



■ Research Brief

March 2024

# HEALTH IN FRAGILE SETTINGS

## A Health-Sensitive Conceptual Model of Fragility

**FRAGILE SETTINGS** “have the worst health indicators and weakest health systems” globally and are frequently used to describe “circumstances where it is challenging to drive advances in, or even maintain, population health,” with women and children among the most vulnerable. Despite this recognition, researchers working on health in fragile settings have observed notable gaps in research and tools linking health and fragility. For actors working to improve health conditions in these contexts, the absence of a health-sensitive conceptualization that reflects the drivers and impacts of fragility and their influence on health has the potential to significantly hinder understanding of the environment in which they operate and risk designing programs that are ineffective, not shock-responsive, and that may do harm.

### This brief presents

a conceptual model designed for MOMENTUM and USAID application. While it may be useful to other actors, it is particularly relevant to a USAID/USAID partner audience.

## BACKGROUND

MOMENTUM Integrated Health Resilience (MIHR), a USAID-funded cooperative agreement, works to improve access to and availability of high-quality, respectful, and person-centered maternal, newborn, and child health (MNCH), voluntary family planning (FP), and reproductive health (RH) care in fragile settings.

In recent decades there has been increasing acknowledgment that fragility has a significant impact on the health of populations, health systems, and local and international health interventions. However, critical gaps remain. The concept of fragility “is increasingly used in the field of global health” yet “its relationship to population health, health service delivery, access, and utilization is poorly specified.” Researchers examining health and fragility literature have similarly found that “[m]ore sophisticated methods of determining the precise relationship of fragility, conflict, and health...are needed.” moreover, interplay between health systems and fragile settings remains “under-researched,” and a “better understanding of the implications of health-care provision in contexts of fragility is necessary.”

**A health-sensitive conceptual model** of fragility addresses a critical gap for health programming in fragile settings. It supports health actors to develop the contextual understanding to strengthen risk management and adaptability; identifies how fragility impacts health; informs program design and MEL; sets priorities in programming and resource allocation; and ensures that no unintended harm will come from that programming.

This brief presents a health-sensitive conceptual model and typology of fragility, with the aim of improving MOMENTUM’s understanding of fragility and how it impacts health and, in turn, strengthens health programming. The conceptual model and typology proposed here are intended as internal guidance for USAID and USAID partnerships/projects such as MIHR,<sup>1</sup> and are designed to inform fragility assessments and contextual analysis as well as monitoring, evaluation, & learning (MEL) approaches, conflict sensitivity, and exit strategies.

The first step to develop the Conceptual Model and Typology was to define/identify the key characteristics of fragility from a health-perspective based on comprehensive and systematic literature reviews, a comparative analysis of leading fragility and risk measurement frameworks and other relevant approaches,<sup>2</sup> and consultations with key MIHR and USAID stakeholders (n=34).<sup>3</sup> This effort provided an outline for the Conceptual Model and Typology. A draft of the model and typology was applied to MIHR’s Fragility, Crisis Sensitivity, and Complexity (F2C) Assessments for South Sudan, Tanzania, Mali, Burkina Faso, and Democratic Republic of the Congo (DRC). These tests informed selected revisions to health-sensitive fragility factors.

## DEFINING HEALTH-SENSITIVE FRAGILITY

The terms *fragility* or *fragile setting* describe a wide range of contexts characterized by shocks, stresses (vulnerabilities) and stressors (stress events), and other factors that interact in various ways to affect the quality of and access to health services, including MNCH/FP/RH. MIHR partner countries are considered fragile contexts; however, what fragility looks like in a given context—e.g., the drivers, impacts and degree of fragility—can differ. For example, while South Sudan—generally regarded as extremely fragile—is characterized by chronic fragility on multiple fronts (political, economic, security, environmental, and social, among others), Tanzania is experiencing more moderate fragility, most prominently highlighted by environmental and economic factors.<sup>4</sup> Understanding the fragility of the settings where MIHR works forms a critical part of program design, including where and how to intervene and monitoring.

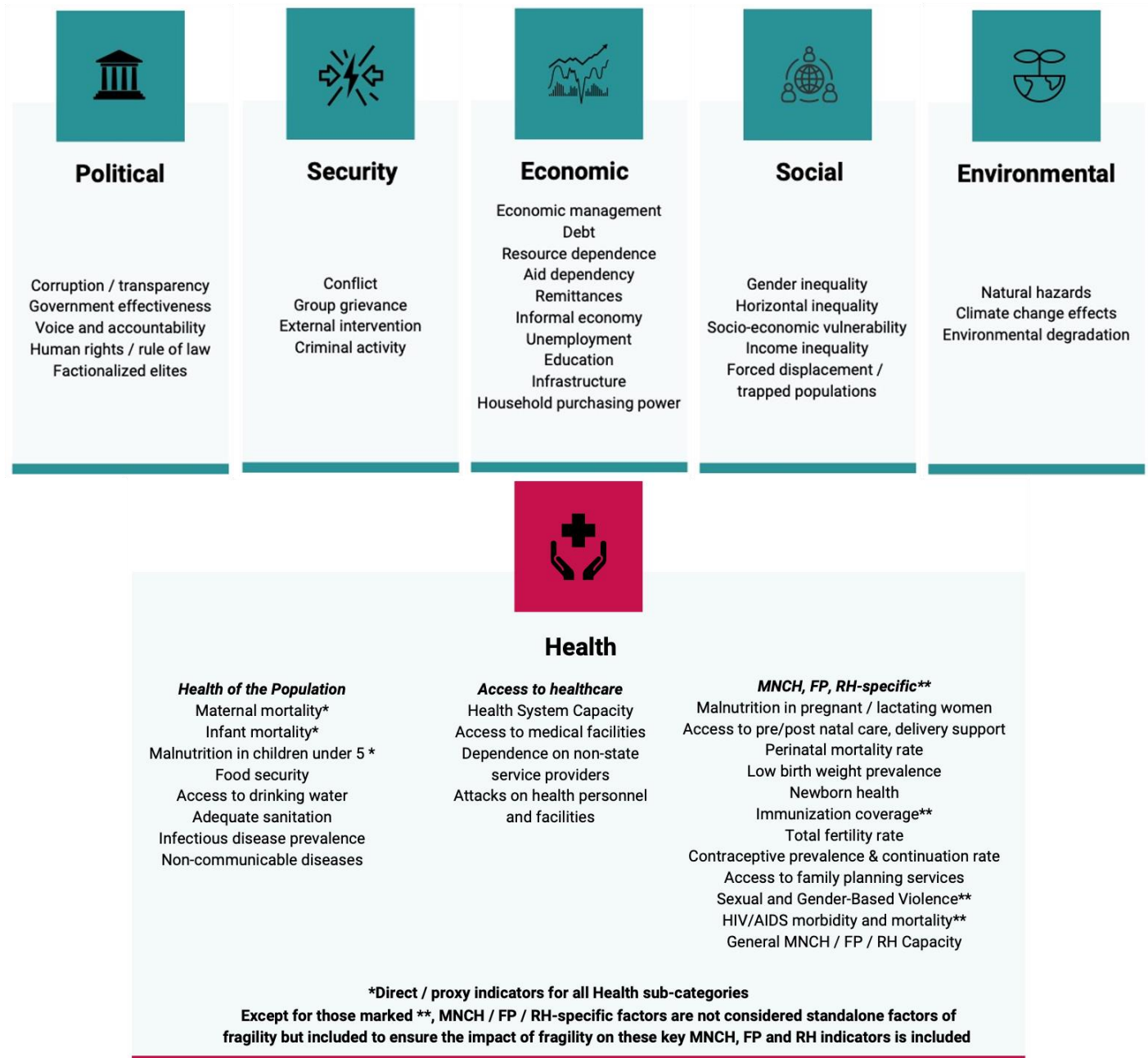
Although fragile settings have been a key concern for decades among humanitarian, development and peacebuilding actors, policymakers, and academics, there remains no consensus on the definition of fragility.<sup>5</sup> However, MIHR has identified several **key characteristics of fragility**, providing a critical foundation anchored in both health-sensitive and risk management perspectives.

First, while there is a tendency to view fragile settings through the prism of specific shocks or stressors<sup>6</sup> (also known as hazards or threats), fragility is not synonymous with crises (natural or man-made), rather, **fragility informs the vulnerability of a context**. For example, the presence of an environmental threat (e.g., flooding) does not determine fragility; rather fragility is reflected by vulnerability and thereby the ability of the context to manage and mitigate the threat. This conceptualization has been increasingly found in the leading fragility measurement frameworks (e.g., Organisation for Economic Co-operation and Development (OECD) *States of Fragility*<sup>7</sup>) and within USAID,<sup>8</sup> **aligning closely with the way vulnerability is described within the risk paradigm**. Here, vulnerability is “determined by physical, social, economic, and environmental factors or processes, which increase the susceptibility of an individual, a community, assets, or systems to the impact of hazards... when hazards combine with vulnerability and exposure, disasters are most likely to occur because exposure increases the impacts, and vulnerability reduces coping capacity.”<sup>9</sup> As a result, understanding the fragility of a context provides an important grounding in risk management (hazards/threats, exposure and vulnerabilities) and opens the door to manage and mitigate pertinent interwoven threats, recognizing how they affect the risk dynamics (the relationship between the different variables of risk).

Second, **fragility, like vulnerability, is multidimensional and needs to be considered across political, security, economic, societal, and environmental dimensions**.<sup>10</sup> Under a health-sensitive approach, the health dimension becomes a standalone, critical sixth dimension. Each dimension contains associated shocks, stressors (stress events), stresses (vulnerabilities), and other relevant factors that should be considered to understand a context’s fragility (see Figure 1).

Third, **these dimensions and factors therein need to be considered in themselves but also how they interact**—a systems perspective ([a set of interconnected things that form behaviors over time](#)). As USAID has articulated, understanding fragility “requires analyzing each component [of the fragile context and] the relationships between them... No component [factor] in the system can be effectively analyzed or addressed in isolation. As one component (factor) of the system changes, others will also change in response, causing the system to shift. To understand fragility, the entire system must be taken into account.”<sup>11</sup> Similarly, the OECD (2018), has observed that, “[assumptions that fragility can be simplified or isolated into one dynamic or another, have long outgrown their utility](#).” These interactions (also referred to as fragility dynamics) can have a significant impact on healthcare, health systems, and health outcomes, with the potential to create substantial direct and indirect barriers to (strengthening) health resilience. The risk management paradigm reinforces this, pointing to the need to evaluate the hazard (shock or stressor), who precisely is exposed, and why they may be vulnerable. It is **the overlap of hazard, exposure, and vulnerability that produces the highest risk**.

**Figure 1. Fragility Factors by Dimension**



Fourth, an important part of understanding fragility and its implications is **the state-society relationship**. Sometimes referred to as the social contract, the state-society relationship considers **legitimacy and trust dynamics** between authorities and the population, such as how identity groups (e.g., based on religion, caste, class, or ethnicity) experience and perceive the institutions that are meant to serve them and the surrounding equity dynamics. When this relationship is dysfunctional or strained, there can be implications for health, as illustrated by the Ebola outbreak in West Africa 2015-2016 (see below). State-society relations are informed by a range of fragility variables (e.g., equity) and consider, among other aspects, how identity groups and communities experience and perceive the institutions that are meant to serve them. While

specific tools have varied over the years, U.S. Government/USAID approaches have remained largely grounded in the social contract theory and the criticality of state-society relations. For example, USAID's *Fragility Analytics Guidance (2019 draft, not publicly released)* describes how, when this relationship is "dysfunctional," it "yields patterns of governance that generate new internal stresses, magnify existing ones, and hamper the response to external stresses, leaving countries increasingly fragile and vulnerable to instability."<sup>12</sup>

### **Fragility and the State-Society Relationship: Ebola in West Africa 2015-2016**

In Ebola-affected countries in West Africa, low levels of trust of the population toward the government—an expression of a strained state-society relationship—were responsible, in part, for "[the initial failure to contain the outbreak.](#)" In Liberia for example, the lack of trust "[contributed to the spread of rumors that the Liberian government had exaggerated or even concocted the Ebola crisis to get access to international funding that could be siphoned off for private uses.](#) [Consequently, Ebola-affected individuals and communities.](#)" This highlights the lack of trust in government as an endemic vulnerability in society. Similar arguments have been made by WHO and *The Lancet*, whose editor-in-chief wrote how Ebola has exposed the breakdown of trust between communities and their governments.<sup>13</sup>

Fifth, there are variations in fragility *within* a given context. Because a context is fragile does not mean that fragility is experienced equally. **The way fragility is experienced by the population can vary across identity groups**, with some groups more vulnerable than others, and in variations in strains on the state-society relationship. For example, it is not uncommon in many fragile settings for power (e.g., political, economic, and security) to be dominated by a specific ethnic group; members of this group as well as those closely affiliated with them may benefit from fragility (e.g., accumulate wealth; clientelism) while the vulnerability (e.g., inequality) of other groups can increase and/or become entrenched, and their trust in and view of the state's legitimacy will be considerably different from the groups who benefit from it.

Fragility can also **vary between different areas of the same country**—fragility as perceived at the national level may play out differently in sub-national areas and vice versa; e.g., because a country ranked among the top 10 most fragile states by the [States of Fragility](#) (OECD) or the [Fragile States Index](#) (Fund for Peace) annual measurements does not mean that all its regions would have the same score or patterns of fragility. Similarly, fragility is not static, but a dynamic system that can (and does) evolve and change—the degree may change or stay the same, but specific interactions and impacts can shift. Moreover, fragility dynamics at different geographic levels can influence each other, and health issues in fragile settings need to consider the relationship between fragility and health outcomes at different levels.

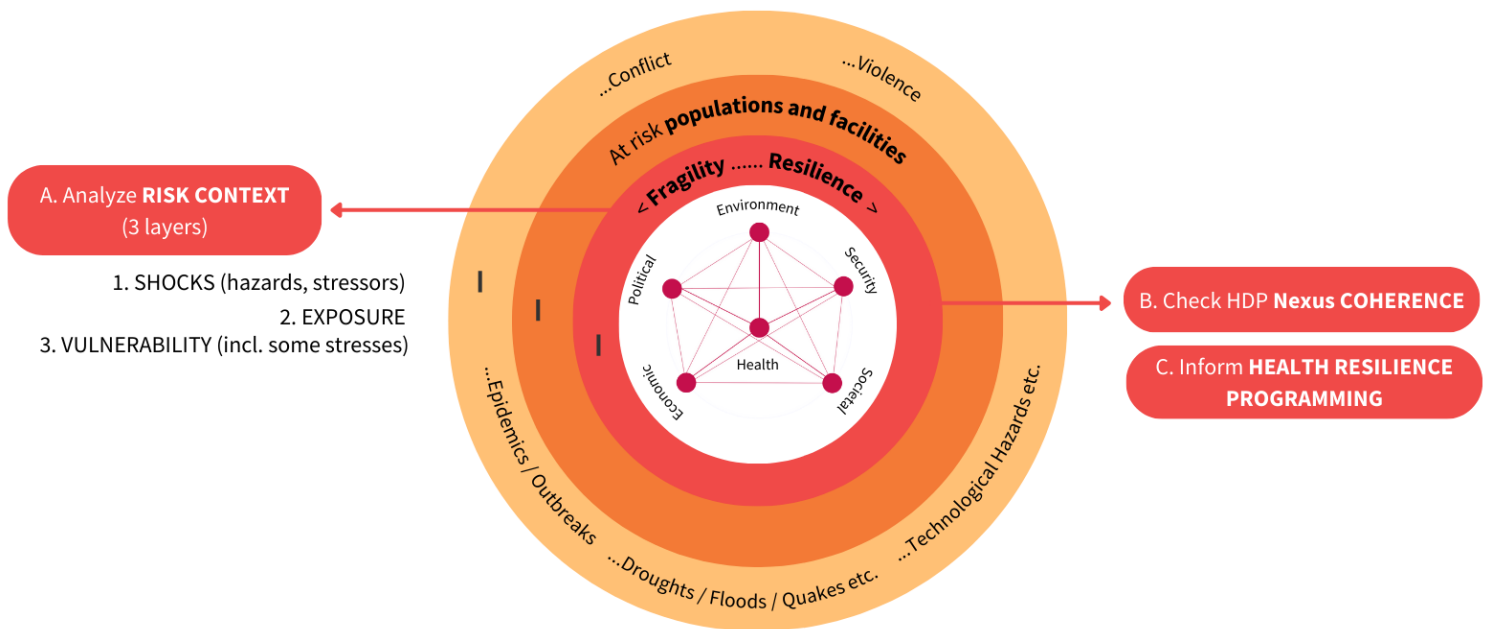
Finally, **understanding fragility underpins and contributes to work on the humanitarian, development, and peacebuilding (HDP) nexus, and the identification of risk scenarios.** It enables a healthy exploration of contexts in which nexus and resilience operate in close alignment with the risk paradigm. It also emphasizes the importance of understanding how each HDP pillar can intentionally (or unintentionally) do no harm to the two other pillars. It also informs resilience; by understanding fragility through vulnerability, the link with resilience becomes clearer. For example, as the Fragile States Index explains, the purpose of a fragility framework is to serve as "[entry points into deeper interpretive analysis by civil society, government, businesses, and practitioners alike—to understand more about a state's capacities and pressures which contribute to levels of fragility and resilience.](#)"<sup>14</sup> Essentially, fragility and resilience are opposites.

**Fragility dynamics can have a significant impact on healthcare and health systems**, with the potential to create substantial direct and indirect barriers to (strengthening) health resilience.<sup>15</sup> Building long-term health resilience may be determined/influenced by how the political, security, economic, societal, and environmental/accessibility dimensions function and impact health outcomes.

## A HEALTH-SENSITIVE CONCEPTUAL MODEL OF FRAGILITY

Figure 2 is a proposed health-sensitive approach to fragility, aligned to the sequencing of steps leading to the design of health resilience programming. It is framed by the risk paradigm in which fragility is aligned with vulnerability—the opposite of resilience. At the center are the fragility dynamics, the interactions between political, security, economic, societal, environment and health dimensions which informs a fragility *synthesis*. In **Step A**, an integrated analysis of the **risk context** is conducted across the three layers (shocks; exposure, including that of facilities; and vulnerability). Here shocks are disaggregated into hazards and stressors (stresses that are events) and general stresses, contextual characteristics that add stress but are an inherent part of the fabric of society, are considered part of the vulnerability. In **Step B**, a **stakeholder analysis** of actors present in a context to support an appropriate focus on humanitarian, development and peacebuilding leading to **Step C**, a strong evidence-based design of health resilience programs. See farther below for a comparison table of key concepts.

**Figure 2. Health-Sensitive Conceptual Model of Fragility: Linking Fragility, Risk, Resilience, and the HDP Nexus**



Source: IRMA, Integrated Risk Management Associates LLC.

# FRAGILITY TYPOLOGY

Fragility exists across a spectrum of intensity from extremely high (e.g., South Sudan) to moderate (e.g., Tanzania), to low or very low (e.g., Norway). By examining the different dimensions and factors that inform fragility,<sup>16</sup> it is possible to determine the degree of fragility (Figure 3).

**Figure 3. Degrees of Fragility**



The fragility dynamics and implications for health outcomes will be specific to that environment; however, MIHR research findings provide general guidance on what may be expected with each degree of fragility and areas that may require further consideration when assessing health programming implications (see Figure 4). Taking into consideration the overlap between fragility and vulnerability, this matrix could also replace the vulnerability component of any layered (three-level) risk analysis. It is possible to build on and refine this matrix as further patterns of health and fragility are observed over time.

**Figure 4. Characteristics of Fragility by Degree**

DEGREE OF FRAGILITY	STATE-SOCIETY RELATIONSHIP	NATIONAL - SUBNATIONAL	BASIC SERVICES	HDP NEXUS	HEALTH
<b>EXTREMELY HIGH</b>	Long-term breakdown in state-society relationship and resulting patterns of governance have generated very low levels of trust and perceived legitimacy of the authorities, contributing to increased vulnerability. Specific groups may be more affected than others.	Very strong likelihood of endemic, long-term, extremely high/high fragility at the national and/or sub-national levels, even if not in the specific district/community targeted. Strong potential for local authorities in certain areas to be disassociated and/or in conflict with national authorities. Combined effects will likely present significant challenges to health resilience programming.	Very strong likelihood basic service provision, including health, is almost exclusively or very heavily reliant on non-state service providers/ external assistance (e.g., international aid and/or remittances) with critical implications for sustainability.	Very high likelihood of HDP considerations, including high probably of protracted humanitarian crises and waves of acute emergencies; this may generate expectations of short-term support and/or other free services on the part of communities where health resilience activities are ongoing.	Fragility dynamics have critical/significant impact on health outcomes and systems; building long-term health resilience will require changes in how other dimension function and influence health.
<b>HIGH</b>	Long-term breakdown in state-society relationship and resulting patterns of governance have generated very low levels of trust and perceived legitimacy of the authorities, contributing to increased vulnerability. Specific groups may be more affected than others.	Likelihood of endemic, long-term cycles of extremely high/high/moderate fragility at the national and/or sub-national levels, even if not in the specific district/community targeted. Strong potential for local authorities in certain areas to be disassociated and/or in conflict with national authorities. Combined effects will likely present significant challenges to health resilience programming.	Strong likelihood basic service provision, including health, is almost exclusively / very heavily reliant on non-state service providers / external assistance (e.g., international aid and/or remittances) with critical implications for sustainability.	High likelihood of HDP considerations, including high probably of protracted humanitarian crises and waves of acute emergencies; this may generate expectations of short-term support and/or other free services on the part of communities where health resilience activities are ongoing.	Fragility dynamics have critical/significant impact on health outcomes and systems; building long-term health resilience will require changes in how other dimension function and influence health.
<b>MODERATE</b>	Weakened state-society relationship and potential resulting patterns of governance have affected trust and perceived legitimacy of the authorities, impacting vulnerability. Specific groups may be more affected than others.	Degrees of fragility may vary in different parts of the country and may have previously experienced high fragility at the national and/or sub-national levels, even if not in the specific district/community targeted. Likelihood that local authorities have some link with national authorities.	Likelihood of the provision of basic services, including health, is at least partially dependent on non-state service providers/ external assistance (e.g., international aid and/or remittances) with implications for sustainability.	Potential for HDP considerations; protracted humanitarian crises are unlikely, but context may experience acute emergencies in response to shocks/stressors that will require external support to manage.	Fragility dynamics anticipated to have some impact on health outcomes and systems; building long-term health resilience in specific areas may require changes in how other dimensions function and influence health.
<b>LOW / VERY LOW</b>	State-society relationship and patterns of governance generally stable, with perceived legitimacy of and trust in authorities.	May have previously experienced moderate fragility at the national and/or sub-national levels at specific points in time, even if not in the specific district/community targeted; previously national high level fragility possible but unlikely. Local authorities have ties with/are an extension of national authorities.	Provision of basic services, including health, is not dependent on non-state service providers/external assistance for a minimum level of service.	HDP considerations not anticipated, with the expectation that the setting has sufficient coping capacity such that should shocks/stressors (natural or man-made) occur, they will not develop into humanitarian crises requiring external intervention.	Fragility dynamics do not have a significant impact on health outcomes.



## STRENGTHENING HEALTH PROGRAMMING

This health-sensitive fragility approach aims to strengthen health programming in several ways:

- **Strategy:** An improved understanding of the fragile context will strengthen the ability to manage risk. It will identify all pertinent threats (shocks and stressors), exposure, and vulnerabilities (stresses), supporting **risk scenario identification**. The fragility synthesis can help answer critical questions such as: What threats are likely to occur? How might/to what extent can the context mitigate and manage them? How might they change the fragility dynamics—what development gains could be lost? What are the potential implications for health and health systems? What measures can MIHR take to ensure continuity of programming, and/or how should MIHR react to the different scenarios and why (e.g., scale-down, scale-up, suspend activities)? How can MIHR support the population’s health should threats occur? This also supports programs to be prepared to **rapidly adapt to changes**, including providing guidance, e.g., how to engage in contexts regularly interrupted by repeated, acute threats or shocks.
- **Identify non-health aspects of the fragile context with significant direct and indirect implications for building health system resilience.** This will inform program design, theories of change, monitoring, evaluation, and learning, and coordination (e.g., which non-health sectors and actors should be engaged and/or monitored).
- **Set priorities in programming and resource allocation** based on an improved understanding of what influences health dynamics and where MIHR can have the greatest impact and ensuring that no unintended harm will come from that programming.

## RECOMMENDATIONS

The Conceptual Model and Typology presented here represent a first critical step to strengthen MIHR’s understanding of fragility, reinforce field programs, and inform health resilience strategy development. The following steps are recommended to maximize potential outcomes:

- Update the F2C assessment approach to incorporate the proposed Health-Sensitive Conceptual Model of Fragility and Typology, including specific guidance on how to examine and determine the fragility of dimensions, and the dynamics *between* dimensions and factors. Identify implications for healthcare, health resilience, and MIHR programming.
- Apply the Conceptual Model and Typology to the completed F2C assessments to: a) show how data already collected can be used and oriented; and b) identify critical gaps that may need to be addressed to provide the more comprehensive understanding of fragility proposed here. This could be conducted through a combination of additional literature review, consultations, and/or a workshop with MIHR staff and teams who conducted the original study. The F2C has been completed in several partner countries and was underway in others at the time of this brief.
- In applying the model, develop fragility systems maps of MIHR operating contexts, and analyze them in relation to the intervention goal and approach to highlight any potential barriers to MNCH/FP/RH and

MIHR updated (March 2024) the F2C based on the feedback and recommendations discussed in this brief. The updated tool will be published as part of a larger *Conflict Sensitivity + Guidance* after the tools and guidance are piloted in 2024.

their implications. In parallel, undertake research to understand how MIHR actions interact with the fragility dynamics of where they operate.

- Undertake research through a risk lens to map common trends in direct and indirect barriers to healthcare (including MNCH/FP/RH), as well as challenges to health resilience in different fragile settings. Update the typology characteristics and explore the potential to generate a complementary programming guidance tool to further inform strategic planning and adaptability.
- Update the MIHR HDN Conceptual Model (and companion graphic) to align with the proposed Conceptual Model and Typology. Update the MIHR General Guidance on Health Resilience (working document) to include a wider risk management lens and the proposed Conceptual Model and Typology.
- Undertake research on the extent to which a fragility synthesis informed by the proposed Conceptual Model and corresponding indicators could be used to measure and monitor fragility, risk, and resilience (including the five dimensions—social, human, physical, environmental, and financial).
- Explore the possibility of a single framework for health risk. It could incorporate the spectrum of MIHR guidelines and tools under one overarching approach in health resilience promotion. This would include but is not necessarily limited to: F2C components (fragility, crisis/conflict sensitivity, complexity-aware monitoring), HDN Conceptual Model, and the General Guidance on Health Resilience, and would also seek to identify relevant links to key USAID tools.
- Review and provide recommendations on how to refine MIHR’s MEL system to inform regular updates of the fragility synthesis in contexts where MIHR works.
- Conduct workshops with MIHR staff engaged in program design and MEL on systems thinking.

## COMPARISON TABLE OF FRAGILITY, RESILIENCE, RISK, AND HDP NEXUS

	FRAGILITY	RESILIENCE	RISK MANAGEMENT	HDP NEXUS
FRAGILITY	Fragility is reflected by vulnerability, which determines the ability of the context to manage and mitigate threats. Other critical features include: understanding the state-society relationship; a multidimensional perspective (political, security, economic, social, environmental; under a health-sensitive approach, health is a standalone dimension); and understanding the relationship (interactions) <i>between</i>	Fragility and resilience are opposites: a fragile context is the opposite of a resilient one. Fragility is more closely linked to state/society relations (and considered at a national and higher sub-national level), while resilience most commonly reflects populations (not disregarding the importance of resilient institutions), with a stronger focus on	Risk management is critical in fragile settings. Key hazards to monitor, (early) warn/anticipate, and mitigate include violent conflict and environmental hazards, with economic shocks becoming more prominent. The prevention sphere is also an important turning point for conflict-sensitive programming and recovery, for conflict resolution.	Fragility is often most closely linked to the Peace pillar of the nexus (given the link to violent conflict). However, fragility can be mitigated in development action that addresses fragility drivers across other dimensions, as well as through “Do No Harm” across the three pillars (e.g., not create situations that worsen or trigger conflict).

	<b>FRAGILITY</b>	<b>RESILIENCE</b>	<b>RISK MANAGEMENT</b>	<b>HDP NEXUS</b>
	dimensions and factors of fragility.	individuals, households, and communities.		
<b>RESILIENCE</b>	Resilience is the opposite of fragility; often at the level of populations (less focused at the state level)	<u>“The ability of people, households, communities, countries, and systems to mitigate, adapt to, and recover from shocks and stresses (stressors) in a manner that reduces chronic vulnerability and facilitates inclusive growth.”</u>	Resilience aims to reduce vulnerability to and is particularly prominent in the prevention and recovery and recovery phases of risk management. <sup>17</sup>	As a long-term aim, strengthening resilience is a goal (expected output) of a HDP nexus effort.
<b>RISK MANGEMENT</b>	Fragility is absorbed into the vulnerability component of risk management but has an impact on results in all spheres.	Resilience is the opposite of vulnerability (see fragility), and the capacity of society (organizations, governments, households, and individuals) to bounce back from a shock is what makes them more resilient.	Risk management is holistic and system wide. It has three distinct components: hazard (event), exposure (people, infrastructure, systems/processes in the trajectory) and vulnerability (the nature of the above). It also has four main spheres (prevention, preparedness/ anticipation, response, and recovery).	The four spheres of risk management lend themselves to inclusive collaboration with H, D, and P actors. The nexus is how the key actors work together to manage risk (i.e., they should collaborate and hand off to each other as spheres evolve through time).
<b>HDP NEXUS</b>	HDP efforts are typically found in fragile contexts because it is here that protracted crises are most common and all actors are (normally) present. Natural hazards are equally good contexts to test HDP; coordination and do no harm are equally important across both more and less fragile contexts.	Resilience is generally linked most closely to the development pillar, although it is increasing among humanitarian actors. <sup>19</sup> However, it is often not the most pressing nexus focus (among competing priorities).	Nexus is a natural fit given the all-hazard nature of the paradigm.	<u>“An intentional process to promote appropriate sequencing, layering, and integration across humanitarian, development, and peace assistance [and actors] in pursuit of a common agenda,”</u> durable projects, and to do no harm.

## Endnotes and References

1. The research objectives focused on producing a conceptual model for MIHR and, by extension, USAID. As a result, the research drew more heavily on USAID perspectives than on those of other donors. Thus, the Conceptual Model is applicable to other actors but is particularly relevant to a USAID/USAID partner audience.
2. Frameworks for the comparative analysis were selected from among the most prominent references for key development donors, including USAID. The fragility factor selection considered the following frameworks: [States of Fragility \(OECD\)](#), [Fragile States Index \(Fund for Peace\)](#), [World Bank Classification of Fragile and Conflict-Affected Situations](#), [Carleton University Country Indicators for Foreign Policy Project \(CFIP\)](#), and [INFORM Risk \(European Commission / IASC\)](#); the analysis also considered authority, legitimacy, and capacity models of fragility through three examples ([Tikuisis et al., 2015](#); [Ziaja, Grävingsholt, and Kreibaum, 2019](#); [CFIP](#)). In order to incorporate USAID's perspective into this analysis, the key "components" of fragility as described in the USAID's 2019 draft/not publicly released *Fragility Analytics Guidance* (state, society, state-society, governance, capacity, and stresses) and the key themes of their descriptions were translated into a fragility indicator table to be able to compare against the other included frameworks. Health dimension factors also draw on a systematic literature review of health and fragility, [Minimum Initial Service Package for Sexual and Reproductive Health \(MISP\)](#), [MOMENTUM/MIHR indicators](#) and the [USAID/Data for Impact Family Planning and Reproductive Health Indicators Database](#) (which includes the [WHO shortlist of reproductive health indicators for global monitoring](#)).
3. MIHR representatives included chiefs of party, technical advisors/leads, senior managers, directors, and select consultants. USAID representatives were from Center of Conflict and Violence Prevention, Global Health, Maternal and Child Health, Center for Democracy, Human Rights and Governance, the Bureau for Humanitarian Assistance (BHA), and representatives from Missions in partner countries (both MIHR points of contact and BHA representatives). Considering the limited time and budget, interviews or focus groups with non-USAID donors/actors to explore their perspectives was not possible. This was mitigated in part by references in the literature as to what frameworks specific donors currently or previously supported or used; however, this information was not available for all key donors in readily available public materials.
4. Fragility rating here is based on [OECD's 2022 States of Fragility](#) and the [2022 Fragile States Index](#).
5. This includes USAID/U.S. Government bodies. For example, USAID's Family Planning/Reproductive Health in Fragile Settings Team has directly adopted the OECD framework and definition in their internal *Fragility Technical Guidance Document* (2022), while the *Food Systems Conceptual Framework: Companion Guide on Fragility, Conflict and Violence*, uses a somewhat more narrow definition: "The vulnerability of a country or region to armed conflict, large-scale violence, or other instability, including an inability to manage transnational threats or other significant shocks. Fragility results from ineffective and/or unaccountable governance, weak social cohesion, and/or corrupt leaders who lack respect for human rights" USAID (2023), *Food Systems Conceptual Framework: Companion Guide on Fragility, Conflict and Violence*, p. 5. Alternatively, the *Global Fragility Act/Global Fragility Strategy* (2020) emphasizes conflict and violence (and with a special interest in extremism) rather than the broader framing found in the *Fragility Analytics Guidance* (2019).
6. The conceptual model isolates stresses that are events (they may be called "stressors," i.e., conflict events).

7. The OECD *States of Fragility* (2020) characterized fragility as the combination of exposure to risk and insufficient coping capacity of the state, systems, and/or communities to manage, absorb, or mitigate those risks. Fragility can lead to negative outcomes including violence, poverty, inequality, displacement, and environmental and political degradation.
8. The draft *Fragility Analytics Guidance* (USAID 2019, p. 1) describes fragility as “a condition of vulnerability to a range of bad outcomes.” USAID’s Family Planning/Reproductive Health in Fragile Settings Team has also directly adopted the OECD framework and definition in their internal *Fragility Technical Guidance Document* (2022). The USAID (2023) *Food Systems Conceptual Framework: Companion Guide on Fragility, Conflict and Violence* described fragility as “The vulnerability of a country or region to armed conflict, large-scale violence, or other instability, including an inability to manage transnational threats or other significant shocks.”
9. United Nations Office for Disaster Risk Reduction (2022), *Global Assessment Report on Disaster Risk Reduction 2022: Our World at Risk: Transforming Governance for a Resilient Future*, Geneva, pp. 2-3.
10. These dimensions have been adapted from the OECD *States of Fragility* measurement framework and informed by a comparative analysis across multiple measurement frameworks and the health and fragility literature. The original research was conducted prior to the OECD 2022 *States of Fragility*, which included a sixth ‘human’ dimension; however, many of the variables covered in the ‘human’ dimension were identified in the initial research and are captured by MIHR’s health dimension, including access to safe drinking water, adequate sanitation, and malnutrition. Most other ‘human dimension’ indicators are captured under other MIHR dimensions, including education and youth unemployment (economic dimension) and various equity (social dimension) indicators. The MIHR dimension has a much more expansive range of health indicators.
11. USAID (2019), *Fragility Analytics Guidance*, p. 1.
12. *Ibid.*
13. Pieterse, P., and T. Lodge (2015), “When free healthcare is not free. Corruption and mistrust in Sierra Leone’s primary healthcare system immediately prior to the Ebola outbreak.” *International Health*, November, 7(6), pp. 400-4.
14. Italics added.
15. Health resilience is defined by MIHR as the ability of people, households, communities, systems, and countries to mitigate and adapt to shocks and stresses in a manner that reduces acute and chronic vulnerabilities and facilitates equitable health outcomes.
16. While a fragility synthesis informing the degree of fragility may draw on specific metrics associated with fragility factors (where available), specific quantitative thresholds for each fragility dimension are not proposed; it is recommended that the fragility classification be informed by quantitative and qualitative information available in the given context, with classifications to be supported by a narrative explanation. While the potential for subjectivity is acknowledged, the presentation of the process and explanation of the findings should

provide supporting evidence for the allocation inviting interrogation. Leading fragility and fragility-relevant risk frameworks (e.g., [States of Fragility](#), [Fragile States Index](#), [INFORM Risk](#)) can provide a point of reference for thresholds at the national level but do not need to be prescriptive.

17. The USAID approach places an emphasis on reducing vulnerability to ‘shocks’ and ‘stresses;’ however, as stresses can also be vulnerabilities this can generate confusion. Overall, the use of ‘shocks’ and ‘stresses’ (linked to the resilience paradigm) introduces a lexicon focused on disassociating sudden/short-term from longer, protracted situations that is not readily aligned to risk management (i.e., avoided or de-prioritized).
18. For example, the ICRC has been vocal about the humanitarian role in ‘resilience actions’ as well as engaging in ‘sustainable development’ and ‘sustainable humanitarian impact’ as part of their work, which they explicitly link to building resilience. ‘Sustainable humanitarian impact’ is defined by the ICRC as “a situation where long-term or chronic needs and protection-related risks arising from armed conflict and chronic violence are durably reduced or prevented. Importantly, this should be done by supporting the resilience of affected people and the essential services and systems they rely on, but also through the actions of duty bearers.” It is acknowledged by the ICRC that the nexus plays an important role in achieving this “impact.”

## MOMENTUM

USAIDMomentum.org

**TWITTER: @USAIDMomentum**

**FACEBOOK: USAID Momentum**

**LINKED IN: USAID-Momentum**

**YOUTUBE: USAIDMomentum2161**

## Acknowledgements

The authors (consultants working under Integrated Risk Management Associates, LLC) would like to acknowledge guidance and input provided by the MIHR staff, in particular Nancy Stroupe and Isabelle Bremaud.

Suggested Citation: Vaughan-Lee, Hannah, and Lezlie C. Morinière. 2024. “Health in Fragile Settings: Health-Sensitive Conceptual Model of Fragility.” Washington, DC: USAID/MOMENTUM.



MOMENTUM Integrated Health Resilience is funded by the U.S. Agency for International Development (USAID) as part of the MOMENTUM suite of awards and implemented by IMA World Health with partners JSI Research & Training Institute, Inc., Pathfinder International, GOAL USA Fund, CARE, and Africa Christian Health Associations Platform (ACHAP) under USAID cooperative agreement #7200AA20CA00005. For more information about MOMENTUM, visit [www.USAIDMomentum.org](http://www.USAIDMomentum.org). The contents of this research brief are the sole responsibility of IMA World Health and do not necessarily reflect the views of USAID or the United States Government.