There is a good discussion on defining FCV countries and their determination. Just to kindly clarify, will UN-Agencies and World Bank have the same countries identified? If this is not the case, there could be confusion amongst countries and partners if there are differences in the listings and the eligibility for WB funding and this may need further explanation. Page 7: Is there a standard template for Risk and Resilience Assessments (RRAs)? There was mention in the strategy of the adjustment/improvement of the RRA tool. Will this be available upon the release of this WB strategy? Secondly, the document mentioned that WB and partners will be conducting these assessments. Will these RRA partners have financial interest in the results of these assessments or will they only be neutral parties?

Section II: Framework For WBG Engagement In FCV
A. Guiding Principles (page 12-17)
We do acknowledge the role and importance of the private providers in the health sector, and the value of private-sector led growth. However, this should come with a caveat that this is not the most appropriate approach in the health sector in FCV settings. The focus in FCV environments is supporting coordinated response of all service providers and transitioning to a nationally owned system that will realise UHC. FCV settings are often characterised by lack of regulation, leading to high risks of poor quality services and medicines. Furthermore, there should be a condition when relying on private health service providers that costs should be reimbursed with public funding, rather than out of pocket payments. The latter gives very poor social and financial protection, leads to delay or not seeking needed health services, and contributes significantly to driving households into poverty when confronted with catastrophic health expenditures. Furthermore, there are public health goods that cannot be ensured through the private sector (immunisation, epidemic preparedness and response, risk reduction, etc)

B. Pillars of Engagement (page 17-29)
We believe that the role of health services can come across more strongly. There are significant opportunities across each of the four pillars for better recognition of the role of health services in building resilience, protecting essential institutions, renewing the social contract between citizens and state, and effectively addressing cross-border crises. The paradigm shift (‘pivot to prevention”) as elaborated by the WBG is much appreciated as prevention of fragility, conflict and violence together with inclusive humanitarian-development-peace efforts are aligned with concretizing actions on the social determinants of health (going into the root causes or driving forces of FCV such as “climate change, demographic shocks, gender inequality, economic and social exclusion, and perceptions of
grievances and injustice”. It is suggested that the reference to climate change be broadened to include environmental change, thus, the use of the phrase “environmental and climate change”. It is suggested to add “perceptions of corrupt and/or inefficient governance” or “perceptions of lack of transparency”. Such as for example in paragraph 12 It would be helpful to clarify how the WBG plans to do the Crisis risk assessment and analytics (see page 19) to make reference to methods applied. With regards to paragraph 81, on engaging with international partners in insecure settings, it would be good to clarify that this is also allowed and promoted in areas that are not under government control, focusing on the highest needs of populations living in such areas (usually health, education, food, livelihoods). With regards to mental health, some of the language is very trauma focused and would need revision in wording to reflect broader mental health conditions or specifically refer to stressful events or PTSD (rather than 'trauma') e.g. Page 27 refers to 'those traumatized by warfare', Page 29 box 8 includes frequent use of term 'trauma') For mental health, as in box 8, there are several references we propose here or in other paragraphs: Please refer to the IASC Principals meeting, hosted by World Bank Group in Geneva on 5th December 2019, which has a session on MHPSS in emergencies and had a recommendation to treat MHPSS as a cross-cutting issue that has relevance within health, protection, nutrition, education and CCCM sectors/clusters, in all emergencies. (meeting minutes and other recommendations available at https://interagencystandingcommittee.org/system/files/2020-01/Summary%20Record%20of%20IASC%20Principals%20Meeting%20-%20December%200.pdf) For the mental health and psychosocial needs in humanitarian situations, please refer to the WHO recent estimates available at https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)30934-1/fulltext and the recommendation, based on return on investment case developed by WB and WHO to invest in management of depression and anxiety treatment available at https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(16)30024-4/fulltext This was also presented in key global meeting by WHO and WB further information available at https://www.who.int/mental_health/advocacy/WB_event_2016/en/. The following WHO/UNDP document also is making the case for investment in mental health; https://apps.who.int/iris/bitstream/handle/10665/325116/WHO-UHC-CD-NCD-19.97- eng.pdf?sequence=1&isAllowed=y. The approach for integrating mental health as a key component in building back better is included in the following WHO report; https://apps.who.int/iris/bitstream/handle/10665/96378/WHO_MSD_MER_13.1_eng.pdf?sequence=8&ua=1 The World Bank and IMC assessment report for mental health in Ukraine also highlight investment case for building back better; http://documents.worldbank.org/curated/en/31071509516280173/pdf/120767-WP-Revised-WBGUkraineMentalHealthFINALwebpdfnov.pdf. WHO welcomes the focus on gender-based violence (GBV) in the World Bank's strategy. GBV is a significant driver of poor health outcomes for women and girls and is a substantial barrier to women's and girls' participation in educational and economic opportunities. GBV has serious short- and long-term consequences on women’s physical, sexual and reproductive (SRH), and mental health as well as on their social well-being. The physical and SRH health consequences of GBV include injuries, untimed/unwanted pregnancy, sexually transmitted infections (STIs) including HIV, pelvic pain, urinary tract infections, fistula, genital injuries, pregnancy complications, and chronic conditions. Mental health impacts for survivors of gender-based violence include Post Traumatic Stress Disorder (PTSD), depression, anxiety, substance misuse, self-harm and suicidal behaviour, and sleep disturbances. WHO suggests placing more emphasis on GBV as a threat to the health of women and girls, and on strengthening the health system approach to gender-based
violence as a key area of investment. The strategy should ensure that health services are highlighted both within the pillar on preventing violent conflict and interpersonal violence and in the work to address pandemics and health crises (as GBV should be well integrated into efforts to strengthen health systems more broadly). We propose the following edits, underlined, for paragraph 72, page 20: 72. The WBG will continue to scale up engagement to prevent gender-based violence, learning from its work on the issue over the last five years. GBV is addressed by reducing violence overall, but in some cases also requires specific approaches. The WBG includes an assessment of GBV risks in its safeguard policies, in line with the UN’s recommendation to undertake effective measures to prevent and respond to violence against women and girls. Response services, in particular health services, play a key role in mitigating the health impacts of GBV and providing opportunities to reduce further risk to women and girls. Ensuring the health system is able to respond to GBV is critical. In this context, enhancing girls’ education, addressing social norms that contribute to GBV, promoting women’s empowerment, ensuring access to services, facilitating policy change, and promoting maternal and child care also contribute to violence prevention. Foundational investments are needed to improve human development outcomes, including women's sexual and reproductive health, maternal and infant mortality rates, mental health challenges, access to services for people with disabilities, and inclusive quality education.

C. Areas of Special Emphasis (page 29-32)

We believe that health is central to the work on human capital and could be better called out in the priority issues discussion. Across the whole document there could be better reference to delivery of quality essential health services as a means to human capital and resilience. MHPSS is only very minimally integrated/mentioned. It would be good to mention psychological distress and mental health condition as one of the key issues to address in FCV settings and to also include MHPSS programming in six high priority issues in FCV settings: (i) investing in human capital--e.g. including strengthening human resources for mental health; (iv) building community resilience and preparedness -e.g. including improved mental health services WHO welcomes prioritisation of social protection schemes and social safety nets. But the interpretation is too narrowly focused on cash transfers and giving the wrong message by implying that it is also a good thing as it allows households to invest in health, education and nutrition. Such approach maintains health systems that are based on charging fees when people are ill, which is not in line with internationally agreed health financing principles, that aim to reduce out of pocket payment in favor of public funding. It would be more appropriate to acknowledge that social protection is the combination of social cash transfers plus ensuring access to social services based on financial protection (such as the contracting of health services supported by the WBG in several fragile countries).

Section III: Operationalizing the WBG’s Strategy for FCV
A. Policies, Processes, and Practices: Ensuring the WBG is Fit-for-Purpose (page 33-37)

On the Geo-Enabling for Monitoring and Supervision (GEMS) initiative, mentioned on page 37, it would be helpful to explain how it works and if it will be used to prevent or reduce impending conflict and violent events.
B. Programming: Maximizing Impact On-The-Ground (page 37-40)

C. Partnerships (page 41-43)

WHO appreciates the acknowledgement of partnerships and that “effective collaboration is underpinned by a shared understanding of the context, the drivers of fragility, and the assessment of needs”. References to joint analysis, as in paragraph 166, and joint planning are also approaches supported under the humanitarian development peace nexus (as referenced in paragraph 78. We do think that either in the section here, or linked to HDN, there should be a stronger statement that WBG colleagues will participate actively in existing coordination platforms, development as well as humanitarian, and assists in fostering operational connections between them. This includes sectoral coordination mechanisms. In some FCV countries, WBG investments in the health sector overlap with humanitarian health programming, but there is no communication between the two and the WBG has no representation in the national health cluster. From our side, we would kindly like to invite the WBG to participate in the Global Health Cluster. We acknowledge the participation of the WBG in the UHC2030 technical working group on fragile settings.

In paragraph 160, reference is made to the direct financing to third parties. One circumstance seems to be missing, when there are serious concerns over fiduciary risks, corruption or poor financial management capacity. Many of the circumstances mentioned seem to be typical characteristics of fragile countries rather than being exceptional. It could be helpful to be more specific on how these mechanisms to finance through third parties work, to make them as transparent and predictable as the mechanisms explained under the financing section. And make reference to ‘workarounds’ as were established in Afghanistan for the health sector (SEHAT) that have government ownership, but financial management with international control. WHO wants to acknowledge the value and potential of the partnership between the WBG, UNICEF, WFP and WHO, under DARES in FCV settings: Deliver Accelerated Results Effectively and Sustainably; https://www.who.int/emergencies/partners/dares-operational-framework-nov17.pdf

D. Personnel (page 43-46)

On paragraph 177 (p. 45): For the capacity building and learning section, is there room for collaboration or linkages with WHO and other UN partners for FCV under WBG? This would move beyond the strategy but we wanted to verify this as there will likely be open-modules on FCV and capacity building for Member States, CSOs, etc.

E. The Financing Toolkit for FCV Settings (page 46-51)

It would be helpful to elaborate in this section on the mechanisms for direct financing to third parties, as referenced in paragraph 160. Furthermore, there is potential overlap in fragile countries with other WBG financing facilities, such as the Global Financing Facility for Women, Children and Adolescents (GFF), the Pandemic Emergency Financing Facility (PEF) and the Famine Action Mechanism (FAM). It
would be helpful to make reference to these and explain how these may also be applied in fragile
countries. On Catastrophe Deferred Drawdown Options (p.50): In some instances, the FCV may have
an early warning of an imminent risk/emergency. It would be helpful to clarify if countries then would
be eligible to apply under this funding mechanism. If not, is there another funding mechanism where
urgent/quick readiness actions could be taken, or would this fall under disaster risk management
funding mechanism?

F. Risk Management in FCV Settings (page 52-53)

Do you have any additional comments or suggestions?

The comments are on behalf of WHO Geneva, combining comments from several departments including
country preparedness, health emergencies, health systems, mental health, and sexual and reproductive
health. We appreciate the efforts of the World Bank Group to put together this important document
and strategy for FCVs. The growing challenge of FCV (i.e., tripling of major violent conflict events in the
past decade or so) has been adequately annotated in the document. While the importance of health
and social services is frequently acknowledged in the document, and there are several paragraphs
indicating a commitment to support access to essential health services and address specific health
related challenges including for example epidemics, mental health, etc, we think it would be good to
make reference to this in the executive summary, as currently this is not mentioned. The International
Finance Corporation (IFC)'s scaling up efforts are laudable. “IFC is committed to increasing the share of
investment commitments in IDA and FCS to reach 40 percent by FY2030”. Regarding operationalizing
the FCV strategy, the 4Ps (i.e., Policies, Programming, Partnerships and Personnel) are appreciated, most
especially the overall human resource strategy to enhance both quantity and quality of WB staff on the
ground; and that partnerships and “effective collaboration is underpinned by a shared understanding of
the context, the drivers of fragility, and the assessment of needs”. WHO acknowledges the value of its
collaboration with the WBG in the health sector in general, and the increasing collaboration in FCV
settings, such as through DARES as mentioned above. If we truly want to operationalise the HDPN,
development partners need to make more explicit investments in such settings. The WBG is making a
clear commitment to doing so through this strategy, and we hope that major donors will follow this
example. We look forward to seeing how we can work together in these countries, working across
humanitarian, development and peacebuilding, in support of health services to those left behind, as well
as for health preparedness and possibly IHR implementation, the role of the health sector to support
peacebuilding, strengthening joint analyses, information management and M&E frameworks, and
environmental health. Within the document, it is not always clear as to the target audience, which may
be linked to the overall flow of the document. In some instances, for example, there is back and forth
shift from the clients/beneficiaries themselves to internal World Bank employees (i.e., recruitment by
offering clear pathways for development of growth within the agency, safety and security of staff, etc.).
Because there were several back and forth shifts to internal practices of WBG as well as programming
and engagement with clients, the strategy was not as clear (or friendly) to first-time readers. Page ix,
Table 1: Measures to Operationalize the WBG FCV Strategy: A chapter on FINANCE is missing.