Doing more harm than good

Why CDC must reform for people and planet
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This report was produced by Global Justice Now, based on initial research by Tim Jones (Jubilee Debt Campaign), Nicholas Hildyard (The Corner House) and Jutta Kill.

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Global Justice Now
66 Offley Road, London SW9 0LS
+44 20 7820 4900 | offleyroad@globaljustice.org.uk
@globaljusticeuk | www.globaljustice.org.uk
Registered Charity No 1064066

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A decade ago, CDC was an institution that seemed to be immersed in a new scandal every other month. It attracted sustained criticism that its investments had questionable impacts for poor communities, were more focused on securing high financial returns than dealing with poverty, were opaque, made extensive use of tax havens, and that its executive salaries were extraordinarily high for an organisation with a supposed development mandate. CDC oversaw a portfolio of dubious investments, ranging from luxury hotels and shopping centres to gated communities and private hospitals.

In 2011, then secretary of state for international development Andrew Mitchell set out a new vision for CDC. His reforms were supposed to make CDC more “socially and environmentally responsible”, with fewer investments in “harmful tax regimes” and greater transparency.1 CDC would ditch its old model, cutting out the ‘middlemen’ in the private equity funds that seemed to be behind so much of the controversy, and instead invest directly in private sector projects in developing countries, buying shares in companies and giving loans and guarantees.

These reforms were lauded at the time and were largely successful in assuaging much of the criticism that CDC was facing. In 2016, the government rushed a bill through parliament to radically increase the amount of development money it could spend through CDC from £1.5 billion to £6 billion. Notes attached to the bill said that this funding was needed to “accelerate the growth” of CDC for it to play “a fuller role” in the UK development programme.

It became clear that the government’s reform had not been purely about improving CDC’s reputation and impact, but a much broader reorientation of British aid towards financial markets and the private sector. As Mitchell has candidly said, in the future British development support would look more like CDC and less like the Department for International Development (DfID). Mitchell and his successors saw in CDC the future of British aid; in their view, the extension of markets and private sector investment to every corner of the world was the best way of tackling poverty. CDC was the vanguard of aid spending and development thinking.

In light of its growing importance, eight years on from Mitchell’s reforms, we have taken another look at CDC. What we have found is that the reforms have made little difference to the concerns we originally had. In this report, we find that CDC remains a deeply flawed organisation that is often doing more harm than good. What’s more, no amount of tinkering around the edges will resolve these problems, because our concerns stem from structural issues with the way CDC works. Only the most fundamental root and branch reform could possibly transform it into an organisation which has a useful impact on development. Without this type of deep reform, CDC is likely to keep on producing scandals.

Nick Dearden
Director, Global Justice Now
1. Executive summary

CDC Group is the UK’s ‘development finance institution’ (DFI). It invests in private companies in the global south through intermediaries – private equity funds – and makes direct investments in private sector projects. CDC remains wholly owned by DfID, and therefore accountable to the British government, but is run by its own management and board structures. Campaigners have been concerned for many decades that CDC was failing in its remit to reduce poverty – and perhaps indeed that its whole approach to poverty reduction was fundamentally flawed.

Our evidence suggests that CDC has often pursued high financial returns over genuine development impact, and that CDC fundamentally confuses ‘development’ with simply promoting a highly financialised version of capitalism, with all the inequality and throwing of costs onto wider society that entails. CDC’s track record of investment reflects a highly problematic approach in which an ideology of ‘the market knows best’ comes first; ensuring transparency, accountability and reducing poverty appear to be low priorities.

In 2010, criticism spurred new international development secretary Andrew Mitchell into reforming CDC. Mitchell set out a package of reforms, announcing that CDC would become a “development-maximising, not a profit-maximising, enterprise”. At the time these reforms were lauded, by some, as transformational, and criticism of CDC receded.

Nearly a decade on, and CDC is a far more powerful institution than it was at the time of Mitchell’s reforms. For Mitchell and his successors, CDC wasn’t a small part of their vision for development but absolutely central to their idea of how poverty could and should be ended. As the government continues to pursue its “mutual prosperity” agenda (using aid to leverage private sector investment in developing countries while developing trading opportunities for British businesses), CDC seems set to take an even bigger role in UK development policy.

However, looking now at the results of the reforms, we find that many of our concerns haven’t gone away. Increasingly, it seems clear that these problems relate to the fundamental mission of CDC.

In particular, we are concerned that:

- The problems with private equity funds remain, and in fact investment through these funds is as high as it was in 2011. Despite Mitchell’s reforms, which were designed to reduce the amount of money being siphoned off by middlemen, CDC continues to invest as much through private equity funds now (£2 billion) as it did in 2011 (£1.9 billion).

- New investments, while potentially more accountable, can actually be just as inappropriate as the ‘fund of funds’ investments. CDC’s model of mobilising private sector investment, particularly in countries where corporate regulation and taxation systems are weak or underdeveloped, makes a just and equitable outcome very uncertain to say the least.

- CDC continues to be driven by the view that privatisation is likely to reduce poverty. There is little evidence that this trickle-down approach is effective at tackling poverty; instead privatisation often leads to widening inequalities. Moreover, CDC’s approach of investing in private sector education and healthcare in the global south has undermined and crowded out public services. The Independent Commission for Aid Impact (ICAI) has argued that a “mutual prosperity” approach to development risks diverting aid “away from the poorest and marginalised” and could undermine public support for aid.

- CDC is continuing to make a high return on its investments. From 2012-18, CDC made an average return on its investments of 9.2% per year – a similar level to before the 2011 reforms.
• There is little to no evidence that CDC is making an impact in terms of tackling poverty, providing genuinely additional resources or making effective use of government resources. CDC still appears to believe that development can be mainly measured by a mixture of the rate of return and the number (but not the quality) of jobs created.7

• CDC funds continue to make extensive use of tax havens.8 Of the companies and private equity funds in which CDC owns more than 20%, two-thirds are based in tax havens.9 CDC claims, with only partial justification, that this is to avoid ‘double taxation’ on investments. However, no progress seems to have been made on ensuring that the funds and companies in which CDC invests genuinely pay appropriate levels of taxation.

• High levels of pay for senior CDC staff remains unacceptable, as does their bonus structure which continues to reward financial returns (up to 3.5% on an investment). This is wholly inappropriate for a development institution.

In 2019, an ICAI review gave CDC an Amber/Red rating (“Unsatisfactory achievement in most areas, with some positive elements. An area where improvements are required for UK aid to make a positive contribution”).10 In the weeks that followed, CDC wrote two carefully worded responses which accepted all of the recommendations of the ICAI review whilst claiming it was already implementing the recommendations.11 However, for an organisation with significant resources and staff capacity (in 2018, CDC employed 235 staff and spent £30.1 million on wages and salaries), CDC should be able to show results, not promises of future progress.12 This means demonstrating improvements (eg, investment committee criteria, staff incentives and culture for investment teams) that will mean CDC investments reach and improve the lives of the poorest and do not destroy the environment.

In this report, we examine our concerns with how CDC invests in greater detail and have provided evidence based on CDC’s most recent publicly-available investment data. We have also provided a series of case studies to demonstrate how CDC’s investments are driving the privatisation of key industries in the global south, are not having a significant development impact, or in some cases are having a demonstrably negative impact for the communities they should be helping.

Our case studies include:

A) The Abraaj Growth Markets Health Fund, which invests in private healthcare institutions around the world. Although these investments are supposedly intended to build new hospitals, it appears that Abraaj has mostly funded existing private hospitals which can’t cater to the poorest and undercut future public provision. There have also been numerous international press reports into suspected investment malpractice by Abraaj’s CEO.13 Other health investments include support for some high end hospitals, including a cosmetic surgery clinic, which appear to market themselves to international patients.14

B) Bridge International Academies, a low-cost, private school chain with significant operations in Kenya, Nigeria and Uganda. Our research has found numerous issues with Bridge schools including: exclusion of poor and disadvantaged children; violation of health and safety and labour conditions; and a severe lack of transparency and accountability. The situation became so serious that authorities in Kenya and Uganda actually tried to stop the schools operating.15 CDC also continues to support elite, high-cost private schools in countries in the global south (eg, GEMS Education, which runs a network of 90 elite private schools including three schools in Kenya and Uganda).16
C) **Feronia Inc,** a company which owns palm oil concessions across the Democratic Republic of Congo (DRC) that were originally obtained under Belgian colonial rule. This land remains hotly contested by local communities and protestors appear to have been met with violence by Feronia security personnel. The company appears to have faced significant financial troubles, with CDC granting numerous loans to Feronia in recent years. Most seriously, a member of Feronia’s security personnel has been accused of murdering a critic of the company’s activities and CDC’s response has been completely inadequate given the seriousness of the claims.

D) **CDC’s investments in fossil fuels.** CDC is still investing in fossil fuel operations and environmentally-detrimental sectors. This includes recent investments in a company which operates coal-burning cement factories in East Africa, a company which owns a petroleum pipeline in Cameroon, and a company which owns a heavy fuel oil-burning power plant in Benin. The evidence presented here undermines the claims made by government ministers in recent months that CDC has “not made any new investments in anything coal-related since 2012” and that it is ensuring that its investments will “soon in real terms” be compliant with the Paris Agreement on climate change.

Given these concerns, our conclusion is that it is not simply a lack of transparency or accountability that is the issue with CDC; it is the entire business model.
2. Recommendations

We therefore believe that reforming this institution will be a mammoth task. However, for a government with sufficient determination and a programme for radical reform, there may be a possible route to making CDC a functional and democratically-controlled institution that has a positive impact. We have therefore set out a series of recommendations below for how this might be achieved.

This reform programme wouldn’t be easy but, given Britain’s reputation as a key player in global development thinking, it could potentially spur very big changes at a global level. These changes would undoubtedly make CDC smaller in terms of its outputs. We regard this as a positive – you simply cannot ensure positive development outcomes on the scale CDC currently operates at.

1. The mandate and structure of CDC must change

CDC needs a new, legally-binding mandate which commits it to reducing poverty, closing global inequalities, doing no harm to the climate and facilitating a just, green transition to renewable energy as its driving objectives, for which its board can be held legally accountable. We propose that CDC should be transformed into a genuine development bank, with the ability to lend to local and national governments in developing countries, and with other donors who share this reformed vision being invited to contribute to its finance and governance. Any CDC investment should, insofar as is possible, be aligned with national development plans and industrial strategies, transforming CDC into a body which meets the publically expressed needs of the economies in which it exists, while honouring (and scaling up) the climate pledges made in the Paris Agreement.

We believe a reformed CDC should incorporate elements of:

- **A national, government-owned development bank**, similar to Germany’s KfW which primarily invests in housing and provides assistance to small and medium enterprises (SMEs). However, a reformed CDC should also learn from the mistakes of other public development banks and should take a comprehensive approach to achieving policy goals. This type of model would be able to redress the structural bias towards lending for property and financial sectors and could help to de-risk green activities.

- **An international, publicly-owned, Green Investment Bank** which would facilitate a just transition to clean energy and green infrastructure. The UK’s original Green Investment Bank was privatised by the Conservative government in 2017. A central Green Investment Bank could help to close the climate finance gap by issuing green bonds as is done in France and the US.

- **Regional development banks** which invest in infrastructure and services in a particular region with specific development needs. This should not be in the form of the Asian and African Development Banks which largely follow the World Bank’s privatisation agenda, but should instead have a mandate to support public services and tackle regional inequalities. Others have argued in favour of a “strong network of regional green banks” supported by a strong central bank.
As part of this mission, CDC should be bound to ensure that any company it is investing in abides by a reformed, fair system for responsible investment which does not involve the avoidance of taxes. All countries in which CDC is operating should be given technical assistance to regulate and tax foreign investment as part of CDC’s activity.24

CDC’s current mandate, to “support growth and jobs that lift people out of poverty and to make a financial return, which we reinvest into more businesses”, can be both counterproductive to tackling inequalities and difficult to measure.25

Instead, CDC should be legally mandated to:

• Strengthen universal public services (eg, health, education) and ensure equal access for all, especially the poorest and most marginalised;
• Support food sovereignty and put small-scale food producers and consumers at the centre of the global food system;
• Support developing countries to manage a just transition to environmentally sustainable modes of development, through “transfers of resources, finance and technology from historic emitters in the global north to the global south”;26
• Invest in genuinely public-public and public-commons partnerships (a proven form of solidarity that helps to build capacity and share knowledge on both sides);27
• Provide direct and sectoral budget support to developing countries to assist with appropriate national industrial strategies.28

Although CDC relies on financial returns to sustain its investments, it should not prioritise making financial returns, nor should the drive to make returns ever trump the absolute minimum requirement to ‘do no harm’.

As with other forms of aid, the legal obligation for the running of CDC should fall on the secretary of state for international development. However, given that there remains a large accountability gap between CDC and the countries it invests in, we propose that a mechanism (eg, a “right-to-redress”) is established to allow government and civil society representatives from borrowing countries to have a say in how CDC invests.

We propose that CDC steers away from fragile states or states with serious governance problems. Such states are unlikely to pass safeguards on public sector investments. Other parts of the UK government, such as DfID grant aid, should be the main UK support for fragile states.

Three vital changes to the current structure can help to ensure and enforce positive development impacts:

• CDC should have an independent evaluation body which reports to parliament on how CDC is meeting its reformed, broader definition of development impact (described above);
• There should be a legally binding right-to-redress for communities who claim they have been negatively impacted by any investment;
• There should be no bonuses for directors or other staff based on the rate of return achieved.
2. Drop the ‘fund of funds’ model
CDC should not make any investments through private equity funds. There is no evidence that these investments are particularly helpful in reducing poverty and inequality; on the contrary, they may even do more harm as there is no way they could meet the safeguards and evaluation recommendations described above. These funds simply don’t have the adequate development experience or drive, and they distort accountability mechanisms.

3. Open up the actors that CDC can fund, including looking at funding of state-owned enterprises, mutuals and cooperatives
CDC should be able to invest in the public sector as well as the private sector. Provision of good quality public infrastructure, from education and healthcare to renewable energy and transport networks, is vital for poverty reduction, reducing inequalities and developing environmental sustainability, subject to strong controls on public debt. CDC should also support the development of “public-commons partnerships” which would enable common, public ownership and democratic control of renewables industries, energy systems and infrastructure.

4. Radically improve development impacts and monitoring, transparency and oversight, and abolish unhelpful incentives for senior staff to maximise returns
All new and existing investments by CDC should be publicly disclosed alongside a rationale for how the investment will reduce poverty and inequality, improve the realisation of human rights, facilitate a just transition to renewable energy or create good, green jobs. This should also include an assessment of:
• How it is additional to other investments;
• How it does not crowd out other local investments;
• Why this investment is struggling to attract capital.

5. Stop promoting public-private partnerships (PPPs), particularly in healthcare and education
Although CDC’s investments in healthcare and education are not on the scale of its investments in infrastructure and financial services (accounting for roughly 10% of the entire portfolio combined), they are a particular cause for concern because of the way in which privately run education and healthcare can undermine the public sector and inhibit equal access to essential services. CDC should therefore not undermine public service provision by investing in the private sector in healthcare and education. While there are obviously gaps in basic service provision in many developing countries, promoting private competition to fledgling public services is no way to improve the quality of those public services in the long term. CDC should divest from private healthcare and education projects.
What’s more, PPPs in any sector tend to pass risk and unsustainable level of debt onto the public sector, while enabling the private sector to make large profits. CDC should not contribute to these problems by investing in PPPs.
6. CDC must not promote unsustainable financing on the public purse

CDC lending or guarantees to the public sector must not be underwritten by the public sector. Where loans are given to the public sector, whether directly to governments or to state-owned companies, they need to be given responsibly. This means that at the macro-level, CDC should not invest in countries where external public debt already risks creating a debt crisis, and should not invest in individual projects that have not been created in a transparent and accountable way.

CDC should only lend for projects which are part of a government debt strategy that has been publicly debated and approved by the relevant national parliament. Details of all loan contracts should be publicly disclosed and agreed by a national parliament before they are signed. All CDC loans should be independently evaluated before, during and after implementation, with all evaluations publicly disclosed at each stage. And CDC should have clear guidelines for cancelling debts if there are significant failures by CDC at any stage in the loan process. DfID grant funding should be used where CDC cannot support investments in public services because of the debt situation of the country concerned.

7. Ensure that all Official Development Assistance (ODA) and UK Export Finance projects are aligned with the Paris Agreement

It is essential during a climate emergency that all elements of government policy, including international development, are mainstreaming environmental concerns. This means instituting an immediate ban on all UK ODA investments in fossil fuel power generation, exploration, production and distribution (with the exception of projects specifically targeted at cleaner cooking), as suggested by the UN Special Rapporteur on Human Rights and the Environment. As Baroness Sheehan highlighted recently, the government has tended to defend some investments in natural gas-powered projects under the logic that these assist in the transition from coal and oil power to renewable energy whilst improving access. This ‘bridge fuel myth’ (or as Sheehan puts it, “total red herring”) should not be endorsed as current plans for the expansion of gas infrastructure will lock in high carbon emissions for future generations. There should be a total ban on fossil fuel investments.

CDC and DfID are, however, not the only institutions spending ODA or investing in fossil fuels. In the five years from 2013 to 2018, UK Export Finance (UKEF) gave £2.6 billion to fossil fuel projects in low and middle-income countries. The Cross-Government Prosperity Fund has also invested £2 million of ODA to “expand oil and gas sector capacity in Brazil, Mexico, China, and India”, representing 29.2% of the Fund’s overall energy spend. Given this, the government must also phase out all UKEF that is currently given to fossil fuels, deforestation-linked commodities or waste incineration, and ensure all UKEF projects are aligned with the Paris Agreement. The government should institute a ban and disinvestment policy from all projects associated with fossil fuels, deforestation-linked commodities or waste incineration that are in receipt of funding through UK institutions, whilst actively advocating for a matching ban and disinvestment policy by all multilateral organisations in receipt of UK aid funding (including the Private Infrastructure Development Group, World Bank Group and European Investment Bank).
3. The state of CDC since 2011

CDC, formerly the Commonwealth Development Corporation, is the UK’s ‘development finance institution’ (DFI). DFIs are a common model for nation states in the global north to invest in private companies in the global south. The DFI model relies on the idea that poverty will be reduced when private capital invests in a place, encouraging markets and business to thrive. DFIs make public investments in order to encourage private investors to also invest their capital – boosting emerging economies and making them appear less risky to others.

CDC is the private investment arm of DfID. It performs this task by investing in private companies in the global south through intermediaries – private equity funds – but in the past decade has been tasked with re-growing its portfolio of direct investments as well. CDC remains wholly owned by DfID, and therefore accountable to the British government, but run by its own management and board structures.

Before 2011, CDC had been part-privatised by the New Labour government, and solely invested through private equity funds, giving money to middlemen who then chose where to invest it. Decisions appeared to be substantially based on what would generate most profit, with limited regional or sectoral parameters. This model was open to serious criticisms, and CDC appeared in the pages of Private Eye on a regular basis as directors on enormous salaries made a fortune from investing in projects which appeared to have very little to do with reducing poverty.

In particular, civil society was critical of several aspects of the institution and its work:
- The ‘fund of funds’ model removed accountability to a series of private equity firms with little development expertise;
- There was a lack of evaluation against meaningful development indicators that made it difficult for the institution to assess how successful it was being.

Too much of CDC’s ‘success’ seemed driven by the belief that high returns must equal positive development outcomes. The institution had very little transparency and, although ultimately under DfID’s remit, secretaries of state were reluctant to accept their responsibility for the institution:
- There was a focus on privatising public services, including by establishing public-private partnerships. This could crowd out public services and undermine long-term local economic development in the global south;
- CDC regularly made high returns, in effect making profit for the UK government from investments in Africa and Asia, something incentivised by the pay structure for senior staff in the company;
- Too many investments were channelled through tax havens, further undermining government revenues and economic development in global south countries;
- CDC regularly made high returns, in effect making profit for the UK government from investments in Africa and Asia, something incentivised by the pay structure for senior staff in the company;
1. The problems with private equity funds remain, and in fact investment through these funds is as high as it was in 2011.

The ‘fund of funds’ model removes accountability and repurposes development funding as hedge fund activity. CDC continues to invest as much through private equity funds now (£2 billion) as it did in 2011 (£1.9 billion). This is despite reforms designed to limit the amount of money which would be directed through third party funds and encourage more direct investment in the private sector in the global south. We see no evidence that this continuing ‘fund of funds’ model contributes to poverty reduction, and it contributes significantly to a lack of transparency and accountability.

To an extent, Mitchell’s reforms have been successful in generating an expansion in direct equity and debt investments, but investment through private equity funds has also continued. By 2018, CDC had £1.98 billion invested through private equity funds compared to £1.91 billion in 2011. The relative proportion invested through private equity funds has fallen, though private equity funds still account for 46% of CDC’s investments (see Graph 1 below).

A smaller percentage of new CDC investments are through private equity funds, but in absolute terms they continue to be as high as they were in 2011, after actually increasing for a number of years.

**Graph 1:** CDC investments by investment type, 2012 to 2018, £ million

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<tr>
<td>2018</td>
<td>2,600</td>
<td>700</td>
<td>2,000</td>
</tr>
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</table>
2. CDC’s new investments, while potentially more accountable, can actually be just as inappropriate as the ‘fund of funds’ investments.

In 2018, only 29% of new investments were through private equity funds, compared to 18% direct equity, 40% loans and 13% in guarantees. However, we can’t assume that the new, more direct investments are necessarily better than the private equity fund investments, particularly if they’re driven by the same ideology of ‘the market knows best’.

This is demonstrated by the $7 million direct investment in Bridge International Academies in 2013 (see Case Study B), a $34.14 million direct investment in Feronia Inc also in 2013 (see Case Study C), a $144 million investment in coal-burning East African cement producer ARM Cement in 2016, and many others. CDC’s continued focus on pushing private sector investment, particularly in countries where corporate regulation and taxation systems are weak or underdeveloped, makes a just and equitable outcome very uncertain to say the least.

3. CDC is driven by an agenda which believes that private sector investment is the only way of meeting the so-called ‘development finance gap’

In particular, CDC’s investments in health and education focus heavily on the private sector, meaning that public services have been crowded out and communities’ rights to healthcare and education have been negatively impacted in the global south (see Case Studies A and B). When services are required in order to realise basic human rights, providing them the private sector is highly problematic. It is almost impossible not to set up a two-tier system, which entrenches inequality. Oxfam’s research into World Bank funding for private education in Uganda and Pakistan, for example, raises concerns over “unequal access, poor quality and low accountability” and argues that “low-fee private schools disproportionately exclude the poorest students and in particular girls, and rely on low-paid, poorly qualified teachers”.

However poor public services might be, establishing a permanent route out of that system for some students does nothing to correct the problems faced by the majority. The projects we look at clearly demonstrate these failures. Public healthcare and education, outside of the market, helped to massively reduce poverty in Britain. It is wrong to impose different solutions on countries in the global south today.

4. CDC is still making high profits on its investments.

From 2012-18 CDC made an average return on its investments of 9.2% a year when measured in pounds sterling – a slightly lower level than before the 2011 reforms. However, under CDC’s strategy it now has a targeted return of 3.5% a year, so it is making almost three times as much profit as it needs to, despite repeated assurances that CDC would prioritise development impact over profitability. CDC says that these returns are artificially high due to the fall in the value of the pound, yet it has still made an average rate of return of 6% when measured in US dollars over the past seven years.

5. We have seen little to no evidence that CDC is making an impact in terms of tackling poverty, providing genuinely additional resources or making effective use of government resources.

CDC does not report on whether its investments are additional to those it assesses the private sector would have made anyway, or on what proportion of its investments are in new activities compared to buying companies which already exist. Of particular concern, CDC still appears to believe that development can be mostly measured by a mixture of the rate of return and the number (but not the quality) of jobs created. These metrics are deeply problematic, especially without a proper assessment of what sort of jobs are created, or whether CDC’s investment made any difference to those jobs being created.
A key problem with CDC is its failure to adequately assess the development impact of its investments. This was supposed to change with the Mitchell reforms, but monitoring and evaluation are still poor and opaque. For example, of CDC’s 50 investments in food and agriculture, nineteen have been in food processing companies, at least twelve are in large-scale farming, five in companies which provide inputs such as fertiliser and four in distribution companies.47 There is effectively no investment in small-scale agriculture, despite evidence that this model can be more productive in terms of yields, less environmentally destructive and can transform the livelihoods of farmers through increased incomes.48 Again, reducing global inequality and dealing with climate change require massive support and investment in sustainable, small-scale agriculture. CDC is taking the opposite approach.

The 2019 ICAI review into CDC’s investments from 2012 to 2018 gave CDC an Amber/Red rating, saying that CDC showed a “lack of clarity on expected development impact”. ICAI says that CDC’s “monitoring of a narrow set of impact metrics and the absence of comprehensive, independent evaluation made it difficult for us to assess its overall impact”.49 CDC claimed in a meeting with Global Justice Now that since the start of 2018 it has set out a clear development rationale for any investment, which the investment can then be evaluated against.50 However, CDC provides very little public information on its investments, beyond the company (and intermediary fund if relevant), country and sector invested in (often, not even the value of the investment is disclosed). This means there is no information on what CDC expect the development impact to be, and how this will be measured and evaluated.51 There is therefore no way for anyone outside CDC to know what development rationale CDC attaches to a particular investment (if any), how this will be measured and reported on, and how it will be evaluated.

Other than financial return, the big indicator by which CDC judges success appears to be job creation, and this is one area on which CDC does report (including direct job creation, indirect job creation and indirect job creation in supply chains).52 However, we consider this measure to be a misleading indicator of CDC’s contribution to ‘development’.

First, the way that CDC measures its contribution towards job creation is misleading. In 2018, CDC claimed that its portfolio employed 852,130 people.53 But CDC does not state whether this is total employment across all the companies CDC has invested in or, as would be more relevant, the jobs in proportion to CDC’s investment – ie, the jobs which CDC could have some claim to have created. Through Freedom of Information (FOI) requests we have discovered that the figure is the total number of people employed across all the companies CDC is invested in.54 The figure is therefore largely meaningless and misleading, as it bears no relationship to CDC’s investments (see Appendix 1). In other words, many of these jobs would have been created regardless of CDC’s investment. CDC also reports on how many jobs were created in the companies it has invested in (in 2018, 32,090 of the 852,130 people employed in companies CDC has invested in were in new jobs) but, again, this is misleading as it does not relate to CDC’s level of investment in those companies.

This relates closely to the question of whether CDC’s investments are making a real difference – or whether they would actually have been made by another actor in the absence of CDC’s investment. In other words, is CDC’s investment really ‘additional’? In the past, CDC has invested in industrial sectors – such as mobile communications in Nigeria – which don’t appear to struggle to attract private investment. In such cases, CDC needs to ask searching questions as to why, other than making high returns, such investments have positive development impact. In its current strategy, CDC states that all its investments must bring ‘financial additionality’ – provide capital that is not provided by the private sector in sufficient quantity – and/or ‘value additionality’ – providing expertise that will improve business processes or standards.
However, CDC does not report on the additionality of its investments, nor does it publish evaluations on how financial or value additionality across individual investments is tracked.

In its response to our FOI request, CDC said: “We are careful not to make a claim on any portion of investee companies’ performance. To do so would require us to solve several sequential measurement challenges”.\(^55\) However, CDC makes no such caveat in its annual report, and politicians talk of CDC’s impact as if its investments had created those jobs. For example, when then secretary of state for international development, Penny Mordaunt was asked in February 2019 how she ensures that new investments made by CDC contribute to poverty reduction, she replied: “CDC invests to create jobs and reduce poverty… almost 750,000 people are directly employed by companies supported by CDC in the poorest countries in Africa and South Asia”\(^56\).

It’s also important to note that ‘job creation’, while important to development, doesn’t prove very much without far more detail: what sort of jobs have been created, where and for whom? The creation of poor-quality, badly-paid and non-unionised jobs are not a path to sustainable development. Job creation can only ever be seen as really positive as part of a much more holistic development strategy. CDC’s current evaluation seems to assume that any growth is positive in and of itself, a version of ‘trickle down’ theory which assumes that adding wealth to the top of society will eventually benefit everyone. In fact, we know that GDP growth can exist alongside widening inequality, creating a deeply unfair economy which is the antithesis of development.\(^57\)

Measuring long-term development impact is by no means a simple task, but that makes rigorous monitoring and transparency all the more pressing to ensure that investment decisions are based on what is good for people and planet and not purely on the profit motive. Allowing the private sector to dictate investment decisions risks leading to structural dependencies on economies in the global north or on low value industries, like the extractive sector, more useful to western markets than to building a just society and a sustainable economy.

The Feronia case (Case Study C) is an example of how destructive and divisive investments like these can be. It is important that CDC does not invest in companies that appear to be undermining workers’ rights, exacerbating inequalities or contributing to environmental degradation. But it must also be able to demonstrate the positive, additional development impact that these investments are having with a rigorous and transparent measurement framework.

6. CDC-backed funds continue to make extensive use of tax havens.

Of the companies and private equity funds in which CDC owns more than 20%, just under two-thirds were based in tax havens in 2018.\(^58\) CDC claims, with only partial justification, that this is to avoid ‘double taxation’ on investments, and in the past CDC has rejected calls from civil society to stop using tax havens. CDC does now gather information and report on where its investments are based; however, no progress seems to have been made on moving towards a system of genuine tax justice and transparency.

In its annual accounts, CDC reports on 116 companies and private equity funds in which it owns over 20% of the shares.\(^59\) Of these, 77 (66.4%) are based in countries commonly seen as tax havens, 52 (44.8%) in Mauritius alone.\(^60\) 25 of the companies or funds are in other OECD countries, 19 in the UK.\(^61\) In short, while CDC is facilitating flows of capital into developing countries, its use of tax havens means that less money is retained by global south governments than would be the case through direct investment or budget support. The UN Committee on Trade and Development estimates that developing countries lose $50 billion to $200 billion a year in fiscal revenues due to a lack of tax justice.\(^62\)

CDC does state that the businesses it has investments in reported tax payments of $3.5 billion in 2017, “primarily in corporate taxes”. It also says a quarter of businesses paid no tax because they had no income or made a loss.\(^63\) However, CDC does not report on the overall profit of businesses it has invested in, nor how much of the tax payments were corporate taxes compared to other forms of tax. Without this...
information, we do not know what the effective tax rate being paid by companies CDC has invested in, and the statement is therefore insufficient.

In response to our FOI request, CDC said that it "does not systematically collect profit data of all its investee companies" and does not keep a record of what proportion of capital CDC provides for the companies it is invested in. Furthermore, the statement "primarily in corporate taxes" comes from CDC analysis of a sample of just ten companies CDC has invested in. These ten account for 64% of the tax CDC says is paid by companies it has invested in, but just 1% of the total number of companies CDC has invested in. It is our view that CDC is spectacularly failing to ensure tax justice – one of the most important elements of the development agenda today.

7. High levels of pay for senior CDC staff remains unacceptable

The National Audit Office (NAO) raised concerns about CDC’s “excessive remuneration packages” in a 2008 report. Although the NAO said, in 2016, that positive changes to remuneration policy has been made since then, 48 CDC employees earned a higher salary than the UK prime minister (more than £150,000 a year) in 2018.

CDC has faced criticism in the past for what has been perceived to be an excessive remuneration policy in an international development context. Prior to the 2011 reforms, CDC’s then chief executive Richard Laing was paid an almost £1 million salary. CDC’s present remuneration policy states that salaries “should enable the recruitment and retention of individuals of the calibre that will allow CDC to achieve its mission” but that CDC employees “will be taking a significant discount (often greater than 50%)” compared to private equity investors in the private sector.

In 2017, the NAO reported that average salaries at CDC had dropped 27% from £123,000 to £90,000 since 2012, but it suggested this could change with a “revised remuneration framework” expected to be submitted for ministers’ approval by March 2017.
4. Case studies

A. CDC’s investments in health

Since the start of 2013, CDC has invested in 74 companies in the health sector, with the aim of leveraging private sector investment to provide healthcare in the global south.74 These investments are primarily in private hospitals, including hospitals which market themselves for international business and an exclusive local clientele (meaning they have a questionable development impact).75

Many of the most problematic private health investments have been made through private equity funds. For example, through the APF-I fund based in Mauritius, CDC has invested in the Nu Cosmetic Clinic in India. Nu Cosmetic Clinic advertises “Vaser Liposuction” for 85,000-350,000 Indian rupees (£950-3,800) and male nose surgery for 75,000-100,000 rupees (£800-1,100).76 CDC has also invested $22.5 million in the Takura II investment fund between 2013 and 2016, which has in turn invested in The Avenues Clinic Hospital in Harare, described by The New Zimbabwean as an “upmarket hospital” which “continues to attract the country’s political elite and foreigners”.77 This market-led, private sector-based approach is highly problematic for any claims that CDC is tackling poverty or inequality. There is significant evidence that the privatisation of healthcare can undermine local public health systems, and can lead to a narrowing of access, reduced transparency and poor working conditions. Given that much of this evidence is accepted in a UK context, and that most politicians sign up to the idea of a predominantly public national health service, it is wrong to use development funding to promote private healthcare in some of the most disadvantaged countries in the world.

Below, we have analysed CDC’s investments in one intermediary fund, the Abraaj Growth Markets Health Fund, as a case study to demonstrate why these investments can be so damaging.

<table>
<thead>
<tr>
<th>Investor in Abraaj</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>IFC (World Bank)</td>
<td>$150 million</td>
</tr>
<tr>
<td>OPIC (US)</td>
<td>$150 million</td>
</tr>
<tr>
<td>Bill and Melinda Gates Foundation</td>
<td>$100 million</td>
</tr>
<tr>
<td>Abraaj</td>
<td>$100 million</td>
</tr>
<tr>
<td>CDC (UK)</td>
<td>$75 million</td>
</tr>
<tr>
<td>African Development Bank</td>
<td>$25 million</td>
</tr>
<tr>
<td>Proparco (France)</td>
<td>$10 million</td>
</tr>
<tr>
<td>Others</td>
<td>$390 million</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1 billion</strong></td>
</tr>
<tr>
<td><strong>Total public and Gates</strong></td>
<td><strong>$510 million</strong></td>
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</table>

Founder and CEO of Abraaj, Arif Naqvi, has promoted the private investment opportunities created by the Sustainable Development Goals.87 Abraaj said the aim of the health fund was to acquire and build hospitals.86 However, it has primarily bought pre-existing hospitals, with only one new hospital apparently built so far. It has been reported that Abraaj’s largest investment was $145 million to buy a 72% stake in Indian private healthcare company CARE in early 2016.89 Of Abraaj’s nine healthcare investments (see Table 2 for details):
Doing more harm than good: Why CDC must reform for people and planet

The revelations about Abraaj’s use of the health fund money to fund expenses and running costs led to a loss of confidence in the whole group. Abraaj’s various funds are now being taken over by different private equity funds. The case has been described by the Economist as the “biggest collapse in private-equity history.”

The Abraaj case demonstrates several key issues with how CDC invests and operates:

1. **Privatisation:** Abraaj’s investments focus exclusively on the private sector and supporting private hospitals. CDC argues that this will leverage further investment and provide greater healthcare access to ‘hard to reach’ communities, but privatisation is never an answer to universal, accountable health coverage. It necessarily excludes many people on the basis of their income, and thereby entrenches inequality. Although often presented as a temporary solution – ‘filling in’ for a poor public sector – privatised healthcare will permanently undermine local public health systems by drawing away resources and money that could otherwise be pushed into public solutions.

2. **Little to no evidence of impact:** Whilst the Abraaj investments are supposed to contribute towards the building of new hospitals, most has gone into existing hospital chains. Of the new hospitals, only one appears to have opened. It is difficult to tell whether CDC’s investment has made a difference or if these hospitals would have been built anyway.

3. **A lack of transparency:** As the summary of Abraaj’s investments suggests, there is very little information provided by CDC on its investments, the impact they have, or any progress made.

4. **A lack of accountability:** CDC’s ‘fund of funds’ model also makes it difficult to trace who is accountable for malpractice or corruption. The evolving case with Arif Naqvi raises questions about the suitability of CDC maintaining its investments in Abraaj funds, but there appears to have been little effort to hold Naqvi or Abraaj accountable by CDC or DfID.
Abraaj investments

<table>
<thead>
<tr>
<th>Abraaj Growth Markets Health Fund investments</th>
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</thead>
<tbody>
<tr>
<td>Abraaj Admiralty Hospital Limited, Nigeria</td>
</tr>
<tr>
<td>Admiralty Hospital was a half-built hospital in Lagos. Abraaj acquired the site to build a private hospital on it. As of April 2018 work was still ongoing.91</td>
</tr>
<tr>
<td>The Avenue Group, Kenya</td>
</tr>
<tr>
<td>In September 2017, Abraaj bought a 56% share of Avenue Group private hospital chain.92 Avenue says it provides private healthcare at affordable rates; one consultation with a doctor cost 1,550 Kenyan shillings in 2017 (£12).93 In 2017, minimum wages in the formal sector ranged between 6,416-11,574 shillings a month.94 So just one consultation is around one week’s wages for someone on the lowest minimum wage. Of course, many people in Kenya live on less than the minimum wage. According to the World Bank, 66% of the Kenyan population live on less than $3.20 a day in purchasing power parity terms.95</td>
</tr>
<tr>
<td>Avicenna Healthcare, Pakistan</td>
</tr>
<tr>
<td>The Avicenna Healthcare investment in Pakistan was meant to build a “450-bed tertiary care” private hospital in Pakistan.96 1.5 acres of land was reported to have been bought for the hospital site but, as of June 2018, construction had been delayed.</td>
</tr>
<tr>
<td>CARE, India</td>
</tr>
<tr>
<td>CARE is India’s fifth largest private hospital provider, with 2,345 beds across central, west and south-east India. The Abraaj Health Fund’s largest single use of money was $145 million to buy a 72% majority stake in CARE in early 2016.97</td>
</tr>
<tr>
<td>Gate Healthcare, Pakistan</td>
</tr>
<tr>
<td>CDC says Gate Healthcare is a partnership between Abraaj and 20 consultants to build a 290 bed hospital in Lahore. The private hospital is branded as Evercare Hospital Lahore. Its website says that the hospital will have 270 beds, rather than the 290 claimed by CDC.98</td>
</tr>
<tr>
<td>Healthlink Management, Kenya</td>
</tr>
<tr>
<td>Healthlink Management was a pre-existing company which Abraaj bought a 75% majority stake of in May 2017.99 The US government’s OPIC fund, which is also an investor in Abraaj, suggests that Healthlink Management own Nairobi Women’s Hospital, a pre-existing private hospital, founded in 2001.100</td>
</tr>
<tr>
<td>Islamabad Diagnostics Centre, Pakistan</td>
</tr>
<tr>
<td>Islamabad Diagnostics Centre (IDC) was founded in 2003. Abraaj made its investment in December 2016.101 The investment was to lead to 30 new diagnostics centres across Punjab, on top of the 20 that IDC already operated.102 This appears to have now been completed as IDC states it operates in more than 50 branches in 10 cities.103</td>
</tr>
<tr>
<td>Metropolitan Hospital Holdings, Kenya</td>
</tr>
<tr>
<td>Abraaj’s investment in Metropolitan Hospital Holdings was made in November 2017, but no further information is provided by CDC on its website.104 The Kenyan competitions authority says Metropolitan Hospital Holdings bought a 100% stake in Ladnan Hospital in September 2017.105 Ladnan is another pre-existing private hospital, which began operating in 2011.106</td>
</tr>
<tr>
<td>Perregrin Properties, Nigeria</td>
</tr>
<tr>
<td>Abraaj’s investment in Perregrin Properties was made in April 2017, but no further information is provided by CDC on its website.107 The US’s OPIC says it is a 160 bed hospital in Lagos.108 However, we have not been able to find any further information about it.</td>
</tr>
</tbody>
</table>
B. Privatising education

For a number of years, CDC has followed (and to some extent led) the trend of national and multilateral DFIs investing in private education. Privatisation in education has been found to lead to economic, geographic, social and disability-related inequalities. In October 2019, over 150 civil society organisations signed a letter to the World Bank condemning the use of aid to invest in private education on the grounds that this “deepens inequalities in education while failing to consistently produce better learning outcomes”.115 Fees, both for tuition and other ‘hidden’ costs, are a barrier to access for the poorest and most marginalised children. Furthermore, low-fee schools only turn a profit by running on extremely low costs, meaning that schools can operate in extremely poor conditions and provide a low standard of education.116 But it is not just low-fee private schools that CDC has invested in; it has also given $45 million in direct equity to GEMS Education, which runs a network of 90 elite private schools (mainly in the Middle East with three schools in Kenya and Uganda).117 Given the clearly exclusionary nature of elite private schools, it is highly questionable whether this is the best way of meeting Sustainable Development Goal 4, to ensure inclusive and equitable quality education for all.

The negative impacts of privatisation have been seen in the UK since 2010 through the expansion of academies. The academy programme was championed as improving school performance by increasing school autonomy and competition between schools. It has not worked: there is no evidence that academies perform better than other state funded schools and plenty that shows the opposite.118 As with privatisation overseas, academisation has further caused problems of inequality, a lack of transparency and a lack of accountability, and has undermined public education. As we will see, the problem becomes much worse when private fees are added into the equation.

CASE STUDY

Bridge International Academies

Bridge International Academies is a for-profit, large-scale network of pre-primary and primary schools, claiming to deliver “great education...at scale and within the limited budgets of developing country governments”.119 According to Bridge, the majority of their schools are government public schools which Bridge supports through PPPs and government partnerships. Bridge runs or supports 2000 schools in India, Kenya, Liberia, Nigeria and Uganda, with ambitions to reach 10 million pupils by 2025. In 2013, CDC invested $6 million in Bridge to “support the company’s plans to expand to more countries throughout Africa, as well as in India”, followed by a subsequent $1.6 million.120

Bridge uses what it calls a “school in a box” model, employing a highly-standardised approach to education. Every school built by Bridge looks the same. The teaching material for each grade classroom is the same and, most importantly, the lessons are the same across all classrooms in the same grade in one country. Bridge uses a system of scripted lessons, and teachers receive lesson plans on an e-tablet, which they have to follow word for word.121

We recognise that most investors in Bridge have positive intentions in wanting to improve access to education. Indeed, Bridge argues that the evidence shows that their methods are the most effective way to improve learning in developing countries. However, there have also been numerous reports raised over poor standards at Bridge schools and concerns with Bridge’s model have been raised on numerous occasions. Our evidence suggests that investing in Bridge is not an appropriate or effective means to educate children in developing countries.

In September 2019, shadow secretary for international development Dan Carden highlighted the case of Bridge in a statement to parliament, saying that parents in Kenya had told him they had been “tricked into believing their kids would benefit from scholarships”, with the result that they were later unable to meet fees and their children missed periods of schooling.122 In the concluding observations of their review of Kenya, the UN Committee on the Rights of the Child raised serious concerns about “the low quality of education, and the rapid
increase in private and informal schools, including those funded by foreign development aid, providing substandard education and deepening inequalities”. In October 2019, the Compliance Adviser Ombudsman (CAO), the World Bank’s investment watchdog, published a report on Bridge’s operations in Kenya. This report raised “substantial concerns” about the environmental and social impacts of the International Finance Corporation’s investments in Bridge.

Research into Bridge has revealed numerous issues with how the chain operates:

1. Exclusion of the poor and disadvantaged:
   CDC claims that “most Bridge students attend free government public schools” and that scholarships are available to families unable to afford school fees. However, a number of studies have found that Bridge schools are inaccessible to the very poor and particularly to students with special educational needs. Studies in Kenya, Uganda and Nigeria all found the mandatory fees to attend Bridge schools to be significantly higher than the $6 per month or $72–74 per year usually claimed by the company. Adding other mandatory items, such as uniforms, the monthly costs jump to an average of $17.25 per month, or $207 per year. Such fees are well out of reach of poorer families. Even relatively better off parents attracted by Bridge marketing can still spend significant proportions of their income – and often struggle to keep up payments. In Kenya, sending three children to a Bridge school was calculated to represent between 27% and 34% of the monthly income of families living on $1.25 a day. As a result, 58% of Bridge students interviewed responded that they had missed school due to non-payment of fees. In Kenya, other concerns have been raised about selective enrolment in Bridge schools with “placement tests” used to determine the grade in which pupils should be enrolled, which may result in some cases in pushing out low performing students. Furthermore, some teachers in Bridge schools in Kenya have reported that Bridge schools do not “generally facilitate or admit children with disabilities and children with special needs”. A 2019 report on Bridge’s involvement in a PPP in Liberia refers to “mass expulsions” made by Bridge schools, affecting over 300 students.

2. Poor quality:
   Teachers in Bridge schools receive scripted lesson plans on an e-tablet, which they must follow word for word: “We just click and teach the pupils. Tap here and teach the pupils. Just like that, following the scripts”. In August 2016, a letter from the Kenyan government questioned the scripted curriculum and confirmed that the materials and curriculum being used by Bridge had never been approved by the Kenya Institute of Curriculum Development (KICD). According to the letter, the curriculum and materials used in Bridge schools had not been licensed because the content was not relevant to Kenyan curriculum objectives, teachers were not allowed flexibility to attend to individual learner needs, and lesson plans were not prepared by teachers but are downloaded a few hours prior to each lesson. As of October 2019, Bridge academies were licensed by Kenya’s ministry of education. In a letter to Global Justice Now in April 2019, CDC argued that Bridge schools have demonstrated evidence of improved outcomes on government exams, and that the upcoming publication of a longitudinal, randomised control trial (RCT) would further demonstrate Bridge’s success. This study was conducted in Liberia and examined the results of a large PPP in which education provision in 93 Liberian primary schools was outsourced to eight different non-state operators, including Bridge. Although the RCT did find that students saw a statistically significant improvement in learning outcomes, the authors also argued that this was “at a high cost and reduced access to education for some children”. One author of the RCT, Justin Sandefur, commented on Twitter that, whilst some statistically significant learning improvements were observed in the first year, there were “stark trade-offs” and that “narrow fixation on test scores came with trouble in other domains”.

3. Failure to meet legal educational standards:
   Bridge’s compliance with legal standards has previously been questioned both in Kenya and in Uganda. In Uganda, a 2016 study found that Bridge neglected legal and educational standards established by the government of Uganda regarding the use of certified teachers, the accredited curriculum, appropriate teaching methods, adequate school facilities, and the proper authorisation of schools. In 2016, the
Ugandan High Court ruled that the government should “regulate private involvement in education to ensure adherence to minimum standards”. Concerns over Bridge schools were also confirmed in August 2016 when the Ugandan minister of education and sports, Janet Museveni, announced during a session of parliament the intention of the government to close the 63 Bridge schools in the country. In a letter dated 29 January 2018, the Ugandan ministry of education and sports warned Bridge that its schools – as well as another 1300 low fee primary schools - would not be able to operate for the 2018 academic year as they were yet to obtain licences. According to CDC, schools “progressing through the licensing process” continued to operate in Uganda, and Bridge claim that all of their schools in Uganda have now been licensed.

4. Undermining public education: Privatisation undermines the capacity of governments to deliver public education systems, and can enable governments to shirk their duty to deliver the right to education for all children. It can draw wealthier students away from public schools, leaving the poorest students in an under-funded and devalued public system. Moreover, Bridge Liberia was found to take this phenomenon one step further in its work as part of the Partnership Schools Liberia programme, where the company was found to “push excess pupils and under-performing teachers onto other government schools”.

5. Violation of health and safety regulations: The status of Bridge’s premises has been raised by several concerned parties. A journalist who conducted research on Bridge noted: “One of these schools was Bridge Diamond in Mukuru… The schoolyard fence was made of patched, bent grey metal and barbed wire. The school building itself was shabby and neglected. In the schoolyard, about 30 feet away from where children enter their classrooms, was a deep trench of fetid garbage and rotting bags of faeces”. When pupils were asked to suggest improvements for their classrooms, their recommendations included improved cleanliness and temperature regulation.

6. Poor labour conditions: In Kenyan Bridge schools, teachers are required to work six days a week (59-65 hours) for a salary that is barely above the poverty line (about $100 a month). Bridge fails to enforce reasonable working conditions, particularly fair working hours. Bridge employment contracts in Kenya stipulate working hours that surpass national law stipulations with no mention of overtime compensation. A teacher’s 2016 contract indicates that they must work six days a week, from Monday to Saturday. It has also been reported that teachers must work on Sundays when required (although this is denied by Bridge). This amounts to 57 and a quarter working hours a week for the teachers and around 62 working hours for the academy managers. Teachers’ salaries stipulated in Bridge’s contracts are below the country-specific national guidelines on minimum wage in Kenya. According to teachers in Bridge schools in Kenya, salaries “range between 9,000 and 12,000 Kenyan shillings (approx. $88.80–118.50) per month, and academy managers’ salaries range between 10,000 and 15,000 shillings (approx. $98.70–148.10) per month”.

7. Little accountability to communities: The UN has warned that low-fee schools have grown faster than governments can handle, and that the rapid expansion of private chains is a particular cause for concern. The involvement of private actors in education reduces transparency and replaces accountability ‘down’ – to children, parents and communities – with accountability ‘up’ – to investors and shareholders. The former chair of the UK parliament’s International Development Committee (IDC) has stated that: “evidence received during this inquiry raises serious questions about Bridge’s relationships with governments, transparency and sustainability”. The 2017 letter concludes: “We would not recommend DFID make any further investments in Bridge until it has seen clear, independent evidence that the schools produce positive learning outcomes”. Several members of the committee also questioned Bridge’s “hostility to independent assessment”.

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C. Undermining human rights and the rule of law

Beyond supporting the privatisation of public services in the global south, CDC has also demonstrated a track record of investing in operations which face heavy criticism from human rights groups for their social and environmental impact. Many of these companies offer commercial opportunities at the expense of local governments and communities, in sectors such as fracking, palm oil and fossil fuel extraction.

These are among the most egregious of CDC’s investments as they are only tenuously linked to the Sustainable Development Goals. In some cases, the use of tax havens to facilitate these investments means that public services are unlikely to see the benefits of these commercial operations. The damaging environmental impact of such activities and, in the worst cases, alarming reports of associated violence, reflect a continuing neo-colonial mindset towards the global south. At a time when we need to focus on supporting global rights, unpicking the legacies of colonialism and tackling climate crisis, these investments demonstrate a highly damaging approach to international development.

CASE STUDY

Feronia Inc

Feronia Inc’s oil palm plantations have been the subject of controversy since the Lever Brothers’ colonial occupation of community land in the early 1900s. Through its subsidiary Plantations et Huileries du Congo (PHC), Feronia operates around 25,000 hectares of oil palm plantations in the DRC (total concession size: 107,000 hectares).\(^\text{155}\) In February 2017, it was reported that CDC was a majority shareholder of Feronia, holding as much as 67% of the company’s shares.\(^\text{156}\) As of November 2019, this has fallen to 41.85%.\(^\text{157}\)

Feronia’s plantations have a strong historical connection to the brutal former colonial Belgian administration and the ongoing opposition by many local communities in the DRC to the plantations shows that economic powers in the global north are continuing to profit from resource extraction in a neo-colonial manner.\(^\text{158}\) There have been ongoing tensions in the area; in 2014, it was reported that there were significant protests against PHC after security guards arrested four people, allegedly for stealing palm nuts from the plantations.\(^\text{159}\)

Our key concerns in the case of Feronia / PHC are that:

1. **Feronia’s concessions derive from a colonial land-grab which continues to affect the human rights of local communities to this day:** The land occupied by PHC goes back to concessions obtained by British business magnate Lord Leverhulme under Belgian colonial rule. Leverhulme wanted the palm oil for his UK-based soap factories at Port Sunlight. Instead of buying palm oil from the villagers at market prices, Leverhulme reached an agreement with the Belgian colonial administration in 1911, giving him concession rights over a massive 750,000 hectare area, encompassing all of Congo’s major oil palm groves.\(^\text{160}\) Shortly after, the Belgian government gave Leverhulme’s company a monopoly over the production and trade of palm oil within these areas. The Belgian colonial army enforced the monopoly and the company’s horrific working conditions with brutal violence.

Communities have opposed these concessions ever since the Leverhulme agreement, including at the time of CDC’s initial investment in Feronia in 2013. In a 2018 complaint to German DFI DEG (which is a lender to Feronia), communities reaffirmed their demand for reparations for lost economic opportunities from the use of their ancestral land since 1911 and for the land to be returned to them.\(^\text{161}\) Communities have cited a number of reasons for why they consider the concession contracts acquired by Feronia with its purchase of PHC from Unilever as invalid:

- Communities never gave consent to the conversion of their ancestral forests to oil palm plantations;
- The concession contracts contain errors that make them null and void;
- The company has breached countless promises it made towards the communities with regards to providing health posts, schools, roads and employment over the decades.\(^\text{162}\)
2. **Feronia appears to be failing financially and has received numerous loans from CDC to stay afloat:**

The evidence we have seen suggests that Feronia has faced severe difficulties in staying solvent, let alone becoming profitable. That is because CDC has granted numerous loans to Feronia in recent years. In September 2019, it was reported that CDC had invested $51.9 million (£42 million) in Feronia since 2013, including a short-term unsecured $3 million (at a 12% interest rate) in January 2019. In October 2019, a further $5 million short-term loan was granted with a further $11 million loan facility issued at the end of November. Since September 2019, it has been reported that Feronia has missed loan and interest repayments on two separate occasions. CDC’s repeated investments, along with investments from other DFIs, appear to be all that is keeping Feronia afloat, on the basis that the company’s collapse would lead to job losses in the area.

Rather than providing any further loans, CDC should immediately begin work to establish an exit strategy from Feronia that addresses the colonial legacy of the plantations whilst also supporting communities to take ownership of the land. Such an exit strategy must begin with a mediation process with the affected communities (the DEG’s complaints mechanism could be a space through which this could be achieved) whereby the company relinquishes its concession claims and the communities are then able to define the conditions under which the company may operate on their lands.

3. **There have been numerous allegations of violent incidents, including fatalities, involving PHC and its employees against local people:**

These incidents have been reported by RIAO-RDC, a Congolese network of environmental and human rights defenders, as involving security personnel, as well as local police, subjecting the local communities to regular harassment. For example, RIAO-RDC reports extensively on the tensions surrounding a strict policy against workers and villagers taking palm nuts (which are widely used in local cuisine) from plantations. Community members have repeatedly told RIAO-RDC that this policy has been governed violently (by PHC security as well as the police). According to one group of community members, this policy resulted in a man being fatally beaten by police in 2015 after being accused of stealing palm nuts from the PHC plantations in Boteka. In a further incident in 2014, RIAO-RDC reported the arrest of several people in connection with suspected palm nut theft, which triggered three days of clashes between the police and local people.

More recently in July 2019, Joël Imbangola Lunea, a member of RIAO-RDC, was brutally beaten and killed near the company’s Boteka plantations. RIAO-RDC have reported to Human Rights Watch that Imbangola had been "facilitating meetings between communities and members of the (DEG) complaint mechanism’s independent panel of experts". Eyewitnesses have alleged that the assailant was PHC’s head of security for the area, Mr Boketsu Ebuka, and allege that he was assisted by another local PHC security guard. Testimonies gathered from eyewitnesses allege that Mr Ebuka referred specifically to Imbangola’s involvement with RIAO when he launched his assault. Feronia has said that Mr. Ebuka was on annual leave at the time of the incident. Mr Boketsu has been arrested for the alleged murder and is currently on trial in Mbandaka where he is being held in prison. CDC reject the claim that the assailant is PHC’s head of security.

In August 2019, CDC “commissioned IBIS Consulting and Salama Fikira to undertake an independent investigation” into the incident, and in November made a statement claiming that the “investigating team did not uncover any evidence that the alleged murder had anything to do with the accused’s status at the time as an employee of Feronia”. In October, shadow secretary of state Dan Carden asked if DfID would launch its own inquiry, receiving a non-committal response from secretary of state Alok Sharma. CDC will not publish the findings of the IBIS investigation until Mr. Boketsu’s trial has concluded.
4. Poor labour conditions: RIAO-RDC have been supporting communities near the plantations for several years as opposition has grown to the company’s occupation of their land and the low wages paid by Feronia. For several years, during which CDC provided funding to Feronia, our evidence suggests that plantation workers were paid less than the legally set minimum wage. A report by Human Rights Watch published in November 2019 also criticised PHC’s use of day labourers on lower pay than contract workers, highlighting that “at one plantation, Congolese authorities imposed a hefty fine for this illegal practice and ordered the company to provide indefinite contracts over the course of two years to 1,500 workers”\textsuperscript{178} Labourers have also reported that “PHC has not provided basic protective equipment” and that the company are in violation of a series of health and safety practices.\textsuperscript{179} Reports, based on interviews with workers on the plantation, have also highlighted that many “suffer from extreme poverty and do not have enough space to produce enough food for their own consumption” owing to PHC’s policies.\textsuperscript{180} Furthermore, Human Rights Watch alleges that pesticides used on PHC plantations can cause impotence, skin irritation, blisters, diminished vision, shortness of breath, elevated heart rate, headaches, weight loss, and chronic fatigue. Over two thirds of the interviewees were said to have suffered some of these symptoms, and “most of the workers who were between the ages of 25 to 46 said they had become impotent since they started their job”.\textsuperscript{181}

5. There appears to be a total lack of transparency or accountability to local communities for Feronia’s actions: NGOs supporting communities affected by Feronia-PHC argue that the company operates with near total impunity when it comes to alleged human rights, labour and environmental violations. They argue that there has been insufficient investigation into accusations against Feronia-PHC and that local communities have had almost no recourse to justice.\textsuperscript{182} As with Abraaj, the case of Feronia calls into question how much due diligence CDC does on its investments and highlights the complete lack of accountability that communities impacted by CDC-funded projects currently have. There are also significant questions to be raised about the logic behind CDC’s continual investment in Feronia despite the company appearing to have little development impact.

In this case, we would recommend that:

- There should be a legally binding right-to-redress for communities who claim they have been negatively impacted by any investment;
- CDC must immediately devise an exit strategy to divest from Feronia, beginning with a mediation process with the affected communities whereby the company relinquishes its concession claims advocate in favour of Feronia’s land being returned to local communities;
- CDC should have an independent evaluation body which reports to parliament and could conduct independent investigations in serious cases (such as the murder of Joël Imbangola Lunea);
- Given that there remains a large accountability gap between CDC and the countries it invests in, we propose that a mechanism is established to allow government and civil society representatives from borrowing countries to have a say in how CDC invests.
- CDC must develop a rigorous measurement framework against which it should justify its future investments in a way which goes beyond the dubious assertion that such investments create jobs.
D. CDC’s investments in fossil fuels and commodity extraction

Throughout 2019, consecutive Conservative governments stated that they were bringing UK aid policy in line with the government’s commitments under the Paris Agreement. In June, then prime minister Theresa May announced that aid spending would be “compatible with our shared climate change goals. For example, when building roads or developing energy infrastructure, we will consider the greenest way to do this”. In September 2019, Boris Johnson announced that the Ayrton Fund would “give British scientists and innovators access to up to £1 billion of aid funding to create new technology to help developing countries reduce their emissions and meet global climate change targets”. Since these announcements, numerous ministers have made statements highlighting the apparent progress the government has made in these areas.

However, throughout this period, CDC has maintained a large portfolio of investments in fossil fuel-based operations involving the use of coal, gas, oil and heavy fuel oil (HFO – a particularly damaging fossil fuel known to emit a range of toxic compounds and particulates including “black carbon”, described as the second leading cause of global warming, with severe impacts on human health). CDC invests, both directly and through other funds, in a range of projects which have a severely detrimental environmental impact including: a coal-burning cement factory, a petroleum pipeline and one of the world’s largest petrochemical producers. This is potentially just the tip of the iceberg, given the difficulty of tracking all of CDC’s investments through the opaque information it publishes publicly. However, even taken by themselves, these investments severely undermine the government’s claims to be aligning all aid spending with the Paris commitments.

Moreover, it is questionable whether these renewables investments are enough to outweigh the bad, particularly given that the current climate crisis requires all aid spending to be meeting the Paris commitments.

Secondly, the government has argued that it may need to invest in fossil fuel operations on occasions where there is no viable alternative to provide energy in a given region. This logic has seen a number of investments in natural gas-fired power plants as an alternative to coal power. This argument does not stand up for two key reasons. As Oil Change International has argued, investing in any fossil fuel operations (and the vast amounts of carbon-intensive infrastructure they require to support them) now means locking in high levels of emissions for decades to come, meaning that we are only increasing our chances of going beyond planetary tipping points. Furthermore, despite the Mitchell reforms in 2011 and a change of strategy away from fossil fuels in 2012, CDC has continued to invest in coal, heavy fuel oil and other damaging sectors, despite ministers claiming that it has not:

1. **Coal:** Ministers claimed several times in 2019 that CDC has not invested in coal-related projects since 2012. Zac Goldsmith, minister of state for environment, food and rural affairs and international development, told the IDC in October that “DfID...has not invested in coal, for example, for around a decade”, and then development minister Harriet Baldwin stated in March that “CDC...has not made any new investments in anything coal-related since 2012”. However, in apparent contradiction to these statements, CDC has continued to invest in coal-related infrastructure, including a $16.6 million investment in South African port operator Grindrod to facilitate the export of South African coal to China via Mozambique in 2014. CDC also made a $144 million investment in the coal-burning cement producer ARM Cement in 2016. In August 2018, it was reported that “CDC Group is emerging as the biggest loser from the collapse of [ARM Cement]...the UK development finance firm has seen over 80 per cent of its initial share value eroded in just slightly more than two years”. This represents a loss of approximately $115.2 million.
2. **Heavy fuel oil**: CDC also has numerous investments in companies that operate HFO-burning power plants. This includes an undisclosed amount invested in 2016 through the Investec Africa Credit Opportunities Fund in Karadeniz Powerships, manufacturer of a fleet of “floating energy ships”. Although these powerships can operate on HFO or natural gas, the 470MW Karadeniz Powership Osman Khan (which this investment appears to specifically relate to as it is providing energy to Ghana) operates on HFO. In March 2018, CDC announced a “$39 million loan investment in Tè Power Company S.A.S.U., to construct a 50MW thermal power plant in Conakry, the capital city of Guinea” – the announcement fails to mention that the plant will be HFO-fuelled. Another undisclosed, intermediated investment was made in February 2019 in Maria Glêta which owns a dual fuel HFO and gas-fired power plant in Benin.

3. **Commodity extraction and related infrastructure**: CDC also has a wide range of investments in services and infrastructure projects designed to facilitate the extraction of fossil fuels and commodities from Africa. This includes: an oil, gas and palm oil transporter in Ivory Coast; a “petroleum products” pipeline in Cameroon; a $12 million investment in Owendo Bulk Port in Gabon, “an export route for locally mined manganese ore and an import and trading route for aggregates and cement constituents” (all 2018); and an oil storage and logistics company in Nigeria (2019). CDC has also invested $140 million (in 2013) in Indorama, one of the world’s largest petrochemicals producers, to “build and operate a fertilizer production facility near Port Harcourt, Nigeria, along with an 84km pipeline to transport gas”.

There are three core arguments about why CDC should immediately divest from these projects and institute a moratorium on any fossil fuel investments:

1. Any investments in fossil fuels or related infrastructure will lock in carbon emissions for decades to come, making it impossible to limit the worst effects of climate change.
2. Even if there is a perceived need for some of these projects, which is highly questionable, there is no justification for why development finance should be spent on supporting highly profitable businesses where the private sector is willing to invest.
3. CDC’s focus on investing in energy and infrastructure reflects the influence of the government’s “mutual prosperity” agenda to use aid as a means of creating trading opportunities for British businesses. This positioning of British businesses to take advantage of new opportunities in oil, gas and renewable energy was highlighted by minister of state at the Department for International Trade Conor Burns in a speech on UK-Tunisia trade and investment last year. As ICAI have highlighted, there are significant risks that the mutual prosperity agenda will lead to a loss of focus on aid being used to reduce poverty, the diversion of aid away from the poorest and most marginalised communities, and the reinforcement of “negative power relations” between the UK and developing countries.
5. Conclusion

Since the publication of ICAI’s report on CDC in March 2019, and even since we began preparing this report, the political context in which CDC operates has shifted significantly. Although there is a growing level of concern across the development sector over the impact of the Global Britain agenda on UK aid policy, the election of a Conservative majority government in December 2019 means that the government’s financialised, market-based version of development will continue over the next parliament.

There have been reports that, following the UK’s departure from the European Union on 31 January 2020, DfID will effectively be merged with the Foreign and Commonwealth Office and aid policy will increasingly be used to set up post-Brexit trade deals.202 Given that CDC is already at the extreme end of using development funds to promote markets and business overseas, could we see CDC given the more important role which Andrew Mitchell once conceived of? Could CDC’s strategy actually reflect the future of British aid spending?

Because of this, the need to give CDC a new mandate, improve its transparency and accountability and ensure that it does not exacerbate poverty, inequality and climate change, is pressing. The Intergovernmental Panel on Climate Change suggests that we now have less than a decade to take sufficient action to meet the demands of the Paris Agreement and limit global warming to 1.5°C.203 Repurposing CDC, to not only do no harm to the environment but to also facilitate a just transition to a zero carbon economy, is therefore crucial.

But it is also vital that CDC is able to tackle global inequalities, sufficiently prove that it is meeting its legal requirement to address poverty, and not act in a way that is detrimental to the human rights of the communities it is investing in.

As we stated above (See ‘Recommendations’), our concerns with CDC run so deep that only a root and branch reform would, in our opinion, transform it into a truly accountable, transparent and effective force for good. This reform should be based on:

- A new mandate for CDC, which transforms it into an international Green Investment Bank, tackling poverty, inequality and climate crisis around the world;
- The end of the ‘fund of funds’ model and the promotion of Public-Private Partnerships;
- A ban on, and divestment policy towards, fossil fuel investments;
- Changes to the type of organisations CDC invests in, with a strong preference for the public sector;
- The radical improvement of monitoring, transparency and oversight;
- A coherent approach to tax justice.

Only by pursuing a bold, positive agenda for reform such as this can CDC be transformed into an institution which is fit for the challenges of the new decade.
CDC has told us it does not collect data on what proportion of the total capital it provides to companies it is investing in. To get a sense of CDC’s role in this job creation, we assume below that CDC provides 20% of the total capital across the companies it invests in. CDC began reporting on the job creation figures in 2014 (see below). When CDC makes an investment, we would not expect it to have an immediate impact on job creation. But over time it should. Below we calculate the average annual new investment in the three years prior to the year in which jobs are reported as having been created. Assuming this was 20% of the investment gives us a figure for investment per job. If this assumption were true, this would mean CDC invests around £100,000 for each job created. Although as CDC point out, other factors create jobs as well as capital investment, and there is no evidence that CDC’s investments are additional – the jobs may have been created anyway.

### Table 3: New jobs reported to be created by CDC compared to size of investments

<table>
<thead>
<tr>
<th>Year</th>
<th>Jobs created in year</th>
<th>Average annual new investment by CDC in previous three years</th>
<th>Total investment if CDC provided 20%</th>
<th>Investment per new job</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>24,000</td>
<td>£492 million</td>
<td>£2,460 million</td>
<td>£102,500</td>
</tr>
<tr>
<td>2015</td>
<td>25,000</td>
<td>£598 million</td>
<td>£2,990 million</td>
<td>£119,600</td>
</tr>
<tr>
<td>2016</td>
<td>44,000</td>
<td>£782 million</td>
<td>£3,910 million</td>
<td>£88,864</td>
</tr>
<tr>
<td>2017</td>
<td>63,000</td>
<td>£974 million</td>
<td>£4,870 million</td>
<td>£77,302</td>
</tr>
<tr>
<td></td>
<td><strong>Average</strong></td>
<td></td>
<td><strong>£97,067</strong></td>
<td></td>
</tr>
</tbody>
</table>

CDC’s new investments in each of the years used to calculate the figures in the third column above are 2012: £397 million\(^{204}\) 2013: £608 million\(^{205}\) 2014: £472 million\(^{206}\) 2015: £713 million\(^{207}\) 2016: £1,161 million\(^{208}\) 2017: £1,047 million\(^{209}\)
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