THE ZERO CLUB – HNP GP (Part 10)

Health, Nutrition and Population (HNP) Global Practice in Africa: 14 Countries, 55 Projects, $ 3.0 Billion Committed, Zero Satisfactory. 1990 to 2026.

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14	55	$3.0 bn	0%
countries	projects	committed	Satisfactory

Executive Summary

The record. The World Bank's Health, Nutrition & Population Global Practice committed $14.9 billion across 207 IEG-evaluated projects in Sub-Saharan Africa. The S+ rate by commitment is 25.1 percent. In 14 countries, the rate is zero: 55 projects, $3.0 billion committed, not one rated Satisfactory or Highly Satisfactory by IEG. This is the Health Zero Club.

The instrument test. The MTI Zero Club (Part 9) documented 14 countries where budget support — Development Policy Financing — never achieved a Satisfactory outcome. The Health Zero Club tests the investment project. Investment Project Financing has procurement, disbursement conditions, results frameworks, and supervision missions that DPFs lack. In 14 African countries, 55 health IPFs over up to 36 years produced zero Satisfactory outcomes. The problem is not the instrument.

The anchor case: Kenya. Kenya is not a fragile state. It is a lower-middle-income country with functioning institutions, a large private health sector, and 36 years of sustained Bank health engagement. Eight health projects. $694 million committed. Ratings: 2 Unsatisfactory, 2 Moderately Unsatisfactory, 4 Moderately Satisfactory. Never once Satisfactory. Commitment grew from $36 million to $191 million. The diagnosis grew more sophisticated. The results did not improve.

The independent test. The Bank's own Human Capital Index — combining child survival, adult survival, stunting, and education — shows that Zero Club countries improved their HCI by +0.038 over the decade (2010–2020). The rest of Sub-Saharan Africa improved by +0.041. In three countries (DRC, Angola, Comoros), the HCI actually declined despite active Bank health lending. $3 billion committed, and the Bank's own index does not reveal gains that are visibly larger than regional trajectories. The CPIA tells a complementary story: Building Human Resources improved in Kenya (+1.0) and Sierra Leone (+1.0), but the Bank's evaluation system never rated a health project Satisfactory in either country. The policy environment improves. The Bank's projects do not achieve their objectives within it.

The structural finding. If both DPFs and IPFs fail to deliver Satisfactory outcomes in the same countries, the problem is not the instrument. It is not the Global Practice. It is something deeper about how the Bank delivers in low-capacity environments. The rating distribution tells the story: 29 Moderately Satisfactory, 17 Moderately Unsatisfactory, 7 Unsatisfactory, 2 Highly Unsatisfactory. The modal outcome is partial achievement. Full achievement: zero.

Case Selection and Methodology

Scope. This paper examines all 207 IEG-evaluated Health, Nutrition & Population projects in Sub-Saharan Africa from the IEG ICRR/PPAR master database (March 2026). Commitment-weighted analysis is used throughout. CPIA data is from the World Bank CPIA database (2005–2024).

Why S+ and not MS+. This analysis uses the Satisfactory or above (S+) threshold. The methodology is identical to Part 9 (MTI Zero Club). Moderately Satisfactory sits at 4 on IEG's six-point scale — below the Satisfactory threshold of 5. A project rated MS has partially or mostly achieved its objectives but has not achieved them satisfactorily. IFC and MIGA both use Satisfactory as the operative benchmark. IDA lending-side corporate reporting normalised MS+ as its headline metric — a category that encompasses projects that have not achieved their objectives satisfactorily.

Why Health. Health, Nutrition & Population is the second Global Practice selected for Zero Club analysis. It was chosen because: (a) it produces the second-largest Zero Club by country count after MTI; (b) it is the largest investment-project-based GP in Africa with $14.9 billion committed; and (c) its instrument mix — overwhelmingly IPFs rather than DPFs — provides the direct test of whether the Zero Club pattern is instrument-specific or institutional.

The IPF vs DPF difference. The MTI Zero Club documented failure in the DPF instrument. Health projects use IPFs — investment projects with procurement, disbursement conditions, results frameworks, and supervision missions that DPFs lack. If Health IPFs also fail at 0% S+, the isomorphic mimicry argument must be reformulated: the problem is not conditionality design but something more fundamental about how the Bank delivers in these countries.

Sample selection. A minimum of two evaluated projects was required to exclude countries whose zero outcome reflected a single operation. Countries with only one IEG-rated health project are excluded because a single rating could reflect project-specific rather than systemic factors. The two-project threshold is conservative: it identifies countries where the pattern has been confirmed at least twice by independent evaluation. An additional six countries with a single evaluated health project also returned zero Satisfactory: Gabon (Fiscal Consolidation DPF, FY2018, $200M, MU), Botswana (HIV/AIDS Prevention, FY2009, $50M, MS), Eswatini (Health/HIV/AIDS/TB, FY2011, $20M, MS), Togo (Maternal & Child Health, FY2014, $14M, MU), Cabo Verde (HIV/AIDS, FY2002, $9M, MS), and Equatorial Guinea (Health Improvement, FY1992, $6M, U). Including these would raise the total to 20 countries where the Bank has never achieved a Satisfactory health outcome in Sub-Saharan Africa.

Limitations. IEG ratings measure project delivery against stated objectives. CPIA scores are complementary diagnostics with their own limitations. The HCI comparison is illustrative rather than causal. The paper does not claim that $3 billion in health lending produced no benefit. The significance is that across 55 evaluated projects in 14 countries spanning up to 36 years, none crossed IEG's threshold for having satisfactorily achieved its stated objectives.

1. The Aggregate Record: Health in Africa

Health, Nutrition & Population committed $14.9 billion across 207 IEG-evaluated projects in Sub-Saharan Africa. The S+ rate by commitment is 25.1 percent. The decade trajectory:

Decade	Projects	Committed	S+ Rate
1990s	53	$2,458M	23.3%
2000s	82	$4,740M	17.6%
2010s	69	$7,593M	30.8%
2020s	2	$123M	0.0%

Source: IEG ICRR/PPAR database, March 2026. Commitment-weighted. Sub-Saharan Africa only.

The 2000s saw the lowest S+ rate at 17.6 percent on $4.7 billion — coinciding with the scaling of multi-sectoral HIV/AIDS projects. The 2010s partial recovery to 30.8 percent was driven by large results-based financing projects in a small number of countries. The rating distribution across all 207 projects: 81 MS (39%), 46 MU (22%), 36 S (17%), 24 U (12%), 9 HS (4%), 4 HU (2%).

The recent record is worse, not better. A companion analysis on mdbreform.com (The Health Record, April 2026) examines the 78 IEG-rated projects closing between FY2015 and FY2026 — the Bank's most recent decade. Commitment: $8.4 billion. S+ rate: 34.6 percent. Below-Satisfactory commitment: $5.9 billion — 71 percent. The headline MS+ rate is 84.6 percent — one of the highest in the Africa portfolio. The gap between 84.6 percent (the Bank's reported headline) and 34.6 percent (the Satisfactory threshold) is wider in health than in any other major sector in Africa. This creates one of the widest gaps between reported portfolio success and the Satisfactory threshold in the Africa portfolio.

GP Comparison

Health's S+ rate of 25.1 percent places it among the weaker-performing GPs in Africa:

Global Practice	Projects	Committed	S+ Rate
Social Protection & Jobs	146	$16.9bn	52.4%
Urban, Resilience and Land	234	$14.3bn	41.6%
Governance	176	$9.2bn	38.8%
Finance, Competitiveness & Innovation	179	$9.9bn	33.1%
Agriculture and Food	193	$11.4bn	32.9%
Water	104	$9.0bn	33.9%
Education	215	$13.2bn	22.6%
Health, Nutrition & Population	207	$14.9bn	25.1%
MTI	375	$37.4bn	24.6%
Energy & Extractives	175	$25.2bn	15.9%

Source: IEG ICRR/PPAR database, March 2026. Commitment-weighted. Sub-Saharan Africa only.

Social Protection achieves 52.4 percent. Governance achieves 38.8 percent. Health's 25.1 percent is comparable to MTI's 24.6 percent — the two largest-volume GPs in Africa deliver the weakest S+ rates. These comparisons are descriptive and do not control for country

difficulty, fragility, or project complexity; GPs operating in harder environments may face structurally lower performance ceilings.

THE GP COMPARISON

The two GPs that commit the most to Africa — MTI ($37.4bn) and Health ($14.9bn) — deliver the weakest S+ rates. Social Protection, with $16.9bn committed, achieves 52.4%. The pattern is consistent with a volume-outcome tradeoff, though causality is not established: high-volume GPs may operate in structurally harder environments.

2. The Zero Club

In 14 African countries, Health has never delivered a Satisfactory outcome. These countries account for 20 percent of all Africa Health commitment:

Country	Projects	Committed	Period	Rating Distribution
DRC	4	$982M	FY2004–2015	3 MS, 1 U
Kenya	8	$694M	FY1990–2016	4 MS, 2 MU, 2 U
Burkina Faso	6	$270M	FY1994–2019	2 MS, 4 MU
Cameroon	4	$253M	FY1995–2016	1 MS, 1 U, 2 HU
Sierra Leone	5	$140M	FY1996–2016	3 MS, 2 MU
Angola	3	$131M	FY1993–2010	2 MS, 1 U
Central African Rep.	3	$98M	FY2002–2019	3 MS
Congo-Brazzaville	3	$89M	FY2004–2014	1 MS, 2 MU
Eritrea	3	$86M	FY1998–2005	2 MS, 1 MU
Lesotho	7	$74M	FY1990–2013	5 MS, 2 MU
Guinea-Bissau	3	$65M	FY1993–2004	1 MS, 1 MU, 1 U
Rwanda	2	$50M	FY1991–2003	1 MS, 1 MU
Comoros	2	$21M	FY1994–1998	1 MU, 1 U
São Tomé & Príncipe	2	$18M	FY1992–2004	1 MS, 1 MU

Source: IEG ICRR/PPAR database, March 2026. Countries with ≥2 Health projects evaluated. Zero S+ by commitment.

The Zero Club includes post-conflict states (DRC, CAR, Sierra Leone), a lower-middle-income country with functioning institutions (Kenya), Sahelian countries (Burkina Faso), commodity-dependent economies (Angola, Congo-Brazzaville), island states (Comoros, São Tomé), and landlocked states (Lesotho). The failure is not confined to a particular country type. The common factor is the outcome: zero Satisfactory.

The rating distribution across the 55 Zero Club projects: 29 Moderately Satisfactory (53%), 17 Moderately Unsatisfactory (31%), 7 Unsatisfactory (13%), 2 Highly Unsatisfactory (4%). The modal rating is MS — partial achievement. This mirrors the MTI pattern exactly: MS is the floor, not the ceiling.

3. The Anchor Case: Kenya

Kenya is the strongest analytical case because it is not a fragile state. It is a lower-middle-income country with functioning institutions, a large private health sector, a Ministry of Health that coordinates Global Fund, Gavi, PEPFAR, and bilateral programmes simultaneously, and 36 years of sustained Bank health engagement. Eight health projects. $694 million committed. Not once Satisfactory.

P-Code	Project Name	FY	Rating	Commit
P001312	POPULATION IV	FY1990	U	$36M
P001339	HEALTH REHABILITATION	FY1992	MU	$31M
P001333	Sexually Transmitted Infections Project	FY1995	MS	$52M
P070920	HIV/AIDS Disaster Response	FY2001	MU	$50M
P066486	Decentralised Reproductive Health	FY2001	U	$98M
P081712	Total War Against HIV/AIDS (TOWA)	FY2007	MS	$135M
P074091	Health Sector Support	FY2010	MS	$100M
P152394	Transforming Health Systems	FY2016	MS	$191M

Source: IEG ICRR/PPAR database, March 2026.

The pattern: 2 Unsatisfactory, 2 Moderately Unsatisfactory, 4 Moderately Satisfactory. Commitment grew from $36M (Population IV, FY1990) to $191M (Transforming Health Systems, FY2016). The modal rating is MS — partial achievement. Full achievement never occurred in 36 years.

The lesson trajectory. IEG identified identical themes across three decades: (1) data availability is critical to monitoring; (2) institutional capacity must be assessed realistically; (3) devolution requires capacity that was not in place. The Decentralised Reproductive Health project (FY2001, $98M, Unsatisfactory) was designed to deliver through a devolved system that did not exist. The lesson was identified. The design was not modified. Commitment continued to grow.

The devolution problem. Kenya devolved health services to 47 counties in 2013. The Bank designed subsequent operations as though county capacity existed. IEG: ‘Data availability is critical to ensure adequate monitoring of project implementation.’ The Transforming Health Systems project (FY2016, $191M, MS) faced ‘challenges in measuring indicators, particularly those related to reproductive health.’ The form of devolution was adopted. The function of service delivery did not follow.

THE KENYA FINDING

Eight projects. $694 million. 36 years. A non-fragile, lower-middle-income country. The Bank’s own evaluation system never rated a single health project Satisfactory. Kenya raises the question of why sustained engagement and institutional maturity still did not produce a single Satisfactory outcome.

4. The Independent Test: Human Capital Index

If the Bank's health lending had produced genuine improvement, that improvement should be visible in the Bank's own Human Capital Index — the flagship measurement that combines child survival, adult survival, stunting, and education into a single productivity score (0–1). The HCI is the Bank's own metric. The question is whether $3 billion in health lending moved it.

4.1 HCI Trends: Zero Club vs Rest of SSA

Country	HCI 2010	HCI 2017	HCI 2020	Change	Proj	Commit
DRC	--	0.369	0.366	–0.003*	4	$982M
Kenya	--	0.518	0.547	--	8	$694M
Burkina Faso	0.320	0.369	0.384	+0.064	6	$270M
Cameroon	0.380	0.394	0.397	+0.018	4	$253M
Sierra Leone	--	0.351	0.363	--	5	$140M
Angola	--	0.361	0.362	–0.001*	3	$131M
CAR	--	--	0.292	--	3	$98M
Congo-Brazzaville	0.409	0.420	0.419	+0.010	3	$89M
Eritrea	--	--	--	--	3	$86M
Lesotho	0.341	0.371	0.400	+0.060	7	$74M
Guinea-Bissau	--	--	--	--	3	$65M
Rwanda	--	0.374	0.380	--	2	$50M
Comoros	--	0.409	0.405	–0.004*	2	$21M
São Tomé	--	--	--	--	2	$18M

*Source: World Bank Human Capital Index, 2020. * = 2017–2020 change (no 2010 data). Scale 0–1.*

The aggregate finding. The four Zero Club countries with 2010–2020 trend data (Burkina Faso, Cameroon, Congo-Brazzaville, Lesotho) improved their HCI by an average of +0.038. Sixteen non-Zero Club SSA countries with equivalent data improved by +0.041. The HCI comparison is illustrative rather than causal — the index is affected by many variables, attribution is impossible, and health projects may prevent deterioration rather than create gains. At minimum, the HCI data do not reveal gains in Zero Club countries that are visibly larger than regional trends, despite $3 billion in Bank health commitment.

Cameroon is the most telling case: +0.018 on $253M in health commitment — less than half the SSA average gain, and the portfolio included two Highly Unsatisfactory-rated projects. **Congo-Brazzaville** gained +0.010 on $89M — essentially flat. **DRC** went backwards from 0.369 to 0.366 between 2017 and 2020 despite $982M committed. **Angola** was flat at 0.362. **Comoros** declined from 0.409 to 0.405.

Kenya at 0.547 is the highest HCI in the Zero Club and among the highest in SSA. But that is precisely the point: Kenya's health system improved through its own institutional development, Global Fund and Gavi coordination, private sector growth, and bilateral programmes. The Bank committed $694M across 8 projects and never achieved Satisfactory. The HCI tells you Kenya's health system works. IEG tells you the Bank's projects within it do not.

THE HCI FINDING

The Bank's own Human Capital Index does not reveal gains in Zero Club countries that are visibly larger than regional trends. Zero Club countries improved at +0.038 over the decade; the rest of SSA improved at +0.041. In three countries (DRC, Angola, Comoros), the HCI declined despite active Bank health lending. The comparison is illustrative rather than causal due to data gaps and heterogeneous country trajectories, but the direction is consistent: $3 billion committed, no visible additionality above the regional baseline.

4.2 CPIA Signals and Project Outcomes

The Bank's own CPIA health-relevant criteria (Building Human Resources, Gender Equality, Social Protection, Cluster C) provide a complementary signal. Building Human Resources improved in Kenya (+1.0), Sierra Leone (+1.0), DRC (+0.5), and CAR (+1.0). But zero Satisfactory ratings persisted in each. Transparency, Accountability and Corruption — the criterion most directly linked to whether health spending reaches its intended beneficiaries — deteriorated in Eritrea (–1.5), Guinea-Bissau (–1.0), Lesotho (–0.5), and Comoros (–0.5).

Country	Human Res	Gender	Soc Prot	Cluster C	TAC
DRC	+0.5	+0.0	–0.5	+0.2	+0.5
Kenya	+1.0	+0.5	+0.5	+0.6	+0.5
Burkina Faso	+0.0	+0.0	–0.5	–0.1	+0.0
Cameroon	+0.5	–0.5	+0.0	+0.1	+0.5
Sierra Leone	+1.0	+0.5	+1.0	+0.8	+0.5
Angola	+0.5	+0.0	+0.0	+0.0	+0.0
Central African Rep.	+1.0	+0.0	+0.0	+0.3	+0.0
Congo-Brazzaville	+0.0	+0.0	+0.5	+0.3	+0.0
Eritrea	+0.0	–0.5	–1.0	–0.4	–1.5
Lesotho	+0.0	+0.0	+0.5	+0.1	–0.5
Guinea-Bissau	+0.0	+0.0	+0.0	–0.1	–1.0
Rwanda	+0.5	+1.0	+0.5	+0.6	+0.5
Comoros	+0.0	+0.0	+0.0	+0.2	–0.5
São Tomé	+1.0	+0.5	+0.5	+0.5	+0.0

Source: World Bank CPIA database, 2006–2024. Change = 2024 minus 2006. TAC = Transparency, Accountability and Corruption.

The CPIA evidence does not establish causality between policy signals and project outcomes. But it suggests that improvements in policy and institutional indicators alone were insufficient to move projects above the Satisfactory threshold. The HCI and CPIA together point toward the same conclusion: the binding constraint is the interaction between project design and actual implementation capacity, not the policy environment alone.

5. The Six Failure Modes

IEG lesson text across the 55 Zero Club projects was analysed systematically. Six distinct failure modes emerge, documented in the Bank's own evaluation language. M&E and monitoring failures appear 58 times. Performance-based financing breakdown appears 42 times. Procurement and fiduciary collapse: 38. Capacity mismatch: 23. Devolution without readiness: 23. Staff turnover: 22. These are not this paper's categories. They are the Bank's own.

1. Overly ambitious design in low-capacity environments. IEG's most consistent finding across the Zero Club is project design that exceeds institutional capacity. Cameroon's Health, Fertility and Nutrition Project (FY1995, $15M, HU): 'Overly complex and risky projects are unwise to embark upon, even in the presence of political pressure to do something.' DRC's Multisectoral HIV/AIDS Project (FY2004, $102M, U): 'Excessive ambition led to an inappropriate plan to cover the entire country with a wide scope of interventions, even though weak institutional systems made achievement of those objectives impossible.' Angola's first health project (FY1993, $20M, U): 'Projects in countries with weak institutional capacity should be less complex.' The lesson was stated in 1993. It was restated in 2004. It was restated in 2016. The design model did not change.

2. Performance-based financing that does not survive contact with reality. PBF is the dominant health financing instrument in the Zero Club — mentioned 42 times in IEG lesson text. The pattern is consistent: PBF shows initial promise, then collapses when government commitment shifts, funding is interrupted, or verification costs consume the budget. Cameroon (FY2016, $163M, U): 'Scaling up too quickly can limit the ability to adopt previous learning.' The PBF verification mechanism produced 'inefficiencies and a lack of transparency.' Burkina Faso (FY2012, $42M, MU): a government policy change 'undermined implementation of the RBF pilot before it was completed.' Congo-Brazzaville (FY2014, $30M, MU): 'Health services under PBF were discontinued due to the lack of funding that resulted from a sharp decline in oil prices.' CAR (FY2019, $53M, MS): PBF administrative costs 'accounted for 35 percent of PBF costs' because the project relied on international NGOs for verification due to low in-country capacity.

3. M&E systems that cannot measure what the project is doing. IEG identifies monitoring failure in 58 of the 55 projects — more than once per project. Kenya (FY2016, $191M, MS): 'Data availability is critical to ensure adequate monitoring. The project faced challenges in measuring indicators.' Local health facilities 'still used paper-based systems that did not facilitate the reporting process.' Cameroon (FY2001, $50M, HU): 'Emphasis on a high output of action plans, without proper attention to the content and context of the plans, can distract from focusing on development effectiveness.' Burkina Faso (FY2002, $22M, MU): 'Monitoring indicators which do not sufficiently point to outcomes can lead to a focus on implementation goals, rather than on development outcomes.'

4. Devolution without capacity (Kenya, Lesotho). Kenya devolved health services to 47 counties in 2013. The Bank designed subsequent operations as though county capacity existed. Kenya (FY2016, $191M, MS): 'Implementation of projects in a devolved context raises the level of complexity. Staffing in the PMT was not sufficient to support and supervise 47 counties, which had frequent staff turnover.' Kenya (FY2001, $98M, U): 'Legal covenants cannot substitute for genuine government ownership and commitment.' The form of devolution was adopted. The function of service delivery did not follow. This is the health-sector equivalent of the isomorphic mimicry the DPO paper identifies in MTI.

5. Post-conflict state absence (DRC, CAR, Sierra Leone). Health projects designed for institutional environments that did not exist. DRC (FY2004, $102M, U): 'The absence of a TTL on the ground in post-conflict situations can critically affect a project's ability to overcome weak structural systems.' DRC (FY2006, $150M, MS): 'The goal of targeting hard-to-reach communities must be adequately supported by a realistic, on-the-ground assessment of capacity to deliver services.' Guinea-Bissau (FY2004, $7M, U): 'The perceived need for rapid response must be balanced by careful design.' 'Creating a new institution is a complex and time-consuming task, particularly in a fragile state.'

6. Staff turnover and institutional amnesia. Bank staff turnover appears 22 times in the lessons. Cameroon (FY2016, $163M, U): 'Maintaining continuity within project teams and implementing sound handover arrangements are critical. Implementation suffered from frequent team changes, notably TTLs from the Bank side, resulting in a significant loss of expertise and continuity.' DRC (FY2014, $15M, MS): 'High staff turnover, an imbalance or underrepresentation of requisite technical skills, and changes in TTLs all can undermine dialogue, problem-solving, and results.' The Bank documents the same lessons across multiple evaluation cycles. The design model does not change. This is institutional amnesia in its purest form.

THE LESSON FINDING

IEG documented the same failure modes across 55 projects and 14 countries over 36 years. Overly ambitious design. PBF that collapses on contact with reality. M&E systems that cannot measure outcomes. Devolution without capacity. The lessons are identified, documented, and repeated. The design model does not change. The pipeline continues.

ICRR Deep Dive:

DRC — $715M to Moderately Satisfactory

A $715 million project that achieved real service gains but never escaped the Moderately Satisfactory equilibrium.

The DRC Health System Strengthening Project (P147555) is the single largest health investment project in Africa. Approved December 2014 at $220M, it grew through five additional financings to $715M by closure in June 2024. IEG rated it Moderately Satisfactory. The forensic detail illustrates the MS equilibrium operating at maximum scale.

Design. PBF payments to health facilities conditional on quantity and quality of maternal and child health services. Originally 140 health zones in four provinces (17 million people). Expanded through restructurings to cover approximately 33 percent of the population, then contracted when some health zones proved too weak. Scope expanded to include adolescent health, community-based nutrition, gender-based violence, and disease surveillance. The nutrition, GBV, and community-based components were never implemented and were dropped in the 2020 restructuring.

What worked. Antenatal care visits (4+) increased from 36% to 65%. Children fully immunised rose from 62% to 71%. Deliveries attended by skilled personnel: 8.3 million cumulative. Contraceptive prevalence rose from 6% to 27%. Out-of-pocket payments for child curative care fell 76%. The PBF mechanism produced real service delivery gains in concentrated provinces.

What did not work. The M&E baseline was drawn from the 1984 census — 30 years before the project started. HMIS data were 'influenced by incentives to over- or under-report progress.' Targets were lowered in the February 2020 restructuring; achievement was then rated Substantial against the reduced targets but only Modest against originals. 'The supply chains and markets for pharmaceuticals, management of health human resources, and physical condition of health facilities were all dysfunctional.' Provinces too dispersed for PBF verification to work were eventually dropped. Pharmaceutical distribution challenges persisted throughout. The retirement reform for Ministry of Health staff was never implemented.

Fraud and fiduciary failure. 'High levels of corruption and inappropriate transactions in the selection of local staff, with fraud and corruption issues particularly in the province of Equator' — which was eventually removed from the project. $906,345 in ineligible expenses from one contract. 'Sundry debtors' accounts of undocumented advances with no indication of attempts to document or collect the payments.' Overlapping full-time appointments due to lack of a unified human resources database. Excessive vehicle leasing at high cost but lack of ambulances.

Efficiency: Modest. PBF administrative costs were 26% of PBF spending. 'Excessive fragmentation in the sources of financing led to a high administrative burden.' The 16-month delay between approval and effectiveness. The EVD response was 'costly due to complicated logistics, the need for security to protect responders in an active conflict zone, and inefficient human resources management.'

The rating. IEG rated the project Moderately Satisfactory. Relevance: High. Efficacy: Substantial (under revised targets). Efficiency: Modest. The project produced real health gains. It also produced fraud, a province removed for corruption, 1984 census baselines, dropped components, lowered targets, and $906K in ineligible expenses. The rating absorbs all of this into a single word: Satisfactory enough. This is the MS equilibrium at $715 million.

ICRR Deep Dive:

Cameroon — $163M to Unsatisfactory

The Cameroon Health System Performance Project (P156679) is the largest U-rated health project in the Zero Club. Approved May 2016 at $127M with an additional $27M from the GFF. PBF scaled from 25% to 100% national coverage across all ten regions. Efficiency rated Negligible — the worst possible rating. The project is the definitive case study of scaling without learning.

The scaling problem. Cameroon's previous health project (the HSSIP) ran PBF in 44 health districts. A dedicated PIU was identified as a key success factor. This project replaced the PIU with a new national technical unit (CTN), expanded PBF to all 194 health districts, added refugee services, added an emergency component, and added a GFF-funded investment case — all simultaneously. IEG: 'The pace of scaling up proved to be overly ambitious. Insufficient internalization of the lessons learned from the previous operation resulted in an overambitious project design.' The FY1995 project ($15M, HU) was rated Highly Unsatisfactory for being too complex. Twenty-one years later, the same lesson applied at eleven times the commitment.

The impact evaluation finding. The project's own impact evaluation (De Walque et al., 2021) found that 'outcome differences between the PBF treatment group and the increased

financing group (control group where no PBF verification mechanisms were included) were not statistically significant.' The verification mechanism that consumed one-third of the project budget produced no measurable additional impact over simply giving health facilities more money. This is one of the most consequential findings in the Zero Club because it directly tests the effectiveness of the Bank's preferred health financing instrument: the Bank could not demonstrate, in a rigorous evaluation, that PBF outperformed unconditional transfers.

Verification costs. $30 million — one-third of total expenditure — was spent verifying payments to health facilities. This exceeded budget projections by 66.8%. An audit of verification agencies (July–September 2023) found 'inefficiencies and a lack of transparency,' including 'ineligible expenditure related to supervision mission costs, salaries exceeding established salary grids, irregular procurement processes, and incomplete financial management documentation.' The project owed verification agencies $5.3 million six months before closing.

The refugee grant. A $30 million IDA Refugee Sub-Window grant was approved in May 2018 for refugees and host communities in Northern Cameroon. 'No data was reported and no activities were carried out.' The full $30M was canceled in December 2022. The CTN lacked technical readiness, the MoPH rejected alternative implementation through NGOs, and the Bank could not find a viable mechanism for utilisation. $30 million approved for some of the most vulnerable people in Central Africa. Zero spent.

Fiduciary collapse. Financial management 'consistently deemed moderately unsatisfactory or unsatisfactory throughout its lifecycle.' Over $1.5 million in ineligible expenditures identified. 'Inadequacies in justifying expenditure for PBF transfers, significant advances to project personnel lacking proper documentation.' No PDO indicators were reported from November 2019 to June 2022 — nearly three years of a $163M project with no results data.

Staff turnover. Three TTL changes. The final transition occurred five months before project closure. 'Resulting in a significant loss of expertise and continuity in PBF both within the World Bank team and the CTN, which persisted until the project's conclusion.'

The rating. Efficacy: Substantial (services did expand). Efficiency: **Negligible.** Bank Performance: Moderately Unsatisfactory. Overall: **Unsatisfactory.** The project expanded PBF to national coverage. It could not demonstrate that the mechanism it used to do so was more effective than simply transferring money. Cameroon will repay the IDA credit in full.

6. Why the Pipeline Never Stops

The Health pipeline operates under different institutional drivers than MTI. The economist career pipeline and DPO instrument advantage documented in the MTI power architecture paper do not apply directly to Health. The drivers are instead:

Global health financing pressure. The Global Financing Facility (GFF), Gavi, and the Global Fund all operate through government health systems that the Bank co-finances. IDA replenishment commitments include health targets. The pipeline is sustained by the institutional architecture of global health financing, not by a single career pathway.

Pandemic preparedness. Post-COVID pandemic preparedness has generated a new wave of health system strengthening commitments. The pressure to build 'resilient health systems' produces lending volumes that may exceed institutional absorptive capacity in precisely the countries that have demonstrated they cannot deliver Satisfactory outcomes on existing health investments.

IDA replenishment health commitments. Each IDA replenishment cycle includes health sector commitments. These commitments generate lending targets that must be met regardless of the outcome performance of the preceding cycle. The pipeline is self-reinforcing: weak outcomes do not reduce future commitment volumes because the commitment volumes are determined by replenishment negotiations, not by outcome data.

The Health Works question. In April 2024, the Bank launched Health Works — a commitment to reach 1.5 billion people with quality, affordable health services by 2030. A $27 billion global portfolio. Fifteen National Health Compacts. $2 billion in co-financing with each of the Global Fund and Gavi. The ambition is real. The machinery is impressive. The Bank's promotional material cites Mozambique as a Health Works success — community health workers doubled, household access doubled. Mozambique's IEG record: 2 projects, zero Satisfactory, $150 million. The distance between promotional reporting and independent evaluation outcomes is one of the central tensions the Zero Club highlights. The 15 National Health Compacts should each carry an annex: what does the IEG record show for this country's health portfolio, and what specifically will be different this time?

7. Counterexamples: Where Health Works

The Zero Club argument is strengthened by acknowledging where Health has succeeded — and explaining why. Four countries with comparable institutional environments achieved substantially higher S+ rates. The conditions for success illuminate the conditions for failure.

South Sudan achieves 67.9% S+ on $248M across 5 projects. Operating under extreme fragility and external constraints that enforced discipline — the same pattern observed in Somalia's MTI portfolio. The key: projects were designed with realistic expectations of what a collapsed state could absorb. Objectives were bounded. External partners (UN agencies, NGOs) managed implementation rather than government. The discipline was imposed by circumstance, not by design choice.

Guinea achieves 62.6% S+ on $151M across 6 projects. Several focused disease-control projects achieved Satisfactory outcomes despite the overall institutional environment. The successful projects targeted specific diseases (malaria, Ebola response) with measurable endpoints. The unsuccessful projects attempted broader health system strengthening. The pattern mirrors the structural finding: vertical delivery outperforms transformational design in the same country.

Mali achieves 61.0% S+ on $245M across 5 projects. Focused nutrition and disease control investments outperformed broader health system strengthening. The nutrition projects had clear anthropometric targets. The health system projects had diffuse objectives spanning multiple ministries. Same government, same health system, different results based on design specificity.

Ethiopia achieves 50.1% S+ on $320M across 5 projects. The largest African health system received sustained Bank engagement with measurable results — the opposite pattern to Kenya. Ethiopia's Health Extension Programme provided a national delivery platform that Bank projects could build on rather than create from scratch. The institutional sequencing was right: the government built the platform; the Bank financed operations within it.

The pattern across all four counterexamples is consistent: Health succeeds where (a) project design is focused on specific, measurable outcomes rather than system-wide transformation; (b) institutional capacity — however limited — matches the project's delivery requirements; (c) external constraints or national platforms enforce implementation discipline; and (d) objectives are bounded rather than aspirational. These are the conditions the Zero Club countries lack. They are also the conditions the Bank's standard health IPF design model does not require.

Rwanda demonstrates that Zero Club status is not permanent. Its two early health projects (FY1991 and FY2003) — both predating the governance transformation — produced zero Satisfactory outcomes. Its later health portfolio, built on community health workers, Imihigo performance contracts, and PBF integrated with national systems, achieved sustained results. Countries can exit the Zero Club pattern when implementation discipline changes. The question is whether the Bank's institutional model accelerates that transition or merely waits for it.

Country	Why It Escaped
Rwanda	Strong state implementation discipline; governance platform built before financing scaled
Ethiopia	Existing Health Extension Programme provided a national delivery platform the Bank could build on
Mali	Narrow, measurable nutrition objectives with anthropometric targets
Guinea	Disease-specific focus (malaria, Ebola) with bounded operational endpoints
South Sudan	External implementation discipline through UN/NGO delivery under extreme fragility

Countries with ≥3 Health projects and >50% S+ rate, or demonstrated escape from the Zero Club pattern.

7.5 The Comparator Test: Same Countries, Different Models

The strongest defense of the Zero Club pattern is that these are structurally difficult countries where health outcomes are inherently hard to achieve. If a second institution — with a different delivery model, different accountability structure, and different performance framework — also fails in the same countries, the defense holds. If it succeeds, the Bank's delivery model is the variable. The evidence is more nuanced than either story.

The Global Fund OIG Evidence

The Global Fund's Office of the Inspector General conducts independent audits of grant performance in individual countries, rating objectives on a four-tier scale: Effective, Partially Effective, Needs Significant Improvement, and Ineffective. OIG audits are available for six Zero Club countries. In three, the Global Fund also fails:

Angola (OIG, 2020): 'Global Fund grants in Angola are performing poorly.' Programmatic data: Ineffective. Domestic financing, community engagement, and implementation: Ineffective. Financial management: Partially Effective. HIV deaths increased 29 percent, TB cases increased 19 percent, malaria incidence increased 48 percent since 2010. The OIG concluded that 'these are systemic issues that will not be addressed with short-sighted tactical fixes.' The Global Fund invested $300 million in Angola since 2004. The Bank committed $131 million to health. Neither institution produced its intended outcomes.

DRC (OIG, 2016 and 2019): The 2016 audit found procurement and supply chain controls 'ineffective' and financial controls 'needing significant improvement.' The 2019 follow-up upgraded supply chain to Partially Effective but financial management remained at Needs Significant Improvement. A 2020 financial review of PSI's grant found $25.3 million in non-compliant expenditure from a $77.5 million sample. The Global Fund has signed $2 billion in grants with DRC since 2003 — making it one of the Fund's three largest portfolios. The Bank committed $982 million to health. Both institutions committed at scale. Neither achieved its performance threshold.

Congo-Brazzaville (OIG, 2022): 'In the past 10 years, little progress has been made in fighting the three diseases. This is a result of both limited national government support and the limited scope of Global Fund grants.' The Bank committed $89 million to health. The Global Fund doubled its allocation. Neither institution's increased commitment changed the trajectory.

Kenya presents the more complex case. The 2015 OIG audit rated financial, health services, and product risks as 'generally effective' — the Global Fund's highest rating. The 2022 follow-up found grants 'performing reasonably well' despite COVID-19 disruptions. HIV prevalence fell from 10.5 percent to 6.0 percent. Yet the Bank committed $694 million to health across 8 projects and never achieved Satisfactory. In Kenya, the Global Fund's focused, disease-specific model delivered measurable outcomes while the Bank's broader health system projects did not. The delivery model matters in Kenya. The institutional environment matters in Angola, DRC, and Congo-Brazzaville.

An Aidspan analysis of Global Fund grant performance ratings (2006–2008, 114 countries ranked) found Kenya ranked #110, Congo-Brazzaville #109, and Guinea-Bissau #106 — all in the bottom 10 globally. The historical data predates the current OIG audit system but suggests the pattern of cross-institutional underperformance was already established two decades ago. Rwanda ranked #4.

Gavi, the Vaccine Alliance

Gavi supports routine immunisation in 41 African countries, including all 14 Zero Club countries. Its delivery model is the most focused of the comparators: specific commodity (vaccines), measurable output (children immunised), vertical delivery with cold-chain requirements that impose their own discipline. In 2024, Gavi achieved its fastest vaccine rollout in history — malaria vaccines deployed across 23 African countries. In Burkina Faso — a Zero Club country with 6 health projects and 0% S+ — the malaria vaccine programme contributed to a 32 percent decline in reported malaria cases between 2024 and 2025. Gavi delivered a measurable reduction in malaria in a country where the Bank committed $270 million to health and never achieved Satisfactory.

The Global Financing Facility

The GFF is the most analytically significant comparator because it is hosted by the World Bank itself. Launched in 2015, it supports 36 partner countries through country-led Investment Cases. Its 2024 report shows that 96 percent of GFF partner countries reduced maternal mortality. The GFF operates through the same World Bank systems, the same country offices, the same IDA resources. The difference is the model: country ownership of an Investment Case rather than Bank-designed project objectives; aligned financing rather than standalone project budgets; focused results chains rather than broad system transformation.

The Cross-Institutional Finding

The comparator asymmetry. The comparator institutions are not directly equivalent to World Bank health IPFs. Their mandates are narrower, their objectives more measurable, and their financing more vertically structured. None attempts the system-wide institutional transformation that Bank health IPFs typically design for. Precisely for that reason, they illuminate the central finding: focused delivery models with enforceable accountability mechanisms appear more capable of producing measurable outcomes in low-capacity environments than broad transformational designs.

But the OIG evidence adds a crucial qualification. In Angola, DRC, and Congo-Brazzaville, the Global Fund's focused model also fails. The institutional environment overwhelms the delivery model. In Kenya, the Global Fund succeeds where the Bank does not — delivery model matters. The evidence suggests two tiers: countries where institutional constraints are so severe that no external institution delivers consistently (Angola, DRC, Congo-Brazzaville); and countries where institutional capacity exists but the Bank's design model does not match it (Kenya). The comparators do not uniformly outperform the Bank. They outperform it where the institutional foundation is sufficient for focused delivery to work. Where that foundation is absent, all institutions struggle.

THE COMPARATOR FINDING

The Global Fund's own OIG rated Angola's grants as 'performing poorly,' DRC's supply chain as 'ineffective,' and Congo-Brazzaville's progress as 'little in 10 years.' In these countries, both institutions fail. In Kenya, the Global Fund succeeds where the Bank does not. The evidence suggests that institutional environment determines the floor — below which no delivery model works — while delivery model determines the ceiling in countries where basic institutional capacity exists.

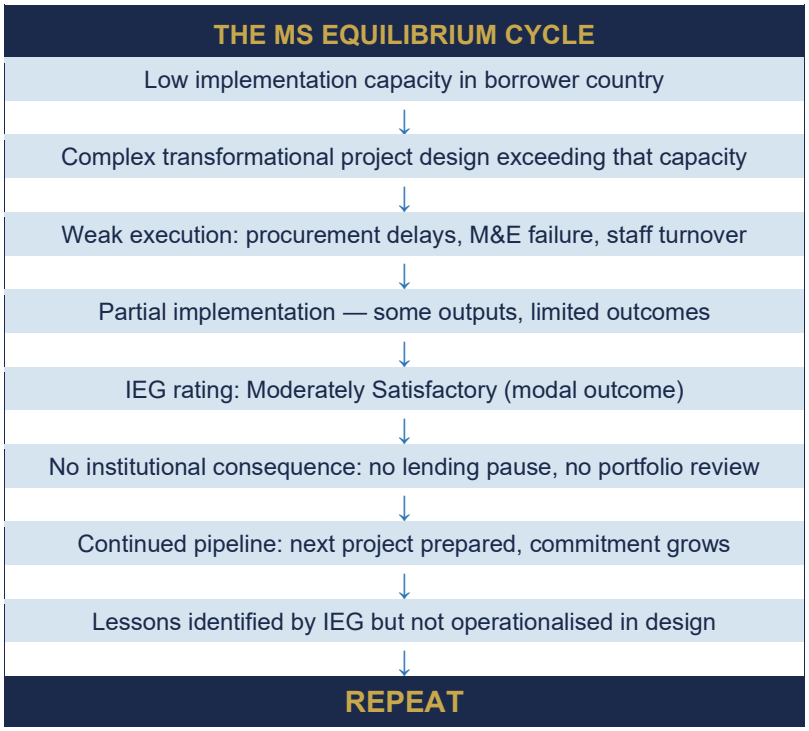
The Bank's health IPF model operates as though the floor has been reached. In half the Zero Club, it has not.

8. What This Paper Does Not Claim

The paper does not claim that no health benefits occurred in the 14 Zero Club countries; that mortality did not improve; that Bank financing was unnecessary; or that fragile states should not receive health support. Many Zero Club projects delivered partial value — that is what Moderately Satisfactory means. Some projects prevented deterioration that would otherwise have been worse.

The paper does claim that the Bank's own evaluation benchmark — Satisfactory, the standard that IFC and MIGA use as their operative threshold — was never reached in these 14 countries across 55 projects and $3 billion over up to 36 years. The same lessons were documented by IEG across multiple evaluation cycles without design modification. Project design repeatedly exceeded implementation capacity. Commitment growth was not tied to demonstrated outcome performance. The Bank's own Human Capital Index shows improvement that did not visibly exceed regional trajectories. These are findings of institutional pattern, not of country failure.

The Moderately Satisfactory Equilibrium



The rating distribution across the 55 Zero Club projects — 29 MS, 17 MU, 7 U, 2 HU — reveals what may be the central institutional dynamic of the entire series. MS is not failure. It is not success. It is the equilibrium: enough delivery to avoid an Unsatisfactory rating; enough disbursement to sustain the pipeline; insufficient achievement for transformation; but institutionally acceptable. The Bank's corporate reporting counts MS as success. IEG's

definition says it is not. The gap between these two standards is the space in which the Zero Club persists.

The SOML evidence. The mechanics of the MS equilibrium are visible in forensic detail in a single operation: Nigeria's Saving One Million Lives PforR (P146583, $500M). A companion case study on mdbreform.com documents how GAVI found procurement fraud in the implementing ministry twelve months before the Bank approved $500 million. Zero of thirty-six states published the quarterly budget reports that were a core programme objective. The Innovation Fund disbursed $0. Performance bonuses were paid to senior FMOH officials from IDA funds. When the fraud was acknowledged in December 2019, the resolution was administrative: a revised Programme Implementation Manual, no Integrity Vice Presidency investigation, and the rating was upgraded from Moderately Unsatisfactory back to Moderately Satisfactory. The rating upgrade was not a reflection of improved health outcomes. It was a reflection of the Bank's acceptance that a process had been agreed. This is the MS equilibrium operating in real time.

The evaluation evidence. Two formal IEG evaluations — Improving Effectiveness and Outcomes for the Poor in HNP (2009) and World Bank Group Support to Health Services (2018) — documented the same findings a decade apart: persistent underperformance in Africa, weak health system strengthening, access improving in 70 percent of projects but quality in only 46 percent. The Bank can get people to clinics. It cannot ensure that what happens inside the clinic is adequate. The 2009 evaluation identified the pattern. The 2018 evaluation confirmed it. The design model did not change. This is institutional amnesia operating at the level of formal IEG sector evaluations, not merely at the level of project lessons.

The MS equilibrium is self-reinforcing. A project rated MS does not trigger institutional consequence — no lending pause, no portfolio review, no design revision. The next project is prepared while the current one is still rated MS. Commitment grows. The diagnosis grows more sophisticated. The lessons are identified, documented, and repeated. The design model does not change. This is not a claim about individual failure. It is a claim about a system that has normalised partial achievement as its operating standard.

9. Conclusion

The Health Zero Club documents the second major pattern of sustained underperformance in the World Bank's Africa portfolio. Fourteen countries, 55 projects, $3.0 billion committed, zero percent Satisfactory. The Bank's own independent evaluation system has never rated a single Health project in these countries as having achieved its objectives satisfactorily.

The MTI Zero Club (Part 9) documented failure in the DPF instrument. The Health Zero Club tests whether the same pattern holds for IPFs — investment projects with procurement, disbursement conditions, results frameworks, and supervision missions that DPFs lack. In these 14 countries, it does. The instrument is not the binding constraint.

The findings are broadly consistent with previous IEG evaluations of health services and FCV environments. The 2018 IEG evaluation of World Bank Group Support to Health Services found that expanding access to services was generally easier than improving service quality and health-system performance — a pattern visible in the Zero Club's own data, where access improved across multiple projects but quality and system-level objectives were rarely achieved. Earlier IEG evaluations of fragile and conflict-affected states similarly identified persistent gaps between project design ambitions and implementation capacity. The Health Zero Club reaches a similar conclusion through a different lens: across 55 projects in 14 countries, the binding constraint appears to be the interaction between project design, implementation discipline, and actual institutional capacity rather than the choice of financing instrument alone.

IEG (2018). World Bank Group Support to Health Services: Achievements and Challenges. IEG (2014). World Bank Group Assistance to Low-Income Fragile and Conflict-Affected States.

Kenya is the case that should trouble the institution most. Not a fragile state. Not a post-conflict environment. A lower-middle-income country with functioning institutions and a health sector that coordinates multiple bilateral and multilateral programmes. The Bank committed $694M across 8 health projects over 36 years. Not once Satisfactory.

The evidence suggests that institutional environment and design-capacity mismatch dominate instrument choice in explaining performance. The six failure cases in the broader series (Nigeria, Angola, Ghana, DRC, MTI Zero Club, Health Zero Club) and the two success cases (Somalia, Rwanda) point toward a common variable: not good governance in the abstract, but enforced implementation discipline — whether through strong state capability (Rwanda) or external constraint (Somalia). Where that discipline exists, the Bank delivers. Where it does not, the pattern documented here persists regardless of instrument, GP, or project design. The evidence therefore points away from country characteristics alone and toward the interaction between institutional capacity, implementation discipline, and project design as the determinants of whether development finance produces its intended outcomes.

THE MISSING COUNTERFACTUAL

What would happen if countries with three consecutive below-Satisfactory health projects automatically triggered an independent portfolio review before another health project could be approved? The Bank has no such mechanism. IEG documents the lessons. Management acknowledges them. The next project is prepared. The counterfactual — a system that connects outcome performance to lending authority — has never been tested because no institutional actor has an incentive to propose it.

THE BOTTOM LINE

The Health Zero Club is not 14 separate country failures. It is one institutional pattern repeated 55 times across two instruments. The MTI Zero Club showed that DPF conditionality rewards legal compliance over functional change. The Health Zero Club shows that IPFs — with their procurement, results frameworks, and supervision — produce the same result in the same countries. The Moderately Satisfactory equilibrium absorbs failure into partial achievement and renders it invisible in corporate reporting. The lessons are identified, documented, and repeated. The design model does not change.

Annex: The Fourteen Zero Club Countries

Each profile summarises the Health portfolio, the IEG diagnosis, and the failure mode. Full IEG lesson text for all 55 projects is available in the companion data annex on mdbreform.com.

DRC — $982M, 4 projects, 0% S+

Post-conflict administrative vacuum

P-Code	Project Name	FY	Rating	Commit
P082516	Multisectoral HIV/AIDS Project	FY2004	U	$102M
P088751	Health Sector Rehabilitation Support	FY2006	MS	$150M
P145965	Human Development Systems Strengthening	FY2014	MS	$15M
P147555	Health System Strengthening for Better MNCH	FY2015	MS	$715M

Source: IEG ICRR/PPAR database, March 2026.

Diagnosis. The country with the largest health commitment in the Zero Club. The HIV/AIDS project (FY2004, $102M, U): ‘Excessive ambition led to an inappropriate plan to cover the entire country with a wide scope of interventions, even though weak institutional systems made achievement of those objectives impossible.’ The $715M maternal health project (FY2015) achieved MS despite being the single largest health IPF in Africa — the scale of commitment did not translate into Satisfactory achievement. IEG: ‘The goal of targeting hard-to-reach communities must be adequately supported by a realistic, on-the-ground assessment of capacity to deliver services.’

Learning evidence. Partially. The FY2015 operation was better designed. But $982M committed to MS suggests volume pressure persists.

Kenya — $694M, 8 projects, 0% S+

Non-fragile state · Devolution without capacity

P-Code	Project Name	FY	Rating	Commit
P001312	POPULATION IV	FY1990	U	$36M
P001339	HEALTH REHABILITATION	FY1992	MU	$31M
P001333	Sexually Transmitted Infections Project	FY1995	MS	$52M
P066486	Decentralised Reproductive Health	FY2001	U	$98M
P070920	HIV/AIDS Disaster Response	FY2001	MU	$50M
P081712	Total War Against HIV/AIDS (TOWA)	FY2007	MS	$135M
P074091	Health Sector Support	FY2010	MS	$100M
P152394	Transforming Health Systems	FY2016	MS	$191M

Source: IEG ICRR/PPAR database, March 2026.

Diagnosis. The anchor case. Eight projects over 36 years. A non-fragile, lower-middle-income country with functioning institutions. Ratings: 2 U, 2 MU, 4 MS. Commitment grew from $36M to $191M. IEG identified identical themes across three decades: data systems inadequate, devolution outpaced capacity, legal covenants substituted for genuine ownership. The Decentralised Reproductive Health project (FY2001, $98M, U) was designed for a devolved system that did not exist. Kenya (FY2016, $191M, MS): ‘Implementation of projects in a devolved context raises the level of complexity. Staffing in the PMT was not sufficient to support and supervise 47 counties.’

Learning evidence. No. The same lessons documented in FY1990 were restated in FY2016. The design model did not change.

Burkina Faso — $270M, 6 projects, 0% S+

PBF collapse · Fragility transition

P-Code	Project Name	FY	Rating	Commit
P000287	HEALTH/NUTRITION	FY1994	MS	$29M
P000308	POPULATION/AIDS CONTROL	FY1994	MU	$30M
P071433	HIV/AIDS Disaster Response	FY2002	MU	$22M
P093987	Health Sector Support & AIDS	FY2006	MS	$48M
P119917	Reproductive Health Project	FY2012	MU	$42M
P164696	Health Services Reinforcement	FY2019	MU	$100M

Source: IEG ICRR/PPAR database, March 2026.

Diagnosis. Six projects over 25 years. The RBF pilot showed promise until government policy changed and 'undermined implementation of the RBF pilot before it was completed.' The most recent project (FY2019, $100M, MU) expanded to support displaced populations but faced 'frequent changes in leadership in key institutions.' Parallel financing through free healthcare and strategic purchasing created confusion. IEG: 'Monitoring indicators which do not sufficiently point to outcomes can lead to a focus on implementation goals rather than on development outcomes.'

Learning evidence. Partially. Design adapted to fragility. But four of six projects rated MU.

Cameroon — $253M, 4 projects, 0% S+

Scaling without learning · PBF overreach

P-Code	Project Name	FY	Rating	Commit
P000411	Health, Fertility and Nutrition	FY1995	HU	$15M
P073065	Multi-Sectoral HIV/AIDS	FY2001	HU	$50M
P104525	Health Sector Support Investment	FY2008	MS	$25M
P156679	Health System Performance Reinforcement	FY2016	U	$163M

Source: IEG ICRR/PPAR database, March 2026.

Diagnosis. The harshest ratings in the Zero Club: 2 HU, 1 U, 1 MS. Cameroon (FY1995, $15M, HU): ‘Overly complex and risky projects are unwise to embark upon, even in the presence of political pressure to do something.’ Cameroon (FY2001, $50M, HU): ‘Emphasis on a high output of action plans, without proper attention to content and context.’ Cameroon (FY2016, $163M, U): ‘Scaling up too quickly can limit the ability to adopt previous learning.’ Three decades. Three damning IEG verdicts. Commitment grew from $15M to $163M.

Learning evidence. No. The FY2016 operation repeated the FY1995 lesson at eleven times the commitment.

Sierra Leone — $140M, 5 projects, 0% S+

Post-conflict · Ebola disruption

P-Code	Project Name	FY	Rating	Commit
P002422	Integrated Health Sector Investment	FY1996	MS	$70M
P073883	HIV/AIDS Response Project	FY2002	MU	$15M
P074128	Health Sector Reconstruction	FY2003	MS	$20M
P110535	Reproductive and Child Health	FY2011	MS	$20M
P153064	Health Service Delivery & System Support	FY2016	MU	$16M

Source: IEG ICRR/PPAR database, March 2026.

Diagnosis. Five projects including two post-conflict operations. The HIV/AIDS Response (FY2002, $15M, MU): NGO capacity was overestimated. The Health Service Delivery project (FY2016, $16M, MU): ‘Greater weight needs to be placed on the capacity and the readiness of implementing agencies.’

Learning evidence. Partially. Post-Ebola operations were more focused. But no project achieved S.

Angola — $131M, 3 projects, 0% S+

Weak institutional capacity · Oil-cushion

P-Code	Project Name	FY	Rating	Commit
P000048	HEALTH	FY1993	U	$20M
P083180	HIV/AIDS, Malaria and TB Control	FY2005	MS	$36M
P111840	Municipal Health Service Strengthening	FY2010	MS	$75M

Source: IEG ICRR/PPAR database, March 2026.

Diagnosis. Angola (FY1993, $20M, U): 'Projects in countries with weak institutional capacity should be less complex, and provide more extensive institutional support and technical assistance.' The Municipal Health Strengthening project (FY2010, $75M, MS) showed progress through Bank flexibility during a yellow fever outbreak but could not sustain institutional change.

Learning evidence. Partially. The FY2010 project built a Bank-government partnership. But none achieved S.

Central African Republic — $98M, 3 projects, 0% S+

Extreme fragility · PBF admin cost

P-Code	Project Name	FY	Rating	Commit
P073525	Multisectoral HIV/AIDS Project	FY2002	MS	$17M
P119815	Health System Support Project	FY2012	MS	$28M
P164953	Health System Support & Strengthening	FY2019	MS	$53M

Source: IEG ICRR/PPAR database, March 2026.

Diagnosis. Three MS-rated projects — the mildest failure mode in the Zero Club. All achieved partial results. The most recent (FY2019, $53M, MS) used PBF but administrative costs ‘accounted for 35 percent of PBF costs’ because verification required international NGOs. CAR is the closest Zero Club country to achieving S.

Learning evidence. Partially. Adaptive management is evident. But PBF cost structures remain unsustainable.

Congo-Brazzaville — $89M, 3 projects, 0% S+

Oil-cushion · PBF discontinuation

P-Code	Project Name	FY	Rating	Commit
P077513	HIV/AIDS and Health (MAP)	FY2004	MU	$19M
P106851	Health Sector Services Development	FY2008	MS	$40M
P143849	Health Sector Project	FY2014	MU	$30M

Source: IEG ICRR/PPAR database, March 2026.

Diagnosis. Congo-Brazzaville (FY2014, $30M, MU): ‘Health services under PBF were discontinued due to the lack of funding that resulted from a sharp decline in oil prices.’ PBF was entirely dependent on external financing and collapsed when oil revenues fell.

Learning evidence. No. PBF sustainability was not addressed between FY2008 and FY2014.

Eritrea — $86M, 3 projects, 0% S+

Isolated state · Limited engagement

P-Code	Project Name	FY	Rating	Commit
P043124	Health Project	FY1998	MU	$22M
P065713	HIV/AIDS, Malaria, STD & TB Control	FY2001	MS	$40M
P094694	HIV/AIDS, TB, Malaria & Repro. Health	FY2005	MS	$24M

Source: IEG ICRR/PPAR database, March 2026.

Diagnosis. Two MS and one MU across $86M. Operations were conducted under severe constraints including a border conflict with Ethiopia. IEG noted community-level health delivery showed promise but government systems were too centralised to sustain it.

Learning evidence. Limited. Only three projects over seven years. No subsequent health lending evaluated.

Lesotho — $74M, 7 projects, 0% S+

Small state · Hospital PPP experiment

P-Code	Project Name	FY	Rating	Commit
P001395	HEALTH/POP. II	FY1990	MU	$18M
P053200	Health Sector Reform	FY2000	MU	$17M
P087843	HIV and AIDS Capacity Building	FY2005	MS	$5M
P076658	Health Sector Reform Phase 2	FY2006	MS	$6M
P104403	New Hospital PPP	FY2008	MS	$6M
P107375	HIV/AIDS Technical Assistance	FY2010	MS	$5M
P114859	Health Sector Performance Enhancement	FY2013	MS	$16M

Source: IEG ICRR/PPAR database, March 2026.

Diagnosis. Seven projects — the most in the Zero Club after Kenya — across only $74M. Five MS and two MU. The New Hospital PPP (FY2008, $6M, MS) was an unusual experiment in public-private partnership for hospital management but was not replicable at scale. Health system reform projects documented persistent challenges in a small state dependent on SACU revenues.

Learning evidence. Partially. Small-scale operations remained pragmatic. But seven projects over 23 years without one S suggests a structural ceiling.

Guinea-Bissau — $65M, 3 projects, 0% S+

Fragile state · Rapid response failure

P-Code	Project Name	FY	Rating	Commit
P001002	Social Sector Project	FY1993	MS	$10M
P035688	National Health Development Program	FY1998	MU	$49M
P073442	HIV/AIDS Global Mitigation Support	FY2004	U	$7M

Source: IEG ICRR/PPAR database, March 2026.

Diagnosis. Guinea-Bissau (FY2004, $7M, U): ‘The perceived need for rapid response must be balanced by careful design.’ ‘Creating a new institution is a complex and time-consuming task, particularly in a fragile state.’ The National Health Development Program (FY1998, $49M, MU) was the largest commitment but rated MU.

Learning evidence. No. Only three projects. The rapid-response lesson was not operationalised.

Rwanda — $50M, 2 projects, 0% S+

Early portfolio · Pre-transformation

P-Code	Project Name	FY	Rating	Commit
P002237	Health & Population	FY1991	MS	$20M
P071374	Multi-Sectoral HIV/AIDS	FY2003	MU	$30M

Source: IEG ICRR/PPAR database, March 2026.

Diagnosis. Two early projects: one MS, one MU. Both predate Rwanda's governance transformation. The Multi-Sectoral HIV/AIDS project (FY2003, $30M, MU) was designed during the post-genocide transition. Rwanda's subsequent health achievements — community health workers, Imihigo performance contracts, PBF integrated with national systems — occurred through later operations not captured in the Zero Club. Rwanda is evidence that the Zero Club pattern is escapable.

Learning evidence. N/A. Rwanda's later success is documented in the Rwanda paper (mdbreform.com/rwanda/).

Comoros — $21M, 2 projects, 0% S+

Small island state · Capacity floor

P-Code	Project Name	FY	Rating	Commit
P000596	Population & Human Resource	FY1994	MU	$13M
P052887	Health Project	FY1998	U	$8M

Source: IEG ICRR/PPAR database, March 2026.

Diagnosis. Two projects: one MU, one U. Both faced the structural constraint of an extremely small island state with limited health infrastructure. IEG noted that project complexity exceeded what Comoros could absorb.

Learning evidence. Limited. Only two projects. The capacity floor was identified but not addressed.

São Tomé & Príncipe — $18M, 2 projects, 0% S+

Small island state · Mildest failure

P-Code	Project Name	FY	Rating	Commit
P002542	Health & Education	FY1992	MU	$11M
P075979	Social Sector Support	FY2004	MS	$6M

Source: IEG ICRR/PPAR database, March 2026.

Diagnosis. Two projects: one MU, one MS. The Social Sector Support Project (FY2004, $6M, MS) showed that small, focused operations could achieve partial results even in the smallest Zero Club country. The earlier Health & Education project (FY1992, $11M, MU) was too broad for the institutional environment.

Learning evidence. Partially. The FY2004 operation was more realistic in scope.

Addendum: Six Countries with One Project, Zero Satisfactory

The following six countries each have a single IEG-evaluated health project in Sub-Saharan Africa that returned a below-Satisfactory rating. They are excluded from the Zero Club by the methodology (which requires at least two evaluated projects to confirm the pattern is systemic rather than project-specific), but their combined record — six countries, six projects, $299M, zero Satisfactory — is consistent with the broader pattern. Including them would raise the total to 20 countries in Sub-Saharan Africa where the Bank has never achieved a Satisfactory health outcome.

Project Name	Country	FY	Rating	Commit
Gabon Fiscal Consolidation & Inclusive Growth OP	Gabon	FY2018	MU	$200M
Botswana National HIV/AIDS Prevention Support	Botswana	FY2009	MS	$50M
Swaziland Health, HIV/AIDS and TB Project	Eswatini	FY2011	MS	$20M
Maternal and Child Health and Nutrition Services	Togo	FY2014	MU	$14M
Cabo Verde HIV/AIDS Project	Cabo Verde	FY2002	MS	$9M
Equatorial Guinea Health Improvement Project	Equatorial Guinea	FY1992	U	$6M

Source: IEG ICRR/PPAR database, March 2026. Note: Gabon project is classified under Health GP in IEG database. Eastern Africa regional project (P111556, $114M, MS) excluded as it is a multi-country operation.

Gabon ($200M, MU): The largest single-project entry. The operation targeted fiscal consolidation and inclusive growth including health spending. Rated MU: fiscal adjustment proceeded but service delivery improvements were not achieved at project closure.

Botswana ($50M, MS): HIV/AIDS prevention support in a middle-income country with high HIV prevalence. Rated MS: prevention messages reached target populations but behaviour change was limited. A functioning health system did not translate into a Satisfactory project rating.

Eswatini ($20M, MS): Health, HIV/AIDS, and TB project. Rated MS: service coverage improved but sustainability was contingent on external financing. The CPIA for Eswatini shows no improvement in health-relevant criteria over the same period.

Togo ($14M, MU): Maternal and child health and nutrition services. Rated MU: disbursement delays and weak community-level implementation. Togo has a second evaluated health project under a different classification that appears in the regional data.

Cabo Verde ($9M, MS): HIV/AIDS project in a small island state with relatively strong institutions. Rated MS: awareness improved but behavioural outcomes were limited. The smallest commitment in the single-project group.

Equatorial Guinea ($6M, U): The oldest entry — FY1992. Health Improvement Project rated Unsatisfactory in a resource-rich state with weak institutional capacity. No subsequent IEG-evaluated health lending.

The methodological exclusion of these six countries is appropriate. A single MU or MS rating could reflect project-specific factors — an unexpectedly strong or weak TTL, a particular

political window, a one-off external shock. The Zero Club methodology requires the pattern to be confirmed by at least two independent IEG evaluations. But the fact that no single-project country achieved Satisfactory either — zero for six — is consistent with the paper's broader finding that the Bank's health IPF model faces structural delivery constraints across Sub-Saharan Africa that are not confined to the 14-country Zero Club.

The Case Study Series

#	Paper	Committed	S+	Status
#1	Nigeria Water	$1.8bn	0.4%	Published
#2	Angola DPF	$2.2bn	0%	Published
#3	South Africa Eskom	$9.13bn	—	Published
#4	Ghana FCI	~$500M	0%	Published
#5	DRC Portfolio	$6.7bn	6.1%	Published
#6	DRC Inga	$107M+	—	Published
#7	Somalia	~$900M	89%	Published
#8	Rwanda	$4.6bn	68.5%	Published
#9	Zero Club — MTI	$10.4bn	0%	Published
#10	Zero Club — Health	$3.0bn	0%	This paper

Companion papers: Policy Without Performance (DPO paper, March 2026), Institutional Power Architecture (April 2026), Game Theory / Institutional Equilibrium (April 2026), The Rwanda Model (May 2026), Five Instruments One Finding (June 2026).

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