ADDRESSING EDUCATION, HEALTH INEQUALITIES IN COUNTRY PARTNERSHIP FRAMEWORK & STRATEGY OF WORLD BANK AND ADB

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This document emerged from a series of discussions with educationists and public health professionals including, but not limited to, Amitabha Sarkar (Swiss Government Excellence Fellow at the Global Health Centre, IHEID, Geneva), Ravi Duggal (independent public health researcher), Dr. Shakeel Ahmed (Executive Director, CHARM, Bihar), Nesar Ahmad (Director, Budget Analysis and Research Centre Trust, Rajasthan), Kiran Bhatty (Senior Visiting Fellow, CPR), Martin Haus (PhD candidate, London School of Economics and Political Science), Meera Samson (Director, CORD), Anita Rampal (Retired, Dean, Faculty of Education, Delhi University), Noopur, Akshay Atmaram Tarfe and Nitin Jadhav (Oxfam India).

Executive Summary:

The Country Partnership Framework (CPF) and Country Partnership Strategy (CPS) are strategic documents prepared by the World Bank Group and Asia Development Bank respectively containing the ambit of interventions they intend to undertake as investments, loans and technical assistance. The CPS and CPF are reviewed and updated every 4-5 years, based on a series of consultations with various stakeholders such as economists, sector experts, academicians, policy analysts, governments and civil society organizations. The World Bank, before releasing its CPF, sets its priorities in the System Country Diagnostic, an economic analytic report that assesses a country's socio-economic and developmental challenges and gaps. Both WBG and ADB will be renewing their cycle of country engagement for the period 2023-2028, a critical juncture for civil society to influence their policies on providing quality education and universal access to health care which have witnessed significant diminution during and after COVID-19.

The next CPF should
1. Support public system strengthening in education and health and reverse privatization and commercialization of and in these sectors
2. Address rising inequality in India
3. Increase transparency and accountability of lending

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BACKGROUND

International Financial Institutions (IFIs) have played a significant role in shaping the development trajectories of many middles- and lower-income countries. Their role has been financial (in the form of lending or grants offered to national and state governments and through private sector investments and grants), technical (through advice to these governments) and ideological (through supporting research and shaping the terms of debate on development). Out of the IFIs that lend to India, the World Bank Group (WBG) and Asian Development Bank (ADB) stand out because of their long history of financing in social sectors like health and education. The World Bank (WB) and ADB support key development initiatives of a country by lending to their government and private sector. India has been a recipient of WBG and ADB financing since 1947[1] and 1966[2] respectively.

Health and education are fundamental human rights and public goods. Ensuring universal and equitable access to good quality public services for everyone is critical for individual well-being and national development. It not only benefits its recipients but also shapes civic behaviour and contributes to economic development. As such, it is critical to ensure that these sectors are not only supported but supported to undertake the appropriate policies and programmes. This is particularly the case after the experience of the COVID pandemic.

India had the world's second-largest caseload of the pandemic with 43.89 million cases and has seen 526,033 COVID-19 deaths. However, even before the pandemic only half of India's population had access to the most basic healthcare services[3]. Citizens paid 58.7% of their health expenditure out of pocket.[4] Countries with high out-of-pocket expenditure have poorer health outcomes and had a higher risk of mortality during the pandemic.[5]

At the same time, India had the world's longest school lockdown. The SCHOOL survey noted that the proportion of school children who were studying online "regularly" was just 24% and 8% in urban and rural areas respectively primarily because of the lack of digital devices.[6] Not only was there no new learning, but children had also forgotten what they had learned in previous years. It is reported that 92% of children lost at least one specific language ability and 82% lost one math ability from the previous year across all classes[7]. This was accompanied by classroom hunger, psychological trauma and growth in child labour. Furthermore, this amplifies existing problems in the education sector including low rates of transition, shortages of infrastructure and teachers and continued challenges concerning educational quality and equity.

While most Indians suffered during the pandemic, there was also a concentration of wealth in the hands of the few. Thus, in India by 2020 the richest 98 Indian billionaires had the same wealth (USD 657 billion) as the poorest 555 million people in India. During the pandemic, India's poor population doubled to

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[1] https://dea.gov.in/sites/default/files/India_WB_0.pdf

[2] https://www.adb.org/sites/default/files/publication/27768/ind-2021.pdf

[3] 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

[4] 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

[5] 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

[6] https://roadscholarz.net/wp-content/uploads/2021/09/English.pdf

[7] https://azimpremjiuniversity.edu.in/field-studies-in-education/loss-of-learning-during-the-pandemic

around 134 million.[8] As such, obscene levels of inequality have contributed to curtailing accessibility and affordability of the most basic essential services. It has also deprived the Indian state of much-needed resources. Research suggests that a wealth tax on billionaires can finance key social sector schemes for 2-6 years.[9] Globally, institutions such as the IMF have proposed wealth taxes for tackling the costs of COVID-19 and countries like Argentina have used progressive taxation to finance public sector services.[10]

As India emerges from the pandemic, it is critical to ensure that the education and health sectors are built back better, but also that it is built back equal.

ADB AND WB'S SUPPORT FOR EDUCATION AND HEALTH DURING COVID PERIOD AND BEFORE

The World Bank and ADB have invested approximately 5.8 Billion USD in the health and education sovereign projects since 2020. Funds have flown to both the national and state governments. Funds have flown to both the national and state governments. A detailed overview of the lending to the two sectors during the pandemic[11] suggests that many of these grants fail to adequately strengthen education and health public infrastructure and enhance human resources in the two sectors and fail to prioritize compliance with established laws and frameworks like the Right of Children to Free and Compulsory Education Act, Patient Rights Charter and the Clinical Establishments Act. They also do not address many of the systemic issues which have been plaguing the health and education sectors such as addressing school drop-out or investing in teacher training through strengthening DIETs in education or managing out-of-pocket

COVID-19 LOANS DURING 2020-22 (IN USD BILLION)

■ Health ■ Education

World Bank: Health 2, Education 1.5
Asian Development Bank: Health 1.8, Education 0.5

STATE AND NATIONAL LOANS DURING 2020-22 (IN USD BILLION)

■ National ■ State

expenditures or strengthening the primary health system. Moreover, the projects fail to adequately address prevailing inequalities in education and health. There is a need for a stronger focus on addressing wealth inequalities and the individual challenges of Dalit, tribal and religious minorities.

At the same time, both Banks have also been promoting the private sector. The World Bank's International Finance Corporation (IFC) has been financing private health care chains such as Apollo and ed-tech

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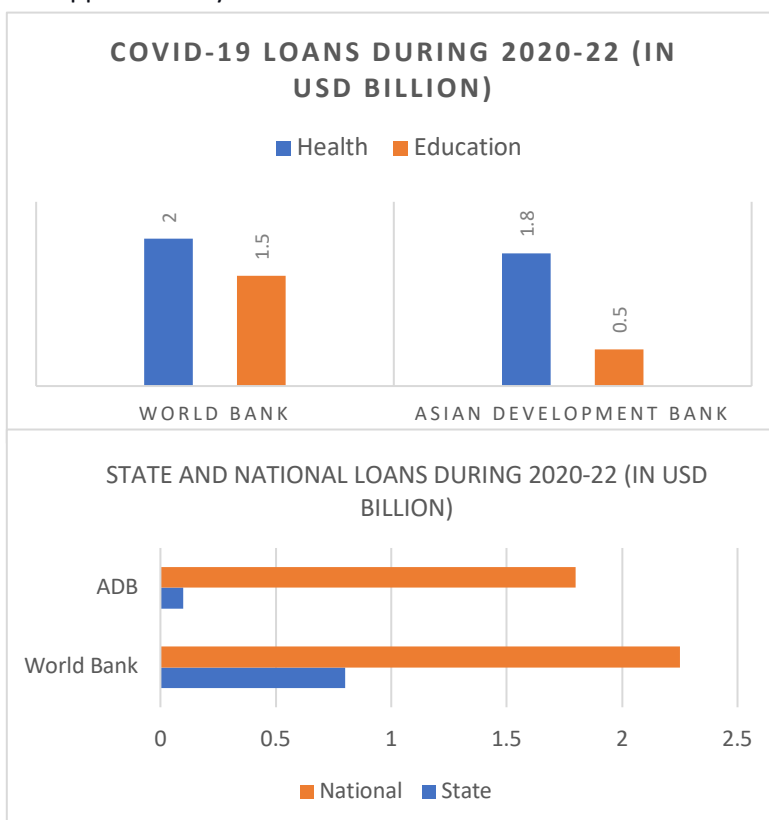
[8] Kochhar, Rakesh, (2021), "In the pandemic, India's middle class shrinks and poverty spreads while China sees smaller changes", Pew Research Center, accessed January 4, 2022, https://www.pewresearch.org/fact-tank/2021/03/18/in-the-pandemic-indias-middle-classshrinks-and-poverty-spreads-while-china-sees-smaller-changes/

[9] https://d1ns4ht6ytuzzo.cloudfront.net/oxfamdata/oxfamdatapublic/2022-01/India%20Supplement%202022%20lo-res%20single.pdf?qpboOXJULM6jrm1QUPjW_e2zSPYHDVhx

[10] https://d1ns4ht6ytuzzo.cloudfront.net/oxfamdata/oxfamdatapublic/2022-01/India%20Supplement%202022%20lo-res%20single.pdf?qpboOXJULM6jrm1QUPjW_e2zSPYHDVhx

[11] https://www.oxfamindia.org/knowledgehub/workingpaper/overlooking-fundamental-analysis-international-financial-institutions-covid-19-era-health-and

companies such as BYJU's as part of their strategy to 'disperse benefits of development. At the same time, support for the private sector is an inherent part of the existing sovereign projects. The effects of privatization are known and support for the participation of non-state actors in health and education sectors would be disastrous, especially in the absence of a robust push for regulation. This is substantiated by observations of the WB's Independent Evaluation Group (IEG) which on average rated 41% of IFC investment projects as mostly unsuccessful/unsuccessful/highly unsuccessful in terms of development outcomes[12].

Both IFIs have invested in the development of human capital by focusing on Health and Education. Thus, education has been the third preferred area of financing of the WBG in India and the share of health financing only increased during the COVID-19 years of 2020-22. While ADB's social sector portfolio has seen growth from $0.5 billion investment or 3% of the country's portfolio[13] to $2 Billion during the COVID period.

WORLD BANK GROUP (WBG) COUNTRY PARTNERSHIP FRAMEWORKS FOR INDIA

The operation of the WB and ADB in India is undertaken in line with their country partnership framework/strategy (CPF/CPS) which determines the strategic direction for their development programmes, private-sector lending/investment and advisory services. They identify the key objectives and results to be achieved through their support to a member country. In the case of the World Bank, this draws upon the Systematic Country Diagnostic (SCD) which is an analysis of the national context, the country's development goals and the WBG's comparative advantage and alignment with the Bank's own goals. Accordingly, the process is critical since it offers scope to influence the resource allocation provided by IFIs for many schemes and programs of the government.

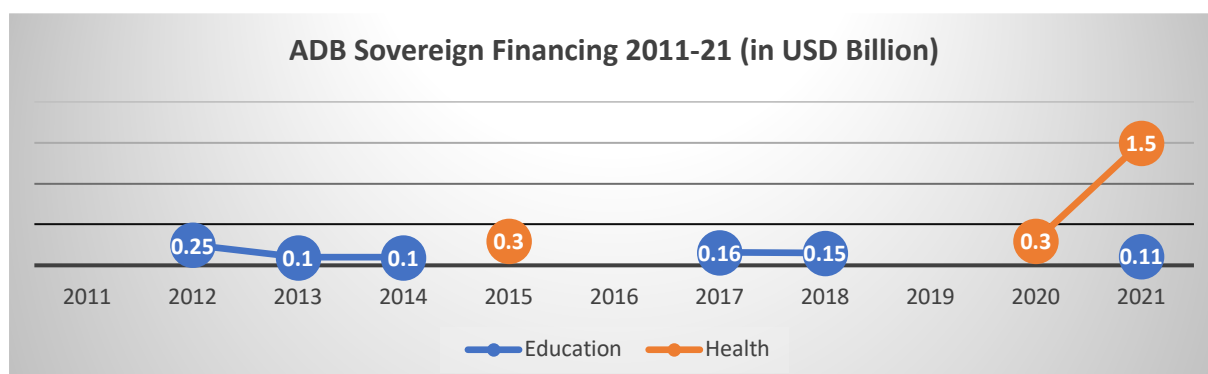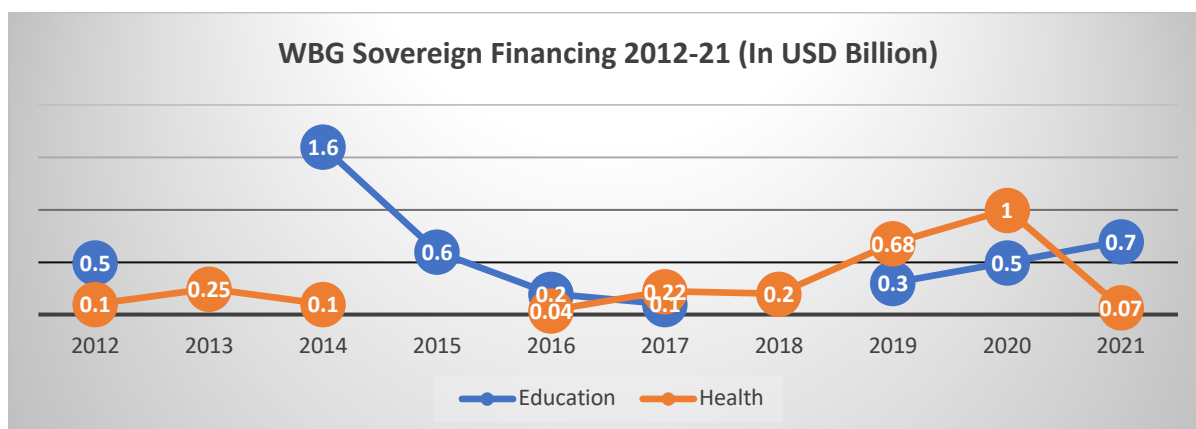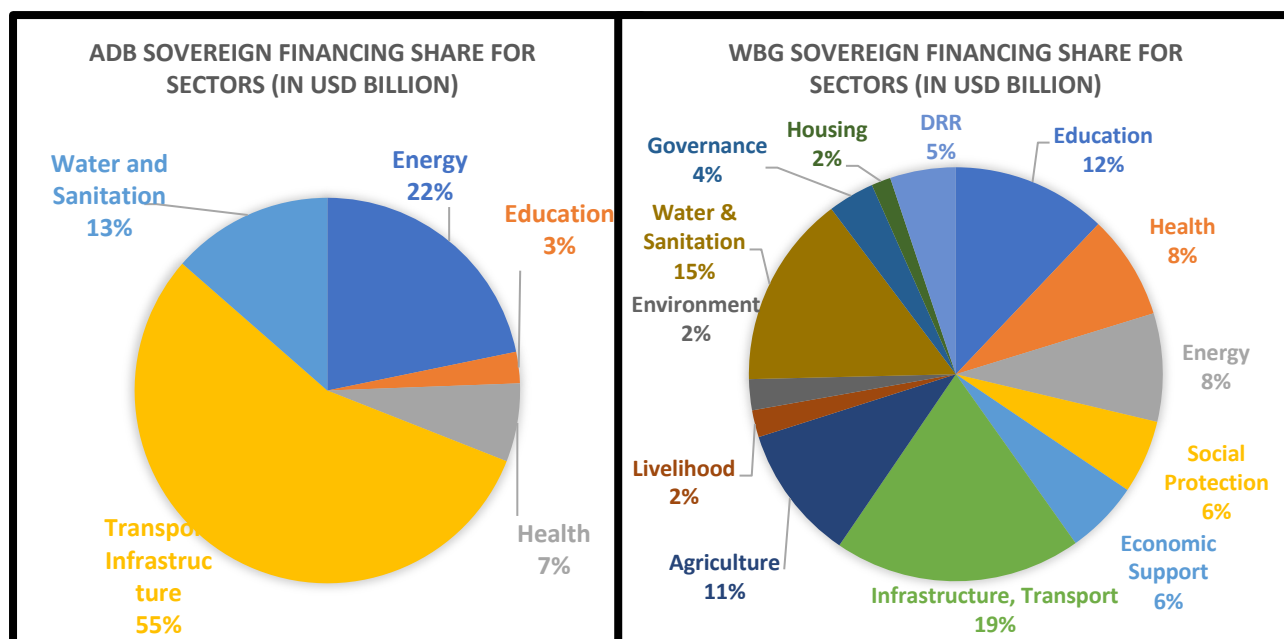| A recap of the specific focus in the last three CPF/CPSs for India			
	CAS 2009-2012	CAS 2013-2017	CPF 2017-2022
WBG's CPF	Support improvements in the organization and delivery of publicly-financed services that would enhance the development effectiveness of public spending, particularly in education, health, social protection	Better accountability arrangements in service delivery, adequate regulation and oversight of private health care providers, and expanded coverage of health insurance among disadvantaged groups. Improving access to education for underprivileged children, retain girls in secondary education, and open opportunities in higher education for all youth. A focus on learning outcomes is warranted across all levels of education	Strengthen the agility, performance and responsiveness of India's public-sector institutions with benefits of growth distributed across the population in terms of, access to services or social protection particularly women and groups from disadvantaged social backgrounds[14]
	CPS 2009-2012	CPS 2013-2017	CPS 2018-2022
ADB's CPS	Enhancing urban accessibility of urban population for public health and supporting other sectors (transport infrastructure) that would	Improve training and skills development through PPPs in the sectors with high youth employment potential (via vocational training and 100% GER in secondary education). Improve urban quality of life that contribute	Reinforce government efforts to develop health systems in urban areas that can deliver quality health services and reach the urban poor and vulnerable. Continued support technical and vocational

[12] 2018 IEG evaluation report

[13] https://www.adb.org/sites/default/files/evaluation-document/182918/files/cape-india.pdf

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

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	lead to improved educational outcomes	to an improvement in urban public health services	education and training (TVET) in high schools and colleges

The WBG has disbursed USD 33 Billion in loans since 2012 with at least USD 7.4 Billion for health and education respectively. The extent of WBG financing for 2012-22 stands at USD 4.7 Billion for education and USD 2.7 billion for health. Over the same period, the ADB has disbursed USD 32 Billion since 2012 with at least USD 0.87 Billion for education (inclusive of skill development projects) and USD 2.1 Billion for Health. At the state level education loans for the decade stood at about USD 362 million, while there have been no health loans for the states.

WBG Sovereign Financing 2012-21 (In USD Billion)

Year	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Education	0.5			1.6	0.6	0.2	0.1	0.3	0.5	0.7
Health	0.1	0.25	0.1		0.04	0.22	0.2	0.68	1	0.07

Education — Health

ADB Sovereign Financing 2011-21 (in USD Billion)

Year	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Education		0.25	0.1	0.1			0.16	0.15			0.11
Health					0.3					0.3	1.5

Education — Health

ADB SOVEREIGN FINANCING SHARE FOR SECTORS (IN USD BILLION)

Water and Sanitation 13%
Energy 22%
Education 3%
Transport Infrastructure 55%
Health 7%

WBG SOVEREIGN FINANCING SHARE FOR SECTORS (IN USD BILLION)

Governance 4%
Housing 2%
DRR 5%
Education 12%
Water & Sanitation 15%
Environment 2%
Health 8%
Energy 8%
Social Protection 6%
Livelihood 2%
Economic Support 6%
Agriculture 11%
Infrastructure, Transport 19%

LOOKING TO THE FUTURE: CPF 2017-22(WBG) & CPS 2022-26(ADB)

The upcoming country partnership framework and strategy frameworks of the WBG and ADB should focus on rebuilding post-COVID-19 and addressing the existing gaps in the public education and health sectors. Public sector entities are important bulwarks in combating inequality as they ensure access to basic services, reduce poverty and redistribute wealth in unequal societies.[15] At the same time, a stronger focus is needed to ensure that both IFIs address rising inequality in India and streamline their functioning to become more transparent and accountable.

WHAT SHOULD BE THE FOCUS OF WBG CPF 2022-2027 AND ADB 2022-2026

1. Support public system strengthening in education and health and reverse privatization and commercialization of and in these sectors

   The focus on supporting the public health and education sectors will need to be continued and concrete steps taken to regulate non-state providers and other private actors in these sectors.

2. Address rising inequality in India

   The WBG and ADB need to take steps to address the worrying levels of wealth inequality in their upcoming country partnership frameworks. For the World Bank, it is further suggested to include an analysis of inequality in the Systematic Country Diagnostic.

3. Increase transparency and accountability of lending

   The lending needs to be more transparent and project implementation must become more transparent. Relevant metrics of success need to be timely disclosed in the public domain with the participation of civil society organizations.

Each of these asks has further been described in the subsequent sections.

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[15] https://publications.iadb.org/publications/english/document/DIA-2018-Chapter-4-Impact-public-spending-equity.pdf

SUPPORT PUBLIC SYSTEM STRENGTHENING IN EDUCATION AND HEALTH AND REVERSE PRIVATIZATION AND COMMERCIALIZATION OF AND IN THESE SECTORS

The WB and ADB through their lending for education and health should

1. Address the immediate fallout of the pandemic: Ensure that education and health systems become more resilient to respond to future emergencies.
2. Build back Better, Build Back Public: Ensure that the public health and education systems that emerge from the pandemic are stronger and rooted in a rights-based understanding.
3. Build Back Equal: Build back more equal education and health systems that address unequal outcomes based on class, caste, ethnic identity, gender, disability and place of residence among others.
4. Minimise outsourcing and public-private partnerships with the private sector, reinforce regulatory laws and mechanisms for overseeing private education and health care delivery and strengthen parent/child- and patient-centred grievance redress mechanisms.
5. Ensure that any use of digital tools serves core educational and health aims, promotes the use of Free Open Source Software in the sectors and addresses issues of privacy, consent, transparency and data governance. The gains through the adoption of new technologies must be weighed against the potential risks including biometric exclusion, discrimination and the growth of surveillance capitalism.
6. Establishing community-led accountability processes for monitoring education and healthcare systems should be prioritised and teachers, health workers and their associations, parents and patients, representative networks and organizations of marginalised communities must be consulted as part of the project design and during project implementation.

This includes the following specific asks for education and health respectively.

EDUCATION

The World Bank has estimated that learning poverty in low and middle-income countries was 53% before the pandemic and is likely to rise to 70% due to school closures and the ineffectiveness of remote learning[16]. India's education system has also borne a deep COVID impact. However, the problems run deeper. Only 25.5% of India's schools comply with the minimum norms laid down under the Right of Children to Free and Compulsory Education Act.[17] Over two lakh schools lack a library facility, nine lakh schools fail to provide functional computer facilities for the students and over 11 lakh schools miss internet facilities.[18] At the same time, there is a growth in the number of private schools with almost 50% of children enrolled in the same.[19] These are under-regulated on several key dimensions. Thus, a recent Oxfam India report highlights that close to 40% of parents of children studying in private schools reported that fees were hiked[20] despite state government bans on the same.

In order to address the COVID impact and build back a more robust and equitable education system, IFIs should prioritize the following specific dimensions:

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[16] UNICEF, UNESCO & World Bank, 2021. Mission Recovering Education. Retrieved from https://thedocs.worldbank.org/en/doc/675f44dfad2b034dd0bc54ba2da25839-0090012021/original/BROCHURE-EN.pdf

[17] Lok Sabha Unstarred Question No. 2186 to be answered on 01.08. 2021. Compliance of RTE guidelines.

[18] https://dashboard.udiseplus.gov.in/assets/images/pdf/UDISE+2019_20_Booklet.pdf

[19] https://d1ns4ht6ytuzzo.cloudfront.net/oxfamdata/oxfamdatapublic/2022-04/Dalit%20Adivasi%20policy%20brief%20April%2026%20V3_0.pdf?7U8q4lZQ5B4i6oV9RvdSLru9hYLjX7pH

[20] https://d1ns4ht6ytuzzo.cloudfront.net/oxfamdata/oxfamdatapublic/2020-09/Status%20report%20Government%20and%20private%20schools%20during%20COVID%20-%2019%20V3.1.pdf

Address the Immediate Fall Out of The Pandemic

Education interventions need to address the consequences of interruption of two years of schooling for India's children. This is unlikely to be a short-term 'remedial' project and will need a longer-term perspective over a minimum of three years.

Asks:
- Ensure all projects focussing on school education include an explicit focus on re-enrolment and accelerated learning for out-of-school and child labour populations.
- Invest in and technically support efforts to address the consequences of learning loss including undertaking
    - Redesign of the curriculum/ academic calendar in consultation with teachers.
    - Strengthen formative assessments to track learning loss.
    - Creation of a safe, secure and protected environment and develop socio-emotional and physical wellbeing frameworks to address holistic adolescent and child health.
- Ensure that all schools and early childhood centres in intervention areas are audited to identify gaps in provisions against COVID protocols.
- Invest in and technically support the development of an Education in Emergencies policy for India for the K-12 space.

The Rationale:
- A Department of Education survey in Odisha shows that 30% of students have not returned to school since offline classes were resumed[21].
- Pedagogic transformation has not been done to address the legacy of learning loss. In a recent Oxfam India survey, two in five parents and children in government schools reported that the regular curriculum was being followed in the months immediately after schools reopened after the lockdown. Only 27% of parents said that an assessment of children's learning levels was being undertaken to refine teaching and 23% of parents said that revision of the last year's syllabus was being done. The status was no better in private schools; 14% of parents in private schools reported that their child's school assessed his/her current learning level as they returned to school. Two in three children in government schools reported struggling to follow what is being taught in class[22].
- Schools were not ready to address the COVID spread. Only 72.7% of schools had extra masks and 4.3% had a quarantine room and a third of school respondents did not receive training on COVID measures[23].
- It is unclear what lessons India's education system has learned from the pandemic and it continues to lack an Education in Emergencies Policy that captures the learning of the pandemic and the experience of other emergencies.

Build Back Better, Build Back Public

The interventions must support the realization of the right to education. In so doing, interventions must invest in a holistic vision of quality that ensures quality teaching by giving educators access to quality tools and ensuring that educational institutions provide quality environments.

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[21] https://www.timesnownews.com/education/30-per-cent-of-students-didnt-return-to-schools-after-covid-pandemic-reports-odisha-government-article-91560121

[22] https://www.oxfamindia.org/knowledgehub/oxfaminaction/status-report-education-during-pandemic-government-and-private-schools

[23] http://img.asercentre.org/graphics/schoolsurvey.pdf

The Asks:

1. Track and invest resources to enhance infrastructure and facilities so that all elementary schools in project intervention areas fully comply with the RTE Act norms.
2. Provide support to the government to prepare a roadmap to expand and improve the public education net to include early childhood and secondary education to ensure universal completion of 12 years of schooling and three years of preschool education by 2030, especially among marginalized communities, in line with India's NEP.
3. Minimize funding for standardized learning assessments and instead use the resources to empower and support teachers to use Continuous and Comprehensive Evaluation (CCE) to assess the progress of their students.
4. Provide technical support and resources to ensure that all children in India are taught by qualified, adequately trained and motivated teachers. This should include
   - Strengthening teacher training institutions, particularly DIETs and envisioning the role of CRCs and BRCs as supportive mentors rather than monitoring officials.
   - Steps for career progression and growth for teachers that go beyond incentivizing performance on test scores and are instead based on a holistic model of education in line with recommendations of the National Education Policy.
   - Filling vacancies within the administration and the academic support structure to ensure necessary capacity is in place.
   - Ensuring labour rights for contractual teachers.
5. Ensure all relevant projects include consultative processes to understand teacher needs by soliciting feedback from teachers and teacher educators, particularly at the sub-district level.

The Rationale:

a. While India has a Right to Education legislation, this currently only covers grades 1-8 including children 6-14 years of age. There is a civil society push to extend the RTE to include early childhood and secondary education and develop clear roadmaps to universalize provision for these stages.

b. 3 in 4 schools in India do not adhere to the basic quality norms as laid down by law. Compliance rates ranged between 63.6% (Punjab) and a mere 1.3% in Meghalaya[24]. A roadmap towards attaining these norms is lacking. At the same time, national norms for early childhood and secondary educational provision have not been laid down. Adhering to these norms would require conscious efforts to equalize resourcing with funding through centrally sponsored schemes channelized to lagging states on priority.

c. Concerns have been expressed about the quality of India's learning data.[25] Research suggests that NAS state averages are unrealistically high and should not be used for making comparisons between districts/states or for assessing improvements over time. At the same time, formative assessments which could generate data that would be of greater use to students and teachers are not being implemented appropriately. Nationally only 58.46% of secondary schools have implemented Continuous and Comprehensive Evaluation (CCE).[26] While India's participation in PISA 2022 is on hold, the entire focus on its participation in global international assessments appears to have been misplaced.[27]

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[24] Lok Sabha Unstarred Question No. 2186 to be answered on 01.08. 2021. Compliance of RTE guidelines.

[25] https://www.ideasforindia.in/topics/human-development/assessing-the-assessments-taking-stock-of-india-s-learning-outcomes-data.html

[26] https://india.tracking-progress.org/wp-content/uploads/sites/35/2021/04/Education-Report-Eastern-Club.pdf
https://www.orfonline.org/research/ten-years-of-rte-act-revisiting-achievements-and-examining-gaps-54066/

[27] http://international-assessments.org/preparing-for-pisa-in-india-skewed-priorities/

> d. According to the UNESCO State of Education Report for India (2021) over 11 lakh teacher positions are vacant in India, with 69% of vacancies in rural areas. 19% of all schools have vacancies.[28] At the same time, improvement of teacher performance is predicated on them being freed from administrative tasks. NEP 2020 mentions in 5.10 that complexes could share counsellors, trained social works, technical and maintenance staff and other personnel which can ease their burden for teachers. This should be implemented on priority. At the same time, the NEP's Clause 5.12 prioritizes freeing teachers from non-teaching work which should be a priority.
>
> e. 42% of teachers across government and private sectors in India work without a permanent contract and earn under 10,000 a month; this figure is as high as 69% in private schools.[29]
>
> f. There are about 550+ DIETs in India, however a significant share of the teacher posts are vacant in these institutes.[30] Distance education courses cannot replace in-person training and hand-holding of teachers. As such, resources need to be prioritized to address strengthening of CRCs and BRCs. At the same time, DIETs need to be empowered to respond to local needs.
>
> g. An analysis of COVID-era loans provided by the World Bank and ADB revealed that only 33% of loans had consultative processes with teachers in the projects[31].

Build Back Equal

It will be critical to prioritize concrete action to address vertical and horizontal inequalities to equalise outcomes. Vertical inequality consists of inequality among individuals or households (usually based on income or wealth), while horizontal inequality is defined as inequality among groups, typically culturally defined e.g. by ethnicity, religion or race. As such, all project proposals must not only recognize the existence of multiple inequalities but also be rooted in a comprehensive review of the challenges faced by the individual communities.

> **The Asks**
> 1. Ensure all project proposals are rooted in a comprehensive review of the education challenges faced by Dalits, Adivasis, Women, Muslims and Persons with Disabilities and focus on addressing wealth inequality. All projects need to have at least one outcome aimed to equalise opportunities, impact data must be disaggregated by social group and income quintile (where relevant) and reports of progress achieved must capture the impact on marginalised communities.
> 2. At least one standalone sovereign project during the coming strategy should directly address inequalities based on class, caste, gender, disability and ethnic and religious minority status.
> 3. Commit to ensuring that no school closure that is camouflaged as consolidation/merger is done with IFI funds.
> 4. Projects need to invest in efforts to address regressive gender norms and financial barriers in secondary education for girls. Projects also need to start focussing on issues of the LGBTQI communities in the country.
> 5. Prioritise equalizing investment to correct inter and intra-state resourcing to ensure equitable educational outcomes. Impact metrics should prioritise tracking the gap between the highest and lowest performing states/districts and channelize technical assistance and resources to closing this gap. At the same time, administrative capacities in educationally lagging states need to be enhanced.

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[28] https://unesdoc.unesco.org/ark:/48223/pf0000379115/PDF/379115eng.pdf.multi

[29] https://www.outlookindia.com/website/story/india-news-low-wages-no-contract-school-teachers-in-india-caught-in-web-of-neglect/396764

[30] http://nceindia.org.in/wp-content/uploads/2017/03/2015-Status-of-DIETs.pdf

[31] https://www.oxfamindia.org/knowledgehub/workingpaper/overlooking-fundamental-analysis-international-financial-institutions-covid-19-era-health-and

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6. Build safeguards in project design to ensure that the introduction of vocational education does not result in premature streaming of children from marginalized communities/poor families out of academic instruction and into vocational courses selected as being in line with traditional caste and gender roles.

7. Ensure an equal start in life by investing in interventions that prioritize investments in early childhood education, particularly ensuring all forms of provision (particularly preschools and Anganwadi centres) adhere to common standards of quality in terms of teacher qualifications and facilities. The focus on Foundational Learning should, however, not result in a single-minded focus on basic literacy and numeracy for the poor.

The Rationale:

- The outcomes of India's education system are grossly unequal based on class, caste and gender lines. Educational access is determined by households' access to resources regardless of gender and caste. Only one project granted during the COVID period mentioned the risks of elite capture in education.[32] Only 11% of children in the lowest quintile of households are likely to reach secondary school whilst almost all of those in the richest quintile complete grade 10. The poorest 20% of children are eight times less likely to complete secondary school than the richest 20% in some states.[33]

- The experience of communities in India is shaped by caste and religion due to widespread cultural-religious practices and discrimination. In 2019-20, one-fifth of Dalits and a quarter of Adivasi children dropped out from higher secondary education; only one in nine who dropped out were from the general category[34]. Muslim enrolment in higher education stands only at 14% in comparison to total enrolment.[35] "Upper Caste" students experience lower harassment in primary and lower secondary school than their lower caste peers.[36]The probability of having a middle and secondary public school remains lower in villages with a majority of Scheduled Caste (SC) and Scheduled Tribe (ST) communities, despite the progress made under Sarva Shiksha Abhiyan.[37]

- According to the 2011 Census of India, only 61% of children with disabilities aged between 5 and 19 were attending an educational institution. While protections for these groups exist in the form of a fairly progressive Rights of Persons with Disabilities Act, 2016 (RPWD Act), most states have not notified state rules for the same, despite the mandatory requirement to do so within six months[38].

- The gender problem analysis in all projects is relatively strong and all projects make robust recommendations, particularly for adolescents[39]. 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. Research by UNESCO revealed that 53% of

[32] GOAL (World Bank-Gujarat)

[33] https://keithlewin.net/wp-content/uploads/2016/05/0.-Synthesis-Equity-in-Access-and-Learning-in-India.pdf

[34] https://thelogicalindian.com/inclusivity/14th-of-tribals-15th-dalits-drop-out-from-secondary-classes-29729

[35] https://dashboard.udiseplus.gov.in/assets/images/pdf/UDISE+2019_20_Booklet.pdf

[36] https://d1ns4ht6ytuzzo.cloudfront.net/oxfamdata/oxfamdatapublic/2022-03/Status%20of%20education%20report_1.pdf?DUJL26fAPq5Pr2kwIjZ8Hnh4H7F9wWyW

[37] https://d1ns4ht6ytuzzo.cloudfront.net/oxfamdata/oxfamdatapublic/2022-01/India%20Supplement%202022%20lo-res%20single.pdf?qpboOXJULM6jrm1QUPjW_e2zSPYHDVhx

[38] https://en.unesco.org/news/n-nose-state-education-report-india-2019-children-disabilities

[39] https://www.oxfamindia.org/knowledgehub/workingpaper/overlooking-fundamental-analysis-international-financial-institutions-covid-19-era-health-and

students from Trans-gender communities skipped classes due to discrimination and bullying. [40]

- While 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, most projects do not include other categories in their framing. Thus, despite Muslim religious minorities being educationally disadvantaged, none of the projects included an explicit focus on the same. Dalits are a category recognized as being discriminated against in India's Constitution, but the specific focus on this category is only included in the framing of four projects. Remedial action is planned for in an even smaller section of projects. None of the projects included any indicators desegregated by persons with disabilities. None of the active projects explicitly address discrimination or correct educational inequalities between the rich and the poor in these states.
- Spending per child is grossly unequal[41]. Thus, in 2017, Bihar spent Rs 8,526 per child per annum on school education while Maharashtra spent Rs 19,035 per child. Furthermore, Kendriya Vidyalayas and Navodaya Vidyalayas, which are considered to be "model" government-run schools in terms of delivering quality education, spent 27,150 INR and 85,000 respectively, which is much higher than the per-student spending by the states.
- India has been in a process of introducing merger/consolidation of government schools resulting in the closure of those with low enrolment, especially in remote areas inhabited by indigenous people. By some estimates, 100,000 schools have been closed between 2010-2020[42]. While this is undertaken with the stated intention of maximizing the availability of school resources and improving quality[43], evidence suggests that this has contributed to a decline in enrolment.[44] At the same time, there is no evidence that learning outcomes are better in larger schools[45].
- Research shows that children who attended higher quality preschools showed better school readiness than those who attended lower quality preschools (Rao & Sun, 2015)[46]. Britto et al., (2017[47]) examined the effectiveness of early childhood interventions in low- and middle-income countries and concluded that both formal and non-formal ECCE programs enhanced cognitive and psychosocial development.[48] The largest effects were associated with programs of higher quality regardless of program type as well as programs for vulnerable children.
- Unless specific caution is taken, 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 may 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

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[40] https://timesofindia.indiatimes.com/india/lgbt-bullying-in-schools-takes-heavy-toll-reveals-unesco-report/articleshow/69718451.cms

[41] https://timesofindia.indiatimes.com/education/news/at-rs-9-167-up-spends-least-on-per-child-school-education-reveals-study/articleshow/58646292.cms

[42] https://www.governancenow.com/news/regular-story/rte-5-years-1-lakh-schools-shut-down-india-national-forum-

[43] https://www.newindianexpress.com/opinions/2020/jul/06/the-curious-case-for-consolidating-schools-2165912.html

[44] https://timesofindia.indiatimes.com/city/jaipur/school-mergers-brought-down-enrolments-study/articleshow/71572089.cms

[45] https://ideas.repec.org/a/eee/injoed/v72y2020ics0738059318307909.html

[46] Rao, N., & Sun, J. (2010). Early childhood care and education in the Asia-Pacific region: Moving towards Goal 1 (p. 97). Comparative Education Research Centre, The University of Hong Kong/UNESCO.

[47] https://ijccep.springeropen.com/articles/10.1186/s40723-021-00086-6

[48] Britto, P. R., Lye, S. J., Proulx, K., Yousafzai, A. K., Matthews, S. G., Vaivada, T., Perez-Escamilla, R., Rao, N., Ip, P., Fernald, L. C., & MacMillan, H. (2017). Nurturing care: Promoting early childhood development. The Lancet, 389(10064), 91–102.

remote areas. This runs counter to the existing literature that warns against the negative equity impact of early streaming.[49]

Minimise outsourcing and public-private partnerships with the private sector, reinforce regulatory laws and mechanisms for overseeing private education delivery and strengthen parent/child-centred grievance redress mechanisms.

Regulate private education while ensuring that the focus is on the delivery of public education in line with the Abidjan Principles[50]. Minimise outsourcing and public-private partnerships with the private sector, reinforce regulatory laws and mechanisms for overseeing education delivery and strengthen grievance redress mechanisms in education.

The Asks
- Given the World Bank's decision to cease investment in for-profit schools invest in building government capacity to audit private educational institutions to ensure that profit is not made. No support must be provided for commercial private schools.
- No aid must be given for private provisions without ensuring that a robust mechanism for regulation of private schools is in place and without putting in place auditing of school accounts. This framework should also include safeguards for ensuring non-discrimination and address segregation based on income resulting from children from families with relatively higher income and/or more privileged backgrounds opting for private provision[51,52].
- Provide support to the governments for the creation of SMC-like structures in private schools including school level committees, districts and state regulation committees created under the state private school regulation legislation.
- Prioritize strengthening the educational system from within, instead of using PPPs as an instrument of reform. Any PPP frameworks that are entered into would need to be in line with provisions of existing human rights law and guidance provided to member states on the issue[53]. This should at the very least ensure that they[54]
  - Do not lead to any form of discrimination or segregation, or create or increase inequality.
  - Do not lead to fee-charging private schools being the only option for compulsory education.
  - Do not undermine the humanistic mission of education.
  - Conform to minimum educational standards, being adequately regulated and monitored.
  - Adhere to principles of transparency and participation during the entire course of the partnership.

The Rationale:

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

[50] https://www.abidjanprinciples.org/

[51] https://www.oxfamindia.org/privateschoolsdalitsadivasis

[52] https://www.oxfamindia.org/knowledgehub/policybrief/private-schooling-india-challenges-achieving-gender-equity

[53] Eg. the periodic reports of different UN Special Rapporteurs who have provided guidance to member states on the issue e.g. https://www.un.org/en/ga/search/view_doc.asp?symbol=A/70/342

[54] https://www.right-to-education.org/blog/framework-assess-role-non-state-actors-education-against-human-rights

- The World Bank has ended funding for fees-paying primary and secondary schools given the risk of exacerbating inequality and undermining the public sector school system[55]. This includes both direct and indirect investments and engagement in PPPs. This principle needs to be followed by the ADB. At the same time, realizing this in practice calls for an examination of the practices adopted by private schools that are covered in existing projects. Thus, in India, private schools are expected to be not-for-profit, but most schools are reported to be making margins of 25%[56]. India's legal framework permits schools to retain a 'reasonable surplus' to be used for the growth and better facilities of said institution and finally, this surplus could not be used for profiteering by the school management[57]. However, what constitutes "reasonable surplus" is ill-defined and the lack of basic financial transparency by schools makes it difficult to verify whether funds were used appropriately. A recent audit of 25 unaided private schools by the Comptroller and Auditor General (CAG) found high levels of malpractice[58]. It would accordingly be critical to audit the finances of existing schools and any investee companies in the education sector ensure that the above principle is adhered to in practice.
- Research highlights that many of the regulatory legislations and provisions are not followed by private schools. Thus, a study in Telangana found that many private schools were taking fees under ineligible heads; none of the schools submitted the Annual Administrative and Audit Reports.[59] During the pandemic, a survey by LocalCircles found that 63% of parents said schools had raised fees during the academic year 2021-22 despite classes having moved online; 33% said that the hike was over 20%.[60] This is despite most state governments prohibiting private schools to raise their fees during the pandemic. A recent Oxfam India survey found that 91% of parents said that they want the government to regulate school fees and ensure that private schools comply[61]. 77% of parents reported that private schools were inadequate in providing safeguards against discrimination based on parents' income, class, caste, gender, disability and other forms.[62]
- A fair amount of evidence exists for the discriminatory practices adopted by or arising from the growth of private schools[63, 64]. According to NSSO data, for a family with a single earning member the average expenditure on private schooling (for two children), constitutes 20% of household income. 54% of children from the top quintile (based on per capita household expenditure) attend private schools while the corresponding figure for the bottom quintile is 12%.[65]

[55] https://ieg.worldbankgroup.org/evaluations/evaluation-international-finance-corporation-investments-k-12-private-schools-7

[56] https://www.forbesindia.com/article/work-in-progress/the-business-of-schools/12062/1#:~:text=In%20a%20stable%20state%2C%20a,an%20annual%20fee%20of%20Rs.

[57] https://www.firstpost.com/india/sc-ruling-on-private-school-fees-govt-regulation-is-important-but-cant-be-long-term-strategy-3273652.html

[58] https://www.thehindubusinessline.com/economy/policy/CAG-says-Delhi-private-schools-cooked-their-books/article20110375.ece

[59] https://www.thehindu.com/news/national/telangana/private-schools-having-a-free-run-cag/article23397765.ece

[60] https://theprint.in/india/63-parents-say-schools-have-increased-fees-despite-classes-being-held-online-survey-finds/691185/

[61] https://www.oxfamindia.org/knowledgehub/oxfaminaction/status-report-education-during-pandemic-government-and-private-schools

[62] https://d1ns4ht6ytuzzo.cloudfront.net/oxfamdata/oxfamdatapublic/2022-03/Status%20of%20education%20report_1.pdf?DUJL26fAPq5Pr2kwIjZ8Hnh4H7F9wWyW

[63] https://www.oxfamindia.org/privateschoolsdalitsadivasis

[64] https://www.oxfamindia.org/knowledgehub/policybrief/private-schooling-india-challenges-achieving-gender-equity

[65] https://centralsquarefoundation.org/State-of-the-Sector-Report-on-Private-Schools-in-India.pdf

- A global study by Oxfam International points to the many disproportionalities caused by PPPs in the education sector which have primarily benefitted upper-income students and widened social disparities.[66] It is critical to strengthen regulatory frameworks for the same.

Ensure that any use of digital tools serves core educational aims, promotes the use of Free Open Source Software and addresses issues of privacy, consent, transparency and data governance.

Institute transparency and accountability of investments via financial intermediaries and publish metrics for mapping impact. Further, investments in ed-tech should identify and manage social risks which propagate inequity and unaffordability. EdTech platforms cannot replace schools; social constructivism, where learners interact with one another, with adult mediation remains essential to education.

The Asks

- Because of malpractices, we suggest a freeze in ed-tech investments by the IFC as instituted for K-12 private schools.[67]
- As a part of its commitment to better define, measure and monitor the development impact of its funding, IFC introduced the Anticipated Measurement and Monitoring (AIMM) system in 2017, which has a specific sector framework to measure projects in the field of education. However, standards of evaluating project impact in EdTech need to more consistently prioritize educational outcomes and include a focus on addressing educational inequalities based on wealth, gender, caste, disability status, tribal, ethnic or religious identity or other grounds.
- IFC as a public finance institution needs to be more cautious in its EdTech investments so that it is not caught on the wrong side of evolving regulation. Tech companies are under probe for violations of laws and ethics in many countries including India.[68, 69T] The IFC should not fund EdTech without a reasonable understanding of the 'wild west' nature of tech spaces which renders them vulnerable to fraudulent practices and exit companies that seem embroiled in such practices.

The Rationale:

- Given that education is legally a not-for-profit sector and in line with the decision by the IFC to cease investment in for-profit schooling it would be desirable to cease investments in for-profit EdTech provision, particularly in India.
- The recent investigation into the IFC's EdTech investments in India found that disclosures on the project performance were inadequate in failing to provide information salient to the education sector. The standards for assessing EdTech projects are also inadequate with the recent investments not consistently and inadequately capturing educational impact. At the same time, monitoring and assessment of social risks are heavily reliant on corporate self-declaration and it is not clear how the IFC responds to information related to consumer

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[66] https://oxfamilibrary.openrepository.com/bitstream/handle/10546/620720/bp-world-bank-education-ppps-090419-summ-en.pdf

[67] *Karti Chidambaram questions practices of EdTech platforms like BYJU's*. The News Minute. (2022). Retrieved 18 May 2022 from https://www.thenewsminute.com/article/karti-chidambaram-questions-practices-EdTech-platforms-BYJU-s-158718.

[68] Singh, M. (2022). India hits Google with antitrust investigation over alleged abuse in news aggregation. Retrieved 18 May 2022 from https://techcrunch.com/2022/01/07/india-hits-google-with-antitrust-investigation-over-alleged-abuse-in-news-aggregation/

[69] Indian agency seeks information, documents from Amazon amid probe: Source - ET Telecom. (2022). Retrieved 18 May 2022 from https://telecom.economictimes.indiatimes.com/news/indian-agency-seeks-information-documents-from-amazon-amid-probe- source/81469024

complaints, court orders, labour practice reports etc. or whether it is cognizant of the high externalities associated with the rapid scaling of technological solutions in education[70].

- According to the 2020 Remote Learning Reachability report issued by UNICEF, only 24% of Indian households had internet connections to access e-education. [71] Only 4% of rural households had a computer and less than 15% of rural households had an internet connection.[72] The costs of accessing technology offerings have been prohibitive. The average price of an EdTech product on the Indian market is equivalent to 77.5% of the per capita income for its lowest wealth quintile.[73] Not only are the poor excluded, but they are also more likely to be left dissatisfied with EdTech offerings. Only 18% of poor and lower-middle-class users are happy with the services offered by EdTech companies compared to 31% of middle and high-income households[74]. The digital divide is gendered. Only 29% of internet users in India are women and 71% of phones are owned by men.

Establishing community-led accountability processes for monitoring the education system should be prioritised and teachers and their associations, parents, representative networks and organizations of marginalised communities must be consulted as part of the project design process and during project implementation

Establishing community-led accountability processes for monitoring education systems should be prioritised. The strategy must ensure that monitoring and governance mechanisms in education systems are rooted in a rights-based accountability framework.

The Asks
- Ensure that each state government receiving support adopts a broad Social Accountability Framework for education arrived upon through consultative processes with civil society. This can draw upon and amplify the recent Guidelines for Social Audit of Samagra Shiksha and emphasize financial transparency.
- Ensure that all projects focusing on strengthening the school education system emphasize enhancing social accountability by investing in structures for community participation (like School Management Committees and Panchayati Raj Institutions) in education. Programmes could include efforts to start an SMC training mission, support for undertaking SMC meetings and organizations across different levels (clusters, blocks, districts, State) and focus on building capacities of these structures and metrics for their enhanced capacities. At the same time, broad coalitions in support of educational renewal need to be supported.
- Civil society networks and alliances, parent associations, professional associations and unions of teachers/Anganwadi workers and organizations representing marginalised communities must be consulted as part of the project design process and subsequently during project implementation.
- Relevant information gathered about the status of schools/AWCs needs to be placed in the public domain to ensure its use for social accountability. Prioritize inclusion of metrics of inequality including disaggregating impact data by social group and wealth quintile in the information gathered.

[70] https://www.oxfamindia.org/knowledgehub/workingpaper/digital-dollar-exploratory-study-investments-ifc-indian-educational-technology-sector

[71] https://data.unicef.org/resources/remote-learning-reachability-factsheet/

[72] Ministry of Statistics and Programme Implementation. Household Social Consumption on Education in India NSS 2017-18. New Delhi: National Statistical Office, (2019) accessed 03 December, 2020 https://bit.ly/2VzERQA

[73] https://centralsquarefoundation.org/wp-content/uploads/EdTech%20Lab%20Report_November%202019.pdf

[74] https://www.scribd.com/document/479115621/20200527-EdTech-Report-Omidyar-V6

- Civil society networks and alliances, professional associations and unions of teachers and women's rights organizations and organizations representing marginalised communities must be consulted as part of the project design process and subsequently during project implementation.

The Problem:
- Many of the projects during the COVID period included a focus on community participation. However, they did not provide for any new devolution of funds or decision-making in the projects. It would be desirable to ensure that the new projects push for strengthening social accountability. This would include strengthening existing structures and processes for social accountability; robust innovations to address questions of capacity would be welcome. The guidelines for social audit under Samagra Shiksha Abhiyan[75] could be used in the projects.
- According to UDISE data 2015-16, 97% of Government & Aided schools have constituted SMCs and 85.87% of elementary schools have constituted SMCs and prepared School Development Plans.[76] However, many of these structures are fairly weak. At the same time, while many World Bank projects include a focus on strengthening of SMCs,[77] there is minimal engagement with other community structures like Panchayati Raj Institutions. Existing WBG research indicates that engaging with PRIs for strengthening audit capacity and providing non-monetary incentives can improve equity outcomes[78]. Deliberative spaces need to be also designed, keeping social and gender inequalities in mind, to build broader citizen coalitions in support of education[79] which also requires top-down support and continued engagement.[80]
- Appropriate evidence related to the functioning of schools should be placed in the public domain. 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 levels to understand the extent of implementation for ensuring social accountability or for supporting implementation.
- Out of 5 projects of World Bank and ADB only 3 projects undertook civil society engagement[81] during the COVID period. None of the World Bank projects included civil society networks, unions or representatives of marginalized communities at the design stage of the projects[82].

HEALTH

India ranks the lowest in the number of hospital beds per thousand population among the BRICS nations; Russia scores the highest (7.12), followed by China (4.3), South Africa (2.3), Brazil (2.1) and India (0.5). India also ranks lower than some of the lesser developed countries such as Bangladesh (0.87), Chile (2.11) and Mexico (0.98). In Oxfam's Commitment to Reducing Inequality Report 2020, India ranked 154th in health spending, fifth from the bottom. This poor spending is reflected in the inadequate health resources and infrastructure that require urgent action,[83] especially in the context of the pandemic.

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[75] https://www.education.gov.in/sites/upload_files/mhrd/files/Guidelines_for_Social_Audit_of_Samagra_Shiksha_scheme.pdf

[76] http://udise.in/Downloads/Publications/Documents/Flash_Statistics-2015-16_(Elementary).pdf

77 STARS,SALT,NECTAR, GOAL

78
https://documents1.worldbank.org/curated/en/099524309192271907/pdf/IDU0df988a0107cf2041a508421047141c0e8943.pdf

[79] https://journals.sagepub.com/doi/10.1191/1464993403ps059ra

[80] https://www.cambridge.org/core/books/oral-democracy/1389E93F8F69AA1AB07B434124CE7582

81 SALT,GOAL

82 https://www.oxfamindia.org/knowledgehub/workingpaper/overlooking-fundamental-analysis-international-financial-institutions-covid-19-era-health-and

83 https://d1ns4ht6ytuzzo.cloudfront.net/oxfamdata/oxfamdatapublic/2021-07/India%20Inequality%20Report%202021_single%20lo.pdf?nTTJ4toC1_AjHL2eLoVFRJyAAAgTqHqG

The pandemic has brought to light serious flaws in the public health system. Several states have documented cases when private providers have defied governmental regulations including price caps.[84] At the heart of the problem is weak regulation of the private sector with no real consequences for failing to adhere to national frameworks both in peacetime[85] and during the pandemic.[86] At the same time, India's flagship insurance scheme Ayushman Bharat/ PM-JAY [87] has lagged in providing insurance coverage. Thus, only 14.25% of people hospitalized for COVID-19 between April 2020-June 2021[88] could receive benefit from its coverage.

Address the Immediate Fall Out of The Pandemic

COVID services should be integrated with non-COVID healthcare interventions and not function as a vertical activity in IFI-supported projects. Efforts need to be made to build system resilience and preparedness for future epidemics and pandemics. At the same time, support for COVID would need to be continued for the duration of the pandemic.

The Asks:
- Invest in the delivery of COVID vaccine boosters which need to be done free of cost through the public system for all adults.
- Continue support initiated under the COVID emergency response and system preparedness projects for health and frontline workers, including those handling biomedical waste, as long as COVID-19 remains a notified pandemic.
- Invest in and technically support India's implementation of the pandemic preparedness framework once agreed.

The Problem:
- By September 29, the country will cover 28.6 per cent of the eligible population of 796 million who will be due for the booster dose[89]
- Frontline workers such as paramedical staff, non-medical staff, medical waste handlers and housekeeping staff have played a significant role in the COVID response. A large proportion has faced challenges in receiving compensation and salaries.[90]
- India ranks 66/195 on the GHS index for pandemic preparedness.[91] While pandemic readiness would have improved during the course of the COVID response, much more needs to be done.

Build back Better, Build Back Public

Comprehensive primary healthcare must be contextualised within a 'Rights' framework and efforts should be directed towards strengthening the public healthcare delivery system at all levels from the

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

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

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

[87] '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.

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

[89] https://www.business-standard.com/article/current-affairs/statsguru-where-does-india-stand-on-covid-booster-shots-as-cases-rise-122073100876_1.html

[90] https://frontline.thehindu.com/the-nation/delhi-health-workers-left-high-and-dry/article32649934.ece

[91] https://www.ghsindex.org/country/india/

village (ASHA and Health and Wellness Centres) to District Hospital. Public health services should be accessible without any barrier whether physical or financial within a universal access framework. Segmented vertical healthcare programs should not be targeted; support should instead be towards comprehensive primary healthcare.

The Asks:
- Support the adoption of the government's goal of the Right to Health and its subsequent implementation through its investment and policy proposals.
- The majority of sovereign loan funding must be devoted to the expansion of Health and Wellness Centres (HWCs), especially to ensure these are fully equipped in terms of infrastructure, human resources and facilities including medicines and diagnostics in line with the IPHS standards.
- At least one full dedicated project on supporting and investing in frontline health workers, especially ASHAs, to ensure that all health personnel are paid a living wage and social security, enjoy good working conditions and have opportunities for adequate professional and career growth.
- Ensure that sovereign lending and technical assistance strengthen medical education through the public system, especially in poorer states.
- Support access to medicines and diagnostics, particularly generics, by providing technical assistance for streamlining the government medicine procurement policy, including more effective implementation of Jan Aushadhi Kendras (JAKs).

The Problem:
1. India lacks a 'Right to Health', although the first steps of framing one are underway[92] and several states are framing their own legislation[93]. Support of the IFIs in the support of this legislation would be welcome. However, none of the health loans provided by the World Bank and Asian Development Bank mention the need for a framework that reinforces the 'Right to Health.'
2. Only 50,069 health and wellness centres (HWCs) are functional out of the target of 1,50,000. This constitutes only 65% of the cumulative target for 2020-21.[94] There has been a steady decline in the proportion of functioning facilities that meet IPHS norms over the last three years. As on March 2018, there were only 7% Sub Centres, 12% PHCs and 13% CHCs functioning as per IPHS norms.[95]
3. India's frontline rural healthcare workers – ASHAs, won the WHO Global Leaders Award for 2022[96]. Despite this, India's 10,47,324 ASHA workers continue to face low wages and the absence of social security and pension.[97] They are officially classified as volunteers and the government is not under obligation to pay a minimum wage[98] and a recent survey found that 30% of failed to receive the insurance cover under the PM Garib Kalyana Yojana that they were entitled to for their work during the pandemic[99]. In contrast, the WBG's research has

[92] https://www.newindianexpress.com/nation/2021/oct/17/first-draft-of-right-to-health-and-healthcare-bill-made-by-private-university-ready-2372294.html

[93] https://www.hindustantimes.com/opinion/right-to-health-laws-need-political-support-101653313036461.html

[94] https://accountabilityindia.in/publication/ayushman-bharat-2/

[95] https://cprindia.org/wp-content/uploads/2021/12/NHM_2019_20.pdf

[96] https://www.who.int/india/india-asha-workers

[97] https://www.hindustantimes.com/india-news/asha-anganwadi-workers-to-go-on-nationwide-strike-today-101632451397778.html

[98] https://www.cbgaindia.org/blog/why-do-asha-workers-in-india-earn-so-little/

[99] https://behanbox.com/2020/06/12/promised-mostly-never-paid-rs-1000-covid-wage-to-million-health-workers/

highlighted the critical need for professional health workforce for strengthening the public health system in India[100].

4. India has 1 doctor for every 1457 citizens[101] as compared to 1 doctor for 1000 prescribed by WHO. India has a requirement of 4.3 million nurses by 2024 to meet WHO's thresholds.[102] One of the reasons for the same is the shortage of medical education institutions. The private sector currently accounts for over 45% of medical colleges in India with the bulk of provision being in richer states instead of those with the highest unmet health needs[103]. At the same time, the government has diluted the norms for establishing new medical colleges and allowed all teaching institutions including private colleges to offer PG programmes, regardless of their infrastructural conditions and faculty shortages[104]. The weak process of certification of private medical colleges.

5. Access to medicines contributes a 43% of the out-of-pocket expenditure in India. The Jan Aushadhi stores were established to provided unbranded generic drugs to ensure access to affordable medicines[105]. However, there are problems with their functioning. Thus, in a recent survey, out of 164 Jan Aushadhi Kendras only 87 were functional and their locations were often uneven and the locations are remote. Thus, the needy cannot reach these JAS, and thus, public awareness is abysmal because of invisibility.[106] Other research undertaken by Oxfam India shows that JAKs experience stockouts, doctors are reluctant to write prescriptions for generic medicines and awareness among patients about generic medicines is low[107].

Build Back Equal:
Prioritize concrete action to address vertical and horizontal inequalities to equalise health outcomes.

The Asks
- Ensure all project proposals are rooted in a comprehensive review of the health challenges faced by Dalits, Adivasis, Women, Muslims and Persons with Disabilities and focus on addressing wealth inequality. All projects need to have at least one outcome aimed to equalise opportunities, impact data must be disaggregated by social group and income quintile (where relevant) and reports of progress achieved must capture the impact on marginalised communities.
- At least one standalone sovereign project during the coming strategy directly address inequalities based on class, caste, gender, disability and ethnic and religious minority status.
- Prioritise equalizing investment to correct inter and intra-state resourcing to ensure equitable health outcomes. The coming strategy should prioritise tracking the gap between the highest and lowest performing states/districts and channelize technical assistance and resources to closing this gap.

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[100] https://openknowledge.worldbank.org/bitstream/handle/10986/33663/Strengthening-Public-Health-Systems-Policy-Ideas-from-a-Governance-Perspective.pdf?sequence=1&isAllowed=y

[101] https://www.business-standard.com/article/pti-stories/india-has-one-doctor-for-every-1-457-citizens-govt-119070401127_1.html

[102] https://www.businesstoday.in/coronavirus/story/india-needs-43-mn-more-nurses-by-2024-to-meet-who-norms-says-nurse-organisation-305794-2021-09-03

[103] https://www.researchgate.net/publication/6807622_Growth_of_private_medical_education_in_India

[104] https://news.careers360.com/medical-colleges-teacher-shortage-mbbs-neet-ug-aiims-nmc-ima-health-ministry-regulations-public-health

[105] https://www.brookings.edu/research/medicines-in-india-accessibility-affordability-and-quality/

[106] Thawani V, Mani A, Upmanyu N. Why the Jan Aushadhi Scheme Has Lost Its Steam in India? J Pharmacol Pharmacother. 2017 Jul-Sep;8(3):134-136. doi: 10.4103/jpp.JPP_38_17. PMID: 29081624; PMCID: PMC5642129.

[107] https://www.oxfamindia.org/knowledgehub/workingpaper/making-generic-medicines-available-all

> - Develop an equity template as an integral part of project monitoring to ensure equity in healthcare access and outcomes as part of the ESS or otherwise. The independent evaluation of the strategy must include a robust equity analysis.

The Problem:
- Health outcomes are unequal in India. The difference between stunted children in SC and ST households and those in households belonging to the general category is 12.6% and 13.6% respectively. One in every two children in India are anaemic, with three out of five children being in SC and ST households[108]. The infant mortality rate is about 20% for the rich and over 55% for the poor[109].
- This is the result of unequal healthcare delivery. 70.4% of Dalit women had problems accessing health care services.[110] Immunization in ST households is 6.2% below the national average. Health-care expenditure on women in India is systematically lower than on males across all demographic and socio-economic groups[111] At the same time, members from marginalized communities experience discrimination. In a recent Oxfam India survey, one in four Indians reported experiencing discrimination in healthcare services due to caste, religion or other factors[112]. The average health expenditure of the poorest 40% of households in India is 30% less than that of the richest 20% of households[113].
- Healthcare spending in India is low overall with India being ranked 154th in health spending. At the same time, resourcing is grossly unequal between various states. Thus, while institutional births is 99.9% in Puducherry, it was only 35.4% in Nagaland. Access to postnatal healthcare was 92.7% in Lakshadweep and 22.3% in Nagaland. Health insurance coverage was 99.4% in Lakshadweep, but 10.4% in Assam[114]. Similarly, gross inequalities in health outcomes exist between districts. It would accordingly be critical to track regional and other inequalities in health to ensure equalization of health outcomes.

Minimise outsourcing and public-private partnerships with the private sector, reinforce regulatory laws and mechanisms for overseeing private health care delivery and strengthen patient-centred grievance redress mechanisms.

Minimise outsourcing and public-private partnerships with the private sector, reinforce regulatory laws and mechanisms for overseeing health care delivery and strengthen patient-centred grievance redress mechanisms in private hospitals.

The Asks
- Refrain from supporting private initiatives and PPPs, instead prioritising building the system's capacity for providing standardised and ethical health services to patients.
- No projects involving engagement with private hospitals and health providers should be implemented in states that do not adhere to India's regulatory frameworks for the regulation of private hospitals including the Clinical Establishment Act (CEA) and the Patients' Rights Charter.

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[108] https://www.oxfamindia.org/knowledgehub/workingpaper/inequality-report-2021-indias-unequal-healthcare-story

[109] https://theswaddle.com/rich-people-outlive-the-poor-by-7-5-years-due-to-health-inequalities-in-india-oxfam-report/

[110] https://asiatimes.com/2018/06/indias-dalit-women-lack-access-to-healthcare-and-die-young/

[111] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0158332

[112] https://economictimes.indiatimes.com/news/india/one-in-4-indians-face-discrimination-in-getting-healthcare-services-due-to-caste-religion-study/articleshow/87872477.cms?from=mdr

[113] https://ruralindiaonline.org/en/library/resource/inequality-report-2021-indias-unequal-healthcare-story/

[114] https://jgu.s3.ap-south-1.amazonaws.com/jslh/Access+(In)Equality+Index+Report+2021.pdf

> These projects must simultaneously prioritize strengthening the regulation of the private health sector, especially price regulation and ethics in practice.
> - All the hospital investment projects and hospital PPP advisory projects should be available for third-party monitoring and evaluation under the leadership of respective governments under whose jurisdiction the interventions fall.
> - Leverage the CPF/CPS to ensure that private investment/non-sovereign lending policies in India adopt zero tolerance of patient rights violations and that investee partners adhere to the Patients Rights Charter in principle and practice.

The Rationale
- Lack of regulation in the private sector, and the need to strengthen resources, governance and quality in the public sector have been identified as issues in the Indian health system requiring urgent redressal according to a World Health Organization (WHO) review[115]. The report highlighted that India has not been able to implement the Clinical Establishments Act. India's regulatory mechanisms in the private hospitals have been weak including failure to ensure capping of costs[116]. COVID-19 produced sundry cases of patient rights violation which led to advisories being issued by the NHRC for adherence with the Patient Rights Charter.[117]
- Out-of-pocket health expenditure is extremely high in India standing at 64.2% compared to the global average of 18.2%.[118] The exorbitant cost of healthcare has forced many to sell household assets and incur debts.[119] A study shows that around 74% of hospitalization cases are financed through savings while 20% of the cases are financed through borrowing.[120] Analysis of bills from four reputed private hospitals in the Delhi and NCR region by the National Pharmaceutical Pricing Authority (NPPA), Govt. of India revealed that they make profit margins from 100% to 1,737% on drugs, consumables and diagnostics and these three components account for about 46% of a patient's bill[121]
- This makes it critical to enhancing the state regulatory mechanisms. There are 39,361 clinical establishments in the country.[122] However, only 2% of hospitals with over 50 beds have been fully accredited in the 17 years since the National Accreditation Board for Hospitals and Healthcare Providers was set up[123].
- It is widely evidenced that public-private partnerships (PPPs) impair healthcare access and equity and are riddled with issues of transparency and accountability, high costs and user fees, transfer of public funds to private entities, fragmentation of services and weakened health worker rights.[124]

[115] https://apo.who.int/publications/i/item/india-health-system-review

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

[117] https://www.thehindu.com/news/national/nhrc-issues-advisory-on-ensuring-patients-rights-during-second-wave/article34487530.ece

[118] The World Bank, (n.d.), 'Out-of-pocket expenditure (% of current health expenditure)', accessed 17 December 2020, https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS

[119] https://d1ns4ht6ytuzzo.cloudfront.net/oxfamdata/oxfamdatapublic/2021-07/India%20Inequality%20Report%202021_single%20lo.pdf?nTTJ4toC1_AjHL2eLoVFRJyAAAgTqHqG

[120] Jena, B., and M. Roul, (2020), 'Estimates of Health Insurance Coverage in India: Expectations and Reality', Economic and Political Weekly, Vol 55, Issue 37, accessed 3 February 2021, https://www.epw.in/journal/2020/37/notes/estimateshealth-insurance-coverage-india.html

[121] https://timesofindia.indiatimes.com/india/private-hospitals-making-over-1700-profit-on-drugs-consumables-and-diagnostics-study/ articleshow/62997879.cms

[122] http://www.clinicalestablishments.gov.in/cms/national_register_of_clinical_establishments.aspx

[123] https://www.moneycontrol.com/news/trends/full-accreditation-of-hospitals-sluggish-but-demand-high-for-entry-level-certification-9120861.html

[124] https://www.epw.in/journal/2021/36/perspectives/public-private-partnerships-healthcare.html

- While private healthcare is unaffordable for everyone, the costs are even higher for marginalized communities like Dalits and Adivasis. As per the National Family Health Survey 2015-16 (NFHS-4) data, 45.9% of the Adivasi population and 26.6% of the Dalit population are in the lowest wealth quintile when compared to 21% in the General Category. Other forms of marginalization also exist with one survey showing that Dalits were denied entry into private health centres or clinics in 21.3% of villages.[125] The same is with Adivasi communities by which private health operators have been exploiting and endangering the lives of Adivasi women by performing fraudulent medical practices.[126]

At the same time, Ayushman Bharat should be treated as principally a health 'assurance' scheme and not only linked to 'insurance'. Support should be provided to convert this scheme into universal access rather than restricting it to just the poor. The scheme should be linked to strengthening public health facilities and not subsidising the private health sector.

The Asks
- Take concrete steps to address financial barriers to healthcare access including moving away from target-based insurance systems, given the evidence of partial population coverage, failure to cover costs of outpatient care and track record of the poor settlement of claims.
- Where there are gaps in public provisioning, strategic purchasing could be done from the private sector under strong regulatory oversight. For existing projects, strengthen governance systems for grievance redressal mechanisms for patients, especially to address instances of denial.

The Rationale:
- According to information shared with Parliament, about 498.7 million people in India had health insurance coverage in the financial year 2019-20 which amounts to only about 37% of the population[127] Only 30% of women and 33% of men aged 15-49 are covered by health insurance or a health scheme, even If the coverage rate has been rising.[128] At the same time, PM-JAY does not cover outpatient care, which contributes about 60% of India's out-of-pocket expenses and its existence shifts care-seeking behaviour to reactive services and aware from cost-effective preventive care[129]. At the same time, private hospitals have been reluctant to participate in PM-JAY.[130] Other estimates suggest that it only covered 14.25% of people hospitalized for COVID-19[131].

[125] https://idsn.org/wp-content/uploads/user_folder/pdf/New_files/India/IIDS_-_Access_to_Health_Care_and_Patterns_of_Discrimination.pdf

[126] https://d1ns4ht6ytuzzo.cloudfront.net/oxfamdata/oxfamdatapublic/2022-04/Brief%20on%20DA%20and%20private%20health%20sector%20issues%20v2.pdf?r7cGmuCUSx69uZLML3dcCpm6j9aqr0OW

[127] http://164.100.24.220/loksabhaquestions/annex/175/AU3003.pdf

[128] http://rchiips.org/nfhs/NFHS-5Reports/NFHS-5_INDIA_REPORT.pdf

[129] https://www.brookings.edu/blog/future-development/2021/04/29/early-lessons-from-indias-health-insurance-scheme-pradhan-mantri-jan-arogya-yojana/

[130] https://www.livemint.com/news/india/private-hospitals-avoid-ayushman-bharat-pmjay-citing-low-charges-11662050592878.html

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

Ensure that any use of digital tools serves core health aims, promotes the use of Free Open Source Software and addresses issues of privacy, consent, transparency and data governance.

Ensure that any use of digital tools in the interventions addresses issues of privacy, consent, transparency and data governance. The IFIs need to likewise weigh the gains through the adoption of new technologies against the potential risks including biometric exclusion, discrimination and the growth of surveillance capitalism among others.

The Asks:

- Given the past negative experience of UID in India, avoid extending direct or indirect support for Universal Health ID which currently carries clear privacy concerns.
- Provide technical assistance to national and state governments in setting up policies and standards for data governance to ensure transparency and patient privacy of any digital health interventions being considered.
- Ensure that all projects on digital health also include a strong component of creating awareness among patients on issues of digital rights and privacy.

The Rationale:

- The government has shown interest in introducing a unique health ID for citizens based on a recommendation by NITI Aayog.[132] The UHIDs have been created without the consent of citizens.[133] There have been concerns about the data security of the patient medical data that may be accessed[134]. Only 750 million Indians use smartphones which are digitally enabled to host complex applications.[135] Furthermore, the use of digital technologies for addressing health services has been shown to exacerbate inequalities and delay health care services in low-income states.[136]
- While privacy is recognized as a fundamental right in India[137], it is yet to adopt a data privacy law[138] and develop a policy on data governance. India ranked second globally in terms of data breaches. India can benefit from international experience of ensuring patient privacy and data security. In the US, data breaches have cost the health industry an estimated 6.2 billion each year.
- At the same time, awareness about data privacy is low in India. Any efforts in the direction of strengthening the digital health infrastructure will need to be accompanied by efforts to also build awareness of digital rights among patients.

Establishing community-led accountability processes for monitoring healthcare systems should be prioritised and health workers and their associations, patients, representative networks and organizations of marginalised communities must be consulted as part of the project design process and during project implementation.

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[132] https://economictimes.indiatimes.com/industry/healthcare/biotech/healthcare/niti-aayog-proposes-surveillance-platform-to-strengthen-indias-public-health-system/articleshow/79719140.cms

[133] https://privacyinternational.org/examples/4600/health-ids-india-voluntary-or-mandatory

[134] https://scroll.in/article/1031157/how-india-is-creating-digital-health-accounts-of-its-citizens-without-their-knowledge

[135] https://www.statista.com/statistics/467163/forecast-of-smartphone-users-in-india/#:~:text=The%20number%20of%20smartphone%20users,1.5%20billion%20users%20in%202040.

[136] https://www.hindustantimes.com/cities/patna-news/poor-vaccination-coverage-among-kids-in-patna-due-to-tech-flaw-in-cowin-govt-officials-101645380732518.html

[137] https://iapp.org/news/a/the-evolution-of-indias-data-privacy-regime-in-2021/

[138] https://indianexpress.com/article/explained/explained-sci-tech/personal-data-protection-bill-withdrawal-reason-impact-explained-8070495/

Establishing community-led accountability processes for monitoring healthcare systems should be prioritised. The strategy must ensure that monitoring and governance mechanisms in healthcare systems are rooted in a rights-based accountability framework.

The Asks
- Ensure that each state government receiving support adopts a broad Social Accountability Framework for health arrived upon through consultative processes with civil society.
- Enhance community-based social accountability in the public health system through the inclusion of Community Based Monitoring and social auditing processes of project implementation; ensure that patient experiences are included in processes of quality assurance supported by the Bank.
- Ensure that all projects focussing on system strengthening enhance social accountability by investing in structures for community participation (like Jan Arogya Samitis, Rogi Kalyan Samitis and Panchayati Raj Institutions) in health at various levels. This will entail prioritising the inclusion of metrics for improvement of the capacity of these structures and interventions to support the same.
- Civil society networks and alliances, professional associations and unions of health workers and women's rights organizations and organizations representing marginalised communities must be consulted as part of the project design process and subsequently during project implementation.

The Rationale:
- Social Accountability is critical for streamlining healthcare delivery[139], especially interventions which go beyond building community awareness. Interventions need to be supported by putting to address hierarchies of power to enable citizens to demand their rights[140]. It is critical to support appropriate processes and work with the structures that can enable this to happen.
- There are over 32,000 Rogi Kalyan Samitis envisaged being constituted at public health facilities at the level of Primary Health Centres (PHC) and above including Community Health Centres (CHCs) and District Hospitals.[141] At the same time, committees have also been established for HWC and Sub-centres. However, many of these structures are weak[142] and not enough effort has been made to support their functioning. Only one project of the World Bank has emphasised building the capacity of Jan Arogya Samitis.[143]
- Civil Society organizations and unions have a critical role in maintaining social dialogue and ensure accountability. Only 40% of World Bank projects had a plan for stakeholder outreach with civil society[144]. While outreach as established by IFIs to health workers in several interventions during the preceding years, engagement with representative civil society networks and alliances or unions of health workers has been lacking.

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[139] https://academic.oup.com/heapol/article/35/Supplement_1/i76/5960441

[140] https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(19)30292-X/fulltext

[141] https://pib.gov.in/newsite/PrintRelease.aspx?relid=98919

[142] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3831692/

[143] World Bank-EHSDP

[144] https://www.oxfamindia.org/knowledgehub/workingpaper/overlooking-fundamental-analysis-international-financial-institutions-covid-19-era-health-and

RECOMMENDATIONS REGARDING INEQUALITY

Need for recognizing the nexus between increased wealth inequality and essential public services. Both IFIs should foreground wealth inequality and elite capture in health and education projects in their respective PADs/PIMs for different projects. Moreover, technical assistance grants can be explored for enhancing progressive taxation systems that finance public systems.

The Asks:

1. Include a focus on the rising inequality in India in its systemic country diagnostic and other processes related to the framing of the new strategies.
2. Undertake regular appraisals and research to generate evidence on the status of inequality in India, including best practices for its regular measurement.
3. Provide technical and financial support including capacity building of
   - Statistical institutions on measurement of inequality
   - Tax department staff for introduction and implementation of a wealth tax and other fiscal measures to address wealth inequality.
4. Use its convening power to draw more attention to the need for stronger implementation of SDG 10 including its focus on reducing inequality and bringing about shared prosperity.

The Rationale:

- Income and wealth inequalities in India are extremely high. In 2020, the income share of the bottom half of the Indian population was estimated to have fallen to only 13%, while the top 10% captured 57% of national income and the top 1% alone got 22%.[145] India had the third highest number of billionaires in the world, just behind China and the United States. The Gini coefficient of India, which is a measure of income distribution inequality, was 35.2 in 2011, ranking 95th out of 157.[146] Concrete measures are, consequently needed to address rising inequality.
- Data on income/wealth inequality is not maintained by the Government. The base data on which this is calculated is a decade old. India's Gini Index in the World Bank's dataset has not been updated since 2011. 140 countries have more updated information on income inequalities than India, including 20 countries that update income inequality data annually. India's neighbours including Pakistan (2018) and conflict-torn Myanmar (2017) have more updated data[147]. India may need support to expose statistical institutions to existing best practice on the collection of data on income and wealth inequality.
- One measure to ensure redistribution and raise untapped revenues and address inequality is the introduction of a wealth tax.[148] This was abolished in India since citing a significant amount of administrative burden on the taxpayer without yielding significant revenue. It may however, be worthwhile to provide the India tax authorities with exposure to enable them to understand the modalities adopted by other governments introducing wealth tax.
- India has been inconsistent in its SDG 10 reporting of income and wealth inequalities. The WB and ADB could play a convening role to ensure that the Indian government takes more concrete measures to address vertical inequalities.

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[145] https://thewire.in/economy/india-world-inequality-report-poor-affluent-elite-progress#:~:text=By%202020%2C%20the%20income%20share,the%20reality%20is%20even%20starker.

[146] https://worldpopulationreview.com/country-rankings/gini-coefficient-by-country

[147] https://www.bqprime.com/economy-finance/under-reporting-income-inequality-weakens-sabka-saath-sabka-vikas

[148] https://www.thehindubusinessline.com/economy/abhijit-banerjee-bats-for-wealth-tax-to-combat-inequality/article30668383.ece#:~:text=Nobel%20laureate%20and%20economist%2C%20Abhijit,at%20a%20literary%20meet%20here.

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RECOMMENDATIONS TO STRENGTHEN IFI-SPECIFIC MECHANISMS

Ensuring seamless access to project documentation and reports for facilitating greater transparency and opening up participatory forums for community-level civil society groups in project design, cycle and closure is critical. Additionally, IFIs should coordinate with the government for ensuring closer oversight of non-sovereign projects.

The Asks:
1. Ensure that all key documents including stakeholder engagement plans, environmental and social safeguard assessments, procurement and progress reviews are disclosed in a timely manner.
2. Ensure transparency by ensuring meaningful participation of representative civil society networks and alliances, unions and associations of teachers and health workers and representative groups of marginalized communities in pre-project consultations and social dialogue and accountability processes across the project cycle.
3. Updated information regarding the status of implementation (including achieved as against targeted) of all projects must be made available in the public domain. This needs to be disaggregated by gender, Dalit, Adivasi, Muslim, persons with disability and income quintile to ensure no one is left behind in the spirit of the SDGs. Data should include adequate granularity to be usable by affected communities in the states where projects are being implemented.
4. We further suggest both IFIs conduct a civic space assessment in key documents like the World Bank's Systematic Country Diagnostic that highlight the anchoring role civil society organizations play in the development and growth of a country.
5. IFIs should coordinate with the Ministries of Health and Family Welfare and Education to assess the areas where private sector investment may be required and ensure that the latter is kept abreast of the progress made on the developmental impact of the investments.
6. All documentation related to strategy development and project formulation, including details of consultations being held, must be disclosed in the public domain to facilitate wider participation.

The Rationale:
- 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 does not enable stakeholders at the state and district level to understand the extent of implementation for ensuring social accountability or for supporting implementation.
- While the IFIs have mechanisms for the participation of civil society as part of its stakeholder engagement processes. However, many of these are, in practice, limited to implementing consultation processes as a check-box exercise without a solid analysis of the enabling

environment for civil society participation, and without fully understanding whether a country's context is or is not conducive to safe and effective stakeholder participation. 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. Thus, India's civic space has been downgraded from "obstructed" to "repressed."[149] A civic space assessment within the Bank's SCD has the 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. Oxfam's Civic Space Monitoring Tool may be used for the purpose[150].

- India's government should create a country coordinating body (CCB) to channel IFC and other IFI private equity resources as per the healthcare needs of the country/states. This body should include representation from governments, WBG India, the IFC, civil society members, parliamentarians, academics, researchers and patient rights activists/bodies. The CCB may be tasked to decide on the priorities for investment and advisory assignments.

CONCLUSION

The World Bank and ADB can play a critical role in leveraging their financing and policy expertise to close health and education gaps in India. Doing so would require both IFIs retaining the levels of spending seen during the COVID period over the coming strategy period.

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[149] https://monitor.civicus.org/India.PeoplePowerUnderAttack.2019/

[150] https://policy-practice.oxfam.org/resources/civic-space-monitoring-tool-understanding-what-is-happening-in-civic-space-at-a-620874/