THE GFF APPROACH IN FRAGILE SETTINGS

OVERVIEW

The task team on fragile settings presented an initial paper at the February 2016 meeting of the Investors Group. The Investors Group recommended focusing on lessons learned from the GFF's current work in fragile settings as well as the GFF's potential role in emergency preparedness and building resilience. Based on this, the task team (see Annex 2) developed a work plan consisting of Investment Case analysis, country case studies, a literature review, and recommendations to the Investors Group. Based on this, this paper explores the context for the GFF's work in fragile settings (including the needs, challenges, and opportunities), the lessons from the GFF's current engagement in fragile areas, and the options for future engagement. The task team convened two meetings to discuss the work's content and recommendations.

SUMMARY OF FINDINGS

Fragile settings have particularly high reproductive, maternal, newborn, child and adolescent health (RMNCAH) needs, and implementing smart, scaled, and sustainable financing is often challenging in these contexts. The GFF is already actively working in fragile settings, with four of the initial 16 countries supported by the GFF Trust Fund classified as fragile and a further three having zones of fragility. Twenty four of the 62 (39%) GFF eligible countries are classified by the World Bank as fragile or conflict-impacted. The question, therefore, is not *if* the GFF will engage in fragile settings, but *how*.

Decision-making on this should be grounded in both the GFF's experience to date and in a thorough understanding of the GFF's comparative advantages vis-à-vis other actors in the development landscape. This paper does this and reviews a number of possible approaches that the GFF could take in fragile settings, ultimately proposing the following:

- First and foremost, the GFF should maintain its current approaches, given that the experience to date indicates that a number of aspects of the GFF model are well-suited to fragile settings; to complement this, more efforts should be placed on documenting and disseminating experiences;
- The GFF should employ a country-tailored approach to intensifying its existing approaches in fragile settings, in ways that respond to the specific needs of individual fragile settings but have no or low additional costs;
- In the future, as additional funding becomes available and further learning occurs in the current fragile settings, new approaches that require additional resources should be considered;
- There are areas outside the GFF's comparative advantages and therefore should not be considered.

ACTION REQUESTED

The Investors Group (IG) is asked to give guidance on the proposed approach.

INTRODUCTION

There is a disproportionate burden of reproductive, maternal, newborn, child and adolescent health (RMNCAH) challenges in fragile settings, with countries classified as fragile having been less successful in reaching the Millennium Development Goals and having worse RMNCAH indicators than non-fragile countries.

The GFF is already actively working in fragile settings, with four of the initial 16 countries supported by the GFF Trust Fund classified as fragile and a further three having zones of fragility. The question, therefore, is not *if* the GFF will engage in fragile settings, but *how*. This paper examines the context within which the GFF is operating (including both challenges and opportunities) and the experience to date, and uses these to propose options for future engagement in fragile settings.

SMART, SCALED, AND SUSTAINABLE FINANCING FOR FRAGILE SETTINGS: MAJOR NEEDS AND CHALLENGES, BUT ALSO OPPORTUNITIES

Major needs

RMNCAH indicators in fragile settings lags behind those of non-fragile low and middle income countries (LICs and MICs). In countries the World Bank classifies as fragile, conflict, and violence impacted[1], the infant mortality rate is double that in non-fragile LICs and MICs (52 per 1,000 live births as compared to 26 per 1,000 live births). Maternal mortality in fragile, conflict, and violence-impacted states is almost four times that in non-fragile LICs and MICs (434 per 100,000 live births vs. 143 per 100,000 live births). Twelve of the 20 countries with the highest maternal mortality ratios and neonatal mortality rates in the world in 2015 are also among the 35 countries the World Bank classifies as fragile, conflict, and violence impacted.

Women, children, and adolescents are particularly vulnerable in fragile settings. Women's increased risk of mortality and morbidity is a function of weakened health systems and reduced access to services exacerbated by gender inequity, increased risk of gender-based violence, and reduced access to adequate nutrition. Children and infants are at increased risk based on vulnerability to infectious disease and malnutrition, limited access to health services, and the increased health risks their mothers are exposed to, limiting their ability to care for their children.[2]

Several recent developments have increased international attention to the risk fragility poses to population health and development. First, fewer fragile countries reached the Millennium Development Goals, including those for reducing maternal, infant, and under-five mortality, than non-fragile countries and more fragile countries were seriously off-track for reaching these goals than their non-fragile counterparts.[3] Failure to reach MDGs also highlighted that global poverty is increasingly concentrated in fragile states.[4]

[1] The World Bank Group, "World Bank Microdata Library"; The World Bank, "2017 Harmonized List of Fragile Situations."
[2] Algasseer et al., "Status of Women and Infants in Complex Humanitarian Emergencies"; United Nations Every Woman Every Child, "Global Strategy for Women's, Children's and Adolescents' Health – EveryWhere 2020 Vision."
[3] OECD, *States of Fragility 2015*.
[4] Ibid.; World Bank, *Global Monitoring Report 2015/2016*.

Second, all three countries heavily affected by the West African Ebola outbreak (Liberia, Guinea, and Sierra Leone) are currently (Liberia and Sierra Leone) or were until recently (Guinea) classified as fragile. Weak health systems were both unable to respond to the outbreak and struggled to maintain routine care during the outbreak. This highlighted the need for strong, resilient systems for health that can cope with emergencies while maintaining routine functions.

Third, humanitarian refugee crises in the Middle East and North Africa stemming from conflicts in Syria, Iraq and Yemen, have drawn attention to the particular risks to women and children in humanitarian emergencies as well as the significant funding gaps in these settings. Recent figures from the High-Level Panel on Humanitarian Financing estimate at least a US $15 billion financing gap.[5] This is expected to rise based on predictions that the cost of humanitarian assistance will double by 2030.[6]

Finally, it is important to recognize that overall trends are clear: poverty and underdevelopment are increasingly going to be concentrated in fragile settings. Currently 21% of the global poor live in fragile states, but this is expected to increase to 50% in 2030.[7]

Major challenges

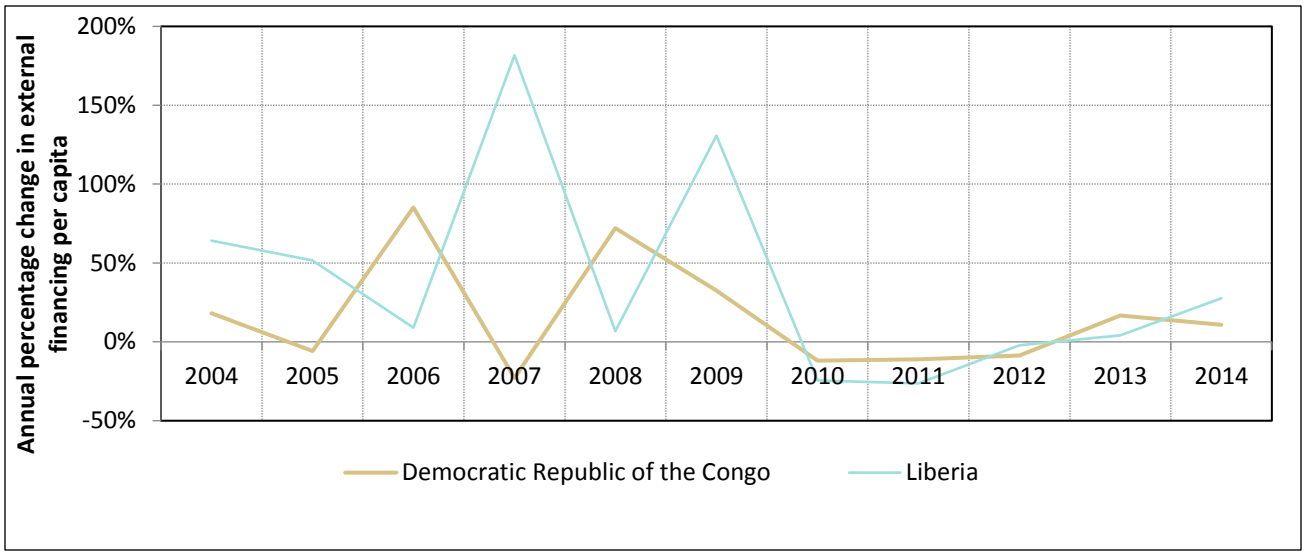
Smart financing

All GFF countries face challenges ensuring that financing for RMNCAH is "smart"[8], but fragile settings confront some particular difficulties.

According to the Organization for Economic Cooperation and Development (OECD), Official Development Aid (ODA) to fragile states tends to be more volatile than aid to non-fragile countries.[9] Figure 1 shows this volatility in Liberia and Democratic Republic of Congo (DRC).[10] The unpredictability inherent in aid volatility limits recipient governments' capacity for medium to long term planning, implementation capacity and ability to maximize resources. Volatility is a particular problem after crises as humanitarian responses tend to receive more funding than the post-crises period, often resulting in sharp funding falls as acute crises end.[11]

[5] "High-Level Panel on Humanitarian Financing, Report to the Secretary-General. Too Important to Fail – Addressing the Humanitarian Financial Gap."
[6] One Campaign, "Financing Stability: How Humanitarian and Development Assistance Must Rise to the Challenge."
[7] Bank Group, IDA 18: Special Theme: Fragility, Conflict, Violence, IDA Resource Mobilization Department, May 31 2016.
[8] See the GFF Business Plan for more information about smart, scaled, and sustainable financing.
[9] OECD, "Fragile States 2014: Domestic Resource Mobilization in Fragile States."
[10] Data used from: World Health Organization. "Global Health Expenditure Database." World Health Organization, 2016. http://www.who.int/health-accounts/ghed/en/.
[11] Newbrander, Waldman, and Shepherd-Banigan, "Rebuilding and Strengthening Health Systems and Providing Basic Health Services in Fragile States"; Canavan and Vergeer, *Fragile States and Aid Effectiveness*.

Figure 1: Aid Volatility in DRC and Liberia



A large number of vertical programs further compound government stewardship challenges and health financing fragmentation. Vertical programs can alleviate the burden of specific diseases and offer measureable, quickly achievable results, but involve substantial investment in duplicative non-integrated systems that fail to strengthen the overall health systems and build resilience.[12]

Scaled financing

RMNCAH needs in fragile settings, particularly those of vulnerable populations such as refugees, are underfunded. Despite worse health indicators than their non-fragile counterparts, between 2005 and 2011 development partners did not increase funding to fragile countries at the same rate as in stable LICs.[13] Patel et al. (2016) found that conflict-affected countries received lower reproductive health official development aid (ODA) disbursements than those not impacted by conflict.[14] In emergencies, donors are unable to raise sufficient funds for response. In Syria, the health component of the Humanitarian Response Plan requires approximately US$441 million, yet only one fifth (US$82 million) is funded.[15]

Sustainable financing

Currently, most health financing in fragile settings is focused on immediate needs and is not sustainable in the long-term. Much of the external aid in fragile settings is off-budget. Governance capacity is often weak and overstretched, underpinned by limitations in stewardship and management capacity.[16] In part

[12] Ranson et al., "Promoting Health Equity in Conflict-Affected Fragile States"; Ayee, "Social Inclusion and Service Delivery in a Fragile and Post-Conflict Environment in Africa."
[13] Graves, Haakenstad, and Dieleman, "Tracking Development Assistance for Health to Fragile States."
[14] Patel et al., "Tracking Official Development Assistance for Reproductive Health in Conflict-Affected Countries."
[15] OCHA, "Syrian Arab Republic: OCHA."
[16] Tulloch, Raven, and Martineau, "HUMAN RESOURCES FOR HEALTH IN POST-CONFLICT SETTINGS"; Eldon, Waddington, and Hadi, "Health Systems Reconstruction and State-Building"; Newbrander et al., "A Tool for Assesåsing Management Capacity at the Decentralized Level in a Fragile State"; Brinkerhoff, "Developing Capacity in Fragile States," February 2010.

due to these challenges, development and humanitarian assistance in fragile settings often bypass national governments, instead going directly to national and international non-state actors.[17] This off-budget funding further limits national governments' ability to develop and execute health financing strategies and plans, making sustained health programming and financing difficult.

Fragility also negatively impacts country capacity to generate revenue. Due to limited absorptive capacity, few tax collection mechanisms, and low investor confidence, fragile states have little fiscal capacity to generate revenue from domestic resources.[18] These conditions limit private sector engagement, further constraining economic growth. On top of this, health tends to receive less attention and fewer resources than other sectors in fragile settings, in favor of security priorities.[19] These conditions limit the potential of domestic resource mobilization (DRM) for health.

Financing opportunities

While there are major challenges to smart, scaled, and sustainable financing in fragile setting, there are also new financing opportunities that can address some of these challenges, particularly with regard to scaled financing.

Dedicated fragile setting financing

Given the growing humanitarian and development needs in fragile settings, donors are increasingly prioritizing programing in fragile settings. For example, the UK Aid Strategy in November 2015[20] allocated 50 percent of all Department for International Development (DFID) spending to fragile states and regions.

IDA18 replenishment includes a doubling of resources to fragile states with a new window for refugees

The World Bank Group's IDA18 replenishment affecting low and lower middle income countries will be finalized in December 2016 and includes a strong emphasis on funding for fragile settings. The proposed replenishment asks for US$14.4 billion for fragile states for the coming three years, which is a doubling of IDA commitments under IDA 17. IDA 18 also includes a proposed US$2 billion Regional IDA sub-window to finance projects benefiting refugees and their host communities in IDA countries.[21] This money would assist several countries in Africa hosting large refugee populations, but may not be available to host countries in MENA who are grappling with the fallout of the Syria crisis (e.g., Lebanon, Jordan).

The availability of increased IDA funding for fragile states has direct implications for the GFF. Since GFF Trust Fund grants are linked to IDA commitments at the country level, an increased IDA envelope can enable countries to spend more resources on RMNCAH.

17 Anderson et al., "Measuring Capacity and Willingness for Poverty Reduction in Fragile States"; Dietrich, "Bypass or Engage?"
18 OECD, "Fragile States 2014: Domestic Revenue Mobilisation in Fragile States, Paris, OECD-DAC, 2014."; Giordano and Ruiters, "Closing the Development Finance Gap in Post-Conflict and Fragile Situations"; Ohiorhenuan and Stewart, *Post-Conflict Economic Recovery*.
19 Ayee, "Social Inclusion and Service Delivery in a Fragile and Post-Conflict Environment in Africa
20 Department for International Development, UK Aid: Tackling Global Challenges in the National Interest, November 2015. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/478834/ODA_strategy_final_web_0905.pdf
21 World Bank Group, IDA 18: Special Theme: Fragility, Conflict, Violence, IDA Resource Mobilization Department, May 31 2016.

World Bank Group Global Concessional Financing Facility

At the United Nations General Assembly in September 2016, the World Bank launched a new Global Concessional Financing Facility (CFF) that aims to raise US$6 billion in concessional financing for development projects in middle income countries affected by refugee crises around the globe over the next five years.[22] Each dollar of grant money raised for this facility will be leveraged to raise four dollars of concessional financing. The initial focus of the CFF is on Lebanon and Jordan, but the fund will be available to other middle income countries dealing with the consequences of protracted crises.

While the CFF initiative is to be lauded as an innovative approach to help bridge the large humanitarian financing gap, early experience is suggesting that recipient countries are more willing to borrow for host communities than refugees. This creates an opportunity to link grants for refugees residing in host countries to CFF financing for the host communities. For example, a proposed project in Lebanon to provide a basic package of health services to host communities that is being supported through concessional financing can be augmented by a grant to expand the same package to refugees, 80 per cent of whom are women and children.

GFF ENGAGEMENT IN FRAGILE SETTINGS

Overview of engagement

The GFF's mandate to address countries with the highest RMNCAH needs necessarily involves engagement in fragile settings. Twenty four of the 62 (39%) GFF eligible countries are classified by the World Bank as fragile or conflict-impacted. The GFF is currently working in a number of fragile settings: of the GFF's 16 initial countries, four (DRC, Liberia, Myanmar, and Sierra Leone) are classified by the World Bank as fragile, three (Cameroon, Kenya, and Nigeria) have fragile areas, and one (Guinea) was until recently classified as fragile and has a health system severely stressed by the Ebola outbreak. Given this current engagement in fragile settings, the question for the GFF going forward is not *if* the GFF will engage in fragile settings, but *how*.

The GFF's work in fragile settings has been guided by a common set of principles and approaches, as initially outlined in the GFF Business Plan. This means that the GFF engagement has been driven by an emphasis on providing smart, scaled, and sustainable financing aimed at improving the health outcomes of women, children, and adolescents, rather than a specific emphasis on addressing the root causes of fragility or explicitly attempting to build the resilience of health systems (with a few exceptions, as discussed later).

Despite fragility not being an explicit focus of the GFF's work to date, experience has shown that the GFF model is well-suited to fragile settings. In particular, the following elements are employed across GFF countries but are particularly relevant in fragile settings:

- An emphasis on health financing reforms;
- A data-driven approach that focuses on equity;
- A horizontal approach that supports health systems strengthening;

[22] https://menafinancing.org/overview/concessional-financing-facility

- A concerted effort to improve coordination, particularly of financiers;
- A multisectoral lens.

The way in which each of these has been used in fragile settings is discussed below with examples from the GFF experience to date. The annex to this paper contains case studies on the GFF's experience in the DRC, Liberia, and Nigeria, to complement the experiences highlighted below.

Importantly, the GFF process is country-led, which means that countries can draw upon different parts of the business model to address different aspects of fragility in accordance with local needs. This ability to adapt to each individual context is particularly critical in fragile settings, as fragility is an overarching concept encompassing a diverse set of situations. One important element of this is the ability to support decentralized implementation at the sub-national level, something that has be a focus in a number of GFF countries.

Country experiences

Health financing reforms

Working on health financing in fragile settings is complicated by the uncertainty and rapidly changing contexts of many fragile settings, which make long-term planning challenging. The GFF has addressed this through a combination of working on full-fledged health financing strategies where the conditions are ripe and focusing on concrete reforms that can be implemented despite challenging situations.

In the DRC, for example, while work is underway on the long-term agenda, the GFF has also prioritized some immediate steps that can improve efficiency and the use of current resources. This includes scaling up strategic purchasing through a results-based financing approach (which is also useful for strengthening local autonomy) and addressing weaknesses public financing management so as to improve budget execution rates (which are extremely low). Strategic purchasing was also employed in conflict-affected northeastern Nigeria, in that case to move quickly to address emergency service delivery needs. During the next phase of the health financing work in Nigeria the focus will be on working with the Ministry of Finance to establish a sustainable mechanism for long term financing of primary care, including in the conflict affected areas of the country.

Liberia is another country in which work is progressing on a health financing strategy. At the same time there is an immediate focus on a key reform, the implementation of a revised resource allocation formula that assigns resources to counties as determined by evidence-based needs and as such improves equity between counties. There is also a focus on improving donor harmonization and reducing aid volatility.

A data-driven approach that focuses on equity

A data-driven approach is at the heart of the GFF's approach to developing Investment Cases. Equity is a particular focus, with equity analysis and tools (e.g., UNICEF's EQUIST) employed in many countries to ensure that disadvantaged and vulnerable populations are identified and prioritized. This approach was not explicitly designed to address fragility, but the effect of its application has been a significant focus on fragile parts of GFF countries.

In Cameroon, for example, the analytical work underpinning the Investment Case led to a focus on four regions, three of which comprise the conflict-affected northern part of the country. Kenya is another country in which the use of a data-driven approach during the development of the country's Investment Framework led to a focus on a set of counties that include the most fragile parts of the country because they had the worst RMNCAH indicators. In Nigeria, IDA and GFF Trust Fund financing focused on the states impacted by Boko Haram because the health indicators there are particularly poor, and explicitly includes tailored approaches based on the extent to which the health system is disrupted, to ensure an equitable level of service delivery in the region.

Although there is generally significant overlap between the parts of a country that are highlighted by a data-driven equity approach and those identified by focusing on fragility, the experience in the DRC provides an interesting case study in the fact that they are not necessarily identical. The analytical work for the DRC Investment Case identified 14 provinces with high RMNCAH needs, which includes one of the provinces most affected by the protracted conflict in the DRC (South Kivu) but not the adjacent province that is also grappling with long-term instability but that has managed to maintain better health indicators (North Kivu).

A horizontal approach that supports health systems strengthening

Health service delivery in fragile settings is generally constrained, as a result of both supply and demand challenges. Although the GFF is focused on improving the health outcomes of women, children, and adolescents, it does not approach this in a verticalized manner but rather looks at both the specific RMNCAH interventions that are needed and the broader health systems strengthening that is necessary to improve health outcomes.

This focus on strengthening systems is particularly beneficial in fragile settings, where capacity constraints are often significant. Specific investments in health systems strengthening are identified in Investment Cases and so focus on different building blocks of the health system depending on individual national contexts.

Human resources for health has been a major emphasis in a number of countries, including to address the challenge of ensuring adequate numbers of trained health personnel in fragile parts of countries. In the DRC, for example, the health workforce is inequitably distributed between provinces. To address these challenges the Investment Case outlines plans to redistribute personnel through a health worker census and revised incentives. This is paired with strategies to increase health worker quality through training programs for medical and logistics personnel, improved training program quality control.

The DRC is also grappling with challenges related to another building block, with weak provincial and health facility level governance a key bottleneck that limits RMNCAH service delivery. To address this, the Investment Case includes capacity building for district and provincial level managers, along with improved systems for accountability to communities. In Kenya, capacity in the underserved and conflict-impacted counties is particularly weak. To address this, two key donors are establishing trust funds to finance capacity building for county level health sector governance.

Liberia is confronting major challenges with another building block, infrastructure, to the extent that 29% of the population must walk more than five kilometers to reach a health center. The Liberia Investment

Case prioritizes increasing the number of health facilities in rural areas and more effectively reaching people in rural areas through a nation-wide community health worker program.

In the DRC, Liberia, and Kenya there are few age-disaggregated data, resulting in limited information on health among the large youth populations. In each of these countries, steps to improve data systems are outlined in the Investment Cases, with particular attention to disaggregated data to increase information on underserved populations.

Across all of these areas, the entry point was not addressing fragility but the investments driven through the process of developing and implementing Investment Cases will nonetheless make significant contributions to building capacity in ways that over the medium to long term contribute to improving systems and institutions and thereby contribute to addressing some of the root causes of fragility. When combined with the equity focus described above, these health systems strengthening efforts can also contribute to reducing inequity, which is a significant driver of fragility.

Most of the GFF countries have taken this broader approach to strengthening capacity rather than explicitly addressing fragility by building the resilience or focusing on preparedness. The major exception to that is Liberia, where the GFF process has been shaped by the context of the Ebola epidemic. As a result, the Investment Case includes as one of its six priority investment areas "emergency preparedness, surveillance, and response", with a particular focus on integrated disease surveillance and response. The Investment Case also incorporates the lessons learned from the Ebola response by including an explicit focus on community engagement. These efforts should improve the resilience of the health sector and so reduce its susceptibility to shocks in the future.

Concerted effort to improve coordination, particularly of financiers

A cornerstone of the GFF approach is the process of aligning financing behind a set of priorities identified in the Investment Case. This approach is particularly valuable in the context of fragile settings, as they are often characterized by a proliferation of donors and a lack of coordination that results in both gaps in financing key areas and duplication of efforts.

This process has occurred in almost all of the fragile settings in which the GFF is currently operating, and has been highlighted as a key way in which the GFF adds value by a number of senior officials in these countries, such as the ministers of health of the DRC and Cameroon.

One particular technique that the GFF is using to promote this is resource mapping, in which key financiers share information about their current and planned financial contributions in an effort to understand the gaps and duplications related to Investment Case priorities. This has the potential to be especially valuable in fragile contexts given the generally weak information systems in these countries and the limits on the part of governments to gather this information given the fact that a significant volume of external financing in fragile contexts is off-budget.

Although most of the emphasis to date in GFF countries has been at the national level, sub-national efforts to improve coordination are underway in the DRC and Kenya. In the DRC, the emphasis has been on working at the provincial level to implement a "single contract" system to simplify relationships between provincial governments and donors to fund a basic package of services, which helps ensure donor

harmonization and reduces off-budget financing. In Kenya, counties are developing their own investment cases within the parameters set out by the national Investment Framework.

Multisectoral lens

Half of the gains in child mortality from 1990-2014 were as a result of non-health factors such as economic growth, education, and sanitation.[23] In fragile settings, health sector weaknesses are compounded by limitations across other sectors.[24] The GFF's multisectoral mandate is therefore an important strength in fragile settings. The full potential of this approach has not yet been realized, but there are some emerging examples of multisectoral collaboration in the GFF context that show the exciting opportunities for further work.

Adolescent health has emerged as a major area of multisectoral collaboration. In Liberia there is clear recognition that adolescent health programs are required to collaborate with the ministry of education and youth, sports, and culture to improve reproductive health education, while in Cameroon conditional cash transfers will target adolescent girls and a results-based financing pilot in the education sector is included in the Investment Case.

Nutrition features in every Investment Case developed to date, with approaches that include addressing household food security in Kenya and using community-based and mobile service delivery teams in Cameroon, the DRC, Liberia, and northeastern Nigeria. In the DRC, the Investment Case includes a significant focus on water and sanitation services.

In an interesting example of an attempt to work on something that is emerging as a key longer-term driver of health outcomes – and which is also a rapidly increasing cause of fragility – Bangladesh is starting to look at the intersection of climate change and health.

There is considerable scope to increase multisectoral efforts in these and in other sectors, such as infrastructure and transport. In both Liberia and Kenya road and water sanitation weaknesses are described as underpinning health system challenges, yet the Investment Cases do not incorporate multisectoral action in these areas even though the World Bank and other partners may be addressing these as part of broader engagement in the country (such as the case of Kenya where road development to the northern counties is a major priority) highlighting further opportunities to address multi-sectoral aspects as part of the GFF.

OPTIONS FOR FUTURE ENGAGEMENT IN FRAGILE SETTINGS

As the preceding section demonstrates, the GFF is already making significant contributions in fragile settings. However, given the needs and the trends discussed earlier, there is a key strategic question about how the GFF engagement in fragile settings should evolve over time.

[23] Kuruvilla, S., et al., "Success factors for reducing maternal and child mortality", Bull World Health Organ 2014;92:533–544.
[24] Kruk et al., "Rebuilding Health Systems to Improve Health and Promote Statebuilding in Post-Conflict Countries"; Li, "The Immediate and Lingering Effects of Armed Conflict on Adult Mortality"; Ghobarah, Huth, and Russett, "The Post-War Public Health Effects of Civil Conflict"; Pavignani and Colombo, "Analysing Disrupted Health Sectors."

Decision-making on this question should be grounded in both the GFF's experience to date and in a thorough understanding of the GFF's comparative advantages vis-à-vis other actors in the development landscape. This section reviews a number of possible approaches that the GFF could take in fragile settings, and proposes the following:

- First and foremost, the GFF should maintain its current approaches, given that the experience to date indicates that a number of aspects of the GFF model are well-suited to fragile settings; to complement this, more efforts should be placed on documenting and disseminating experiences;
- The GFF should employ a country-tailored approach to intensifying its existing approaches in fragile settings, in ways that respond to the specific needs of individual fragile settings but have no or low additional costs;
- In the future, as additional funding becomes available and further learning occurs in the current fragile settings, new approaches that require additional resources should be considered;
- There are areas outside the GFF's comparative advantages and therefore should not be considered.

Each of these four areas is described in turn below.

Maintain current approaches

As reviewed above, many of the GFF's current approaches appear to be appropriate for fragile settings. Maintaining these approaches described above therefore should be at the core of the GFF's approach in fragile settings going forward.

To maximize the benefits of this approach, a stronger emphasis will be placed on capturing and disseminating lessons learned, as documentation of what works in fragile settings is extremely limited. The GFF places a strong emphasis on results measurement and so as part of this will support implementation research that builds the evidence base on what works in fragile settings. There is broad need for evidence in relation to specific goals such as equity, efficiency, and effectiveness, developing specific competencies such as capacity and health systems resilience, techniques including contracting out and technical assistance, and the most effective methods to improve each component of the health system.[25] South-to-south networks can also support innovative approaches and effective implementation strategies in fragile settings.

Intensify existing approaches: country-tailored fragility approach

The GFF's current approach in fragile states addresses many key challenges across fragile settings. To more systematically and rigorously address these challenges at no or minimal cost, the GFF will employ a country-tailored fragility approach. The approaches described below are extensions of the GFF's current work rather than entirely new activities and so represent an intensification of the existing engagement with fragile settings rather than a departure from it. Given that, they can be implemented at no or minimal cost.

[25] Waldman and Lopez-Acuna, "Neglected Health Systems Research: Health Policy and Systems Research in Conflict-Affected and Fragile States"; Woodward et al., "Health Systems Research in Fragile and Conflict-Affected States."

Being "country-tailored" means that the approaches below will not be systematically rolled out in all GFF countries. Rather, these represent a menu of options that can be deployed selectively based on the context of individual countries, which is particularly important given the diversity of fragile settings.

Contribute to strengthening the humanitarian-development nexus in areas of GFF comparative advantage

In the global discourse on fragility, the conceptual approach to the relationship between the humanitarian and development spheres is evolving, out of recognition that conflicts and displacements are increasingly protracted. Additionally, in many countries, the distinction between "humanitarian" and "development" phases is increasingly blurry.

These shifts necessitate thinking about long-term development issues even in the midst of acute crises, rather than assuming that these can be thought of as two distinct phases. The GFF is well-positioned to contribute to this in two ways.

First, the GFF can build on its existing health financing work to more proactively support ministries of finance and of health to smooth the transition between humanitarian and development financing. As illustrated earlier in the cases of the DRC and Liberia, fragile settings often have highly volatile aid flows, much of which are off-budget. This would go beyond the support that the GFF is currently providing but fits well with the broader GFF agenda of focusing on smart financing.

Second, the GFF can engage further in supporting the coordination of development partners. In most acute crises, well-established protocols exist for coordination (typically led by the UN Office for the Coordination of Humanitarian Affairs) and (as discussed further below) the GFF would not seek to replicate that work. However, these structures are often not set up to facilitate the link to a long-term development agenda, and in particular do not contribute to strengthening the stewardship of ministries of finance and health or facilitating the links between humanitarian and development actors. In line with the GFF's broader emphasis on supporting coordination among financiers, the GFF could more proactively engage on this agenda to strengthen coordination mechanisms and contribute to sustainable financing.

Explicitly contribute to strengthening response capacity, by building resilient health systems and linking with emergency preparedness efforts

Health systems strengthening is an important pillar of the GFF approach, but as discussed earlier these efforts are generally not aimed specifically at building response capacity by strengthening resilience or addressing emergency preparedness. In fragile settings, the GFF can more proactively work with countries to include an explicit focus on strengthening response capacity.

Refining the Investment Case guidance note to highlight some of the ways that response capacity can be strengthened is one approach that can be implemented without additional costs, and then supporting countries that are particularly interested in this area to learn and document lessons. For example, Kruk et al.[26], describe five key attributes of a resilient health system: awareness, diversity, self-regulation, integration, and adaptability. Many of the investments described in Investment Cases will contribute to

[26] Kruk et al., "What Is a Resilient Health System?"

improving these, but more benefits could be garnered if more deliberate thinking about these aspects informed the selection of priorities in Investment Cases.

For example, results-based financing features in many Investment Cases and this can play an important role in strengthening modularity (i.e., the ability of a system to function in a decentralized manner if parts are cut-off in an emergency), but at the moment this is rarely positioned as an explicit strategy to improve the resilience of the system, which means that it may be a missed opportunity to be considered in a country's broader preparedness approach.

Finally, based on country-specific needs, GFF can link with other emergency preparedness and resilience-building bodies such as the Pandemic Emergency Facility (PEF) to incorporate emergency preparedness in Investment Cases.

Ensure focus on RMNCAH is retained in case of crisis

Any stable GFF country in a development stage may unexpectedly face a crisis that brings it into the humanitarian phase. The GFF's attention to RMNCAH is critical, as women, children, and adolescents in countries that experience emergencies face disproportionate burdens in the transition from development to a humanitarian phase. The GFF is ideally suited to ensuring that the financial needs associated with the health of women, children, and adolescents in emergencies are adequately addressed in government systems (e.g., through dedicated contingency funds or budgetary line items) and the elaboration of longer-term sustainable plans that will last beyond the humanitarian phase.

Encourage programming on the fertility-fragility nexus

The relationship between fertility and fragility is complicated and operates in both directions. Research suggests a higher rate fertility rate among women but lower survival rate among children in some sub-groups in fragile settings (e.g., refugees).[27] This has significant implications both on the RMNCAH status of women and children as well as the broader contours of the current debates on migration. This particular vulnerability needs to be explored further which can be supported through analytical work and addressed through pilot interventions.

On the other hand, addressing high fertility rates can be an important component of harnessing the demographic dividend and starting a virtuous cycle (particularly when paired with efforts such as educating girls and creating jobs for youth) that puts countries on a trajectory to economic growth and increased societal stability. There are considerable opportunities to scale up approaches to address the root causes of fragility by addressing high fertility, such as in countries in the Sahel. These are also countries that are traditionally underfinanced from both domestic and external resources as compared to the RMNCAH needs.

[27] Verwimp P and J V Bavel, "Child Survival and Fertility of Refugees in Rwanda", *European Journal of Population*, June 2005, Volume 21, Issue 2, pp 271–290. Available at http://link.springer.com/article/10.1007/s10680-005-6856-1

Possible new approaches in future, as additional resources are available

As the GFF learns from its current approach in fragile settings, achieves results in stable countries, and mobilizes additional resources, it will be worth considering expanding the approaches that the GFF uses in fragile settings. The approaches described below would come with additional costs so are not proposed for the time being but could add value if additional financing is available.

Consider fragility-specific innovative financing

In fragile settings, innovative resource mobilization mechanisms can be key to address constraints on domestic resource mobilization and provide financial support in case of natural disasters or other emergencies. Innovative financing mechanisms in humanitarian contexts are relatively new and there is currently limited evidence on their effectiveness, but there are some innovations that could be particularly well-suited to fragile settings. For example, development impact bonds as a means to frontload financing to scale up priority interventions and to share risk across public and private sectors. As part of the Investment Case in Cameroon, a development impact bond will be used to support kangaroo mother care. Similarly some humanitarian organizations, such as the International Committee of the Red Cross, are exploring using humanitarian impact bonds in fragile settings.

Prioritize fragility in country selection

The Investors Group agreed to a set of criteria to guide the selection of new countries at its third meeting in Geneva in June 2016. Fragility was not a criterion included at that time, but it could be added to strengthen the GFF's focus on fragility.

Change GFF country eligibility criteria to capture high-need populations not in GFF eligible countries

The universe of countries that are part of the GFF are those contained on the list of 75 countries facing high RMNCAH burdens, as assessed by the Countdown to 2015 initiative. The list was further narrowed by removing high and upper-middle income countries, leaving 63 countries. Jordan, Lebanon, Libya, and Syria are not included among these, but are grappling with serious emergencies (or the consequences of serious emergencies in neighboring countries) that are seriously undermining health systems and resulting in increased health risks for women, children, and adolescents. Syria has particular poor RMNCAH indicators and is experiencing such a significant deterioration in its economy that it may switch from being a country that can only access IBRD financing to become IDA eligible in the near future. The GFF eligibility list could be expanded to include these countries or others with populations with high needs.

Areas outside the GFF's comparative advantage

Some approaches have arisen in discussions related to fragility that have been assessed and determined to be outside the GFF's comparative advantage and so will not be pursued.

Rapid fund disbursement in emergencies

The GFF is not designed to quickly disperse funds for emergency situations. While the facility can finance targeted projects in short timeframes, as happened in northeastern Nigeria, it is important to differentiate between this type of non-emergency response and the quick release of funds over a period of days which is required for an emergency response. Explicit commitment to engaging in the latter may put the GFF in a difficult position if it is unable to quickly release lifesaving funds for emergency situations.

Humanitarian actor coordination

Although the GFF has a key role in supporting the coordination of financiers, in fragile settings that are confronted with acute crises this is under the mandate of the United Nations Office for the Coordination of Humanitarian Affairs, which facilitates the humanitarian cluster system, coordinating actors by sector. As discussed above, in some countries the GFF may have a role in supporting links between humanitarian and development financing, but this is a specific role that does not conflict with the broader mandate of OCHA.

Non-RMNCAH health needs

Fragile settings often feature increased morbidity and mortality due to a broad range of factors (e.g., injuries). The GFF is not the appropriate vehicle to take on this broader agenda.

ANNEX 1: CASE STUDIES

Democratic Republic of Congo (DRC)

Context

In recent years, the Democratic Republic of Congo (DRC) made considerable progress in reducing the under-five mortality rate from 148 deaths per 1,000 live births in 2007 to 104 deaths in 2013. Despite this reduction, the maternal mortality ratio remains high with 846 deaths per 100,000 live births, and other reproductive, maternal, newborn, child, and adolescent health (RMNCAH) indicators continue to perform poorly with, for example, contraceptive prevalence rate remains low at 8.1% for all women of reproductive age and 7.8% for women in a union (unmet needs is estimated at 28%) and chronic malnutrition among children under-five persisting at 43 percent (DHS, 2013-2014). This poor performance is further compounded by economic and geographic disparities. For example, only 36 percent of children in the poorest wealth quintile are immunized compared to 65 percent in the richest wealth quintile (DHS, 2013-2014).

Health expenditure is low, $13 per capita compared to $140 in sub-Saharan Africa. The health sector is financed primarily by external sources (40%), out of pocket (40%), and limited public financing (15%). Prevalence of catastrophic health expenditures at national level is 9.2%, however the incidence of catastrophic payment is 12.1 among the poorest 20% (lowest quintile).

RMNCAH service availability, demand, and quality are low. For example, most health facilities do not provide family planning services with almost 33% of health zones covered by functional family planning services. Furthermore, despite the fact gender based and sexual violence (GBSV) is quite high nationwide with 52% of women who have experienced physical violence, 27% sexual violence and more than 52% spousal violence, integrated GBSV is almost inexistent country wide except for the conflict areas (such as the Kivus). Health facility-level governance capacity is limited. Information systems are weak, with efforts to expand CRVS still in the early stages. The health workforce is insufficient (<2 midwives/1000 people) with key specialties not available such as midwives. Furthermore, the health workforce is poorly distributed, poorly remunerated (only 30% of the workforce receives a salary), and under-qualified. Supply chains is fragmented and inefficient with limited capacity, thus resulting in poor availability and quality of drugs, particularly at the provincial level. Despite the health sector challenges, community engagement in the health sector is relatively strong.

GFF added value

The Investment Case takes an equity lens, prioritizing 14 underserved provinces. Strong accent is put on improving public financial management (PMF) to improve budget planning, execution and maximize funding utilization. Efficiency is at the core of the Investment Case, which will be done through resource pooling at the provincial level via contracting in through the "Contrat Unique" (single contract), the objective of which is to have a one budgeted plan of activities at the provincial health administration that is financed through domestic and external funds available at the province level with single fiduciary arrangements (accountability, internal audits, etc.), and one single monitoring and evaluation system as well as reporting mechanism. The single contract system addresses fragmentation of external funding at the provincial level and improve accountability and transparency. In turn, performance based funding

(PBF) contributes to financial management capacity development at the health facility level (both health centers and referral hospital) though open data, autonomy, and payment made to bank accounts rather than in cash and strong verification and counter verification systems. Along with PBF, fixed fee for service schedule will be defined (including cost of drugs) will be defined and subsidized in order to make services more accessible to the population. Access to a minimum package of services will be made available to the most vulnerable free of charge in an effort to make services accessible to the bottom 20% of the population. Along with equity and efficiency gains, both of these financing reforms improve governance and transparency.

To address state capacity challenges, the Investment Case outlines a strategy to build institutional capacity by reinforcing existing system and putting performance contracts at all the level of the health management system to improve the governance and capacity of key actors in the sector focusing on the supply chain, service delivery and provincial health administration. Such emphasis aims at improving provincial governance capacity to manage contracts including accountability systems and community engagement. Community based engagement and incentivization is at the core of the Investment Case, with community platforms being reinforced to not only provide IEC but also RMNCAH services. Multisectoral interventions to address malnutrition and gender based violence are introduced as well interventions to strengthened health information systems, including CRVS. Improvement of the health information system will improve quality of data availability at the provincial and national level on population health status.

How the Investment Case is financed

It is expected that the Investment Case will be financed through government resources as well as a broad ranges of the partners investing in the health sector (and beyond, as some of the activities are outside the health sector and so resources will be drawn from water and sanitation, agriculture and education). To date a new allocation to contribute to filling the gap of the Investment Case has been made by the World Bank, which is investing $150 million in new IDA grant resource in addition to the current $220 m IDA project. A grant from the GFF Trust Fund of US$40 million will be linked to this project.

Liberia

Context

Liberia's health system was severely damaged by the country's civil war and further weakened by the recent Ebola outbreak. Liberia's maternal mortality ratio (1,072/100,000), neonatal mortality rate (26/1,000), and under 5 mortality rate (94/1,000) are high. Challenges run throughout the health system.

Total health expenditure is low with government expenditures well below needs. Out of pocket expenditure is high and regressive. Over fifty percent of Total Health Expenditure (THE) in fiscal year 2011-2012 was from out of pocket expenditures and people in the lowest wealth quintile paid almost as much as those in the highest quintile according to the 2013 Liberia Demographic and Health Survey. External sources provided about eighty percent of the FY 2015/2016 health resources. There are a large number of donors and a need for improved alignment and harmonization. Resource allocations across counties is not evidence based or coordinated, resulting in inequities between counties as well as inefficiencies. There is lack of coordination between community structures and many vertical efforts focusing on different interventions and services.

Both health workforce and supply chains are under-developed. County level leadership, management and governance capacity, as well as accountability systems, require improvement. Data collection and use is limited, particularly disaggregated data. Quality of care at health facilities requires particular improvement with, for example, only 30% of newborns receiving skilled care. There are large regional disparities in service delivery. The south-east region is the poorest and least-served, while generally facilities are concentrated in urban areas. Liberia has a large young population and high teenage pregnancy with limited availability of adolescent health services.

These health service delivery and demand challenges are underlined by weaknesses outside of the health sector including limited road infrastructure and low secondary school enrolment, particularly among girls. Gender inequity, including gender-based violence, is a major issue in Liberia.

Several innovative initiatives helped stop the country's Ebola outbreak including a successful community mobilization effort and a public-private partnership to mobilize resources towards stopping the outbreak.

GFF added value

The Liberia Investment Case was developed in a process designed to be inclusive and government-led. It prioritizes programs to six underserved counties, addressing geographic inequities, with phasing to additional counties depending on available resources. The case also prioritizes adolescent health services. The Investment Case defines a coordinated, efficiency focused financing strategy moving towards UHC. An improved resource allocation formula aims to allocate resources across counties based on needs.

Health systems strengthening and capacity building are incorporated in all aspects of the case. Technical assistance (TA), peer-to-peer learning, and increased support for health facilities based on performance assessments are proposed in the Investment Case. It also outlines results based financing (RBF) at the county and health facility level. The Investment Case includes multisectoral programming, particularly for adolescent health and addressing GBV norms.

Community engagement is a priority area, based on the Ebola response's successes. Performance measurement and accountability mechanisms are incorporated throughout the Investment Case. Emergency response, specifically strengthened integrated disease surveillance and response systems, as well as a data use and reporting framework, are incorporated within the Investment Case. Disaggregated data collection is also included.

How the Investment Case is financed

The Government of Liberia, US Agency for International Development (USAID), the UK Department for International Development (DFID), the German Government, Japan International Cooperation Agency (JICA), the European Community (EC), the Global Fund for AIDS, TB, and Malaria (GFATM), the World Bank (WB), and the Global Alliance for Vaccines and Immunizations (GAVI) will each support different components described in the Investment Case. The GFF Trust Fund will support this with a US$16 million grant.

Northeastern Nigeria

Context

There is active insecurity in Nigeria's northeastern region. Health services have stopped in some areas and service functionality is limited in others: health facilities are damaged and many health workers have left. Some local administrations have completely collapsed. On top of this, there is substantial internal displacement. Northeastern Nigeria has worse health indicators than most other zones in Nigeria.

GFF added value

The GFF has a regionally focused project aimed at re-establishing health services in the northeastern region using an equity-focused strategy that emphasizes access for the poor. The program uses a tiered approach based on the level of health service disruption due to the conflict, with flexibility to respond to the emergent situation.

In areas with minimal disruption the program supports results based financing (RBF), to ensure service quality and accountability, along with local governance capacity building. In areas with moderate disruption, the program uses RBF with mobile health teams for remote areas. In areas with substantial health service disruption, the program contracts out non-state service providers along with mobile health teams for difficult to access areas. Strengthened community outreach to improve government trust, along with psycho-social support to address the conflict's impacts are important components of the strategy.

The project finances Nigeria's Federal MoH and National Primary Health Care Development Agency (NPHCDA) to contract Civil Society Organizations (CSOs) for health service delivery in target areas. Contract Management and Verification Agencies (CMVAs) manage contracts within local governance areas and Independent Verification Agencies (IVAs) evaluate contract performance. Both CMVAs and IVAs are also CSOs. The State Primary Health Care Development Agency (SPHCDA) selects and manages delivery organizations, CMVAs, and IVAs. State MoHs provide overall stewardship for the project.

How the project is financed

The initial project is financed with 20 million dollars from the GFF Trust Find and 125 million dollars from the International Development Agency (IDA). The GFF has provisionally committed an additional 20 million dollars with IDA funding under consideration for the Investment Case, which will be integrated into the Nigeria National Strategic Development Plan II (NSHDP II).

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ANNEX 2: MEMBERS OF THE TASK TEAM

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