

THOUGHT LEADERSHIP ARTICLE

Global Health | Blended Finance | Fragile States

The Health Financing Gap Nobody Is Talking About

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There are almost no blended finance deals recorded in health in fragile states. Emergency humanitarian health funding in active conflict settings runs at fifty times the level of health development investment. When the emergency money stops and it always does, the health system is left without the financing infrastructure to sustain itself. This article names the problem, explains why it persists, and maps what the instrument architecture for blended health finance in fragile states could look like.

When a civil war enters its third year, the international community knows what to do. Emergency medical teams deploy. Trauma centres receive funding. Disease surveillance is rebuilt, at least partially, at least in the capital. Humanitarian health agencies scale up. The money flows, unevenly, inadequately, but it flows. And then, eventually, it stops. What is left behind is not a health system. It is the memory of one.

This is the health financing cliff in fragile and conflict-affected states and it is the most consequential gap in international development finance that almost nobody in the blended finance community is discussing. While billions of dollars in concessional capital have been mobilised for energy, financial inclusion, and agricultural SME lending in fragile contexts, the health sector in these environments has been almost entirely passed over. The reasons are structural, the consequences are irreversible, and the instrument logic for addressing it already exists, borrowed directly from sectors where it has worked.

THE NUMBERS THAT DEFINE THE PROBLEM

Start with Syria, because Syria is where the data is clearest.

A 2023 peer-reviewed analysis by Alkhalil and colleagues, covering the decade of conflict from 2011 to 2019, found that humanitarian health aid to Syria ran at **fifty times** the value of health development aid across that period. Development health finance constituted just **2 percent** of aggregate health and humanitarian funding, compared to 22 percent for the combined average of fragile states¹. Two percent. Not a rounding error. A category that has effectively ceased to exist.

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Syria is not an anomaly. It is a data point at the extreme end of a structural pattern. In the most acutely fragile contexts globally the 61 identified by the OECD as experiencing high or

extreme fragility, home to 2.1 billion people and 72 percent of the world's extreme poor emergency response absorbs all available oxygen. Long-term health investment never arrives. And when emergency funding eventually retreats, as it must, the health system is left without the financing architecture to sustain itself ².

The IMF's March 2026 analysis puts the fiscal dimension in sharp relief: across approximately 38 fragile and conflict-affected states, the median tax-to-GDP ratio sits at around 10 percent. Most of these governments are structurally unable to sustain domestic health financing at minimum service delivery thresholds. The WHO's baseline estimate requires roughly USD 86 per capita annually, a figure that is simply out of reach for states whose revenue base has been hollowed out by conflict ³.

WHERE THE MARKET IS AND WHERE IT ISN'T

Here is the bluntest version of the blended finance problem in health: there is almost nothing there.

The Convergence Finance Historical Deals Database, the most comprehensive available record of blended finance transactions globally does not list health as a discrete category in its fragile and conflict-affected states breakdown. Energy accounts for 31 percent of FCS blended transactions. Financial services account for 20 percent. Agriculture accounts for 9 percent. Health does not clear the reporting threshold. The deal flow is too thin to measure⁴.

WHY THIS IS NOT A VERDICT ON INVESTABILITY

The absence of health deals in fragile states does not mean health is structurally uninvestable in these contexts. It means the preconditions for blended health finance, reliable payment systems, enforceable contractual frameworks, functioning regulatory bodies, a private health sector with sufficient institutional capacity are precisely what conflict and fragility destroy first, and what takes longest to rebuild. The barriers are real. They are also the same category of barriers that deterred energy investment in the DRC before the Nuru transaction, and agribusiness investment in Yemen before the HSA Foods deal. In both cases, instrument innovation, not market maturation was the enabling condition.

The question is whether the health sector is ready for the same conversation.

THE FINANCING CLIFF IN ACTION

Understanding what the cliff looks like in a specific health context requires moving beyond aggregate data. The Gavi vaccine alliance transition evidence provides a health-specific illustration of precisely the mechanism that blended finance is designed to prevent: the withdrawal of concessional financing before domestic systems have developed the institutional and fiscal capacity to sustain the function independently.

A synthetic control analysis by Kolesar, Spruk, and Tsheten (2023) examined countries transitioning out of Gavi's concessional support and found significant heterogeneity in outcomes: while some countries maintained immunisation coverage, Bosnia and Herzegovina and Ukraine experienced precipitous declines in vaccination coverage following graduation falling well below their synthetic controls ⁵.

The mechanism is identical to the broader financing cliff dynamic: external financing withdrawal before domestic systems can sustain the function independently. The lesson is not that graduation policies are wrong. It is that transition without a financing bridge produces predictable, measurable harm and that the harm is concentrated in the most vulnerable populations. For bilateral health agencies and impact investors with health mandates, this is precisely the gap that instrument design should target.

BUILDING THE BRIDGE: WHAT INSTRUMENTS ALREADY EXIST

The good news is that the instrument logic for blended health finance in fragile states already exists. It does not need to be invented. It needs to be applied and it is available in three forms that have already demonstrated traction in analogous fragile-context sectors: financial inclusion, agricultural SME lending, and renewable energy access. Each maps directly onto a dimension of the health financing problem.

1. Results-based health financing linked to system-strengthening outputs.

The output-based aid model disbursing to health providers against verified service delivery outputs such as antenatal visits, immunisation doses, or facility deliveries has been piloted in DRC, Afghanistan, Haiti, and South Sudan. The next step is to blend this with concessional co-investment in underlying system capacity: tying a portion of disbursement to institutional outputs such as health worker retention rates, supply chain performance metrics, and laboratory accreditation milestones. This produces a financing structure that simultaneously delivers services and builds the system capable of sustaining them. The IDA PSW results-based facilities and the We-Fi performance incentive model provide working structural templates.

2. Health-focused portfolio guarantee structures.

The NASIRA model deployed by FMO in West Bank and Gaza, and the IDA PSW Small Loan Guarantee Program operating across 39 countries, have demonstrated that portfolio-level first-loss guarantees can shift commercial bank lending behaviour in fragile and fragility-adjacent markets, enabling lenders to reach borrowers they would otherwise decline. The same structure, applied to portfolios of loans to private health facilities, pharmaceutical distributors, and community health insurance schemes, could catalyse private investment in health infrastructure that no single-project guarantee could unlock. The instrument exists. The pipeline and the investable counterpart need to be developed alongside it.

3. Community health insurance blended vehicles.

Where community-based health insurance schemes have achieved meaningful enrolment Rwanda's Mutuelle de Santé is the most cited model in the literature. They create a premium revenue base that, at sufficient scale, that can support private investment in health infrastructure. Blended capital that subsidises premium collection, provides first-loss coverage against catastrophic claims, and supports scheme governance could accelerate the transition from donor-dependent schemes to partially self-sustaining financing vehicles. Mobile payment infrastructure, where it has achieved meaningful penetration in fragile markets, reduces premium collection costs and makes this model increasingly viable.

WHAT NEEDS TO HAPPEN AND WHO SHOULD ACT

None of the instrument pathways described above can be operationalised without addressing three foundational gaps. Each gap has a corresponding action that specific actors in this audience can take.

⇒ **A systematic transaction inventory**

No published database currently catalogues blended finance transactions in the health sector in fragile states with the specificity that Convergence Finance provides for the broader market. You cannot design instruments for a pipeline you cannot see. The action required is modest: a targeted data collection exercise, commissioned by a bilateral agency or multilateral health funder with access to DFI project disclosure systems, INGOs, and health financing initiative databases. This is a six-month piece of work, not a multi-year programme.

⇒ **A cost-of-health-system-collapse study**

The Mueller modelling for the World Bank–UN Pathways for Peace report quantified the economic cost of conflict prevention failure in aggregate macroeconomic terms, an average of USD 33 billion per year in prevented economic losses from a functioning prevention system.⁶ An equivalent analysis focused specifically on health system collapse, measuring the economic burden of preventable mortality, disability-adjusted life years lost, and epidemic outbreak costs attributable to health system financing discontinuity would provide the investment case for health sector blended finance in a form usable by DFI investment committees. Without it, the sector is making the case in moral terms to audiences that need economic ones.

⇒ **A private health sector mapping exercise**

Blended finance requires an investable counterpart. Before instruments can be designed and deployed, there must be a systematic understanding of who the private health providers, pharmaceutical distributors, and diagnostic service operators in fragile contexts actually are, including their capitalisation, governance structures, geographic coverage, and financing needs. Bilateral agencies with existing FCAS health portfolios such as USAID, FCDO, KfW already have the in-country relationships to commission this mapping. It is a precondition for pipeline development.

THE URGENCY IS NOT ABSTRACT

The humanitarian-development financing cliff in health is not a future problem. It is happening now, in the emergency response corridors of every major fragile state, every time a donor cycle ends or a peacekeeping mission draws down and the development investment that should be waiting on the other side is not there.

The blended finance community has demonstrated, across energy, agribusiness, and financial inclusion, that instrument innovation can unlock commercial capital in environments that were considered inaccessible. Health is the next frontier and by every measure, the most consequential one.

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The health sector in fragile states is the largest unaddressed gap in the blended finance landscape. The instrument logic to address it already exists. The actors with the mandate, the relationships, and the analytical capacity to develop the pipeline are in this audience. What is missing is the institutional decision to treat health system financing continuity in fragile states as a blended finance problem not only a humanitarian one.

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