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Health Financing Strategies In Fragile And Conflict-Affected Settings: Lessons From Humanitarian And Development Synergies

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Abstract: *Health financing in fragile and conflict-affected settings (FCAS) presents complex challenges due to weak governance, insecure environments, and limited institutional capacity. Traditional financing mechanisms, which are often rigid and siloed, are inadequate for the dynamic needs of conflict zones. This study analyzes adaptive and hybrid financing models that integrate humanitarian assistance with long-term development approaches to support more resilient health systems. Drawing on case studies from South Sudan, Yemen, and the Democratic Republic of Congo, the analysis highlights the effectiveness of pooled funding, flexible donor strategies, joint planning platforms, and community engagement in improving health service delivery. Findings show that hybrid models are better suited to maintaining continuity, equity, and system responsiveness during protracted crises. Local ownership, especially through participatory planning and accountability mechanisms, is a key enabler of sustainability. However, challenges remain, including short funding cycles, fragmented coordination, and capacity limitations in financial and health information systems. Addressing these barriers requires a shift from isolated interventions toward integrated, inclusive, and long-term financing strategies. The study concludes that institutionalizing humanitarian-development synergies is essential for building adaptive, accountable, and equitable health systems in FCAS. These insights provide valuable guidance for donors, policymakers, and international agencies committed to improving health outcomes in complex emergency settings.*
Keywords: *Health Financing, Fragile Settings, Conflict-Affected Areas, Development Synergy, Policy Analysis.*

INTRODUCTION

Fragile and conflict-affected settings (FCAS) are environments characterized by persistent violence, political instability, weak governance, and disrupted service delivery, including health systems. In such contexts, health infrastructure is often severely damaged, the health workforce is depleted, supply chains are disrupted, and populations are displaced or highly mobile (World Bank, 2022). These conditions create profound barriers to achieving universal health coverage

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(UHC) and ensuring equitable access to essential health services. The World Health Organization (WHO) emphasizes that over 60% of preventable maternal deaths and 45% of child deaths occur in FCAS, underscoring the critical need for targeted financing strategies to sustain health services in these contexts (WHO, 2021).

Health financing plays a pivotal role in shaping the structure and functionality of health systems. However, traditional models of health financing—largely based on predictable budgeting, stable institutions, and long-term policy cycles—are ill-suited to the volatility of conflict zones (Kruk et al., 2015). In FCAS, financing mechanisms must be not only flexible and responsive but also capable of fostering system resilience amidst ongoing disruptions. According to Blanchet et al. (2017), resilience in health systems refers to the capacity to absorb shocks, adapt to change, and transform in response to long-term challenges. Achieving this requires financing models that move beyond emergency response and support longer-term health system strengthening.

Historically health financing in FCAS has been dominated by humanitarian aid, which prioritizes rapid, short-term responses to acute needs. While humanitarian actors play a vital role in saving lives during crises, their interventions are often fragmented, donor-driven, and lack sustainability (Ager et al., 2015). Conversely, development financing—typically channeled through government systems and multilateral institutions—aims to support policy reforms and institutional capacity building. However, development assistance often avoids high-risk FCAS due to perceived instability, weak absorptive capacity, and political sensitivities (OECD, 2020). The disconnection between these two financing streams results in duplication, inefficiencies, and missed opportunities for synergy.

In recent years, there has been increasing momentum toward integrating humanitarian and development financing approaches, especially in protracted crises where humanitarian assistance alone is insufficient (Barber & Bowie, 2008). This integration has given rise to hybrid financing models that combine the flexibility of humanitarian funding with the long-term orientation of development assistance. These models are designed to ensure continuity of care, strengthen

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national institutions, and progressively build more resilient health systems, even in the face of ongoing instability (Clarke & Dercon, 2016).

Several countries have piloted innovative financing arrangements in FCAS. For example, the Health Pooled Fund (HPF) in South Sudan brings together multiple donors under a common financing umbrella, reducing fragmentation and supporting service delivery through non-state actors (HPF, 2021). Similarly, in Yemen, the Emergency Health and Nutrition Project (EHNP), funded by the World Bank, channels resources through UN agencies to sustain critical services while also supporting national planning processes (World Bank, 2020). These examples suggest that adaptive financing mechanisms—those capable of adjusting to changing contexts—are key to enabling effective responses in FCAS.

The COVID-19 pandemic has further highlighted the importance of resilient health financing systems. FCAS faced significant challenges in mobilizing resources for pandemic response due to pre-existing system weaknesses and competing emergencies (UNICEF, 2021). Nonetheless, countries that had previously invested in hybrid financing strategies were better able to maintain essential health services and scale up response efforts. As such, lessons learned from FCAS are not only relevant to conflict zones but also offer broader insights into managing health shocks and ensuring equity in crisis-prone settings (Nishtar et al., 2021).

Despite growing interest in adaptive financing, there remains limited empirical research on how hybrid models function in FCAS and what institutional arrangements are most effective. Issues such as donor coordination, accountability, local ownership, and the role of non-state actors require closer examination. Furthermore, there is a need for policy frameworks that explicitly link humanitarian assistance with system-building goals, rather than treating them as sequential or mutually exclusive phases (Vogus & Graff, 2015).

This study aims to contribute to the evolving discourse on health financing in FCAS by analyzing adaptive financing mechanisms and exploring how humanitarian-development synergies can support health system resilience. Drawing on policy analysis and comparative case studies from South Sudan, Yemen, and the Democratic Republic of Congo, the study highlights practical strategies, implementation challenges, and policy implications. The central argument is that hybrid financing models—rooted in flexibility, collaboration, and long-term vision—are essential for ensuring continuity, equity, and effectiveness in health service delivery in conflict-affected contexts.

METHOD

This study employed a qualitative policy analysis approach using a comparative case study design to investigate health financing strategies in Fragile and Conflict-Affected Settings (FCAS). This approach was chosen for its strength in capturing the complexity of policymaking processes in unstable environments and in facilitating cross-contextual learning through the in-depth exploration of selected cases (Walt et al., 2008).

Data collection was carried out using four complementary techniques. First, document analysis was conducted to examine a range of secondary sources, including peer-reviewed journal articles, reports from major international organizations (e.g., WHO, World Bank, GAVI, and the Global Fund), policy briefs, and strategic health financing frameworks. These documents provided historical, contextual, and policy-relevant data on health financing mechanisms in FCAS (Bowen, 2009).

Case selection was guided by purposive sampling, focusing on three representative countries South Sudan, Yemen, and the Democratic Republic of the Congo chosen based on their prolonged exposure to conflict and the presence of both humanitarian and development financing modalities. The comparative nature of these case studies enabled the identification of common patterns, divergences, and contextual factors influencing the effectiveness of adaptive financing models (Yin, 2018).

Key informant interview data were drawn from previously published interviews, evaluation reports, and stakeholder consultations. These included insights from policymakers, international donors, NGOs, and national health officials, providing practice-based perspectives that complemented the policy documents (Patton, 2015). The analysis was structured using two

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conceptual frameworks: the WHO Health Systems Building Blocks and the OECD-DAC Fragility Framework, which facilitated a systematic examination of how financing strategies influence service delivery, governance, and resilience in conflict-affected health systems (World Health Organization, 2010).

RESULT AND DISCUSSION

The Role of Pooled and Flexible Funding

In fragile and conflict-affected settings (FCAS), health financing systems are often overwhelmed by the volatility and unpredictability of humanitarian needs. Traditional line-item budgeting systems, which are structured, rigid, and designed for stable governance environments, are inadequate in situations where emergencies evolve rapidly and resource needs shift without notice (Clarke & Dercon, 2016). In these contexts, pooled and flexible funding mechanisms have emerged as essential tools for enabling adaptive and coordinated responses across humanitarian and development actors.

Pooled funding refers to a financing mechanism in which multiple donors contribute to a common fund managed by a neutral intermediary or multilateral agency. This structure allows for reduced transaction costs, better alignment of donor priorities, and greater responsiveness to emerging needs (Barber & Bowie, 2008). In South Sudan, for instance, the Health Pooled Fund (HPF) has been instrumental in sustaining essential primary healthcare services across all ten states. Managed by Crown Agents and funded by donors such as the UK Foreign, Commonwealth & Development Office (FCDO), Canada, Sweden, and the European Union, HPF supports over 800 health facilities and has become the cornerstone of health service delivery in a highly unstable context (HPF, 2022).

Similarly, in Yemen, the Yemen Humanitarian Response Plan (YHRP) channels funding through coordinated UN agencies such as WHO, UNICEF, and UNFPA. This approach enhances synergy among international actors while reducing duplication of efforts. Flexible disbursement modalities under the YHRP allow for quick reallocation of resources in response to sudden disease outbreaks, displacement crises, or supply chain disruptions—issues that are endemic in Yemen's conflict zones (UNOCHA, 2021).

These pooled funds provide a buffer against the fragmentation often associated with bilateral aid or project-specific funding. They enhance coordination across sectors—including maternal health, nutrition, and disease surveillance—by aligning actors under a unified strategic framework. Moreover, pooled funding mechanisms typically emphasize local engagement, directing support through national and sub-national implementing partners. This not only builds local capacity but also promotes sustainability beyond donor cycles (OECD, 2020).

An added advantage of flexible funding is the ability to shift financing priorities in real time. During the COVID-19 pandemic, for example, HPF was able to reallocate resources swiftly to support risk communication, procurement of personal protective equipment (PPE), and the training of frontline health workers. These capabilities are absent in traditional health financing approaches, which are constrained by budgetary inflexibility and bureaucratic approval processes (Nishtar et al., 2021).

Nevertheless, pooled funding is not without its challenges. Governance and accountability mechanisms must be robust to prevent mismanagement and ensure transparency. In FCAS, where national institutions are weak or compromised, the role of third-party monitoring becomes vital. Furthermore, donor alignment remains a persistent issue, as some partners prefer earmarked contributions that may distort national priorities or create parallel systems (Bennett et al., 2015).

Indicator	South Sudan (HPF)	Yemen (YHRP)
Fund Managers	Crown Agents (on behalf of FCDO and others)	WHO, UNICEF, UNFPA under UN OCHA
Number of Facilities Supported	800+	Approx. 2,000 (across sectors)
Key Donors	UK, Canada, Sweden, EU	USAID, ECHO, KfW, DFID
Flexibility Level	High – Rapid reallocation within states	High – Responsive to sudden crises
Use of Local Partners	Strong emphasis on local NGOs	Mixed – UN-led with some local subcontracting
Third-Party Monitoring	Yes	Yes (through UN oversight mechanisms)

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Indicator	South Sudan (HPF)	Yemen (YHRP)
COVID-19 Response	Reprogramming of funds for PPE, training	Expanded vaccine cold chain and diagnostics

Table 1. Comparative Overview of Pooled Health Financing Mechanisms in South Sudan and Yemen

The success of pooled and flexible funding mechanisms underscores the necessity of rethinking traditional financing architecture in conflict settings. These mechanisms have not only demonstrated effectiveness in ensuring service continuity, but also in laying the groundwork for long-term health system resilience. As such, they serve as a bridge between emergency relief and sustainable development, embodying the “humanitarian-development-peace nexus” increasingly emphasized in global health discourse (OECD, 2019).

Synergies Between Humanitarian and Development Actors

The divide between humanitarian response and development programming has historically limited the effectiveness and sustainability of health interventions in fragile and conflict-affected settings (FCAS). While humanitarian actors focus on immediate, life-saving interventions, development actors aim to strengthen systems, policies, and governance for long-term impact. The traditional separation of these approaches often results in duplication, resource inefficiencies, and gaps in service continuity (Bennett et al., 2015). To address these issues, hybrid models that foster synergies between humanitarian and development actors have gained prominence as key strategies for building resilient health financing systems.

In the Democratic Republic of Congo (DRC), the implementation of the Global Financing Facility (GFF) alongside ongoing humanitarian support has provided a valuable example of integrated financing. By aligning humanitarian health response with long-term development planning, the GFF initiative has improved maternal, newborn, child, and adolescent health (MNCAH) outcomes in a country plagued by protracted conflict and weak institutional capacity (World Bank, 2021). Instead of waiting for post-conflict stability, the GFF initiative was layered on top of emergency programs, enabling a gradual transition toward nationally owned health priorities.

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Joint planning platforms have been instrumental in facilitating this integration. In the DRC, coordination bodies involving government representatives, donors, humanitarian NGOs, and multilateral agencies meet regularly to harmonize service delivery, pool resources, and agree on shared targets. This approach ensures that investments in emergency response do not operate in isolation, but rather contribute to system strengthening efforts. Such platforms also facilitate resource mapping, reduce overlaps in service provision, and support the scaling of successful interventions (UNICEF, 2021).

One critical area of synergy has been in maternal and child health services. In many conflict-affected provinces, humanitarian actors initially delivered essential MNCAH services through mobile clinics and vertical programs. With GFF's entry, these services were gradually integrated into the formal health system, with capacity-building programs for local health workers, investments in infrastructure, and strengthened health information systems (GFF, 2020). This progression exemplifies the "humanitarian-development-peace nexus," wherein humanitarian action lays the foundation for sustainable health development (OECD, 2019).

Another example is the Humanitarian-Development Nexus Framework implemented by the UN system in coordination with the Congolese Ministry of Health. This model emphasizes joint risk analysis, shared outcomes, and collective accountability. In practice, this has translated into increased coherence in funding strategies and reduced competition between short-term and long-term actors (UNOCHA, 2020). Moreover, joint monitoring and evaluation mechanisms have helped track progress and make iterative adjustments to programming based on real-time data (UNDP, 2021).

Despite these gains, challenges remain. Humanitarian and development actors often have different operational cultures, funding cycles, and accountability frameworks. Humanitarian agencies are usually funded through short-term, flexible instruments, while development aid is typically tied to multi-year planning and government systems (Kharas et al., 2018). Misalignment in objectives and timelines can hinder coordination unless explicitly addressed through joint frameworks and inclusive governance.

To visualize the synergy, the figure below illustrates how GFF and humanitarian platforms interact across three key stages: emergency response, system integration, and capacity transfer.

Figure 1. *Humanitarian-Development Synergy Pathway in the DRC*

This synergy approach is not exclusive to the DRC. Similar models have been piloted in countries such as Somalia, Yemen, and South Sudan, where humanitarian and development actors have collaborated under country-specific compacts or sector-wide approaches (ICRC, 2020). These examples reinforce the idea that resilience is not achieved by sequential transitions, but through concurrent and coordinated investments.

Fostering synergies between humanitarian and development actors enables more strategic, coherent, and sustainable health financing in FCAS. It ensures that humanitarian interventions build toward long-term system goals, rather than operating as isolated responses. For global health policymakers and donors, institutionalizing these synergies through joint planning mechanisms, flexible financing, and inclusive governance remains critical.

Local Ownership and Community Involvement

Building health system resilience in fragile and conflict-affected settings (FCAS) requires more than just increased financial inputs. Legitimacy, inclusive governance, and local ownership are critical dimensions that determine whether health financing mechanisms are sustainable, equitable, and responsive to the needs of affected populations (Kruk et al., 2015). Without community trust and engagement, even the best-funded initiatives risk failure due to limited uptake, weak accountability, and cultural disconnect.

Evidence from South Sudan, Yemen, and the Democratic Republic of Congo (DRC) reveals that financing mechanisms are most effective when they incorporate local actors—including civil society organizations, traditional leaders, community health workers, and decentralized authorities—into planning, implementation, and monitoring processes. Such inclusive approaches not only promote contextual relevance but also enhance program transparency and community resilience (Blanchet et al., 2017).

For instance, in the DRC, local health committees known as Comités de Développement Sanitaire (CODESA) serve as essential community structures that bridge the gap between formal health systems and the populations they serve. These committees participate in budgeting decisions, oversee facility-level service delivery, and facilitate dialogue between citizens and providers. Donor-supported financing platforms such as the Global Financing Facility (GFF) have increasingly recognized and funded such community-led accountability structures (GFF, 2020).

In South Sudan, humanitarian partners working under the Health Pooled Fund (HPF) have piloted models that involve local councils in service prioritization and resource allocation. Feedback loops between local leaders and facility managers have improved responsiveness to pressing health needs—particularly in hard-to-reach and conflict-prone areas (HPF, 2022). Similarly, in Yemen, local NGOs have acted as implementing partners in the Yemen Humanitarian Response Plan (YHRP), enabling culturally adapted interventions and improving access in high-risk zones (UNOCHA, 2021).

One promising avenue is Community-Based Health Insurance (CBHI), which has shown potential to strengthen domestic resource mobilization and risk pooling in fragile contexts. Though still limited in scale, pilots in the DRC and Yemen have demonstrated that, with adequate subsidies and governance support, CBHI can expand financial protection for vulnerable populations (World Bank, 2021). Key success factors include community sensitization, local claims management, and transparent fund administration.

Additionally, social accountability mechanisms such as scorecards, citizen report cards, and participatory planning tools have proven valuable in elevating community voices and promoting

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demand-side governance. These tools not only improve service satisfaction but also incentivize local health authorities to perform better and respond to feedback (UNDP, 2021). Incorporating such mechanisms into national financing strategies strengthens the legitimacy and efficiency of public health investments.

Figure 2. *Levels of Community Involvement in Health Financing in FCAS*

Despite these advances, significant barriers persist. Tokenistic participation, weak institutional capacity, and donor-driven timelines often limit meaningful community engagement. Moreover, in many FCAS, civil society is underdeveloped or politically constrained, requiring international actors to invest in capacity building, facilitation, and trust-building over time (Ager et al., 2015).

To ensure that financing mechanisms are both resilient and equitable, donors and governments must shift from “doing for” to “doing with”—recognizing communities not just as beneficiaries but as partners in governance. This implies redistributing power, building local capacities, and embedding participatory structures into national policy and budget cycles (OECD, 2020). Local ownership and community involvement are not peripheral to health financing—they are foundational. Their integration into financial architecture strengthens accountability, improves service delivery, and enhances the adaptability of health systems in contexts of crisis and recovery.

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Challenges in Integration and Sustainability

Despite growing international consensus on the need for integrated and adaptive health financing models in Fragile and Conflict-Affected Settings (FCAS), a range of persistent operational, institutional, and political challenges continue to hinder progress toward sustainable health systems. These challenges threaten to reverse gains made in harmonizing humanitarian and development approaches and risk undermining local and national health governance structures (OECD, 2020).

One major constraint is the short-term nature of donor funding cycles. Humanitarian assistance is often allocated on an annual or emergency basis, while development financing typically requires multi-year commitments. The lack of synchrony between these funding streams creates temporal misalignment, making it difficult to plan for longer-term investments such as infrastructure, capacity building, or health workforce development (Kharas et al., 2018). Moreover, volatile political environments in FCAS often trigger sudden donor exits or reprogramming of funds, which can abruptly disrupt continuity of care (ICRC, 2020).

Another major issue is the institutional silos and overlapping mandates of the actors involved. Humanitarian and development agencies frequently operate under separate governance structures, reporting mechanisms, and accountability standards. This can result in duplication of services, fragmentation of health programs, and wasted resources (Bennett et al., 2015). Additionally, institutional rivalries between United Nations bodies, international NGOs, and local authorities have at times obstructed collaboration and slowed down coordinated responses (UNOCHA, 2021).

In several FCAS contexts, development financing is politically sensitive and is sometimes resisted or delayed by national actors. In fragile post-conflict settings where legitimacy is contested, development funds are often perceived as entrenching one political faction over another. This sensitivity complicates efforts to align donor assistance with national health strategies and may force development actors to operate through parallel systems, weakening local ownership (World Bank, 2021).

Capacity constraints in financial management, procurement, and health information systems (HIS) further exacerbate these challenges. Many FCAS governments lack the institutional and human resource capacity to manage donor funds transparently, absorb complex grants, or generate real-time health data for evidence-based planning. This undermines accountability, transparency, and monitoring, which are essential for long-term sustainability (WHO, 2020). Weak public financial management systems also limit domestic revenue mobilization and reduce trust among external partners (UNDP, 2021).

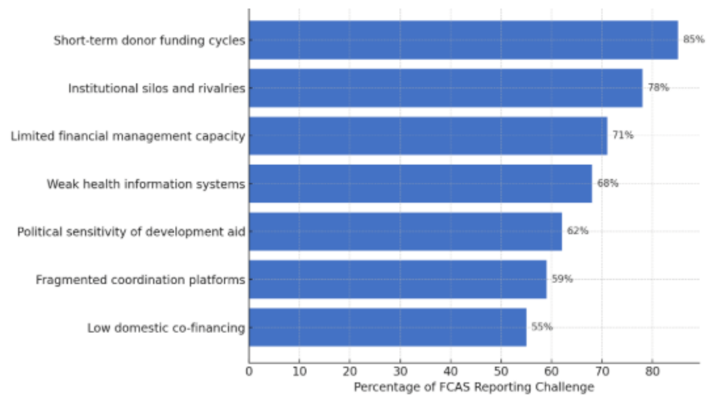

Figure 3. *Key Barriers to Sustainable Health Financing Integration in FCA. (Data compiled from WHO, OECD, World Bank, and UNICEF reports)*

Addressing these challenges requires deliberate investment in coordination architecture, policy coherence, and national systems strengthening. Mechanisms such as joint funding compacts, pooled funds with shared governance, and integrated monitoring frameworks have shown promise in aligning incentives and reducing fragmentation (GFF, 2020). Capacity building for national ministries in budgeting, procurement, and data management is equally essential. While integrated financing holds great potential for health system resilience in FCAS, its long-term success depends on structural reform, predictable funding, and political will. Donors, UN agencies, and governments must collectively shift from project-based approaches to system-level transformations, ensuring that progress is not only rapid but also enduring.

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CONCLUSION

Adaptive and hybrid financing strategies present a compelling opportunity to enhance the resilience and responsiveness of health systems in fragile and conflict-affected settings (FCAS). By bridging the traditionally segregated domains of humanitarian relief and development assistance, these models facilitate a more coordinated, context-sensitive, and sustainable approach to health financing. The integration of humanitarian urgency with development foresight ensures continuity of care during crises while laying the foundation for long-term system strengthening. As demonstrated in the case studies of South Sudan, Yemen, and the Democratic Republic of Congo, flexible pooled funds, joint planning platforms, and community-driven mechanisms have enabled greater alignment of donor resources, improved service delivery, and promoted local ownership. However, the full potential of these approaches can only be realized if persistent barriers such as fragmented funding cycles, institutional silos, weak financial systems, and limited local capacity are systematically addressed. For policymakers and international donors, this necessitates a shift from project-based interventions toward integrated strategies rooted in shared outcomes, inclusive governance, and sustained investment in public health infrastructure. Moreover, the participation of local authorities, civil society organizations, and affected communities must be institutionalized, not treated as supplementary. This ensures that health financing mechanisms are not only technically effective but also politically legitimate and socially responsive. Importantly, the convergence of humanitarian and development financing should be treated not as an exceptional or temporary solution to crisis, but as a core design principle in global health architecture. Institutionalizing this nexus in policies, budgets, and accountability frameworks will enable health systems in FCAS to absorb shocks, adapt to changing contexts, and ultimately move toward equitable and universal health coverage. Therefore, future strategies must embed flexibility, inclusivity, and resilience at the heart of financing models to ensure no one is left behind, even in the most fragile settings.

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