IFC Sustainability Review and Public Services: Technical Briefing Note

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INTRODUCTION

Universal public services are one of the most powerful tools governments have for reducing inequality, as well as for addressing reparative, gender and climate justice. Access to affordable, quality public services, such as health care and education is recognised as a human right for all. However, rising income and wealth disparities, especially post-COVID, are deepening exclusion. Market-based service delivery also continues to entrench inequality, positioning quality essential services as only accessible to those with the ability to pay and as such, often bypassing the poorest and most marginalised communities.

The IFC continues to invest in the provision of a variety of public services, in particular in education and health. In education, while the IFC took the welcome and considered step to indefinitely freeze[1] funding for fee-charging private K-12 education, it continues to pursue investments in this sector in edtech, higher education, as well as providing advisory services in many other areas such as Early Childhood Education. In health, the IFC continues to support significant work in this area, with $9 billion invested in healthcare to date.[2]

Therefore, based on our involvement in these sectors and experience representing CAO (Compliance Advisor Ombudsman) complainants and other affected communities, we submit lessons and concerns from these sectors. Evidence has continued to accumulate, highlighting the systemic challenges, unmitigated risks, significant harms and gaps in effective remedy for public service workers (particularly teachers, doctors), women, children, patients and other vulnerable groups as a result of IFC's investment approach. These concerns and harms continue to be documented, with the evidence indicating that IFC's current Environmental and Social (E&S) risk and mitigation assessment system is not well equipped to address the systemic concerns arising from the growth of private financing or the specific concerns related to patients' rights violations, for example, particularly in contexts where the regulatory environment and enforcement mechanisms are weak. This latter point was particularly salient in the IFC'S 2025 portfolio review of its direct investments in private health care.

Improving the Performance Standards is one way in which threats to the enjoyment of the right to health and the right to education can be addressed, while enhancing accountability for the IFC's current approach to investment in these sectors. We welcome the opportunity to contribute to the review and to strengthen the sustainability framework and have provided inputs below on four key areas as per their relevance to public service delivery.

The following is a technical briefing note homing in on observed gaps and evidence from WBG projects within public services sectors, specifically IFC investments in health and education. The brief reviews the Performance Standards 1, 2 and 4 in light of available evidence from the education and health sectors. For each standard under review, we will provide an overview of our key concerns, undertake an analysis of the standard in question based on existing components and structure of the standard and also outline any gaps identified, supplementing this with specific evidence drawn from experiences with IFC clients or projects. We then provide a summary of our key recommendations for each section. The standards are not mutually

[1] IEG (2022) International Finance Corporation Management Response. Link

[2] IFC (2026) IFC's Work in Health. Link

exclusive, and our analysis may have similar components appearing across the relevant standards.

All of our recommendations are guided by human rights principles and a commitment to ensuring that the IFC's investments "do no harm" to either people or the environment. Without these recommendations being met or incorporated, it is unlikely that the IFC's E&S Framework would be adequate for the continued investment in these sectors. More specifically our overarching asks are as outlined below and are further detailed under each specific section:

We recommend:

i. Upgrading risk assessment tools, to include more emphasis on systemic risks and impacts posed by the project, as well as include human rights impact assessments and mandatory site inspections where vulnerable groups are found. In addition, all category A/B/FI projects and advisory projects in the social sectors should require the application of the full assessment suite.
ii. Strengthen protection for vulnerable groups in particular, patients, children, the elderly and any low-income groups being served or targeted. The presence of any of these groups should automatically trigger higher risk categorization (A or FI-1), risk assessment and risk management actions, particularly where said vulnerable groups and weak regulatory enforcement coexist.
iii. Close all critical implementation gaps identified, with a view to addressing: the culture of tick-box compliance; staff incentives for effective monitoring and supervision of clients; contracting for sufficient leverage at all stages of the project cycle; improve transparency and public disclosures on ESAP implementation; and sanctions for repeatedly non-compliant clients.
iv. Require effective and functioning ESMS and ESAPs for all FI investments, particularly those engaging in the social sectors.
v. Address labour and working conditions (PS2) in particular addressing emerging risks and concerns around casualization, aggressive commercial/ revenue targets that compromise patient care or education quality.
vi. Improve transparency and disclosures, including the disclosures around: project impacts; co-investor involvement and their E&S responsibilities on the project page; and limiting inappropriate application of non-disclosure agreements that limit transparency or redress.
vii. Embed consumer protection principles (pricing transparency, product safety, redress) into PS1.

SECTION I - Performance Standard 1 (PS1): Assessment and Management of Environmental and Social Risks and Impacts

This section addresses systemic gaps in IFC's risk identification and management framework. It critiques the inadequacy of current risk assessment guidance and tools and examines flaws in environmental and social categorisation that routinely

underestimate risks—particularly where vulnerable groups are concerned. We then document persistent implementation failures and provide specific analysis around financial intermediaries, stakeholder engagement, grievance mechanisms, and consumer rights protections. The section closes with recommendations to upgrade and strengthen assessment tools, bridge implementation gaps, strengthen FI requirements, enhance transparency and accountability, and embed consumer protection principles into PS1.

I. Identification of Risks and Impacts

a. Risk Assessments and Risk Management

When it comes to the social sectors, IFC's E&S systems have fallen short in their ability to account for risks that go beyond the immediate impact of the project catchment area to those that are more systemic in character. The following section touches on this, inadequacies in the current tools and assessments used, as well as gaps in the project cycle particularly for advisory projects.

In relation to systemic risks, this includes but is not limited to the significant risks raised by growing commercialization, privatization and financialization of education or healthcare provision, including the undermining of public health systems and exacerbation of health and gender inequalities at the system level.[3] This is particularly relevant as the World Bank Group's investments are ultimately meant to lead to stronger, better-quality and more equitable national health and education systems as development outcomes. Instead, we have observed a dangerous trend, with IFC investments contributing to widening inequalities in health, including contributing to a two-tier system of health; subjecting those who cannot afford care to the denial of emergency treatment; patient detentions; and pushing families into poverty with catastrophic out-of-pocket expenses, among other. In Nigeria, for example – which has the world's worst maternal mortality rate – childbirth at an IFC funded Lagoon Hospital starts at nine months' income for the poorest half of Nigerians, while a caesarean at another IFC -backed hospital would cost 24 years' income for the poorest 10%.[4] In India, the IFC's investments overwhelmingly went to high-end urban hospitals out of reach for most Indians: Oxfam's research found that only 14% of IFC-financed hospitals were located in the 10 states with the weakest health systems, and despite being allotted free public land on condition of serving the poor, several IFC clients consistently failed to provide free care.[5] The investments are failing to address crucial healthcare needs and are not strengthening public systems, but are rather

[3] Hunter BM, McCoy D, Cordilha AC, Marriott, A., Roy V, Stein F, and Wood B (2025). Private Financial Actors and Financialisation in Global Health. United Nations University International Institute for Global Health, Kuala Lumpur. Link

[4] Marriott, A. (2023) Sick Development: How rich-country government and World Bank funding to for-profit private hospitals causes harm, and why it should be stopped. Oxfam International. DOI: 10.21201/2023.621529, Link

[5] Taneja, A., Sarkar, A. (2023) First, do no Harm: Examining the impact of the IFC's support to private healthcare in India. Oxfam India. Link.

prioritizing profits over patients, thereby exacerbating disparities between wealthy and marginalized populations.

In addition, and according to the WHO, globally, around 1 in every 10 patients is harmed when receiving hospital care and more than 3 million deaths occur annually due to unsafe care. Similarly, in low-to-middle income countries, as many as 4 in 100 people die from unsafe care.[6] IFC client hospitals are some of the largest private healthcare providers in LMIC contexts and the evidence indicates that they are silently contributing to these numbers.[7] We have also observed rising harm and compromises to patient safety, worsening labour conditions and other negative impacts[8] as a result of an approach that promotes the involvement of for-profit commercial actors in the provision of key social services, and particularly where the investments intersect with weak regulatory contexts. With the private sector at par or even superseding public provision in some contexts, the Performance Standards must be sufficiently robust to address systemic risks and guard against entrenching barriers to accessing quality healthcare and education. In addition, they should also clearly address the risks and potential impacts raised by the regulatory environment, political economy, corruption, elite capture, or cleavages in state capacity.

Secondly, given that the WBG is aiming to ensure that 1.5 billion people have access to quality healthcare, it is even more crucial now, to ensure that a human rights approach to due diligence is adopted and that all IFC risk assessment tools and methodologies (e.g. the cumulative impact assessments (CIA) and contextual risk assessments (CRA)), are updated, up to the task and explicitly integrate human rights impact assessment frameworks, particularly where vulnerable populations are involved.

Particular lessons can be drawn from CAO complaints and the concerns that have been reliably evidenced and raised by civil society organisations. For example, the impact of staff incentives schemes on health outcomes within hospitals is a critical emerging issue that deserves more attention.[9] It would be important to ensure that health impact assessments incorporate the attendant risks that emerge from poorly designed performance systems or revenue targets, and to address their potential implications for patient care or wellbeing. In addition, if an ethical approach to healthcare is indeed to be embraced, assessments should also identify the risk of medical debt, the abusive debt-collection tactics that patients and their families are often subjected to, including patients being forced into slavery or indentured labour, which all come about due to out-of-pocket spending and catastrophic health expenditure.[10] These issues do not

[6] WHO (2023) Patient Safety. Link.

[7] Marriott, A. (2023) Sick Development: How rich-country government and World Bank funding to for-profit private hospitals causes harm, and why it should be stopped. Oxfam International. DOI: 10.21201/2023.621529, Link

[8] Oxfam International (n.d) Sick Development - Link

[9] Taggart, K., Marks, S., Kocieniewski, D., Finch, G. (2025, August 26) *A Private Equity Giant Took Over African Hospitals. Then the Complaints Rolled In*. Bloomberg, Link.

[10] Marriott, A. (2023) Sick Development: How rich-country government and World Bank funding to for-profit private hospitals causes harm, and why it should be stopped. Oxfam International. DOI: 10.21201/2023.621529, Link; Dooley, B., Reddy, M. (2025, July 8) *How the World Bank Left African Hospital Patients "Detained" and in Crushing Debt*. Mother Jones, Link; Dooley, B., Reddy, M. (July 9,

appear to be adequately covered by the current assessments yet are routine forms of 'harm' experienced in contexts in which the IFC routinely invests and where national regulations are inadequate or too weakly enforced to address them. We note here for example, that out-of-pocket payments continue to push over 150 million people into or deeper into poverty across the WHO Africa Region for instance. These risks should not be ignored.[11] It is also vital to the Bank's commitment to achieving gender equality to ensure risk assessments capture the essential role that public services play in the lives of women and girls, especially by alleviating overwhelming care (paid and unpaid) responsibilities.

Several specific shortcomings have been identified with current tools and methodologies thus far, for example:

- The CIA is currently insufficient as it stands, as it is limited by its methodology, or more specifically the nature and scope of the Valued Environment and Social Components (VECs) it prioritises, which are quantifiable biophysical data over qualitative social impacts. As such it insufficiently captures the nuances of social impacts and should be expanded to include these, including systemic impacts.
- The IFC's Health Impact Assessment (HIA) tool in turn, also prioritizes environmental over social impacts. While it recognizes the necessity of assessing social determinants of health and states that a HIA could be triggered if there is any 'potential for significant changes in key social determinants of health' or if there is 'anticipated impact on local health services and infrastructure, it however does not expand on these social determinants in as sufficient detail as it does the potential environmental issues. Given the observed impacts with IFC projects, stronger guidance is clearly required.
- In addition, while HIAs may be useful and appropriate for assessing changes in population health outcomes, they often fail to adequately cater for system-level risks. This is important given the nature of the WBG's interventions and their interactions with health financing and financial protection systems, particularly in low to middle-income countries. We note here, for example, that while policies and donor programs may improve specific population level health outcomes, they may unintentionally weaken health systems as has been observed with the impacts of vertical programs.[12] Instead, a Health System Impact Assessment (HSIA), including an assessment of the health financing system, is necessary and should be a supplementary tool to identify these system-level risks, especially given the interconnectedness of health system components and the nature and positioning of the healthcare facilities the IFC invests in.

2025) 'Where would I find this amount of money?': Private hospital patients in Kenya grapple with crushing debt. The International Consortium of Investigative Journalists. Link

[11] WHO (2024) UHC Day: High health-care costs in Africa continue to push over 150 million into poverty: new WHO report. WHO Africa Region, Link; Garcia-Diaz, R., Sapkota, V. P., & Flores, G. (2024). Persistency of catastrophic out-of-pocket health expenditures: Measurement with evidence from three African countries-Malawi, Tanzania, and Uganda. *Social Science & Medicine*, *357*, 117156.

[12] Gatome-Munyua A, Sparkes S, Mtei G, Sabignoso M, Soewondo P, Yameogo P, et al. Reducing fragmentation of primary healthcare financing for more equitable, people-centred primary healthcare. *BMJ Global Health*. 2025;10:e015088. https://doi.org/10.1136/bmjgh-2024-015088; Osborne A. Rethinking global health financing: from philanthropy to public good. Glob Health Res Policy. 2025 Dec 9;10(1):63. doi: 10.1186/s41256-025-00462-6. PMID: 41366501; PMCID: PMC12687544.

Conversely, human rights impact assessments provide a better assessment of social risks and outcomes, including human rights violations than the CIA or CRA would be able to in isolation. Therefore, it is imperative that the existing tools be supplemented to accommodate the assessment of risks and impacts to access, affordability, and quality of education, health, social protection or other public services and in particular there be an examination of the potential equity implications and distributional impacts, including for all disadvantaged groups in these locales. A human rights approach to due diligence is explicitly grounded in international human rights law and can be conducted in parallel with or integrated into the CIA for all social sector or health/education projects.

Thirdly, there is also an apparent and significant gap in the assessment and oversight of advisory projects, which are broadly deemed to be of 'less risk' and which are also not subject to Board approval. We note here that IFC-supported PPPs entail locking the government into concessions or contracts with private players for a protracted period and yet fail to account for long range negative risks and impacts. For instance, the wide-ranging fiscal and health system impacts of the IFC advisory project in Lesotho (implemented from 2006), a health Public Private Partnership to design, build, maintain and operate the Queen 'Mamohato Memorial Hospital, which was 'mired in controversy and at one point cost the country over half of its annual national health budget. The partnership has since collapsed' without accountability for the role and contributions of the IFC.[13] Similarly, Oxfam in its report on the IFC's investments in India, noted that the 'inflexibility of such an approach has proven problematic in accommodating inevitable changing health needs' and that provisions relating to equity, transparency or accountability for impacts were often absent at contracting or were not reviewed or adapted over the contract period.[14] It is evident from the current and growing[15] evidence on health[16] that patient rights violations are not well embedded or configured into this system.

Lastly, we are aware that the IFC began a consultation on a potential Good Practice Note on Contextual Risk Screening. However, to the best of our knowledge this is yet to be finalised. We also note that the IFC guide to Human Rights Impact Assessment and Management (HRIAM) is not referenced at all in the IFC updated Environmental and Social Review Procedures Manual. The HRIAM manual as well, when referencing the right to health or education, steers clear of providing any emphasis on the quality of said services.

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[13] Marriott, A. (2014). A Dangerous Diversion: Will the IFC's flagship health public–private partnership bankrupt Lesotho's Ministry of Health? Oxfam International. Link; Oxfam International (n.d). Sick development. Link ; Marriott, A. (2023) Sick Development: How rich-country government and World Bank funding to for-profit private hospitals causes harm, and why it should be stopped. Oxfam International. DOI: 10.21201/2023.621529, Link p. 40.

[14] Taneja, A., Sarkar, A. (2023) First, do no Harm: Examining the impact of the IFC's support to private healthcare in India. Oxfam India. Link.

[15] Marks, S., Taggart, K., Kocieniewski, D. (2026, January 30) Faulty Equipment Pushed a World Bank Backed Hospital into Crisis. Link

[16]Marriott, A. (2023) Sick Development: How rich-country government and World Bank funding to for-profit private hospitals causes harm, and why it should be stopped. Oxfam International. DOI: 10.21201/2023.621529, Link ; Open letter (18 September 2025) Civil Society to Ajay Banga Makhtar Diop and the World Bank Group Board Urgent Call for Accountability: WBG Board's failure to address IFC-Funded Patient Abuse and Systemic Harms- Link .

Recommendations

i. Clarity and more specific guidance should be provided in PS 1 about what type of environmental and social categories trigger which specific risk assessments. It should be made mandatory to undertake the full suite of assessment for any social sector projects classified to be in category A or B or F1-4. This would include but not be limited to a: Cumulative Impact Assessment (CIA), Contextual Risk Assessment (CRA), Social Impact Assessment (SIA), Health Systems Impact Assessment (HSIA), Human Rights Due Diligence, Gender and Social Inclusion Assessment (GSIA), and a Distributional Impact Assessment (DIA).
ii. We understand that there is updated guidance on child protection and Gender Based Violence (GBV), for instance with the development of the 'Good Practice Note: Addressing Child Safeguarding in the Private Sector'. All updated guidance pertaining to this and other vulnerable groups should be firmly embedded into performance standard 1.
iii. We propose that a Human Rights Impact Assessment (HRIA) Guidance and Toolbox are added to any CIA and CRI and that any projects delivering healthcare or education, directly or indirectly, or any projects serving vulnerable populations should trigger a comprehensive CRA, CIA, HSIA and HIA, rather than qualifying for rapid appraisal as many currently do.
iv. The scope of social determinants in the IFC's current Health Impact Assessment (HIA) should be clarified and updated to include risks and key issues identified in ongoing and past IFC health investments, including the risks introduced by staff incentive schemes and the risks of financial hardship.
v. Additional tools or components should be integrated into the broader risk assessment framework to supplement the HIA, particularly for any projects that provide or impact healthcare delivery. These should include:
    - Health Need Assessments (HNAs) – this should be made mandatory for all health sector projects.
    - The Environmental and Social Management System (ESMS) Implementation Handbook and HIA toolkit should be updated to reference the Ethical Principles in Healthcare (EPiHC) and any emerging global best practice on patients' rights. Up-to-date and accurate assessments measuring clients against the EPiHC principles should be developed and applied to any healthcare investments, with any gaps clearly flagged in the Environmental and Social Action Plans (ESAP). PS1 should explicitly indicate that non-compliance to any of the EPiHC principles should be considered a breach of contract leading to suspension or disbarment.
    - Given the governance challenges already observed across IFC health clients,[17] the sustainability framework update should include tools that assess clinical

[17] Taneja, A., Sarkar, A. (2023) First, do no Harm: Examining the impact of the IFC's support to private healthcare in India. Oxfam India. Link

governance performance or include integrity governance frameworks in the assessment of any social sector investments.

- Patients require distinct and special attention in any HIA pertaining to health investments. The IFC should include explicit reference to the Patient's Rights Charter in any HIA. WHO recommends that landscape assessments of patient safety be undertaken, including the policy environment, safety risks, practice gaps, barriers to improvement and areas of progress that can be strengthened. This should be a mandatory component of risk assessments of projects that will impact patients.
- Social Impact Assessment (SIA) or Vulnerability Assessments can be utilized to ensure all risks introduced by exposure to hazards are adequately captured.
- Risk assessments should adequately assess the level of emergency preparedness and response of services, ensuring assessments for service continuity that accommodate aspects of non-discriminatory care (for health), equitable distribution of resources, transparency, accountability, affordability and the meaningful participation of affected populations.
- Value chain assessments could be relevant in the access to medicines space, with clients required to assess risks to equitable access and distribution of medicines, and the CIA, in such a case accommodating measures on self-reliance, extent of technology transfer, regulatory robustness and so on, that address any projects' contributions to health sovereignty.

vi. For projects in the health sector, we recommend that health system experts and health system financing experts (which are not the same as health financing experts or health economists), are contracted to assess the system impacts of a health investments, looking not only at the performance within the walls of a health facility, but also its impact on access to other facilities and on financial protection.

vii. Suggested amendments (in red) to clause 2 in the introduction of PS 1 to read – "*While the client cannot control these government or third party actions, an effective ESMS should identify the different entities involved and the roles they play, the corresponding risks they or an abdication of their duty may present to the project, client, stakeholders or potential beneficiaries, and opportunities to collaborate with these third parties in order to help achieve environmental and social outcomes that are consistent with the Performance Standards".*

viii. The ESMS implementation handbook for health care facilities, published in 2015, makes no reference to human rights, and patients' rights are mentioned in a limited fashion. There is a clear focus on operational management and promotion of occupational and environmental risk prevention and mitigation. However, this does not include sufficient focus on patients or human rights protections including, for instance, whether the client has established processes to ensure that patients are sufficiently aware of their comprehensive rights and the quality of care they should receive as well as options for recourse. There is also insufficient attention given to the negative impacts of a poor working environment; ill designed or inappropriate incentive structures; or the specialised care and approaches required for vulnerable groups.

ix. All advisory projects in the social sector should be distinctly assessed against the Performance Standards and published on an advisory project page.
x. The IFC guide to Human Rights Impact Assessment and Management (HRIAM) should be clearly referenced in the IFC updated Environmental and Social Review Procedures Manual and should have clear emphasis on the quality requirements of said services.
xi. There should be public consultation and transparency on the design, functionality and efficacy of the IFC's chosen early warning system or mechanisms, particularly on the criteria used to flag client non-compliance and clarity on what data from the system should be included in public disclosures.
xii. Suggest that footnote 12 on pg. 3 of the PS1 document be moved from the footnotes and incorporated into the main body of text and be edited as follows (edits in red): "In any investments in healthcare or education, or involving any of the vulnerable groups mentioned and in limited high risk circumstances, ~~it may be appropriate for~~ the client should ~~to~~ complement its environmental and social risks and impacts identification process with specific human rights due diligence as relevant to the particular business".
xiii. We further recommend that IFC's exclusion list be updated to reflect IFC management's decision taken in 8 June 2022 to halt: "i) direct investments or advisory services related to the provision of education in fee-charging (for-profit and not-for-profit) K–12 schools; (ii) public-private partnerships related to school privatization or the provision of education in fee-charging K–12 schools; (iii) indirect investments in fee-charging K–12 schools through private equity fund clients."[18]

b. Environmental and Social Categorization

The IFC's system of environmental and social categorization, which is supposed to reflect the magnitude of risks and impacts, is flawed.[19] Firstly, the categorization informs IFC's institutional requirements for assessment, supervision as well as disclosure in accordance with IFC's Access to Information Policy. There are currently four main categories A, B, C, F1-3. According to the IFC's Annual Report for 2022 (p. 15), 2.7% of new projects were classified as category A, 41.2% category B, 7% category C, and 48.3% were financial intermediary projects.[20] The CAO stated in a recent report that since 2013, 50% of CAO complaints have related to projects that IFC/MIGA expected to carry limited risk of adverse E&S impacts (category B projects). A large body of evidence also indicates that projects are often categorized wrongly due to administrative bias,

[18] World Bank (2022) International Finance Corporation Management Response, Link; World Bank. 2022. An Evaluation of International Finance Corporation Investments in K–12 Private Schools. Independent Evaluation Group. Washington, DC: World Bank

[19] IFC (2026) Environmental and Social Categorization. IFC. Link

[20] IFC (2022) Stepping Up In A Time Of Uncertainty. Link

resulting in several oversight gaps including leniency and a hands-off approach when it comes to FI investments.[21]

Secondly, the term disadvantaged or vulnerable groups is commonly understood to address people who, due to gender, ethnicity, race, age, disability, economic status, political stance, culture, dependence on natural resources, religion or social standing, might be disproportionately affected by projects and have limited capacity to claim rights or benefits (or seek remedy), including the elderly, indigenous peoples, women, children, the poor, and landless individuals. The current definition within the standards is limited and could do with further enumeration. According to PS1, where individuals or groups are identified as disadvantaged or vulnerable, the client will propose and implement differentiated measures so that adverse impacts do not fall disproportionately on them and they are not disadvantaged in sharing development benefits and opportunities. However, various implementation failures indicate that assessments are lacking in sensitivity and are as such failing to capture the full scope or depth of disadvantage or vulnerability, particularly associated with projects in the health and education sectors.

This was well demonstrated in the Bridge International Academy (hereinafter referred to as Bridge) cases[22], where the IFC completely overlooked children as a vulnerable group despite the Performance Standards clearly outlining that they fall under this categorization. As such, the IFC has had to significantly enhance its child protection and sexual and gender-based violence policies and instruments. Other vulnerabilities remain, particularly around patients, workers and consumer rights. It is evident that an intersectional approach should be adopted when analysing risk in cases where vulnerable groups are present. This would identify heightened risk in cases where factors such as gender, age, or social class overlap. We would recommend that the presence of vulnerable groups within a project more significantly inform the environmental and social categorization of a project.

Recommendations

We therefore propose that:

i. The definition[23] of vulnerable groups be expanded and greater emphasis be given to groups such as patients, children, students, the elderly, and low-income beneficiaries as these are where adverse impacts with IFC clients have already been observed. We also seek that the following groups be included as disadvantaged or vulnerable

[21] Gallu, J. (2023) ADVISORY NOTE Insights on Remedy. The Remedy Gap: Lessons from CAO Compliance and Beyond. CAO. Link; Inclusive Development International (IDI). (2016). *Outsourcing Development: Lifting the Veil on the World Bank Group's Lending Through Financial Intermediaries*. *Link and Link; Donaldson, C (2021)* Financial Intermediary sub-project data exposed for the first time. Medium. Link.

[22] Bridge-01; Bridge-02 ; Bridge-03; Bridge-04 or Learn Capital 01-04.

[23] Commonly recognized vulnerable groups include: Children, Women & Girls, Persons with Disabilities, Migrants, Refugees, & Asylum-Seekers, Older Persons; Ethnic & Racial Minorities/Indigenous Peoples; LGBTQI+ Persons, or other nationally relevant characteristics, like Dalits

groups, for all projects in the social sectors: Undocumented Migrants and Asylum Seekers; Informal Sector Workers; and Persons Experiencing Homelessness.

ii. A more comprehensive and holistic focus on disadvantage and vulnerability be adopted. To achieve this, we recommend that:
   - A higher risk categorization can be automatically triggered in cases where vulnerable groups are deemed to be present and where regulatory enforcement is also deemed weak, as this directly impacts the adequacy of monitoring and supervision that follows. Amendments should be made to the criteria that inform project categorization, such that any project attending to, or directly or indirectly affecting any of the above vulnerable groups or parties automatically be categorized in A or FI-1 categories.
   - The presence of any of the vulnerable groups mentioned above should prompt a full scale ESIA.
   - Site inspections and appraisal missions should be mandatory for any project engaging or potentially affecting vulnerable groups, with no exceptions for repeat clients or well-known assets projects.
   - The following edits (in red) be made to clause 12 of PS1*: "Where the project involves specifically identified physical or social elements, aspects and facilities that are likely to generate impacts, and as part of the process of identifying risks and impacts, the client will identify individuals and groups that may be directly and differentially or disproportionately affected by the project because of their disadvantaged or vulnerable status."*

iii. In-depth labour audits be conducted by independent specialists and be made a mandatory component of risk assessments for any projects engaging or affecting any potential vulnerable groups. The audit should form part of the ESIA prior to approval and be undertaken periodically throughout the lifetime of the investment. This ensures that the systemic issues related to labour and working conditions are identified pre-investment to inform the investment decision and ESAP that is subsequently developed.

iv. All ESIAs should also include standalone Gender and Social Impact Assessments (GSIA) and Distributional Impact Assessments (DIA) that include baseline data that is disaggregated by sex and other relevant characteristics, which must be disclosed, and all project risk screening tools should include gender risk criteria.

II. Implementation Gaps and Failures

a. Capacity and Competency Gaps

Various reports indicate that there are institutional gaps at the IFC that impact their capacity to: adequately weight risk factors around poverty and vulnerability; and adequately assess the scale and complexity of risks pertaining to innovative projects or novel models that are aiming for rapid scale. The Bridge cases are again illustrative of these shortfalls, where despite several risk factors apparent at project onset and the potential scale of the project, IFC did not require their client to prepare a comprehensive E&S assessment of the overall risks and impacts of its

business activities in accordance with PS1. IFC's pre-investment review failed to adequately assess the scale and complexity of safeguarding risks across a large, geographically dispersed network of schools, despite the project's profile involving vulnerable children in a low-income, high-risk setting.[24] IFC itself lacked the internal expertise and capacity to manage child protection/ child safeguarding risks effectively at the time of investment and failed to evaluate the client's organizational capacity and systems to prevent, manage and mitigate complex social risks such as child protection.[25]

The concerns raised in relation to IFC's client BYJUS[26] are also illustrative: heralded as an innovative approach and application of education technology, through digital platforms for teaching and learning in India. BYJUS reportedly became a rising star, attracting a range of institutional and philanthropic donors. However, shortly after the IFC client was overwhelmed by lawsuits, complaints of financial mismanagement and negative impacts on staff and on children that remain unaddressed and unaccounted for.[27] This is particularly relevant given that the IFC continues to pursue innovations in social sectors while it remains unclear what capacity they can offer to prevent, address or mitigate any negative impacts arising from these innovations or technologies on vulnerable groups in these sectors. This includes any innovations in diagnostics, telemedicine, edtech and other digital products, for which we have not seen any forthcoming guidance. IFC has similarly admitted to key capacity gaps in the health sector and has only in 2025 committed to enhancing its staff capacity and expertise as a direct response to the range of reports around human right violations emanating from IFC client hospitals. [28]

It is apparent that there is a critical gap in expertise when it comes to determining what constitutes an appropriate level of risk or hazard, even where client services and actions have the potential to lead to harm or even death. This is evidenced by the range of harms already witnessed in IFC projects related to health (e.g. patient detentions, medical equipment failures, overbilling etc[29]) and in education (e.g. child sexual abuse, the death and injury of children on IFC client property etc), where the right level of expertise would have anticipated risk and rightly identified the appropriate safeguards to have in place.[30] While hiring of staff or consultants with

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[24] CAO (2023) Compliance Investigation Report Regarding a Complaint about IFC's Investment in Bridge International Academies (Bridge-01). Link

[25] CAO (2023) Compliance Investigation Report Regarding a Complaint about IFC's Investment in Bridge International Academies (Bridge-01). Link

[26] BYJUS https://disclosures.ifc.org/project-detail/SII/38562/byju-s

[27] Ray,S., Jain, K., Birru, P., Mohata, R. (2024) A case study of BYJU'S failure. World Journal of Advanced Research and Reviews, 21(03), 674–689. Link

[28] World Bank Group (February 20, 2025) World Bank Group Statement on Private Healthcare Concerns. Link

[29] Oxfam International (n.d) Sick Development. Link ; Marks, S., Taggart, K. Kocieniewski, D (2026, January 30) Faulty Equipment Pushed a World Bank-Backed Hospital Into Crisis. Bloomberg. Link ; Dooley, B., Reddy, M. (2025, July 8) *How the World Bank Left African Hospital Patients "Detained" and in Crushing Debt*. Mother Jones, Link.; Taggart, K., Marks, S., Kocieniewski, D., Finch, G. (2025, August 26) *A Private Equity Giant Took Over African Hospitals. Then the Complaints Rolled In*. Bloomberg, Link.

[30] CAO (2023) Bridge-01 Compliance Investigation Report – Link ;CAO (2023) Compliance Investigation Report. CAO Initiated Investigation of IFC's Investment in Bridge International Academies (Bridge-04) Link; CAO. Kenya: Bridge International Academies-02/Kenya. Link

the expertise is an action the IFC will take to address some of these deficits, questions remain as to whether additional staff will fully or effectively address said gaps, particularly if the sustainability framework is not enhanced to ensure these safeguards are firmly in place.

b. Inadequate Supervision of Compliance with National Laws and Regulations

Client compliance with national laws and regulations is a requirement under PS1. PS1 also states "*At times, the assessment and management of certain environmental and social risks and impacts may be the responsibility of the government or other third parties over which the client does not have control or influence*." We assess this clause against current practice, where the IFC continues to invest in systemically weak regulatory contexts. For instance, in India, IFC failed to adequately account for the prevailing regulatory crisis and apparent lack of effective governance in private healthcare which had resulted in widespread patients' rights violations at IFC client and former client hospitals in India.[31] The growing evidence base around IFC health investments indicates that non-compliance or unresolved regulatory compliance issues relevant to PS1 are often not adequately weighted or given the attention they deserve.

For example, in the Bridge cases, the IFC was aware at the time of its investment in Bridge International Academies that it was not in compliance with requirements under Kenyan law regarding the registration of schools and use of certified teachers, which were relevant to addressing E&S risks and impacts under PS1 and PS4. IFC overlooked regulatory non-conformance by the client, presenting Bridge as a company using commercially reasonable efforts to comply with national regulations. IFC did not explicitly address the client's continued noncompliance and neglected to provide adequate attention to this lapse during the supervision process, showing some bias for the legal ambiguity that favoured their client's expansion. The project E&S Action Plan did not include actions to address non-compliance with school registration.[32] Non-Compliance with Kenyan education law - a relevant E&S issue - later had significant negative implications for the project, in particular for those who suffered irreparable harm. A key aspect to consider, therefore, within or in parallel to the Contextual Risk Assessment would be the adoption of more thorough policy and regulatory impact assessments.

c. Failures in Monitoring and Enforcing Compliance

Distinct failures have been observed with the IFC's environmental scanning and monitoring systems as well as their supervisory approach. For instance, in a recent review of IFC's investments in healthcare in India, it was apparent that despite information being available and in the public domain on a range of regulatory and compliance issues, the IFC failed to undertake the appropriate level of preventive or mitigative actions, nor did they provide any communication as to what corrective actions were being undertaken. In this review, an analysis of local media reports showed records of patients' rights violations and concerns across IFC's client hospitals. The analysis assessed instances of non-compliance with national or local regulations, identifying complaints which regulators had upheld. The result was a list of over sixty reported

[31]Taneja, A., Sarkar, A. (2023) First, do no Harm: Examining the impact of the IFC's support to private healthcare in India. Oxfam India. Link

[32] CAO (2023) Compliance Investigation Report Regarding a Complaint about IFC's Investment in Bridge International Academies (Bridge-01). Link

patients' rights violations upheld by Indian authorities, where some form of restitution had been provided or where penalties were imposed. The highest number of cases reported were from the IFC clients - Apollo (16 complaints), Max (16 complaints), and Fortis (24 complaints) Hospital groups which were repeated and direct investment clients in IFC's India health sector portfolio, with most pertaining to issues around overcharging, governance failures and patients' rights violations.[33] A public account of any corrective action taken in these instances, and since, remains absent.

Similarly, in the education sector, in the Bridge Cases specifically, we have mentioned that the IFC did not consider non-compliance with Kenyan education law an E&S issue even though PS1 (paras. 6 and 15) requires client compliance with E&S relevant provisions of national law. IFC presented Bridge as a company using commercially reasonable efforts to comply with some regulations despite the law requiring all private schools to achieve registration and to have all teachers registered as per the law. The CAO, however, found little evidence that IFC followed up to ensure that their client was making sufficient progress in registering schools under the prevailing regulations. In 2014, the client's Environmental and Social Action Plan (ESAP) included a commitment to put in place procedures to ensure compliance with regulatory requirements. By 2019, only 53 Bridge schools were reported as registered - equivalent to 18 percent of Bridge schools in Kenya at the time. In 2021, the final year of IFC's investment, only 23 of 111 remaining Bridge schools in Kenya were reported registered.[34]

The Bridge Cases also showed distinct lapses in verification during ESDD and supervision in regard to PS4, EHS guidelines, and the relevant GIIPs. Documentation from the CAO outlines the difficulties IFC faced obtaining detailed site-level information from the client, with the client ignoring reporting schedules and requirements which hindered effective oversight. In addition, IFC had an inadequate response to incidents of non-compliance, where for over five years (2014-2020), IFC's supervision did not adequately assess or address Chile Sexual Abuse (CSA) risks, gaps in safeguarding policies, or staff training needs.[35] After being informed of specific CSA allegations/ incidents in 2020, IFC's supervision improved but remained insufficient, failing to ensure that a comprehensive, survivor-centred investigation and response was fully implemented before exiting the investment.[36] We are not aware of any sanctions or disciplinary action taken at the IFC or against the client in response to these findings.

In addition, a recurring implementation challenge, which also reflects some gaps in the implementation of the Sustainability Policy, is the IFC's use of leverage, with several projects

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[33] Taneja, A., Sarkar, A. (2023) First, do no Harm: Examining the impact of the IFC's support to private healthcare in India. Oxfam India. Link

[34] CAO (2023) Compliance Investigation Report Regarding a Complaint about IFC's Investment in Bridge International Academies (Bridge-01). Link

[35] CAO (2023) Compliance Investigation Report Regarding a Complaint about IFC's Investment in Bridge International Academies (Bridge-01). Link; CAO (2023) Compliance Investigation Report. CAO Initiated Investigation of IFC's Investment in Bridge International Academies (Bridge-04) Link

[36] CAO (2023) Compliance Investigation Report. CAO Initiated Investigation of IFC's Investment in Bridge International Academies (Bridge-04) Link; IDI, Accountability Counsel (2025 March 13) One year on: No remedy or accountability for survivors of sexual abuse at World Bank Group funded schools in Kenya. Inclusive Development International. **Link**

indicating either the absence of sufficient leverage or misuse of available leverage to compel their clients to comply with the standards or for client to implement the necessary remedial actions.[37] This is particularly challenging once the investment period nears its end or where the IFC has exited the project, such as in the Bridge cases.[38] IFC's failure to ensure E&S compliance prior to exiting its investment in Bridge in March 2022 is noteworthy. The IFC divested while many of the aforementioned harms and risks remained unaddressed, which left a legacy of risk with their client and more importantly, left survivors with the burden of fighting through a complex and unclear path to remedy.

These and other examples demonstrate a consistent inability by the IFC to effectively verify or manage client compliance, or to ensure corrective actions are implemented. In the examples shared, the IFC demonstrated a heavy reliance on client self-report which existed in parallel to the lack of verification, which created an environment ripe for risk.

d. Failures in Due Diligence

A clear challenge lies in the IFC's limited capacity to design and implement E&S due diligence reviews that are "appropriate to the nature and scale of the activity" or "commensurate to the level of environmental and social risks and/or impacts." This was clearly observed in the Bridge cases and appears to be a critical gap, given the emerging evidence in the health sector.[39] The IFC recently admitted to their need to strengthen due diligence and supervision in the health sector.[40] A critical underlying issue here appears to be the culture of 'tick-box' compliance where clients do the bare minimum by, for instance, only reporting the presence of an ESMS or ESAP. The IFC then subsequently fails to test the efficacy and efficiency of said system and its capacity to effectively identify and address harms. This somewhat flippant approach to due diligence was evident in the Bridge Cases (01-04) where the CAO found that the IFC often undertook shallow document reviews, relying on client documentation or self-reporting, and failing to undertake their own comprehensive analysis. Neither did the IFC address the quality or adequacy of client submitted information. In addition, there were clear gaps in the approach used to assess the client's capacity to address risks, particularly in the context of rapid scale or expansion of the project in the local context. Specific examples are provided below:

i. The IFC focused its due diligence analysis on documentation from Bridge related to plans and procedures to address various E&S risks and impacts. The CAO reported that the IFC did not review the adequacy of plans for achieving the outcomes required in relevant Performance Standards. According to the CAO, IFC's limited document review provided an

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[37] CAO (2026) Leveraging IFC's Influence to Enhance Environmental and Social (E&S) Outcomes. CAO. Link

[38] CAO (2023) Bridge-01 Compliance Investigation Report – Link ;CAO (2023) Compliance Investigation Report. CAO Initiated Investigation of IFC's Investment in Bridge International Academies (Bridge-04) Link

[39] Open letter (18 September 2025) Civil Society to Ajay Banga Makhtar Diop and the World Bank Group Board Urgent Call for Accountability: WBG Board's failure to address IFC-Funded Patient Abuse and Systemic Harms. Harms. Link ; Marks, S., Taggart, K. Kocieniewski, D (2026, January 30) Faulty Equipment Pushed a World Bank-Backed Hospital Into Crisis. Bloomberg. Link

[40] World Bank Group (February 20, 2025) World Bank Group Statement on Private Healthcare Concerns. Link

insufficient basis to establish the project's key impacts and risks. These shortcomings were compounded by IFC's failure to conduct site visits and led to significant gaps in its understanding of the E&S risks and impacts associated with Bridge's business model and the client's capacity to manage them.[41]

ii. Similarly, IFC's Environmental and Social Due Diligence (ESDD) documentation lacked a systematic analysis of Bridge's capacity to manage E&S issues, or what capacity would be needed as Bridge moved to scale up rapidly in Kenya and elsewhere. More specifically:

- IFC's ESRS for the project, submitted to the IFC Board to support project approval, lacked sufficient information to assess the "capacity, maturity and reliability of the client's E&S corporate management system". Second, it failed to assess "the E&S performance of a representative set of past and prospective identified projects as a measure of management effectiveness."[42]
- IFC due diligence documentation mentions that Bridge did not have an ESMS at the time. In the absence of an ESMS, IFC noted that Bridge maintained an audit/quality control function that made regular school visits to ensure implementation of company plans and procedures. However, IFC did not review any of these audit/quality control protocols or any results of the audit function in identifying and addressing E&S risks and impacts. IFC then allowed three years to lapse around the requirement of having a comprehensive ESMS in place.
- There is no evidence that IFC assessed the adequacy of the existing allocation of roles and responsibilities in managing E&S issues related to school construction and operation. Nor was there any indication that IFC assessed client performance in executing these roles and responsibilities.[43]

e. Transparency and Non-Disclosure Agreements (NDAs)

Challenges were raised in the Bridge cases regarding accountability gaps introduced due to confidentiality agreements signed between the IFC and Bridge, which limited the scope and progress of the CAO's investigation, and ultimately hindered transparency and adequate oversight of the investment.[44] This has had direct implications on broader institutional accountability and remedy.

Recommendations

i. The IFC should provide a comprehensive capacity assessment report of their clients ESMS function, and have this presented to the Board prior to board

[41] CAO (2023) Compliance Investigation Report Regarding a Complaint about IFC's Investment in Bridge International Academies (Bridge-01). Link

[42] Ibid.

[43] Ibid.

[44] CAO (2023) Compliance Investigation Report. CAO Initiated Investigation of IFC's Investment in Bridge International Academies (Bridge-04) Link ; David Pred, Margaux Day, World Bank Group Board of Directors & President Ajay Banga (22 November 2023) Public Letter – Link; R. Grim, N. Wadekar (2023) 'Neutralize Adler' Whistleblower: The World Bank Helped Cover Up Child Sex Abuse at a Chain of For-Profit Schools It Funded," The Intercept (Oct. 17, 2023)

approval, with clear conditions set out to address gaps before the investment is approved. A summary of this gap assessment should be published in the public domain, in addition to the ESAP.

ii. Experts in poverty, gender and human rights should be contracted to support IFC teams undertaking any risk assessments for projects in which vulnerable or disadvantaged groups are considered potentially affected communities. These experts should also be engaged in the assessment of any innovations or innovative projects or the piloting of any models in IFC's efforts towards market creation.

iii. All projects, particularly those in fragile contexts or those directly or indirectly affecting vulnerable or disadvantaged communities, should require a thorough policy and regulatory impact assessment, with ESAP's clearly delineating IFC's oversight role as well as the role of the client and/ or any third parties. For investments in the health sector - such policy and regulatory impact assessments would require health and education systems, including health finance and education finance systems expertise. In addition, the assessment should require an assessment of regulatory enforcement capacity and existing regulatory enforcement gaps, and how either of these potentially impact project beneficiaries or potentially affected communities.

iv. Regarding monitoring and review, Clauses 22-24 of PS1 should be amended to clearly delineate the role of the IFC in the monitoring and review of effective implementation of the ESAP and how this and reporting will be contractually enforced.

v. It would be prudent to also categorize or recategorize as high risk, any projects that have been flagged for noncompliance of any PS requirements beyond the first 1-2 years of implementation or that have been flagged by other investors or regulatory bodies as being non-compliant. Debarment should be considered a suitable response should recurring noncompliance be identified or where remedy actions that have been identified have not been effectively addressed beyond a reasonable period.

vi. IFC contracting templates should be reviewed to ensure that their design allows for the operationalization of leverage across the contract cycle, at and post- exit.

vii. Any well evidenced failure or resistance on the client's part to implement or report on progress of the Environmental and Social Action Plans (ESAPs), or other aspects of the management programme, should attract significant sanctions. This would include clients who have been observed to significantly delay reporting or who persist in non-compliance beyond the agreed period. The Sanction hierarchy should be clear and embedded into the contracting.

III. Financial Intermediaries (FIs)

All financial intermediaries are mandated to implement the IFC's Performance Standards across their portfolios. The application of IFC's E&S requirements by FIs however must be significantly strengthened given key weaknesses identified by the CAO and others over the years. For example, the CAO found poorly prepared due diligence reports, weak E&S Action Plans, and

limited FI supervision of sub-projects, resulting in inadequate demonstration of PS implementation.[45] Additionally, in one study of IFC health investments in India, it was found that health projects were categorised as FI-2 or FI-3, which meant they were designated as having no or minimal E&S risk for most investments. No ESAPs were deemed necessary or were not disclosed, making it difficult to understand the impacts of these investments from IFC's perspective. Yet violations and harms were documented and endured across these FI clients within the IFC's portfolio.[46] Addressing the gaps in FI due diligence and supervision is even more crucial given the increasing presence and engagement of FIs across the IFC portfolio, more so where FIs are engaged in the social and essential service sectors.

Evidence from the health sector demonstrates why an effective and functioning ESMS and ESAP should be made a requirement for all FI investments, particularly those engaging in any social sector. For instance, the Abraaj Growth Markets Health Fund, which was at the centre of a major corruption scandal leading to the collapse of the Abraaj Group, was liquidated and renamed the Evercare Health Fund and since May 2019 has been managed by TPG Growth. The fund had under it several healthcare subprojects, including Nairobi Women's and Avenue Hospitals in Kenya, all of which have been recently implicated in a range of patients' rights and labour violations.[47] This investment was classified as a FI-2 (medium risk) investment and considered an experienced fund manager with the capacity and systems in place to manage risks. However, the Abraaj scandal[48] and many other similar examples demonstrate the necessity for more stringent ESMS monitoring of all FI clients.

Recommendations

i. PS 1 and client contractual agreements should be updated to address FI involvement and the role of the client in ensuring there is sufficient E&S due diligence, risk identification and management at the sub-project level. In our view, key gaps that need to be addressed in this regard include:
    a. FI capacity building to adequately mitigate E&S risks and impacts at the sub-project level.
    b. IFC documenting and retaining sufficient information about actual E&S performance at the sub-project level, including sufficient evidence of

[45] CAO (2025) Multi-Regional: CAO Compliance Audit of IFC's Financial Sector Investments. Compliance Advisor Ombudsman. Link.

[46] Taneja, A., Sarkar, A. (2023) First, do no Harm: Examining the impact of the IFC's support to private healthcare in India. Oxfam India. Link

[47] Marriott, A. (2023) Sick Development: How rich-country government and World Bank funding to for-profit private hospitals causes harm, and why it should be stopped. Oxfam International. DOI: 10.21201/2023.621529, Link; Taggart, K., Marks, S., Kocieniewski, D., Finch, G. (2025, August 26) *A Private Equity Giant Took Over African Hospitals. Then the Complaints Rolled In*. Bloomberg, Link; Finch, G., Taggart, K., Kocieniewski, D. (2025 January 17) Patients Detained, Denied Care at Hospitals Funded by World Bank, Bloomberg, Link. ; Dooley, B., Reddy, M. (July 8, 2025) The World Bank set out to transform health care for the poor in Africa. It drove patients deeper into poverty - Link; Dooley, B., Reddy, M. (2025, July 8) *How the World Bank Left African Hospital Patients "Detained" and in Crushing Debt*. Mother Jones, Link.

[48] Le, Adam (2022) Behind the headlines: Abraaj's fall from grace. Private Equity International. Link.

effective ESMS implementation, doing no harm or the attaining of positive development outcomes.

c. Improved client reporting obligations to allow the IFC to sufficiently verify the use of funds.

ii. ESMSs and ESAPs should be a requirement for all FI investments, particularly those engaging in any social sector. In addition:

a. Any criteria within the ESAP touching on the development of a policy, procedures and plans should carry a measure for the measurable and effective implementation of said policy.

b. Any adjustment of priority actions should be publicly declared. Moreover, any actions within the ESAP that would have an impact on the vulnerable groups listed, should be considered priority actions

c. Any noncompliance with existing legislation or regulations should be reported and carry with it appropriate sanctions.

IV. Stakeholder Engagement

The depth and quality of stakeholder engagement needs to be enhanced and regularly monitored, particularly at the project or sub-project level. This may require significant capacity building and retooling of IFC's stakeholder engagement function to enhance its efficacy. In the first instance, there needs to be an acknowledgement that the definition of the 'stakeholder' in relation to health and education investments is often unclear or limited to the narrowest interpretation, referencing only those within a particular geographic locality. In reality stakeholders in health for instance, in relation to hospitals or other health related products, is much further. Running parallel to this, we acknowledge community, indirectly and directly affected persons, and other stakeholder's broad lack of knowledge of IFC involvement in its investment projects. In all the CAO cases in which we have been involved, no complainants were aware of the IFC's involvement or oftentimes who owned the company. In the first complaint filed against Bridge there were numerous instances of this, but also and in addition, key stakeholders such as parents and teachers being mistreated and subjected to participatory mechanisms that were ineffective channels of engagement.[49]

It is evident that there exist significant gaps in the understanding and implementation of meaningful consultation and engagement. Another example, stakeholder engagement should not be considered a data collection exercise, but one of meaningful consultation for the duration of the investment. In the Bridge cases, the IFC accepted household surveys undertaken by Bridge's marketing team as forming all or a significant part of their stakeholder engagement process. A household survey does not constitute meaningful stakeholder engagement, nor does it adequately assess the nuanced needs of disadvantaged or vulnerable communities, if not explicitly designed to do so, nor does it often assess the "adverse environmental and social impacts to Affected Communities", in addition to their various limitations.[50]

[49] EACHRights (2018) Letter to the IFC: 'Submission of Complaint' Link.

[50] Cirenia Chávez Villegas and Emma Samman (2015) Exclusion in household surveys Causes, impacts and ways forward https://media.odi.org/documents/9643.pdf ; Seidler V, Utazi EC, Finaret AB, Luckeneder S, Zens G, Bodarenko M, Smith AW, Bradley SEK, Tatem AJ, Webb P (2025) Subnational

In addition, there is the presumption that communities only seek or desire engagement following the filing of claims or complaints. However, our experiences with communities show that contrary to this, communities would also appreciate transparent reporting on project impacts or how it affects them throughout its lifetime, such as health outcomes in the district in which the client is situated.[51] Client reporting on progress to meet items on the ESAP is often non-transparent, with no feedback provided to stakeholders. Yet there should be regular engagement or communication on these items to all those concerned.

Thirdly, while the IFC discloses private equity fund involvement in projects, past experiences demonstrate the need to also disclose all past and present co-investors involved in any of its projects, and the nature of their involvement while IFC was actively invested in that project. In the Bridge case, the IFC divested and exited its investment with an E&S risk legacy still pending, and remedy still being negotiated with no commitments extracted from the client or other co-investors in the project. The IFC was therefore forced to bear the full responsibility for remedy. Affected communities reached out to co-investors they were aware of seeking redress. However, the response was tepid at best: some co-investors stated that they were awaiting to observe IFC actions on the matter, others claimed that they had no role in governance and oversight of the investment and were partners with limited liability, while others remained non-responsive to any queries from affected communities. This led to a situation in which all other co-investors assumed no responsibility for the failures in due diligence and supervision of an investment they contributed to. It was also unclear to communities whether or how IFC was using its convening power to engage with other co-investors in the project to address the harm they experienced and what options or pathways for remedy remained through co-investors.

This experience indicated a glaring need for the IFC to discuss and improve its approach to co-investments in its efforts to remain accountable to communities. This is especially pertinent in the health sector, where co-investment is increasingly a key feature of its approach to promoting local manufacturing and access to medicines in low-income countries. It is crucial that communities are aware of the full suite of investors engaged in projects affecting them. As such, there should be a clause within the PS that requires the clear and accessible identification of all co-investors on the IFC's project disclosure pages, including an outline of the lateral responsibilities held, and the levels of responsibility of each investor across financial risk, managerial control including management of E&S risks, remedy and legal liability.

Lastly, disclosure of information remains a significant component of stakeholder engagement under PS1 and, in conjunction with IFC's Access to Information Policy, aims to help affected communities and other stakeholders understand the risks, impacts and opportunities of the

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variations in the quality of household survey data in sub-Saharan Africa. Nat Commun. 22;16(1):3771. doi: 10.1038/s41467-025-58776-5. PMC12015360.https://pmc.ncbi.nlm.nih.gov/articles/PMC12015360/; Klasen, S., Lechtenfeld, T., Povel, F. (2013). Using Household Surveys to Capture Vulnerability: Issues and Challenges. In: Klasen, S., Waibel, H. (eds) Vulnerability to Poverty. Palgrave Macmillan, London. https://doi.org/10.1057/9780230306622_4.

[51] World Bank (2021) Insights into Grievance Mechanisms: Findings from a Survey of Grievance Focal Points in Project Implementation Units. http://hdl.handle.net/10986/37637 - Link; Ellis, B.S., Gilli, R.S., Schluep, M. (2025), Responsible Mining Index – Stakeholder engagement dialogue, mine sites in Zimbabwe and Peru, World Resources Forum Association, St Gallen, Switzerland. Link

project. However, the culture and practice of non-transparency remains a pervasive challenge when it comes to IFC projects, particularly intermediated investments. Commercial sensitivity or confidentiality is an argument usually used, even where it is evident that the principle can still be respected while promoting transparency and meaningful consultation with stakeholders and potentially affected communities. Various analyses show that 'commercial sensitivity' is often used defensively without justification, overused and at times may even contradict client or private sector proponents who support meaningful disclosure.[52]

Recommendations

For effective stakeholder engagement, the following issues should be considered:

i. PS 1 Clause 29 should be amended to include disclosures of the identity and accurate contact information of all co-investors in a project and provide public notification of any changes in ownership, particularly for FI clients. A record of ownership and any relevant cooperative agreements should be made available on the project page, specifically outlining a commitment to a joint approach to remedy should a situation arise that calls for it.
ii. ESAPs should be up to date and publicly disclosed, particularly for FI projects and sub projects
iii. ESAPs should be consulted with potentially affected communities and local stakeholders, when they are designed but also throughout the lifetime of the project.
iv. Regarding information disclosures, IFC should ensure that project disclosures are accessible and in local language. The exact geolocation of the project and sub projects should always be provided or outlined on the project disclosure page, which should also include stakeholder engagement reports outlining decisions arrived at and actioned. This would be a critical resource that communities can refer to.
v. PS1 should clearly indicate that clients should provide sufficient time for stakeholder feedback or consolidation of feedback across stakeholder groups whenever they undertake outreach on a particular issue. Data collection methodologies should ensure women's effective participation (e.g., separate focus groups and safety measures where appropriate, timings compatible with care responsibilities).
vi. PS1 and the AIP should require the clear and accessible identification of all co-investors in a project on the IFC project disclosure pages, including an outline of the lateral responsibilities held and the levels of responsibility of each investor across financial risk, managerial control including management of E&S risks, remedy and legal liability.
vii. Informed consultation and participation process (ICPs) should apply to health sector projects, with patient and health workforce groups regularly participating throughout project implementation. This is recommended particularly given the level of vulnerability and potential for adverse events that can result in significant harm, reduced capacity or even death, as well as the debilitating effects of catastrophic health expenditure in low-income contexts. This should be extended to any patients or stakeholders who have raised grievances at the project level and the invitation extended

[52] James, P., Paxton, S. (2024) What works: How to measure and disclose private capital mobilisation to increase private investment and close the SDG financing gap. Publish What You Fund. Link.

beyond the formal representatives of these stakeholder groups. In addition, ICP verifiers or measures should be publicly shared, and all documentation of how complainants' concerns are addressed and what decisions have been made as a result be published in the public domain. This allows for continuity of the protection of community concerns even as the membership may shift

V. External Communications and Grievance Mechanisms

Regarding grievance redress, often at the project level, complainants remain largely unaware of the existence of accountability mechanisms.[53] Where they might have some awareness, it is also unclear to affected communities how the project level mechanisms and IAM should interact or at which point or at which level an issue has sufficient weight to trigger IAM involvement. The burden is left on affected communities to make these associations. [54]

CSOs have also found that often project level mechanisms may exist on paper but are, however, largely non-operational or are rarely effective, i.e. often not adequately or appropriately resourced, conducting little to no outreach, nor providing sufficient engagement or feedback once an issue is raised.[55] There are particular challenges in transparent and comprehensive communication on decisions taken or progress on pending actions, with often nothing placed in the public record.

Recommendations

i. Regarding external communications and ongoing reporting to affected communities: the nature, depth and quality of ongoing reporting to affected communities should be specified and monitored.

ii. PS 1 should require that clients communicate through signs, brochures, highly visible/accessible links or other acceptable means, the existence of the project-level grievance mechanism and the CAO, detailing how to access it at every project site or community in which the project/investment is situated or which it affects.

iii. Under PS1 clause 34, the IFC states that clients will be encouraged to provide periodic reports on environmental and social issues. It should be clearly emphasised in PS1 that clients are responsible for providing an accurate record and regular account to the IFC of the list of grievances and other issues received, and how they have documented and responded to any grievances raised. IFC should in parallel also publicly disclose or report on how clients are being held accountable.

[53] Saper, A. (2012). The International Finance Corporation's Compliance Advisor/Ombudsman (CAO): An examination of accountability and effectiveness. *NYU Journal of International Law and Politics*, *44*(4), 1279–1329. https://nyujilp.org/wp-content/uploads/2012/04/44.4-Saper.pdf; CSO Submission (2020)Realizing the Right to an Effective Remedy within the IFC/MIGA Accountability Framework. Link; Gallagher, K. (September 23, 2021) Access to information: Is the IFC leaving communities in the dark? Bank Information Centre. Link

[54] CAO (2025) 2025 Annual Report. 25th Anniversary Edition. CAO. Link Link ; World Bank (2021) Insights into Grievance Mechanisms: Findings from a Survey of Grievance Focal Points in Project Implementation Units. World Bank. Link

[55] CAO (2025) 2025 Annual Report. 25th Anniversary Edition. CAO. Link

iv. The relevant level of disaggregation of any E&S data submitted by the client, should be outlined and consulted on with potentially affected communities. This allows for the feedback to have better utility, as the reporting of highly aggregated data is often of limited or no use to communities or their representatives.

v. PS1 should mandate the requirement of multiple safe options for complaints to be submitted, and the confidential handling of GBV-related grievances, including the monitoring of gender patterns in complaints, and creating dedicated safe spaces and channels for women, girls and minoritised genders specifically.

vi. PS1 Clause 35- clients should be required to regularly evaluate the efficacy of their grievance mechanisms, measuring and reporting on 'remedy outcomes' (how often their mechanisms deliver remedy) and also measuring their mechanism against progressive frameworks such as the good policy paper[56] or other alternatives of similar or higher rigour.

vii. PS1 should reflect the content of the IFC remedial framework to ensure that IFC clients are compelled to put into place a remedial scheme or fund that would be utilized when negative impacts are experienced or where risks or other impacts need to be offset.

VI. Consumer Rights Protections

While we recognize health, education and social protection as fundamental rights and public goods that should not be relegated to commodities or purchasing power, we understand that the IFC's mandate is with private sector provision and as such a consumer protection perspective offers several lessons and insights into further obligations of the IFC and its clients. The growing gap between the world's 'heaviest' and 'lightest' consumers or those with high purchasing power and those without it, has been observed and this presents several questions around ethics, equity and justice. Here we often find that it's the rights of 'capital' and the heaviest consumers that are protected, while consumers such as patients, parents, students are left vulnerable to the vagaries and exploitation of the market. Legal and financial protections are often designed to safeguard "investors" and "high-end consumers," while the "small-scale consumer" (the student or patient) lacks limited recourse. This is yet another example of how the IFC's absence of safeguards in this area is entrenching inequalities and deepening social stratification.

The World Bank Group has addressed consumer protection for financial products and services rather than adopting a broader purview that incorporates the potential risks consumers or service beneficiaries face around a range of products and services, particularly in low-access environments.[57] Consumer protection has been described as being a useful and important tool for promoting the Sustainable Development Goals, addressing the intrinsic disparities found in

[56] Multiple Authors (2023) Good Policy Paper Guiding Practice from the Policies of Independent Accountability Mechanisms. Link

[57] The World Bank Group (2022) An Introduction To Developing a Risk-Based Approach to Financial Consumer Protection Supervision. Link

the consumer-supplier relationships, such as bargaining power, information asymmetries, knowledge and other resources.[58] This approach offers and introduces relevant dimensions for the sustainability review helping address the 'Product Safety" gap for end-consumers of products or services emanating from IFC clients.

There are various consumer risks in the social sectors which are expounded on in Box 2, many of which have been highlighted in the media or in CAO complaints and which remain largely unaddressed.

These challenges appear to have been exacerbated by the rising involvement of private equity in the delivery of services such as healthcare, with little to no accompanying accountability. In the social sectors, often consumers (students, patients, parents) engage in transactions where they have significantly less power, information, and expertise than the service providers (educational institutions, hospitals, pharmaceutical companies, agricultural MNCs). This leads to several consumer protection issues and several risks that should be considered during E&S risks assessment. These include poor quality of products and services; pricing irregularities; exploitative practices; negligence; privacy and data security; misinformation; misleading

Box 2: Common risks consumers face in the health and education sectors

- **Medical Errors and Safety:** Risks include failure to diagnose, delayed treatment, surgical complications, and medication errors.
- **Data Privacy and Cybersecurity:** Healthcare systems handle highly sensitive personal and medical data, making them prime targets for cyberattacks, phishing and data breaches, which can compromise privacy and lead to financial fraud. Safety and clinical validation on various apps and other digital health technologies is not assured. Educational institutions in turn collect vast amounts of personally identifiable information (PII) from students and staff. They are also frequent targets for cyberattacks, phishing, and data breaches, rising identity theft and data loss.
- **Financial Burden and Debt Risks:** The rising costs of services and related out-of-pocket expenses can lead to financial distress, significant debt **or** poverty and can act as a major financial liability for consumers long after they accessed the service or may make users forgo necessary treatment. In addition, those seeking health services are particularly vulnerable to predatory lending which is rife in many low-income countries.
- **Misleading Information and Deceptive Practices** deceptive advertising, false claims about program outcomes (like job placements), the quality of the programme leading consumers to invest in poor-value services or the imposition of hidden fees, transaction charges or unfair contracting. with many vulnerable groups and consumers falling prey.
- **The use of dangerous and defective products-** as referenced in the Bloomberg article concerning the use of faulty medical equipment at IFC client hospital, AAR Hospital in Kenya.
- **Lack of price transparency –** price transparency in the health sector has remained a significant challenge across several jurisdictions. In some countries there is also open collusion and price fixing or rigging when it comes to health services. For example, a four-year investigation by the Competition Commission of India370 concluded that hospital chains, including IFC investee hospitals, had been abusing their dominance in the market by overcharging for services and products.
- **Lack of Redress:** Consumers may face difficulty in resolving complaints, especially regarding academic judgment or service quality, leading to potential legal disputes for breach of contract.

[58] UNCTAD (2017) Achieving the Sustainable Development Goals through Consumer Protection. UNCTAD. Link.

information/ false marketing and so on as outlined in Box 2.[59] These risks can lead to physical harm or death, financial and emotional distress, and costly yet poor development outcomes.

The current standards only reflect these issues to an extent, mainly relying on the enforcement of national regulations and standards. However, given the prevalence of regulatory loopholes and lack of enforcement capacity, particularly in low-income countries, these issues continue to be overlooked. A recent example was provided in a Bloomberg article published in January 2026[60] that highlights the risks introduced by inadequate oversight over the procurement and management of medical equipment at healthcare facilities. The article spotlights four IFC clients - a hospital, a medical equipment supplier and two financial intermediaries - showcasing the significant and potentially tragic consequences for patients resulting from the use of faulty medical equipment. In addition to this being a violation of their patient rights, it is also an example of an infringement of their consumer rights. PS1 is currently inadequate for adequately assessing these types of risks.

Various policy prescriptions are emerging now reflecting the urgency needed to address these issues. This includes policy recommendations put forward by the UN Special Rapporteur on poverty and human rights, aiming to protect low-income consumers and ensuring affordability and sustainability**.** They include repair, durability and reparability standards and anti-obsolescence regulation.[61] Complementary measures alongside this include bans or restrictions on advertising of harmful products, embedding sustainability and consumer literacy into education curricula, regulating credit to prevent exploitative consumer debt, and incentivizing cultural shifts toward wellbeing-focused lifestyles.

In addition, while it is mainly individuals or direct beneficiaries that are considered consumers, we note that governments are also consumers, and by extension the public. Therefore, there is added impetus to ensure that sufficient safeguards are built in to protect or promote the public interest in PPP arrangements or any other advisory projects that the IFC participates in. For instance, according to the Bank as part of its 'Health Works' initiative, the IFC will support "governments to establish public-private partnerships that help the public health sector leverage private sector capabilities for service delivery." Therefore, should there be a surge in private sector activity including within the health sector, then adequate consumer protections should be put in place, and the public interest must be adequately safeguarded.

This would include consumer protections around Information Asymmetry & Misrepresentation; Service Quality and Pricing, Transparency and Accountability, Contractual Fairness; Redress Mechanisms, Performance-Linked Payment. We therefore propose that risk assessments

[59] EACHRights (2018) Letter to the CAO: 'Submission of Complaint' Link; CAO (2026) Kenya: Bridge International Academies-01/Kenya. Link; Taneja, A., Sarkar, A. (2023) First, do no Harm: Examining the impact of the IFC's support to private healthcare in India. Oxfam India. Link.

[60] Marks, S., Taggart, K. Kocieniewski, D (2026, January 30) Faulty Equipment Pushed a World Bank-Backed Hospital Into Crisis. Bloomberg. Link

[61] New Economies for Eradicating Poverty (2026) Right to repair and anti-obsolescence. Link; De Schutter, O. (2026) The Roadmap for Eradicating Poverty Beyond Growth- DRAFT – 21.04.2026. Report of the Special Rapporteur on extreme poverty and human rights. Human Rights Council Sixty-second session 15 June-10 July 2026. Link

integrate consumer protection elements and may reference different frameworks including "Vulnerability-by-Design" Framework, Inspired by Consumer Financial Protection Bureau & Financial Conduct Authority (UK), or aligning with global standards like the G2/OECD High-Level Principles on Financial Consumer Protection, which aim to ensure fair treatment of consumers, disclosure, and recourse mechanisms.

Recommendations

1. PS1 should establish a more sophisticated interpretation of the 'duty of care' that IFC's clients must offer to consumers of their products or services and explicitly provide a risk assessment and monitoring framework that assess the application of consumer protection principles at the client or project level. These principles shall include but are not limited to the product and service quality; dignified treatment; truthful and transparent information; appropriate pricing; ethical marketing; protection from unethical and illegal practices; access to redress and accountability; sustainable consumption; privacy of client information.
2. Product/ service safety should be integrated in the Environmental, Health, and Safety (EHS) Guidelines.
3. Consumer protection should be explicitly embedded into all procurement contracts.
4. Where applicable, PS1 should require assessments of:
    a. Whether products and practices generate good outcomes for consumers, tracking indicators such as complaint types, over-indebtedness, price transparency or responsible pricing, fair treatment, data privacy and consumer harm.
    b. Existing staff incentives, business models and organisational culture, and their potential impacts on service or product quality, or consumers at the start and throughout the lifetime of the project.
    c. Stakeholder governance models including an assessment of the requirements for worker participation in company boards and the nature or state of value-added reporting. es.
    d. Data protection and privacy, particularly where ed-tech, health technologies, and digitalisation of health systems is concerned.
    e. Ethical corporate governance: The IFC needs to ensure that corporate governance is not focused solely on short-term shareholder value, but that the public interest and sustainable development remain guiding features within the governance model. There should be assessments on the binding limits present particularly on practices such as excessive share buybacks (that may have significant trade-offs in terms of service quality, could raise product prices or negatively impact the work environment), the existence and efficacy of independent regulatory oversight, and the alignment of executive remuneration with environmental and social performance.

SECTION II - Performance Standard 2 (PS 2): Labour and Working Conditions

This section focuses on how IFC's investments in private healthcare and education can contribute to precarious employment, suppression of labour rights, and unethical performance incentives that compromise patient care and worker wellbeing. Drawing on evidence from Kenya and India, the analysis argues that PS2 could be strengthened by requiring independent wage-benchmarking studies, capping working hours, improve monitoring of labour conditions; extending equal protections to all contract types, and mandating gender-specific risk assessments for healthcare labour, among other issues detailed below.

Evidence indicates that the drive to maximize revenue or profit has contributed not only to patient harms, but also to glaring impacts on the health workforce. This has been well documented in IFC client hospitals in a variety of contexts such as Kenya[62], India, and the USA. For example, in reference to hospitals such as CARE Hospital in India, formerly an IFC client, respondents shared that increasing corporatization and ownership of hospitals by private equity firms was leading to higher incidences of medical malpractice and exploitation of patients in India.[63] Various other reports indicate that the privatisation and financialization of health is limiting clinical autonomy, leading to higher staff turnover, increasing burnout, and increasing the use of restrictive and unfair contracting, among other impacts.[64] We layer here additional gender considerations given that women are disproportionately overrepresented in the healthcare and social care workforce, especially in low-paid roles, whilst being underrepresented in leadership roles[65].

In Kenya's healthcare sector, where the IFC invests, there is systematic reliance on precarious employment which has led to the suppression of labour rights, particularly in private facilities.[66]

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[62] Taggart, K., Marks, S., Kocieniewski, D., Finch, G. (2025, August 26) *A Private Equity Giant Took Over African Hospitals. Then the Complaints Rolled In*. Bloomberg, Link; Owaah (6 February 2020) Customers, Not Patients: The Nairobi Women's Hospital Saga**.** The Elephant. Link.

[63] Marriott, A. (2023) Sick Development: How rich-country government and World Bank funding to for-profit private hospitals causes harm, and why it should be stopped. Oxfam International. DOI: 10.21201/2023.621529, Link

[64] Saha, A (24 February 2026) Doctors cannot be treated like Factory workers, regular employees: HC rebukes Chennai Hospital, slaps Rs 1 Lakh costs. Medical Dialogues. Link ; Marathe S, Hunter BM, Chakravarthi I, Shukla A, Murray SF. The impacts of corporatisation of healthcare on medical practice and professionals in Maharashtra, India. BMJ Global Health. 2020;5:e002026. https://doi.org/10.1136/bmjgh-2019-002026; Hasen Masoud, R (2025) Medicine in the Age of Private Equity: The Ethics of Profit in Patient Care. October 21, 2025. Georgetown Law-The Denny Center for Democratic Capitalism; Rickert J. (2024) On Patient Safety: The Danger of Private Equity Involvement in Healthcare. Clin Orthop Relat Res;482(6):936-939. doi: 10.1097/CORR.0000000000003096.

[65] World Health Organisation, Value gender and equity in the global health workforce

[66] Mbuthia, D., Zhao, Y., Gathara, D., Nicodemo, C. McGivern, G., Nzinga, J., English, M. (2024) Public service motivation, public sector preference and employment of Kenyan medical doctor interns: a cross-sectional and prospective study. *Hum Resour Health* 22, 61. https://doi.org/10.1186/s12960-024-00945-6; Ameso, E.A., Prince, R. J. (2022) Striking health workers: Precarity and healthcare in neoliberal Kenya Anthropology Today, Vol 38, No 4. https://rai.onlinelibrary.wiley.com/doi/epdf/10.1111/1467-8322.12742; KBC Channel 1 (2026, January 8) *KMPDU expresses concerns over "exploitation" of foreign*

The dominant model is pervasive casualisation through short-term locum contracts, which deny doctors job security, pensions, paid leave, and comprehensive health coverage including maternity care, directly contravening the Decent Work Agenda.[67] Recent reports from the Kenya Medical Practitioners, Pharmacists and Dentists Union (KMPDU) and testimonies before parliamentary health committees, confirms that management in many private hospitals actively resist unionization through intimidation, disregarding of court orders, and victimization of members to block recognition and collective bargaining agreements. This environment enables unfair terminations and non-renewals of contracts for those advocating better conditions, effectively silencing dissent and creating a climate of fear and instability. This does not appear to receive adequate attention in the current standards.

Another implementation gap not currently addressed by PS2 requirements or the EPiHC principles is the role of performance management or incentive structures in shaping staff or worker behaviour within service delivery. Substantial concerns have been raised with the IFC regarding the human resources management practices and working conditions of teachers and doctors, including issues with contracting, pay, and other labour rights.[68] Often accompanying this is an unethical approach that exploits various loopholes in legislation as well as shortcomings in regulatory enforcement capacity. As such, unethical human resource management practices have emerged such as the use of broad, punitive non-compete and non-disclosure clauses that restricted the mobility of teachers' pursuit of alternative options, as was observed in the Bridge case.[69] In health, we have observed the use of aggressive performance, commercial or revenue targets and inappropriate incentive structures which pervert clinical priorities and lead to maladaptive staff behaviour and inappropriate or poorer quality services. This unethical approach compromises care or services on offer, and in many cases has led to harm.[70]

In addition, the Kenya Medical Practitioners and Doctors Union states that doctors often and consistently work excessive hours, often exceeding 210 hours per month against the standard 160hrs, coupled with erratic scheduling that disrupts work-life balance. This is worsened by understaffing that burdens clinicians with excessive administrative tasks, diverting focus from patient care and concurrently, compensation is deemed deeply unfair and stagnant. In addition, it is their perspective that the contradictory dual status of locum staff—treated as employees for

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doctors by private hospitals. Youtube. **Link**; KMPDU (8 January, 2026) Statement on The Employment of Foreign Doctors in Kenya. Link; Bretton Woods Project, New investigation highlights harms of for-profit healthcare funded by IFC-backed private equity group, 2025.

[67] Scanlon, Michael, "Towards a New Health Politics in Kenya: Labor Organizing and Strikes by Health Workers in the Public Health Sector" (2025). Graduate Doctoral Dissertations. 1106. https://scholarworks.umb.edu/doctoral_dissertations/1106.

[68] Oxfam (n.d.) Sick Development. 2024 Washington DC Panel | Public Health vs Private Wealth? Link ; Open letter (18 September 2025) Civil Society to Ajay Banga Makhtar Diop and the World Bank Group Board Urgent Call for Accountability: WBG Board's failure to address IFC-Funded Patient Abuse and Systemic Harms. Link ; EACHRights (2018) Letter to the CAO: 'Submission of Complaint' Link;

[69] EACHRights (2018) Letter to the CAO: 'Submission of Complaint' Link; CAO (2023) Compliance Investigation Report Regarding a Complaint about IFC's Investment in Bridge International Academies (Bridge-01). Link

[70]Taggart, K., Marks, S., Kocieniewski, D., Finch, G. (2025, August 26) *A Private Equity Giant Took Over African Hospitals. Then the Complaints Rolled In*. Bloomberg, Link; Owaah (2020, February 6) Customers, Not Patients: The Nairobi Women's Hospital Saga. The Elephant. Link.

taxation purposes, but as independent contractors for reduced benefits or employer matched contributions—allows employers to evade legal responsibilities while diminishing workers' net income. The COVID-19 pandemic starkly exposed this vulnerability, as locum doctors infected at work were denied treatment by their employers, lacking the medical cover they provide to others. Furthermore, there have been complaints of lack of institutional support for continuing education or specialization, leading to widespread career stagnation among medical professionals. It is unclear whether the IFC is implementing Contextual Impact Assessments that adequately incorporate these realities from a labour perspective.

Recommendations

We recommend that PS2:

i. *Restrict casualization of professional labour and Promote Secure Employment:* with the Bank's emphasis on creating quality jobs, the IFC should require their clients to maintain a minimum ratio of permanent to non-permanent (*locum, casual, short-term contract*) professional staff. The use of non-permanent contracts should be limited to genuine temporary needs (e.g., seasonal peaks, specific short-term projects) and not for core, ongoing functions. This directly counters the model of "pervasive casualization" and ensures a stable, secure workforce with access to full benefits.

ii. Mandate explicit protections for freedom of association: the language in PS 2, clause 13 and 14 should be enhanced to require by for instance, requiring that IFC clients in healthcare and education services have a public, board-endorsed policy explicitly affirming their commitment to ILO Conventions 87 and 98 on Freedom of Association and Collective Bargaining. Compliance should also include refraining from threats or intimidation and encourage prompt engagement in bargaining once legal recognition thresholds are met. Similarly, language can be borrowed from the World Bank's ESS in relation to workers' organizations and legitimate workers' representatives being respected and provided with information needed for meaningful negotiation in a timely manner. This moves clients beyond passive compliance and requires a proactive stance against the "suppression of freedom of association" observed.

iii. Enforce fair and transparent compensation and working hours: PS2 should require that the IFC clients conduct and publish biennial, independent wage-benchmarking studies to ensure remuneration aligns with national and sector standards. Furthermore, the standards should mandate the implementation of a verifiable system to monitor and cap working hours, ensuring compliance with national laws and preventing excessive overtime. This addresses "substandard remuneration" and "excessive working hours" by creating mechanisms for transparency and accountability.

iv. *Guarantee Equal Protections for All Worker Categories* -PS 2 must state clearly that all core labour protections—including access to non-retaliatory grievance mechanisms, occupational health and safety provisions, and non-discrimination—apply equally to all workers, regardless of their contract type

(permanent, locum, or outsourced). This closes the loophole that allows for the "dual status of locum workers" and ensures all personnel are protected

v. Require gender risk assessments and distributional impact assessments for all contracted and supply chain labour in healthcare settings.

SECTION III - Performance Standard 4 (PS4): Community Health, Safety, and Security

The section reviews PS4 as well as the draft Environmental, Health, and Safety Guidelines for Health Facilities provided for consultation in 2025.[71] The section argues that PS4 is too narrowly focused on physical infrastructure and location-specific hazards, while failing to address psychosocial risks, the safety of patients as distinct community members, and the extended circle of affected stakeholders. Lastly, the section recommends amending PS4 to recognise worker realities that may compromise patient safety, raises the possibility of engagements with community health workers, and also calls for better alignment with World Bank's ESS2 on occupational health.

As currently designed, PS4 emphasizes physical safety and prevention of health and environmental risks tied to a specific locale or catchment but fails to adequately address social or psychosocial risks inherent in these settings or in provision of health and education services, neither does it provide adequate safeguards for vulnerable individuals. The definition of affected communities remains quite limited, particularly in the health and education sectors directly where affected communities could extend far beyond a physical location especially when you consider the workforce, secondary stakeholders such as patients families or care givers who also bear the burden of care or treatment, or quite crucially those affected by the extended reach of health or education related technologies.

The Bridge cases highlighted several significant lapses in the implementation of PS 4, particularly regarding child protection and safeguarding with significant failures in protecting students from preventable injuries or child sexual abuse. Overall, the project failed to meet PS4 requirements to safeguard the community from social risks, including sexual exploitation. As part of the overarching failure to assess child protection and safeguarding risks, the IFC did not require the client to assess risks to community safety, from the perspective of children. We argue that an assessment of risk from a patient perspective and other vulnerable groups is particularly critical given the rising evidence of harm in IFCs health investments.

In the Bridge cases, there were also PS4 deficiencies identified across the board, including deficiencies in WASH facilities and building and infrastructure safety, which posed a threat not only to students but to any children passing through or by the school all which were situated in close-knit informal settlements. CAO reports also found that IFC did not ensure the client's child protection protocols were consistent with PS4 and noted that IFC's due diligence did not adequately assess the client's capacity to provide inclusive education or make reasonable

[71] The World Bank Group (2025) Environmental, Health, and Safety Guidelines. Health Care Facilities. Draft for consultation. Link

accommodations, which relates to broader issues of equity and access. As such, unsurprisingly there was evidence of over 100 cases of "potentially preventable" injuries to students due to school negligence or lack of safety management measures.[72]

From our experience in a recently filed CAO case on health, we have found that patients and their families at the IFC client hospital in question were also often expected to have access and understanding of the patient charter as well as to know how to advocate for their rights, even while handling emergency or distressing health situations. In addition, as has been mentioned the recent report highlighting the experience of several patients at an IFC client hospital who were subjected to procedures using faulty medical equipment, also supplied by an IFC client, is also illustrative of some risks that are being overlooked under PS4.[73] It is evident that despite improvements made so far, the IFC needs to develop further guidance to protect children and vulnerable groups from occupational health and safety hazards.

Recommendations

i. While PS2 speaks to worker protections, an added dimension that could be addressed under Performance Standard 4 would be to recognize and assess worker well-being in relation to its potential impacts on patient or community safety. PS 4 should be amended to acknowledge that worker burnout, fatigue from excessive hours, and psychosocial stress are significant risks to patient and community safety, including impacting the quality of care. IFC clients should monitor and mitigate these risks as part of their community health and safety management plans. This reframes "degradation of working conditions" not just as a labour issue, but as a critical patient safety issue that the IFC must address.
ii. Similarly, performance standard 4 should be amended to prohibit 'Ethically Compromising Performance Targets': This would require the introduction of language in PS 4 that prohibits investee companies from implementing performance management systems for clinical staff based on purely financial or patient-volume targets. Performance metrics should instead be based on quality of care and patient outcomes. This directly targets the "aggressive commercial targets" that create professional and ethical conflicts for medical practitioners.
iii. Based on the draft Environmental, Health, and Safety Guidelines for Health Facilities (2025)[74] Section 4.2.1 (48) on 'biological hazards' should incorporate the following edits:
    - Provide staff, patients, and visitors with clear information about the patient charter and infection control policies and procedures, ensuring all the provided information is in accessible language taking into account simplicity, local

[72] CAO (2023) Compliance Investigation Report Regarding a Complaint about IFC's Investment in Bridge International Academies (Bridge-01). Link

[73] Marks, S., Taggart, K. Kocieniewski, D (2026, January 30) Faulty Equipment Pushed a World Bank-Backed Hospital Into Crisis. Bloomberg. Link

[74] The World Bank Group (2025) Environmental, Health, and Safety Guidelines. Health Care Facilities. Draft for consultation. Link

language(s) and any need for reinforcement of critical information through pictograms, diagrams, and verbal instructions where necessary.
    - Provide health care workers with regular and specific infection control training, ensuring that this is up to date against industry standards and regularly audited for improvements.
    - Provide adequate supplies of quality, certified (to relevant international or national standards) PPE for healthcare workers involved in direct patient contact and waste management, including overalls, aprons, leg protectors, boots, heavy duty gloves, helmets, visors/face masks and eye protection (especially for cleaning of hazardous spills), and respirators (for spills, highly infectious airborne diseases, e.g., COVID-19, or waste involving toxic dust or incinerator residue) as necessary.45 PPE should be suitable for different genders and sizes and accommodate cultural norms such as head coverings.

iv. Section 4,2.4 of the draft Environmental, Health, and Safety Guidelines for Health Facilities (2025),[75]should be explicitly aligned with and adopt language from the World Bank ESS 2, chapter 2, section D on 'Occupational Health and Safety (OHS)', clauses 27-31. The World Bank's ESS2 establishes a more comprehensive and robust framework for managing occupational risks, requiring a proactive and continuous risk assessment process that includes both physical and psychosocial hazards for instance in clauses 27 and 28.
    - Clause 27 and 28 reads as follows: "27. Workplace processes will be put in place for project workers to report work situations that they believe are not safe or healthy, and to remove themselves from a work situation which they have reasonable justification to believe presents an imminent and serious danger to their life or health. Project workers who remove themselves from such situations will not be required to return to work until necessary remedial action to correct the situation has been taken. Project workers will not be retaliated against or otherwise subject to reprisal or negative action for such reporting or removal. 28. Project workers will be provided with facilities appropriate to the circumstances of their work, including access to canteens, hygiene facilities, and appropriate areas for rest. Where accommodation services are provided to project workers, policies will be put in place and implemented on the management and quality of accommodation to protect and promote the health, safety, and well-being of the project workers, and to provide access to or provision of services that accommodate their physical, social and cultural needs."

v. The management strategies for the listed hazards in Section 4.2.4 if the draft Environmental, Health, and Safety Guidelines for Health Facilities (2025),[76] related to worker welfare are vague and can be made more effective and auditable. We propose the following concrete edits:

[75] The World Bank Group (2025) Environmental, Health, and Safety Guidelines. Health Care Facilities. Draft for consultation. Link

[76] The World Bank Group (2025) Environmental, Health, and Safety Guidelines. Health Care Facilities. Draft for consultation. Link

- Provide appropriate sleeping quarters that are clean, secure, and gender segregated.
- Provide access to appropriate recreational facilities and ensure the consistent availability of affordable nutritious food options, particularly for staff working extended hours.
- Implement management programs to prevent and address drug and substance abuse, ensuring confidentiality and the necessary support.
- Implement a zero-tolerance policy on workplace violence and harassment, backed by a clear, confidential, and safe reporting mechanism and ensure that all managers receive mandatory training on humane management practices, conflict de-escalation, and their specific role in enforcing the violence prevention policy.
- Establish a mental health at work programme alongside policy guidelines for confidentially accessing psychological support and training on identifying and managing work-related stress and preventing burnout.
- Develop and implement a fair and predictable shift scheduling policy, providing management with adequate training on shift management to ensure the avoidance of erratic and unpredictable scheduling on worker safety, mental health, and patient care. The lack of appropriate planning imposes a significant mental burden on workers, disrupting work-life balance and contributing to stress and exhaustion of doctors and other healthcare workers.

vi. Section 4.2 of the draft Environmental, Health, and Safety Guidelines for Health Facilities (2025),[77] particularly section 4.2.4, should include a dedicated section on Community Health Workers (CHWs). Our rationale for this is that in the IFC's approach to investing in private healthcare, the IFC states that it focuses "on strengthening private hospitals that can meet the growing demand from patients across a broad spectrum of income groups", which includes low-income patients who make up the largest percentage of the 4 billion people lacking access to quality, affordable healthcare. In addition, the IFC states that their clients are committed to filling "gaps in available care, and sponsoring programs to help the communities around them." Accra Medical Centre is a case in point, financed via the IDA Private Sector Window, where the IFC aims to advise on 'its strategy to service lower income patients'. While community health workers are not typically affiliated to private facilities, there are increasing instances where their expertise and reach will be drawn on, even by private actors, in order to meet the WBGs 1.5 billion target on health. Therefore, we recommend the following be included into the draft guidelines:
    - Clients must develop a clear policy governing any engagement with CHWs should that possibility arise, whether they are employed directly, through third parties, or are volunteers. This policy must ensure CHWs are covered by the same OHS protections as facility-based staff, with additional considerations for their community-based work. Specifically, the policy should speak to clear terms of engagement; fair compensation; appropriate labour and working

[77] The World Bank Group (2025) Environmental, Health, and Safety Guidelines. Health Care Facilities. Draft for consultation. Link

conditions; gender specific risk assessments; comprehensive hazard assessments; targeted training and equipment, including storage facilities for said equipment. The policy should also be clear on what conditions third party contractors engaging with CHWs need to adhere to including access to equipment, facilities and grievance mechanisms and the effective engagement of CHWs under PS1as a key stakeholder group.

- There should also be a dedicated assessment of CHW occupational risks (biological, ergonomic, safety, psychosocial).
- The section on CHWs should adopt or have explicit alignment with the WB ESS Chapter 2, section F clauses 34-38.

vii. We also advise the adoption and explicit alignment of the EHS guidelines to the WB ESS language in ESS 2 section 4.2 clauses 34-38, specifically clauses 34 and 35 as follows:

- "In all such circumstances, the Borrower will require measures to be implemented to ascertain whether such labour is or will be provided on a voluntary basis as an outcome of individual or community agreement."
- 35. Accordingly, where the project includes the provision of labour by community workers, the Borrower will apply the relevant provisions of this ESS in a manner which reflects and is proportionate to:(a) the nature and scope of the project; (b) the specific project activities in which the community workers are engaged; and (c) the nature of the potential risks and impacts to the community workers. Paragraphs 9 to 15 (Working Conditions) and paragraphs 24 to 30 (Occupational Health and Safety) will be assessed in relation to community labour and will be applied in a manner which reflects (a) to (c) above. The way in which these requirements will apply in the circumstances of the project will be set out in the labour management procedures."

viii. Update PS4 to reflect any institutional advancements, policy or guidance on child protection and safeguarding, and the prevention of sexual exploitation and abuse arising from the implementation of the Bridge case management action plans.