Towards More Inclusive Health Programs

A Learning Brief

Table of Contents

Towards More Inclusive Health Programs - A Learning Brief

▌ Who is this for?

This brief provides an introduction to health inclusion in India for program implementers in public health and development. While inclusion as an objective is inherent in development sector efforts, actors are currently at different stages of their inclusion journey, and facing a diverse set of challenges. While some stakeholders may be concerned about identifying and reaching 'last mile' or 'base of pyramid' populations with their intervention, others may be struggling to recruit and retain a diverse workforce, measure their coverage of different groups, or include an inclusion lens across the project cycle. Wherever you are on this inclusion journey, the Inclusive Development Resource Guide aims to support your efforts, and this brief is the first piece of that support.

Effectively supporting an inclusion journey begins with establishing a shared understanding of inclusion in programs, the rationale for pursuing it, and the inclusion needs inherent in the program context. The brief will provide program implementers and decision-makers with an introduction to **the concept of inclusion, an overview of who still needs to be included in India, and a framework for how particular individuals and groups come to be excluded.**

You can refer to the Inclusion Resource Guide for complementary resources to this one, including the guide to available toolkits and best practices, and Inclusion directory.

Inclusive Health Programming Resource Guide

Inclusive Health Learning Brief

Inclusion Tools and Best Practices

Inclusion Experts Directory

▌ Why do we need to think about inclusive health programming?

The case for investing in inclusion

As a principle, inclusion is explicitly at the heart of the global goals for Universal Health Coverage and Sustainable Development, spurring greater focus on inclusion in health and development programs. The World Health Organisation recognises the linkages between poor health outcomes and social exclusion, highlighting that **health inequities are systematically linked to 'social factors, including education, employment status, income level, gender and ethnicity (WHO, 2017).'**

The following are some clear reasons to invest specifically in inclusion:

1. Improve effectiveness of investments
Empowering marginalised communities to become full partners in health interventions improves appropriateness, sustained engagement and impact, and accountability.

2. Strengthen health systems
Identifying and including the most excluded populations for any program creates access pathways that other development programs can build on to maximise collective impact.

3. Contribute to equity
A focus on health access and empowerment of the most marginalised helps to reduce inequities, by breaking the cycle of ill-health and poverty and opening opportunities for agency, power and aspiration.

4. Contribute to economic development
In the words of the World Economic Forum, 'Inclusive growth can be thought of as a strategy to increase the extent to which the economy's top-line performance is translated into the bottom-line result society is seeking, i.e., broad-based expansion of economic opportunity and prosperity (WEF 2017).

Costs of Inclusion

It is important to acknowledge that an inclusive approach to health programs imposes some additional costs that may discourage implementers from using it. It is only by accepting and accounting for these that a program can implement inclusion as thoroughly and for as long as it takes to show impact.

1. Challenge of adequate resourcing
An inclusive approach requires additional investments, at least initially, in participatory program/product design, building diverse teams, revamping internal processes and systems, and creating internal and external buy-in, particularly among leadership.

2. Slower journey to scale
Programs that use an inclusive approach, including iterative learning and adaptation to reach the most excluded, can take longer to show results than anticipated and imply additional costs for implementers and donors. .

3. Politics of identifying excluded groups:
Many groups are excluded because of inter-group socio-political and economic dynamics in a specific context. In such situations, prioritising these groups may result in backlash from others, both for the program and the community in question. Certain populations may themselves not want to be singled out, due to stigma.

4. Balancing competing priorities:
Addressing systemic inequalities requires a willingness to persist with efforts that may not show results within a project period, may create higher risks and produce lower returns on investment. Programs and policymakers may need to make difficult decisions on whether to prioritise immediate outcomes or long-term goals.

While these costs are significant and each program will need to account for them according to their own capacities, some clarifications may help to make them less overwhelming:

1. Inclusion is not a zero-sum game. While some programs may be targeted at the needs of a specific excluded group, other inclusive programs be universal in their approach, while acknowledging and addressing the additional barriers faced by specific groups among its beneficiary population. Either way, investments in inclusion benefit everyone in the group.

2. Inclusion does require additional resources, but these resources are a fixed cost. Once the program and organization have institutionalised the behaviour change and mindset shifts required, there are long-reaching dividends in all future work.

To better understand these costs and benefits, and their implications, it is first necessary to understand inclusion as a concept, and the context of its application.

What is Inclusion?

Rather than offer a single one-size-fits-all definition, a more effective way to understand inclusion is to think about what it seeks to achieve, through what actions, and under what conditions it works best.

1. Inclusion is 'the concept that every person, regardless of identity, is instrumental in the transformation of their own societies and their inclusion throughout the development process leads to better outcomes (USAID, 2018).'

2. This approach aims to help achieve the human right to health, as enshrined in the International Covenant on Economic, Social and Cultural Rights: '[T]he right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Ravindran et al, 2018).'

3. This right to health can be realised by 'accountably, affordably, and reliably expanding health care access to the poor and most vulnerable' – in other words, promoting inclusive health access (USAID, 2019).

What does inclusion look like in practice?

For Donors: Ensuring 'strengthened commitment and capacity' by supporting in-country systems and empowering governments, while involving local actors as co-designers, co-implementers, and co-owners of programmes (USAID, 2019b).

For Communities:
o Marginalised groups increase their exercise of agency and social participation through co-development of interventions for their health
o Entire communities demand and experience improved quality of life

For Implementers: Ensuring that the interventions:
o Do no harm to already vulnerable groups
o Ensure that decisions are not made 'for them, without them'
o Ensure effective access for all potential beneficiaries
o Ensure equitable access, wherein those most in need can access services as easily as those least in need (MacLachlan et al, 2012)

For Evaluators: Measuring not just overall efficiency and effectiveness, but equally:
o Evidence-based identification, successful coverage and sustainable engagement of vulnerable populations, not only as clients/beneficiaries of health services, but also as providers and partners
o Availability & sequencing of quantity of health care, quality of health services, and accessibility to health services (Verdier-Chouchane and Karagueuzian, 2016)

Reasons given by implementers for why some people feature in programs less often than others

"Working with these people is very challenging, and we don't have the time or expertise to do it effectively."

"We don't think there are many of them in our communities."

"We find it hard to identify them in our communities."

"We don't think they can make a valuable contribution."

"We don't have the skills or experience to work with them."

"We don't have the resources to meet the needs of such people."
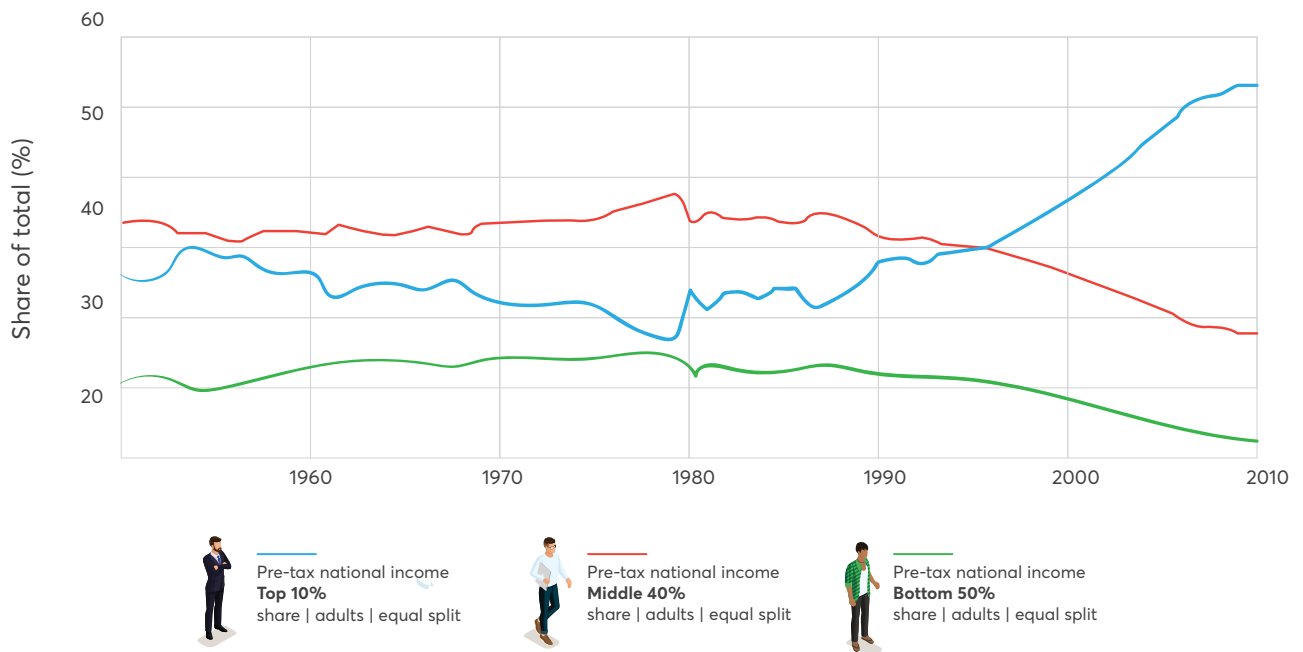
Source: WaterAid 2014

Who do we need to include in India?

Inequality in India is one of the highest in the world, and is on the rise (World Inequality Lab, 2018) (See Chart 1). Despite substantial improvements over the past two decades, health outcomes in India continue to be closely tied to socio-economic status (Chart 2). Alongside the substantial contribution of socio-economic status, other factors such as social identity and geographical location are also expected to affect an individual's ability to access the health care she needs (Box 1). While it is essential for specific programs to identify and prioritise the needs of vulnerable populations within the population they work with, it is simultaneously useful to have an overview of the national picture on health inclusion. This section identifies key excluded groups across the country overall, whose special needs may be relevant for partners across different health areas to recognise and address.
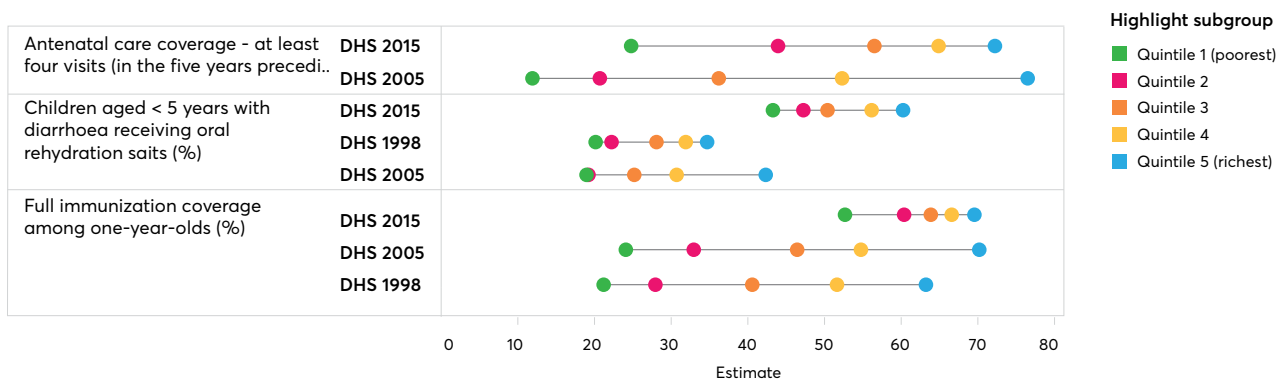
Scheduled Tribes   **People with Disabilities**   **Urban Poor**   **Scheduled Castes**   **Sexual & Gender Minorities**   **Youth & Adolescents**

Chart 1 : Income inequality, India, 1951-2015[10]

Share of total (%)

Pre-tax national income
Top 10%
share | adults | equal split

Pre-tax national income
Middle 40%
share | adults | equal split

Pre-tax national income
Bottom 50%
share | adults | equal split

Source: World Inequality Database.

Chart 2: Changes in Inequality in health outcomes over time, 1998-2015[11]

Antenatal care coverage - at least four visits (in the five years precedi.. — DHS 2015, DHS 2005

Children aged < 5 years with diarrhoea receiving oral rehydration saits (%) — DHS 2015, DHS 1998, DHS 2005

Full immunization coverage among one-year-olds (%) — DHS 2015, DHS 2005, DHS 1998

Estimate

Highlight subgroup
- Quintile 1 (poorest)
- Quintile 2
- Quintile 3
- Quintile 4
- Quintile 5 (richest)

Source: WHO Health Equity Monitor, India Country Profile.

Inequality in Numbers
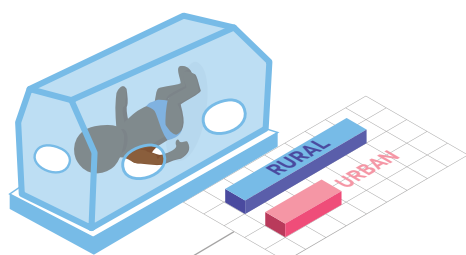
**Infant Mortality Rate** is 29 per 1,000 live births in urban India, but 46 in rural India.

While 7.6% of women in Kerala aged 20-24 were **married before the age of 18**, the corresponding figure in Bihar was 42%

On average, Scheduled Caste woman **lives 14.6 years less** than a woman from a 'higher' caste.

Child Mortality Rates were disproportionately high amongst Scheduled Tribes (ST) - 13.4 per 1,000 live births against 6.6 for groups who are not SC, ST or OBC.
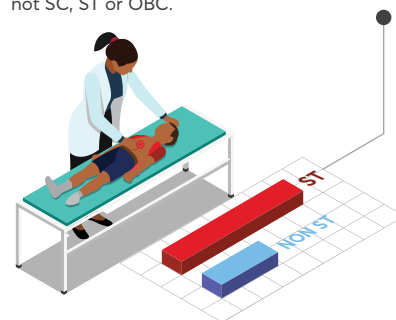
Only 47.1% of children aged 12-23 months in Assam are fully immunized, while the figure in Kerala is 82.1%. Muslim children have **lower rates of immunization** than other religious groups.
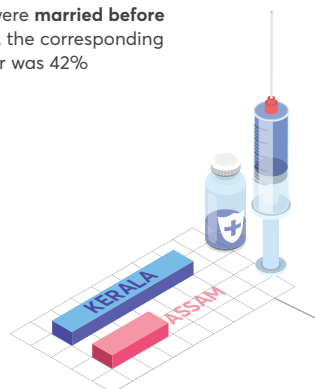
Sources: Government of India 2014; UN Women 2018; National Family Health Survey 2015-16; Institute for Healthcare Policy and Innovation 2015.

What are the characteristics of those who need to be included?

USAID defines marginalised populations as: **"People who are typically denied full access to legal protection or social and economic participation and programs (such as police protection, political participation, access to healthcare, education, employment, etc.), whether in practice or in principle, for either historical, cultural, political, or other contextual reasons"**. These groups often suffer from discrimination in the application of laws and policy and/or access to resources, services, and social protection, and may be subject to persecution, harassment, and/or violence. They may also be described as "underrepresented", "at-risk," or "vulnerable" (USAID 2018).

For the purposes of this brief, groups among whom a majority of members systematically lack access to appropriate, affordable and quality health services are considered 'excluded groups'. It is important to note that an individual may be a member of more than one excluded group, and may thus face exacerbated, 'intersectional' exclusion.

How did we identify these groups?

The groups were identified through a three-stage process, using mixed methods research:
o Literature review on socially excluded populations in India
o Groups emerging as significant were verified through key informant interviews with inclusion experts and practitioners
o Simultaneously, data on access to basic RMNCH services was disaggregated by available demographic dimensions: caste status (SC, ST, OBC), age, geography, religion and wealth. Significant correlation to lack of access on multiple indicators was taken as evidence of exclusion

Combining the results of these three sources of information, the groups that emerged as significantly excluded were **Scheduled Tribes, People with disabilities, Urban poor, Scheduled Castes, Sexual and Gender minorities, Youth and adolescents.** Other groups, including migrants, home-based workers and others also emerged as significant, but due to limitations of available data they are not presented here.

Scheduled Tribes

Size: Close to 700 tribes (Das & Mehta, 2012) comprising 104 million people which is 8% of India's population (Census of India, 2011)

Geography: Significant populations in Central and Northeast India.

Economic Status: 40.6% of STs live below the poverty line (compared to 20% of total population). An ST member are half as likely to have a mobile phone or television, a third as likely to have motorised vehicle, and a fifth as likely to have access to the internet as non-ST person. An ST person is also 40% more likely to drop out of school, and just 2 out of 3 group members are literate (Government of India, 2018a, 2014; Das and Mehta 2012).
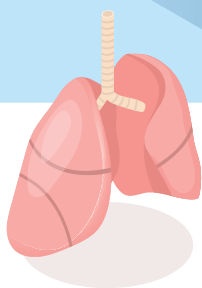
703 of every 100,000 ST people has tuberculosis, as against 256 for the general population. Half of India's deaths due to malaria are among ST people (Government of India 2018a).

Health Status

Health indicators for the group are poor (Learning4impact 2019; Government of India 2018a):
o 40% of eligible ST women have **never used a family planning method**.
o 10.5% of women aged 15-19 have **begun childbearing**
o 21% of ST mothers received **no antenatal care** before their last birth, 32% did not give birth in health facilities, while a third received no postnatal checkup at all
o 9% of ST children received **no immunization**
o 40% of women use a hygienic method of menstrual protection, while 3 out of 4 **still use cloths during their periods**
o Half of India's **deaths due to malaria** are among ST people
o Per capita **monthly OOP expenditure** among ST people on healthcare was Rs 24, as opposed to Rs 54 for the Indian population as a whole
o The group also faces **high transport costs**: Rs 416 for STs to get to a delivery institution, as opposed to Rs 290 for non-ST

Social Determinants of Health

Social determinants of health are weaker for the group (Government of India 2014):
o A larger proportion of Scheduled Tribes **live in 'dilapidated' houses** (6.25% as against 5.35% national average)
o ST people in rural areas are **more likely to lack access to electricity** than other groups (55.30% as against 46.20%)
o **Fewer** ST people have **latrines** within the house (22.6% as against 46.9%)
o 6.2% of the group are **reliant on open and potentially contaminated sources of water** (springs, streams, rivers etc) as compared to 1.9% of all social groups

People with Disabilities

Size: 26.81 million Indians are living with disabilities (Census 2011). This is considered to be an underestimate. World Bank (2009) estimates place the number at between 55-90 million.

Geography: Spread across India, with a relatively lower concentration among urban populations.

Economic Status: A household with a disabled member is more likely to be poor. This 'earning gap' between disabled people & others is compounded by a 'conversion handicap', where the same amount of money brings lower access to well-being because of the lack of enabling environments. Disabled people are also significantly less likely to be employed or married, and disabled children to be out of school (World Bank 2009).

Women and girls with disabilities are at heightened risk of sexual violence: While data is lacking for India, disabled women and girls across the world are respectively **1.5 times** and **2.9 times** as likely to face sexual violence. With mental health issues or intellectual disabilities, those figures rise to **4 and 4.6 times** respectively.

Health Status

Data on health of people with disabilities is not available in the NFHS. Based on smaller studies, people with disabilities face significantly higher health needs (World Bank 2009; SIDE 2012; Human Rights Watch 2014, 2018; WHO, undated):

o 80% of this group sought healthcare in a single year, with women, those disabled from birth, those living in Northeastern states, and those belonging to ST groups significantly **less likely to seek care**.

o Conversely, higher levels of education, co-residence with parents and urban residence made a disabled person more likely to seek care.

o PwDs face a **high incidence of chronic diseases** (including diabetes and epilepsy), as well as high incidence of depression (20%).

o People with disabilities had 4.6 times higher risk of diabetes and 5.8 times higher risk of depression compared to people without a disability. These risks were significantly higher in men.

Social Determinants of Health

Social determinants of health are poor for this group (WHO 2018):

o As a result of significant stigma, as well as low mobility and access to livelihoods, disabled people are **largely 'invisibilized'** to the health system

o 32-33% of non-disabled people are **unable to afford health care** globally, compared to 51-53% of people with disabilities[25]

o Meanwhile cost of transportation, staff behaviour, accessible infrastructure and knowledge gaps were **significant barriers reported.**
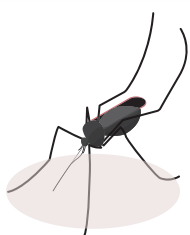
Urban Poor

Size: 150.77 million Indians are urban poor, forming the bottom two quintiles of the urban population (Census of India 2011, NFHS-4).

Geography: Across the country

Economic Status: 18% of urban poor households in India **lack access** to electricity, 81% to an improved sanitation facility, 87% to clean cooking fuel, and 77% lack access to any health scheme or insurance . A quarter of urban poor men and almost half of women have had **no education**. Scheduled caste members are overrepresented in this group, making up 18% of the urban population but 29% of the urban poor (Swasti 2019).

Among the urban poor, the homeless are particularly vulnerable.
'For the 32 official dengue deaths in Delhi from August through October of 2015, there were close to 500 deaths of homeless persons in just August and September. Although it is not clear what proportion of these are attributable to dengue, many likely are, seeing as a large number of homeless persons interact with garbage on a daily basis (either for a living or to subsist) and have no choice but to sleep near stagnant pools of water, both risk factors for infection. Dengue is far from being a leveller for this population (Nambiar, Ganesan and Rao 2015).

Health Status

Based on data from NFHS-4 (2015-16), health indicators for the group were poor (Swasti 2019; Ravi et al 2015; Dutta 2018; Mander et al 2017):
- 41.5% of urban poor women have **never used a family planning method**
- 36.4% of urban poor women were **married before age 18**
- 27% of urban poor mothers received **no antenatal care** before their last birth, and 28.5% of mothers did not give birth in health facilities
- 8.2% of urban poor children received **no immunization**
- 46.4% of urban poor **children were stunted**, and 23.6% were wasted
- **TB prevalence** of 521 per 100,000 people, compared to 316 for the general population.
- Reports suggest that the homeless significantly face the burdens of addiction, cancer, TB, respiratory diseases, gastro-intestinal diseases, skin conditions, and mental illness
- Most **street children** suffer from one or more of - TB, cold & cough, water-borne diseases, food poisoning & diarrhoea, and skin diseases caused by unhygienic and overcrowded living conditions·

Social Determinants of Health

Social determinants of health are also weaker for the urban poor, and particularly for some subpopulations. Less than half of the street children access health care during any illness and this too on an outpatient basis. In general, homeless populations have difficulty in getting ID documents due to not having an address, which restricts access to basic services. (Mander et al 2017; Save the Children 2015)

Scheduled Castes

Size: 216 million (16.6% of the Indian population)

Geography: Across the country, with 76% living in rural areas (Government of India 2018b).

Economic Status: As many as 32% rural and 22% of urban SCs **live below the poverty line** (compared to 20% of total population). More than 52% work as agricultural labourers in rural areas, and 43% as safai karamcharis in urban areas. In rural areas, 49% still use kerosene for lighting. 75% of men and 56% of women are literate[34]. It is estimated that SC status causes a **15% wage differential** between equally qualified workers (Government of India 2018b; Madheswaran and Attewell 2007).
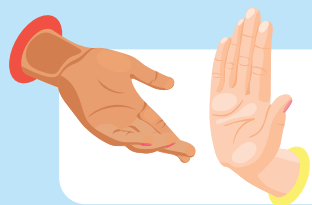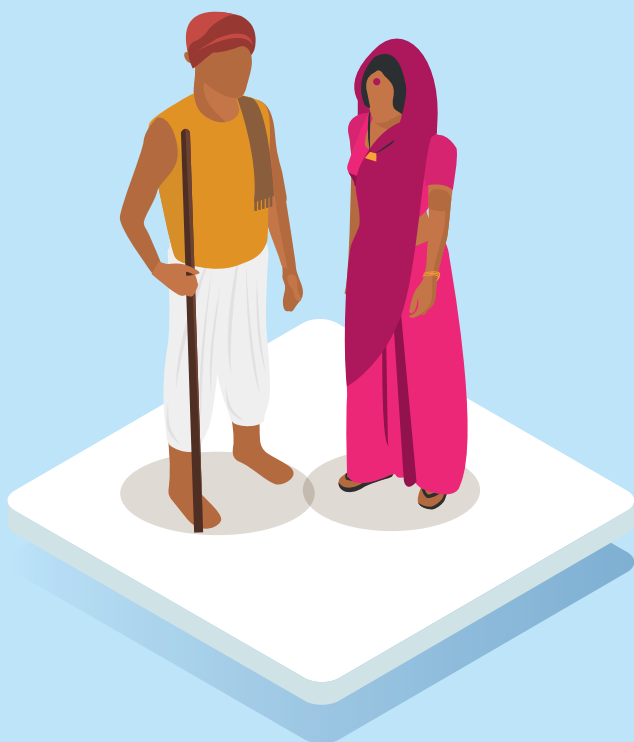
Caste-based discrimination also affects service access: 94% of SC children in one study faced discrimination in the form of touch when accessing healthcare. 33% of public health workers refuse to go to Dalit homes.

Health Status

Based on data from NFHS-4 (2015-16)[36], health indicators for the group were poor:
o On average, an SC woman has a **life expectancy** 14.6 years shorter than that of a woman from a 'higher' caste
o 39% of SC women have **never used a family planning method**
o 8.8% of adolescent SC women have begun **childbearing**
o 18% mothers received **no antenatal care** before their last birth
o 22% of mothers did not give birth in health facilities, while 30% received **no postnatal checkup** at all
o 5% of children received **no immunization**
o 55% of women use a hygienic method of menstrual protection, while two-thirds of women **still use cloths during their periods**
o 378 out every 100,000 people from this group **have TB**, compared to 316 for the general population

Social Determinants of Health

Social determinants of health are weaker for the group (Government of India 2018b; Tiwary 2018; Asia Dalit Rights Forum 2017):
o There is also a higher and rising rate of **violent crime** or violation of basic rights faced by SC people[38,39]
o **Caste-based discrimination** also affects service access: 94% of SC children in one study faced discrimination in the form of touch when accessing healthcare. 33% of public health workers refuse to go to Dalit homes[40]

Sexual & Gender Minorities
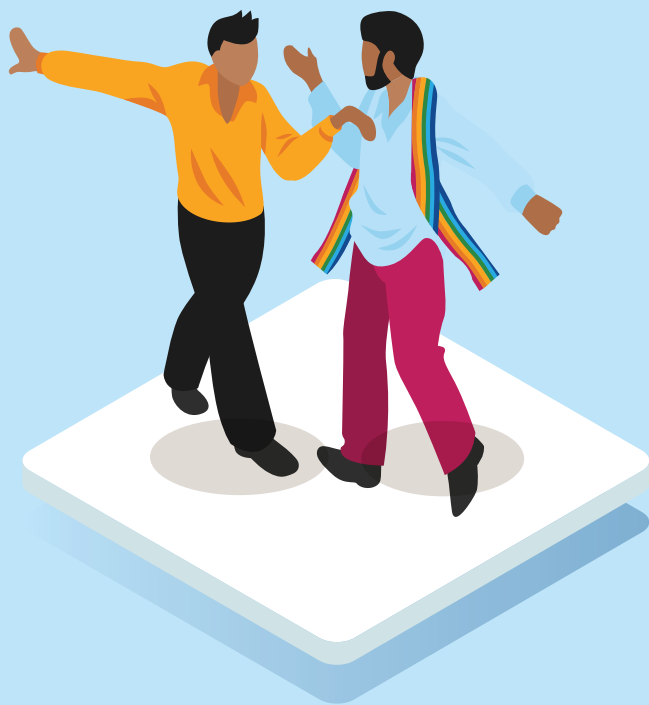
Size: Estimates of the population vary widely, between 2.5 million and 104 million (BBC 2012; The Guardian 2018). According to Census 2011, the transgender population is approximately 490,000 (Government of India 2018b).

Geography: Across the country.

Economic Status: While no large-scale data exists on the status of this group, small studies suggest that transgender and gay people are much **more likely to be living in poverty**. Transgender people are less likely to be working and less likely to have a secure source of livelihood than the general population, and an estimated 62% of transwomen engage in sex work. About half of LGBTQ white-collar workers report **facing workplace discrimination** (Subramanian et al 2015; World Bank 2014).

A study on three psychosocial health conditions: depression, frequent alcohol use, and victimisation due to violence, found that 70% of MSM respondents and 91% of transgender respondents faced one or more of these.

Health Status

Beyond sexual and reproductive health services, data is scarce on the health of this community. However, evidence from smaller studies suggest that health indicators for the group are poor (Swasti, undated; NACO 2011; Chakrapani et al 2017):

o 45% of transgender people **reported having faced violence** in Tamil Nadu and Karnataka, among them 21% had faced 7+such incidents

o Almost 2/3rds of transgender people have **no access to treatment for STDs**. While 7.2% of transgender people are living with HIV, only 59% of them had been referred for HIV testing and 67% had not been given proper counselling about antiretroviral therapy (ARV)

o A study on three **psychosocial health conditions**: depression, frequent alcohol use, and victimisation due to violence, found that 70% of MSM respondents and 91% of transgender respondents faced one or more of these

Social Determinants of Health

Social determinants of health are also weaker for the group: **Higher poverty as well as discrimination from healthcare providers**, affects health-seeking among the group, though this is likely to differ widely between subpopulations (Shaikh et al 2016; Kosenko et al 2013).

Youth & Adolescents

Size: 243 million (UNICEF 2011). Married adolescents make up 11.01 million (Census of India 2011)

Geography: Across the country.

Economic Status: Half of all children in India are **multidimensionally poor**. 1 in 5 adolescents drop out of secondary education (class 9-10). One-third of female and two-thirds of male youth aged 15-24 were employed (UNESCO 2013; NFHS 2009).

One-fifth of married women aged 15-19 had unmet needs for family planning. Almost 90% of these women had never used a family planning method, compared to 40% of all women in India.

Health Status

Based on data from NFHS-4 (2015-16), health indicators for the group were poor:
o 1 in 2 girls and nearly 1 in 3 boys aged 15-19 has **anemia**, twice the global average
o 1 in 3 women aged 20-24 were married before age 18, and 34% of these women have **faced physical, emotional or sexual violence** (MDM Odisha 2015)
o 1 in 5 married women aged 15-19 had **unmet needs for family planning**, and 88.8% have never used a family planning method, compared to 39.8% of all women
o 8% of women aged 15-19 are already pregnant or mothers. 14.7% of these mothers received **no antenatal care** before their last birth, and about 85% utilized safe delivery services
o 37% of children born to adolescent mothers did not receive full **immunization**, and 6% received no immunization
o 88% adolescents use a hygienic method of menstrual protection, and 65 million adolescent women live in houses **without a functioning toilet** (Dasra 2018).

Social Determinants of Health

o School dropout, early marriage and social norms that limit agency affect adolescents' ability to access health information and services.
o Adolescent girls in particular face backlash in response to efforts to improve their health and agency. A study found that 85% of organizations working with adolescents reported at least one case of entitlements denied, and 75% reported violence or forced seclusion, in response to their interventions (Dasra 2019).

What prevents Inclusion?

Specific groups systematically lack access to health services they need due to a combination of complex barriers they face along the way. These barriers are frequently overlapping, but also interlock to produce greater inequities. Identified from a review of literature on health equity and inclusion, the key barriers faced in access to health are discussed below:

Material Barriers: Physical deterrents which increase health risks or prevent health-seeking. E.g. distance to health facilities, lack of/unaffordable transport, inaccessible or poor quality infrastructure, unsanitary environments.

Social and Cultural Barriers: Social perceptions and cultural practices that deter health-seeking, either among the unreached group, or among other groups towards the unreached group. E.g. Linguistic and cultural gaps, stigma, prejudice and discrimination.

Financial Barriers: Healthcare costs that prevent most of the group from accessing services, due to the general socio-economic status of the community. E.g. High cost of health services in nearby facilities, little or no social protection or affordable credit, informal or insecure low-wage employment.

Systemic Barriers: Systemic disadvantage faced by one social group compared to other groups with whom they coexist. E.g. Persistent and disproportionate poverty and powerlessness, policy gaps

Institutional Barriers: Inability to navigate existing processes and systems within healthcare and related institutions. E.g. Procedures insensitive to the group's needs, documentation requirements, need for financial and digital literacy.

Knowledge Barriers: Gaps in knowledge, either within the excluded group or amongst other groups of people such as healthcare professionals, which deter their healthcare seeking. E.g. Information about disease transmission and prevention, beliefs about health, low awareness of rights and entitlements.

Strengths and limitations of this approach

Strengths:

A clear framework for action:
Using the social inclusion approach presents a clear pathway for action- By addressing the key barriers faced by the groups engaged by your program, it is possible to show progress on inclusion.

Preventing 'And other vulnerable groups' syndrome:
While every health program looks to address the needs of underserved groups, it is necessary to identify specific groups and map the diverse challenges they face in order to show progress (Chemonics 2019).

Limitations:

Group identification:
The groups identified at an all-India level may differ quite widely from priority groups in any specific program area. Changes in context and group dynamics over time may also affect the relevance of the groups presented.

Program capacity:
Some key barriers- like systemic or financial barriers- may be beyond the program's mandate to address, or out of its sphere of influence.

Inclusion Challenges Worksheet

▌ What does this worksheet do?

Acts as a guide for organizations implementing health programmes to reflect on how inclusive (of excluded groups) their work is, and how to reach the 'last mile'. Those involved in program design and implementation can use this worksheet to identify opportunities for making their programs more inclusive.

What is inclusion?

In development programs it means 'accountably, affordably, and reliably expanding health care access to the poor and most vulnerable.'. Some of the key groups excluded from health services in India are Scheduled Tribes, Scheduled Castes, adolescents, LGBTQ people, religious minorities, the urban poor, migrants & women.

Name of Program:

Nature of Program:

Kind of Support	● Technical support	● Implementation	● Technical support
Area of Support	● Maternal and Child Health	● Reproductive Health	● Infectious Diseases
	● Non-communicable diseases	● Health systems strengthening	● Partnerships and Financing
	● Other		

Locations:

Value proposition/ Intended impact:

What change can your intended beneficiary expect from the intervention?

▌ How to use this sheet

The following table identifies some key barriers to inclusion for programs. For each barrier, use the scale in column 3 to identify the impact of the barrier on your program, and the scale in column 5 to identify the scope for your program to improve in that area.

For scoring, use the following scale: Nil = 1; Low = 2; Mild = 3; Moderate = 4; High = 5
The tally at the bottom of column 3 suggests how important an inclusive approach is to your program, while that at the bottom of column 5 suggests the scope for your program to do more in this space.

Guided by these scores, you can use the questions in section 3 to reflect on next steps for your program. Beneath each question, there are suggested sub-questions to guide your reflection.

Inclusion Challenges	For the excluded, this looks like	Impact on Program	Programs are inclusive when	Opportunity to improve
Material Barriers	Physical deterrents which increase health risks or prevent health-seeking. E.g. distance to health facilities, lack of/unaffordable transport, inaccessible or poor quality infrastructure, unsanitary environments.	1 Nil 2 Low 3 Mild 4 Moderate 5 High	Programs identify and bridge material barriers that specifically/ disproportionately disadvantage excluded groups	1 Nil 2 Low 3 Mild 4 Moderate 5 High
Social & Cultural Barriers	Social perceptions and cultural practices that deter health-seeking, either among the unreached group, or among other groups towards the unreached group. E.g. Linguistic and cultural gaps, stigma, prejudice and discrimination.	1 Nil 2 Low 3 Mild 4 Moderate 5 High	Programs identify the potential effects of social norms and cultural practices on program's theory of change and address them proactively.	1 Nil 2 Low 3 Mild 4 Moderate 5 High
Financial Barriers	Healthcare costs that prevent most of the group from accessing services, due to the general socio-economic status of the community. E.g. High cost of health services in nearby facilities, little or no social protection or affordable credit, informal or insecure low-wage employment.	1 Nil 2 Low 3 Mild 4 Moderate 5 High	Programs include financial support mechanisms or linkages appropriate to the context and group	1 Nil 2 Low 3 Mild 4 Moderate 5 High
Knowledge Barriers	Gaps in knowledge, either within the excluded group or other groups such as healthcare professionals, which deter healthcare seeking. E.g. Information about disease transmission and prevention, beliefs about health, low awareness of rights & entitlements.	1 Nil 2 Low 3 Mild 4 Moderate 5 High	Programs include financial support mechanisms or linkages appropriate to the context and group	1 Nil 2 Low 3 Mild 4 Moderate 5 High
Institutional Barriers	Inability to navigate existing processes and systems within healthcare and related institutions. E.g. Procedures insensitive to the group's needs, documentation requirements, need for financial and digital literacy.	1 Nil 2 Low 3 Mild 4 Moderate 5 High	Programs work actively with institutions to address accessibility, appropriateness and quality of services for excluded groups	1 Nil 2 Low 3 Mild 4 Moderate 5 High
Systemic Barriers	Systemic disadvantage faced by one social group compared to other groups with whom they coexist. E.g. Persistent and disproportionate poverty and powerlessness, policy gaps that affect specific groups, disabling environments and public spaces.	1 Nil 2 Low 3 Mild 4 Moderate 5 High	Programs map and recognize structural barriers that may affect project outcomes, and design for advocacy if relevant.	1 Nil 2 Low 3 Mild 4 Moderate 5 High

| Questions for Reflection

In what ways does your programme currently engage health unreached groups?

a. Which frequently excluded groups are directly engaged by your programme?
b. How are the programme components adapted to address their specific needs?

How might your programme strengthen its inclusion of these groups?

a. Which excluded groups are present in your programme target audience, but are not directly addressed by your program?
b. Which of the above barriers (material, social and cultural, financial, knowledge, institutional, systemic etc.) do you think are most significant in addressing the needs of these excluded groups? How do you currently address the barriers?
c. Which aspects of your programme could be altered to better address the needs of excluded groups?
(Consider policies and organizational structure, employment practices and work culture, awareness and adaptation, accessibility-related practices and infrastructure, products and services)

Action Statement

a. What would you like to learn more about?
b. What would you like to discuss with your implementation or field teams?
c. What innovations or adaptations would you incorporate in current or future programs?
d. Are there any collaborations beyond your programme you would like to explore?
e. What data would you like to capture to highlight inclusion in your program?

References

Asia Dalit Rights Forum (2017). 'Progress Toward Inclusive Sustainable Development in India: A study of Dalits and Adivasis in 2030 Agenda'. https://www.slideshare.net/hrfchennai/asia-dalit-forum-report?from_action=save

BBC. 2012. 'India has 2.5m gays, government tells supreme court'. https://www.bbc.com/news/world-asia-india-17363200

Census of India, 2011. http://www.census2011.co.in/scheduled-tribes.php

Chakrapani, V. et al. 2017. 'Syndemics of depression, alcohol use, and victimisation, and their association with HIV-related sexual risk among men who have sex with men and transgender women in India.' https://www.ncbi.nlm.nih.gov/pubmed/26457339/

Chemonics, 2019. From Design to Implementation: How USAID's Solicitations and Resulting Awards Include Underrepresented Groups. https://chemonics.com/wp-content/uploads/2019/07/USAID_Solicitations_Awards_Include_UnderrepresentedGroups_05.2019.pdf

Das, M.B. and Mehta, S.K., 2012. 'Poverty and Social Exclusion in India: Adivasis'. http://siteresources.worldbank.org/EXTSOCIALDEVELOPMENT/Resources/244362-1265299949041/6766328-1285599693282/India-PSE-Adivasis_Brief.pdf

Dasra, Kiawah Trust and USAID, 2018. 'Spot On': Improving Menstrual Management in India. https://www.dasra.org/assets/uploads/resources/Spot%20On%20-%20Improving%20Menstrual%20Management%20in%20India.pdf

Dasra. 2019. Action Reaction: Understanding and overcoming backlash against girls' exercise of agency in India. https://www.dasra.org/assets/uploads/resources/Understanding%20and%20overcoming%20backlash%20against%20girls%20exercise%20of%20agency_vf.pdf

Dutta, N. 2018. 'Street Children in India: A Study on their Access to Health and Education.' International Journal of Child, Youth and Family Studies, 9(1): 69-82.

Government of India (Expert Committee on Tribal Health). 2018a. Tribal Health Report India http://tribalhealthreport.in/

Government of India (Ministry of Tribal Affairs). 2014. 'Report of the High Level Committee on Socio-Economic, Health and Educational Status of Tribal Communities in India.'

Harsh Mander, Deepthi Srivastava, Preeti Mathew and Satya Pillai (2017), 'Little Men and Little Women of City Streets: Urban Street Children.' India Exclusion Report 2017;

Human Rights Watch. 2014. 'Treated Worse than Animals'. https://www.hrw.org/report/2014/12/03/treated-worse-animals/abuses-against-women-and-girls-psychosocial-or-intellectual

Human Rights Watch. 2018. 'Invisible Victims of Sexual Violence'. https://www.hrw.org/report/2018/04/03/invisible-victims-sexual-violence/access-justice-women-and-girls-disabilities

Institute for Healthcare Policy and Innovation. 2015. 'Rural and Hindu children have the highest immunization rates in India,' https://ihpi.umich.edu/news/rural-hindu-children-have-highest-immunization-rates-india

Kosenko K, Rintamaki L, Raney S, Maness K. 2013. 'Transgender patient perceptions of stigma in health care contexts'. https://www.ncbi.nlm.nih.gov/pubmed/23929399/

Madheswaran, S. and Attewell, P., 2007. 'Caste discrimination in the Indian urban labour market: Evidence from the National Sample Survey.' https://www.epw.in/journal/2007/41/caste-and-economic-discrimination-special-issues-specials/caste-discrimination

Malcolm MacLachlan et al. 2012. 'Inclusive Health', Tropical Medicine and International Health, Vol 17: 1, https://onlinelibrary.wiley.com/doi/pdf/10.1111/j.1365-3156.2011.02876.x

MDM Odisha, 2015. 'Rashtriya Kishor Swasthya Karyakram'. http://mdmodisha.nic.in/Capacity%20Building_on_18_JAN_2015/5_RKSK.pdf

Ministry of Social Justice and Empowerment, Government of India. 2018. Handbook of Social Welfare Statistics. http://socialjustice.nic.in/writereaddata/UploadFile/HANDBOOKSocialWelfareStatistice2018.pdf

NACO, 2011. Hijra-Transgender Strategy: Specific HIV Interventions. http://naco.gov.in/sites/default/files/4.%20TG_paper_NACO%20shortversion.pdf

Nambiar, D., P Ganesan and A Rao. 2015. 'Who Cares?: Urban Health Care and Exclusion.' India Exclusion Report 2015, pp. 29-66.

NFHS, 2009. Profile of Youth in India (NFHS-3). https://www.youthpolicy.org/wp-content/uploads/library/India_2009_Profile_of_Youth_EN.pdf

Ravindran, TK Sundari, R Gaitonde and PN Srinivas. 2018. 'Structural drivers of inequalities in health', in TK Sundari Ravindran and Rakhal Gaitonde (eds), Health Inequities in India: A Synthesis of Recent Evidence, Springer.

Save the Children. 2015. Life on the Street. https://www.savethechildren.in/sci-in/media/PDFs/LIFE-ON-THE-STREET-(Final)-Rev-4.pdf

Shaikh, S. et al. 2016. 'Empowering communities and strengthening systems to improve transgender health: outcomes from the Pehchan programme in India.' https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4949313/

South India Disability Evidence (SIDE) Study. 2012. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4228146/

Subramanian, T., Chakrapani, V., Selvaraj, V., Noronha, E., Narang, A. and Mehendale, S., 2015, 'Mapping and Size Estimation of Hijras and Other Trans-Women in 17 States of India: First Level Findings'. https://www.ijhsr.org/IJHSR_Vol.5_Issue.10_Oct2015/1.pdf

Swasti (Unpublished study). Study on transgender health.
Swasti. 2019. Analysis conducted by Learning4impact based on data from National Family Health Survey, 2015-16.

The Guardian. 2018. 'Campaigners celebrate as India decriminalises homosexuality.' https://www.theguardian.com/world/2018/sep/06/indian-supreme-court-decriminalises-homosexuality

Tiwary, D., 2018. 'NCRB data: Insults made up 50% of crimes against Dalits.' Indian Express. https://indianexpress.com/article/explained/ncrb-data-insults-made-up-50-of-crimes-against-dalits-traps-of-corrupt-officials-spiked-6082791/

UN Women. 2018. 'Turning Promises into Action.' http://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2018/sdg-report-gender-equality-in-the-2030-agenda-for-sustainable-development-2018-en.pdf?la=en&vs=948

UNESCO Institute for Statistics. 2013. Data on Adolescents out of school in India. https://data.worldbank.org/indicator/SE.SEC.UNER.LO.MA.ZS?end=2013&locations=IN&start=2013&view=bar

UNICEF 2011. Adolescence: An Age of Opportunity http://unicef.in/PressReleases/87/Adolescence-An-Age-of-Opportunity

USAID (Inclusive Development Working Group). 2018. Suggested Approaches for Integrating Inclusive Development Across the Program Cycle and in Mission Operations. https://usaidlearninglab.org/sites/default/files/resource/files/additional_help_for_ads_201_inclusive_development_180726_final_r.pdf

USAID. 2019a. 'Inclusive Health Access Prize 2019' Fact Sheet, accessed via https://competitions4dev.org/healthaccessprize

References

USAID. 2019b. Integrating the Journey to Self-Reliance into Project Design.
https://usaidlearninglab.org/sites/default/files/resource/files/integrating_j2sr_into_pd_2pager.pdf

Verdier-Chouchane and Karagueuzian (2016), 'Concept and Measure of Inclusive Health Across Countries,' African Development Bank,
https://www.afdb.org/fileadmin/uploads/afdb/Documents/Publications/Working_Paper_239_-_Concept_and_measure_of_inclusive_health_across_countries.pdf

WaterAid. 2014. 'Understanding and addressing equality and inclusion in water, sanitation and hygiene work.'
https://washmatters.wateraid.org/sites/g/files/jkxoof256/files/equality-non-discrimination-and-inclusion-in-wash-a-toolkit.pdf

WHO, undated. Violence against adults and children with disabilities.
https://www.who.int/disabilities/violence/en/

WHO. 2017. '10 facts about health inequities and their causes'.
https://www.who.int/features/factfiles/health_inequities/en/

WHO. 2018. Disability and Health.
https://www.who.int/news-room/fact-sheets/detail/disability-and-health

WHO. Undated. Health Equity Monitor, India Country profile.
https://www.who.int/gho/health_equity/country_profiles/en/

World Bank. 2009. People with Disabilities in India: From Commitments to Outcomes.
http://documents.worldbank.org/curated/en/577801468259486686/pdf/502090WP0Peopl1Box0342042B01PUBLIC1.pdf

World Bank. 2014. The Economic Cost of Stigma and the Exclusion of LGBT People: A Case Study of India.
http://documents.worldbank.org/curated/en/527261468035379692/pdf/940400WP0Box380usion0of0LGBT0People.pdf

World Economic Forum. 2017. The Inclusive Growth and Development Report 2017.
http://www3.weforum.org/docs/WEF_Forum_IncGrwth_2017.pdf?source=post_page---------------------------

World Inequality Lab. 2018. World Inequality Report 2018.
https://wir2018.wid.world/files/download/wir2018-full-report-english.pdf