

# TACKLING SOCIAL EXCLUSION IN HEALTH AND EDUCATION

Case Studies from Asia

SUMMARY REPORT

for

Department for International Development

Asia Division

by

Janet Gardener, GHK International

Ramya Subrahmanian, Institute for Development Studies

*July 2006*

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**IDS**  **INSTITUTE OF DEVELOPMENT STUDIES**

**GHK Consulting Ltd.**

526 Fulham Road, London SW6 5NR, UK

Tel: +44 (0)20 7471 8000 Fax: +44 (0)20 7386 0784 email@ghkint.com www.ghkint.com

## ACKNOWLEDGEMENTS

The authors are extremely grateful for the invaluable assistance of all the stakeholders concerned with all the case studies included in this report. In particular, we would like to thank:

- The Ministry of Local Government, Rural Development and Cooperatives, Bangladesh; staff of the Urban Primary Health Care Programme (UPHCP) and the Bangladesh Women's Health Coalition
- The Research & Evaluation Department of BRAC and the Rural Development Department and programme officers and field staff in Nilphamari and Rangpur districts
- Md Hasanur Rahman for his invaluable help with field research in Bangladesh
- The Ministry of Education, HMGN, Nepal; the District Education Officer and officials in Sindhupalchowk; programme staff and field officers of Save the Children Fund (Norway) in Kathmandu, Nepal
- The Deputy Municipal Commissioner (Education), Municipal Corporation of Greater Mumbai and officers from the Public Health Department, and project staff from the Women's Health-Centred Project
- Action Aid and partner NGOs in Balangir and Bhubaneswar, Orissa
- DFID Advisers from Asia Division and from country offices in India, Nepal and Bangladesh

Finally, our special gratitude to all those members of the different communities where field work was conducted who gave up their time and showed such patience in contributing to the study.

The findings and views expressed in this report are those of the authors and do not necessarily represent those of DFID, the Governments of Nepal, Bangladesh and India, or the organisations interviewed or studied. Any inaccuracies are also those of the authors.

July 2006

# 1 INTRODUCTION

This paper draws together some of the lessons from a study commissioned by DFID to identify ways of tackling social exclusion through promising practices in health and education in the Asia region (Gardener & Subrahmanian 2005). The objective of this study was that its findings would serve as a basis for accelerating progress towards achieving the Millennium Development Goals for primary education, child mortality and infant mortality. The premise of the study is that such progress is contingent on approaches which can address social exclusion as opposed to conventional poverty-targeted programmes.

The study is based on six case studies from across the Asia region:

- In education they were:
  - Community-based Education Management Information System (C-EMIS) in Nepal,
  - Residential Care Centres for migrant children in/from Orissa, India,
  - Female Stipend Programme in Bangladesh.
- And in child, infant and maternal mortality:
  - Urban Primary Health Care Programme in Bangladesh,
  - Ultra-Poor, Village Elites and Access to Primary Health Care in Bangladesh,
  - Women Centred Health Project in Mumbai, India.

Through these case studies, this paper uncovers some of the processes through which ethnic minorities, disadvantaged castes, the ultra-poor, women and migrants have been excluded; outlines the ways in which projects have identified social exclusion and found ways to realign incentives for greater inclusion; and seeks to draw programmatic lessons for the design and implementation of more effective responses.

## 1.1 What is social exclusion?

Our understanding of social exclusion is of a dynamic process with many varied dimensions. Social exclusion may be defined as:

*... inequalities arising from the interplay of social differentiation and restricted entitlement and access to resources which compounds vulnerability, restricts prospects for upward mobility, and increases the probability of inter-generational chronic poverty.*

The dimensions of social differentiation include:

- ascribed identities (caste, race, gender, ethnicity),
- differences in cultural beliefs or practices (religion, language, ethnicity),
- nationality or citizenship based on birth,
- attributed and real differences with respect to ability (the mentally and physically challenged),
- 'lifestyle choices' based particularly on sexuality (homosexuality, sex workers).

The study draws on Gore's (1997) conceptualisation of social exclusion as a process through which power is structured by historical political processes (legacy); social relations and rule-based processes of regulation (governance); and institutions – the 'rules of the game'.

Kabeer (2000) focuses on issues of process underlying relational exclusion: 'A focus on processes of exclusion ... draws attention to the production of disadvantage through the active dynamics of social interaction, rather than through anonymous processes of impoverishment and marginalisation'.

## 1.2 Social exclusion and the MDGs

Asia has seen rapid growth over the past 20 years, and a 10 point decline in the overall incidence of poverty (Farrington 2006). However, the uneven progress of growth and poverty reduction, within as well as across countries, poses distinct risks to achieving the MDGs by 2015.

In many Asian countries, the quality of growth and poverty reduction is being undermined by rising inequality and insecurity (Kabeer 2006). Inequality and insecurity are reflected in a number of striking disparities in the access of specific social groups in Asia to health and education. These excluded groups have a higher concentration of children out of school and lower health indicators. Achieving the MDGs in these countries will require distinct effort on the part of governments and development agencies to support these groups to access and utilise services. The case studies reviewed here suggest that meaningful progress towards the MDGs requires an understanding of social exclusion which informs approaches that go beyond numerical targeting and introduce inclusive supply-side reforms.

In **India**, **caste and tribal ethnicity** remain strong markers of disadvantage, strongly correlated with particular occupational/livelihood strategies. Among different economic groups, the most vulnerable groups are the agricultural labour households (rural) and the casual labour households (urban). Membership of these groups strongly overlaps with Scheduled Caste (SC) and Scheduled Tribe (ST) status. The dual phenomenon of being an assetless casual wage labour household, in either rural or urban areas, from either an SC or ST group has accentuated the 'prevalence, depth and severity' of poverty. Disaggregated data for religious minorities and by gender across various indicators also shows inequalities, particularly between Muslim and Hindu groups, and gender inequalities systematically across *all* social groups.

In **Nepal**, there is a significant rural-urban divide and remoteness, causing increasing poverty in Mid-Western and Far-Western regions and in remote mountain districts; secondly, there is deep-rooted discrimination based on social differences of **gender, caste and ethnicity**. Poverty is higher among indigenous group minorities reflecting a severe deprivation of opportunities in all aspects of life. The other hardest hit group is the dalits (low caste). The situation of women among these groups is worse.

In **Bangladesh**, by contrast, linguistic and religious homogeneity is the norm, though there are small pockets of ethnic minorities. Here, the dominant axes of inequality are those of **gender** and **ultra-poverty**. Despite significant progress towards meeting the MDGs over the last decade, there remain entrenched inequities in health and education indicators, and a 'structural break' in the depth of poverty experienced by the ultra-poor.

### 1.3 Understanding social exclusion

Understanding social exclusion requires an understanding of the processes through which certain groups are first differentiated and then denied access to certain assets, services and other benefits available to the wider community. The study has drawn on Hooper (2003) to delineate these processes by addressing the following questions:

1. **Country/sector experience** What are the forms of exclusion experienced? Which groups are excluded from the rights and services necessary for achievement of the MDGs?
2. **Community-level dynamics** What are the community-level dynamics which impact on diversity and exclusion, the interplay of processes of differentiation and structures of inequality. How is exclusion experienced?
3. **Structure and behaviour of institutions** What creates differential treatment by providers as well as constraints on access?
4. **Mechanisms of policy and decision-making** How do policy and legal frameworks ensure (or diminish) opportunities for the socially excluded?
5. **Systems of accountability and governance** What are the prevailing systems of accountability and governance? Is there a mandate for working with and for the poor, the socially excluded and women? How is it framed and guaranteed?

Bangladesh, India and Nepal were the three countries selected for case study since they provide: contrasting social, economic and political contexts with contrasting characteristics and extents of social exclusion; similar institutional contexts for health and education service delivery; and innovations and reforms aimed at tackling social exclusion. Each country shows varied progress towards MDGs and significant inequalities in national health and education indicators.

The case studies were selected to provide: diversity of exclusion (eg caste, ethnicity, ultra-poverty, gender, migrants); adequate examples in health and education; service delivery measures with potential for replication; examples at various levels of the policy-service delivery chain; examples of different types of partnership (GO-NGO-donor); and good practice as well as cases where lessons are still being learnt.

While the case studies presented in this paper have contributed to a deeper understanding of process and practices of exclusion, the lessons ultimately rest on the evidence they provide of how wider change processes and multi-dimensional programming can restructure incentives so as to foster processes of inclusion. The case studies reveal that socially inclusive reforms in health and education service delivery are possible where incentives for inclusion are aligned between supply-side institutional practice and demand-side user communities. Only more inclusive services can accelerate and achieve progress towards the MDGs.

## 2 EDUCATION CASE STUDIES

### 2.1 Community-based Education Management Information System, Nepal

The Community-based Education Management Information System (C-EMIS) project, run by Save the Children (SCF) Norway in the Surkhet and Sindhupalchowk districts of Nepal, began as a pilot project in 2000 under a three-year agreement with the Ministry of Education. Its aim was, in building on Nepal's process of decentralisation, to provide a greater degree of accessibility and inclusion in education for girls and children from disadvantaged communities, especially dalit families. Its objectives centred on increasing access to and enhancing the quality of education by improving the information used for planning and systems of accountability.

The C-EMIS was set in a context of conflict and a government policy response supported by development agencies which, after nearly a decade of decentralisation reforms, sought to promote the representation of 'socially and economically backward tribes and ethnic communities, down-trodden and indigenous people'<sup>1</sup>. In the context of the increasingly damaging Maoist insurgency, the 2002-07 Tenth Five Year Plan identified social inclusion as one of its four pillars, and promoted decentralised, inclusive education as a central means of reducing gender, ethnic and caste-related disparities. The core strategy requires school education to be managed locally, with increased community participation, and education funding to be determined in part by local levels of enrolment of girls, ethnic minorities and low caste groups.

#### 2.1.1 *Processes of social exclusion*

In 2001 nearly 30 per cent of Nepali children lacked access to basic primary education. Across the country, rural children are worse off than urban children. Girls are worse off than boys and educational inequalities are particularly pronounced for low-caste and indigenous groups.

Children from these groups are excluded through social and economic barriers such as household poverty and lack of awareness of educational rights, landlessness and migration. These are combined with institutional barriers such as registration requirements and partial and politicised allocation of school places and scholarships.

Despite the decentralisation of school management and funding, institutional barriers continue to limit access to education. The allocation of government education resources is subject to nationally set criteria such as the level of poverty in a district, the composition of the school population and the rate of enrolment. However, decentralisation has meant that the final decision regarding allocations rests with the District Education Officer (DEO). In the absence of functioning local structures for transparency and accountability, allocation is 'captured' by the majority population. This is compounded by the low representation of dalit or ethnic group members in local government structures, and a correspondingly low awareness by these marginalised communities of their rights.

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<sup>1</sup> 1999 Local Self-Governance Act (SGA)

### 2.1.2 **Processes of inclusion**

The C-EMIS sought to increase access to education, and improve its quality, by improving the information used for planning and systems of accountability. Information and data were to be gathered with the active involvement of the community as a basis for the development of community-based and child-centred indicators and criteria, including tools for measuring inclusiveness and learning achievements. The data and indicators would help district and local level stakeholders to identify critical gaps in the existing primary education system – especially where schools were failing to meet the needs of marginalised, discriminated against and poor communities. The C-EMIS differed from the nationally-prescribed EMIS in two key respects:

1. Data was to be collected on the basis of the whole community rather than just the school to ensure that it reflected issues as they affected the whole community, and was not confined only to the school-going population.
2. Data was to be collected by the community (*tole* [hamlet] committees) rather than by the school, and was to be reported to community authorities (School Management Committees, Ward and Village Development Committees) before submission to the DEO.

These data collection, analysis and planning methods were actively learnt and applied by the community, with participation by members of minority ethnic communities and low-caste groups. The C-EMIS demonstrably encouraged self-analysis, strengthened local ownership of education and increased community awareness of educational status. Parents were proud to be involved, and more willing to take responsibility for school management.

One consequence of the C-EMIS exercise, according to the participants, was that School Implementation Plans (SIPs), which are prepared by the SMC, became more community-based. This, combined with additional government resources for schools, provided incentives for improved enrolment and attendance of girls and dalit/ethnic minority children. Thus, a new focus entered into the SIPs, aimed at motivating educationally-deprived children and their parents through community action, and at accessing government programmes for additional teachers, classrooms, scholarships and assistance for special needs children through school-based action.

SMC representatives found that linkages within the community and with ward, village and district stakeholders improved, bringing about a more ready flow of information about education benefits and rights and a more supportive stance on the part of the DEO.

In areas where the C-EMIS has operated the longest, it has been found that the disadvantaged have become more aware of available opportunities and are demanding access, quality and accountability.

These qualitative improvements were backed by improved enrolment and drop-out figures. All the schools in which the C-EMIS process had been applied showed an increase in child enrolment and a reduction in drop-out rates. SMCs reported that, following the C-EMIS process, enrolments stood at more than 95 per cent, and included children from all dalit and ethnic community households. Head teachers reported improved survival and pass rates.

Despite Nepal's insecure and volatile political environment, and the consequently unstable nature of its policy context, the programme has proven generally popular: not

only have there been requests for the programme to be started in neighbouring VDCs but, despite destroying all VDC offices, the Maoist insurgents have permitted the C-EMIS process to continue. At the national level, the Ministry of Education has agreed a uniform format for data collection based on the C-EMIS format, and has requested districts to adopt the C-EMIS process.

### 2.1.3 **Lessons**

The case study illustrated the degree to which social inclusion in primary education can be improved using a set of community-based processes and participatory education planning and monitoring tools. Key lessons are:

1. **A community-based process has the potential to promote social inclusion.**  
A community-based process facilitates:
  - identifying target group children through social mapping,
  - tracking target group children through ongoing monitoring of enrolment and attendance and use of children as community monitors,
  - accuracy of information systems building to an EMIS disaggregated by gender, ethnicity and caste,
  - accountability in management and delivery through School Management Committees,
  - local advocacy for inclusion through NGO community organisers,
  - more effective targeting of resources for improved schooling.
2. **The success of C-EMIS relies on a favourable policy environment empowering local communities.** The policy framework supports inclusive measures and processes within a decentralised planning and management structure which have enabled funding to respond to local level action. C-EMIS illustrates the use of decentralised, performance-linked block funding tied to strong, socially accountable SMCs.
3. **Representation of socially excluded groups is critical for strategic change and requires long-term support.** C-EMIS has been successful in including socially-excluded groups in information-gathering and representation on informal committees. Strategic impact on social and institutional exclusion will be more effective by representation of these groups, possibly through reservations, on formal structures in local government and school management, and employment as teachers and education officials
4. **Support by local NGOs for facilitation and capacity-building is required.** C-EMIS is a process-based approach requiring long-term support for community-based action.
5. **Scaling-up requires long-term support at local and national levels.** Whilst scaling-up community-based action requires long-term support for replication at local level, strategic impact at scale requires national level advocacy for policy and administrative change and technical assistance to ministries to, for example, integrate EMIS and C-EMIS systems.
6. **Getting incentives right is key to success.** It seems that incentives are key to the success of the C-EMIS. DEOs have an incentive to utilise the C-EMIS data as they receive funds from the centre to allocate between schools; and

communities have an incentive to map participation because receipt of funds at school level rests on achieving certain levels of school enrolment, for which dalit children's enrolment is necessary. This incentive is sustained now because even local elites have little choice for their children's schooling apart from government schools, and hence it becomes a matter of their interest to ensure dalits participate.

7. **An inclusive approach is effective.** The experience of SCF is that the use of the inclusive Education for All approach to 'broker' social inclusion has been more effective than the targeted approach adopted for dalit girls' education.

## 2.2 Residential Care Centres, Orissa

The concept of Residential Care Centres (RCCs) emerged in 2002 out of a partnership between the District Collector of Balangir district and ActionAid. RCCs were conceived as a means of providing care and education for the children of migrant workers from Balangir who would otherwise have to drop out of school when their parents migrated out of the district in search of work. The scheme provided for a room to be set aside at night for six months for the residential accommodation of 20-25 children in well-functioning primary schools with relatively good infrastructure and a willing and supportive local community. Each RCC is staffed by volunteer residential carers and provides food and basic amenities.

The programme has been extended to provide schooling for children at the destination site. Migrant labour from Balangir has been tracked to destinations in Andhra Pradesh, particularly the brick kilns in and around Hyderabad. Here, ActionAid has established 16 Bridge Course Centres which take children from about 100 brick kilns. Funding is divided between the Orissa Sarva Shiksha Abhiyan (SSA) and the Government of Andhra Pradesh. Similar cooperation for migrants has been started in Chattisgarh.

The policy context is in large part shaped by Balangir's status as one of India's poorest districts. The district receives considerable financial assistance from central government, including relief programmes to address drought-induced distress. However, positive impacts from these programmes are difficult to discern. Migration is not an issue that is explicitly dealt with by state or district government, as it is viewed as a household preference for which the state bears no responsibility. 'Migration denial' is compounded by the scarcity of data on the scale and patterns of migration.

### 2.2.1 *Processes of social exclusion*

Orissa's Balangir district is one of the poorer districts in a state which is now the poorest in India, with nearly half the population living below the poverty line. Having experienced several droughts for many decades, most recently in 1996 and 2000, the district is also well known as a source of migrant labour. Although migration is a widespread phenomenon in India, what distinguishes the migration from Balangir are the conditions under which it takes place: debt bondage forces primarily landless agricultural workers and marginal farmers to sell their labour to organised networks of contractors. The migration of entire families means that children are absorbed into the workforce at their destination and, as they are away for 6-8 months, miss out on the school year. Language differences in the case of inter-state migration mean that children cannot attend schools even if there is a will. Commonly, employers of migrant labour keep their labour force under restrictive conditions.

The extreme poverty of the region means that there is little protection for children in the community, as relatives are unable to provide for the children of others. Thus, leaving the children behind is not an option for most migrant parents. Children account for nearly a third of migrants, leading to a 45 per cent school drop-out rate during the migration season.

Three overlapping forms of social exclusion are evident in the case of debt migration in Balangir: caste, land ownership and education. The former two come together to determine the experience of economic distress, resulting in educational exclusion. Intergenerational transmission of poverty increases the chances that children will grow up to lead lives of chronic poverty.

### **2.2.2 Processes of inclusion**

The RCCs have enabled the rights and needs of some migrant children to be protected in a context in which large-scale distress migration is not fully recognised in state policy. As well as facilitating social inclusion, they have played an important role in social protection.

The RCCs have sought to allow children to continue their education without the disruption caused by migration, as well as to ensure that children remain within a community which provides them with care and support during the long period of residence. This has been achieved by building on existing schooling infrastructure rather than creating additional educational alternatives.

An indicator of the successful take-up of the scheme is the fact that the RCCs accommodate more girls than boys, suggesting that parents place a sufficiently high level of trust in the scheme and in the school to be willing to leave young girls behind. This trust can be attributed in part to the local recruitment of volunteer carers who are more likely to know the families of the children, know where the parents are, how long they can be expected to be away, and have a good rapport with the children.

### **2.2.3 Lessons**

Lessons from this intervention may be summarised as follows:

1. **Research offered a valuable basis for advocacy.** Survey-work by NGOs allowed mapping of patterns of education and migration, particularly school drop-outs. Research offered a valuable basis for advocacy, to make visible the issues facing migrants, and to demonstrate the conditions causing migration. The importance of such advocacy – naming patterns and sites, naming the kinds of abuse experienced, and detailing the impacts on children – has an important role to play where there is not much policy receptivity to the issue of migration and the responsibilities of the state.
2. **The presence of ActionAid at both ends of the migration chain** offers an important mechanism for monitoring the quality of services and assessing progress on alleviating the costs of distress migration. ActionAid's role in helping to create convergence between the two states of Orissa and Andhra Pradesh in providing for migrant children's education also sets a valuable precedent for other states.
3. **A needs-based response** can help to start addressing structural dimensions of the problem through more immediate entry points. The case study illustrates efforts to create alternatives for parents so that negative spirals in their children's

development and inter-generational transmission of poverty can be disrupted. The importance of government schools expanding their mode of provision to accommodate those with different needs is critical in Balangir, given the lack of alternatives to government provided education.

4. **Linking education interventions to the overall livelihoods strategies** and choices of parents, and viewing the decision to educate children as part of a very complex calculus that parents make, is a strategic path to follow when tackling the education exclusion of migrants' children.
5. **Building on community-level commitment to the well-being of all children.** The intervention succeeds because the community is committed to it. In a situation of high levels of poverty and significant out-migration, there is clearly a level of sympathy that remaining parents have for the conditions of migrants – it could be them the next year.
6. **Simplicity of the model.**
7. **State-NGO partnership was vital** in making the intervention possible, the government's commitment to supporting migrant children's education has seen the model spread to other parts of the district.

## 2.3 Female Stipend Programme, Bangladesh

The Female Stipend Programme (FSP) in Bangladesh began as series of pilots in the early 1980s and has expanded to cover all rural areas since the mid-1990s. The FSP aims to increase girls' enrolment in grades VI-X with a view to increasing the number of educated women participating in the economic and social development of Bangladesh, increasing the social status of women and reducing population growth by curbing early marriage. The FSP provides stipends and tuition waivers to girls living in all non-municipal areas in Bangladesh attending grade VI-X classes. The stipend varies between 25-60 taka<sup>2</sup> per month, with tuition costs of 10-25 taka going directly to the school. Attached to the stipend are qualification criteria including a minimum 75 per cent attendance rate, a minimum 45 per cent performance in annual school exams and the requirement that girls remain unmarried until the SSC exam or the age of 18.

The FSP aligned with the then prevailing developmental objective of addressing poverty and development through expanding universal access to education. This was combined with the objective of using girls' education as a means of population control by delaying marriage, and promoting contraception and birth spacing. The programme was set in a policy context characterised by strong political commitment to expanding access, cutting across all political parties and administrations. Foreign aid provided for the large-scale construction of new classrooms, teacher recruitment and the introduction of community-based, NGO and non-formal provision. In 1990, free, compulsory primary education was introduced as well as free tuition for girls in grades VI-VIII.

### 2.3.1 Processes of social exclusion

Despite the proliferation of education providers in Bangladesh, and the emphasis on girls' education, social exclusion is perpetuated at the institutional level by a decline in the quality of provision, and the extent to which its relevance and delivery may lead to

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<sup>2</sup> 100 taka = GBP1 (approximately)

underachievement and drop-outs. This decline in quality has affected girls disproportionately. Heavy investment in demand financing has led to overcrowded classrooms, and concerns that this has lowered educational quality by reducing individual attention or interaction opportunities for students. Quality of education in madrasah schools has become a particular object of concern. Although parents feel madrasahs provide a safe environment for their daughters, the gender gap in exam passes is much higher than in other schools, and those schools without any SCC exam passes are more likely to be madrasahs.

Even in schools run by the Bangladesh Rural Advancement Committee (BRAC, an NGO), where there are overt gender objectives, it has been found that girls are less likely to get teachers' attention, less likely to have their experiences reflected in national textbooks, less likely to do well in maths, and less likely to succeed overall (Raynor & Chowdhury 2004). This is reinforced by a tendency for schools to devote more resources to 'bright' children, which favours children from higher income families. These concerns are reflected in figures which show that in terms of SCC passes, despite increasing enrolment and higher attendance by girls, results for boys remain better than those for girls.

Community-level exclusion is founded on traditional gender norms for women in Bangladeshi households. Dowry, early marriage and the traditional roles of wife and mother all constrain motivations for parents to send girls to school. There is also a fear for girls travelling outside the home. Nevertheless, a large percentage of girls completing primary school do enrol in secondary school, and their attendance record is generally better than that of boys.

When girls do drop out, it is usually because their families are unable to afford fees, books or transport. Poverty continues to be a major excluding factor, even after a decade of the full FSP. Very few of the poorest girls graduate to secondary education.

### **2.3.2 Processes of inclusion**

The period during which the FSP has operated has seen girls' enrolment in secondary school expand such that it is now generally accepted that girls can and should attend secondary school. It is estimated that by 2003, 4.4 million girls were enrolled at secondary school, of which 65-81 per cent were receiving the stipend. Pass rates for girls also improved (before reversing in 2002 with the introduction of a new curriculum). This has led to an environment in which parents with educated daughters are respected within their communities, and the increasing recognition of the value of girls' education has encouraged communities to contribute to the costs of schooling girls (usually 'bright' girls) from families which would otherwise not be able to afford it.

The programme is reported to have met its goals in helping to delay marriage and the birth of the first child, and increasing birth spacing. It is also reported that girls from study areas have greater professional ambitions, are more likely to be employed, have more confidence in resisting unwanted marriages, and are more likely to be the main decision-maker when it comes to the education of their children.

### **2.3.3 Lessons**

Despite its origin in almost exclusively fertility-related objectives, the FSP has succeeded in bringing about a broader shift in the way girls' education is valued in Bangladesh's more traditional, rural areas. This has served to dismantle some of the

institutional barriers to the inclusion of girls, not only in education but also in employment. Key lessons are:

1. The scaling-up of the stipend programme has been the result of **sustained political will** based on a consensus among the national elite on the vital role of education in poverty reduction and economic development.
2. The mechanism itself provides **performance-based and mutual incentives** for government, schools, parents and girls, fulfilling different but convergent objectives.
3. An increase in enrolment has negatively affected the **quality of education** with a differential negative impact on the achievement of girls.
4. Stipend **qualification criteria can be exclusionary**. The stipends themselves are now being received by those girls who are able to do well – many of whom come from affluent families. Girls from poorer families will continue in school if they are bright, but the girls from poorer families who are not so successful at passing exams are now more likely to be forced out.
5. Universal programmes require constant **monitoring and review using disaggregated data**. The continued utility of the universal stipend is called into question. A more closely targeted programme aimed at the girls from poorer families for whom the stipend is a *real* need could lead to a much smaller-scale and sustainable project.
6. A more closely targeted programme, however, calls for disaggregated monitoring and evaluation in terms not only of gender but also poverty and more difficult **targeting mechanisms** though, for example, means-testing and voucher systems.
7. There is a need to **look 'beyond access'** and to create a school environment which meets the needs of all girls. This may include revisions to the curriculum to make it more relevant and accessible, and a new approach to secondary level qualifications, particularly for less academic students.
8. There is also a need to **sustain the demand for girls' education** through providing the further education and employment opportunities for girls to realise their aspirations and for parents and communities to value their educational achievements.

### 3 HEALTH CASE STUDIES

#### 3.1 Urban Primary Health Care Programme, Bangladesh

The first five-year phase of the Urban Primary Health Care Programme (UPHCP) began in 1999, and provided funding for the construction of 190 clinics on donated land, and finance for the delivery of the Ministry of Family Health and Welfare (MoFHW) Essential Services Plus Package (ESP) through NGOs. The programme is executed by the Ministry of Local Government, Rural Development & Cooperatives (MLGRDC) under 16 partnership agreements between the UPHCP and NGOs or consortia of NGOs in four City Corporations (Dhaka, Chittagong, Khulna and Rajshahi). The first phase was co-funded with a US\$40 million loan from the ADB and grants from the Nordic Development Fund and UNFPA. A second five-year phase (covering all six City Corporations and five municipalities at a cost of US\$90 million) has been approved by the ADB, and is under consideration for funding by DFID.

The project's primary objective has been to improve the health of the urban population, especially the urban poor, and to reduce preventable mortality and morbidity, particularly among women and children, by increasing access to health care. It has a secondary objective of building the capacity of the City Corporations' Health Departments, and has provided training to 1,000 staff in health financing and management. This is to be achieved through a service delivery model which contracts NGO partners to run a hierarchy of Corporation-owned clinics, with services provided free for the 'hard core' poor and on a sliding scale for the poor and non-poor. Drugs are provided free to the poor and at a 25 per cent discount to market rates for the non-poor.

##### 3.1.1 *Processes of social exclusion*

The exclusion of the poor from primary health care services in Bangladesh is perpetuated through a combination of social and institutional barriers, mistrust of medical health services, customary beliefs, financial costs, and the configuration of service delivery models.

Social and institutional barriers include the lack of awareness by the poor of the services available to them, compounded by a lack of awareness of health issues and how best to seek treatment. This problem is particularly acute for the floating migrant population which does not settle for long enough to find out about available local health services, or to register for the Red cards which provide entitlements for the hard-core poor. Women are particularly inhibited by embarrassment in expressing their problems, even within their family, as well as social and religious customs which prevent them from travelling unless accompanied by a husband or brother. There is also a perception among the poor that they will be treated in a humiliating way by the clinic or hospital staff, or that access to services, and the cost, depends on having a personal relationship with clinic staff or some other influential person/patron.

This reflects a generally low level of trust in government services, with perceptions of informal charges and discretionary provision of drugs. In the private/NGO sector, charges are not standard and often not transparent, and private clinics are suspected of profiteering. Often, communities prefer to buy drugs over the counter rather than visit a clinic.

This reluctance to visit clinics is sustained by a fear of allopathic medicine, and a particular fear of surgery which is perceived as high-risk and expensive, with a prolonged treatment period. Instead, some poor communities prefer to consult traditional healers such as the *kabiraj*, a spiritual healer.

The poor are also materially excluded through the cost – not just in terms of fees for services, but also travel costs, the cost of medication, and the opportunity cost of having to take time off work if opening hours do not allow for out-of-hours consultations.

Finally, integrated clinic-based primary and reproductive health services may exclude those poor, especially women, who face difficulties with mobility and who would be better served by outreach services.

### **3.1.2 Processes of inclusion**

Phase 1 of the UPHCP has seen a number of positive impacts. With the necessary infrastructure in place, the ESP, with its free service component, is now being delivered where it was not readily available before. The programme has established 16 City Maternity Centres (CMCs), 124 Primary Health Care Centres (PHCCs) and 106 satellite clinics. With the exception of Chittagong, outreach services are now being provided under all partnership agreements. Provision of ante-natal care has risen from 56-73 per cent in 1999 to 80-87 per cent in 2004, and vaccination coverage has increased from 65 per cent to 79 per cent. The performance of clinics has also improved across all cities.

However, despite positive health trends, there is little evidence to attribute impacts to UPHCP and no evidence that the programme is reaching the poorest. Utilisation of the clinics remains low, and project records have not captured utilisation by different social groups. The research conducted for this study suggested that, while the clinics are not being used by high and middle income groups, nor are they being used by the very poor. A one-month study across the four cities showed that an average of 16 per cent of patients received free treatment (falling to a low of 2.5 per cent and 4.2 per cent in the two Chittagong locations which are run by the City Corporation) – although this includes TB and family planning services which are free to all.

This experience has suggested a number of ways of improving the inclusive impact of the UPHCP in Phase 2. These include targeted social marketing and disaggregated analysis and information systems to track performance, and management which has incentives and the capacity to take corrective action where performance is low. Attention will also be paid to restructuring the performance-based NGO partnership agreements to give greater weight to pro-poor service delivery over cost recovery. Mechanisms to increase accountability to the poor, using the existing management structures, may also be considered.

### **3.1.3 Lessons**

The UPHCP has sought to fill an important gap in primary health care provision in urban areas by improving availability of clinics. The clinics and outreach services provided under the programme have made services relatively accessible physically, and have demonstrated the provision of quality care. However, barriers to inclusion have persisted. Methods for overcoming these may include: **targeted social marketing** to include outreach work and satellite clinics, identification of at-risk households, publicity and pricing structures; **targeted exemption schemes** (including

targeting particular conditions) to address perceived or actual costs; and **improved organisational practice** to establish locations and opening hours for increased accessibility.

More specifically, reaching the poor will depend on:

- localised analysis of who is excluded and why,
- disaggregated information and monitoring systems to track performance,
- performance-related incentive mechanisms to give weight to pro-poor performance above cost recovery,
- accountability mechanisms which include the poor and excluded in health facility management structures,
- staff training to address inappropriate behaviour by health staff and management,
- an integrated approach to improve service provision as well as strengthen productive, human and social capital.

### **3.2 Ultra-Poor, Village Elites and Access to Primary Health Care, Bangladesh**

The extreme poor in rural Bangladesh, despite the country's improving development indicators, continue to remain outside the reach of national or international interventions. In particular, the extreme poor have been excluded from the widespread NGO rural development programmes which are based on micro-finance, and which the extreme poor are too poor to access. Since 2002 BRAC has been working to improve access to primary health care for the ultra-poor under a Special Investment Programme for the Specially Targeted Ultra-Poor (the STUP programme), which forms part of a broader five-year programme (Challenging the Frontiers of Poverty Reduction: Targeting the Ultra-Poor). This broader programme sought to support almost two million identified ultra-poor women from within existing BRAC programmes through enterprise development, health care and social development. The STUP programme was targeted at the extreme poor who were thus far excluded from any programmes.

The STUP programme was piloted in the three northern districts of Kurigram, Rangpur and Nilphamari, where 5,000 women took part, and extended in 2003 to these and a further four districts to include a further 10,000 women. At the time of the study, the programme had identified 20,000 ultra-poor participants in 12 districts and was in the process of identifying a further 25,000 participants in existing and new areas. The expectation was that the programme would be expanded to 70,000 participants by 2006.

The STUP aimed not only to reach poor women who had previously been excluded from health care programming, but also to widen its approach, working on several fronts to build internal and external processes and networks, bolstering human and social capital, and thereby enabling beneficiaries to claim rights to health and other services. Within the framework of an integrated, livelihoods approach, the programme was based on a quantitative, qualitative and participatory exercise to identify the poorest households and select beneficiaries from among them according to measures of exclusion and inclusion. In the absence of savings and credit, beneficiaries were provided with grants as a means of kick-starting income generating activities, for which they also received training, inputs and technical support. A monthly living allowance

was provided to cover the start-up period, and after two years a micro-credit facility would be made available, depending on accumulated savings.

These activities were designed so as to provide sustainable incomes for the women, on the basis of which they were then able to access BRAC's mainstream health programme. This provided health education, rights awareness, health advice and basic curative treatment, support from a STUP Health Programme Officer, treatment at the BRAC hospital or from BRAC panel doctors, free medicines and individual support for accessing government health facilities at district and sub-district level.

A key component was to bring about the involvement of village elites through a Gram Daridro Bimochon (GDB) (Village Poverty Alleviation) Committee on which business people, teachers or imams served together with men and women representatives of the poor. This complemented social mobilisation activities aimed at forming groups among the STUP women. The formal mandate of the committees is to protect ultra-poor participants in crisis, help resolve their problems and ensure children are enrolled in school – with a further mandate for providing latrines, tube wells and house repairs.

The BRAC intervention, starting three years after the UPHCP, was set in much the same policy context. BRAC's focus on the ultra-poor began in 2002 after three decades of relief work, livelihoods approaches and a programme built around microfinance, education, health and social development. The experience of these years was that these interventions were still not reaching the extreme poor, for whom micro-finance was beyond reach and food aid was not enough to deliver sustainable change.

### **3.2.1 Processes of social exclusion**

The STUP programme has been implemented in much the same context of social exclusion as that of the UPHCP. Just 18 per cent of the rural ultra-poor use government or NGO clinics or hospitals, and only 13 per cent use private qualified physicians. Of the rest, 23 per cent are treated by the *kabiraj* (traditional herbalist or spiritualist), 15 per cent use untrained allopathic ('quack') doctors and 30 per cent use semi-trained allopathic practitioners including local drug vendors and rural medical practitioners.

These trends reflect obstacles to primary health care access based on perceptions of the cost of services and quality of service providers, social and institutional barriers, customary beliefs and the configuration of service delivery models, as described above. Interviews with STUP beneficiaries found that most had not been outside of their village before the programme, and had neither the knowledge nor the confidence to get themselves to health care centres, or to demand treatment.

### **3.2.2 Processes of inclusion**

The STUP programme was able to improve inclusion of the ultra-poor in health care provision through interventions on a number of fronts: livelihoods, social capital and access to health services.

With the help of the grant from BRAC, 70 per cent of beneficiaries had built the foundation for a sustainable income, and 95 per cent of targeted households now had at least two meals a day compared with 53 per cent before the programme. Groups had also saved enough to be able to access BRAC loans after two years (although a significant proportion of these loans appear to have been for investment in enterprises operated by husbands or brothers). Beneficiaries felt that their social status within the

village had improved, and there was a marked confidence among the women combined with self-esteem and pride in their achievements.

The programme sought to build the social capital of beneficiaries from the outset, through group formation, frequent interaction with BRAC staff, and information and awareness campaigns. BRAC supported the formation of women's savings and credit groups which the women felt had built confidence and capacity in issues such as dealing with local government and health officials.

These activities were bolstered by the GDB Committee and the involvement of village elites. The committee was a response to the emergence of a degree of resentment, not only within the general community but also within the Village Organisations (VOs) around which BRAC's mainstream programme was organised. This resentment against the women who benefited from a transfer of assets left them vulnerable to theft; the GDB Committee was conceived as a means of embedding traditional authority in the village into the incentive structure of the programme, legitimising its activities and aims, facilitating local ownership and serving as a platform for village conflict resolution. This involved a careful balancing of support for the role of elites as patrons and protectors of the poor with ensuring the programme was not subject to elite capture. While the performance and effectiveness of the committees has varied, there has been significant support, resource mobilisation and provision of latrines and house repairs.

However, the STUP women's groups have not, as anticipated, accessed existing BRAC VOs, suggesting a limit to the extent to which they have been able to leverage their social capital.

In terms of access to health, the wider programme which STUP fed into was found to have been effective in overcoming information-related constraints on the use of health care and in creating a sense of entitlement to the use of government health facilities. Its financing for needed diagnostic tests and drugs meant that the generally adequate professional competence of doctors at government facilities could be accessed, while advocacy activities and the introduction of a STUP ID card were successful in reducing demands for informal payments to service providers. STUP participants, in particular, displayed a high level of awareness of the availability of health facilities, and were more likely to consult trained health professionals. More than half of the STUP participants reported visiting the Upazila Health Centre for the first time since joining the STUP programme.

While improved access has been accompanied by marked improvements in health status, with large reductions in chronic food insecurity and severe malnourishment, these outcomes appear to be related more to improved, sustainable incomes. Child malnutrition has not declined as markedly.

### **3.2.3 Lessons**

- 1. The importance of an integrated approach to social inclusion and health service delivery.** The STUP programme shows the need for, and success of, an integrated approach to inclusion of the ultra-poor in health service delivery. It is clear that improvement of the service itself is a necessary but insufficient condition to enable access for this group. An integrated approach to building sustainable livelihoods including increasing both productive and social capital to provide time, finance, knowledge and group support has proven successful thus far.

2. **The importance of disaggregated information and analysis.** The approach has benefited from a clear understanding of the social and economic differences within those normally aggregated as 'the poor'. This analysis has been made possible by BRAC through ongoing disaggregated monitoring and impact assessment of its development programmes.
3. **The usefulness of political economy analysis.** The approach has also benefited from continued learning of, and response to, the political economy of village life.
4. **The importance of monitoring to ensure sustainability.** Inclusion in service delivery depends on the increased economic, social and political capital achieved by the ultra-poor. Not only has this required intensive support, it is not yet clear whether the participants' increased livelihood security, confidence and esteem will be sufficient to sustain this inclusion in the absence of BRAC support.
5. **The need for intensive support and advocacy.** Increased access by the ultra-poor to health services has required intensive group and individual support to excluded groups to provide information, confidence and self-esteem amongst the ultra-poor. It has also relied on advocacy by BRAC and representation through the use of STUP ID cards. Responsiveness on the part of service providers is due in part to the latent 'watchdog' role performed by BRAC on behalf of its programme members.
6. **Sustained improvement to the quality of service is needed.** Continued utilisation by the ultra-poor of government health facilities also relies on improved staffing and drug supply to sustain any confidence in the service.
7. **A targeted but holistic approach.** The STUP programme is an example of a targeted approach to social inclusion which recognises the multiple causes of exclusion from health services and addresses them within a wider, multi-sectoral development programme.

### 3.3 Women Centred Health Project, Mumbai

The Women Centred Health Project (WCHP) was implemented within Mumbai's public health system from 1996 in response to women's articulated needs for better information and for services that also addressed men's reproductive knowledge and health seeking. The project was developed jointly by the Municipal Corporation of Greater Mumbai (MCGM) and NGO and academic partners in India and Europe.

The project sought to address exclusion from health services through a 'Quality of Care' approach with three interlinked dimensions: quality of delivery, quality monitoring and capacity, and quality assurance. Five issues related to quality of care were identified and mechanisms developed to address: layout issues (comfort), waiting time, complaint mechanisms, privacy and confidentiality, and client-provider communication.

A Women's Counselling Centre was established in one ward of the city, located in a secondary hospital outpatient clinic. Two Auxiliary Nurse and Midwives (ANMs) were selected from a group trained as part of the project's capacity building component, and appointed as counsellors in the clinic. Working in partnership with the doctors in the clinic, the counsellors provided detailed information and advice to women who either referred themselves or were referred by the clinic's doctors.

The WCHP came about in a context of inadequate health facilities, with a geographical distribution which means patients with minor ailments tend to go to tertiary hospitals rather than health posts or dispensaries. Facilities are also unevenly spread across different areas of the city, with far more facilities in the more affluent parts of the city, particularly South Mumbai, and fewer in the northern and eastern suburbs which have a greater concentration of low income social groups. The problems of access are compounded by the high dependency of low income populations on daily and/or informal wages, raising the opportunity costs of access to health care. This acts as a further incentive to choosing tertiary health care, where all investigations and referrals take place on the same premises, over primary care. Additionally, health posts and dispensaries may only be open during working hours. These factors have resulted in inefficient use of the health system, where quality is relatively high. Overcrowded facilities result in up to 32 per cent of reported ailments remaining untreated, and frequent recourse to the private sector.

### **3.3.1 Processes of social exclusion**

Social exclusion in relation to reproductive health arises from the interplay of several factors: intra-household and socially constructed inequalities that constrain women from paying attention to their health; the quality and delivery of health services that have traditionally been oriented around fertility control rather than holistic approaches to women's sexual and reproductive health; and costs of health care delivery which constrain the health access of women, and particularly poor women.

In Mumbai, women's access to public health services that enable them to address their common sexual and reproductive health problems has been constrained by the lack of services that are oriented towards these needs. Lack of information in the course of treatment seeking, and the attitudes and behaviour of health care providers, contribute to delays in seeking and receiving treatment.

Social exclusion from maternal health care, in particular, reflects the quality of care provided by health services, low involvement of men, and women's own inhibitions. Inadequate client-provider communication has been identified as one of the key factors undermining quality of care, resulting in inadequate information and counselling with regard to reproductive health. Overcrowded clinics, understaffing of outpatient departments, chaotic waiting procedures and the resultant stress under which doctors operate are compounded by women who do not have their records in order, or are unable to articulate their needs or provide full case histories. Women may also resist treatment out of inhibition or misinformation.

It is probable that the low confidence of women in seeking treatment is related to a lack of support and understanding of women's gynaecological health issues on the part of men. Men rarely accompany their wives during consultations, and conflicts in decision-making may mean that medical advice is overruled by family decision-makers. As a result, men's involvement is largely restricted to financially supporting treatment.

The inhibitions of women themselves have served as a significant barrier to access and information. A large proportion of women interviewed prior to the WCHP refused to discuss their sexual behaviour, and embarrassment causes some women to turn to home remedies or dispensaries when they should be seeing a doctor, thereby delaying treatment. Their discomfort in the presence of doctors is exacerbated by the lack of privacy during consultations, poor provision of information regarding diagnosis,

treatment and after-effects, and a 'moralising, judgemental and sometimes callous' attitude of staff.

### 3.3.2 **Processes of inclusion**

The establishment of the counselling centre, and its work to ensure women are better informed, has had three key impacts. Better informed women are better able to question doctors, discuss their treatment and make informed choices. A large proportion of women return with their husbands on the encouragement of the counsellors, to enable counsellors to inform and influence husbands. Better informed women also tend to comply more with medical advice, making doctors very supportive of the counselling centre. And the presence of dedicated counsellors helps to reduce waiting times through their responsibilities for explanation and information which enables doctors to treat patients more efficiently.

In order to raise men's involvement, a male cadre of health outreach staff was trained under the WCHP to engage in discussions with men. However, the project found that reproductive health issues remain a sensitive area for men – both the staff and the clients – and much more work needs to be done to strengthen the involvement of male providers and clients in reproductive health. Where men did discuss reproductive health issues, they tended to be related to women's conditions and seldom focused on their own reproductive health.

### 3.3.3 **Lessons**

The project yielded a number of lessons with regard to tackling social exclusion within health care delivery systems. Programmatic lessons may be summarised as follows:

1. **Specialised services are needed for reproductive and maternal health.** A principal lesson provided by the experience of the counselling centres is the need for specialised services aimed directly at addressing the social and institutional factors that contribute to the exclusion of women, poor women in particular, from seeking reproductive health care. Without the social support to help explain their health issues, provide information and emotional support to strengthen their decision-making, women are likely to be unable to assert control over their health, comply with medical advice and follow through on post-treatment health care.
2. **A client-centred approach is critical** and must be a part of overall health systems reform. Client-centred initiatives may be developed on many fronts thereby supporting the work of the counsellors. For example:
  - A Patients' Charter and other quality assurance mechanisms, such as 'suggestion boxes' within wards, can create the enabling environment to support frontline workers.
  - Improvements to the client-provider interface give women greater confidence in services which respond to their needs for basic information and encourage them to seek advice when required and follow through on treatment.
  - Improvements in the physical layout of reproductive health care centres provide privacy, both for women and male clients.
3. **Working within the system.** Sustainability of such interventions is greatly enhanced when the new services are set up within the public health system and

staffed by medical personnel, rather than social workers brought in from outside the system.

4. **Incentive systems are needed** to counter hierarchies within the system. Conflicts between 'technical' and 'social' dimensions are not necessarily surprising in the context of the medical profession, but hierarchies both in terms of authoritative knowledge and within staff structures may exacerbate such conflicts. Building trust is a matter of time and may also point to the importance of devising an incentive structure that facilitates the building of new relationships within the traditional health delivery system.
5. **Identify drivers for an enabling policy environment.** Some drivers of change are apparent in the case of the WCHP, which have enabled MCGM to fully support the changes recommended, despite significant systemic constraints:
  - Sound empirical grounding for initiative: The design of the WCHP was based on results of research which brought together clinical, epidemiological and social dimensions in partnership with the public health department (estimates for Mumbai city in maternal mortality or reproductive morbidity are not easily available).
  - Impact on clients: When clients are happier with services provided they are more likely to follow through and place their trust in the public health department. For MCGM officials, this is a positive result.
  - Partnership with MCGM from the outset: MCGM's support and involvement in the research study was critical for ownership and support.
  - International exposure: The MCGM is active in seeking international avenues for learning and sharing of experiences and hence is keen to follow up on new ideas and partnerships with international and local organisations.
  - Women change sponsors in leadership positions: Several women were in key positions within the MCGM and within the Public Health Department during this process and were key actors in pushing and sustaining efforts.

## 4 CONCLUSIONS AND LESSONS

The selection criteria for case studies for this report encouraged a focus on supply-side mechanisms for tackling social exclusion, as a way of seeking replicable, institutional mechanisms that can operate at a level of scale. The case studies highlight the possibilities for governments to introduce responsive mechanisms within systems of service delivery using partnerships with NGOs and through strengthening the supply-demand interface. They demonstrate the potential for governments, and service delivery systems, to tackle exclusion in health and education through institutional mechanisms.

Although the mode of implementation in many of these case studies resembles 'projects', generated through some form of NGO-government partnership, in all cases the mechanisms developed are situated clearly within the supply-side, and within systems of provision that reach out to the poor. Thus, as in the case of the Mumbai pilot of quality innovations in reproductive health care, the location of the innovation within the mainstream health system suggests the inherent potential to impact on poor women. In addition, the case studies demonstrate reforms within government systems and behaviour which indicate a level of scale that goes beyond the 'project' mode. Examples include the priority treatment given to ultra-poor and women in primary health care in Bangladesh, and the integration of community-based and disaggregated educational information systems in Nepal.

However, the case studies also have different implications for scaling up, some being more process-intensive than others in their establishment and development. The lessons here point to the value of research, piloting, learning and demonstration, and the need for capacity-building.

The study has provided a detailed examination through case studies of the community-level and institutional factors contributing to exclusion from education and health services, and the mechanisms which have been designed to address that exclusion. Each of the interventions analysed in the case studies has uncovered specific lessons about the nature of exclusion and context-specific opportunities for fostering greater inclusion. The findings are summarised in Table 1.

**Table 1: Summary of processes of exclusion and inclusive mechanisms**

<b>Community-level factors</b>	<b>Institutional factors</b>	<b>Case study mechanisms</b>
<b>EDUCATION</b>		
<ul style="list-style-type: none"> <li>▪ Household poverty</li> <li>▪ Traditionally perceived roles for women and girls</li> <li>▪ Lack of awareness of rights</li> <li>▪ Few livelihood options leading to migration</li> <li>▪ Social marginalisation/discrimination</li> </ul>	<ul style="list-style-type: none"> <li>▪ Lack of disaggregated management data</li> <li>▪ Restrictive registration requirements</li> <li>▪ Discriminatory allocation of school places and scholarships</li> <li>▪ Inappropriate curriculum for rural working children</li> <li>▪ Poor quality and discriminatory teaching</li> <li>▪ Language barriers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Participatory school planning &amp; monitoring (C-EMIS, Nepal)</li> <li>▪ Financial incentives for inclusion</li> <li>▪ Residential Care Centres for migrant children (India)</li> <li>▪ Female Stipend Programme (Bangladesh)</li> </ul>

Community-level factors	Institutional factors	Case study mechanisms
<b>HEALTH</b>		
<ul style="list-style-type: none"> <li>▪ Social barriers arising from low mobility and lack of voice</li> <li>▪ Lack of information and awareness</li> <li>▪ Customary beliefs deter use of allopathic, mainstream care</li> </ul>	<ul style="list-style-type: none"> <li>▪ Poor attitude of staff to poor and women</li> <li>▪ Professional hierarchies</li> <li>▪ Informal charges</li> <li>▪ Lack of disaggregated information or monitoring</li> <li>▪ Poor quality or inappropriate services</li> <li>▪ Poor accessibility (timing, location, cost or perceived cost and lack of outreach)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Livelihoods and rural primary health care (BRAC, Bangladesh)</li> <li>▪ Urban Primary Health Care (GO-NGO partnership, Bangladesh)</li> <li>▪ Counselling centres within health departments (India)</li> </ul>

Despite these differences amongst the case studies, there are some common themes that emerge. Programmes have a variety of origin either as: designed targeted responses, targeted responses within universal programmes, or improvements in delivery systems, eg through disaggregated monitoring and data collection, amongst others. An innovative feature of most of our case studies is that targeting has been within the supply framework, rather than only oriented to stimulating demand (through the provision of demand-side incentives and subsidies) which is normally associated with measures to tackle exclusion. Developing mechanisms *within* the provision of health and education, these innovations address a range of factors that exclude communities as well as constrain effective service delivery. They focus on the interface between supply and demand. Below we highlight some key points.

#### 1. Inclusive good practice relies on some key mechanisms:

- **Empirical evidence of exclusion and disaggregated information systems.** Successful cases have been able to provide empirical evidence of exclusion. Effective evidence has included disaggregated and localised data, eg C-EMIS had locally-owned data which built awareness and developed inclusive delivery mechanisms.
- **Empirical evidence of exclusion enables advocacy for inclusive reforms.** Prior research provided the basis for inclusive interventions, but importantly provided evidence to promote partnerships and influence institutional reform for inclusive public service delivery.
- **Needs-based and targeted responses focus attention on excluded groups** and raise visibility of issues of exclusion. It seems that engagement and support is easier within broadly targeted programmes. However, specially focused delivery mechanisms necessarily include targeted incentives especially to cover/subsidise cost and give social recognition (exemption schemes, identity cards, stipends).
- **Integrating supply- and demand-side approaches.** Sustained inclusion relies on strengthening livelihood security, as well as increasing political and social capital and providing reliable services.
- **Community-based approaches have encouraged inclusion** by exposing exclusion through participatory survey and monitoring, community-based management through SMCs with mechanisms to ensure representation and

accountability of excluded groups, community involvement in the care of vulnerable groups. Community involvement helps to build a constituency of support for inclusion and promotes social accountability.

- **Field-based support for capacity-building at interface of demand and supply.** Most cases have required intensive field-based support for fostering and nurturing inclusive processes.
- **Inclusive accountability mechanisms** for central government programmes and local level management. Examples include local management committees benefiting from representation of excluded groups, and the potential in health through decentralised health management. However, structural changes are likely to depend on national advocacy (for example through strengthened organisation of excluded groups' advocacy organisations), and increased representation of excluded groups on local and national management committees.

## **2. Mechanisms for addressing exclusion need to be supported by wider change processes**

Institutional change is often incremental and needs patient advocacy and piloting to show effectiveness and impact. Research (case studies of inclusive practice) provides an important 'influencing tool'.

In particular, behavioural change takes time and requires capacity building prior to and during the initiation of new mechanisms.

Scaling-up is possible through existing structures – all case studies operate within government structures and many have already scaled up. However, both pilots and subsequent scaling-up require additional funding support for field-level expenditure. There is also potential for convergence with government programmes and it is important to exploit this potential in order to promote reform.

## **3. Incentives are important to ensure that elites or non-excluded groups support the change**

It is important for programme research and design to get incentives right. This implies the critical importance of understanding the political economy of the intervention particularly in terms of assessing potential gains and losses to different groups of stakeholders. Successful cases have the majority interest engaged through provision of incentives for their support.

## **4. Drivers of inclusion should be identified and engaged**

The case studies identified the following drivers of inclusion:

- Favourable policy environment – for example, an inclusive and decentralised framework in Nepal (education); contracting-out for NGO/GO partnership in urban health (Bangladesh); local partnerships built at district-level (Orissa, Andhra Pradesh and rural Bangladesh); inclusive national development strategy (girls education, Bangladesh). However, the policy environment may also be constrained where there is competition from other sectoral priorities, as highlighted in the Mumbai case.

- Multi-actor partnerships:
  - o Bureaucracy. Individual bureaucrats may drive initiatives though innovators may tend to be isolated.
  - o Donors can forge partnerships around agendas for inclusion.
  - o NGOs have skills and capacity for community-based activity.
- GO-NGO-donor partnerships enable:
  - o intensive field-level support for community-based approach and social capital development,
  - o innovative methods,
  - o targeted, specialist services,
  - o quality monitoring and advocacy/'watchdog' function,
  - o potential for influence, convergence and scaling-up.

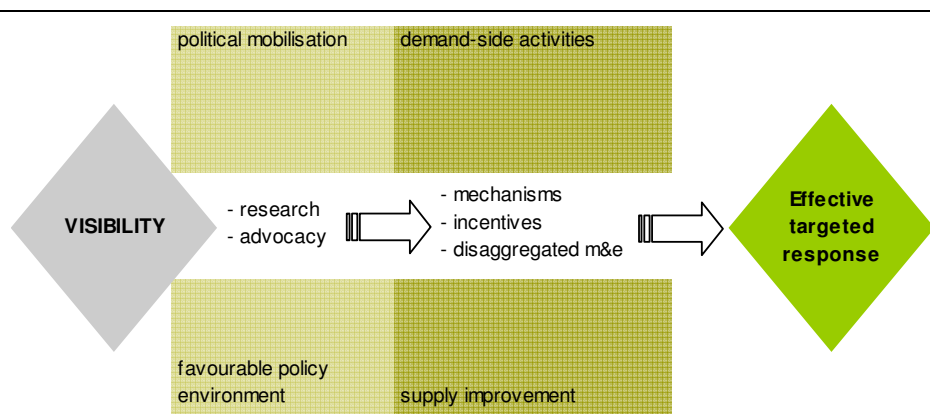
**5. Sustainability of social inclusion is likely to rely on:**

- local and national accountability structures sustaining demand for inclusion and improvement,
- continued quality service. Improvement of universal programmes is critical to inclusion – service must deliver to sustain utilisation.

**4.1 Policy implications**

These findings point to a number of implications for the way programmes are delivered by donors and implementing agencies. Key to effective delivery is the conclusion that tackling social exclusion demands a multi-dimensional and integrated response which takes account of both context-specific and wider change processes (Figure 1).

**Figure 1: Approaches to social exclusion**



The main policy implications are:

- Case studies show that institutional change through service delivery reforms can help accelerate progress towards MDGs by improving access and quality of services in a way that tackles constraints faced by excluded groups.
- Incentives that enable communities to work together to address exclusion can further help to promote greater social cohesion and overcome aspects of discrimination against excluded groups.

- Targeted mechanisms *within* overall systems reform can support particular needs of excluded groups. These could include:
  - social protection measures to address livelihood based vulnerability linked to health and education access,
  - subsidies, scholarships to provide incentives at community and household levels,
  - redressing mechanisms and grievance procedures at the point at which services are accessed by excluded groups,
  - specific services that address the underlying causes of exclusion,
  - disaggregated monitoring and management information systems (based on evidence from social analysis) to provide evidence of, and impact on, exclusion.
- These reforms are time and effort intensive, but can offer quick gains in reaching excluded groups.
- In particular, donors can support quick gains as well as long-term processes of change in the following ways:
  - invest in research based advocacy that raises visibility of experiences and processes of exclusion,
  - support civil society groups that work with excluded groups to institute advocacy but also to work with government to enable supply-demand interlinkages,
  - encourage investment in pilot projects so that possibilities for change are visible to policy makers for scaling up and sustainability.
- Where donors support governments to achieve MDGs through budgetary support and sector support, the donor needs to:
  - focus attention on information disaggregation,
  - improve monitoring and evaluation systems to track changes in access and quality of services reaching excluded groups,
  - push for multi-sectoral focus on exclusion including looking at costs of accessing services and economic/livelihoods vulnerability.

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