SOCIAL INCLUSION: WHAT DOES IT MEAN FOR HEALTH POLICY AND PRACTICE?

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WORLD BANK GROUP
Health, Nutrition & Population

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SOCIAL INCLUSION: WHAT DOES IT MEAN FOR HEALTH POLICY AND PRACTICE?

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Abstract: This paper applies the tenets of social inclusion to health policy and practice, arguing that achieving the goal of Universal Health Coverage (UHC) will be impossible without considering social and economic inclusion. The idea of social inclusion in the achievement of UHC goes well beyond a focus on local-level interventions to an expansive notion that addresses the policy environment, social practices, and institutions. The paper summarizes ways in which social exclusion affects access to health services and health outcomes. It argues that social exclusion plays out through practices, processes, and behaviors of service providers, elites, and those most likely to be excluded. Such practices may permeate the structure and function of both formal and informal institutions. Through a discussion of the design and delivery of policies and programs, the paper highlights ways in which social inclusion can be advanced toward UHC. Finally, it draws from the experience of World Bank–supported interventions to highlight illustrative actions toward social inclusion in ways that can affect health outcomes. The expected audience of this paper are teams involved in the financing, design, and delivery of health programs, both within the World Bank and outside. The paper concludes with the exhortation to define the scope of "social inclusion" so that interventions can be targeted to those who are most likely to be excluded that interventions can be targeted to those who are most likely to be excluded.

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired immune deficiency syndrome
CDD	Community-Driven Development
DPO	Development Policy Operations
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GovRJ	The Government of Rio de Janeiro
HIV	Human immunodeficiency virus
MCH	Maternal and child health
PWD	Persons with disabilities
SCDs	Systematic Country Diagnostics
SGBV	Sexual and gender-based violence
TSSM	Total Sanitation and Sanitation Marketing
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
UHC	Universal Health Coverage
WBG	World Bank Group

SUMMARY

The concept of social inclusion has risen in importance on the global policy agenda because of four important developments. First, the "Leave No One Behind" agenda of the Sustainable Development Goals (SDGs) is an exhortation for social inclusion; second, although tremendous advances have been made in meeting the Millennium Development Goals (MDGs), many countries have not reached the goals, even as the Sustainable Development Goals set a higher bar in many respects; third, there is heightened concern about inequality and the fact that some groups systematically fall behind in progress on a number of indicators; and fourth, there is growing concern about the distribution of the benefits of globalization and its effects on social exclusion.

This paper summarizes ways in which social exclusion affects access to health services and health outcomes. It argues that social exclusion plays out through practices, processes, and behaviors of service providers, elites, and those most likely to be excluded. Such practices may also permeate the structure and function of both formal and informal institutions. Second, through a discussion of the design and delivery of policies and programs, the paper highlights ways in which social inclusion can be advanced toward Universal Health Coverage (UHC). Finally, it draws from the experience of World Bank–supported interventions to highlight illustrative actions toward social inclusion in ways that can affect health outcomes. The expected audience of this paper are teams involved in the financing, design, and delivery of health programs, both within the World Bank and outside.

The paper concludes with the exhortation to define the scope of "social inclusion" so that interventions can be targeted to those who are most likely to be excluded. In the health practice, gains in UHC will depend largely on the extent to which such groups are identified, rigorous analysis conducted, and such interventions designed that they address the underlying causes of poor outcomes and not just their symptoms. As the World Bank (2013a) points out, social inclusion is not always about doing more, it is about doing things differently. Identifying and rigorously evaluating opportunities to overcome social exclusion requires far greater attention if the vision of universal inclusion is to be realized within UHC. Social inclusion is integral, not incidental, to universality.

PART I – SOCIAL INCLUSION: WHAT DOES IT MEAN FOR HEALTH POLICY AND PRACTICE?

WHAT IS SOCIAL INCLUSION AND WHY DOES IT MATTER?

The concept of social inclusion has risen in importance on the global policy agenda because of four important developments. First, the "Leave No One Behind" agenda of the Sustainable Development Goals is an exhortation for social inclusion; second, although tremendous advances have been made in meeting the Millennium Development Goals, many countries have not reached the goals; third, there is heightened concern about inequality and the fact that some groups systematically fall behind in progress on a number of indicators; and fourth, there is growing concern about the distribution of the benefits of globalization and its effects on social exclusion.

The World Bank report, *Inclusion Matters: The Foundation for Shared Prosperity* (World Bank, 2013a), defines social inclusion as the *process of improving the terms for individuals and groups to take part in society*. In elucidating this deceptively simple definition, it adds: social inclusion is the **process of improving the ability, opportunity, and dignity of people, disadvantaged on the basis of their identity, to take part in society**. The report underscores the salience of social identity and group characteristics in understanding social inclusion.

Among the most common identities resulting in exclusion are gender, race, caste, ethnicity, religion, sexual orientation, disability, mental health status, and addiction. Social exclusion based on such group attributes can lead to lower social standing, often accompanied by poorer outcomes in terms of income, human capital, employment, and voice, in national and local decision making. Addressing social exclusion is a priority for global actors as disparate as UNDP (UNDP 2013), UNICEF (Micklewright 2002), and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM 2014) .

The World Bank (2013a) recognizes that social inclusion is intrinsic to both goals of the World Bank Group (WBG): reducing extreme poverty and boosting shared prosperity. In terms of diagnostics, the idea of social inclusion takes poverty analysis beyond correlates to uncovering underlying causes. Social inclusion can affect rich and poor countries and peoples alike, and it affects shared prosperity. The policy construct of social inclusion takes the discussion about prosperity beyond income dimensions to non-income and even non-economic dimensions. Social inclusion therefore is part of an expanded idea of prosperity that is often correlated with, but not the same as, income (World Bank 2013b). This paper applies the tenets of social inclusion to health policy and practice, arguing that achieving the goal of UHC will be impossible without considering social and economic inclusion. The idea of social inclusion in the achievement of UHC goes

well beyond a focus on local-level interventions to an expansive notion that addresses the policy environment, social practices, and institutions.

An important contribution of the World Bank (2013a) is its insistence that change is possible and that it can be influenced. The report shifts away from a view of exclusion being immutable and path-dependent because it is embedded in norms, politics, and culture. The report emphasizes that policy matters and argues that policies that promote social inclusion are those that *do things differently, not necessarily those that do more*. Moreover, no single set of policies or programs can be classified as "social inclusion policies" or "social inclusion programs." Depending on the "wrong" that needs to be addressed or the "right" that needs to be strengthened, a range of interventions may be used (World Bank 2013a, 2013b). Figure 1.1 lays out a set of stylized steps toward social inclusion. These begin with framing the right questions, such as: Who is excluded?; What are the mechanisms and processes of exclusion?; Why does such exclusion takes place?; and finally, What can be done to correct the wrongs?

Figure 1.1: Social Inclusion: Stylized Steps from Diagnosis to Action

Source: Das 2016.

This paper summarizes ways in which the exclusion of groups disadvantaged on the basis of their identity, affects access to health services. It argues that social exclusion plays out through practices, processes and behaviors of service providers, elites, and those most likely to be excluded. Such practices may also permeate the structure and function of both formal and informal institutions. Second, through a discussion of the design and delivery of policies and programs the paper highlights ways in which social inclusion can be advanced towards UHC. Finally, it draws from the experience of World Bank-supported interventions to highlight illustrative actions towards social inclusion in ways that can affect health outcomes. The expected audience of this paper are teams involved in the financing, design and delivery of health programs, both within the World Bank and outside

PART II– HOW DOES SOCIAL INCLUSION PLAY OUT? PRACTICES AND PROCESSES

Individuals and groups are excluded through behaviors and practices, including stereotypes, prejudices, and stigma that are socially constructed and influence day-to-day interactions. These practices play out at different levels, often underpinned by and ingrained in social norms, and in the beliefs of those who exclude and those who are excluded. The exclusion of less-valuable citizens starts in the household, through family power dynamics, often mirroring the normative structure of society. Practices of exclusion continue at the community level and translate into exclusion by formal and informal institutions (World Bank 2013a). Violence as an extreme practice of exclusion deserves special mention, as it lies at the intersection of social and public health issues; sexual and gender-based violence (SGBV) is a particularly pernicious form.

Excluded groups may reject the terms under which they are being included, in turn, rejecting health interventions, thus leading to poor outcomes. For example, evidence of the use of health care by indigenous communities in different parts of the world shows that inclusion must transcend mere provision of services. The World Bank (2013a) cites the example of Adivasi (or Scheduled Tribe) women in India, who seldom give birth in health facilities; the attendant lack of care is one of the leading causes of high maternal mortality. When asked in the National Family and Health Survey (2005) why they do not give birth in health centers, the majority of responses from Adivasi women indicated that they did not think it necessary. Is this a reflection of low demand for health care? The World Bank (2013a) argues that what masquerades as low demand has complex and often concealed determinants. Qualitative reports show how Adivasi women may be humiliated when trying to access services; this discourages them from going to health facilities. These results are echoed in qualitative research from the Peruvian Sierra region, which shows that lack of respect for cultural practices and values is one of the most important reasons why indigenous women do not seek to give birth in health facilities.

Rejection of the terms of inclusion, in the foregoing case, of health services, is also a rejection of indignity and humiliation and an assertion of self-esteem and self-worth. Interestingly, the application of the idea of dignity to policy and practice has been led by health professionals medical ethicists who have focused on the terminally ill, the elderly, those with significant physical and cognitive impairments (Das 2015). The fact that indignity or the perception thereof affects outcomes is now being increasingly recognized. Beach and colleagues (2005), using data from the Commonwealth Fund 2001 Health Care Quality Survey of 6,722 adults living in the United States, analyzed the association between two measures of respect (involvement in decisions, treatment with dignity) and outcomes (satisfaction, adherence, receipt of optimal

preventive care). After adjustment for respondents' demographic characteristics, the probability of reporting a high level of satisfaction was higher for those who had been treated with dignity. Being involved in decisions was significantly associated with adherence for whites; whereas being treated with dignity was significantly associated with adherence for racial and ethnic minorities (Beach et al. 2005).

Related to the idea of indignity, but not the same, are notions of discrimination and stigma, which may also affect the health-seeking behavior of excluded groups. The case of HIV has shone a bright light on issues of stigma and discrimination, by uncovering ways in which some groups are excluded because of their identity. The epidemic is mostly concentrated now among sexual and ethnic minorities, people who inject drugs, those who are mentally ill and homeless, and low-income regions and countries. Stigma keeps excluded groups from seeking information, adopting preventive behaviors, being tested, disclosing serostatus, and accessing treatment even where services are available. People living or associated with HIV and AIDS, moreover, are at risk of losing their spouses, family support, employment, property, livelihood, and social status. These effects are more prominent in already-disadvantaged groups. For example, women and children are more prone than men to property seizure, abandonment, and violence as a result of their HIV status or association with the disease (DFID 2007).

PART III – DESIGN AND DELIVERY OF PROCESSES AND PROGRAMS TOWARD SOCIAL INCLUSION

Social exclusion is multifaceted, and practices affecting one arena can lead to or reinforce exclusion in another. Policy responses must equally be multisectoral. Intent, design, delivery, monitoring, and accountability are all critical, and they need not be about doing more but about doing things differently. A good diagnostic is the foundation on which good design sits, since it identifies clearly the problem that needs to be solved and the questions that need to be answered.

This section discusses how health programs can be delivered differently. For instance, stereotypes that are often ingrained in service providers can affect how they treat their clients, but attitudes can be changed. There is growing interest in developing "cultural competencies" among service providers. This has been taking place in health care and social work and is growing in education and other sectors. Evaluations of cultural competence training, although rare, show that such training can improve the attitudes of health care providers and increase patient satisfaction (World Bank 2013a, based on Betancourt and Green 2010). Holding providers accountable not merely for their presence and their technical skill, but also for cultural competence as a performance indicator is likely to do much to ensure that cultural minorities feel comfortable accessing services. In a strongly worded statement, the Social Inclusion Scoping Group of the Royal College of Psychiatrists highlighted the exclusion that persons with mental health challenges and intellectual disabilities face, arguing strongly for a "recovery-oriented practice" (Social Inclusion Scoping Group of the Royal College of Psychiatrists 2009).

Making a change toward social inclusion is often about addressing the political economy and power relations at both local and national levels. For instance, excluded groups often lack voice and the power to influence decisions. In this regard, the global HIV response provides a powerful example of how voice influences decisions. Under the banner "nothing for us without us," AIDS activists globally influenced budget allocations, research priorities, drug approval procedures, drug availability, and service delivery models. Innovative means of community-based monitoring can enhance downward accountability of providers and maintain a system of checks and balances. Traditionally excluded groups can be involved in the surveillance of health facilities to monitor their opening and closing hours, and the availability of health personnel, amenities, and infrastructure. Simultaneously, incentives may be given to service providers to reach and stay in remote areas.

Finally, the financing of health systems can often be regressive, with disproportionately deleterious effects on the groups that need the greatest support. Unless the distributional impacts of health care financing are rigorously analyzed and monitored, they do not find place in policy adjustments. Also, the

quality of spending and hence, of positive impacts emanating from such expenditure is also of essence. In fact, the areas that need the greatest attention are often those that have the weakest institutions and the poorest quality of spending. Therefore, financing needs the careful application of a social inclusion lens.

PART IV — WHAT DO WE KNOW FROM THE EXPERIENCE OF WBG-SUPPORTED INITIATIVES?

The WBG supports its clients and partners through three main instruments: lending, knowledge generation, and technical assistance. Often these instruments come together in a single operation targeted at specific excluded groups or are mainstreamed into broad-based programs. In many cases, multisector engagements, ranging from actions that are mandated as part of budget support operations to components of other projects, can have a bearing on the health outcomes. In Panama, the Strengthening the Social Protection and Inclusion System Project combines group-based with geographical targeting to address chronic problems of exclusion. Some of its components focus on delivering services in indigenous territories, or *comarcas*, that have poverty rates of 80 to 90 percent and the slowest decline in poverty. Within the targeted geographical areas, the project focuses on maternal and child health (MCH) and on the needs of the elderly and persons with disabilities (PWD). The project drills down even further in its design and attempts to define a methodology to measure quality, *culturally appropriate* MCH services, including the training of health care workers in cultural competency.

In Serbia, the Delivery of Inclusive Social Services Project targeted historically excluded groups such as the Roma, the elderly, and PWD. A recent Implementation Completion and Results Report indicated that the project implemented an effective program of recruiting and financing Roma health mediators trained in a range of skills to work in primary health centers. The project also provided better immunization and facilitated the provision of personal documents and health cards and better access to reproductive health services for Roma women and other vulnerable groups such as the elderly and PWDs (World Bank 2015).

In still other cases, social inclusion may be addressed through Development Policy Operations (DPO)—programs that seek to catalyze policy reform. An innovative DPO in Brazil uses reforms in urban mass transport infrastructure and network as a means to increase access to and delivery of gender-focused legal, social, and economic inclusion resources and services. The government of Rio de Janeiro (GovRJ) uses the existing *Supervia* trains and *Teleférico* cable cars (an important mode of transport for Rio's many hillside shantytown inhabitants) to deliver gender-focused information and services. It links female riders to

services that improve their security, and is an important mechanism to implement the provisions of the Maria da Penha Law (national Anti-Domestic Violence Law) (World Bank, 2013c).[1]

A number of HIV/AIDS programs have had a strong track record of reaching groups that are most excluded and stigmatized. In Andhra Pradesh and Karnataka, two Indian states hard hit by the epidemic, the AIDS program has targeted a high-risk, stigmatized group—female sex workers—through outreach, condom promotion and distribution, clinical services, community mobilization, and social support. Over time, the initiative evolved to better meet the needs of these women, who have gradually taken on greater leadership responsibilities within the program. The program expanded from a focus on basic services to tackle underlying determinants of vulnerability, including violence from clients, police, and intimate partners and to promote economic literacy and inclusion. Between 2003 and 2011, the prevalence of HIV/AIDS among the female sex workers declined from 20 percent to 7 percent in Andhra Pradesh and from 15 percent to 5 percent in Karnataka. This improvement has played an important role in reducing India's overall epidemic by approximately 60 percent, from a projected 5.5 million cases to 3 to 3.5 million cases (El-Saharty and Nagaraj 2015).

Community-driven development (CDD) initiatives are often broad-based area development programs that provide an opportunity to integrate the needs of the most excluded citizens. The Tamil Nadu Empowerment and Poverty Reduction Project in India is one such example. Like other CDD programs, it was based on principles of participation, empowerment, and downward accountability. It has mobilized groups of PWDs into savings and credit "self-help groups," with national identity cards (that facilitate access to government programs). Almost 75,000 PWDs received assistance in starting an economic activity as a result. The focus on persons with mental disabilities led to grants to assimilate them into community activities. Similarly, Peduli, a project linked to Indonesia's Program for Community Empowerment initiative, gave grants to civil society to work with "marginalized and invisible groups." In a consultative process that involved local communities Peduli generated a list of groups that the program would support—an example of community-based targeting through a process that reflected the community's framing of the idea of social inclusion (World Bank 2013a).

There are also promising examples of pilot programs to promote social inclusion that have the potential of being scaled up. In the Democratic Republic of the Congo, where there is high prevalence of sexual and gender-based violence (SGBV), a pilot to prevent SGBV and support children and adolescent survivors works to strengthen nongovernment capacity and equip provincial authorities to monitor the quality of services. The ultimate objective is to establish an accreditation mechanism and to expand the program (World Bank 2014a). The activities of other partners such as UNICEF reinforce such efforts (USAID 2016).

Finally, data, research, and diagnostic work are public goods that often have significant influence on policy and practice. The idea of "inclusion" is being

increasingly mainstreamed into the WBG's strategic frameworks in client countries, and macro-level Systematic Country Diagnostics (SCDs) are now mandated for country teams and have to precede a new Country Partnership Framework (or the WBG-client strategy in the country). A recent review of the first 17 SCDs shows that most made prolific use of the term "social inclusion" or more frequently, of the term "inclusion," but conflated both these constructs with almost any positive development outcome. Conversely, some SCDs address aspects of social inclusion without necessarily referring to social inclusion (Das 2016).[2] This is inherent in the fact that social inclusion has multiple meanings, and its variants are being used more frequently in the policy literature over the last few years. Other organizations have also mainstreamed social inclusion into their strategic processes (UNICEF 2008, US State Department 2009).

Apart from country-level diagnostics, more focused sector knowledge also affects programming. For instance, in Sudan, investment in the Global Fund–supported HIV programs for female sex workers and men who have sex with men substantially increased after the release of a World Bank–led allocative efficiency analysis. The effect of this change in resource allocation—without adding more funding—was expected to benefit socially excluded populations and, indirectly, all other populations. The optimized resource allocation was estimated to avert approximately a fifth of new HIV infections and AIDS-related deaths in the medium term and potentially more in the long term. In a context of legal barriers and stigma associated with socially excluded groups like sex workers and men who have sex with men, the allocative efficiency study, which established a combination of epidemiological and economic benefits, was instrumental in informing an evidence-informed policy choice (World Bank 2014b).

Still other studies evaluate the impact of ongoing programs, which in turn can lead to tweaks in design or implementation. One such study examined the impact of the Total Sanitation and Sanitation Marketing (TSSM) program cofinanced by several partners including the Asian Development Bank (ADB 2012). Introduced in East Java, Indonesia, in 2007, the TSSM promoted collective behavior change, moving from open defecation to more hygienic practices. The study looked at differential impacts by household type and ethnic groups. Its results showed that female-headed households in TSSM experienced a reduction of 5.8 percent in the prevalence of diarrhea among children under five-years old. Moreover, there were significant differences in impact by ethnic group: persons of Javanese ethnicity (which have done well in human development indicators, overall) experienced no improvements in outcomes, while the Madurese showed significant improvements in children's anthropometric measures. Other ethnic groups showed a reduction in open defecation compared to nonexposed households. The study concluded that since sanitation campaigns reach households, and intra-household responsibilities for sanitation practices depend partly on culture and social norms, some components of TSSM may be mainstreamed toward greater social inclusion (Borja-Vega 2014).[3]

PART V — CONCLUSION

The idea of social inclusion has, in recent years, become something of a catch-all—a concept that can denote almost any positive welfare outcome. In advancing toward social inclusion, it is important to define its scope so that interventions can be targeted to those who are most likely to be excluded. In the health practice, gains in UHC will depend largely on the extent to which such groups are identified, rigorous analysis conducted, and interventions designed to address the underlying causes of poor outcomes and not just their symptoms. As the World Bank (2013a) points out, social inclusion is not always about doing more; it is about doing things differently. Identifying and rigorously evaluating opportunities to overcome social exclusion requires far greater attention if the vision of universal inclusion is to be realized within UHC. Social inclusion is integral, not incidental, to universality.

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