. In Nigeria it was common to find girls who were not educated beyond primary school level because of the costs or distance involved in accessing secondary education, increasing the chances of marriage at a young age. As highlighted earlier, those who were supported by their families to attend secondary schools were vulnerable to exploitation because of their precarious financial situation.

Some community members were, however, aware of the importance of education and the negative effect on growth and development for both adolescent girls and wider society. Peer researchers in Nigeria and Myanmar highlighted that, in the context of a patriarchal society, girls would not be empowered to speak up, challenge or make demands on the existing systems both within their communities and in society more broadly without education. For women who did take on political roles in Myanmar, their engagement could be further constrained by the lack of childcare support and competing demands arising from domestic responsibilities as well as the overall lack of public safety and the fear of gender-based violence that such roles could attract.

Adolescent girls in these contexts were often not involved in key decisions that affected their lives relating to education, work and marriage. Girls in rural areas of Nigeria pointed out how important it was for them to be able to decide about who they marry and that being involved in decisions concerning their education or trade would enable them to commit fully to these. The links between community and political dynamics were also recognised - the ability of an adolescent girl to participate in decision making at the family and community level had implications for future participation in political and leadership roles and for broader societal development.

> "without being educated, you cannot be seen or known in the community…when a female is educated, she can express herself and she is well recognized in the community. It is important for the development of the communities… when I want to marry, my husband will respect me, and I will be able to express myself and be respected."
>
> AG1, aged 16 Gwgwalada, Nigeria

During the COVID-19 pandemic, some adolescent girls in Kazakhstan, Bangladesh and Kenya faced additional barriers to education from the lockdown, being expected to contribute to household chores through this period with negative consequences for their learning. Women in Kazakhstan and Bangladesh could also struggle with the expectation, which fell mainly on them, to provide educational instruction to children during lockdown. Those who needed to work or had limited education themselves were unable to meet this expectation effectively, so that children did not receive the support they needed for online education. Existing disadvantage was thus transmitted to the next generation within these communities.

> 'I don't follow [two daughters'] education much. They used to go to school by themselves. Now that school is closed they are helping in work''
>
> Indigenous mother, Bangladesh

Ethnicity and religion

All pilot studies included ethnic or religious minority population groups, many of which were overrepresented in informal settlements and/or deprived or rural areas. There is existing evidence in each context that these groups experience worse outcomes from public services[10] and our findings highlight reasons for such outcomes. For example, at the policy level, while routine data was collected on ethnic and religious minorities in Nepal, this was not analysed to understand health inequalities that affected these groups or to address these in health planning processes. Language and caste discrimination were additional factors that could influence access and outcomes in all study contexts.

> The information of patient's such as ethnicity, education, etc. are in the registers at ward and clinic level. It remains there. It doesn't come here.
>
> Key Informant Municipality 2, Nepal

Women from ethnic or religious communities could experience additional gender disadvantage in terms of social norms within these populations, combined with the wider social exclusion of women, that meant they were under represented in policy and practice decision-making. Lack of access to alternative legal frameworks for women living under customary laws in Myanmar or in rural areas of Nigeria was also a key reason for social exclusion and violence affecting women.

Politics in Kibera and in Kenya more widely, was seen to be based on mobilisation of ethnic groups involving ethno-regional patronage, historical grievances and political violence, with residential areas often similarly divided on ethnic lines. Both religious and ethnic divisions could also adversely influence perceptions of minorities in Nigeria, creating and reinforcing social exclusion. In Myanmar, a combination of history, culture and politics have resulted in a fractured society linked to communal violence involving groups that are collectively termed Ethnic Armed Organisations.

In such contexts, allocation of resources for public services in areas where ethnic and religious minorities were concentrated was shown to be deliberately unjust in many of the pilot reports, constraining access to healthcare, education and sanitation facilities and creating costs for these services that were not present for the more powerful populations in each context. At the same time, these populations were overpoliced and coerced in Kibera, Myanmar and Vietnam, indicating that public service resources were focused on controlling rather than supporting these groups.

Recommended solutions at policy, organisation and community levels

Common themes identified across diverse contexts and across diverse excluded populations suggest the following recommendations have international relevance. These approaches were agreed as relevant to future public service development by policymakers and practitioners involved in a number of multistakeholder workshops held to discuss pilot study findings and were considered to have potential for scaling up across the relevant country context. In all contexts, policy and practice development that responded to the needs outlined in the pilot reports was seen as a first step to achieving the large scale changes required to reduce inequities.

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[10] Citations for this evidence are provided in each pilot report

Make public service inequities visible

- Train and equip staff in public services to generate and report good quality evidence about public service access and outcomes for diverse social groups through routine data collection and periodic surveys on key health indicators disaggregated by gender, age, ethnicity, religion, migration status, education, occupation, disability status, location and other relevant stratifiers. Integrate equity-related outcome measures into public service programmes and interventions through a combination of supportive and regulatory mechanisms. Involve private providers in data collection and reporting where they contribute significantly to the sector involved.
- Train and equip staff in public services to conduct equity-focused analysis of existing data. Combine this with quantitative and qualitative research to identify inequalities for each group as well as intersectional disadvantage. Participatory research that directly links to policy and practice development is particularly empowering to excluded groups.
- Ensure disaggregated data is used during public service planning processes to allocate resources that would address inequities and support the scaling up of local activities. Identify good practice examples, such as the collection of disaggregated data at local levels in some health facilities in Nepal, as a starting point to inform public service planning more widely. Establish leadership, accountability and independent oversight for equitable planning processes and allocation of resources.

Ensure representation of excluded groups in decision-making

- Employ and involve those from excluded groups in in work to improve awareness and critical thinking about inequity, both in wider society and within excluded communities themselves. Build on this awareness to develop inclusive and detailed solutions to inequity.
- Support excluded groups to contribute to collaborative decision-making in public service policy and practice development. Provide adequate support, both financially and practically, to ensure equitable participation. The capacity to play an active part in decision-making processes is closely tied in with better access to education provision and employment opportunities, both of which are constrained by existing structures.
- Create transparent planning processes and regular channels of communication to involve excluded communities in local, regional, national and international planning programmes and operations on a long term and equitable basis.
- Support existing NGOs that already advocate and work to empower excluded communities. For example, Kituo Cha Haki Kibera, a youth-led community based grass roots organisation advocates for local community members to address the economic and social challenges they face. The organisation employs community based paralegals and draws on evidence-based research to challenge human rights violations. Women-led organisations in Myanmar played a similar role in improving family and community outcomes. Routine involvement in planning processes and financial support would enable such groups to inform decision-making and challenge the current structural causes of exclusion.
- Make specific provision for the representation of those experiencing intersectional disadvantage, such as women and young people from ethnic and religious minorities.
- Identify, support and promote positive role models from excluded communities and mentors to highlight routes out of deprivation and social exclusion that are supported by public services.

Create multi-sector partnerships

- Develop and invest in approaches to reduce disadvantage that cross multiple public service sectors and that address the complex impact of public service exclusion on

people from disadvantaged groups. Improve access to high quality public services for health, education, housing, water and sanitation and criminal justice. Establish strong leadership for such initiatives.

- Address the discriminatory social context in which public services operate and the links between disadvantage in, for example, health, education, policing, housing and sanitation. Establish independent oversight of police authorities and ensure policing enhances community security and safety rather than diminishing this.
- Create linkages between public service information systems in different sectors, as well as with private providers where relevant, to obtain a fuller picture of unmet needs and inequities.
- Identify good practice examples of multisector interventions that have been evaluated and scaled up. In Nepal, for example, a system of social audit to monitor service use and ensure accountability in primary health care and the use of subsidies for vulnerable populations to improve hospital access were highlighted. Hospital-based One Stop Crisis Management Centres also provide coordinated services across diverse sectors to survivors of gender-based violence (MOHP, 2018).

Target specific groups

- Develop and implement specific policy support for increased agency by women, young people, ethnic and religious minorities on matters that directly affect them. For example, representative Community Based Management Committees were recommended in Nigeria as an acceptable way for elected community members to drive development issues forward within their communities and to formally engage with public service providers and policymakers. The need for adequate support to run these Committees was highlighted.
- Address issues that particularly affect women, young people and ethnic or religious minorities in deprived areas, including gender-based violence, police brutality, substance abuse and public service discrimination. Increase access to formal legal processes for challenging injustice, especially for women. Link such work to programmes addressing social sustainability and economic development.
- 'Build back better' following the lessons learnt during the COVID-19 pandemic to mitigate the impact of COVID-19 on excluded groups and transform current policy and practice so that public services work well for everyone. Challenge historical approaches that create and reinforce inequities for socially excluded groups.

Focus on education and economic inequities

- Prioritise increased access to free good quality education and employment opportunities as key routes out of deprivation and exclusion. Involve universities in capacity-building and work-study programmes and in research to generate policy and practice solutions.
- Redistribute education funding and resources to disadvantaged schools and marginalised learners. Invest in digital inclusion education and devices for staff, parents and students from excluded backgrounds to promote educational equity.

- Support families financially to eradicate child labour. Promote greater employment opportunities through multisector initiatives such as Kazi Mtaani in Kibera, Kenya, which employed youth and helped reduce crime in the informal settlement during the pandemic when most residents had lost their jobs and closed their businesses. Extend such initiatives to public services more widely and ensure salaries are sufficient to enable those employed to fully meet their living costs.

CONCLUSION

Our findings provide detailed insights into how inequalities are created and maintained at macro-, meso- and micro-levels for the populations involved in the pilot studies and how these processes may reinforce each other to maintain social exclusion. Recommendations developed with the input of all key stakeholders take account of the social and political context in which studies were conducted and have been grounded in evidence from current literature to suggest potential solutions that contribute to policy, service and social development? Follow-on research to test implementation of these suggested ways forward and to evaluate interventions in practice are now needed. Pparticularly urgent is the need to evaluate interventions addressing the 'poverty penalty''; political aspects of exclusion; the cyclical reinforcement of exclusion through structural abuse, neglect and violence; and intersectional disadvantage experienced by young people and women from disadvantaged populations.

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APPENDIX: WORKSHOP PARTICIPANTS

SITE	POLICY & PLANNING	SERVICE PROVIDERS	COMMUNITY MEMBERS, NON-GOVERNMENT ORGANISATIONS	ACADEMIC, OTHER
BANGLADESH	- Director General, Directorate General of Medical Education - Senior Secretary, Ministry of Primary and Mass Education - Ex-Additional Secretary, Ministry of Health and Family Welfare - Ex-Director, Primary Health care, Directorate General of Health Services - Senior Epidemiologist and Divisional Coordinator, National Public Health Committee for COVID-19 Management - Member of Public Service Commission	Public Health Specialist & Executive Member, Early Childhood Development (ECD) network	Executive Director, ARK Foundation	- Public Health Specialist & Equity Researcher - Senior Journalist, Head of News, ATN News Limited
KAZAKHSTAN	- Dr Baurzhan Bokayev Professor and former Dean of the National School of Public Policy of the Academy of Public Administration under the President of the Republic of Kazakhstan, Researcher at Maxwell School of Citizenship and Public Affairs, Syracuse University - Kuanysh Tastanbekova University of Tsukuba - PhD (Consultant Researcher, World Bank) - Ayesha Vawda World Bank (Head of Education, World Bank)	- Gulnaz Kasbayeva Primary school teacher, school-lyceum №73, Nur-Sultan city - Akhmetzhanova Svetlana Beketovna School Principal, Ecological school-gymnasium №13, Kokshetau city	- Victoria Charbonneau 'Caring Heart', Taraz (NGO for orphan children and single mothers in distress)	Khalida Azhigulova, Socio-legal researcher in public international law and human rights, national coordinator of the Street Law legal education project for school children

KENYA	- Dr Sellah Kingoro, National Gender and Equality Commisiion - Siyama Ismael, CDF Kibera Constituency - Tom Ogeto, Ministry of Interior Coodination - Roselyne Mkabana, Nairobi Metropolitan Services - Hon. Magembe Makina, ward Nairobi County Assembly - Everline Bowa, Child Services	- Edwin Asani, Nairobi Water and Searage Company - Mrs Mwaura, Teacher Representative form School in Kibera - Peggy Adhiambo, Shining Hope for Communities (SHOFCO) - Benard Owino, Michael Oduor, Local CBO/Foundation on Inequalities	- Youth From Kibera: Wasanii Sanaa, Justine Ondiere, Angeala Hope, Kombedho Michael, - Teresia Kemunto, Youths Affair/ Youth Fund - Nehemiah Amwocha, Chief Kibera - Yasah Musa, Davis Oenga,Terry Anne, HAKI Africa	Professor Winnie Mitullah; Judith Atieno, University of Nairobi
NIGERIA				

NEPAL	• Input to a number of policy meetings at the Ministry of Health			•
VIETNAM	• Department of Health, • Department of Labour – Invalids and Social Affair, • Management Board of the Industrialised Zone	Labour Unions	10 migrant workers	•