OVERLOOKING THE FUNDAMENTALS: AN ANALYSIS OF INTERNATIONAL FINANCIAL INSTITUTIONS' COVID-19 ERA HEALTH AND EDUCATION PROJECTS IN INDIA

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[1] https://www.oxfamindia.org/knowledgehub/policybrief/strengthening-teaching-learning-and-results-states-stars-recommendations-improved-implementation

Contents

EXECUTIVE SUMMARY

The impact of COVID-19 on the health and well-being of Indians has been disastrous. India has had 43.89 million cases and 526,033 deaths. It had the world's second-largest cumulative caseload of the pandemic. The principal IFIs stepped in to provide support during this period. From 2020 to 2022, India received support worth 11 billion USD for 21 sovereign health and education projects including loans, grants and technical assistance from the World Bank, Asian Development Bank, New Development Bank and Asian Infrastructure Investment Bank; seven more projects are in the pipeline (including sovereign loans and grants) worth approximately 2.5 billion. Much of the support furthered the large donors (World Bank and ADB's) long-term lending priorities for India.

For this report, Oxfam reviewed seven education projects and 14 health projects disclosed during the pandemic, between 1 January 2020 and 5 July 2022. This includes both approved and pipeline projects for which information has been placed in the public domain. We recognize that the final contours of pipeline projects may change during the course of their finalization. The report provides an analysis of the overall focus of the projects, the activities to be undertaken and include a specific focus on the challenges of marginalized communities and wealth inequalities. Early outcomes of the projects, where disclosed, have also been examined.

While the support for the two sectors was welcome, the projects missed the opportunity to rebuild stronger and more equitable public education and health systems. Most projects failed to address the dynamics of discrimination faced by India's marginalized communities, especially Dalits and Muslim Minorities which are among the most marginalized social groups in India. Most projects lack attention to addressing wealth inequality or a roadmap to equalize cross-state inequalities. Many projects also continued the trend of IFIs promoting the private sector as a vehicle for the delivery of public services a trend that has itself exacerbated inequalities in access to quality essential services. While most projects have been pan-India supporting centrally sponsored schemes, funding to states has shown a shift away from the most educationally lagging, populous states, focusing instead on smaller and higher-performing states. While some of these priorities are also reflective of the policy priorities of the government of India or the recipient states, the present report focusses on the responsibility of the IFIs.

Education:
The seven projects reviewed for this study covered the entire duration of schooling from early childhood to secondary and vocational education. Most lacked an explicit focus on addressing the impact of the pandemic, beyond promoting digital modes of instruction despite evidence that these were exclusionary. They instead appeared to be framed to be in line with the existing Country Partnership Framework/Strategy and emphasized the initially identified areas of priority, albeit somewhat modified in line with prevailing realities. The projects include a number of positive steps to improve quality of education. However,

- While most projects had a robust gender framing, none of the projects explicitly address ethnic or caste-based discrimination or correct educational inequalities between the rich and the poor in these states. There is a lack of explicit commitment across the entire gamut of projects to ensure schools are free (including free from any hidden charges and not just tuition fees), especially when it comes to early childhood and secondary education. Few steps to bring out-of-school children into school are discernible.
- All projects have included steps to build the capacity of teachers, principals and local officers and invest in teacher training including strengthening infrastructure of teacher training institutes. However, the omission of pre-service teacher training is somewhat disappointing. Given the shortage of teachers in India, it is also disappointing that only one project explicitly commits to hiring additional teachers in mainstream government schools. In early childhood education, in particular, failing to address the shortage of educators risks putting the entire strategy at risk.

Regrettably, most projects view teachers as people to be 'monitored', 'managed' and whose 'capacity has to be built, to improve learning outcomes' and not catalysts of change.

- The desire to improve learning assessment and developing teaching-learning materials and refine curricula are welcome. However, the heavy emphasis on standardized learning assessments discernible across some of the projects appears to misdiagnose the causes of poor student performance. Poor learning outcomes of India's students are tied to historical, cultural and economic aspects of its society and insufficient and equitable investment in public schools that disadvantage students from marginalized backgrounds. This approach also ignores evidence of the failures of similar testing-based accountability approaches in improving learning and reducing inequities. Efforts would have been better invested in addressing the factors responsible for poor learning such as reliance on non-mother tongue-based instruction, addressing the discriminatory messages communicated by the organization and operation of schooling (including caste-based discrimination and teachers holding low expectations for children from marginalized communities), absence of home support for neo-literate parents, classroom hunger and other factors.
- Some efforts are being made to enhance the number of schools. However, this has largely focused on setting up better-resourced, elite exemplar/schools of excellence and in some instances project design recognizes the risk that the creation of new schools will contribute to the consolidation or permanent closure of small, low enrollment schools which risks shrinking enrollment more widely.
- While the effort to strengthen citizen voice in the intervention is welcome, there is limited new devolution of funds and decision-making to communities in these projects. It is not clear what new measures are being considered in this regard in most projects or how these activities will learn from existing experiences of similar measures.
- Four of five World Bank-funded projects included some role for non-state actors in the delivery of core functions of education, in line with its CPF. This includes running schools and outsourcing core functions hitherto undertaken by the public system. The World Bank projects have failed to provide essential safeguards for engagement of the private sector like ensuring that all projects are not-for-profit in practice by strengthening the regulation of private schools. At the same time, there is a growing body of evidence to show that PPPs and private education do not necessarily deliver better education outcomes and at the same time risk increasing the gap between the rich and poor.

The rollout of the projects has been slow. Given the continued closure of schools, significant progress does not appear to have been made on dimensions involving work in the field. This slow rollout could offer one explanation for the fact highlighted in a recent Oxfam India report focusing on the rollout of project STARS. Of the 2,300 teachers, community members and government officials covered by its consultations, none was aware of or consulted by the government or the World Bank regarding the project.

Health:
A total of 16 health loans, grants and technical assistance projects have been approved by IFIs for health work in India from 1st Jan 2020- 5th July 2022. This includes support from all IFIs active in India for immediate health responses during the pandemic and more long-term measures like pan-national system support and COVID vaccination.

The COVID-19 health projects are straightforward in their objective of mitigating the negative fallout from the pandemic, although the more recent interventions like the World Bank's latest PHSPP (Transforming India's Public Health Systems for Pandemic Preparedness Program) project expand the mandate to cover pandemic preparedness more broadly. The COVID-related health work supported included positive measures like developing health infrastructure to respond to COVID-19, strengthening prevention and patient management, building staff and management capacities, enhancing awareness

of COVID-19, augmenting vaccination and contributing to evidence-building. At the same time, the development of infectious disease contingency plans, mapping of zoonotic disease hotspots and strengthening disease surveillance are prioritized in some of the more recent projects. However, it is greatly concerning that a large share of projects do not substantially contribute to the long-term strengthening of India's public health system by augmenting the public primary health system, filling staffing gaps, addressing working conditions of frontline health workers or expanding treatment facilities. Neither have they been able to leverage an increase in longer-term investments in health from the government of India. While the ADB's stated intention to strengthen COVID-19 vaccination is appreciated, the delivery of vaccination through private sector vaccination centres has been found to negatively impact both the effectiveness and equity of India's vaccination drive. Given the evidenced over-charging and patient exploitation by the private sector during Covid-19, and the significant dependence on the public on the public health system it is of deep concern and entirely inappropriate for the World Bank under the PHSPP to set a target that 40% of early detection of disease outbreaks should be in private hospitals. Of equal concern is that lack of any apparent effort to address the catastrophic impact of user fees and other out of pocket payments across the country, particularly in the private sector.

Disclosure of progress made has been weak with only the World Bank issuing regular Implementation Status and Results Reports (ISR) which indicate the extent to which impact is being achieved for individual projects. This makes it difficult to understand the extent of progress made. These reports point to fairly robust progress in ensuring the availability of essential infrastructure and strengthening surveillance facilities. India suffered from severe PPE shortages at the beginning of the pandemic and now has a surplus. 142,350 district hospital doctors and nurses have reportedly been trained on WHO standards of COVID clinical treatment. The share of health workers receiving the insurance for essential health workers has not been disclosed by the WB, the concerned ISR suggests that as per the government's administrative data, the insurance scheme covers 2.2 million health workers. However, as of February 2022, India has only paid compensation to 1616 deceased healthcare workers under the scheme. According to information shared with Parliament, only six of the 36 states and union territories maintain records of health workers who died due to COVID-19.

While COVID-19 was one of the prime reasons for health assistance to India, many projects address more long-term issues related to public health. These include seven projects supported by the World Bank and ADB. Since many of these are new, information about the impact being achieved is not available. A number of projects included positive steps like strengthening Health and Wellness Centres and training of health personnel.

The long-term development health work supported by the IFIs includes
- Support the delivery of health care, especially primary healthcare including improving functioning of health and wellness centres and improving community access to primary health facilities is welcome. However, while the emphasis on improving quality is commendable, the use of results-based financing for strengthening program delivery in weak and under-resourced public health systems is deeply problematic, particularly from an equity perspective. At the very least, human resource shortages need to be addressed before introducing performance-linked incentives.
- While the intention to capture patient experiences in some projects is appreciated, the apparent heavy emphasis on external verification mechanisms for quality assurance is limiting. While availability of information on patient experiences is essential for reform, but it does not guarantee that action is taken. Stronger efforts are needed to enhance social accountability and grievance redress for patients and create a conducive policy climate for issues of patients' rights including implementation of instruments like the Patients Rights Charter and institutionalizing mechanisms for grievance redress.
- A number of projects aim to improve the delivery of health insurance-based secondary and tertiary healthcare coverage by aiming to strengthen the design of national and state insurance

schemes, supporting enrollment and plugging leakages within the system. However, this narrow focus is misplaced given the evidence of low population coverage, limited access to existing insurance schemes. It is not clear what measures will be taken to redress widely reported abuse and exploitation by private actors including denial of treatment, cherry picking patients and procedures that bring greatest returns from the insurance scheme while charging the same patients out of pocket for other treatment, and the abuse and denial of patient rights. No explicit steps to address out of pocket expenditure beyond this are visible in projects which prioritize private sector engagement.

- Greater emphasis should have gone to ensuring the availability of adequate human resources in the public health system. The projects have thus simultaneously failed to augment staff strength or influence state governments and health systems to undertake this reform.

- A number of projects promote engagement with the private sector. However, any process of engagement with the private sector in India must take into cognizance the fact that existing regulatory frameworks in India are not effective. Thus, the Clinical Establishment Act (CEA), 2010 has been adopted by only 11 states to date and are inadequately implemented even in these cases. Promoting health insurance to access private hospitals without simultaneously strengthening state regulatory capacities to ensure compliance with minimum standards carries real risks.

- Ensuring the availability of human resources and building staff capabilities has been built into only a few projects. Greater emphasis should have gone to ensuring the availability of adequate human resources in the public health system. India has a shortage of active health workers with the density of doctors and nurses/midwives being estimated to be 6.1 and 10.6 respectively. This is well below the WHO threshold of 44.5 doctors, nurses and midwives per 10,000 population. None of the projects explicitly address the human resource issues of India's frontline ASHA workers.

- The intention to strengthen community voice by strengthening Jan Arogya Samitis (including linkage with women's health groups) including strengthening their role in planning, oversight of spending and grievance redress is positive. However, more could be done to strengthen social accountability including promoting measures like social audits.

Most projects include text on addressing the concerns and needs of vulnerable populations. However, the inclusions read as generic and it Is not clear how the specific needs of the specific populations are being addressed. As in education, none of the projects explicitly recognize Muslim minority populations as a vulnerable group. The World Bank, ADB and AIIB appear to have incorporated a gender lens in their projects. Gender-specific measures have included, a specific focus on engagement with women among the community stakeholders identified and some specific challenges of women in the health workforce. Few projects explicitly address wealth inequalities in health. The WB Gujarat project alone flags the risks of elite capture of healthcare.

A significant share of the projects involve engagement with the private sector either through support for insurance schemes or entry into direct PPPs. Thus, the ADB project on strengthening private sector response included a target of a 20% increase in the empanelment of private hospitals for the provision of COVID services under PMJAY. Despite the heavy emphasis on engagement with the private sector, none of the projects explicitly emphasize the need for its regulation, including compliance with existing regulatory frameworks like the Clinical Establishment Act, although a past ADB project preceding the study period included a target of the number of facilities registered under the Clinical Establishment Act. While PMJAY-affiliated hospitals are expected to adhere to national norms for hospitals under the scheme, no robust measures are being proposed to address the great variation in quality and costs of services provided for all citizens or to address the reported failure of regulation. This omission is particularly unfortunate given the track record of several private hospitals having indulged in manipulative practices at the height of COVID-19.

Processes and Modalities accompanying the projects

- All projects are congruent with existing government schemes and tap into government institutions. However, the details of the expenditure of most national loans are hard to trace in the government books of accounts at the state or sub-state levels. Progress on the projects is difficult to track using government mechanisms. While projects STARS and ASPIRE (pipeline) are being packaged as centrally sponsored schemes within the overall Samagra Shiksha framework, no dedicated project framework has been announced for the schemes and the government of India states that they will be implemented purely based on the World Bank Project Appraisal Document. At the same time, there is no dedicated reporting on the progress made on a state by state basis. This makes it difficult to understand the current status of implementation, the bottlenecks experienced and the impact achieved.

- The World Bank and ADB score relatively well among the various IFIs in terms of the level of disclosure of project information. However, even for the WB, delays in disclosure hinders democratic dialogue. Projects from AIIB and NDB lacked adequate project disclosures and all the information could only be derived from the WB-ADB disclosures for the loans they co-financed.

- Five of ten World Bank projects disclosed detailed stakeholder engagement plans and ADB disclosures provide some insights into its plans for three loans; AIIB and NDB do not separately disclose details of consultations. Even for the WB, there are questions about the quality of consultation, especially at the design stage; no national education civil society networks were consulted pre-finalization. The details of representatives consulted by the ADB are not in the public domain. While some consultations were held with frontline health workers and teachers, none of the pre-finalization consultations appear to have involved professional associations or unions. At the same time, while some individual NGOs were consulted, limited signs appear of outreach to civil society networks and alliances or representative voices of marginalized communities, especially at the design stage. Finally, none of the detailed reports of these consultations have been disclosed.

- While the WB and ADB disclose the impact achieved, the level of detail in the ISR does not enable stakeholders at the state and district level to understand the extent of implementation for ensuring social accountability or for supporting implementation.

- There is a growing reliance of IFIs on Program-for-Results Financing (PforR) in India. While the WB's CPF aims to have 10% of projects are expected to be prioritized. However, 40% and 60% of WB health and education projects respectively use PforR methodologies. At the same time, two ADB projects used Results Based Lending methods. The introduction of results-based financing in some of these projects is problematic because this explicitly ties the World Bank's resources to the achievement of specific policy agendas which is a form of conditionality. UNESCO has urged caution in disbursing aid to education through results-based payments.

INDIVIDUAL IFIs

While present report provides an overview of the lending across sectors, each institution has its own policies and lending priorities and individual programmatic strengths which are summarized below. It is critical to note that the CPF and CPS of World Bank and ADB will be entering their new cycle of partnership in 2022-23. As such, the experience of the work in the last two years would be critical for shaping the funding priorities of the two biggest lenders for public services in India.

		Education	Health	Overall project governance
WB	What it does	• Supports online and distance modes of delivering instruction during the pandemic • Focuses on improving educational outcomes, teacher capacity, improving learning assessments, curriculum and teacher learning materials. Focus on strengthening early childhood and secondary (especially technical and vocational) education. • Some emphasis on improving school infrastructure including hiring teachers (SALT), setting up residential schools (GOAL) or upgradation of infrastructure in schools (SALT, NECTAR). • Provides focus on girls, persons with disabilities and indigenous people.	• Sought to strengthen early COVID response including detection, surveillance, tracking, monitoring, equipping of health care workers and limiting the loss of human lives. • More recent projects prioritize pandemic prevention and preparedness • Provides support for health and wellness centres including quality certification, improving the delivery of NCD/mental health and access to medicines • Seeks to improve the delivery of health insurance	• All WB projects have provided ample information on the finances, environmental and social impacts of projects. • Seven of ten World Bank projects have detailed stakeholder engagement plans and details of stakeholder engagement are available for five projects. • All projects disclose detailed metrics of success and information about the progress of the projects except the COVID emergency response loan is available in the public domain.
	What it could have done better	• Inadequate focus on the return of children to school, addressing teacher burnout or offering them support (part of only one project). While some of the projects include remedial education, no project shows the scale of ambition necessary to address the legacy of two years of learning loss or address specific challenges of marginalized communities. • Most projects do not include categories beyond the statutory categories of girls, PWDs and indigenous people. Addressing discrimination based on caste, religious minority status or wealth inequalities is not prioritized. Most outcome indicators are not disaggregated by excluded groups. Even when social groups are included, these mentions are often cursory and it is unclear how their concerns are addressed in the project design. • Promotion of TVET for marginalized communities and remote areas carries risks of premature streaming and enhancing inequality.	• The reliance on performance-based incentives in health systems that still lack basic services is problematic, particularly from an equity perspective. • While emphasizing engagement with the private sector, it does not address fundamental challenges of the private sector in India including weak regulation, poor adherence to quality standards, equity, high OOPE and minimal patient protection • While the COVID relief was expected to improve the share of health workers receiving insurance, this figure has not been disclosed. There is evidence of this impact being underachieved. • Few projects include an in-depth analysis of the specific marginalization experienced by marginalized communities. No specific focus on Dalits, Muslim minorities and limited effort to address the specific challenges faced by indigenous people.	• While outcomes of projects are disclosed, more detailed disclosures would be desirable to enable affected communities to understand what activities are being undertaken. The level of detail in the ISR does not enable stakeholders at the state and district level to understand the extent of implementation that could help to either track or support the implementation SEPs in some projects. • None of the project consultations included civil society networks, unions or representatives of marginalized communities at the design stage of the projects.

		• Does not correct educational inequalities between poor and rich states or explicitly commit to ensuring that all school education will be free. • Does not commit to supporting states in the implementation of the RTE Act. • Prioritizes standardized learning assessment, over the more pedagogically useful formative assessments. • Gains through setting up of new schools in the project in Gujarat are likely to be countervailed by impending planned permanent closure of small, low-enrollment schools.	• Despite this heavy emphasis on engagement with the private sector, none of the projects explicitly emphasize the need for its regulation, including the need for compliance with existing regulatory frameworks like the Clinical Establishment Act. • Fail to address challenges of India's frontline health workers like ASHAs.	
ADB	What it does[2]	• Seeks to a) Boost foundational learning and STEAM and employability skills, b) build continuous development of teachers/strengthen teacher training institutions, c) address secondary dropout, d) strengthen national curriculums, assessments and state capacity for outcome planning, and e) and improve the functioning of a few exemplar schools. • Commits to universal access and inclusion in early childhood and school education and supporting states in the implementation of the RTE Act • Seeks to ensure that all state MIS and monitoring data is segregated by social category.	• During the pandemic supported the detection, surveillance, tracking, monitoring, equipping of health care workers and limiting the loss of human lives. Also, provide resources for procurement of the COVID Vaccine. • Improve delivery of health insurance including promoting digital solutions, monitoring systems, communication strategies and addressing enrollment gaps of women. • Delivery of COVID services and vaccines, albeit including a focus on the private sector. • Some focus on supporting the public health system, particularly planning capacities.	• Makes detailed disclosures of projects • ADB has disclosed some stakeholder engagement plans for three projects.
	What it could have done better	• Fails to recognize risks of increasing inequality through the establishment of a new layer of exemplar schools. • While recognizing the challenges related to equity, does not address discrimination or correct educational inequalities between poor and rich states or explicitly commit to ensuring that all school education will be free.	• The reliance on performance-based incentives in health systems that lack basic services is problematic, particularly from an equity perspective. • Few projects include an in-depth analysis of the specific marginalization experienced by these communities. • The target of ensuring a 20% increase in empanelment of private hospitals for the provision of COVID services is problematic since	• Information about project impact is extremely limited.

[2] ADB's sole education project ASPIRE is still not approved and some of the details may change.

			private hospitals' engagement with the immunization process was implicated in slowing the vaccination drive and exacerbating vaccine inequalities. • Despite this heavy emphasis on engagement with the private sector, none of the current projects explicitly emphasize the need for its regulation, including the need for compliance with existing regulatory frameworks like the Clinical Establishment Act. • Fail to address challenges of India's frontline health workers like ASHAs. • Little effort has been made to strengthen community voice in healthcare.	
AIIB	What it does	Provides co-financing for the World Bank's GOAL program.	Provides support for the government's COVID emergency response and the ADB loans or procurement of COVID-19 vaccines.	Provides the project summary on the website.
	What it could have done better	No information is disclosed about the use of AIIB's own funds are used. One can infer some of the uses from the disclosures made by the WB and ADB.	No information is disclosed about the use of AIIB's own funds are used. One can infer some of the uses from the disclosures made by the WB and ADB.	No information about the projects is available beyond the project summary. However, some of this could be inferred from WB and ADB disclosures. AIIB and NDB do not separately disclose details of consultations undertaken for project development.
NDB	What it does	NA	Provided co funding for the COVID-19 Emergency program	Provides the project summary on the website.
	What it could have done better	NA	No information is disclosed about the use of NDB's own funds are used. One can infer some of the uses from the disclosures made by the WB and ADB.	No information about the project beyond the project summary is in the public domain.

Recommendations:

Multilateral Development Banks should

Do much more to support inclusive, equitable, good quality public education provision and
- Support the development of strategies to address the consequences of India's school lockdown and put in place robust strategies to prevent dropouts, address learning loss, deal with trauma and take steps to build back an improved education system.
- Support universal secondary completion through free, quality and equitable education delivered through the public education system.
- Address intergenerational, social and economic barriers to the education of Dalits, Adivasis and religious minorities.
- Take conscious measures to stop promoting educational inequality by supporting elite strands within the education system; instead safeguard against the commercialization of education including by ensuring that investments are not directed to profit-oriented providers.
- Develop a supportive roadmap for teachers and other educational personnel to ensure that they are adequately trained, supported and have access to adequate spaces for growth and development; and take steps to address the teacher shortage.
- Include specific metrics of the extent to which state governments can ensure that all schools comply with the national minimum statutory norms as laid down under the Right of Children to Free and Compulsory Education Act, 2009.
- Avoid supporting the privatization of education. Do not use public funds to promote the expansion of the private school net in India, prioritize utilizing internal systemic capacities instead of relying on PPPs and private actors for improvement of education delivery.
- Put in place robust measures to ensure citizen voice in education delivery through supporting formal mechanisms for the participation of parents and civil society in project design, monitoring and social auditing of project implementation.
- Collaborate more proactively with social movements and teachers to ensure the delivery of truly transformative education.

Do much more to support strong, equitable public health systems
- Invest in strengthening public primary healthcare provision by continuing to strengthen and universalize the expansion of Health and Wellness Centres.
- Support and invest in health care workers including addressing Human Resource issues like staff shortages (especially those of specialists), contractualization, inadequate living and working conditions and limited professional and career growth of health personnel.
- Ensure that patients' experiences in the primary healthcare system are not only recorded but also institutionalize mechanisms for grievance redress. A precondition of funding to states should include the requirement for recipient governments to notify and implement the Patients' Rights Charter and institutionalize grievance mechanisms under the same.
- Develop a disaggregated monitoring framework for tracking the extent of access to health care for Dalits, tribal groups and other marginalized communities, particularly women.
- Minimize outsourcing and public-private partnerships with the private sector, strengthen regulatory laws for overseeing health care delivery and institute standard guidelines and protocols, reduce dependence on insurance mechanisms and prioritize public systems strengthening.
- Take concrete steps to address financial barriers to access including the removal of user fees and moving away from insurance systems, given the evidence of partial population coverage, failure to cover costs of outpatient care and track record of poor settlement of claims. Support should be provided for the universal use of more affordable generic medicines where available, and for the implementation of clear and transparent price caps on treatment and medicines

provided by the private sector to being to counter India's catastrophic and impoverishing levels of out-of-pocket payments for health
- Strengthen social accountability in the public health system and mechanisms for obtaining patient feedback as part of program delivery.

They should also, across both sectors and beyond, ensure
- Adherence of minimum standards to ensure greater and more meaningful participation of civil society and social movements in pre-project consultations and social dialogue and accountability processes across the project cycle. At the same time, a civic space assessment should be included in key documents like the World Bank's Systematic Country Diagnostic.
- A stronger focus on equity, including a focus on wealth inequalities and a formal framework to acknowledge and act upon the unique challenges faced by India's marginalized groups and constitutionally recognized categories such as SCs, STs and Muslim Minorities. A stronger focus on intersectionality within the gender interventions would also be desirable.
- A recognition of the dire need to act upon the systemic issues affecting India's health and education sectors including chronic underfunding, inequality and discrimination in the health and education systems of India.
- A more critical analysis of the role of the private sector in education and health and putting in place safeguards to prevent the involvement of for-profit players, profiteering and rights violations by the private sector in public services.
- Enhanced Parliamentary oversight and accountability to public bodies in India as the loans would be repaid by the state exchequer.
- A process of evaluation of project impact should be strengthened to include people's voice. Social audits can be used as a tool for evaluation.

Availability of updated and desegregated information regarding the status of implementation (including achieved as against targeted) of all projects and the interest charged for any loan must be made available in the public domain. This should include adequate granularity to be usable by affected communities in the states where projects are being implemented.

CHAPTER I: COVID ERA LENDING FOR HEALTH AND EDUCATION IN INDIA: AN INTRODUCTION

SARS-Cov-2 or COVID-19 has caused a global developmental crisis that has reversed years of progress. It is estimated that half a billion people have been pushed into extreme poverty due to health care costs during the pandemic[3]. The pandemic risks pushing an entire generation of children out of education, risking intergenerational impacts.[4]

The situation has been no different in India. Its first case of COVID-19 was confirmed by the Government of India (GoI) on 30th January 2020 in the state of Kerala. India's response to COVID-19 was initiated in the second week of January and states were directed for health sector preparedness on January 17, and point of entry surveillance was initiated the same day[5]. Since then, India has had 43.89 million cases and 526,033 deaths due to COVID-19[6]. Officially, it has the world's second-largest cumulative number of COVID-19 cases, but reports suggest that the toll count could be several times higher than the official numbers[7]. This has been a grievous loss in terms of lives lost and disrupted. Rising poverty levels impelled by unemployment, inaccessibility of public services and weak social welfare cover have wreaked havoc on India's marginalized communities.

The pandemic's tragic toll has been exacerbated by the historic legacy of relative neglect of public services. India's public education and health systems have been historically underfunded and have been unequal. It has also exacerbated social and income inequalities in India. Women, the poor, especially India's Dalit[8], Adivasi[9] and religious minority communities, particularly Muslims, have been hard hit.

As the pandemic enters the third year, however, it is critical to examine this trend against the backdrop of longer-term developmental trends in the country. As the world recovers from new strains of the virus, there is speculation about what would come next for the pandemic[10]. There are fears that COVID-19 would eventually turn endemic[11] and that we may see sporadic outbreaks in the years to come[12]. Accordingly, it would be important to take a longer-term view of the pandemic's impact and not see it as a standalone incident. **Public health and education systems need to become more robust and resilient going forward**.

THE PANDEMIC's IMPACT ON HEALTH AND EDUCATION

As per official statistics, the pandemic has carried away half a million lives in India[13] due to COVID-19 alone; given challenges with official statistics, the real toll is higher. There has also been a decline in Maternal and Child Health indicators due to the disruption of service delivery during lockdowns and with

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[3] https://www.who.int/news/item/12-12-2021-more-than-half-a-billion-people-pushed-or-pushed-further-into-extreme-poverty-due-to-health-care-costs

[4] https://blogs.worldbank.org/education/global-education-crisis-even-more-severe-previously-estimated

[5] Press release by the Ministry of Health and Family Welfare, posted on 12 March 2020 -
https://pib.gov.in/PressReleaseIframePage.aspx?PRID=1606079, accessed on July 20, 2021

[6] https://ourworldindata.org/coronavirus/country/india as of 23 July, 2022

[7] https://www.deccanherald.com/national/india-s-covid-19-death-toll-may-be-4-11-times-higher-economic-cost-is-30-of-gdp-study-1030812.html

[8] Dalit (from Sanskrit meaning "broken/scattered") is a name for people belonging to the lowest castes in India many of which were seen to outside the four fold caste system. The official designation is Scheduled Caste.

[9] Adivasis is the collective term of the tribes of the Indian subcontinent. Most belong to the Scheduled Tribe category under the constitutional provisions of India.

[10] https://www.nature.com/articles/d41586-022-00510-y

[11] https://www.npr.org/sections/coronavirus-live-updates/2022/01/18/1073802431/fauci-says-covid-19-wont-go-away-like-smallpox

[12] https://www.cnbc.com/2022/02/02/covid-will-never-become-an-endemic-virus-scientist-warns.html

[13] https://www.worldometers.info/coronavirus/country/india/

the allocation of healthcare workers toward COVID management[14]. Care for pre-existing illnesses and those requiring periodic and consistent care, especially among socioeconomically disadvantaged patients and those in remote areas, was severely affected[15]. **By some estimates, life expectancy at birth in India dropped by two years in 2020 relative to 2019**[16]. The impact has been grossly unequal with those who were poor or residing in remote areas being worst affected[17].

When it comes to education, India experienced the world's second-longest school lockdown. This has had an unprecedented impact on the education of its children, especially the youngest. During the first wave of the pandemic, one survey pointed out that 64% of parents in rural India feared they will drop out without extra support[18]. In 2020 80% of parents in government and 59% in private schools reported that education was effectively not delivered[19]. In 2021, only 28% of rural students were reportedly studying regularly online and 37% were not studying at all[20]; the corresponding figures were 4% and 43% respectively for Dalit and Tribal students. The consequence of this was learning deprivation with 92% of children having experienced learning loss in at least one language ability[21]. India may lose 400 billion dollars in future earnings because of the substantial learning losses[22]. Apart from this, the impact in terms of psychological trauma, loss of psychosocial support, classroom hunger and increase in child labour cannot be quantified.

Those from poor **families have been disproportionately at risk of dropout and had their education disrupted by the closure of schools**, also bringing disruption of school-based social protection measures. The increased reliance on technological solutions to education delivery during the pandemic has exacerbated the digital divide making it into an educational divide. Only 2.7% of Indians in the poorest wealth quintile had access to a computer and 8.9% to internet facilities at the start of the pandemic.[23] The digital divide is also a gender divide; Indian women are 15% less likely to own a mobile phone, and 33% less likely to use mobile internet services than men[24].

IFIs AND THEIR ROLE IN DEVELOPMENT

An international financial institution (IFI) is a financial institution that has been established by more than one country. Its shareholders are national governments, even if other organizations and international institutions could be members. These include Multilateral Development Banks like the Asian Development Bank and the World Bank that provide loans and assistance to countries meant to increase the technical and operational capacities of crucial public sectors like health, education, infrastructure, finance and rural development. IFIs play an influencing role in complementing the development agendas of countries around the world. They play a multi-layered role vis-à-vis development projects by way of loans and grants, by providing technical support to governments and implementation partners, and by forwarding emergency financial assistance to deal with economic and social instabilities in any country. They also shape global policy discourse and knowledge both through research conducted by them and policy advice offered. This outsized role of the IFIs in terms of shaping national policy and practice has been critiqued over the years.

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[14] https://www.oxfamindia.org/knowledgehub/workingpaper/inequality-virus-india-supplement-2021
[15] https://www.sciencedirect.com/science/article/pii/S027795362200065X
[16] https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-021-11690-z
[17] https://www.oxfamindia.org/knowledgehub/workingpaper/inequality-virus-india-supplement-2021
[18] https://theprint.in/india/64-kids-in-rural-india-fear-they-have-to-drop-out-if-not-given-additional-support-survey/625146/
[19] https://www.oxfamindia.org/knowledgehub/oxfaminaction/status-report-government-and-private-schools-during-COVID-19
[20] https://counterviewfiles.files.wordpress.com/2021/09/locked-out-emergency-report-on-school-education-6-sept-2021.pdf
[21] https://www.newindianexpress.com/nation/2021/feb/10/COVID-impact-92-students-lose-language-foundational-ability-with-schools-remaining-closed-2262322.html
[22] https://economictimes.indiatimes.com/industry/services/education/school-closure-may-cost-over-400-billion-to-india-cause-learning-losses-says-world-bank/articleshow/78618189.cms?from=mdr
[23] https://www.oxfamindia.org/knowledgehub/workingpaper/inequality-virus-india-supplement-2021
[24] https://www.orfonline.org/expert-speak/indias-gendered-digital-divide/

IFIs lend money. Borrowings aimed at the public sector are known as sovereign loans while support to private sector entities is termed non-sovereign financing. IFIs also occasionally provide grants (especially for LICs) and technical assistance which are not loans and thus do not have a repayment caveat.

IFIs AND INDIA

India is a member of four of the five constituents of the World Bank Group, the International Bank for Reconstruction and Development (IBRD, which focuses on providing loans, grants and credit to middle-income and creditworthy poorer countries), the International Development Association (IDA which makes low or no-interest loans and grants (especially to low-income countries), the International Finance Corporation (IFC which provides investments, advice and asset management to companies and governments) and Multilateral Investment Guarantee Agency (MIGA which insures lenders and investors against political risks)[25]. It is a founding member of IBRD, IDA and the IFC and WB lending to India has been ongoing since 1948. Historically, most funding to India from the World Bank has been from the IBRD[26]. The visual below shows the disclosed total World Bank lending to India at the project level (based on unaided data), for the period from FY2013 to FY2022 in millions of US$ equivalent. It does not include Trust Funds, Financial Intermediary Funds (FIFs) Commitments and loans to IFC or IBRD/IDA guarantees.
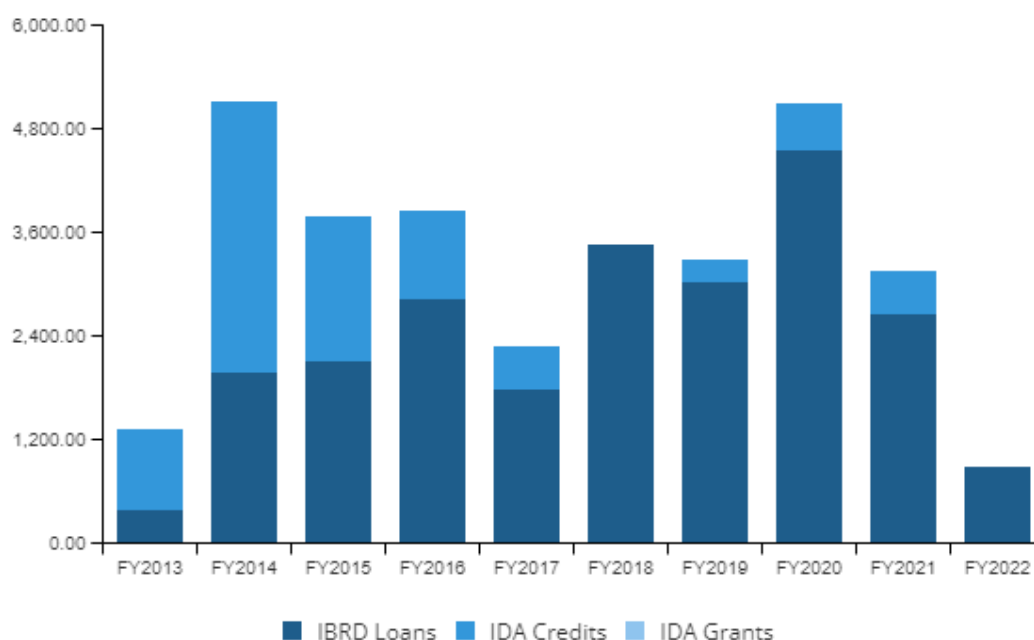
India is a founding member of the Asian Development Bank (ADB) since 1966. The New Development Bank (NDB) is a multilateral development bank set up by the BRICS nations with all the five-member countries as its founding members having equal voting rights and shares[27] in the bank and providing lending to only BRICS countries. The Asian Infrastructure Investment Bank (AIIB) specifically supports infrastructure projects in the Asia region; India is the second-largest shareholder[28] and the biggest recipient of AIIB funds[29]. These IFIs are the subject of this analysis as providing the majority of international support for the education and health sectors in India.

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[25] https://dea.gov.in/sites/default/files/India_WB_0.pdf
[26] As on 31/05/2022. Accessed from https://financesapp.worldbank.org/summaries/ibrd-ida/#ibrd-len/countries=IN/
[27] Bangladesh and the UAE have recently joined as shareholders holding under 2% shares each: https://www.ndb.int/about-us/organisation/shareholding/
[28] https://www.cenfa.org/briefing-paper-an-indian-perspective-on-ndb-aiib/
[29] https://economictimes.indiatimes.com/news/economy/finance/adb-aiib-processing-2-billion-loan-for-india-to-buy-covid-19-vaccines/articleshow/87310509.cms?from=mdr

India is also a member of the African Development Bank Group, the International Fund for Agricultural Development, the Global Environmental Facility, and the Green Climate Fund[30]. However, none of this funding is intended to be devoted to the education and health sectors in India. India also receives funds from the European Investment Bank (largely for infrastructure enhancement) and bilateral sources[31]. India is also a contributor to the IMF.[32]

Historically, India has been one of the largest borrowers from the World Bank in the preceding years[33] with the lion's share of funding going to infrastructure projects. Indeed, India has been the largest recipient of World Bank loans over the last 70 years.[34] The financial assistance was accompanied by technical assistance and policy advice.

IFIs IN THE COVID PERIOD GLOBALLY

In response to the spread of the COVID-19 pandemic, IFIs have acted swiftly by providing financial aid in the form of short-term loans as an emergency response and for economic recovery, extending long-term systematic support by way of complementing government schemes and policies and providing assistance to prevent future outbreaks.

The World Bank authorised the establishment of the US $14 billion Fast Track COVID-19 Facility (FTCF)[35] or the 'COVID-19 Strategic Preparedness and Response Program'(SPRP) [36] which was launched on March 3, 2020. FTCA/SPRP together include allocations worth $6 billion for governments (from IDA/ IBRD) and $8 billion for the private sector (via IFC)[37] aimed at complementing the funding of developing countries across the world to ensure a rapid emergency response to COVID-19. The SPRP sets out a framework to guide the content of all recipient country projects under a Multiphase Programmatic Approach (MPA). India was one of the more than 100 countries to have received the FTCF/SPRP funding under the auspices of the MPA. It has six components which include a. emergency COVID-19 response, b. strengthening multi-sector national institutions and platforms, c. supporting national and sub-national prevention and preparedness, d. community engagement and risk communication, e. implementation management and f. monitoring and evaluation, and, g. a contingency emergency response component (CERC).

The Asian Infrastructure Investment Bank (AIIB) created the 'Crisis Recovery Facility (until April 16, 2022) in April 2020[38] to help member countries, or clients, in alleviating and mitigating economic, financial and public health pressures arising from COVID-19. The facility offers up to $13 billion, and provisions for both public, as well as private sector financing. Moreover, to cater to its low-income member countries towards affordable finances, the AIIB further set up a Special Fund Window (SFW) to reduce the financial

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[30] https://dea.gov.in/multilateral-institutions-divisions

[31] https://www.indiabudget.gov.in/doc/rec/annex13.pdf

[32] https://dea.gov.in/sites/default/files/about_IMF%20%281%29.pdf

[33] https://theprint.in/economy/india-was-largest-borrower-from-world-bank-for-6-out-of-last-10-years/197583/

[34] https://www.business-standard.com/article/specials/india-largest-recipient-of-world-bank-loans-over-70-years-116011300637_1.html

[35] Project Appraisal Document on a COVID-19 Strategic Preparedness and Response Program, April 2, 2020, International Bank of Reconstruction and Development and International Development Association World Bank Group's Operational Response to COVID-19 https://www.worldbank.org/en/about/what-we-do/brief/world-bank-group-operational-response-covid-19-coronavirus-projects-list

[36] https://www.worldbank.org/en/about/what-we-do/brief/world-bank-group-operational-response-covid-19-coronavirus-projects-list

[37] Project Appraisal Document on a COVID-19 Strategic Preparedness and Response Program, April 2, 2020, International Bank of Reconstruction and Development and International Development Association https://documents1.worldbank.org/curated/en/993371585947965984/pdf/World-COVID-19-Strategic-Preparedness-and-Response-Project.pdf

[38] https://www.aiib.org/en/news-events/news/2020/AIIB-Looks-to-Launch-USD5-Billion-COVID-19-Crisis-Recovery-Facility.html

burden of eligible members. The SFW mechanism provides a buy-down of interest rates, to provide relief from debt distress.[39]

The New Development Bank (NDB) on June 16, 2020, priced its inaugural benchmark, a $1.5 billion, 3-year COVID-19 response bond in the international capital markets. It stated that the proceeds from the bond will be used to finance sustainable development activities in its member countries, which includes emergency assistance to address the COVID-19 pandemic and economic recovery[40]. In September 2020, the NDB further priced a $2 billion, 5-year COVID-19 bond[41]. The NDB has approved and disbursed multiple COVID-19 emergency economic recovery loans, and COVID-19 emergency response loans to India, Russia, China, Brazil and South Africa.

The ADB's COVID-19 Response is a $20 billion package to support its developing member countries in countering the severe macroeconomic and health impacts caused by COVID-19, including $2.5 billion in concessional loan and grant resources, as well as $2 billion earmarked for the private sector (non-sovereign). The Asia Pacific Vaccine Access Facility (APVAX) is ADB's $9 billion vaccine initiative offering rapid and equitable support to its developing member countries as they procure and deliver effective and safe COVID-19 vaccines.[42]

An overview of IFI lending to India suggests that while the rapid response has been critical to combat the pandemic, the quantum of spending has not been adequate to respond to the crisis. The crux of spending should and indeed has come through domestic resource mobilization. At the same time, given that much of the external financing has been through loans, this risks adding to the national debt burdens for India as it does for other Asia-Pacific economies[43]. India's external debt has risen throughout the pandemic and stood at 87.4% in Financial Year 2021[44]. However, it remains broadly sustainable, [45] even though it has caused speculation that low public spending during the pandemic could be caused by the desire for fiscal consolidation.[46]

Analysing the role of these institutions is critical to ensure transparency of the funds spent by them and to ensure transparent and inclusive governance processes, particularly for essential services like health and education. It is also critical to understand how this support may have shaped the policy discourse and agenda domestically. In so doing, it would be particularly important to understand how this support has been able to address social inclusion and rising income and wealth inequalities. In so doing, it would be particularly critical to examine the extent to which the projects have benefitted India's historically marginalized communities during the current crisis and beyond.

IFIs: LOOKING BEYOND PANDEMIC FINANCING

The last two years of **IFI support**, furthermore, n**eeds to be seen in the context of longer-term lending priorities for India**. While the COVID crisis dominated the headlines, disbursements of long-term development grants and loans continued during this period. These have by and large followed regular

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[39] For more information on SFW, please see AIIB paper dated May 7, 2020 - https://www.aiib.org/en/policies-strategies/COVID-19-Crisis-Recovery-Facility/_download/COVID19-SFW-Paper_pub-2020-05-14.pdf

[40] NDB press release dated June 17, 2020, available at - https://www.ndb.int/press_release/ndb-prices-inaugural-usd-1-5-billion-3-year-COVID-response-bond-international-capital-markets/

[41] NDB press release date September 23, 2020, available at https://www.ndb.int/press_release/ndb-prices-usd-2-billion-benchmark-bond-support-COVID-emergency-response/

[42] https://www.adb.org/countries/india/covid-19-response

[43] https://www.unescap.org/sites/default/d8files/knowledge-products/PB117_MDB%20financing%20policy%20brief.pdf

[44] https://www.bloombergquint.com/union-budget-2022/budget-2022-bringing-public-debt-down-requires-a-strong-growth-path

[45] https://dea.gov.in/sites/default/files/Quarterly%20Report%20on%20India%27s%20External%20Debt%20as%20at%20end-December%202021.pdf

[46] https://www.newindianexpress.com/opinions/editorials/2022/jan/03/austerity-during-covid-times-is-notthe-way-forward-for-indian-economy-2402475.html

financing terms and risk criteria. Approvals have also used similar procedures, but have in some instances been fast-tracked. As such, it would be critical to further the longer-term agenda of building robust and effective public education and health systems. This is, in turn, shaped by the longer developmental agendas of the IFIs. A particular area of concern is the **track record of the biggest lender- the World Bank, which has a history of support for the private sector provision of public services**. Thus, an Oxfam study of World Bank support between 2013 and 2018 found that a fifth of education projects included support for the private provision of education[47]. Another review by Oxfam of the World Bank's COVID-19 health lending to 71 countries found that the WB has missed critical opportunities to strengthen public health systems which would have been critical for delivering health for all in the future.[48]

IFI LENDING TO INDIA DURING THE COVID PERIOD

During the reference period- 2020 to 2022, India received help from a range of institutions including the WB, ADB, AIIB and NDB with a focus on scaling up economic stabilization, social protection and rapid health response assistance programs. The four major banks have together provided project amounts of over US$ 6.8 Billion to the Government of India as a direct response to the pandemic.
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The WB and ADB COVID-19 relief strategy in India followed existing government initiatives. As such, in the first phase, the Government of India tackled the health aspects and partnered with the World Bank for a $1 billion health project. In the second phase, the Government of India (GoI) invested $ 23 billion in a social protection program to support the poor and vulnerable communities during the lockdown, and the Bank provided financing of $ 1.7 billion. In the third phase, the Government of India focused on economic stabilization and reducing the costs of the lockdown. AIIB's COVID-19 Crisis Recovery facility toolkit[49] emphasised financing of immediate health sector needs arising from the pandemic, steps for economic resilience and financing to address liquidity constraints in infrastructure and other sectors.

The **WB and ADB have situated this support within their existing Country Partnership Frameworks**. The remaining banks do not have formal long-term strategy documents specifically focussing on India. The World Bank has accorded India with strategic focus through its interventions which targeted both national and state governments.[50] Similarly, the Asian Development Bank provided emergency assistance to contain the disease and establish social protection measures for relief to the poor and other vulnerable groups. It also approved financing to help the government improve equitable access to comprehensive primary health care in urban areas.[51] It is critical to note that the CPF and CPS of World Bank and ADB will be entering their new cycle of partnership in 2022-23. As such, the experience of the work in the last two years would be critical for shaping the funding priorities of the two biggest lenders for public services in India. A critical review of the lending can shape the funding priorities in the coming four to five years. ADB is another critical IFI active in India which has made critical investments. Thus, the Asian Development Bank (ADB) committed $3.92 billion in sovereign loans to India in 2020, including $1.8 billion in projects to support the Government of India's coronavirus disease (COVID-19) pandemic response; it also committed $356.1 million through its non-sovereign operations to India.[52] This is said to be ADB's highest-ever annual lending commitment to India since the start of its lending operations in 1986. This has included support for health including COVID-19 emergency response and vaccination interventions.

India is the second-largest shareholder in the AIIB, after China, with a 7.65% voting share and India has a 20% voting share in the NDB. AIIB's long-term strategic focus is on sustainable infrastructure (particularly

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[47] https://www.oxfam.org/en/research/false-promises
[48] https://oxfamilibrary.openrepository.com/bitstream/handle/10546/621113/bp-catastrophe-catalyst-world-bank-covid-19-041220-en.pdf?sequence=3
[49] https://www.aiib.org/en/policies-strategies/COVID-19-Crisis-Recovery-Facility/_download/AIIB-CRF-Toolkit.pdf
[50] https://www.worldbank.org/en/news/feature/2018/05/21/world-bank-group-draft-country-partnership-framework-india-fy18-22
[51] https://www.adb.org/news/covid-19-support-spurs-adb-record-lending-commitment-india
[52] https://www.adb.org/news/COVID-19-support-spurs-adb-record-lending-commitment-india

green infrastructure) and cross-border infrastructure (transport, pipelines and telecom) and private capital mobilization; its COVID-era support for health and education was part of special COVID-19 relief. NDB's mandate is to mobilize resources for infrastructure and sustainable development projects in BRICS complementing the efforts of other IFIs, and not to prescribe policy, regulatory and institutional reforms to borrowing countries[53]. As such, funding by NDB and AIIB does not include a clear focus on education or health and neither have a dedicated India strategy.

Infrastructure development remained a priority area for lending throughout the period. Support for the health sector, however, formed a significant area of investment. Education did not appear to reflect a high-level priority area in the strategies of the IFIs, although some education-related financing was disbursed during this period. Support was also extended for social protection measures.

Overall quantum of IFI support to India approved during the pandemic, by sector (Active Projects in USD Millions). (Jan 2020- 1 July 2022)				
Sectors	WB	ADB	AIIB	NDB
Transport and Roads	1302	3327	856	741
Power and Energy	135	1311	1145	
Urban development, water and sanitation	1427	899	610	80
Agriculture & Animal Husbandry	365	110		
Housing	400	450	200	
Improving governance and public systems	512	54		
Health	2072	1800	1000	1000
Social protection	1862	-	600	
Education	1550	500	250	-
Supporting economic stabilization	1250	1500	750	1000
TOTAL	10875	9951	5411	2821

Most WB sovereign funding was through IBRD and another 6% of the funds were IDA non-concessional. IDA provides zero-interest rates or concessional financing and IBRD provides market-benchmarked loans. India became an IDA graduate in 2014[54], which resulted in a gradual diminishment in its IDA's financing. Only 3% of the funding during the 2020-22 period was IDA concessional. IDA financing was mainly provided for social protection projects. Thus, it could be expected that cumulative lending would be expected to contribute towards external debt.

Share of WBG Sovereign Financing (2020-22)

92% — IBRD
3% — IDA Concessional
5% — IDA Non-Concessional

[53] https://www.ndb.int/wp-content/uploads/2017/08/NDB-Strategy.pdf
[54] https://ida.worldbank.org/en/about/borrowing-countries/ida-graduate
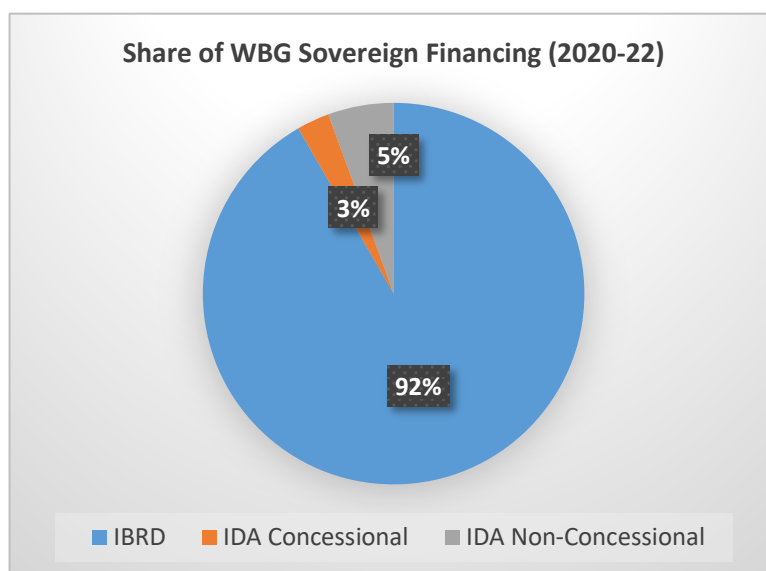
EXAMINING THE COVID-19 ERA PROJECTS IN INDIA IN CONTEXT OF IFIs' POLICY AND LENDING FRAMEWORKS

The COVID era relief to India must be situated in the context of their longer-term lending priorities for India. The long-term policy direction of the World Bank has provided much of the structure for the loans and grants made by IFIs in these sectors made during this period (beyond those immediately geared towards COVID relief). The World Bank's support has been seen in the light of the current Country Partnership Framework (CPF) for the period 2018-2022. The AIIB also committed to using the World Bank Program-for-Results framework and is pledged to provide co-financing to initiatives taken by ADB and the WB as part of its COVID-19 crisis recovery facility. The implications of these measures on the education and health sectors have been examined in the subsequent chapters. At the same time, it would be critical to note that commercial investment in private, for-profit companies has also been ongoing throughout the period in parallel to these loans via the IFC and non-sovereign lending of the ADB. However, this analysis has been outside the purview of the present analysis. Similarly, an analysis of commercial investment through intermediaries has not been undertaken. Thus, a deep dive into the AIIB to the National Investment and Infrastructure Fund of Funds'[55] support for social infrastructure through private equity funds was not undertaken.

THE PRESENT STUDY'S OBJECTIVES

The analysis aims to explore IFI COVID-19 era policies, programmes and practices with the aim of pushing them to become more gender-transformative, inequality reducing and socially inclusive. The paper assesses the sovereign lending to India by IFIs during the pandemic by looking at the funding priorities and governance policies for health and education projects that have been approved in India since the start of the pandemic.

The objectives of the analysis are:
   a. To provide comprehensive information on IFI COVID-19 era health and education loans, and act as a vital point of reference for stakeholders to understand emergency and other loan structures and their utilisation.
   b. To assess the potential implications (short and long term) of IFI loans on government policies related to inequalities in health and education.
   c. To provide recommendations for appropriate utilisation of funds to ensure they prioritize disadvantaged, vulnerable and marginalised groups.
   d. To advocate an all-inclusive long term COVID-19 response and recovery plan in health and education services, and ensure commitment to gender policies.
   e. Contribute to the existing discourse around IFI response to the pandemic via programmes/policies and practices.

METHODOLOGY

This paper aims to understand the projects undertaken by the four IFIs during the COVID-19 era in India. To this end, we have analysed health and education projects approved from the onset of the pandemic in India in January 2020, through 1 July 2022. It is important to note that we have analysed projects that are only classified as either health and/or education. For projects which are classified as 'COVID-19 response', or 'emergency assistance', we have only looked at the health or education components (if mentioned substantially) within these projects. The analysis is done principally by way of looking at the Project Information Documents (PID) and/or the Project Appraisal Documents (PAD). Sources have been added wherever we have referred to any other project or bank documents.

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[55] https://www.aiib.org/en/projects/details/2018/approved/_download/India/National-Investment-and-Infrastructure-Fund-of-Funds-I-June-24-2020.pdf

While we have attempted to look at the extent to which the projects have been able to deliver on the stated objectives, an in-depth analysis of the same is outside the purview of this paper. One is constrained by the availability of disclosed information about the progress achieved under the projects. Many have also been approved fairly recently meaning the information available is scanty.

Chapter 2 provides an overview of the COVID-era projects in India. Chapters 3 and 4 provide an in-depth look at the projects in education and health interventions respectively, particularly with a focus on addressing education and health inequalities. Chapter 4 looks at the IFI governance measures of these projects. While each chapter contains specific recommendations, Chapter 5 provides some overarching recommendations based on the overall analysis.

CHAPTER II: OVERVIEW OF LENDING

The story of India's fight against the pandemic and the role of the IFIs starts in January 2020 when the first COVID-19 case was officially detected in India. Almost all IFIs included in this study disbursed emergency loans in March and April 2020 that primarily dealt with cushioning the effects of COVID-19. Subsequent lending has continued to include components critical for COVID response and recovery.

During this period the World Bank (WB) approved seven projects with a focus on either health or education. The AIIB had three projects during this period. ADB extended three loans and one grant along with four technical assistance grants. Incidentally, there were also two loans meant for social protection and economic stabilization that had health components financed by World Bank, AIIB and ADB. Lastly, the NDB has one active project during this period. These projects provided immediate aid to India to enable it to respond to the pandemic.

TRANSITIONING FROM COVID RELIEF TO COVID-INFORMED DEVELOPMENT WORK

As the crisis stretched, however, the projects merged with the longer-term development agenda of these IFIs. The World Bank's ongoing CPF is aimed toward supporting "resource-efficient growth, enhancing competitiveness and enabling job creation and investing in human capital.[56]" It seeks to do so through leveraging the private sector, engaging a federal India by working at both the national and state levels, strengthening public institutions, and supporting a "Lighthouse India" by promoting knowledge exchange within the country and between India and the rest of the world. Education and health interventions are part of its overall focus on "building human capital" in line with the priorities of the CPF. This is aimed to eliminate extreme poverty and foster the middle class. The World Bank's CPF sought to enhance investment in the early years of children's development, improve the quality of education in schools and colleges, and increase the quality of health service delivery and financing and access to quality healthcare.

This is also part of the WB's strategy of moving away "from an earlier approach of broad support for centrally sponsored schemes for improving access to education" to instead "design support for national programs for primary and secondary education in a manner that incentivizes state-level innovation and performance in achieving better learning outcomes". As such, the current CPF was intended to have a strong state-specific focus. It also sought to promote delivery models that leverage the private sector to deliver services. As such, the IFIs while providing much-needed resources for the delivery of public services at this time of crisis, also shaped development agendas as the subsequent chapters would show.

HEALTH AND EDUCATION PROJECTS (LOANS and GRANTS) APPROVED JAN 2020- 1 JULY 2022

IFI	Education	Health	Non-Health projects having health component	Which government do projects support		Quantum of resources invested by IFIs
				National	State	
WB	5	5	2[57]	6	6	$ 4.5 Billion
AIIB	1	2	2[58]	3	2	$2.1 Billion
NDB	0	1	-	1	-	$1 Billion

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[56] https://www.worldbank.org/en/cpf/india
[57] Contains two loans for social protection-Accelerating India's COVID-19 Social Protection Response Program & Resilient Kerala
[58] Contains two loans for social protection- CARES and Resilient Kerala

ADB	1	6[59]	1[60]	7	1	$3.4 Billion
Total	**7**	**14**	**5**	**15**	**9**	**$ 11 billion**

PIPELINE LOANS AND GRANTS (as of 1 July 2022)

IFI	Education	Health	Total Sovereign Projects	Quantum of resources invested by IFIs
World Bank	4[61]	2[62]	6	$ 1.9 Billion
ADB	1	0	1	$ 500 Million
Total	**5**	**2**	**7**	**$ 2.4 billion**

It would also be critical to note that a change in the strategic direction of the IFIs is anticipated given that the ADB is in process of revisiting its CPS[63] and the WB is expected to start the process later in the year. The NDB has revised its global strategy in 2022[64] with social infrastructure (which includes education and health) as one of its priorities.

FOCUS ON STATES AS UNIT OF CHANGE AND THEIR SELECTION:

The projects covered most of India through the support of some pan-national centrally sponsored schemes. However, many of the projects were focused on individual states. This is in line with the World Bank's intention to target catalytic interventions and strike strategic partnerships with selected states to trigger wider change. The World Bank's CPF suggests that at least 30% of the value of total commitments in its portfolio is expected to still be allotted to Low-Income States/Special Category States[112]. Low-Income states include Assam, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan and Uttar Pradesh while the Special Category States include the northeast states of Manipur, Meghalaya, Tripura, Nagaland and Mizoram.

With the World Bank providing the biggest share of funding, this shapes the overall spread of IFI interventions. **The support in education shows a clear move away from working with larger, developmentally lagging, populous states and instead focusing on smaller and higher-performing lighthouse states.** This means that the parts of the country with the lowest development outcomes (including the poorest education and health outcomes) would, accordingly, receive substantially lower levels of direct support from IFI resources (except states in Northeast India).

While the strategic intention of the Bank to leverage specific policy shifts may be understood, this investment moves away from using these resources to address the needs of states in most need. The specific criteria for the selection of these particular states have been questioned by the education focussed Parliamentary Standing Committee which has called for the criteria to be relaxed to enable more states to benefit[65].

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[59] Consists of 2 loans- India: Strengthening Comprehensive Primary Health Care in Urban Areas Program under the Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PM-BHIM) and Responsive COVID-19 Vaccines for Recovery Project, 1 grant- COVID-19 emergency response, 3 Technical Assistance grants: Strengthening Universal Health Coverage in India: Supporting the Implementation of Pradhan Mantri Jan Arogya Yojana, Supporting COVID-19 Response and Vaccination Program & Supporting New Infrastructure Development through Public Private Partnerships and Implementation Monitoring of National Infrastructure Pipeline

[60] Consists of social protection: ADB CARES loan

[61] Consists of Uttar Pradesh Knowledge-based Response to Schooling and Teaching, Chhattisgarh: Accelerated Learning for a Knowledge Economy, Maharashtra Skills Development Project & Multidisciplinary Education and Research Improvement in Technical Education).

[62] Consists of Systems Reform Endeavour for Transformed Health Achievement in Gujarat (SRESTHA-G) and Assam Secondary Health care project

[63] https://www.adb.org/countries/india/overview#future

[64] https://www.ndb.int/about-us/strategy/strategy/

[65] https://rajyasabha.nic.in/rsnew/Committee_site/Committee_File/ReportFile/16/144/323_2021_7_15.pdf

Geographies covered by IFI Investments on school education and health system strengthening during the COVID period (current and pipeline projects)		
	Education	Health
Pan-India	Support for MoE, CBSE	Pradhan Mantri Jan Arogya Mission, Pradhan Mantri Ayushman Bharat Health Infrastructure Mission(PM-ABHIM), COVID-19 Emergency Response
World Bank State Interventions		
The Low-Income States	Odisha, Rajasthan,[66] Madhya Pradesh, Chhattisgarh[67] and Uttar Pradesh[68]	Odisha and Uttar Pradesh[69]
Special Category States	Nagaland	Meghalaya[70,71], Mizoram[72] and Assam[73]
Lighthouse	Andhra Pradesh, Kerala, Gujarat and Himachal Pradesh	Gujarat[74], Andhra Pradesh and Kerala[75]
Others	Maharashtra[76]	Punjab and Tamil Nadu[77]
ADB State Interventions		
ADB States	Assam, Gujarat, Jharkhand, Tamil Nadu and Uttarakhand[78]	Andhra Pradesh, Assam, Chhattisgarh, Gujarat, Haryana, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Rajasthan, Tamil Nadu, Telangana and West Bengal[79]
Other interventions		
AIIB	Gujarat[80]	

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[66] This has been classified as a lighthouse state for the purpose of the STARS Loan.

[67] https://projects.worldbank.org/en/projects-operations/project-detail/P179249

[68] A new pipeline loan is under development by the World Bank; at the time of writing no information is available beyond the fact that this is.

[69] https://documents1.worldbank.org/curated/en/099345106042220184/pdf/P1781460bdd4610690ae540bcf055171d7c.pdf

[70] https://projects.worldbank.org/en/projects-operations/project-detail/P178967

[71] https://documents1.worldbank.org/curated/en/099345106042220184/pdf/P1781460bdd4610690ae540bcf055171d7c.pdf

[72] https://documents.worldbank.org/en/publication/documents-reports/documentdetail/648751617501700816/india-mizoram-health-systems-strengthening-project

[73] https://projects.worldbank.org/en/projects-operations/project-detail/P179337

[74] https://projects.worldbank.org/en/projects-operations/project-detail/P178252

[75] https://documents1.worldbank.org/curated/en/099345106042220184/pdf/P1781460bdd4610690ae540bcf055171d7c.pdf

[76] STARS and Maharashtra Skills Development Project

[77] https://documents1.worldbank.org/curated/en/099345106042220184/pdf/P1781460bdd4610690ae540bcf055171d7c.pdf

[78] Under project ASPIRE

[79] This a RBL for MOHFW. Listed are ADB project states within this RBL. https://www.adb.org/sites/default/files/project-documents/53121/53121-001-pam-en.pdf

[80] https://www.aiib.org/en/projects/details/2021/_download/india/summary/AIIB-PSI-P000479-Gujarat-Education-Infrastructure-and-Technology-Modernization-Program.pdf

CHAPTER III: THE EDUCATION PROJECTS

It is impossible to underestimate the impact that the pandemic has had on the education sector in India. India has had one of the world's longest school lockdowns; elementary schools in India had been closed for over 500 days[81]. The resulting disruption is expected to reverse gains of the last 20 years of global progress in children's education, especially girls' and the reduction of child labour.[82]

Other critical policy measures were also taken in the interim. This analysis is being undertaken a year since the enactment of India's new National Education Policy (NEP), its first in over 30 years. This offers a new strategic direction for the country and many of the project documents explicitly engage with this new policy's objectives. At the same time, the projects need to further the realization of the right to education and fulfilment of global commitments like the Education 2030 agenda. Domestic legal frameworks including the Right of Children to Free and Compulsory Education Act offers a critical framing document for any programmatic interventions in India.

The present chapter provides an overview of the IFIs' overall strategic focus concerning education in India, an overview of the COVID era education lending to India, an analysis of the plans so far and a summary of the impact achieved so far. The chapter ends with recommendations.

RECOVERING EDUCATION POST COVID

UNESCO, UNICEF, and the World Bank have jointly identified three priorities for education in COVID recovery: bringing all children back to schools for complete or partial in-person instruction, recovering learning losses, and preparing and supporting teachers.[83] Reopening schools safely calls for steps to protect the health and well-being of learners, teachers and educators, tracking those at risk of not returning to school, ensuring that schools offer to catch up and remedial learning programmes and boosting school health and nutrition programs. It is recognized that social inclusion and gender equality should be promoted through education. UNESCO has called for this to be a moment to build more resilient education systems that rely on teachers who are trusted and respected, ensure students have the skills needed to create a more equitable future and tap into the power of education to build back more inclusive, resilient and innovative societies.[84]

India has taken several policy steps to address the impact of the pandemic on education. This has included steps taken by the national government and a range of measures taken by its States[85]. These have included extensive efforts to support digital and distance education, the development of alternative academic calendars as a first step to dealing with learning loss and tools for teacher training, among others. However, **not enough efforts were taken to address the digital divide or to work towards an early physical re-opening of schools**. Much of the support extended by IFIs has followed the same government strategies.

IFIs' EDUCATION STRATEGIES DURING THE PANDEMIC

The World Bank's global response has emphasized supporting continued learning to mitigate the damage occurring due to earning loss, increased dropouts, and higher inequality. It also stressed the need for government spending on education at a time when families have less disposable income to support

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[81] https://scroll.in/article/1001846/its-500-days-since-children-went-to-school-in-india-everything-is-opening-why-arent-schools

[82] https://www.un.org/development/desa/en/news/sustainable/sustainable-development-goals-report-2020.html

[83] https://blogs.worldbank.org/education/mission-recovering-education-2021

[84] https://en.unesco.org/news/time-roll-out-educations-recovery-package

[85] https://www.cnbc.com/2022/02/02/covid-will-never-become-an-endemic-virus-scientist-warns.html

education at home. It[86] highlights the need for the COVID-19 education response to be undertaken in three stages- viz

a) Coping: dealing with the sudden closure of schools through protecting student health and safety and preventing learning loss
b) Managing Continuity: by ensuring schools reopen safely, student dropout is minimized and learning recovery starts
c) Improving and accelerating by building back better education that is stronger and more equitable

Similarly, the ADB recognizes three stages to the process including

a) Response (focussing on sustaining teaching and learning during the closure of educational institutions due to COVID-19; expected to last 3-10 months)
b) Recovery (preparing for reopening, addressing lost time for students and enabling the transition to higher levels of education; expected to last 6-24 months)
c) Rejuvenation (including strengthening teaching and learning through the use of new tools and techniques, expansion of online education to complement face-to-face learning; expected to last 8-36 months)

ADB's strategy, furthermore, focuses on six priority actions including ensuring uninterrupted learning, revamping teacher training and supporting teachers including the use of digital tools, developing digital content, promoting learning opportunities for students who lack access to devices, connectivity or a favourable learning environment at home, strengthening assessments and examinations and exploring "innovative financing arrangements and partnerships" to support innovations.

AIIB has also recognized the role played by technology during the COVID-19 pandemic in facilitating the continuous functioning of educational services and extended support for projects where the application of technology delivers better value, quality, productivity, efficiency, resilience, sustainability, inclusion, transparency or better governance along the full project life cycle as stated in its recent corporate policy.[87]

Thus, the stated strategies of all the IFIs are framed in terms of providing long-term support to build back a more equitable and quality education system. All strategies look at greater use of Educational Technology, both immediately and in the long-term response.

WORLD BANK AND OTHER IFIs' LONGER TERM STRATEGIC APPROACH FOR EDUCATION IN INDIA

The response during the COVID-19 period must be seen in the backdrop of the longer-term educational strategies of these IFIs in India. The World Bank and ADB include a focus on education in their country's strategies while AIIB and NDB lack such strategies.

The World Bank has been a long term funder of education in India. The current CPF includes education as part of its "Focus Area 3", viz Investing in Human Capital. More specifically, its priorities include early childhood education (ECE) and improving the quality of education in schools. The latter is largely focused on the improvement of learning outcomes and preparing youth for future jobs through "strengthening teacher performance through professional development and accountability systems, building institutions and systems to identify ways to improve learning outcomes, and improving governance and quality assurance within schools" (CPF).

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[86] https://www.worldbank.org/en/topic/education/publication/the-COVID19-pandemic-shocks-to-education-and-policy-responses
[87] https://www.aiib.org/en/policies-strategies/strategies/.content/index/_download/AIIB-Corporate-Strategy.pdf

The focus of this strand of work for the WB is to address "issues of public service quality and efficiency" and "affordability" of key education services that it considers critical for human development. Its strategies include promoting innovative practices in individual states, mobilizing resources into these sectors and promoting learning. In so doing, delivery models that leverage the private sector are expected to be promoted. IFC in particular is expected to support the private sector provision of quality education including the use of digital platforms, with a particular focus on rural and small towns. This is part of a larger global strategy of the Bank to promote private sector modes of delivery[88, 89].

ADB includes its work on education in India in its current Country Partnership Strategy (India, 2018-22- Accelerating Inclusive Economic Transformation) as part of its Pillar 1: boosting economic competitiveness to create more and better jobs and has supported work on technical and vocational education and training. ADB has seen its role as "introducing quality vocational education in high schools and colleges, leveraging private sector involvement in TVET infrastructure, and pilot testing and scaling up technology-based skills training[90]". In contrast, the WB's CPF has a clear focus on human capital development "investing in children's early years" and the strategic emphasis for the school education of the World Bank is on strengthening teacher performance, strengthening institutions and systems to identify improvements in learning outcomes and inform practice and governance reforms.

ANALYSIS OF COVID-ERA PROJECTS IN EDUCATION

The projects cover all stages of school education from early childhood to secondary. These included five projects funded by the World Bank and one project apiece funded by ADB and the AIIB respectively. The AIIB project provides co-financing for a project by the WB. As such, **the World Bank emerges as the IFI whose long term strategic direction has shaped the agenda of other IFIs as well**. ADB's school education lending complements the World Bank's interventions in school education. ADB would also undertake interventions based on its priority areas and intends to leverage work undertaken by UNICEF in the intervention states.

In addition to the projects analysed, a World Bank-funded project for Uttar Pradesh for improving educational quality through technology-enabled decentralized service delivery[91] is in the pipeline for which no information is currently available in the public domain. This has not been included in the analysis in the absence of information.

Most projects covered the **entire duration of schooling from early childhood education to secondary and vocational education** in line with the World Bank's more integrated approach to education. Most covered all stages of education except the World Bank-funded "Facilitating school to work transition" which only covered secondary education and the project NECTAR which did not have a standalone explicit emphasis on ECCE.

In addition to the above, there are **some ongoing projects which predate the pandemic** and which have not been included in the analysis. For the World Bank, this includes some interventions which wound down during the COVID period including the 'Nai Manzil' intervention with a focus on secondary education and vocational skills for Minorities (2016-2021 with a project cost of 100 million) and Enhanced Teacher Effectiveness in Bihar (2015-2021 with a commitment amount of 250 million USD)

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[88] https://documents1.worldbank.org/curated/en/168331522826993264/pdf/124888-REVISED-BRI-PUBLIC-Maximizing-Finance.pdf

[89] https://www.oxfam.org/en/research/false-promises

[90] https://www.adb.org/sites/default/files/institutional-document/363331/cps-ind-2018-2022.pdf

[91] https://projects.worldbank.org/en/projects-operations/project-detail/P177966

The present analysis **only covers early childhood and school education**. However, the World Bank[92] and ADB[93] have or had projects on Higher and technical and vocational education during this period. The World Bank's Project MERITE[94] focuses on tertiary technical education. A Maharashtra Skills Development Project is also under consideration[95]. The pipeline project MPOWER is a multi-disciplinary intervention with a focus on adolescents including education, skills and counselling and the transition to the world of work. ADB is also supporting an Assam Skill University Project[96] with a focus on technical and vocational education and training (TVET) and higher education. Given neither project focuses on school education, both these projects have not been included in the detailed analysis.

As such, the COVID-era projects to India have included the following. Each row corresponds to a single intervention funded through various sources.

	World Bank	ADB	AIIB
1	Strengthening Teaching-Learning and Results for States (STARS) (loan) & Facilitating school to work transition (WORK) (Grant)	Accelerating State Education Program to Improve Results (ASPIRE)	
2	Gujarat - Outcomes for Accelerated Learning (GOAL) and Gujarat Outcomes For Accelerated Learning (Goal) (Additional Financing)		Gujarat Education Infrastructure & Technology Modernization Program
4	Nagaland: Enhancing Classroom teaching and resources project (NECTAR)		
5	Supporting Andhra's Learning transformation (SALT)		
6	Uttar Pradesh Knowledge-based Response to Schooling and Teaching (Pipeline)		
6	Multidisciplinary Education and Research Improvement in Technical Education (MERITE) (Pipeline)		
7		Assam Skill University	
8	Meghalaya Program for Adolescent Wellbeing, Empowerment and Resilience (MPOWER) (Pipeline)		
9	Maharashtra Skills Development Project[97]		
10	Chhattisgarh: Accelerated Learning for a Knowledge-Economy[98]		

Three individual projects together support project GOAL (WB GOAL 1 & 2 and AIIB). It was also initially expected to receive co-financing from the ADB. However, this appears to have been withdrawn. Instead, another WB loan is being proposed to compensate for this funding shortfall (henceforth, pipeline project GOAL II). The resulting framework and other key dimensions for the project remain unchanged and the

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[92] For the World Bank this including the National Agricultural Higher Education Project (Approved 2017 with commitment amount of 82.5 million dollars), the MP Higher Education Quality Improvement Project (Approved 2016 with commitment amount of 300 million USD), Technical Education Quality Improvement Project III (approved in 2016 and with a commitment amount of 201.5 million) and the Odisha Higher Education Program for Excellence and Equity (approved August 2017 with a commitment amount of 218 million USD) which predate the pandemic. It has also supported the Skill India Mission (approved 2017 with support of 250 million USD), among other measures and its support to Tejaswini for the socio-economic empowerment of adolescent girls includes a focus on vocational and secondary education (approved in 2016 with a commitment amount of 63 million).

[93] ADB's support for vocational education include the still active projects- Madhya Pradesh, Himachal Pradesh and Odisha Skills Development Projects.

[94] https://documents1.worldbank.org/curated/en/099500001032211227/pdf/Concept0Projec0Education000P177917.pdf

[95] https://projects.worldbank.org/en/projects-operations/project-detail/P177965

[96] https://www.adb.org/projects/53277-002/main

[97] https://projects.worldbank.org/en/projects-operations/project-detail/P177965

[98] https://projects.worldbank.org/en/projects-operations/project-detail/P179249

two projects are being considered as one project for this analysis. This new support will fund activities in an additional 6,000 schools under the Government's Mission Schools of Excellence program bringing the total intervention schools to 12,000[99]. Accordingly, all three loans together are considered to be supporting a single project.

Given that this analysis only includes one project apiece supported by AIIB and ADB (and no projects from the NDB), it is not possible to extrapolate from this to the overall strategy of the various IFIs in India. The analysis has accordingly been done in terms of individual projects and not the individual funders.

Lastly, it would be important to note that this period also saw significant investment by the World Bank's IFC in the ed-tech sector through direct investment in several companies. Thus, a new investment in UpGrad, an Edtech firm was done by IFC during this period[100]. There has been no commercial investment in running K-12 schools by the IFC in India. A detailed analysis of EdTech provision, however, is outside the purview of this analysis. ADB does not have active non-sovereign lending in education in India.

Financing of the projects

A total of **3198 million USD has been committed to early childhood and school education-related projects by the World Bank**. In addition, ADB will extend 500 million USD for the project ASPIRE and AIIB offers 250 million as co-financing for GOAL. WB's Facilitating School to Work Transition is the only grant.

Financing of education projects (January 2020- 1 July, 2021) by the World Bank (in millions USD)							
	Nature	Status	Summary	Break up of financing			Project Duration
			Total Project	IBRD funding	Trust Funds	Government funding	
GOAL	Loan	Active	2783.10	500		214.30	2021-2028
GOAL II	Loan	Active	714	250			2021-2026
NECTAR	Loan	Active	85	68		17	2021-2026
SALT	Loan	Active	1020	250		770	2021-2027
WORK	Grant	Active	2		2		
STARS	Loan	Active	3,346	500		2846	2020-2026
MERITE	Loan	Pipeline	560	280			2023-?
UP[101]	Loan	Pipeline	-	500	-	-	2023-?
Maharashtra	Loan	Pipeline		300			2024-?
Chhattisgarh	Loan	Pipeline		300			2023-?

	Funding for ADB and AIIB Projects (including those with WB co-financing) during the COVID period (in USD Million)								
	Nature	Status	AIIB	ADB	IBRD	Government	Others	Total project cost	Duration
GOAL (AIIB)	Loan	Active	250		500	321		1071	2022-2028
ASPIRE (ADB)	Loan	Approved		500		1385[102]		1885	2022-2028
Assam Skill University	Loan	Active		112		28	1.1 [103]	140	2021-2024

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[99] https://documents1.worldbank.org/curated/en/099540102072237308/pdf/Appraisal0Stag0Financing000P177915.pdf
[100] https://disclosures.ifc.org/project-detail/SII/45142/upgrad-2021
[101] Uttar Pradesh Knowledge-based Response to Schooling and Teaching. In the absence of disclosure of documents, it is not possible to ascertain the total funding envelope for the project.
[102] Denoted as counterpart financing
[103] Including 1 million from the Japan Fund for Prosperous and Resilient Asia and the Pacific and 150,000 from the Climate Change Fund

Complementarity with existing schemes

All projects for which information is disclosed[104] have been framed as **supporting national and state policy priorities of the government of India**. These include the implementation of the new National Education Policy and Samagra Shiksha Abhiyan[105,106] at the national level. Project ASPIRE includes a focus on supporting the creation of exemplar schools. State-specific projects complement state schemes and policy measures like Gujarat's Mission schools of Excellence Program[107] and the Nagaland government's "Communitization of public institutions and services Act[108]". Other examples include state-specific schemes like the School Leadership Development Programme, Nagaland and the Nada Nedu Scheme, Andhra Pradesh[109]. Most projects do not overlap in terms of state focus, apart from the focus on Gujarat which receives support from both AIIB and the World Bank.

Objectives and outcomes expected to be served by the projects

In terms of the specific objectives of the projects, it would appear that **most were framed as being about the improvement of educational, especially learning, outcomes** (all five projects), followed by those having a focus on the attainment of specific governance reforms (four) and those with a focus on improvement of the learning environment. Only one project (ADB's ASPIRE, pipeline) explicitly commits to supporting states in the implementation of the provisions of the RTE Act.

The outcomes to be achieved mirrored these by including improvement of learning environments, teacher development and governance reforms, including decentralization. Four have explicit outcomes dedicated to the measurement of learning outcomes, albeit most included an element of doing so. Three each focussed on foundational learning and vocation and STEM education respectively. COVID recovery was recognized as an outcome of only two projects- the WB's GOAL and the ADB-supported ASPIRE projects.

Objectives	Outcomes
• Improved educational outcomes- GOAL, SALT, STARS, WORK, ASPIRE • Governance reforms- GOAL, NECTAR, SALT, STARS, ASPIRE • Child-friendly learning environments- AIIB, NECTAR, SALT, ASPIRE • Ensuring Completion- STARS, WORK • Universal access and inclusion in early childhood and school education- ASPIRE	• Improving Learning environment – GOAL, AIIB, NECTAR, SALT, WORK, ASPIRE, • Decentralization and other governance reforms- GOAL, NECTAR, SALT, WORK, STARS, ASPIRE • Teacher development and curriculum: GOAL, AIIB, SALT, WORK, STARS, ASPIRE • Enhancement and/or measurement of learning outcomes - GOAL, AIIB, ASPIRE, STARS • Foundational learning- SALT, STARS, ASPIRE • Vocational and/or STEM education- WORK, STARS, ASPIRE • COVID recovery- GOAL

PLANS FOR ADDRESSING THE IMPACT OF COVID

Most projects lack an explicit focus on addressing the impact of the pandemic, even if all of the documents included some components of responding to COVID-19. This has largely been through the insertion of standalone sections within the relevant documents, instead of being integrated and placed at the heart of the strategies being planned. Few of the World Bank documents, furthermore, reflect

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[104] The present analysis has been made based on the five projects for which information is available. The three strands of project GOAL are being considered to be a single intervention.

[105] Samagra Shiksha is an overarching centrally sponsored programme for the school education sector extending from pre-school to class 12.

[106] https://samagra.education.gov.in/

[107] https://www.adda247.com/upsc-exam/mission-schools-of-excellence-project-of-gujarat-government/

[108] https://www.nagaland.gov.in/storage/PostFiles/The-Nagaland-Communitisation-of-Public-Institutions-and-Services-Act,-2002.pdf

[109] https://vikaspedia.in/schemesall/state-specific-schemes/welfare-schemes-of-andhra-pradesh/manabadi-nadu-nedu

serious planning for the second stage of the education response- viz. "Managing Continuity", let alone including steps for building back a better education system. One possible exception to this is the project NECTAR which appears to address many more of the longer-term needs of COVID recovery. In contrast, STARS includes a Contingent Emergency Response Component to respond to the pandemic, but none of the documents pertaining to it explicitly spells out the activities to be undertaken; the PAD simply lists some initiatives undertaken by the Ministry of Education to address the COVID-19 situation. These emphasise the use of technology systems, adoption of digital classrooms and development of online materials. ADB's ASPIRE includes a robust emphasis on COVID recovery including prevention of post-COVID-19 dropout, mitigating the impact of the pandemic on students' learning and strengthening digital learning-teaching capacities across schools.

The specific components related to the impact of COVID in the existing disclosed projects include

1.   **Developing and supporting online mechanisms of instruction:** The lion's share of the **COVID-19 education response has emphasized online and distance modes of delivering instruction**. This has included mapping availability and ensuring optimum use of existing devices including- technology support at the local level (device mapping, promoting access at citizen service centres or village offices and mobile learning vehicles; GOAL), use of school-based TVs for online lessons or TV broadcast under supervision of parent committee (SALT), rapid assessment of remote learning environment for various socio-economic levels to inform remote learning mechanisms (NECTAR), transition to e-learning platforms for teacher training and peer-to-peer learning and maintenance of electronic teacher records (STARS) and provision of tablets and connectivity devices (NECTAR).

Small group and other modes of face-to-face instruction have not been explored in most projects over the one and half years of the school lockdown, despite plentiful evidence of the digital divide. At the same time, **disappointingly few projects have spelt out activities to directly intervene to address the digital divide by ensuring the availability of devices or enhancing connectivity**. NECTAR's PAD alone appears to state the intent to undertake a socio-economic assessment of the impact of the remote learning environment to plan steps to address the digital divide. Similarly, project SALT recognizes the differences in access in tribal areas and seeks to develop some solutions.

Digital Devices for accessing home learning in Gujarat[110]

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[110] https://blogs.worldbank.org/education/gujarat-model-managing-learning-continuity-during-COVID-19

Television	Smart Mobile/Tablet	Internet Facility	Normal Mobile Phone	DTH & Set Up Box	Radio	Computer/Laptop	No Devices
51.86%	48.76%	31.37%	30.96%	19.75%	1.20%	0.81%	7.89%

*as on 14 August, 2020
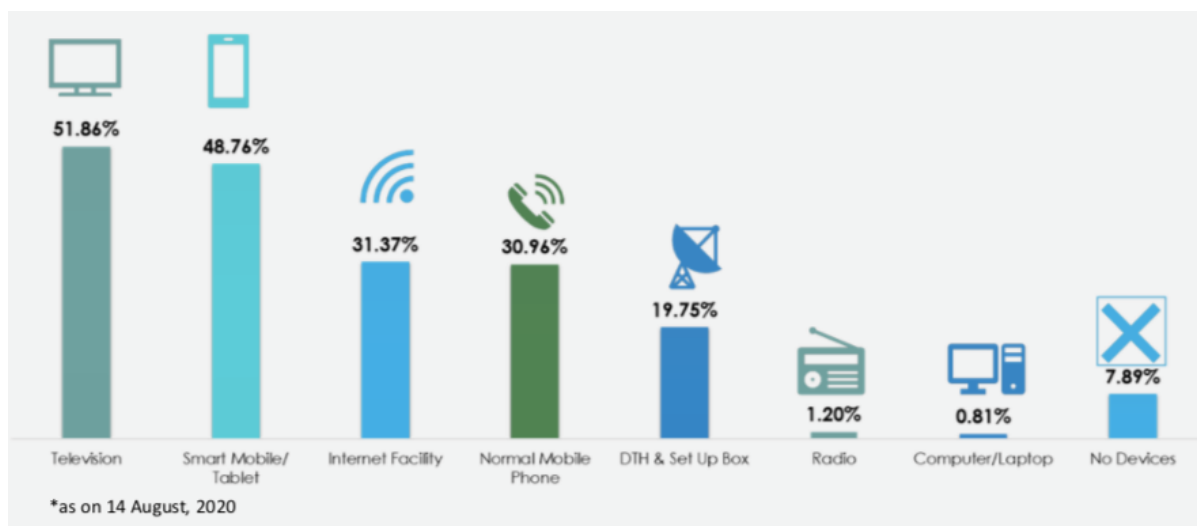
2. **Developing mechanisms for learning assessment and instruction to students:** This has largely included the **development of digital materials for home-based instruction** for use in individual states or as part of the national platform and some print materials. Gujarat used periodic assessment tests as a means to track learning[111]. Most of these strategies were not deliberately targeted to address the specific wealth, social identity and gender digital divides. The specific activities included:

i. Development and dissemination of a home-learning program including virtual sessions and dissemination through digital modes and physical media (GOAL, NECTAR);

ii. Promoting the use of DIKSHA (Digital Infrastructure for School Education)[112], India's national digital platform for educators serving as a repository of free-to-use content for use by education and a platform for teacher training[113] (GOAL, STARS)

iii. Enhancement of home-based learning opportunities for 3-8-year-old students through the development of physical learning kits for parent-guided learning (SALT)

iv. Tracking of learning to support remedial programs through the administration of the Periodic Assessment Tests system (GOAL).

3. **Readiness for re-opening:** Only three projects included a focus on safe reopening by ensuring that infrastructure is conducive to maintaining COVID protocols and only one explicitly stated that it would develop a plan for the same. This has included the development of a safe reopening plan to guide reopening (NECTAR) and ensure the availability of safe drinking water, handwashing points and functional and maintained toilets (SALT, NECTAR[114]).

4. **Support for a return to school:** Tracking and monitoring children in communities at risk of dropping out and undertaking community outreach to get all children back to school (NECTAR) was included in only one project. **None of the projects explicitly spell out strategies for dealing with the learning loss of students who may not have been able to access online modes of learning during the lockdown on their return to face to face instruction**. None of the projects explicitly focus on the delivery of accelerated learning packages or upscaling remedial instruction in the immediate aftermath of school reopening. These have been some of the most critical recommendations of the World Bank for both coping with the immediate crisis and the return to normalcy. Policy advice for the recovery stage includes running re-enrolment campaigns to minimize dropout. Similarly, once students are back in school, the Bank recommends learning recovery to be the top priority to prevent permanent impact on students.

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[111] https://blogs.worldbank.org/education/gujarat-model-managing-learning-continuity-during-COVID-19
[112] https://diksha.gov.in/
[113] https://www.youtube.com/watch?v=hFCg3Qb-Ljk
[114] Taking the form of grants to SMC/SMDCs.

5.   **Addressing the personal and emotional needs of teachers:** The pandemic has had an impact on teachers, predominantly women, who need support. However, support for schoolteachers through counselling and peer networks to address potential burnout issues caused by long disengagement with school activities (NECTAR) was likewise only explicitly mentioned in one project. **Prioritization of teachers in vaccination drives or any proactive measures for the social protection of teachers was not flagged in any of the project documents.**

6.   **Building up systematic resilience:** Some steps for resilience building were included in two projects. Capacity building of personnel for rapid response systems for disasters (GOAL) and roll out of courses on planning and management of remote learning, technology and digital pedagogical skills for teachers (SALT) was also mentioned only in one project apiece.

7.   **Addressing unique specific needs of vulnerable populations:**
Few of the COVID focussed measures explicitly address the needs of marginalized communities. Measures like addressing the digital divide, enhancing online or offline instruction for historically excluded communities or vulnerable individuals or mitigating the unequal impact of learning loss based on family income or Dalit, Adivasi and other social categories were not discernible.

8.   **Health or Health education programmes:** No projects mentioned institutionalizing any new health or health education programmes as part of school re-opening protocols. Similarly, none of the projects explicitly talked about instituting new supplementary nutrition programs or ensuring uninterrupted school feeding programs. This is even though the World Bank's advice includes the need for a stronger focus on addressing student health and safety.

9.   **Social and community interventions:** Few of the projects included comprehensive services to help address learning loss and improve the overall welfare of the communities. In contrast, the World Bank recommends targeted financial support for at-risk students during the lockdown. At the same time, community participation in education could have been strengthened further.

STRENGTHENING EDUCATION SYSTEMS BEYOND THE PANDEMIC

While most projects lacked a robust focus on the COVID-19 scenario, they appeared to be framed to be in line with the existing World Bank CPF and emphasized the initially identified areas of priority at the start of the project period, albeit somewhat modified in line with prevailing realities. The present analysis looks at the focus of the existing interventions being planned for education.

1.   Ensuring Equity and Non-Discrimination

Education is a universal right that applies to everyone equally without discrimination. However, discrimination often results in significant numbers of children missing out on school or receiving an inferior quality of education. At the same time, international human rights law provides for special protection of the right to education for marginalized groups including girls and women, national ethnic and linguistic minorities, persons with disabilities, indigenous people, people living in poverty and a whole host of other categories.[115] The World Bank Groups Education Strategy 2020 is reported as placing equity at its heart. Explicit instructions have been given to country teams for ensuring the inclusion of persons with disabilities, indigenous peoples and sexual and gender minorities.[116]

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[115]
https://unesdoc.unesco.org/in/documentViewer.xhtml?v=2.1.196&id=p::usmarcdef_0000366556&file=/in/rest/annotationSVC/DownloadWatermarkedAttachment/attach_import_2691991b-d5ca-4449-a0c6-0f638a350b19%3F_%3D366556eng.pdf&locale=en&multi=true&ark=/ark:/48223/pf0000366556/PDF/366556eng.pdf#1474_19_ED_handbook_right_to_ED_INT_E.indd%3A.48984%3A499

[116] https://documents1.worldbank.org/curated/en/590781562905434693/pdf/Equity-and-Inclusion-in-Education-in-World-Bank-Projects-Persons-with-Disabilities-Indigenous-Peoples-and-Sexual-and-Gender-Minorities.pdf

Despite this global recognition, **the World Bank's CPF assumes that "issues of education access and gender balance have largely been resolved in India, but the pervasive low quality of education has led to poor learning outcomes"** (CPF). This overwhelming emphasis on quality despite the reality of a highly unequal education system risks ignoring the underlying social and economic reasons responsible for the learning levels. Given the right to equality for all, it would also be critical to examine how the impact of wealth inequalities on education is addressed and redressed through these projects.

All the projects for which detailed information is available **have included a focus on girls, persons with disabilities and indigenous people in line with the explicit focus on these groups by the World Bank**. Most projects do not include other categories in their framing. Thus, **despite Muslim religious minorities being educationally disadvantaged, none of the World Bank projects included an explicit focus on the same**. **Dalits** are a category recognized to be discriminated against in India's constitution, but the specific focus on this category is only **included in the framing of three projects**. Discrimination based on caste is an explicitly prohibited category covered by the category of occupation and descent[117]. The EU parliament has recently called for an EU policy to address caste discrimination[118]. Regional disparities and the differential experiences of the rich and poor children are not included in most projects. As the accompanying table shows, only a subset of these projects has explicitly spelt out strategies to address the problems identified.

STATUS OF EDUCATION AMONG MUSLIMS & DALITS

Literacy rates among Indian Muslims are the lowest among all socio-religious communities in the country[119]. Muslims form the highest proportion of youth and young adults who had never enrolled in any formal education programs. Muslims also have the maximum proportion of school dropouts; the probability of a Muslim student discontinuing school is almost twice that of Hindus. They comprise 14% of India's population but account for 4.4% of students enrolled in higher education, according to the 2014-'15 All India Survey on Higher Education[120]. Despite this evidence, regular data on the educational progress of Muslims has been limited with official statistics rarely reporting on Muslims.

Dropout among Dalits remains high in the face of a centuries-long legacy of discrimination. 18.64% of Dalit students drop out at the secondary level[121]. The poor educational status of Dalits is due to both social and physical factors. The extreme poverty in which most Dalit families live is another underlying reason why the drop-out rate of Dalit children is so high. India has just one secondary school for every 10 Dalit dominated villages and the chance of getting a new one drops from 75% at the primary level to 9% at the secondary level in Dalit/Adivasi dominated villages[122]. This is likely to affect girls from within these communities. Due to the unwillingness of higher-caste groups to live side by side with Dalits, Dalit families often live in remote areas, away from the main villages and schools. This residential pattern has two major implications. Firstly, the location of schools within the main villages, and hence within higher caste areas, makes it difficult for Dalit children to gain access to schools, due to caste tensions. Secondly, the great physical distance to schools often results in Dalit children dropping out, as the distance is simply too far to walk on an everyday basis.[123]

An even smaller fraction of the project documents includes **disaggregated impact indicators**. If the differential impact on specific socially and economically excluded groups is not built into the project design or captured, it is not clear how the specific experiences of these communities would be recognized.

[117] https://www.ohchr.org/sites/default/files/Documents/Issues/Minorities/GuidanceToolDiscrimination.pdf
[118] https://idsn.org/press-release-european-parliament-calls-for-an-eu-policy-to-address-caste-discrimination/
[119] https://timesofindia.indiatimes.com/india/literacy-rate-for-muslims-worse-than-sc/sts/articleshow/77514868.cms
[120] https://aishe.gov.in/aishe/home
[121] https://news.careers360.com/udise-plus-education-minister-ramesh-pokhriyal-nishank-school-dropout-sc-st-obc-class-10
[122] https://timesofindia.indiatimes.com/india/how-caste-determines-where-a-school-will-be-set-up/articleshow/80684878.cms
[123] http://dalitmarch.org/discrimination-education.html

In contrast, the World Bank's guidance on inclusion lay down some general indicators for evaluating inclusive education for disadvantaged learners which have not been adequately used.[124]

All projects' impact is disaggregated by state/district of intervention. **Few projects**, however, **explicitly state that they would aim to address inequalities in inputs and outcomes either between or within states**. Thus, GOAL is one of the rare projects that go further and prioritizes addressing within-state disparities. The framing of the priority districts also included an explicit focus on tribal districts (particularly those with particularly vulnerable tribal groups), border districts and those with geographically difficult/hard-to-reach terrain.

	The extent of focus on issues of equity and inclusion (six projects[125])					
	Girls [126]	Persons with disabilities	Indigenous people	Dalits	Muslim minorities	Differential experiences of rich/ poor
Recognized in social impact analysis	6	5	6	4	0	0
Remedial Action planned for	5	4	4	2	0	0
Whether any indicators disaggregated	2[127]	0	3	3	0	0

The subsequent section looks at the way that different groups of social exclusion and discrimination are captured in project documents.

Gender-based inequalities

The gender problem analysis in all projects is relatively strong and all projects make robust recommendations, particularly for adolescents. Some of the challenges to girls' education recognized include School-Based Gender-Based Violence (SBGBV included in GOAL, NECTAR, STARS, SALT), early dropout (ASPIRE), early marriage and unpaid care work (GOAL, SALT), low expectations and regressive social norms (Work, STARS, ASPIRE), limited employment rates of women (Work, STARS) and insufficient and non-gender-disaggregated facilities in the institutions (STARS, NECTAR, ASPIRE). SALT and ASPIRE also include a component of addressing the early formation of gender stereotypes in early childhood and early grades. ASPIRE explicitly prioritizes the collection of gender desegregated data.

Some of the specific activities being planned to address the above include:
a) Focus on adolescent girls including Life-skill training (NECTAR and GOAL), vocational counselling (NECTAR) and job-oriented skills and entrepreneurship training (GOAL)
b) transport facilities/vouchers (GOAL)
c) targeted school-level planning and monitoring of enrolment and attendance rates of girl students (GOAL) and interventions to prevent dropout of girls from marginalized communities (ASPIRE)
d) community-level behaviour change campaigns against early marriages (GOAL)
e) develop a referral mechanism to monitor instances of school-related gender-based violence by engaging the community through regular sensitization (GOAL) and anonymous reporting (NECTAR)
f) promoting STEM-related job roles for girls (NECTAR)
g) reshape teachers' gender biases (NECTAR, SALT) and undertake teacher training on gender and socially inclusive education (ASPIRE)
h) reshape gender attitudes of children and adolescents themselves (SALT, NECTAR)

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[124] https://documents1.worldbank.org/curated/en/590781562905434693/pdf/Equity-and-Inclusion-in-Education-in-World-Bank-Projects-Persons-with-Disabilities-Indigenous-Peoples-and-Sexual-and-Gender-Minorities.pdf
[125] GOAL 1 and 2 are being counted as a single project
[126] ASPIRE has only one DLI with gender explicitly built into the name of the indicator. However, out of the nine DLIs, eight incorporate specific gender targets or measures to improve female opportunities in learning or in the state education system.
[127] Only GOAL and ASPIRE

i)   supporting girls-only residential schools (ASPIRE)
j)   sex-segregated sanitation facilities in intervention schools (ASPIRE)
k)   capacity development of woman teachers, school leaders, state councils of educational research and training, district institutes of education and training, and field staff (ASPIRE)
l)   Ensuring all learning-teaching contents are gender-inclusive (ASPIRE)

While the focus on the education of girls is welcome, it would be critical to recognize and address the various intersectionalities between gender and other forms of exclusion and ensure educational systems are transformational for girls who come from marginalized communities. A more coherent strategy to address the specific barriers to the education of Dalit, Adivasi and Muslim students would be critical, not only in its own right but also to ensure universal completion of girls.

At the same time, it would be critical to remember that the **right to free education only extends to lower secondary education** in India. In view of this, it is unfortunate that the financial barriers to secondary and early childhood education have not been explicitly addressed.

When it comes to **transgender children** as a category, the ESSA for GOAL and SALT merely mentions that this is a priority category under the NEP/Samagra Shiksha; neither project includes this category in the main PAD of the project.

Social Inclusion and wealth inequalities

Unfortunately, the mention of other horizontal inequalities is cursory across the documents. While the impact on indigenous groups has been included in all World Bank projects as part of the statutory indigenous people assessment, other excluded groups are barely mentioned. This is in contrast with the World Bank Directive on Addressing the Risks and Impacts on Disadvantaged or Vulnerable Individuals or Groups[128] Directive establishes its responsibility to identify and mitigate risk and impacts on any group or individual identified within its operation that may be disadvantaged or vulnerable. ADB's ASPIRE is positive in committing the project to a specific focus on ensuring retention of girls from marginalized communities, teacher training on socially inclusive education, ensuring teaching-learning contents are socially inclusive and ensuring that all state MIS and monitoring data is segregated by social category.

None of the active projects explicitly address discrimination or correct educational inequalities between the rich and the poor in these states. There is a **lack of commitment across the entire gamut of projects to ensure schools are free** (including free from any hidden charges and not just tuition fees); no projects explicitly address financial barriers to accessing school. While schooling is free in government elementary education, fees remain barriers at secondary level. At the same time, it would be critical to ensure that **private schools which receive support through IFI funds are free**. The World Bank's IFC has recently decided to not resume its investment in fees charging K-12 schools[129]. This principle should be extended to the non-commercial investments of the IFIs as well.

Social group and class as determinants of education in India

Educational attainment increases with household wealth. In India, women and girls in the lowest wealth quintile have completed a median of 0 years of schooling, compared with a median of 9.1 years for females in the highest wealth quintile[130]. At the same time, the quality of education available to the rich and poor is grossly unequal in India. While elites can afford to purchase the best of education in elite fees-paying private (or even

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[128] https://ppfdocuments.azureedge.net/9598117e-421d-406f-b065-d3dfc89c2d78.pdf
[129] https://ieg.worldbankgroup.org/evaluations/evaluation-international-finance-corporation-investments-k-12-private-schools-7
[130] http://rchiips.org/nfhs/nfhs-4Reports/India.pdf

> public) schools, the poor are often relegated to low-quality government schools that have been set up to service remote rural areas and urban slums. Privatization and commercialization of education have exacerbated educational inequalities in India.

None of the projects, furthermore, explicitly prioritize **ensuring universal secondary completion, addressing child labour, staffing and adequately resourcing all schools** (to the levels of Kendriya Vidyalaya and Navodaya Vidyalaya schools given their recognised superior performance), **mainstreaming mother tongue-based multi-lingual education and address the needs of migrant families**. GOAL II, states that some planning would be done for "language related issues" based on the need assessment in tribal areas, but no details are currently available.

Indeed, while most projects flagged the absence of multi-lingual education as being of particular significance for tribal communities (GOAL, SALT, STARS), no specific steps are discernible to address it in any intervention. Difficult terrain is flagged as a challenge (GOAL, SALT) which appears to be largely addressed through promoting residential provision. Residential modes of delivery of education for indigenous learners have been proven to be highly problematic in a range of contexts[131]. STARS includes a broad intention to ensure that a share of Teacher Education Institutions could be selected from aspirational districts/Educationally Backward Blocks which may be expected to result in more teachers conversant with the local culture, but no mechanisms are being envisaged for including tribal culture and traditions in the curriculum. [132]

Some steps to strengthen ownership of schools by historically marginalized communities have been envisaged. Thus, STARS includes an emphasis on building capacity and ownership of SMCs from areas with high tribal populations (Schedule V areas) to encourage community-driven management of schools and bridge gaps in administrative delivery of education. GOAL prioritizes the inclusion of indigenous people in the planning process. However, the interventions fail to build a true two-way connection between the school and the community by apparently placing more emphasis on community awareness building (GOAL), monitoring of learning outcomes and addressing grievances related to construction (SALT) and training of BRCCs/CRCCs[133] to "deal with local circumstances" (GOAL) instead of addressing head on the **issues of identity and dignity** that may be of concern to the communities themselves.

When it comes to the other groups, the mention is even more passing. The social impact analysis of GOAL barely mentions that SCs are prioritized under SMSA and that their inclusion would accordingly need to be prioritized through the training of concerned officials. ASPIRE flags the intention to pay special attention to Dalits and Adivasis and monitor progress for these social categories. SALT and STARS highlight that SCs lag behind their peers and need to be prioritized. WORK recognizes limited digital access in tribal blocks as part of the context analysis, recognizes the risk of exclusion in Dalit-Adivasi dominated blocks and recommends targeted awareness generation, digital mapping exercises and adoption of low-cost technologies. ADB's ASPIRE highlights the need for specific planning to prevent dropouts of Dalit and Adivasi communities, ensure that all content is socially inclusive and undertake teacher training for socially inclusive education.

Overall, **few clear pro-equity measures have been spelt out to address intergenerational, social and economic barriers to the education of Dalits, Adivasis and religious minorities.** Given India's history of

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[131] https://thewire.in/education/can-india-learn-from-canadas-dark-history-of-residential-schools-for-indigenous-children

[132] https://documents.worldbank.org/en/publication/documents-reports/documentdetail/107941591127035009/final-fiduciary-systems-assessment-strengthening-teaching-learning-and-results-for-states-p166868

[133] Block and Cluster Resource Persons. Block Resource Centres (BRCs) and Cluster Resource Centres (CRCs) were established in each block of every district by the government to conduct in-service teacher training and to provide academic support to teachers and schools on a regular basis as well as to help in community mobilization activities.

social stratification based on caste, a successful inclusive intervention needs to address intergenerational, social and economic barriers to their education.

Given the evidence that both learning and completion are linked to family income[134], these projects **need to have a more coherent strategy to correct educational inequalities between the rich and the poor** in these states. This would entail a more conscious strategy for addressing familial poverty and the provision of scholarships and other incentives to students to ensure completion. More conscious efforts to support a reading culture in the home including the availability of libraries and learning materials would be important to overcome intergenerational disadvantages. A clear strategy for addressing child labour would be critical to the success of the intervention.

Addressing out of school and strengthening Remedial Teaching:
Few steps to bring out of school children into school are discernible. STARS and ASPIRE propose the creation of a gender-disaggregated baseline of dropouts, but such explicit measures are infrequent. While this may not have been prioritized during the framing of the CPF, addressing this is critical in the COVID context. In a recent survey, the Odisha government found that 30% of students have failed to return to school post the pandemic[135].

A few projects include a focus on remedial teaching for those who fail to achieve desired learning outcomes. ASPIRE is an exception by including a strong focus on reducing dropouts at the secondary level. GOAL I & II emphasize strengthening remedial teaching including the development of remedial class materials to assess progress, development of digital self-learning courses, undertaking afterschool and summer camp-based remediation and situational analysis of remedial teaching to identify gaps in capacity. SALT proposes the piloting of a technology-enabled PAL system in about 700 residential schools for tribal learners and girls from marginalized communities and poor families. As such it is expected to reach over 140,000 students and provides some customized remedial learning to children with partial teacher supervision.

2. Concrete Steps to Support Teachers
Quality learning cannot happen without good teaching. Good teaching is, in turn, predicated on the availability of high-quality candidates for teaching, who receive high-quality initial teacher training and then support across their careers. Teachers are the most important educational resource and determinant of the quality of education. Having professionally qualified, trained, supported and motivated teachers are at the heart of the educational endeavour. No educational system can be better than the quality of its teachers.

Indeed, **all projects have included steps to build the capacity of teachers, principals, and local officers and invest in teacher training**. This has included a welcome focus on strengthening teacher training institutions, but not pre-service training. Some of the actions include:
- Strengthening teacher training institutions including DIETs, SCERTs and SIEMETs (STARS, SALT, GOAL, NECTAR, ASPIRE), construction and operationalization (with 75% staff) of five DIETs (GOAL II).
- Design teacher policies, tools and standards[136] to ensure teacher accountability (NECTAR, GOAL) including data on teacher presence in classrooms (NECTAR).
- Improve teacher's knowledge by reducing the number of grade-level learning competencies identified for critical teacher training (GOAL II)

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[134] https://www.oecd.org/education/school/50293148.pdf
[135] https://www.indiatoday.in/education-today/news/story/odisha-govt-finds-that-30-students-failed-to-return-to-schools-post-pandemic-1949988-2022-05-16
[136]such as teacher competency-based standards; teacher development strategies; standards, curricula and training for school leadership development and for data collection and assessments.

- State-level agency designated to carry out periodic teacher training needs assessments, a system created for teachers to record their training needs and 30% of teachers provided with needs-based teacher training (GOAL II)
- Develop and implement specific solutions for improving need-based teacher professional development[137] (ASPIRE), school-based learning and peer-to-peer learning for teachers; (SALT) and facilitating peer learning by leveraging social media (STARS).
- Provide training on specific aspects of education provision and management, including resilience of education to climate change; environmental and social aspects and gender; career development; relationship with the communities and role in infrastructure, development and maintenance; (NECTAR), leadership skills and disaster risk management; (SALT).
- **Technology use for teacher management and education** (STARS) or use of blended modes (ASPIRE). Ensuring that additional DIETs in Gujarat are strengthened with minimum basic package of digital infrastructure to deliver online professional development for teachers
- Developing and curating resources for use by teachers (STARS, NECTAR, ASPIRE). The use of DIKSHA is also prioritized in most interventions.
- Save teacher time through technology portals to managing student data (STARS),
- Hiring teachers in mainstream schools (SALT) or the specific type of schools supported through the intervention (ASPIRE).

The commitment to strengthen the infrastructure of teacher training institutes at district and sub-district levels and the intention to ensure need-based teacher training is appreciated. However, the **omission of pre-service teacher training is somewhat disappointing**. Given the shortage of teachers in India, it is also **disappointing that only one project explicitly commits to hiring teachers in mainstream government schools**. In **early childhood education, in particular, failing to address the question of the shortage of teachers risks putting the entire strategy at risk**.

Overall, **too many of the projects view teachers as people who are to be 'monitored', 'managed' and whose 'capacity has to be built, to improve learning outcomes' and not catalysts of change**. They are not seen as independent, autonomous individuals capable of making their own decisions within the classroom. Most projects include measures to create performance standards for teacher management and evaluation without spelling out concrete measures of how educators will be involved in determining what they should be evaluated on. Similarly, **no explicit measures to make teaching an attractive career or adequate steps whereby teachers will be treated as respected professionals are visible**.

3.Ensuring Quality of Education:
For ensuring quality, a sufficient number of qualified teachers need to be provided with the necessary tools to be effective and instruction should happen in a conducive environment.

Quality tools:
Teachers need to be equipped with appropriate curricula, learning assessments, inclusive teaching and learning materials and resources, including but not limited to digital tools.

Improving learning assessment: A significant priority of the WB's work on quality education is strengthening national learning assessment mechanisms. This is reflected in a strong focus on strengthening learning assessment in a range of its projects.

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[137] Through On-site teacher training, on-site and remote individual coaching, and an online repository of materials

- Nationally: India's participation in the next round of PISA, setting up of an independent National Assessment centre to manage participation and support for building capacity to develop technical standards for national assessments, refine development, administration and analysis capacities (STARS).
- At the State level:
  o Creation and strengthening of assessment cells/state assessment in States (STARS, GOAL, SALT, ARISE)
  o Participation in PISA 2028 (GOAL)
  o Enhancing the capacities of teachers to undertake and use data from formative assessments (STARS, NECTAR)
  o Creation of online question banks (STARS)
  o Creation of a technology-enabled assessment platform for teachers to create assessments and handle data (STARS, GOAL[138])
  o Improving the quality and utility of assessments to identify individuals in need of remedial support (STARS, SALT, GOAL[139]) and deliver more targeted remedial learning programs
  o Strengthening school leaving certificate examination (NECTAR)

While supporting teachers to understand the current learning levels of students and enabling them to fine-tune instruction to better reflect current learning gaps is critical, the **heavy emphasis on standardized learning assessments discernible across some of the projects appears to misdiagnose the causes of poor student performance**. There appears to be an assumption that one of the root causes of poor learning outcomes in India, is the inadequate availability of data on learning outcomes. This diagnosis, in turn, implies that having a strong system of assessment and accountability will result in good teaching, good governance, and therefore good student performance.[140] However, in reality, **poor learning outcomes of India's students are tied to historical, cultural and economic aspects of its society which disadvantages students from marginalized backgrounds**[141,142]. This approach, furthermore, also ignores **evidence of the failures of similar testing-based accountability-based approaches in improving learning and reducing inequities** both in 'mature economies' where competency-based assessments, psychometric expertise, and incentive-based governance have been promoted for decades without results.[143] Efforts would have been better invested in **addressing the factors responsible for poor learning such as reliance on non-mother tongue-based instruction, addressing the discriminatory hidden classroom curriculum (including caste-based discrimination and teachers holding low expectations from children from marginalized communities), absence of home support from neo-literate parents, classroom hunger** and other factors.

Curriculum and teaching and learning materials: Several projects include a focus on the development of teaching-learning materials and refinement of curricula, especially as they apply to early childhood and vocational education. Project ASPIRE has an explicit focus on supporting Learning Enhancement Programmes and curriculum resources at primary and secondary levels. The focus at the primary level

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[138] Technology assisted Periodic Assessment Tests (PATs)

[139] Diagnostic test Nidaan Kasauti

[140] Gorur, R. 2017. Towards Sustainable, Collective and Participatory Accountability in Education 2030. (Background paper for Global Education Monitoring Report 2017/8)

[141] https://www.researchgate.net/publication/292502567_Dalit_and_adivasi_in_schools_Some_preliminary_research_themes_and_findings

[142] https://www.jstor.org/stable/23528806

[143] Valverde, G. A. 2014. "Educational Quality: Global Politics, Comparative Enquiry, and Opportunities to Learn." Comparative Education Review 58 (4): 575–589

will be on foundational literacy and numeracy, while the focus for secondary education would be on 21st Century and vocational skills. Support would likewise be extended for the development of digital learning content, including local language translations, to promote their use in schools, homes, or distance learning media. GOAL II likewise includes a component of making teaching-learning material for learning enhancement available in project schools.

Quality Environment

Quality environment for teaching and learning which is supportive, comfortable, safe and secure, having appropriate facilities to encourage student learning is essential to ensure learning and creates an environment where parents, students, teachers, other staff and administrators can come together for the common goal of ensuring quality education for all students. ASPIRE will support the development of national standards of quality for use by the states.

New Schools: GOAL provides for the setting up of schools of excellence, including at least 150 residential girls' schools (KGBVs and girls' hostels) and up to 500 residential schools for socio-economically disadvantaged students. At least one Emerging School of Excellence may be established in each cluster and act as a hub that would cater to two to three Aspiring Schools of Excellence (spokes) for capacity building and other quality reform initiatives. However, the Environmental and Social Assessment document suggests that this opening or up-gradation of schools will be **accompanied by consolidation or permanent closure of small, low-enrolment schools**. As such, it is not clear whether this would result in the true enhancement of school capacity. While it proposes to close government schools, it also includes support to 5,734 private aided schools under the Emerging or Aspiring Schools categories.

Studies into the impact of mergers show they decrease enrolment. Rajasthan, one of the first states to consolidate schools at scale, saw a 7% fall in enrolment in consolidated schools (compared to 1.4% for the rest of the states). The move hit children with disability hardest, contributing to a 22% decline in enrolment. Girls were 4% more likely to drop out than boys. Dalit and Adivasi students were hard hit. Villages which have 'small' schools are more disadvantaged in terms of essential public services such as all-weather roads and government health facilities or banks and post offices. [144]Additionally, these villages are less likely to have an alternative to the 'small' school, either government or private. Accordingly, schools likely to be closed are likely to be the poorest and doing so will deprive children of already marginalized and excluded communities of access to nearby alternatives.[145] Research shows that despite differences in facilities between small and larger schools, there are no differences in eventual learning outcomes between them. **School closure risks hardship and risk dropouts without demonstrating significant improvement in learning or quality of education**.[146]

Project ASPIRE likewise seeks **to establish 1,800 exemplar schools in its five intervention states**. These schools are intended to have upgraded learning facilities, sex-segregated sanitation facilities, digital laboratories and learning resources and have core subject teachers and are supposed to serve as demonstration sites for innovative teaching and learning practices. It would be critical to note, however, that India has 1.5 million schools and it is unclear whether a significant impact would be achieved by enhancing the infrastructure in under 1% of schools. This investment would not have a significant impact

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[144] https://accountabilityindia.in/wp-content/uploads/2019/08/School_Consolidation_Rajasthan_Final-.pdf
[145] Ambrish Dongre, Vibhu Tewary, Pain without gain?: Impact of school rationalisation in India, International Journal of Educational Development, Volume 72, 2020, 102142, ISSN 0738-0593
[146] Ambrish Dongre, Vibhu Tewary, Pain without gain?: Impact of school rationalisation in India, International Journal of Educational Development, Volume 72, 2020, 102142,ISSN 0738-0593

on education in India but exacerbates inequality. All schools need to meet the minimum standards of the RTE Act and not just exemplar schools. Official statistics suggest that barely 25.5% of schools in India meet these minimum norms[147].

Furthermore, this is not the first time that the government has sought to set up schools of excellence to trigger demonstration effects. A Scheme for setting up 6,000 Model Schools to serve as a benchmark of excellence was launched in 2008,[148] albeit that had a strong emphasis on establishing schools in PPP mode. It was transferred to the states for implementation in 2015 pending review.[149] At the same time, other elite government schools like Kendriya Vidyalayas are already in existence. It is unclear how a different result would be achieved by creating exemplar instead of model schools.

Improving school infrastructure: Most of the World Bank's state-specific projects propose steps to **enhance specific components of school infrastructure including physical infrastructure and facilities** (SALT and GOAL) and **digital infrastructure** (NECTAR, GOAL). ASPIRE will also intervene to improve facilities in schools, albeit with a focus on the exemplar schools. The specific actions proposed include:
  - SALT: Includes an explicit focus on school facility up-gradation to ensure adherence with minimum infrastructure standards in schools.[150]
  - GOAL: Improving the availability of digital devices in schools, recommended architectural layouts and enhancing the resilience of school buildings.
  - GOAL 2: Labs (computer/digital infrastructure, STEM, environment), teaching learning material for learning enhancement, improved building infrastructure (classrooms, labs, library space, garden, playground), sporting facilities and in-schools resource rooms for children with special needs. Incentives to enable 250 additional schools with meeting minimum performance criteria that are context-specific and the development of 25 additional Lighthouse schools in Priority Districts
  - NECTAR: development of infrastructure including electricity, network, hardware and software, tools for offline use, maintenance and service plans, as well as content and educational resources; enhancing human capacity to effectively access and use digital teaching and learning resources through providing technical assistance and carrying out pilots to improve the capacity of teachers and learners and strengthening data collection and monitoring of progress in terms of deployment and effective use of ICT in education. Indeed, NECTAR alone specifically mentions an intention to equalize opportunities for digital learning and provision of additional support to those (teachers and learners) who may be disadvantaged.
  - ASPIRE: improve learning environments in schools with adequate facilities, resources, and required subject teachers and create and adopt digital learning contents appropriate for local contexts and in local languages.
  - STARS: Developmentally appropriate curricula, standardized teaching-learning materials kits and classroom layouts for early childhood education, enhancing the availability of resources for learning enhancement activities and the use of technology for teacher training.

3. Addressing the Needs of the Specific Sub-Sectors of the School Education System

Improving delivery of Early Childhood Education: Most World Bank projects include a focus on Early Childhood Care and Education (ECCE) and foundational learning (KG to Grade 2). While ADB's ASPIRE mentions the intention to engage with issues of early childhood education, the focus appears to be more on primary and secondary education. The nature of interventions included the following:
  - Aligning preschool and primary grade curriculum, materials, and pedagogy recognizing the unique needs of each stage, but also establishing a pedagogic connection between early

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[147] Lok Sabha Unstarred Question No. 2186 to be answered on 01.08. 2021. Compliance of RTE guidelines.
[148] http://pibmumbai.gov.in/English/PDF/E0000_H112.PDF
[149] http://download.ei-ie.org/Docs/WebDepot/Srivastava%202016%20CED%20Proof.pdf
[150] re-establishing the structural integrity of buildings in cyclone and flood-prone areas, facilitate climate-resilient adaptations to facility design/specifications, and facilitate a switch to energy and water-efficient fixtures.

childhood and school education. This includes the development of teacher training packages (SALT, GOAL, STARS[151]), teacher training for Anganwadi workers[152] (SALT) and early grade schoolteachers (GOAL, SALT), provision of standardized training and learning materials (GOAL, SALT[153], STARS) and development of enhanced classroom layouts (STARS).

- Learning assessment- including setting learning competencies/standards (GOAL)
- One year of preschool education in 3,599 schools in 66 Integrated Tribal Agency Blocks (ITDA)/tribal blocks including extending teacher training and teaching learning material support (SALT) and 1,000 additional schools in Gujarat (GOAL)
- Upgrade school infrastructure for ECE (SALT and GOAL) and infrastructure repair (SALT)
- Strengthen ECE quality assurance through accreditation and monitoring (GOAL, STARS)
- Develop a mid-term state strategic plan for expanding preschool at primary schools – development of the ECE model (GOAL)
- Development of parent engagement strategies to build awareness about the importance of ECE (STARS) and to promote enrolment and retention of children (SALT).[154]

While the increased emphasis on the early years and the plans to develop new curricula and materials is welcome, the specific focus in the projects misses addressing the real challenges of this sub-sector. Few projects include concrete measures for ensuring uniform standards of quality in early childhood education in India or the project states. **At the heart of the problem of quality in early childhood education** is not the absence of early childhood education curricula, but the **failure to develop and enforce minimum standards of quality**. India's National Education Policy lists four pathways for delivering ECCE for the age group 3-6 years i.e. (a) standalone Anganwadis; (b) Anganwadis co-located with primary schools; (c) pre-primary schools/sections covering at least age 5 to 6 years co-located with existing primary schools; and (d) stand-alone pre-schools. This multiplicity of ill-defined pathways having their diverse quality standards is also reflected in the WB's projects. Most early childhood education delivery happens through the ICDS system where the single Anganwadi worker finds preschool education to be only one of the six services she is accountable for; she is also not trained up to professional preschool teacher standards. While the introduction of preschool education in 3.500 schools under SALT is appreciated, it is far from being delivered universally, the project document is silent about the continued existence of preschool delivery in Anganwadi centres in the state.

Strengthening Technical and Vocational Education
Strengthening vocational education is part of two World Bank projects- STARS and Work which aim to enhance the school-to-work transition process for students by strengthening in-school vocational education delivery mechanisms. The World Bank also supports the Ministry of Skill Education and Development through the WBG Skill India Mission Operation (SIMO) and WBG Skills Strengthening for Industrial Value Enhancement (STRIVE) which supports the Industrial Training Institute strengthening. ADB's ASPIRE program seeks to introduce science, technology, engineering, arts and mathematics (STEAM), vocational, and 21st-century skills learning for secondary students. Some of the specific activities being supported include:

- Development of state-specific STEAM education interventions. (ASPIRE)
- Development of National and State Curriculum Frameworks on STEAM. (ASPIRE)
- Awareness and advocacy on vocational skills including needs assessment and campaigns to showcase the potential of vocational career education. (Work, STARS)

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[151] STARS' PAD explicitly states that this would be an e-learning platform
[152] Anganwadi is a type of government supported child care centre in India. They were started by the Indian government in 1975 as part of the Integrated Child Development Services program to combat child hunger and malnutrition. Anganwadi means "courtyard shelter" in Hindi. The Anganwadi Woman is employed to provide additional and supplementary healthcare and nutritional services to children and pregnant women and deliver early childhood education.
[153] Apparently only in tribal schools
[154] SALT's emphasis is on tribal blocks alone

- Creation of 100 hub schools where students can gain hands-on experience. (Work)
- Creating e-content for the 21st Century and vocational skills for grades 6-12 and teacher training (Work).
- Career counselling initiatives. (STARS)
- In-school vocational education and market relevance. (STARS)
- Creation of gender-disaggregated baseline of dropouts and specific actions targeting girls for life-skills training for adolescent girls and vocational education in domains that are considered to hold potential for women to become economically productive. (STARS)
- Measures to promote vocational education for marginalized communities, Educationally Backward Blocks (EBBs) and aspirational districts. (STARS)

While the **introduction of STEAM education is a positive measure, the introduction of vocational education and career counselling in secondary education risks streaming children from poor families (and marginalised communities) into vocational education instead of other more academic pursuits**. This would also be expected to reiterate existing gender and social identity-based stereotypes. Instead of considering this to be a risk, the STARS PAD flags that vocational education would be particularly critical for children from marginalised communities and in remote areas. This runs counter to the existing literature that warns against the negative equity impact of early streaming.[155]

4. Strengthen Citizen Voice in the Education System

Several projects included some measures for enhancing community participation in public education. This has largely included work with existing structures for community participation like the SMCs or Parent Associations (in AP), but also strengthening processes of planning and social audits within the system. Some of the specific actions have included

- Building capacities of SMCs through training on their role in school infrastructure development and maintenance and improving ownership of the public system (NECTAR), development of standard operating procedures streamlining interplay of SMCs/SMDCs with district administration, designing and extending Performance Incentive Grants to School Management Committees SMCs/SMDCs (NECTAR).
- Strengthen Annual Work Plan and Budget processes (AWPB) processes to ensure better alignment with the School Development plans (SDPs) Between GOAL I and II, the plan is to strengthen decentralized planning in 18 districts. (GOAL II)
- Improved training of School Management Committees (SMCs). 20 percent of SMCs in Priority Districts will be supported for the development of evidence-based SDPs, increasing the net coverage of SMCs trained under the GOAL Program from 50 to 70 percent (GOAL 1 and 2). This will entail training of district and block-level teams regarding stakeholder community-led planning and plan appraisal for enhancing accountability through stakeholder empowerment and includes engagement with representatives from NGOs, tribal populations and disabled persons along with a focus on improved Management Information Systems (MIS) and accountability systems through the use of technology.
- Development and implementation of social audit tools (SALT, NECTAR).
- Establishment of village-level inter-departmental committees in select blocks to monitor instances of early marriages, drop-outs, and physical and/or sexual harassment of girls (SALT).
- Support for mitigating school-related gender-based violence, including through training of teachers, administrate officials and Parent Committees; creation of a web portal for reporting of grievances; and creation of a holistic identification, response, and redressal system (SALT) and strengthening grievance redress mechanisms to address SRGBV (GOAL, NECTAR).
- Training to SMCs/SMDCs with a focus on their role in school infrastructure development and maintenance (NECTAR) and improving ownership of the public system (NECTAR).

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[155] https://www.oecd-ilibrary.org/docserver/9789264130852-sum-en.pdf?expires=1649520057&id=id&accname=guest&checksum=91F223F513760A91FF82E1A4E5730D70

The **focus on community participation is welcome**. However, there is **no substantial new devolution of funds and decision making to communities in these projects**. it is not clear what new measures are being considered or how these activities will learn from existing experiences of similar measures. A clearer focus on strengthening these structures and processes and robust innovations to address questions of capacity would be welcome.

5. Other Governance Reforms

An overarching focus of the work is the systematic transition towards the creation of school complexes under the National Education Policy (SALT, NECTAR, Work, ASPIRE[156]); the specific roadmaps being adopted are, however, fairly different. At the same time, efforts are also made to support planning, monitoring and social accountability processes. More specifically, the focus under the projects includes

- **Planning**: Support for state and district-level educational institutions to develop results-oriented annual work plans and budgets (SALT, GOAL, ASPIRE) including through community participation.
- **System Monitoring:** Strengthen monitoring and evaluation processes, make these more accurate (ASPIRE), client-centred, ensure data protection, security and privacy provisions. At the same systems and capacities of functionaries will be enhanced to utilize them (NECTAR) and strengthen system-level assessments (SALT) undertaken; ASPIRE seeks to strengthen MIS for efficient management of the state educational system.
- **Strengthening fiduciary systems:** Risk assessments of several World Bank-funded projects have rated the Integrated Fiduciary Systems Assessment (IFSA) risk to be substantial, largely given limited staff at the state and district levels. Accordingly, most projects have included steps to improve financial systems at the state level. At the same time, critical vacancies at the state level have been flagged as risks to the implementation and substantiality of programs; it is hoped that these problems would be addressed going forward.
- **Strengthening effectiveness of middle management**, comprising district and sub-district education personnel through capacity-building classroom observations, LEP monitoring, mentoring and support to school management staff, and promotion of community engagement (ASPIRE). It would also include knowledge-building on environmental management, climate change, disaster management, the gender-differentiated needs of female and male students, as well as monitoring of SRGBV issues in collaboration with SMCs and SMDCs. (NECTAR).

Decentralising decision-making requires the devolution of funds and real decision-making power. This requires not just investment in the capacity of front-line and mid-level bureaucracy, but also in **increasing their discretionary powers**[157] **while fostering social accountability**. This, in turn, calls for a higher level of trust. **Trust and in turn collaboration across different levels within the administration, are entirely ignored in these projects**. Spaces for these more equal relationships were conspicuously absent. At the same time, true mechanisms for building the capacity of the system from within through building capacities of existing structures for delivering system support (viz the Cluster and Block resource centres) and teacher training (e.g. District Institutes of Education and Training) are lacking.

6. Role of Non-State Actors

Four of five World Bank-funded projects[158] included some role for non-state actors in the **delivery of core functions of education in line with its stated strategy**. This has included multiple forms including

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[156] ASPIRE seeks to "develop quality government schools as leader schools across each state"

[157] says the World Bank's research arm: "Designs that do not address the trust deficit will miss an opportunity to use economic theory and research to build trust in public institutions at a time when it is urgently needed" (https://openknowledge.worldbank.org/bitstream/handle/10986/33663/Strengthening-Public-Health-Systems-Policy-Ideas-from-a-Governance-Perspective.pdf)

[158] Other than NECTAR

a) non-state actors taking on running of schools either by taking over existing government schools (STARS, GOAL), supporting existing non-state schools (GOAL, STARS, SALT) or fostering school choice (STARS),
b) outsourcing some components of specific services like teacher training, school leadership or assessment (GOAL, Work, STARS, SALT) or ICT/distance education (STARS)

Two projects, additionally seek to promote the role of civil society in social accountability, social dialogue and engagement with citizens at large (work transitions and NECTAR). ADB's project ASPIRE does not explicitly refer to the promotion of non-state actors in education delivery or adopting a PPP mode of delivering interventions.

Additionally, a Multi-Donor Trust Fund under STARS is being considered which is envisaged as a pooled fund for financing work of donor interest that "may not adhere strictly to government norms and funding thresholds". J P Morgan has invested $ 10 million into the MDTF for five years with a focus on school to work transition strategies and skills development. It is unclear why a separate fund that is not in line with government norms is needed. The Facilitating schools to Work transition project have included for-profit educational institutions as part of the I-STARS project bid. This potentially violates the spirit of the agreement made by the World Bank during the Board approval of the STAR project that the project would only involve work with non-profit actors.

When it comes to promoting non-state partnerships, the **World Bank projects have failed to provide essential safeguards for engagement of the private sector like explicitly committing in all projects to keeping provisions not-for-profit**. This is particularly critical given the recent decision by the IFC to stop investing in for-profit K-12 education provision. The STARS project framework has made no explicit distinction between for-profit and not-for-profit education providers and includes a range of partnerships in their purview. At the same time, while school education in India is expected to be a not-for-profit sector, many schools continue to make profits in practice. Thus, successful low fees private schools achieve profit margins of 20-70%[159]. As such, **clear steps need to be taken to regulate private schools to ensure that profits are not made in practice.** At the same time, it will be essential to move beyond ensuring that **no support is provided for for-profit provision**, to ensure that none of the support goes for fees-charging education[160].

Most schools with whom partnerships appear to be considered are indeed government-aided schools that are legally expected to be not-for-profit (Gujarat and Andhra Pradesh). Project GOAL will involve support to 4, 500 private aided schools towards recurring costs like teacher salaries. However, it also supports the establishment of residential schools of excellence; the government of Gujarat has recently announced the launch of residential schools of excellence on PPP mode in the state. Other projects provide for the role of non-state actors in technical support to the government (STARS, Work transitions) and curriculum/material development (work transitions).

There is a growing body of evidence that shows that **PPPs and private education do not necessarily deliver better education outcomes and at the same time risk increasing the gap between rich and poor**. Recent academic studies and reviews have found mixed evidence on learning outcomes in education PPPs, and no evidence that they consistently perform better than public schools. Studies have also raised strong and consistent concerns about the impact of education PPPs on inequality and socioeconomic

[159] https://idronline.org/budget-private-schools-education-india/
[160] https://ieg.worldbankgroup.org/evaluations/evaluation-international-finance-corporation-investments-k-12-private-schools-7

segregation. One study of 17 countries found that, "in the majority of countries, [PPP schools] are reinforcing social disparities by disproportionately serving students in upper income quintiles.[161]"

While the involvement of non-state actors has not been included as a priority area in the education project by ADB, the education sector has been included in its new pipeline project on Supporting New Infrastructure Development through Public-Private Partnerships and Implementation Monitoring of the National Infrastructure Pipeline[162]. The focus under the same, however, appears to be on tertiary education.

IMPLEMENTATION STATUS AND RESULTS SO FAR

Given the recent nature of many of these projects, outcome data is not available for most projects. At the time of writing, reports on progress (Implementation Status and Results Reports) were available for four projects- viz STARS[163], GOAL, [164]WORK[165] and NECTAR[166]. All of these were funded by the World Bank.

Overall, progress is being rated by the lender as being "satisfactory" in two of the three projects for which results have been disclosed; project STARS's progress is being considered as "Moderately Satisfactory". WORK is ranked satisfactory in terms of progress towards achievement of PDO and moderately satisfactory in terms of overall implementation progress[167]. All projects have completed fiduciary and management tasks about the project roll out like the setting of concerned Project Management Units (NECTAR, STARS, GOAL) and Independent Verification Agencies (STARS, GOAL), Environment and Social System assessment nodal persons (STARS) and the development of the SIG Manual (STARS).

However, **given the continued closure of schools, significant progress does not appear to have been made on dimensions involving work in the field**. Progress on STARS has included undertaking the national standardized assessment on language in Grade III, the development of the Performance Grading Index (released using data from 2018-19), completion of the PISA 2021 field trial, identification of interstate learning partnerships and the notification of the National and state Assessment Centres. In Gujarat, project GOAL saw the preparation of performance-based grants mechanisms for schools, the notification of the Gujarat Assessment Centre and the state agency designated to carry out periodic teacher training needs and a package for the training of ECCE teachers; a continuous learning plan has been developed as part of the state COVID-19 strategies. However, none of the reports refers to the rollout of remedial programmes to address learning loss, new robust measures to support teachers or measures to enhance infrastructure and facilities in schools.

This slow rollout could offer one explanation for the fact highlighted in a recent Oxfam India report focussing on the roll-out of project STARS. Of the overall 2300 teachers, community members and government officials covered by the Oxfam India consultations, none was aware of or consulted by the government or the World Bank regarding the STARS project[168].

RECOMMENDATIONS

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[161] https://oxfamilibrary.openrepository.com/bitstream/handle/10546/620720/bp-world-bank-education-ppps-090419-summ-en.pdf
[162] https://www.adb.org/sites/default/files/project-documents/55336/55336-001-tar-en.pdf
[163] ISR 1, 2, 3
[164] ISR 1, 2
[165] ISR 1
[166] ISR 1, 2, 3
[167] https://documents.worldbank.org/en/publication/documents-reports/documentdetail/099930006082213660/p175827010b18a02b09cbc0c94470046a74
[168] https://www.oxfamindia.org/knowledgehub/policybrief/strengthening-teaching-learning-and-results-states-stars-recommendations-improved-implementation

Multilateral Development Banks should do much more to support inclusive, equitable, good quality public education provision and

1. Support the development of strategies to address the consequences of India's school lockdown and put in place robust strategies to prevent dropouts, address learning loss, deal with trauma and take steps to build back a more robust education system.
2. Support universal secondary completion through free, quality and equitable education delivered through the public education system. This, in turn, calls for a stronger focus on early childhood education with a view of building robust foundations for the subsequent educational experience.
3. Address intergenerational, social and economic barriers to the education of Dalits, Adivasis and religious minorities. The indicators and metrics of project impact need to go beyond the standard focus on improving access for girls, persons with disability and indigenous people but address the needs of Dalits and Muslim minorities as categories of relevance for India.
4. Take conscious measures to stop promoting educational inequality by supporting elite strands within the education system, and instead take concrete measures to safeguard against the commercialization of education including by ensuring that investments are not directed to profit-oriented providers.
5. Develop a supportive roadmap for teachers and other educational personnel to ensure that they are adequately trained, supported and have access to adequate spaces for growth and development. Concrete steps to address the shortage of key education personnel, support teacher agency and supportive supervision instead of further contributing to their monitoring and surveillance.
6. Include specific metrics of the extent to which state governments can ensure that all schools comply with the national minimum statutory norms as laid down under the Right of Children to Free and Compulsory Education Act, 2009.
7. Avoid explicitly or implicitly supporting the privatization of education. Do not use public funds to promote the expansion of the private school net in India, prioritize utilizing internal systemic capacities instead of relying on PPPs and private actors for improvement of education delivery. Instead,
   a. Build capacity from within the system, particularly by empowering and trusting the middle layer of administration
   b. Ensure any partnerships entered into are non-contractual and non-commercial and in the spirit of multi-Stakeholder partnerships adopted in the UN system
   c. Push for the introduction of a comprehensive regulatory framework for private actors in education to ensure non-state actors adhere to their human rights obligations.
8. Put in place robust measures to ensure citizen voice in education delivery through supporting formal mechanisms for the participation of parents and civil society in project design, monitoring and social auditing of project implementation. Existing structures for community participation in education need to be strengthened.
9. Collaborate more proactively and proactively with social movements and teachers to ensure the delivery of truly transformative education[169,170].

CHAPTER IV- THE HEALTH PROJECTS

The impact of COVID-19 on the health and well-being of Indians has been disastrous. India has cumulative had a cumulative 43.89 million cases and 526,033 deaths due to COVID-19[171]. While reported death rates per million people appear to be relatively low (373.72 per million), India had the world's second-largest

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[169] Transformative education involves teaching and learning geared to motivate and empower happy and healthy learners to take informed decisions and actions at the individual, community and global levels.
[170] https://en.unesco.org/news/five-questions-transformative-education
[171] https://ourworldindata.org/coronavirus/country/india as of 23 July, 2022

cumulative caseload of the pandemic. The WHO estimated 4.7 million COVID-linked deaths in India[172]. There has been some controversy about the estimates[173] [174].

Most states were unprepared to support their citizens to stay indoors and observe social distancing[175] and the chronically neglected public health system was also not able to cope with the added pressure of the pandemic. It is estimated that even before the pandemic only half of India's population had access to even the most basic healthcare services[176]. Citizens paid for 58.7% of their health expenditure out of pocket,[177] This is significant since countries with high out-of-pocket expenditure have poorer health outcomes and had a higher risk of mortality during the pandemic.[178]

Intermittent lockdowns and the refocusing of the health system to shift responding to the pandemic **disrupted the delivery of other public health services**. One study showed a 64% spike in mortality among patients needing life-saving and ongoing care between March-May 2020 and a 25% excess mortality in the four months after the imposition of lockdown; the poor and Dalit patients faced the greatest disruptions to their care, which may also explain their higher mortality[179]. Women were hard hit with pregnant women belonging to poor families often being left unassisted as most public health care institutions were turned into COVID-19 testing facilities and hospitals[180]. Access to ante and post-natal care, safe abortions, contraception and other sexual and reproductive health services were disrupted along with safe delivery services. Estimates showed that it is likely that 25.63 million couples could not access contraception, leading to 2.38 million unintended pregnancies, more than 6.7 lakh unplanned births and 1.45 million abortions (more than 6 lakh of which were unsafe) and 1.743 maternal deaths beyond what was expected in normal times[181]. Moreover, 1 million fewer children were vaccinated in April 2020 risking the health of the next generation[182]. Care for chronic diseases like tuberculosis also suffered collateral damage where it is estimated that there has been a 45% decline in the number of cases registered for treatment.[183]

The COVID pandemic has also highlighted the **consequences of an unregulated private sector** including gross overcharging and denial of care[184]. Reports of private providers refusing to comply with state directives like price capping have been reported from several states[185]. At the heart of the problem is weak regulation of the private sector with no real consequences for failing to adhere to national

[172] https://www.thehindu.com/sci-tech/health/who-estimates-47-million-covid-linked-deaths-in-india-10-times-official-count/article65385669.ece

[173] https://economictimes.indiatimes.com/news/india/india-questions-whos-methodology-to-estimate-covid-19-mortalities/articleshow/90888895.cms?from=mdr

[174] https://timesofindia.indiatimes.com/india/whos-methodology-has-been-robust/articleshow/91522817.cms

[175] https://d1ns4ht6ytuzzo.cloudfront.net/oxfamdata/oxfamdatapublic/2021-01/The%20Inequality%20Virus%20-%20India%20Supplement%20%28Designed%29.pdf?RrFsF8iTfT.g_PfT0H7HLpMvSTrb.M__

[176] Oxfam and Development Finance International (DFI). (2020). Fighting inequality in the time of COVID-19: The Commitment to Reducing Inequality Index 2020. https://www.oxfam.org/en/research/fighting-inequality-time-covid-19-commitment-reducing-inequality-index-2020

[177] National Health Systems Resource Centre. (2019) National Health Accounts Estimates for India (2016-17). New Delhi: Ministry of Health and Family Welfare, Government of India, accessed 03 December, 2020 https://bit.ly/2JG5IHS

[178] J. Assa and C. Calderon. (2020). "Privatization and Pandemic: A cross-country analysis of COVID-19 rates and health-care financing structures". UNDP/HDRO, accessed 03 December, 2020 https://bit.ly/3lCIb8b

[179] Dupas, Pascaline and Jain, Radhika. (2020). "Locked out of critical care: Covid-19 lockdown and non-COVID mortality". Ideas for India, accessed 03 December, 2020 https://bit.ly/36DFdMp

[180] Garg, Suneela, Basu, Saurav, Rustagi, Ruchir and Borle, Amod. (2020) "Primary Health Care Facility Preparedness for Outpatient Service Provision During the COVID-19 Pandemic in India: Cross-Sectional". JMIR Public Health Surveillance, 6(2): e19927, accessed 03 December, 2020 https://dx.doi.org/10.2196%2F19927

[181] https://www.frhsi.org.in/images/impact-of-covid-19-on-indias-family-planning-program-policy-brief.pdf

[182] S, Rukmini. (2020). "COVID-19 Disrupted India's Routine Health Services". India Spend, accessed 03 December, 2020 https://bit.ly/3qldAQ5

[183] https://scroll.in/article/1017579/in-indias-battle-against-the-covid-19-pandemic-tb-care-has-suffered-collateral-damage

[184] https://www.tribuneindia.com/news/editorials/profiteering-during-covid-274152

[185] https://theleaflet.in/lessons-from-private-sector-engagement-with-covid-19-for-universal-health-care/

frameworks both in peacetime[186] and during the pandemic.[187] At the same time, India's flagship insurance scheme Ayushman Bharat/ PM-JAY[188] has not been able to address the issue of costs of COVID treatment during the pandemic. Thus, **only 14.25% of people hospitalized for COVID-19 between April 2020-June 2021[189] could receive benefit from its coverage**.

As such, it would be critical to examine the extent to which the projects initiated during this period were able to address COVID-19's direct impact and respond to the other challenges thrown up by the pandemic.

GLOBAL HEALTH STRATEGIES ADOPTED BY IFIS FOR PROJECTS DURING THE PANDEMIC

It is estimated that in 2019, health spending globally was 8.8 trillion dollars. 54.8 billion was disbursed in development assistance in 2020 of which 13.7 billion was targeted for the COVID-19 health[190] response. Global International Financial Institutions stepped up to respond to the health consequences of the pandemic.

Thus, the World Bank's response was aimed to **strengthen national health facilities, augment the availability of well-trained frontline health workers, support the availability of critical supplies and equipment and ensure access to vaccines**. The initial focus was on testing, case tracking, treatment, purchase of medical and laboratory supplies and training of medical staff[191]. This involved identifying interested suppliers and negotiating prices and conditions, procuring testing kits, ventilators, medicines, and personal protective equipment and setting up new isolation wards, upgrading existing wards, and expanding intensive care units. Disease surveillance was also supported and steps were taken to strengthen preparedness for disease outbreaks, revamp infectious disease hospitals, and strengthen a network of high containment biosafety laboratories to ensure that public health systems were better prepared to cope with health emergencies in the future.[192] The World Bank also supported the development of roadmaps for strengthening Primary Health Care centres (PHCs) post-COVID-19 in its Strategy Refresh for the post-COVID world. At the same time, it is supporting countries' access to vaccines including through COVAX as well as procurement directly from manufacturers, as well as strengthening readiness for safe vaccine distribution and deployment. At the same time, the IFC seeks to increase the capacity of vaccine manufacturing.

The Asian Development Bank also intervened to support its developing member countries. The bank began refocusing existing projects in late January 2020, and in February provided grants and technical assistance to help governments meet emergency health needs, including supplies and equipment. It set up a rapid financing instrument called the **COVID-19 Pandemic Response Option**, or CPRO, with the stated intention to help governments protect the poor and vulnerable groups. ADB launched the $9 billion Asia **Pacific Vaccine Access Facility** (APVAX) in December 2020 to help the Bank's developing country members procure and deliver COVID-19 vaccines rapidly and equitably. The bank cooperated with the World Health Organization (WHO) on joint policy analysis and knowledge sharing. ADB is also engaged with key global vaccine partners to develop and implement mechanisms for vaccine delivery.[193]

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[186] https://www.oxfamindia.org/knowledgehub/workingpaper/analysing-regulation-private-healthcare-india

[187] https://www.bmj.com/content/370/bmj.m3506

[188] 'Prime Minister's People's Health Scheme' or PM-JAY; also referred to as Ayushman Bharat Scheme is a national public health insurance fund of the Government of India that aims to provide free access to health insurance coverage for low income earners in the country.

[189] https://www.downtoearth.org.in/news/governance/myth-of-coverage-how-india-s-flagship-health-insurance-scheme-failed-its-poorest-during-pandemic-80988

[190] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)01258-7/fulltext#seccestitle160

[191] https://thedocs.worldbank.org/en/doc/bb1b191f6b1bd1f932d0ddc5492987ec-0090012021/original/WBG-Responding-to-the-COVID-19-Pandemic-and-Rebuilding-Better.pdf

[192] https://www.worldbank.org/en/news/feature/2020/06/16/how-the-world-bank-is-mitigating-the-impacts-of-COVID-19-in-the-health-sector

[193] https://www.adb.org/sites/default/files/institutional-document/691766/adb-annual-report-2020.pdf

AIIB initiated joint action with other multilateral development banks, private partners and other financiers to respond to the economic, financial and public health challenges triggered by COVID-19 by launching the **COVID-19 Crisis Recovery Facility**, a special purpose finance modality that mobilized financings to help members respond to the immediate threats posed by COVID-19 in public health by assisting the purchase of medical equipment, strengthening their capacity for virus detection, testing and monitoring and improving their communications strategy to contain the spread of the virus. This has since been expanded to USD 20 billion[194] and includes a focus on procurement, distribution and deployment of vaccines, measures to support COVID response, preparedness and recovery while continuing to fund emergency health care measures that may be needed. Some projects helped prepare national health systems for pandemics in the longer term.[195]

The **NDB aligned their health emergency assistance projects to SDG 3 on Good Health and Well-being by helping to contain onward transmission of COVID-19 and manage the disease**. It focused on funding critical healthcare expenditures that would enhance healthcare capacity and strengthen national health systems' preparedness. In 2021, it issued a 2.5 billion pandemic support and sustainable bond to finance covid-19 emergency support for member countries of the Bank.[196]

Early analysis of these responses has highlighted that they have largely remained apolitical and prioritized the delivery of international public goods[197]. The health response of the ADB saw a significant increase in allocations in 2020 to address the impact of the health crisis and while the early stages of the crisis saw a rise in the use of grants and concessional lending, non-concessional loans and sovereign operations dominated the longer-term crisis period.[198] Furthermore, given the scale of the problem, there are concerns that the global response may not have been adequate. [199] At the same time, there are concerns that subsequent measures like the World Bank's vaccination program have neglected questions of equity[200]. Oxfam International's analysis of the World Bank's COVID-19 Strategic Preparedness and Response program highlights that the lack of attention to free health care access constitutes a "fatal flaw" in the same; only 8 of 71 health projects include fee waivers or any other attempts to reduce financial barriers to accessing healthcare during COVID-19[201]. The same reports how two-thirds of the projects lack plans to increase the number of healthcare workers. Other criticism highlights how the World Bank's COVID lending has promoted private sector involvement in the response and beyond[202]. The present analysis looks at some of these concerns with a focus on India.

GOVERNMENT OF INDIA'S RESPONSE TO MANAGE COVID–19 AND STRENGTHEN THE HEALTH SYSTEM

India's response was affected by the limitations imposed by its relatively weak public health system. India has historically neglected health spending which was the fourth-lowest in the world before the pandemic[203]. While allocations increased in the intervening period, spending by both the centre and

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[194] https://www.aiib.org/en/news-events/news/2022/AIIB-Expands-COVID-19-Crisis-Recovery-Facility-to-USD20-Billion.html

[195] https://www.aiib.org/en/news-events/annual-report/2020/_common/pdf/2020-aiib-annual-report-and-financials.pdf

[196] https://www.ndb.int/press_release/ndb-issues-usd-2-25-billion-pandemic-support-and-sustainable-bond/

[197] https://link.springer.com/article/10.1007/s11558-021-09440-2

[198] https://www.cgdev.org/sites/default/files/how-effectively-asian-development-bank-responding-covid-19-early-assessment.pdf

[199] https://www.cgdev.org/blog/world-banks-response-our-analysis-its-covid-relief-efforts

[200] https://www.brettonwoodsproject.org/2021/03/world-bank-support-to-covid-19-vaccination-fails-to-address-fundamental-barriers-to-equitable-access/

[201] https://oxfamilibrary.openrepository.com/bitstream/handle/10546/621113/bp-catastrophe-catalyst-world-bank-covid-19-041220-en.pdf

[202] https://www.eurodad.org/never_let_a_pandemic_go_to_waste

[203] https://timesofindia.indiatimes.com/india/indias-health-budget-fourth-lowest-in-world-oxfam/articleshow/78597933.cms

states remained low[204]. States were estimated to spend, on average, 1.1% of GDP on health in 2021-22[205] and only Delhi and Puducherry spent more than 8% of their budget[206]. The overall expenditure on health increased in all states and Union Territories[207] on the back of the pandemic rising to 2.1% of GDP.[208] However, most **additional funds were spent to directly tackle the pandemic while the remaining components either stagnated or decreased**[209]. A concerted push to address systemic problems of strengthening primary healthcare, minimizing out-of-pocket expenditure and meeting the shortfall of human resources has been lacking.[210]

Its national lockdown in March 2020 was among the strictest in the world[211], but as time passed, mask-wearing and social distancing measures were abandoned culminating in the deadly second wave of the pandemic[212]. While India is one of the world's leading vaccine manufacturers, its vaccination campaign was slow to take off and eventually missed the stated target[213]. The situation was substantially based on the legacy of a weak public health system and the consequent reliance on the private health care system including for vaccines which fuelled inequity. In 2016, India was ranked 145 out of 195 countries on The Lancet's index of global healthcare access and quality[214]. The World Health Organization drew attention to the critical gaps in India's healthcare infrastructure by noting that the rapid surge of COVID-19 cases had put immense pressure on the health systems, which were already overburdened since the start of the pandemic.[215]

Within these constraints, India adopted the range of public health measures that were recommended for the pandemic, but **the response was frequently delayed**. The National Institute for Disaster Management has laid down specific strategies for preparedness especially through a mix of institutional measures such as public awareness campaigns, creating a web of COVID isolation and COVID care centres and providing protective gear kits for women health care workers etc.[216] India's initial response was impaired by low testing rates and the failure to ensure the delivery of essential health services[217]. The second wave has highlighted the need to strengthen the availability of essential equipment, medicines, infrastructure and logistics for responding to the pandemic.[218]

With a large number of hospitals in the private system, many states had to temporarily resort to taking over private hospitals[219]. Many patients experienced overcharging while availing of treatment- in one study 75% of COVID patients experienced overcharging.[220] In the face of popular anger over the high costs

[204] https://accountabilityindia.in/publication/national-health-mission-budget-briefs-2022-accountability-initiative-centre-for-policy-research/
[205] https://rbi.org.in/Scripts/PublicationsView.aspx?id=20877
[206] https://theprint.in/india/most-states-havent-enhanced-health-budget-share-to-over-8-pc-parliamentary-panel/887004/
[207] https://www.news18.com/news/india/centres-covid-emergency-funding-quadrupled-as-states-uts-proposed-budgets-to-bolster-health-facilities-4784384.html
[208] https://www.deccanherald.com/business/union-budget/covid-19-pandemic-pushes-indias-health-expenditure-to-21-of-gdp-1076641.html
[209] https://accountabilityindia.in/publication/national-health-mission-budget-briefs-2022-accountability-initiative-centre-for-policy-research/
[210] https://prsindia.org/files/budget/budget_parliament/2022/DfG%202022%20Health%20and%20Family%20Welfare.pdf
[211] https://ourworldindata.org/grapher/covid-stringency-index?country=~MYS
[212] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8106236/
[213] https://www.bbc.com/news/world-asia-india-55571793
[214] https://www.thehindu.com/sci-tech/health/india-145th-among-195-countries-in-healthcare-access-quality-lancet/article61833237.ece#:~:text=India%20ranks%20145th%20among%20195,access%20and%20quality%20since%201990.
[215] https://www.who.int/southeastasia/news/detail/28-04-2021-address-critical-gaps-urgently-who
[216] https://nidm.gov.in/PDF/pubs/TWPCVR_2021.pdf
[217] https://www.brookings.edu/blog/future-development/2020/07/02/how-well-is-india-responding-to-covid-19/
[218] https://www.bbc.com/news/world-asia-india-56891016
[219] https://scroll.in/article/957556/coronavirus-three-states-take-over-private-hospitals-what-does-the-fine-print-say
[220] https://www.ndtv.com/india-news/75-covid-19-patients-were-overcharged-by-hospitals-claims-survey-report-2557903

of COVID treatment, most states introduced some form of price capping.[221] Despite this, the Indian Supreme Court had to step in to enforce these provisions.[222]

At the heart of the response has been the effort of India's underpaid, largely female, volunteer frontline Community health workers who have been undertaking public awareness, contract tracing and community surveillance activities.[223] This was recognized with India's ASHA workers[224] having recently won WHO's Global Health Leaders Award.[225] India's health workforce has suffered from a shortage of personal protective equipment, inadequate training of health workers on protective practices, inadequate physical and mental support and shortages of human resources.[226] The extent to which these challenges are being addressed needs to be examined as part of the analysis of the IFI response in India.

IFIs' LONG TERM STRATEGIC APPROACH FOR HEALTH IN INDIA

The support for health delivered during the COVID period needs to be seen in the context of the longer-term strategies for health that individual IFIs have. The World Bank has a dedicated section on health in its Country Partnership Framework whereas the other IFIs include it as an outcome emerging from their economic development programs. World Bank incorporates the strategy of investing in human capital as known by its CPF's key objective 3.4, which is to improve the quality of health service delivery and financing and access to quality health care. By focusing on improving and expanding the coverage, scope and quality of primary healthcare delivery, it supports universal access to healthcare under World Bank's "One Health Approach". ADB's Country Partnership Strategy document highlights health as a priority within the "inclusive urbanization" vertical and included a focus on strengthening provision for the urban poor and other vulnerable populations. It also prioritizes health as one of the areas of work under the cross-cutting theme of promoting private sector development[227].

Broadly speaking, the health strategies that IFIs in India have prioritized have included
- **Promoting the private sector:** The World Bank's CPF had prioritized the intention to expand support to GoI's initiatives in universal health coverage by prioritizing the improvement of the delivery of health insurance. IFC sought to supplement this by mobilizing private sector capital to expand "affordable, quality healthcare and create a mass market for lower-income populations". IFC's activities include direct investments in private sector ventures and health care service providers, PPPs, as well as advisory services for the central and state governments. These cover investment in private hospital chains, financial and technical support for health PPPs and investment in the pharma sector. The ADB too sought to ensure access to social services including bringing improvement in the efficiency and quality of health services delivery that reach the urban poor and vulnerable by undertaking inclusive urbanization. To an extent, this is expected to be realized by partnering with the private sector. The World Bank also seeks to unlock new models of health financing [228] by streamlining health insurance and PPPs.
- **Improving planning and management of health systems and delivery of quality of health service delivery in the public sector:** Both the World Bank and ADB also seek to strengthen the delivery of healthcare in the public system. This includes strengthening the standards of service and improving the planning, execution and monitoring of health delivery irrespective of the nature of the provider. At the same time, there is a clear focus on enhancing the accountability of the public

[221] https://timesofindia.indiatimes.com/india/hospital-cost-capped-but-covid-can-cripple-80-of-families/articleshow/78610372.cms
[222] https://indianexpress.com/article/india/sc-on-covid-19-cap-private-hospital-costs-or-open-more-state-facilities-7110662/
[223] https://www.telegraph.co.uk/global-health/science-and-disease/dont-do-job-will-india-accused-exploiting-female-health-volunteers/
[224] Accredited Social Health Activist (ASHA) is a trained female community health activist. Selected from the community itself and accountable to it, the ASHA will be trained to work as an interface between the community and the public health system.
[225] https://www.who.int/india/india-asha-workers
[226] https://journals.lww.com/jfmpc/Fulltext/2020/09090/Protecting_Indian_health_workforce_during_the.9.aspx
[227] https://www.adb.org/sites/default/files/institutional-document/363331/cps-ind-2018-2022.pdf
[228] https://www.worldbank.org/en/topic/universalhealthcoverage#2

sector. Thus, the ADB Country Strategy seeks to enhance the accountability, efficiency and effectiveness of the public sector and boost the returns of public investment, ensure its adequate resourcing and "right-sizing" and improve the functioning of front-line service delivery platforms. Considerable efforts are also made to enhance planning and management systems. Thus, the Asian Infrastructure Investment Bank (AIIB) has a focus on health under its sustainable cities strategy which includes building freestanding health facilities within urban boundaries, such as hospitals; and clinics.

AIIB and NDB do not have disclosed strategies for the improvement of the health sector or strategies for India. In terms of their global strategy, AIIB looks at health improvement as part of its multisectoral integrated development strategy while the New Development Bank aims to create positive healthcare outcomes as a by-product of increasing employment opportunities resulting in the improvement of living standards.

ANALYSIS OF COVID-ERA HEALTH PROJECTS IN INDIA

IFIs have provided support to supplement India's emergency response to the pandemic. In addition, some of the World Bank projects aim to strengthen health systems, particularly in the northeastern states.[229] More recent projects focused on supporting India's vaccination programme for the purchase of vaccines.

A total of **16 health loans, grants and technical assistance projects** have been committed by IFIs for health work in India from 1st Jan 2020- 1 July 2022. This includes support from all IFIs active in India for immediate health responses during the pandemic and more long-term measures like pan-national system support and COVID vaccination. The World Bank has also intervened with support for specific states. Many of the projects have been jointly supported by several IFIs. A summary of the support is provided below.

		World Bank	ADB	AIIB[230]	NDB[231]
	COVID focused				
1	COVID-19 Emergency Response and Health Systems Preparedness Project	Transforming India's Public Health System for Pandemic Preparedness (PHSPP)[232] India COVID-19 Emergency Response and Health Systems Preparedness Project (Henceforth: WB Response)[233]	COVID-19 Emergency Response Project[234] Support to address the outbreak of COVID-19 and strengthen preparedness for communicable diseases in South Asia[235]	COVID-19 Emergency Response and Health Systems Preparedness Project	Emergency Assistance Program in Combating COVID-19
2	Social Protection (including insurance for frontline workers)[236]	India's COVID-19 Social protection Response	COVID-19 Active Response and	COVID-19 Active Response	COVID-19 Emergency Program

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[229] https://www.orfonline.org/expert-speak/COVID19-the-state-of-health-care-facilities-in-indias-north-east-63889/

[230] No separate disclosures have been made about progress achieved under the project by the lending Bank

[231] No information about project progress has been disclosed separately by the lending Bank

[232] https://projects.worldbank.org/en/projects-operations/project-detail/P175676

[233] ISR 4 is available

[234] https://www.adb.org/projects/54337-001/main

[235] No information on progress has been disclosed. Key documents can be obtained on https://www.adb.org/projects/54201-001/main

[236] Given that the social protection related projects were not principally targeted towards improvement of health, we have not included the project amount in the subsequent calculation of financing.

		(PMGKY[237]; including credits for Phase 1[238] and 2) **[239]**	Expenditure Support (CARES) Program[240]	and Expenditure Support Program CARES	Loan for Supporting India's Economic Recovery
3	Vaccination		COVID-19 Response and Vaccination Program ($ 2 million; henceforth, Henceforth, COVID Vaccination)[241] "Responsive COVID-19 Vaccines for Recovery Project under the Asia Pacific Vaccine Access Fund" (henceforth ADB- Asia Vaccine)[242].	Responsive COVID-19 Vaccines for Recovery Project (henceforth, AIIB Vaccines)[243]	
Not explicitly COVID focused					
4	National Public Systems	India's Enhanced Health Service Delivery Program (EHSDP)[244]	Supporting Health Systems Strengthening Project[245] Supporting New Infrastructure Development through Public–Private Partnerships and Implementation Monitoring of National Infrastructure Pipeline[246]		
5	National Health Insurance		Strengthening Universal Health Coverage in India: Supporting the implementation of Pradhan Mantri Jan Arogya Yojana[247]		
6	National Urban health		Strengthening Comprehensive Primary Health Care in Urban Areas Program under the Pradhan Mantri Ayushman Bharat Health Infrastructure Mission[248]		

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[237] Pradhan Mantri Garib Kalyan Yojana

[238] Now closed

[239] This was not principally focused on health but included components of insurance including health insurance of health workers

[240] https://www.adb.org/projects/54182-001/main

[241] https://www.adb.org/projects/55082-002/main

[242] Approved. https://www.adb.org/projects/55082-001/main

[243] Approved. https://www.adb.org/projects/55082-001/main

[244] https://projects.worldbank.org/en/projects-operations/project-detail/P175676

[245] Approved https://www.adb.org/projects/55262-001/main

[246] https://www.adb.org/projects/55336-001/main

[247] https://www.adb.org/projects/54009-001/main

[248] https://www.adb.org/projects/53121-001/main

7	Support for individual states	Meghalaya Health Systems Strengthening Project henceforth WB Meghalaya)			
		Mizoram Health Systems Strengthening Project (henceforth, WB Mizoram)			
		System Reform Endeavour for Transformed Health Achievement in Gujarat (SRESTHA-G)[249]			
		Assam Secondary Healthcare System Reform Project[250]			

Of these, two ADB projects- viz Asia vaccine (pipeline loan) and COVID system preparedness in South Asia (technical assistance) **include countries beyond India**. These will run for the period 2021-24 and 2022-25. Financial allocations specifically for India are not available.

Additionally, **some projects which are not principally focused on public health have health components**. Thus, the project on Disaster Risk reduction supported by the AIIB and World Bank's Resilient Kerala project ($ 125 million each) includes a component of implementing One Health Community Surveillance systems (henceforth, AIIB Kerala and WB Kerala). A supplementary loan for Additional Financing for the same is in the pipeline from the World Bank.[251] At the same time, the WB-supported program for Animal health system support for Improved One Health (pipeline) has small components of public health. However, the detailed analysis only focuses on interventions with a clear direct health component. The ADB-supported pipeline (approved) project "Supporting New Infrastructure Development through Public-Private Partnerships and Implementation Monitoring of National Infrastructure Pipeline" covers several sectors including health.[252]

There are also some ongoing IFI-supported **health projects in India whose start predates the start of the pandemic**. A large number of national and state interventions supported by the World Bank predate COVID-19[253]. Ongoing pre-COVID interventions in health by ADB include Supporting Strategic Interventions in the Health Sector Towards Achieving Universal Health Coverage (approved in 2019 and slated to run into 2022 with support of 225 million USD)[254] and Supporting the National Health Authority

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[249] No information is disclosed about the same

[250] https://projects.worldbank.org/en/projects-operations/project-detail/P179337

[251] The detailed document for the same have not been disclosed till now.

[252] https://documents1.worldbank.org/curated/en/366531615896676453/pdf/Disclosable-Restructuring-Paper-India-COVID-19-Emergency-Response-and-Health-Systems-Preparedness-Project-P173836.pdf

[253] For World Bank this list includes the Program towards elimination of Tuberculosis (approved March 2019 with 400 commitment amount), the Uttarakhand Health Systems Development Program (Approved in 2017 with commitment amount of 100 million), Tamil Nadu Health System Reform Program (approved March 2019 with a commitment amount of 287), the Nagaland Health Project (Approved in 2016 with a commitment amount of 48 million dollars). The WB has also historically supported the National Nutrition Mission (also known as the ICDS systems strengthening and nutrition improvement project) and the ICDS System strengthening and nutrition improvement program (ISSNIP) has health components.

[254] https://www.adb.org/projects/53355-001/main

(approved in 2019 and closed in 2021)[255]. The NDB and AIIB had not historically supported work on public health and the only support has been part of the COVID response window.

At the same time, the health sector has also seen a fair amount of **investment by the IFC** into the pharma sector. The IFC provided two loans of US$ 40 Million to Biological E. Ltd to expand its vaccine and pharmaceutical products as part of the "Make in India" initiative launched by the government to make India a destination for the production of goods and to boost the national economy.[256] Another loan of US$ 40 Million to Glenmark Ltd. under the IFC COVID-19 response facility to fund the Company's ongoing capital expenditure program in India.[257] One equity financing towards MEDGENOME INC. of US$ 31 Million Access to genetic diagnostic services and targeted medication (ii) Market creation by significantly deepening the genomic segment via demonstration and replication, and capacity building channels[258] and US$ 50 Million financing of multi-year capital expenditure of Hikal Ltd. manufacturer of active intermediates and ingredients offering products to global pharmaceutical, crop protection, animal health and speciality chemical companies.[259] The ADB has also invested in health with three non-sovereign projects during this period inclusive of financing of up to $20,000,000 (in Indian rupee equivalent) from the ordinary capital resources of the Asian Development Bank (ADB) in non-convertible debentures (NCDs) to be issued by Apollo Hospitals Enterprise Limited (Apollo) for the COVID-19 Hospital Capital Support Project, debt financing of up to $20,000,000, (in Indian rupee equivalent) from the ordinary capital resources of the Asian Development Bank (ADB) in nonconvertible debentures (NCDs) to be issued by Global Health Private Limited (GHPL) for the COVID-19 Hospital Service Delivery Project and INR400 million ($ 5 Million) from ADB's Ordinary Capital Resources for a secured, non-convertible debenture (NCD) to scale up Krsnaa's, a private diagnostic lab chain's, coronavirus disease (COVID-19) screening and detection capacity during the COVID-19 pandemic.

FINANCING OF COVID-ERA PROJECTS

The COVID era projects constitute a total commitment of 11 billion USD. This includes a total of USD 4.5 billion from the World Bank, USD 2.1 billion from ADB and USD 3.4 billion from AIIB. In addition, India received a billion dollars from NDB. On average, project sizes were larger for WB-funded projects and included a stronger component of supporting state-specific interventions. ADB, instead, has funded several relatively small technical assistance projects and grants to support specific interventions. The details of the financing of each ADB projects are included in Annexure I.

Loans and Grants for Health Sector (Sovereign): 1 January 2020- 1 July 2022

IFI	Number of active COVID projects (loans)	Number of active/completed Non-COVID focused projects	Number of active grants/TA projects	Number of pipeline loan projects and TA's	Total donor funding Commitment for active projects	Total donor funding commitment for pipeline projects
World Bank	5	0	0	3	US$ 2 Billion	US$ 350 million[260]
ADB	2	0	4	1	US$1.8 Billion	US$ 2 Million[261]
AIIB	2	0	0	0	US$ 1 Billion	-
NDB	1	0	0	0	US$ 1 Billion	
Total	**10**	**0**	**4**	**4**	**US$5.8 Billion**	**US$ 352 million**

Non-Sovereign Loans and Financing to the Private sector

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[255] https://www.adb.org/projects/53285-001/main
[256] https://disclosures.ifc.org/project-detail/SII/44216/biological-e-ii
[257] https://disclosures.ifc.org/project-detail/SII/44289/rse-glenmark
[258] https://disclosures.ifc.org/project-detail/SII/45102/medgenome
[259] https://disclosures.ifc.org/project-detail/SII/45374/hikal-iii
[260]PHSPP: Transforming India's Public Health Systems for Pandemic Preparedness Program, Systems Reform Endeavour for Transformed Health Achievement in Gujarat (SRESTHA-G) & India's Enhanced Health Service Delivery Program.
[261] Supporting India's Health Systems

IFI	Private Sector Company	Investment Amount
World Bank/IFC	Hikal Limited	US$ 50 Million
	Medgenome Inc[262].	US$ 31 Million
	Glenmark Pharmaceuticals Limited[263]	US$ 40 Million
	Biological E. Limited	US$ 30 Million
	Total	***US$ 151 Million***
Asian Development Bank	COVID-19 Hospital Service Delivery Project (Global Health Private Limited)	US$ 20 Million
	Krsnaa COVID-19 Diagnostic Services Project	US$ 5 Million
	India: COVID-19 Hospital Capital Support Project (Apollo Hospitals Enterprise Limited)	US$ 20 Million
	Total	***US$ 45 Million***

COMPLEMENTARITY WITH GOVERNMENT HEALTH INTERVENTIONS

COVID-19 support largely supplemented existing government schemes and programs under the overall national framework of Ayushman Bharat including specific components like those having a focus on health insurance (AB-PM-JAY). Other schemes referenced include the Pradhan Mantri- Ayushman Bharat Health Infrastructure Mission (PM-ABHIM)[264] with a focus on the development of health infrastructure. State-specific projects have focused on the state infrastructure like the Mizoram State Health Care Scheme (MSHCS). The implementing agencies selected for these projects include central government health agencies like the Ministry of Health and Family Welfare, state departments of Health and Family Welfare etc. In the spirit of the overall WBG strategy that focuses on supporting the work of the states, funding was also extended to state-specific schemes like the Meghalaya Health Insurance Scheme (MHIS) and the Mizoram State Healthcare Scheme (MSHCS).

PROJECTS ADDRESSING THE IMPACT OF COVID-19 AND OTHER PANDEMIC PREPAREDNESS

The COVID-19 health projects are straightforward in their objective to mitigate the negative fallout from the pandemic. Much of the assistance provided by the World Bank, Asian Development Bank and Asian Infrastructure Investment Bank and New Development Bank for mitigating impacts of COVID-19 has focussed on increasing the detection, surveillance, tracking, monitoring, equipping of health care workers and limiting the loss of human lives. However, many of the longer-term projects aim to strengthen the governance, accountability, the resilience of public health systems functioning in primary healthcare. The World Bank, ADB, AIIB and NDB have looked at health as part of a larger package aimed at the response and economic recovery post-COVID-19. The recent PHSPP project expands the scope by including a focus on pandemic preparedness more broadly. The specific COVID-related health work supported under these projects includes

1) **Developing critical health infrastructure to respond to COVID-19:** A majority of the projects were focused on enhancing the provision of key facilities needed to support the immediate COVID response. This included
   a. Enhancing oxygen supply and oxygen delivery systems (WB, ADB, AIIB)
   b. Enhancing isolation capacity in district hospitals (WB, ADB)
   c. Personal protective equipment and infection control products and supplies (WB, AIIB)
   d. Procurement of medicines (AIIB)
   e. Enhance COVID testing (AIIB, ADB)
   f. Purchase of thermal scanners and other steps to increase screening, testing and improved surveillance at points of entry (ADB)

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[262] https://disclosures.ifc.org/project-detail/SII/45102/medgenome
[263] https://disclosures.ifc.org/project-detail/SII/44289/rse-glenmark
[264] https://pib.gov.in/PressReleasePage.aspx?PRID=1776530

2) **Strengthen surveillance, prevention and patient management functions to manage COVID-19 and future disease outbreaks** (WB, AIIB) through a range of measures including

   a. Guidance for MoHFW to prepare infectious disease contingency plans (AIIB, ADB).
   b. Establishment of Integrated Health Information Platform and a new division for research in disease elimination at ICMR's National AIDS Research Institute, creating health emergency operation centres (IHEP) and establishment of Epidemic Intelligence Service Cell at the NCDC and expansion of the network of viral research laboratories (WB, PHSPP)
   c. Enhance detection capacities through updated training of surveillance workers, improving reporting by frontline health workers using existing surveillance information and contact tracing of known cases. (WB, ADB)
   d. Enhance laboratory capacity to diagnose human and animal diseases at the national and provincial level through procuring and replenishing supplies of reagents and kits; upgrading virus repository and reference reagents; standardizing sample collection, channelling, and transportation; determining sites most in need of introduction of point-of-care diagnostics and engaging private laboratories to expand capacity to test and manage COVID-19.
   e. Building a network of Biosafety Level 3, high containment laboratories with high biosafety standards, expanding point-of-care molecular testing for viral disease in sub-district and district laboratories and sample transport mechanisms; (PHSPP)
   f. Promotion of commercialization of technologies to prevent, diagnose and treat infectious diseases through the strengthening of ICMR's Medical Device and Diagnostic Mission Secretariat to create relevant policies and establish a public-private platform to engage with the industry (PHSPP)
   g. improving disease surveillance systems in humans and animals and health information systems across the country, bolstering community-based disease surveillance capacity through increased personnel and the use of ICT systems to track and monitor infectious outbreaks, developing human resources with core competencies in integrated disease surveillance creating institutional mechanisms and capacities for epidemic response at the district level and strengthening referral transport systems and linkages.
   h. Enhance core capacity to deliver the One Health approach to prevent, detect, and respond to infectious disease outbreaks in animals and humans. Mapping of zoonotic disease hotspots and establishment of sentinel sites reporting of zoonotic diseases (PHSPP)
   i. Build capacity in contingency planning for epidemics including the development of (i) state-level emerging infectious disease contingency plans for high prevalence states and (ii) guidelines for sustaining essential health services for women and children during epidemic/pandemic situations (ADB CARES).[265]

3) Enhancing staff capacities

Some of the projects focus on addressing the specific needs of the staff at the front lines of the response. This includes

   a. Retaining skilled health workers through extra payments (such as hazard pay and death benefits in line with GoI norms for compensation).
   b. Expanding service delivery capacity through the deployment of healthcare and other workers to respond to COVID-19. This surge in service delivery was expected to ensure that responding to COVID-19 does not weaken other areas of the health system (WB).
   c. Enhance capacities of district hospitals doctors and nurses on guidelines on the clinical treatment of COVID-19 (AIIB CARES).
   d. The AIIB project aimed to ensure health personnel including ASHAs were covered by insurance. Roll out of health insurance scheme for health workers including sanitation workers, ward boys, nurses, community health workers (ASHA workers), paramedics and technicians. (WB PMGKY).

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[265] https://www.adb.org/sites/default/files/project-documents/54182/54182-001-tar-en.pdf

e. The ADB-COVID CARES project focuses on strengthening healthcare staff capacity in responding to and managing infectious diseases with community engagement through (i) conducting training on IPC in the selected state, (ii) improving risk communication and community engagement, and (iii) rolling out programs for psychosocial wellbeing of medical personnel and frontline health workers, especially targeting women, using digital tools.

f. The ADB CARE program emphasized rolling out programs for the psychosocial well-being of medical personnel and frontline health workers, especially targeting women, using digital tools.

g. Capacities of 1000 public frontline health workers will be built in prevention, detection and response to disease outbreaks. One of the metrics is to enhance the number of women taking part in training programmes by NCDC.

h. Building technical capacities of young scientists/researchers to undertake collaborative research (PHSPP).

4) **Enhance management capacity** for preventing, detecting, and responding to the threat posed by COVID-19. Some of the specific activities include
   a. Strengthening National and State health systems to support prevention and stop onward transmission of COVID-19 (NDB Emergency, AIIB Emergency).
   b. Improving resilience of public health sector and health emergency response system (NDB Emergency, AIIB Emergency).
   c. Strengthen pandemic research and strengthen institutions and platforms for One Health (AIIB Emergency).
   d. Strengthen community engagement and risk communication around COVID (AIIB Emergency) and COVID-19 vaccination (ADB Vaccine).
   e. Support implementation management, capacity building, M&E (AIIB Emergency, ADB COVID SA).

5) **Building awareness of COVID-19 via community mobilization:** The need for community involvement in spreading messages around social distancing and appropriate COVID-19 behaviour has been an integral part of the response. Steps in this direction have been supported by the WB, AIIB and ADB.
   a. promotion of social distancing and other comprehensive communication and behaviour change interventions, a communication campaign for schools and parents to protect themselves and steps towards promoting hygiene practices including the use of masks (World Bank).
   b. ADB provided support to undertake community outreach, especially targeting the poor, women, older people, persons with disabilities, residents in rural and remote areas, and other disadvantaged minority groups. Actions to be undertaken included engagement with various networks and platforms, including women's groups in rural areas, community-based frontline workers (including Anganwadi and social health activist workers) appointed under the Integrated Child Development Services program of the Ministry of Women and Child Development.

6) **Strengthening vaccination**. The ADB and ADB/AIIB co-financed projects sought to
   a. Strengthen national COVID-19 vaccination program planning and implementation (by bringing in domain experts, strengthening monitoring, data analysis and learning).
   b. Enhance cold chain capacity for COVID-19 vaccination in rural and remote areas with limited electricity.
   c. Support private sector engagement in COVID-19 vaccination, support management and safe disposal of immunization waste and strengthen awareness of COVID-19 vaccination programs among disadvantaged groups.

d.   Enhance safe and effective procurement of vaccines including supporting vaccine costs, taxes and other financial charges. This will also be co-financed by the ADB project.[266]

e.   Build stakeholder capacity to implement the national vaccination program (ADB Vaccine).

f.   Specific efforts would also be undertaken to ensure analysis based on gender and priority vulnerable groups for vaccines to ensure equitable vaccine deployment. Development of materials for citizen outreach to address vaccine hesitancy and involvement of local partnerships to enhance vaccine communication would also be done.[267]

7) **Knowledge:** The interventions also sought to support evidence building, innovation and data management to supplement current and future efforts. This includes

a.   Strengthening pandemic research and institutions and platforms for One Health (AIIB Emergency).

b.   Supporting implementation management, capacity building and M&E (AIIB Emergency, ADB COVID SA).

Some of the investments made in this strand of work will contribute to the **enhancement of the systemic capacity to enable a robust response to COVID-19, strengthen health surveillance**, establish epidemic response processes and augment India's critical care infrastructure, especially in urban areas, has been critical. Many of these measures have been overdue. However, it is **unclear to what extent the support during the pandemic has contributed to the overall strengthening of India's public health system as a whole in the long run**. **None of the projects with an explicit COVID-19 health focus have sought to significantly enhance the capacities of India's public primary health system, fill staffing gaps or expand treatment facilities**. **Neither have they been able to leverage an increase in increased long-term investments in health from the government** of India. This is a missed opportunity for bringing about much-needed systemic reform to address the gaps in India's public health system.

At the same time, while the intention to ensure India is ready for future pandemics as part of the PHSPP is appreciated, the specific strategy excessively relies on technological surveillance. One will have to wait and watch to see the sustainability of the intervention. The maintenance of the infrastructure and resources created after the completion of the project is a potential concern, especially if there is no subsequent pandemics.

While the focus on enhancing the specific technical skills of frontline staff to deal with the consequences of the pandemic is appreciated, it is unfortunate that **none of the projects address the specific challenges faced by India's health workers during the pandemic**. Few projects appear to focus on addressing health workers' psychosocial needs despite World Bank recognizing that emotional and mental support is required for frontline health care workers.[268] Indeed, many health workers have not been paid at all during the pandemic[269]. Media reports suggest many of them also failed to get adequate access to masks and gloves[270].

Particularly disappointing is the **absence of programmatic focus on India's feminized frontline health workforce**. India's ASHA workers have historically been officially considered to be volunteers, paid an honorarium which does not constitute minimal wages, but have been expected to put in long hours to undertake their duties. Their volunteer status has been criticized, as being conceptualised as an extension of the caring and nurturing role of women, rather than as professional workers who need to be duly

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[266] https://www.adb.org/sites/default/files/project-documents/55082/55082-001-rrp-en.pdf

[267] https://www.adb.org/sites/default/files/project-documents/55082/55082-001-gap-en.pdf

[268] https://blogs.worldbank.org/health/supporting-mental-health-and-resilience-frontline-covid-19-coronavirus-health-care-workers)

[269] https://www.mid-day.com/mumbai/mumbai-news/article/covid19-frontline-doctors-not-paid-for-three-months-now-23021286

[270] https://www.forbesindia.com/article/take-one-big-story-of-the-day/asha-workers-the-underpaid-overworked-and-often-forgotten-foot-soldiers-of-india/69381/1

compensated. During the pandemic, they have been given an array of tasks including contact tracing, supporting those under self/home isolation, undertaking surveillance and vaccine distribution. This is over and above the expectation that they undertake antenatal and post-natal check-ups, assist women to undergo safe deliveries, immunization, sanitization and other work. At the same time, many of the ASHA workers who died due to COVID-19 have not received compensation as per the declared schemes.[271] While their role has been lauded in some of the projects (e.g. PHSPP), concrete action to address these critical gaps is missing.

At the same time, the **ADB's stated intention** to strengthen COVID-19 vaccination is appreciated, although delivery of vaccination through private sector vaccination centres has been found to negatively impact both the effectiveness and equity of India's vaccination drive[272]. The government had earlier reserved 25% of COVID-19 doses for delivery in the private sector, but only 7% of India's vaccines were delivered by the same[273] contributing to artificial shortages which hit India's poorest hardest and led to long queues, stock outs, cancelled appointments and erratic supply costing multiple labour days lost of vaccines skipped. At the same time, despite the imposition of price caps on the delivery of vaccination in private hospitals, the costs were still prohibitive. Thus, the vaccine could cost 24-38% of the monthly income of an average Indian family of three adults[274]. In August, the government removed the reservation of doses for the private sector,[275] even if paid vaccines in the private sector continue to be delivered. An earlier version of India's COVID-19 vaccination policy had even more severe negative equity consequences[276]. A recent survey showed that 83% of Indians wanted vaccination to be delivered completely free of cost through the government like previous vaccination drives.[277] The problem of reliance on the private sector persists through the decision of the central government to not deliver universal free booster vaccination for the priority population- those over 60 years of age and frontline and health workers[278]. The central government states that is part of it opted for making the private sector the sole site of purchasing booster doses for the majority of the country's population to enable the return of the public system to "normal functioning.[279]"Several state governments have, however, chosen to deliver vaccines out of their own costs,[280] especially in the face of rising COVID rates[281]. More explicit efforts to address vaccine inequality are needed.

At the same time, the PHSPP project explicitly aims to ensure that 40% of the early detection of disease outbreaks should be in private hospitals (compared to a value of 0% at the baseline). While the desire to maximize capacities is appreciated, it is it is concerning that the project incentivizes this given the equity challenges with India's private hospital system.

At the same time, **more concrete efforts to address out of pocket expenditure and user fees, particularly in the private sector, at the height of the pandemic would have been desirable**. Media reports of

[271] https://thewire.in/government/families-of-bihars-asha-workers-who-died-of-covid-19-still-havent-been-compensated
[272] https://d1ns4ht6ytuzzo.cloudfront.net/oxfamdata/oxfamdatapublic/2021-07/India%20vaccine%20brief%20-%2013%20July.pdf?vd8V0cBMy58X6npADVQ8bvg8e03L0YFk
[273] https://timesofindia.indiatimes.com/india/covid-19-since-may-1-private-sector-gave-7-of-jabs-despite-25-quota/articleshow/84778026.cms
[274] https://d1ns4ht6ytuzzo.cloudfront.net/oxfamdata/oxfamdatapublic/2021-07/India%20vaccine%20brief%20-%2013%20July.pdf?vd8V0cBMy58X6npADVQ8bvg8e03L0YFk
[275] https://www.indiatoday.in/coronavirus-outbreak/vaccine-updates/story/govt-tells-vaccines-manufacturers-stop-reserving-25-covid-doses-for-pvt-sector-1836416-2021-08-04
[276] https://www.oxfamindia.org/knowledgehub/policybrief/peoples-covid-19-vaccine-india-no-one-safe-until-everyone-safe
[277] https://www.oxfamindia.org/press-release/patients-rights-and-inequality-vaccine-surveyA
[278] https://economictimes.indiatimes.com/news/india/booster-doses-allowed-for-all-adults-from-april-10-in-private-centres-govt/articleshow/90726279.cms
[279] https://theprint.in/health/as-booster-uptake-lags-in-pvt-sector-officials-say-health-system-cant-be-in-covid-mode-forever/916244/
[280] https://www.ndtv.com/india-news/delhi-bihar-to-reimburse-centre-for-free-booster-shots-2911356
[281] https://zeenews.india.com/india/covid-19-fourth-wave-in-india-begins-country-sees-8084-new-infections-in-24-hours-2473197.html

instances of profiteering[282,283] dominated the headlines and several states had to step in to take action on complaints of overcharging[284].

DISCLOSED IMPACT OF COVID-FOCUSSED PROJECTS

Disclosure of progress made has been weak with only the World Bank issuing regular ISRs which indicate the extent to which impact is being achieved for individual projects. This makes it difficult to understand the extent of progress made through the specific loans provided. One also had to rely on the disclosures by the World Bank to understand the impact of co-financed projects.

These point toward fairly robust progress made by India in **ensuring the availability of essential infrastructure and strengthening surveillance facilities**. Thus, the World Bank's disclosures suggest that all district hospitals are reported to have isolation capacity, 99.85% of district health centres have PPEs and infection control products and supplies and 96% of RT-PCR designated laboratories meet external quality control standards[285]. Given the duration of the pandemic, extra investments had to be made in the development of surveillance tools, drugs, hospital beds, PPEs and necessary equipment like ventilators resulting in the restructuring of the WB's COVID loan[286] resulting in frontloading of the expenses for the emergency response. India suffered from severe infrastructure and PPE shortages at the beginning of the pandemic and now has a surplus.[287]

While the above progress made in augmenting the infrastructure for surveillance is appreciated, concerns have been voiced about **consistently inadequate COVID testing in India**[288] [289] While the WHO recommends a daily positivity rate of below 5%, 381 of 741 districts in India had a value higher than 10% in May 2021[290] during the second wave. A third of India's districts maintained a value of above 5% during the third wave in January 2021[291]. Thus, despite considerable progress, more needs to be done to strengthen India's testing regime.

Efforts have also been made to address the needs of key health staff under the projects. Thus, **142,350 district hospital doctors and nurses have been trained on WHO standards of clinical treatment**[292]. Efforts have also been made towards community awareness of health. Thus, it is disclosed by the WB that 79% of the population was able to identify three key symptoms of COVID-19 and three prevention measures. It is also reported that 88.5% of grievances were received and redressed within the government's stipulated timeline[293]. No information about the impact of the COVID-19 vaccination interventions is yet available.

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[282] https://www.deccanherald.com/opinion/main-article/when-hospitals-make-1000-profit-on-syringes-1097647.html
[283] https://scroll.in/article/1023156/harsh-mander-how-some-exploited-indias-covid-19-crisis-to-make-money
[284] https://www.tribuneindia.com/news/editorials/profiteering-during-covid-274152
[285] https://documents1.worldbank.org/curated/en/541921637370842473/pdf/Disclosable-Version-of-the-ISR-India-COVID-19-Emergency-Response-and-Health-Systems-Preparedness-Project-P173836-Sequence-No-04.pdf
[286] https://documents1.worldbank.org/curated/en/366531615896676453/pdf/Disclosable-Restructuring-Paper-India-COVID-19-Emergency-Response-and-Health-Systems-Preparedness-Project-P173836.pdf
[287] https://www.hindustantimes.com/india-news/from-shortage-last-year-india-now-has-surplus-of-ppe-kits-n95-masks-101620620597446.html
[288] https://theprint.in/opinion/capacity-is-not-whats-hindering-indias-testing-rate-government-price-caps-are/460106/
[289] https://www.deccanherald.com/opinion/omicron-is-india-testing-enough-1072861.html
[290] https://www.downtoearth.org.in/news/health/covid-19-more-than-half-of-india-still-not-testing-enough-data-shows-77060#:~:text=More%20than%20half%20of%20India%20is%20still%20not%20testing%20enough,higher%20than%2010%20per%20cent.
[291] https://economictimes.indiatimes.com/news/india/one-third-of-indias-districts-record-over-5-test-positivity-rate/articleshow/88822010.cms
[292] https://documents1.worldbank.org/curated/en/541921637370842473/pdf/Disclosable-Version-of-the-ISR-India-COVID-19-Emergency-Response-and-Health-Systems-Preparedness-Project-P173836-Sequence-No-04.pdf
[293] https://documents1.worldbank.org/curated/en/541921637370842473/pdf/Disclosable-Version-of-the-ISR-India-COVID-19-Emergency-Response-and-Health-Systems-Preparedness-Project-P173836-Sequence-No-04.pdf

The **true share of health workers receiving the insurance for essential health workers has not been disclosed by the WB**, the concerned ISR suggests that as per the government's administrative data, the insurance scheme covers 2.2 million health workers. The real test of the success of any insurance scheme is the extent of its delivery. The insurance offered already excluded assistance for medical expenses of COVID survivors and claims were held up by a range of administrative barriers; by one estimate only 0.013% of the target population received benefits from this provision as of April 2021[294]. **As of February 2022, India has only paid compensation to 1616 deceased healthcare workers under the scheme**[295]. According to information shared with Parliament, **only six of the 36 states and union territories maintain records of health workers who died due to COVID-19**.[296]

STRENGTHENING HEALTH SYSTEMS BEYOND PANDEMICS

While COVID-19 was one of the prime reasons for health assistance to India, some projects address more long-term issues related to public health. These include seven projects supported by the World Bank and ADB[297]. The pipeline Assam project for which no details have been disclosed would presumably also fall in this category.

Many of these are new and, as such, information about the impact being achieved is not available. Both the WB Meghalaya and Mizoram projects have until now disclosed one ISR report each. It is too early to gauge the progress being made since only the baseline has been established for both interventions. The progress being made is being rated as satisfactory.

Some of the broad actions being planned as part of the non-COVID focused interventions supported during this period include the following:

1) **Building states' capacities and governance reforms**

Most longer-term projects include an element of building states' capacity to support the implementation of public health programmes. The activities being planned included

1. **Development of frameworks and strategies** to strengthen states' quality of program and project design (ADB Health system), capacity for implementation (ADB PMJAY) and enhancement of project management capacities (ADB Health systems).
2. **Planning and management Capacity**
   a. Improving the quality of program and project design, project management capacity and supporting production and exchange and knowledge to inform project design(ADB Health System). Similarly, the Meghalaya health project prioritizes information, monitoring and management of health systems.
   b. Strengthen procurement and supply chain management systems to improve the supply of medicines and consumables (WB Meghalaya). Reduction in stockouts of essential medicines in government health services is one of the metrics of success for the project.
   c. Undertake research and support exchange between states (e.g. EHSDP)
3. **Monitoring**. Key deliverables under the EHSDP project are improvement of CPFC data quality (including setting up an independent verification system), development of a CPHC Performance Monitoring Framework, a district measurement framework and an HWC Health Index. The CPHC Index is expected to be developed at the HWC and district levels and disseminated to the public

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[294] https://theleaflet.in/why-have-only-0-013-healthcare-workers-received-benefits-under-the-pm-garib-kalyan-insurance-scheme/

[295] https://www.livemint.com/news/india/centre-paid-rs-808-cr-claims-to-kin-of-healthcare-workers-who-died-of-covid-minister-11644378742329.html

[296] https://www.livemint.com/news/india/centre-paid-rs-808-cr-claims-to-kin-of-healthcare-workers-who-died-of-covid-minister-11644378742329.html

[297] ADB PMJAY, ADB Urban, ADB Health system strengthening and WB Gujarat, Mizoram and Meghalaya

to foster accountability. States will publish the annual district health index report for a proportion of districts and establish a rewards framework (which could be monetary (e.g., enhanced budget bonus) or non-monetary (e.g., peer recognition (EHSDP)

4. **Enhancing transparency of the health sector's public financial management**: EHSDP will involve simplifying PFM data by reducing the number of budget lines and resource pools under the NHM. This measure can both reduce the administrative burden on states and encourage better budget execution by making transfers across pools more flexibly achieved.

2) **Support delivery of health care, especially primary healthcare**

The World Bank's CPF seeks to support citizens' access to quality healthcare, through improvements in public sector provision and private sector activities. This included strengthening standards of service, as well as planning, execution, and monitoring systems to increase the effectiveness and efficiency of public and private investments in the sector.[298] Similarly, the ADB's country partnership strategy pillar 2: provides inclusive access to social services by providing better services for the urban poor[299]. As such, many of the projects include a focus on improving primary healthcare services. This includes

1. **Reform in Internal Performance Assessments:** The EHSDP seeks to support the implementation of the National Quality Assurance Standards (NQAS), a national framework to certify public health care facilities at primary and secondary levels, including the HWCs. It will enable MoHFW will conduct a diagnostic analysis to develop a framework for supporting states to develop implementation strategies on quality of care. Similarly, the WB projects in Mizoram and Meghalaya stress strengthening Internal Performance Assessments and quality certification. This is intended to bring about a performance-based financing system through Internal Performance Agreements (IPAs) between the DoHFW and its subsidiaries.[300] The Mizoram project, however, adds a caveat that while the NQAS accreditation is a desirable goal, it will need to be achieved through the systematic achievement of a series of targets that facilitate short-term achievement and long-term sustainability.

2. **Improving Health and Wellness Centres** is part of several projects with a focus on improving the functioning of primary health centres/health and wellness centres. It is the primary focus of the EHSDP project seeking to incentivize increasing footfalls at HWCs and strengthening their operationalization. These include urban health centres in 13 states (ADB Urban), expanding quality certification(Meghalaya)/ adherence with CPHC guidelines of centres (ADB Urban) and improving NCD and mental health facilities (SRESTHA-G). Other areas of emphasis are improving access to essential medicines (WB- Meghalaya, ADB- Urban) and enhancing the quality of care (SRESTHA-G). Specific projects have also addressed the needs of key constituencies, particularly adolescent girls and urban areas.
   a. Increase availability of rural HWCs (EHSDP). A 27% increase in HWCs is anticipated from the baseline data during the course of the project with an increase in service delivery packages provided.
   b. Review GOI HWC operationalization indicators, reporting and processes to expand the number of HWCs opened and expanding the service delivery package (EHSDP).
   c. The projects seek to ensure improvement of healthcare delivery. Thus, EHSDP & Meghalaya projects seek to improve household access to primary healthcare facility. One of the metrics of success of the Meghalaya project is the Increase in the number of

[298] https://documents1.worldbank.org/curated/en/277621537673420666/pdf/126667-R2018-0190-REPLACEMENT-India-CPF-Final-post-Board-08242018.pdf
[299] https://www.adb.org/sites/default/files/project-documents/53121/53121-001-rrp-en.pdf
[300] https://indiaeducationdiary.in/new-world-bank-project-to-improve-healthcare-services-in-meghalaya-india/

inpatient and outpatients utilizing government health services at the primary and first reference levels (Meghalaya). Similarly, ADB will support demand-side interventions such as improving health-seeking behaviour and improving patient satisfaction in HWCs by improving outreach services, strengthening frontline workers' capacity in risk communication and health promotion and increasing the number of urban HWCs capturing patient satisfaction information.[301] Improving primary healthcare services in urban areas by increasing the number of HWCs meeting CPHC guidelines, increasing screening for NCDs, monitoring the availability of essential medicines and increasing the provision of specialist services in urban HWCs.[302]

d. EHSDP aims to improve the linkage between households and primary care facilities through promoting household visits by ASHAs (or equivalent) to provide information for pregnant women and NCD screening).

e. EHSDP aims for an increase in the population screened based on established national protocols, increasing the proportion of women receiving 4 or more NACs and the number of infants receiving full immunization (EHSDP). A mechanism for population-based screening through a Community Based Assessment Checklist (CBAC) for eligible persons in all households will be undertaken, with additional facility-level screening encouraged for those found to be of high risk. (EHSDP). Screening for NCDs in public health facilities (SRESTHA-G) and improved surveillance systems for improving early detection and response to outbreaks (SRESTHA-G).

f. A performance incentive system for HWCs based on the CPHC Performance Monitoring Framework will be strengthened to enhance HWC performance. (EHSDP).

g. The ADB seeks to improving urban primary care by digital tools, quality assurance mechanisms, human resources and scalable models for engagement of the private sector in improving healthcare. This includes the establishment of a technical division for urban health, strengthening planning capacity at the state and sub-state levels, increasing adoption of innovative practices including private sector engagement and strengthening of quality assurance system in HWCs.

3. **Capturing patient experiences.** The EHSDP will support the MoHFW to develop, in consultation with states, a template for a patient experience measurement tool in Year 1 of the Program for states to subsequently adapt and pilot. This is expected to help to improve demand for quality and strengthen the feedback loops between the people and health facilities.

4. **Other measures to improve health service delivery** including

h. Strengthening technical infrastructure like neonatal and paediatric intensive care units and strengthening forward and backward referral linkages (Meghalaya).

i. Design, development and piloting of innovative models to improve health service delivery are prioritized under both WB Mizoram and Meghalaya. For the former, this includes engaging community platforms and frontline workers, supporting community and home-based palliative care, screening for non-communicable diseases, developing comprehensive primary care services through health and wellness centres, and use of commercial drones for emergency supplies and telemedicine to improve access to services.[303]

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[301] https://www.adb.org/sites/default/files/project-documents/53121/53121-001-rrp-en.pdf
[302] https://www.adb.org/sites/default/files/project-documents/53121/53121-001-rrp-en.pdf
[303] Mizoram Health Systems Strengthening Project

    j. Improving management and disposal of biomedical waste. It is commendable to see an emphasis on the disposal of biomedical waste in private health facilities, an area that is often neglected (WB Meghalaya).

The intention to see **an improvement in the public healthcare systems is commendable, particularly the EHSDP** including the focus on streamlining systems, ensuring the availability of essential medicines and addressing training gaps. The intention under the EHSDP to enhance footfalls in HWCs and under the Meghalaya project to Increase the number of inpatient and outpatients utilizing government health services could be a model for some of the other states. While an emphasis on improving quality is critical, there are some concerns.

The use of results-based financing for strengthening program delivery, particularly in weak and under-resourced public health systems like Mizoram and Meghalaya, **is problematic, particularly from an equity perspective**. At the very least, human resource shortages need to be addressed before introducing performance-linked incentives.

Furthermore, the apparent heavy emphasis on **NQAS and other external verification mechanisms for quality assurance is limiting.** Verification mechanisms by external agencies may have some value, but it is not a replacement for robust mechanisms of **social accountability like social audits** that will have a more sustained impact. At the same time, EHSDP aims to ensure that 1900 HWCs gain NQAS certification (compared to 127 at the start of the project). In contrast, India had 80,764 HAWCs[304] in 2021. The target was to ensure that 1,50,000 Sub Health Centres(SHC), Primary Health Centres (PHC) and Urban Primary Health Centres (UPHC) were transformed into Health Wellness Centres by 2022[305]. This process will touch only a fraction of India's HWCs.

The intention to **capture patient experiences is appreciated** and can produce useful information that can improve the quality of care delivered if quality tools are used and action is taken on the emerging perspectives[306]. However, the **availability of information is an essential, but not an adequate condition for action.** These measures need to be accompanied by stronger efforts to enhance social accountability and grievance redress for patients. At the same time, steps need to be taken to ensure a conducive policy climate for patients' rights by ensuring the projects are based on and ensure implementation of instruments like the Patients Rights Charter[307]. State Governments are responsible for adopting, implementing and monitoring the Charter of Patients' Rights, including ensuring its display in public and private healthcare facilities as well as on their health department websites, allocating the budget for its promotion and setting up grievance redressal mechanisms for patients[308]. **Accordingly, a precondition of funding to states should include the requirement for recipient governments to notify and implement the Charter and institutionalize grievance mechanisms under the same**.

The Mizoram project is correct in flagging fragmentation of health services as a potential challenge but fails to recommend any solution for the same. Most support, however, appears to go into the process of streamlining insurance provision.

    3) **Improve delivery of health insurance-based secondary and tertiary healthcare coverage:**

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[304]
https://pib.gov.in/Pressreleaseshare.aspx?PRID=1783807#:~:text=Update%20on%20Ayushman%20Bharat%20%E2%80%93%20Health%20%26%20Wellness%20Centres&text=As%20per%20the%20budget%20announcement,AB%2DHWCs%20have%20been%20operationalized.
[305] https://nhm.gov.in/New_Updates_2018/publication/AB-HWC-Brochure-June-2021-English.pdf
[306] https://www.sciencedirect.com/science/article/pii/S2405579419300713
[307] http://clinicalestablishments.gov.in/WriteReadData/3181.pdf
[308] https://pib.gov.in/PressReleaseIframePage.aspx?PRID=1797699

Several projects prioritize improving and expanding the coverage of national and state health insurance schemes. These include the ADB- PMJAY and UHC and WB-Mizoram and Meghalaya projects[309]. The activities include efforts to

a) **Strengthen the design of national and state insurance schemes**
   a. Digital solutions for PM-JAY implementation including strengthening IT-based systems to improve administration, strengthen claim management and fraud detection and improve digital solutions for strategic purchase of care. (ADB-PMJAY).
   b. Develop "innovative models for financing and service delivery" by enhancing the development of networks of partnerships, supporting expert forums and exploring the establishment of an innovation facility (ADB-PMJAY).
   c. Improve design and management of State Health Insurance Programs (WB Mizoram and WB Meghalaya).
   d. Evidence-based approaches for improvement of the health sector including an exchange of knowledge (ADB Health system).
   e. Strengthen states' capacity for implementation of insurance interventions including improving monitoring, evaluation and knowledge management, developing a strategy for stakeholder awareness and generally aiming to build mechanisms to consider patient experiences (ADB- PMJAY). The ADB UHC technical assistance aims to undertake an assessment of the priority areas for improvement of UHC and develop the ADB strategy for the health sector in India.
b) **Support enrolment in insurance programmes.**
   a. Develop and roll out targeted communication/behaviour change modules to disseminate information among women beneficiaries, particularly in women-headed households. (ADB- PMJAY).
   b. Undertake a review to identify districts/blocks with a poor enrolment of women beneficiaries in health insurance schemes. To bridge this gap, the component will support capacity-building measures and offer performance-based incentives to insurance enumerators in select districts/blocks. (Mizoram)
   c. Leverage the power of women-led groups to enforce village-level monitoring and uptake of health insurance among women.

The projects support existing government insurance schemes including plugging leakages within the system. However, **this narrow focus is misplaced given the large-scale under-reach and limited access to the PMJAY**. The strategy fails to critique the policy that insurance mechanisms may not be best placed for a country like India, especially in the absence of robust, free, publicly provided services. Insurance mechanisms tend to spend scarce public resources on private provision of very specific health services instead of focussing on easy access to publicly provided primary care which may stop the escalation of many illnesses currently using PMJAY. Early evaluation of the experience of implementation of PMJAY in Chhattisgarh found neither an increase in the utilization of hospital care nor a reduction of catastrophic health expenditure[310] post-enrollment in the scheme. Many empanelled private hospitals used these government-funded insurance schemes to enhance profits[311]. Inadequate steps for regulation for the private healthcare system in India have also compounded these problems. Any process of engagement with the private sector in India must take into cognizance the fact that existing regulatory frameworks in India are not effective. Thus, the

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[309] The Assam pipeline project, for which programmatic details have not yet been disclosed, will also presumably fall in this category.
[310] https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-020-09107-4
[311] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0251814

Clinical Establishment[312] **Act (CEA), 2010 has been adopted by only 11 states with all UTs to date**. As such, promoting health insurance for accessing private hospitals without simultaneously strengthening the regulatory capacities of the state to ensure compliance with minimum standards carries real risks.

In contrast, projects appear to support the **expansion of these schemes, including in areas with limited penetration of the private sector**[313]. Thus, the Mizoram project seeks to promote it **despite the project assessment document highlighting that 86% of all ailments in rural areas are treated in government hospitals** (compared to a national average of 32%). Similarly, the Meghalaya project highlights that barely 56% of the population is reached by the Megha insurance scheme. It is unclear what efforts would be done to address systemic capacities and grievance redress for communities before the proposed move to set targets for enrollment at the village level.

4) **Ensuring availability of human resources and building staff capabilities:**
   Some of the interventions being considered include
   - Development of an HRH strategy for public health facilities for adaptation by states. This will include capacity building of existing health care workers, continuous professional development, functional human resources information system (HRIS), task sharing/shifting, creation of a public health cadre, and performance measurement, among others. (EHSDP)
   - Develop strategies that focus on increasing the number of health care workers, introducing reforms in contractual arrangements and recruitment, and filling vacancies. (EHSDP)

Greater emphasis should have gone to ensuring the availability of adequate human resources in the public health system. India has a shortage of active health workers with the density of doctors and nurses/midwives in India is estimated to be 6.1 and 10.6, respectively. This is well below the WHO threshold of 44.5 doctors, nurses and midwives per 10,000 population[314]. This shortage is particularly acute in rural areas[315]. The Meghalaya project does acknowledge the existence of staff shortages. Thus, it points out that almost 60% of specialist posts are vacant. The Meghalaya project is rare in acknowledging the potential need to create additional health cadres. However, most projects appear to be failing to address this fundamental problem of India's health system. **The projects have thus simultaneously failed to augment staff strength or influence state governments and health systems to undertake this reform.**

The bedrock of India's health system is provided by its Accredited Social Health Activists (ASHAs) who have contributed to improved community health awareness and behaviour change and had historically played a critical role in improving the health and well-being of their communities[316,317,318]. Even before the pandemic, they were overworked and underpaid, however, their work amplified during the pandemic with them being in the forefront for contact tracing, testing and spreading awareness many times without adequate training and protective gear.[319] The extent of attention to

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[312] https://timesofindia.indiatimes.com/business/india-business/11-states-all-uts-except-delhi-have-adopted-clinical-establishment-act-govt/articleshow/67286073.cms

[313] https://science.thewire.in/health/ab-pmjay-scheme-health-insurance-packages-cashless/

[314] https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-021-00575-2

[315] https://ijmedph.org/sites/default/files/IntJMedPublicHealth_2013_3_1_8_109305.pdf

[316] Agarwal S, Curtis SL, Angeles G, Speizer IS, Singh K, Thomas JC. The impact of India's accredited social health activist (ASHA) program on the utilization of maternity services: a nationally representative longitudinal modelling study. Hum Resour Health. 2019;17(68):1–13.

[317] Saprii L, Richard E, Kokho P, Theobald S. Community health workers in rural India: analysing the opportunities and challenges Accredited Social Health Activists (ASHAs) face in realising their multiple roles. Hum Resour Health. 2015;13(95):1–13.

[318] Marwa AA, Thrift AG, Riddel M, Kavumpurathu RTT, Gomathyamma KM, Clara KC, et al. Evaluation of a training program of hypertension for accredited social health activists (ASHA) in rural India. BMC Health Serv Res. 2018;18(1):320.

[319] https://www.epw.in/engage/article/high-risk-without-recognition-challenges-faced

their issues can be gauged from the fact that at the height of the pandemic, they threatened to strike demanding that they be provided personal protective equipment and other basic safety measures[320]. While EHSDP promises to undertake outreach and sensitization activities to make workplaces, safer, unfortunately, **none of the projects explicitly and fully engaged with the core issues of ASHA workers**.[321]

While not addressing staff shortages, many projects do include capacity building of specific existing health personnel. Thus, in Mizoram, the project seeks to have an investment in the improvement of clinical knowledge and standardizing of clinical practices.

5) **Strengthening community voice:**
Activities with a clear focus on engagement with communities include the following:
   a. Strengthening Jan Arogya Samitis (JAS) based on existing NHM guidelines. Functional JASs are defined as those where HWCs prepare annual reports and audits. (EHSDP)
   b. Strengthening planning and improved oversight of the spending of untied funds by the JAS (EHSDP)
   c. Encourage states to improve the representation of women grassroots leaders in JASs and strengthen links with Mahila Arogya Samitis (MAS) (women's health groups) for improved uptake of reproductive healthcare services, preventive care, and screening for non-communicable diseases such as cervical cancer and breast cancer. MASs will be involved in planning and monitoring health programs in urban areas, including slums. (EHSDP) Effective community engagement, particularly involving women representatives at the local level, including in planning, decision making and monitoring (Meghalaya).
   d. JAS in catalysing grievance redressal including utilizing the patient feedback. The JAS will review the functionality of the system of complaints, undertake community outreach, hear patient concerns, act as a grievance redressal platform and escalate relevant issues and complaints to the appropriate structures[322].
   e. Strengthening governance, accountability, institutional and management capacity and citizen engagement (SRESTHA-G).
   f. Communication campaigns to improve enrolment in insurance (Mizoram), particularly among women.
   g. Remapping ambulance services (Meghalaya).

Relatively little emphasis has been placed on building mechanisms for strengthening local self-governance structures or enhancing community-based social accountability in the public health system. The commitment under the EHSDP to ensure at least 40% of HWCs have functional Jan Arogya Samiti's is a notable exception to the trend. While its role in the planning process would be a critical step towards improvement in the public health system, **other enabling measures for community ownership including strengthening the social accountability ecosystem, ensuring social audits and linkage with other structures already in existence for community participation in health**, particularly the Panchayati Raj system **will be important**. Few efforts are also visible to tap into the experiences of patients in the processes described for quality assurance. Community institutions like Village Health and Sanitation Committees, ASHAS and ANMS are listed as affected parties and elected representatives and CBOs are classified as interested parties in the various Stakeholder engagement plans, but these remain at the periphery of the overall implementation plans.

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[320] https://www.business-standard.com/article/current-affairs/asha-workers-crucial-to-india-s-vaccination-drive-threaten-to-walk-out-121120200145_1.html
[321] One of the key components of the National Rural Health Mission is to provide every village in the country with a trained female community health activist ASHA or Accredited Social Health Activist. Selected from the village itself and accountable to it, the ASHA will be trained to work as an interface between the community and the public health system.
[322] https://documents1.worldbank.org/curated/en/099345106042232155/pdf/P1781460c6cf320b00b1af0c913abec3508.pdf

ADDRESSING HEALTH INEQUALITIES IN PROJECTS- COVID AND BEYOND

Most projects include text on addressing the concerns and needs of vulnerable populations. However, the **inclusions read generic and it Is not clear how the specific needs of the specific populations are being addressed**. The ADB project focuses on target beneficiaries in the urban population of more than 256 million, including the urban slum population of 51 million and the vulnerable population in the 13 states. However, no disaggregation is made available based on caste and social groups.

The extent of addressing the inclusion of vulnerable groups under health strengthening projects (n=10)[323]				
	Women	Dalits	Indigenous People	Addressing income/ wealth inequalities
Recognized in social impact analysis	9[324]	3[325]	5[326]	0[327]
Remedial Action planned	8[328]	3[329]	4[330]	0
Whether any indicators disaggregated	5[331]	0	0	0

Gender Analysis

The World Bank, ADB and AIIB appear to have incorporated a gender lens in their projects. Gender-specific measures have included, a specific focus on engagement with women among the community stakeholders identified and some specific challenges of women in the health workforce.

Thus, the World Bank, ADB and AIIB project for health preparedness will focus on- **targeted training for health care professionals**. Thus, one priority is ensuring that they are sensitized on gender-based violence (GBV) and trauma issues to enable them to connect survivors via India's existing referral mechanisms. PHSPP seeks to prioritize the training of women young scientists. In Meghalaya and Mizoram, gender disaggregation is to be undertaken for tracking patient intake in hospitals through monitoring and reporting mechanisms entrusted to district hospitals. In this way, the project seeks to improve the management and monitoring system. The PHSPP particularly priorities ensuring the availability of gender-disaggregated data, including surveillance data including the number of women impacted by communicable diseases The Mizoram project seeks to **increase the usage of health insurance and related benefits for women**. It also aims to empower women's bodies to track and cover women groups under insurance schemes of the state and centre. The WB Gujarat project includes a particular focus on improved service delivery for **adolescent girls** through the strengthening of the Rashtriya Kishor Swasthya Karyakram.

A particularly positive development is that of the Meghalaya project which supports a **review of the HR policy to promote women professionals' entry, transition and career advancement** across various job roles in the health sector. Both these projects, also target at increasing the uptake of health services by the indigenous tribal populations residing in the hilly and autonomous areas of the two northeastern states.[332] Similarly, PHSPP will involve a review of the HR policies and organizational culture to promote gender equality in the workplace through establishing safety cells, promoting flexibility of working hours, promoting childcare options and development of women networks for support to and mentoring of young women professionals.

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[323] ADB Systems, ADB Urban, ADB PMJAY, WB Meghalaya, WB Mizoram, WB Gujarat

[324] NDB COVID emergency loan

[325] Only ADB PMJAY, EHSDP, PHSSP

[326] WB Meghalaya, Mizoram, EHSDP, PHSSP and ADB PMJAY

[327] However, the pipeline SRESHTA-G talks about the risk of elite capture

[328] Except NDB COVID emergency loan and AIIB Vaccine Recovery Loan

[329] ADB PMJAY

[330] AD-PM-ABHIM, Vaccines Recovery, WB-Mizoram and Meghalaya

[331] Not World Bank Mizoram, Meghalaya or any of the AIIB and NDB projects.

[332] ESS, Mizoram Health Systems Strengthening Project, World Bank Document

The ESDP project of the World Bank recognizes gender disparities in accessing healthcare due to out of pocket spending and limited autonomy in decision-making due to restrictive gender norms.

The ADB projects focuses on the gender dimension in all of its project goals. Thus, its project for strengthening health systems focuses on improving outreach services and frontline health workers' capacity to support and facilitate access to services and health-seeking behaviours among the poor and the vulnerable, especially women and girls in urban areas. The RBL program includes specific actions and targets that will benefit women, such as

(i)   HWCs offering screening for cervical cancer and breast cancer
(ii)   Outreach services that address gender-based violence issues
(iii)   Employment for 40% of women at the new urban health technical division
(iv)   Gender-responsive service provision in the revised CPHC guidelines, as well as state road maps for CPHC in urban areas
(v)   Providing benefit and awareness for accredited social health activists and Mahila Arogya Samitis (community women's health committees), who are 90% women, from the training on infectious disease response.

There are no specific provisions for transgender persons.

Indigenous Communities

While several projects follow the statutory framework in **recognizing SCs and STs** as marginalized communities and include a section on the indigenous people in the project document. However, few projects include an **in-depth analysis of the specific marginalization experienced** by these communities. There is also a limited emphasis on indigenous practices and culture as a determinant of public health.

The projects for Mizoram and Meghalaya aim to benefit the local indigenous population with an improved health care delivery system. The project financed by the World Bank and AIIB incorporates a training manual for health care staff to better provide services concerning the dignity, aspirations, identity and culture of the ST and other vulnerable populations. The project incorporates free and prior informed consultations for activities impacting them and takes necessary consent where facilities and infrastructure might need to be established.[333] The HPSPP project recognizes the risks of exclusion of traditionally vulnerable groups like tribal blocks and Schedule V areas of Odisha, Andhra Pradesh, Meghalaya and Tamil Nadu and proposes the development of an inclusion monitoring template to monitor the functioning of Jan Arogya Samitis[334] and tribal health programmes in general. Similarly, EHSDP has a focus on improving access and quality of health service delivery in tribal blocks, particularly in Tamil Nadu and Odisha. A multi-stakeholder consultation with participating states is being considered to seek feedback on state-level programming for tribal communities. EHSDP recognizes that Adivasi populations have below-average health outcomes.

Dalits, Muslim Minorities and Wealth Inequalities

ADB PMJAY and WB Gujarat are exceptional in recognizing Dalits as a vulnerable group but do not flag explicit plans to address the core reasons for this community's marginalization arising from caste-based discrimination. HPSPP prioritizes improving access and quality of health delivery to Dalits in aspirational districts and tribal-dominated blocks, but without an explicit analysis of the specific challenges faced by Dalits. EHSDP stands out as a project analysis that starts with a recognition of inequalities in the

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[333] Environmental and Social Management Framework for India COVID-19 Emergency Response and Health Systems Preparedness Project World Bank Document.
https://documents1.worldbank.org/curated/en/542641622039279499/pdf/Environmental-and-Social-Management-Framework-ESMF-India-COVID-19-Emergency-Response-and-Health-Systems-Preparedness-Project-P173836.pdf
[334] JAS is a multi-stakeholder committee established in Health and Wellness centres comprising of panchayat members, youth, women self-help group members and patient representatives

healthcare sector, including inter-state, rural-urban, gender and social identity. This includes inequalities in terms of access to and quality of care and distribution of healthcare resources, particularly the deployment of the health workforce.

None of the projects explicitly recognize Muslim minority populations as a vulnerable group. This is despite the fact that evidence points toward unequal healthcare outcomes in India. Thus, on average a woman from a dominant caste lives 15 years longer than a Dalit woman[335]. Similarly, Muslims have been found to have a lower female literacy rate, lower institutional births, and poor nutrition[336]

Dalits and Muslims Minorities: The need for a robust focus[337]

On average, an upper-caste woman lives 15 years longer than a Dalit woman in India. Similarly, infant mortality rates (IMR) among Dalits are significantly higher than those of more privileged groups. The Dalit IMR is appr. 45 (deaths in 1,000) compared to 32 for the general category. 60% of India's Dalit children are anaemic – compared to a national average of 50%. The number of stunted children in Dalit and Adivasi households are consistently high compared to other castes. The percentage in Dalit households is almost 43 compared to 31 in general category households. Although average medical expenditure has increased across all social groups in India, significant inequality persists. Dalits face explicit discrimination in access to health care in terms of disparity in care provisioning[338] One study found[339] that Dalits were denied entry into private health centres or clinics in 21.3% of villages. There were significant differences between Brahmins and other castes in terms of waiting time in the private sector[340].

Similarly, health outcomes for Muslim minorities often lag behind the majority community. Hindu households perform better than Muslim households, especially on indicators of access to healthcare. Institutional births and access to food supplements under ICDS which are 10% less for Muslim households as compared to Hindu households; 8% fewer children are immunised in Muslim households

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F**ew projects explicitly address vertical inequalities in health**. The WB Gujarat alone flags the risks of elite capture of healthcare. This is despite the clear evidence of unequal health outcomes based on wealth. The rich, on average, live seven and a half years more than the poor[341].

Wealth Inequality in India

Life expectancy at birth was 65.1 years for the poorest fifth of households in India as compared with 72.7 years for the richest fifth of households. This constituted an absolute gap of 7.6 years and a relative gap of 11.7 %[342]. Wealth inequalities set in early- while the top wealth quintile of 20 per cent section had a Neonatal Mortality Rate of 14.6%, it is three times, ie., 40.7% for the poorest wealth quintile[343]. This is a result of unequal access to healthcare. Thus, there is a six-fold difference between the richest and poorest quintile in institutional delivery[344]. The poor are more likely to receive poor-quality services. At the same time, with much of the secondary and tertiary care in the private sector, out of pocket expenditure remains a significant concern. Health expenditures are responsible for more than half of Indian households falling into poverty; the impact of this has been

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[335] https://www.oxfamindia.org/knowledgehub/workingpaper/inequality-report-2021-indias-unequal-healthcare-story
[336] https://www.oxfamindia.org/knowledgehub/workingpaper/inequality-report-2021-indias-unequal-healthcare-story
[337] This section draws on the India Inequality Report 2021, unless otherwise stated.
https://www.oxfamindia.org/dalitadivasiprivatehospitals and
https://www.oxfamindia.org/knowledgehub/workingpaper/inequality-report-2021-indias-unequal-healthcare-story
[338] https://idsn.org/wp-content/uploads/user_folder/pdf/New_files/India/IIDS_-
_Access_to_Health_Care_and_Patterns_of_Discrimination.pdf
[339] https://us.sagepub.com/en-us/nam/untouchability-in-rural-india/book230642
[340] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6188850/
[341] https://www.oxfamindia.org/knowledgehub/workingpaper/inequality-report-2021-indias-unequal-healthcare-story
[342] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6528758/
[343] https://www.downtoearth.org.in/blog/economy/wealth-inequality-and-children-s-right-to-survival-in-india-64342
[344] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3093249/

> increasingly pushing around 55 million Indians into poverty each year[345]. A majority of the poor are also Dalits, Adivasis and Muslims.

Role of Non-State Actors

A significant share of the projects involves engagement with the private sector either through the support for insurance schemes or through entry into direct PPPs.

Thus, the project on strengthening private sector response included a target of a **20% increase in the empanelment of private hospitals for the provision of COVID services** under PMJAY (ADB- PMJAY). The World Bank and AIIB's joint project for COVID-19 preparedness enlist the support of private laboratories to expand the capacity to test and manage COVID-19. In Meghalaya and Mizoram, private sector engagement is solicited for various purposes including strengthening infrastructure, linkages, knowledge exchange etc. ADB's current projects also emphasize **using the services of the private sector for increasing the coverage of primary health centres for achieving UHC targets**. The considerable emphasis given to insurance-based provision has been described earlier.

Despite this heavy emphasis on engagement with the private sector, **none of the ongoing projects explicitly emphasize the need for its regulation, including the need for compliance with existing regulatory frameworks like the Clinical Establishment Act**[346]. Over a decade since its enactment, the CEA 2010 is currently being implemented only in 12 states[347,348]. At the same time, no robust measures are being proposed to address the great **variation in quality and costs of services provided.**[349] This omission is particularly unfortunate given the track record of several private hospitals having indulged in manipulative practices at the height of COVID-19. [350] ADB's support in past - to the National Urban Health Mission through a $300 million RBL - to the MOHFW kept 'Increased number of facilities registered under the Clinical Establishments Act' as a target within its Program results Framework. This metric should be applied to all projects involving engagement with the private sector.

Past research has highlighted how subsidies like fees exemptions in private hospitals are not passed to patients (55.3% instances as per a study undertaken in Maharashtra)[351]. At the same time, while many of the project documents flag the existence of out of pocket expenditures (and suggest insurance as the solution to the same), **there is relatively little emphasis on low settlement of claims** as part of existing insurance schemes, except one ADB technical assistance project which seeks to provide technical assistance to improve claims management. The question of **high out of pocket expenditure as part of outpatient care** is not addressed. None of the projects focuses on introducing or strengthening price capping in the private healthcare system. The sole exception is the fact that 'Reduced household OOPE as a percent of Total Healthcare Expenditure' is included as a target within the Program Results framework of the ongoing ADB RBL on Strengthening Comprehensive Primary Health Care in Urban Areas Program under Pradhan Mantri Ayushman Bharat Health Infrastructure Mission. None of the documents have highlighted the need to strengthen the **implementation of the Patients Rights Charter** by private hospitals. Any steps to promote private sector participation or other contracting in healthcare

[345] https://www.tribuneindia.com/news/archive/comment/medical-debt-a-major-cause-of-poverty-in-india-866182

[346] https://www.oxfamindia.org/knowledgehub/workingpaper/analysing-regulation-private-healthcare-india

[347] http://www.clinicalestablishments.gov.in/cms/Home.aspx

[348] https://telanganatoday.com/telangana-govt-adopts-clinical-establishment-act-to-regulate-private-hospitals

[349] Kasthuri A. Challenges to Healthcare in India - The Five A's. Indian J Community Med. 2018;43(3):141-143. doi:10.4103/ijcm.IJCM_194_18

[350] https://www.bmj.com/content/370/bmj.m3506

[351] https://www.adb.org/sites/default/files/publication/783876/sawp-091-assessment-maharashtra-state-health-system.pdf

in India are dangerous unless clear steps are laid down to introduce pro-poor regulation, secure patients' rights[352] and concrete steps are taken to address health inequalities.

CONCLUSIONS AND RECOMMENDATIONS

While the support to India for healthcare in the backdrop of the pandemic through these projects is welcome, they constitute something of a missed opportunity. The current mix of projects fails to bring with them the much-needed reforms to strengthen India's public health system, one of the world's most underfunded and weakest. Greater investment is needed to address critical gaps in primary healthcare in particular. At the same time, many projects have unquestioningly supported the engagement with the private healthcare sector in India, either through strengthening insurance-based provision or PPPs. None of the projects addresses the **existing weaknesses of the private system including overcharging, irrational treatments and violations of patients' rights in general**. Little nuancing has also been done to address the specific challenges arising from vertical and horizontal inequalities in health in India.

In view of the above Multilateral development Banks should

- Invest in strengthening primary healthcare provision by continuing to strengthen and universalize the expansion of Health and Wellness Centres.
- Support and invest in health care workers including addressing staff shortages, contractualization, inadequate living and working conditions and limited professional and career growth.
- Ensure that patients' experiences in the primary healthcare system are not only recorded, but also institutionalize mechanisms for grievance redress. A precondition of funding to states should include the requirement for recipient governments to notify and implement the Patients' Rights Charter and institutionalize grievance mechanisms under the same.
- Develop a disaggregated monitoring framework for tracking the extent of access to health care for Dalits, tribal groups and other marginalized communities, particularly women. Recognize the risks associated with a healthcare system of variable/poor quality fuelling inequality and take steps to redress elite capture.
- Minimize outsourcing and public-private partnerships with the private sector, strengthen regulatory laws for overseeing health care delivery and institute standard guidelines and protocols, reduce dependence on insurance mechanisms and prioritise public systems strengthening.
- Take concrete steps to address financial barriers to access including by moving away from insurance systems, given the evidence of partial population coverage, failure to cover costs of outpatient care and track record of poor settlement of claims.
- Strengthen social accountability in the public health system and strengthen mechanisms for obtaining patient feedback as part of program delivery.

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[352] https://www.oxfamindia.org/knowledgehub/oxfaminaction/securing-rights-patients-india

CHAPTER V – PROCESSES AND MODALITIES ACCOMPANYING THE PROJECTS

Having examined the extent to which the projects have been able to address the specific needs of the education and health sectors, it would be critical to look at the overall governance of the projects. This includes the extent of disclosures being made, the extent of participation of civil society in project design and roll out and any conditionalities imposed as part of these projects. These dimensions are covered in this chapter.

COMPLEMENTARITY WITH GOVERNMENT SCHEMES AND INSTITUTIONS

All projects are congruent with existing government schemes and tap into existing government institutions. The project support can be seen in the context of a move towards utilizing 'country systems'[353], which aim for increased aid effectiveness and increased ownership of countries over their development policies and practices. The projects as such largely use country systems.

However, one consequence of the structuring of the project is that progress on the projects has become difficult to track using the government mechanisms. Thus, Projects STARS and ASPIRE are being packaged as centrally sponsored schemes within the overall Samagra Shiksha framework. However, **no dedicated project framework has been announced for them and the government of India states that they will be implemented purely based on the World Bank Project Appraisal Document**[354]. At the same time, no dedicated reporting on the progress achieved under these projects is being done on a state by state basis. This makes it difficult to understand the current status of implementation, the bottlenecks experienced and the impact achieved.

Simultaneously, many of the WB projects are ranked as carrying **substantial risk** as a result of weak institutional capacity for implementation and the fiduciary systems are flagged as requiring support. Thus, the implementation of STARS is subject to several recommendations to strengthen procurement, financial management and implementation mechanisms in the government[355]. These have largely been constructive suggestions that would hopefully strengthen the overall governance mechanisms in these states.

AVAILABILITY OF INFORMATION IN THE PUBLIC DOMAIN

The World Bank and ADB score relatively well among the various IFIs in terms of the level of information disclosure. All WB projects on education and health during this period have provided information on the finances, environmental and social impacts of the projects, and further the bank's commitment plans against the impacts. All projects have displayed detailed project documents and ESS plans. Similarly, most ADB projects have disclosed a fair amount of documentation. However, the disclosure of the full project document did not happen until after Board approval which hindered democratic dialogue about the aims of the project for Project STARS. At the same time, in several projects there is a considerable gap between the project being announced and project documents being uploaded.

The AIIB projects co-financed initiatives by the other banks and hence one can derive some information about the same from WB and ADB disclosures. However, the AIIB itself has not been disclosing separate

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[353] Country systems have been defined by the Paris Declaration 2005 as "national arrangements and procedures for public financial management, accounting, auditing, procurements, results framework and monitoring."

[354] E.G. Lok Sabha Unstarred Question No. 2430 To Be Answered On 13th December, 2021 and Rajya Sabha Unstarred Question: 2602 Date Of Answer: 18.03.2021

[355] https://documents1.worldbank.org/curated/en/107941591127035009/pdf/Final-Fiduciary-Systems-Assessment-Strengthening-Teaching-Learning-And-Results-for-States-P166868.pdf

actions taken with its resources. Accordingly, no information about the consultations, activities to be undertaken, impact intended to be achieved or progress made with the AIIB share of resources is in the public domain. For another AIIB project in India, COVID had also led to the suspension of the norms for proper consultation and information disclosures making project implementation less participatory[356].

However, reporting by the NDB has been the weakest. In April 2020 the NDB approved a $1 billion project for the GoI as an emergency assistance (Emergency Assistance Program in Combating COVID-19). Information on the implementation strategy or project framework is lacking even in March 2022. In the **absence of details, it is difficult to understand operational details in terms of the agencies to be involved in the procurement of goods and services**, whether consultations were held, what the grievance redress mechanism is set up, and what the project achieved during the first year since its approval. Inadequate disclosures by the NDB have a long history. Oxfam India[357] and South Africa[358] have both highlighted the need to strengthen disclosure and grievance redress mechanisms of the NDB.

Disclosure in accordance with the standards and other good practices by IFIs in India (education and health)[359]				
	World Bank	ADB	AIIB[360]	NDB[361]
N	10	3	3	1
Total projects supported by concerned IFI[362] (N for subsequent analysis)	10	3	3	1
Environmental and Social Safeguards (ESS) in place[363]	10	3	0[364]	0
Stakeholder Engagement Plan (SEP) in place	5[365]	2[366]	0[367]	0
Procurement Plan in place[368]	6[369]	2[370]	0	0
Details of stakeholder consultations undertaken for project finalization have been disclosed	5[371]	0	0	0
Whether CSOs were consulted during the development of the project	4[372]	0	0	0
Whether teachers or health workers were consulted	4[373]	0	0	0
Metrics of success have been disclosed	10	3	1[374]	0
Information about progress on the project is available in the public domain[375]	7[376]	0	1[377]	0

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[356] http://www.bricsfeministwatch.org/pdf/AIIB-Roads-to-Inequality-Report-from-Gujarat.pdf

[357] https://www.oxfamindia.org/workingpaper/6096

[358] https://www.oxfam.org.za/wp-content/uploads/2021/05/oxfam-ndb-full-report-web.pdf

[359] This analysis does not include pipeline project

[360] The AIIB has followed the WB processes for the projects that they co-fund and do not disclose undertaking separate processes. Some of the details could be inferred from the WB documents, but doing so does not reduce the need for the Bank to undertake its own due diligence and planning. The AIIB projects included COVID emergency, COVID vaccine and the Gujarat project.

[361] This also follows the processes of the co-financing Bank.

[362] This constitutes the n for subsequent analysis.

[363] For World Bank- all health and education loans, For ADB this includes COVID-Vaccine, Assam Skill University.

[364] AIIB has used ESS of co-financing IFIs, only for COVID-19 Vaccines project the ESS is not available.

[365] For World Bank- COVID emergency loan, Mizoram, Meghalaya health loans, SALT,NECTAR, For COVID-Vaccine, Assam Skill University.

[366] COVID Vaccines is not available.

[367] The AIIB project summary include a paragraph on the stakeholders for the project in two projects (COVID emergency health n).

[368] For World Bank- all health and education loans except GOAL. For ADB- COVID-Vaccine, Assam Skill University.

[369] Except for GOAL,GOAL II, EHDS and PHSPP

[370] No available for PM-ABHIM

[371] For World Bank- not done for COVID emergency response loan. For PHSSP and EHSDP, this was done only for the ESS.

[372] For World Bank- Mizoram, Meghalaya health loans, SALT,GOAL. Similarly, selected two CSOs were consulted on the ESS under the PHSSP.

[373] Only GOAL, SALT, Mizoram and Meghalaya projects made outreach to these groups.

[374] Available only for COVID-19 emergency health and system preparedness.

[375] For World Bank- all health and education loans except COVID emergency response loan, For ADB-PM-BHIM, COVID-Vaccine, Assam Skill University, For AIIB- Covid-19 vaccine, Gujarat education loan. The ISR for the WORK grant has been disclosed.

[376] Not available for GOAL II, EHDS & PHSPP.

[377] Monitoring report available for COVID-19 emergency response and health system preparedness project.

Grievance Redress mechanism notified	10	2[378]	2[379]	0

Information provided in the procurement plans does assist in knowing the quantum of private and public sector resources being used for these project goals. One of the grey areas in the analysis was the **selection of private agencies for the supply of equipment and utilities**. IFIs should disclose within their procurement plan on what basis and criteria these agencies have been selected and provide relevant purchase details. ADB, AIIB and NDB should follow the practice of the World Bank, which has provided its procurement plans in all of the active projects.

Procurement plans have been disclosed for six World Bank and two ADB projects. One media report highlighted how World Bank had made universal procurement conditional in its emergency loan project which had opened the gates for procurement from foreign suppliers.[380] This means domestic policies including preferential market access for small and medium enterprises and start-ups would not be applicable for this 1 billion dollar project.

NDB's INFORMATIONAL DISCLOSURE POLICY

The sheer lack of information on the specifics of the programme is concerning. This draws attention to the bank's Information Disclosure Policy (IDP) dated June 2017, which states that *'the bank is committed to a policy of information disclosure to promote transparency and enhance accountability in its operations.* This commitment of the NDB has been recognised in Article 15 of its Articles of Agreement (AoA). Point 1.1.1 (promoting transparency). Given the nature of the project, which is geared toward 'public health / social safety in times of crisis, the bank has no reason to invoke the confidentiality clause or provide such limited information. On the contrary, it has all the reasons to promote full transparency towards public health and social safety measures. The bank in its ESF itself categorises this project as 'B' and highlights that the project will have a positive impact. The issue of operational information is central to project support such as this and is reiterated in the IDP, which calls for the bank to establish a process for disclosing information not only after approval but also during the project life cycle.

Furthermore, the loan documents failed to take into consideration the existing realities that have emerged in COVID-19. For most of the loans, detailed action plans which could have enabled establishing a connection between the IFI project and specific spending allocations to departmental activities were missing. The details of the specific expenditure under most of the national **loans could not be easily traced in the government books of accounts at the state or sub-state levels**. It has also been difficult to understand the breakup of the allocations made in terms of the extent of resources allotted to the states and retained by the central government. This has affected civil society's ability to track the utilization and provide social accountability for this expenditure.

The **ESS safeguards and plans for the loans provided comprehensive referencing to laws that would deal with unintentional project risks**. This seemed like a checklist exercise of listing provisions. One could have hoped for much more intensive exercise of understanding the project's impact on marginalized communities. This could have been facilitated through consultation with civil society, especially given that some of the projects have been marked as carrying substantial risk. This could have helped some new solutions to emerge. Fundamentally, all projects need meaningful consultations.

EXTENT AND NATURE OF CONSULTATIONS

Five of the ten World Bank projects have disclosed detailed stakeholder engagement plans. Two projects STARS and GOAL do not disclose stakeholder engagement plans, whereas PHSSP, EHSD and GOAL II shared some of the outcomes of the consultations in other documents. Both are PforR projects which could be

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[378] Available only for PM-ABHIM & Assam Skill University

[379] Not available for COVID-19 Vaccines project

[380] https://www.thehindu.com/news/national/no-preference-for-make-in-india-in-world-bank-project-to-curb-covid/article32655167.ece

one reason why the information is not disclosed. However, SALT, another PforR project has a detailed stakeholder plans. While this is a positive development, there are questions about the quality of consultation, especially at the design stage. Thus, the World Bank's STARS project is based on visits to 25 schools, two teacher training institutes and a consultation workshop held in Delhi. No national education civil society networks were consulted at the pre-finalization stage[381]. While subsequent consultations were undertaken, these do not replace the need for civil society to contribute to the project design. Spaces for ongoing dialogue, based on adequate disclosed information about the progress achieved, are missing.

At the same time, given the experience of shrinking space across the world, it would be critical to ensure that critical documents from the IFIs take stock of the question of civic space. Thus, the **World Bank's Systematic Country Diagnostic should include an analysis of civic space**. For the Bank to effectively implement its commitments to stakeholder engagement in today's reality of restricted civic space in many of the countries in which it operates, it needs first to better understand the constraints, challenges, gaps and opportunities that enable or constrain civil society participation in a country's development process. Such an analysis holds to potential to build an understanding of the environment in which stakeholder engagement happens and the different dimensions of civic space at local and national levels; identify areas to be addressed or strengthened; facilitate open discussions and reflections on civic space trends and dimensions; inform decision-making on strategies, programming, risk management on issues related to potential social conflicts, stakeholder engagement and participation of civil society; and feed into project's risk assessment and flag contexts with greater risk of reprisals against those criticizing or raising project concerns.

ADB's disclosures provide some **insights for its stakeholder engagement plans for all three loans**. However, the information disclosed is fairly inadequate and varies considerably from project to project. One project provides a fairly detailed stakeholder list and plan, another offers a snapshot overview of the stakeholders, channels for disclosures and communication points, while the third includes its stakeholder engagement plan in the indicator framework. The details of the representatives consulted are not in the public domain.

AIIB and NDB do not separately disclose details of consultations undertaken for project development by relying on processes undertaken by the WB or ADB.

Given the COVID context, many of the consultations have been held virtually which may have additionally affected the quality of the consultations. The World Bank undertook many of these **consultations virtually thus leaving out a large section of beneficiaries who are poor, vulnerable and lacking access to ICT**. It is perplexing as to why the IFIs did not involve the **representatives of the concerned marginalized communities** to input into ESS in a large number of projects. At the same time, there are serious questions about the quality of consultations with **delayed disclosure and the absence of consultations at the design stage**. While some have included some consultation with frontline health workers and teachers, **none of the consultation documents mentions consultations having been undertaken with their professional associations or unions**. At the same time, while individual NGOs have been consulted, limited signs appear of outreach to civil society networks and alliances or representative voices of marginalized communities. Finally, **none of the detailed reports of these consultations have been disclosed**. These need to be put in the public domain for transparency in their information systems.

INFORMATION ABOUT METRICS OF SUCCESS AND PROGRESS OF PROJECTS

All World Bank projects disclose detailed metrics of success and information about the progress of the projects except the COVID emergency response loan is available in the public domain. Similarly, the

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[381] https://www.oxfamindia.org/knowledgehub/workingpaper/world-bank-funded-project-stars-critique

detailed outcomes are also disclosed for the ADB projects. No separate detailed disclosures have been made for the AIIB and NDB projects.

While the WB and ADB disclose the impact achieved, the **level of detail in the ISR does not enable stakeholders at the state and district level to understand the extent of implementation with a view of either tracking or supporting implementation**. The disclosure formats could be strengthened to enable stakeholders to truly understand the extent of the progress made. At the same time, it would be critical to ensure mechanisms are in place to support civil society engagement with the roll-out of the project across the project cycle.

An examination of the conditions of effectiveness for the Loans suggests that many of the loans by the World Bank are conditional on the implementing entity (the concerned line ministry or state government) creating a Program Management Unit for the implementation of the project. At the same time, a Project Implementation Manual is expected to be prepared. Other projects expect an independent verification agent to be onboarded. **Most of these documents produced through these processes are not in the public domain**.

FINANCIAL ARRANGEMENTS ATTACHED TO THE PROJECTS

Borrowings from IFIs are typically undertaken to supplement domestic revenue shortfalls to manage the current account deficit. Domestic revenue shortfalls occur because of lower tax collections, especially indirect taxes such as corporate tax and increased spending which can cause a fiscal deficit. This impels the government to borrow from IFIs for its public sector and is categorized as external debt. Thus, India manages its borrowings or external debt with the overarching objective of keeping the current account deficit within sustainable limits by financing it with a prudent mix of debt and equity flows. Loans from multilateral and bilateral sources under external assistance– are the largest constituent of sovereign debt with a share of 4.9%. In 2020 India had a total of US $ 60 Billion in borrowings from a range of International Financial Institutions.[382] As discussed earlier, India's debt burden is reaching somewhat troubling proportions.

Furthermore, this lending is taking place against the backdrop of the government not taking adequate measures to explore all domestic sources of revenue. Thus, an additional one per cent wealth tax on the 98 richest billionaire families would finance Ayushman Bharat for more than seven years or a four percent of tax on wealth on the 98 billionaires can take care of the Mid-Day- Meal Programme of the country for 17 years.[383] It has also not made adequate use of its Special Drawing Rights Allocation from the IMF which could have been spent to shore up public spending on essential services[384]. At the same time, one could also question whether the current spending priorities of the government are most appropriate.

Almost all loans provided during this period have a Front-end Fee (0.25%) of the project amount and a Commitment Charge is one-quarter of one per cent (0.25%) per annum on the Unwithdrawn Loan Balance. Interest rates per year range from 3-8% depending on the number of years of the loan. The loans are provided at flexible rates of interest which were governed according to the London Interbank Offered Rate (LIBOR) but were transitioned by March 2021 to the USD based on the Secured Overnight Financing Rate (SOFR)[385] which would have resulted in some interest rate changes. The market-based interest rate offered under IBRD allows the flexibility for countries to choose the relevant interest rates and repayment period for sovereign loans.

[382]https://dea.gov.in/sites/default/files/India%27s%20External%20Debt%20-%20A%20Status%20Report%202019-20.pdf
[383] https://www.oxfamindia.org/press-release/inequality-kills-india-supplement-2022
[384] https://www.thenewsminute.com/article/let-s-talk-about-india-s-sdrs-using-imf-s-rs-13-lakh-crore-allocation-boost-our-social
[385] https://www.pwc.com/us/en/industries/financial-services/regulatory-services/libor-reference-rate-reform/sofr-transition.html

In the fiscal year 2021, India was the second-highest borrower of IBRD, with IBRD commitment standing at USD 2468 Million for its public sector.[386] For ADB sovereign loans India is listed as a country requiring the least concessions on its borrowings. Most AIIB loans given during this period are governed by a standard interest rate with a final maturity not exceeding 18.5 years, including a grace period of 5 years.

Among all the loan documents analysed none have categorically mentioned the rate of interest for repayment of the loans. This is mainly because of the flexible rate of interest offered by most IFIs. The references to working out the interest rate are provided on the websites of these IFIs that group countries based on their income-economy status. While the loan documents provide the global referential rates that would govern the entirety of the project based on international market dynamics.

India would be repaying these loans over decades. The following is the repayment schedule for the various loans:

Repayment Schedule for IFI loans during COVID-19[387]		
	Repayment Schedule	
	Begins from	Final instalment date
World Bank Loans		
STARS	September 15 2026	September 15, 2037
GOAL	June 15, 2028	December 15, 2037
NECTAR	June 1, 2026	June 1, 2035
SALT	December 15, 2027	December 15, 2054
Mizoram Health Strengthening	September 15, 2026	September 15, 2035
Meghalaya Health Strengthening	April 15, 2027	October 15, 2035
COVID-19 emergency response	September 15, 2025	September 15, 2038
ADB Loans		
Responsive COVID-19 Vaccines for Recovery (Phase 1)	May 1, 2025	November 31, 2031
Responsive COVID-19 Vaccines for Recovery (Phase 2)	May 1, 2025	November 31, 2026
Strengthening Comprehensive Primary Health Care in Urban Areas Program under the Pradhan Mantri Ayushman Bharat Health Infrastructure Mission	June 1 2026	December 1, 2040
Assam Skill University	June 1, 2027	December 1, 2041
AIIB Loans		
India COVID-19 Emergency Response and Health Systems Preparedness Project (under the COVID-19 Recovery Facility)	November 11, 2025	May 31, 2043
Gujarat Education Infrastructure and Technology Modernization Program	June 31, 2028	Dec 31,2044

It is worth noting that with Mizoram and Nagaland being underdeveloped states which have received World Bank projects for education and health, there is a need for World Bank to elaborate on why it didn't waive these front-end fees and commitment charges given that the recent intergovernmental group of 24 had recently suggested that WBG should consider waiving these specific fees for facilitating COVID recovery.[388]

THE RELIANCE ON RESULTS-BASED FINANCING

The **World Bank's CPF for India commits it to the use of Program for Results (PforR), its results-based financing instrument, in 10% of projects in terms of numbers and 12% of commitment volume with the education sector being particularly prioritised**. 60% (three of the five) disclosed WB education projects[389]

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[386] https://www.worldbank.org/en/about/annual-report#anchor-annual
[387] Final loan documents for the newly approved GOAL 2, EHSDP and PHSPP have not been uploaded at time of writing
[388] https://www.imf.org/en/News/Articles/2021/04/05/g24-communique-april-5-2021
[389] STARS,GOAL,SALT

during this period use PforR methodologies. At the same time, two of five WB health projects[390] also use PforR (another pipeline WB health project is also slated to use PforR)[391]. Similarly, ADB's internal review of its RBL instrument found it to be broadly effective in enhancing accountability and supporting government-owned development programs.[392] Two ADB projects (one apiece in health and education) used RBL[393]. At the same time, one AIIB project[394] used the WB PforR methodology.

UNESCO has urged caution in disbursing aid to education through results-based payments[395]. There is an overall absence of clear and conclusive evidence of the impact of the methodology[396]. Furthermore, the history of implementation of PforR and related methodologies, suggests that while it may potentially enhance result orientation, it does not fulfil the principle of country ownership and results in inconsistent application of the principle of the use of country systems. Indeed, it has been criticised as potentially another attempt to impose conditionality on aid.[397]

Thus, the commitment to PforR in the WBG's CPF and subsequent provisions in the individual projects commit it to explore delivery models that leverage the private sector to deliver quality education including through public-private collaboration and the provision of supplementary education services, such as leveraging technology to enhance learning outcomes and building on lessons derived from IFC investments in the EdTech space. This explicitly ties the World Bank's resources to the achievement of specific policy agendas which is a form of conditionality. Thus, the State Incentive Grant (SIG) Manual for Project STARS details the targets, conditionalities and points for accessing funds and includes a "mandatory" component for participating states to engage "non-state actors" -- private parties -- for substantial roles in public education. Disbursement of money was linked to meeting the set targets. This has, however, been rendered no longer mandatory in the March restructuring of the project[398]. Further details of the policy focus which is backed by PforR have been included in the education and health chapters.

RECOMMENDATIONS

IFIs should strengthen

a)   Disclosures for all projects putting all information in the public domain, including information about the details of inputs received during the consultations and the progress being made against the projects.

b)   These disclosures should be in a form to enable project-affected communities to understand the specific purpose that the projects would serve. Thus, for multi-state projects, it would be critical to ensure that resource allocations and implementation are traceable to the state level to provide a basis for engagement.

c)   All projects should ensure meaningful consultations with representative civil society organizations including teacher/health associations and unions, health/education networks and the representative organizations of marginalized communities should be included as part of the consultation. This should be in addition to engagement with individual organizations and frontline workers that forms existing practice in the World Bank.

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[390] EDHSP, PHSSP

[391] SRESHTA-G

[392] https://www.adb.org/sites/default/files/institutional-document/192626/midterm-review-rbl-programs.pdf

[393] ADB PM-ABHIM and ADB-ASPIRE

[394] Gujarat Education Infrastructure and Technology Modernization Program

[395] https://unesdoc.unesco.org/ark:/48223/pf0000261149

[396] https://www.r4d.org/wp-content/uploads/Literature-Review-OBA.pdf

[397] https://unesdoc.unesco.org/ark:/48223/pf0000261149

[398] https://documents.worldbank.org/en/publication/documents-reports/documentdetail/099745003032222027/disclosable0re0for0states000p166868

d)   Voice of marginalized communities need to be included in these consultations, including representatives of communities beyond the statutory constituencies of indigenous people and women. Separate consultations with the various excluded communities need to be undertaken.

e)   IFIs providing sovereign loans to under-developed states should consider waiving front-end fees and commitment charges for public sector financing.

f)   All IFIs should provide the rate of interest or the range of interest being charged for projects for a middle-class country like India which has graduated from receiving concessional lending. This could be part of either the project information document or the loan agreement. Additionally, all IFIs should disclose the final worksheet for loan choices offered to the government that determines their relative flexible interest rate selected for different loan products.

CHAPTER VI : CONCLUSION AND RECOMMENDATIONS

The COVID-19 pandemic pushed the IFIs to roll out immediate packages that would help India to manage the challenges of lockdown, sudden health burdens and educational gaps. The subsequent projects have also provided additional resources for specific interventions. The experience of tracking the projects over the last two years has provided us with seven critical insights.

1. There is a need for minimum standards to ensure greater and more meaningful participation of civil society and social movements in pre-project consultations and social dialogue and accountability processes across the project cycle. At the same time, a civic space assessment should be included in key documents like the World Bank's Systematic Country Diagnostic.

2. Need a stronger focus on equity, including a focus on wealth inequalities and a formal framework to acknowledge and act upon the unique challenges faced by India's marginalised groups and constitutionally recognised categories such as SCs, STs and Muslim Minorities. A stronger focus on intersectionality within the gender interventions would also be desirable.

3. IFIs need to recognise the dire need to act upon the systemic issues affecting India's health and education sectors including chronic underfunding, inequality and discrimination in the health and education systems of India.

4. Need a more critical analysis of the role of the private sector in education and health and putting in place safeguards to prevent the involvement of for-profit players, profiteering and rights violations by the private sector in public services.

5. Need enhanced Parliamentary oversight and accountability to public bodies in India as the loans would be repaid by the state exchequer.

6. Process of evaluation of project impact should be strengthened to include people's voice. Social audits can be used as a tool for evaluation.

7. Updated and desegregated information regarding the status of implementation (including achieved as against targeted) of all projects and the interest charged for any loan must be made available in the public domain. The disclosure of the progress achieved should include adequate granularity to be usable by affected communities in the states where projects are being implemented.

People and not government infrastructure and machinery should be placed at the heart of the IFI project design. With poverty and inequality increasing in India in the wake of the COVID pandemic, IFIs' financing for health and education has to increase. They need to be open and transparent about their loans to enable people, movements, alliances, networks and CSOs to hold them and their financing to scrutiny.

ANNEXURE I: FUNDING FOR HEALTH PROJECTS

Financing of health projects by the World Bank (in millions USD)							
	Nature	Status	Summary		Funding from		Project Duration
			Total project cost	Total WB Financing	IBRD	Govern ment	
COVID-19 Emergency Response	Loan	Active	500	1000	1000		2020-25
PHSPP	Loan	Active	1260	500	500	1660	2022-2028
Enhanced Health Service Delivery (EHSDP)	Loan	Active	1221	500	500	42000	2022-27
Meghalaya	Loan	Active	50	40	40	10	2022-27
Mizoram	Loan	Active	40	32	32	8	2021-27
SRESTHA- G	Loan	Pipeline	7984.14	350	350	7984.14	2023-?
Assam Secondary Healthcare System Reform Project[399]	Loan	Pipeline		251.03	251.03		2023-?

ADB funding for health projects during the COVID period (in USD Million)							
	Nature	Status	GoI	ADB	Other co-financing	Total	Duration
COVID-19 Emergency Response	Grant	Active			3[400]	3	2021
Supporting COVID-19 Response and Vaccination program (ADB Vaccines)	Technical Assistance	Active		2	5[401]	7	2021-24
Supporting health systems strengthening Projects	Technical Assistance	Approved		2		2	2021-24
Strengthening UHC in India: Supporting the implementation of PM-JAY	Technical Assistance	Active		0.2	2[402] [403]	2.2	2020-23
Strengthening Comprehensive PHC in Urban areas Program under the PM ABHIM[404]	Loan/TA	Active	828.86	300	2.9[405]	1128.86	2021-25
Supporting New Infrastructure Development through Public–Private Partnerships and Implementation	Technical Assistance	Active		1.5		1.5	2022-25

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[399] https://projects.worldbank.org/en/projects-operations/project-detail/P179337
[400] ARDRF Government of Japan for COVID-19
[401] Includes 5 million provided by JICA and 2 million from the Technical Assistance Special Fund
[402] Republic of Korea e-Asia and Knowledge Partnership Fund (half a million)
[403] 1.5 million under the Japan Fund for Prosperous and Resilient Asia and the Pacific
[404] Formerly known as the PM Atmanirbhar Swasth Bharat Yojana
[405] Includes 2 million from the Japan Fund for Prosperous and Resilient Asia and the Pacific and 900, 000 from the High Level Technology Fund.

Monitoring of National Infrastructure Pipeline							

Funding for AIIB Projects in co-financing with ADB and WB during the COVID period (in USD Million)							
	Nature	Status	AIIB	ADB	IBRD	Government	Total	Duration
Vaccines for recovery	Loan	Approved	500	1500		57.77	2057.77	2021-25
Health System preparedness	Loan	Approved	500		1000	0	1500	2020-24