Commentary

Fragile, handle with care: Refining a key concept for global health and development

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Karin Diaconu, Sophie Witter, Arek Dakessian, Giulia Loffreda and Alastair Ager

Correspondence to Alastair Ager (aager@qmu.ac.uk)

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Development and global health research have long applied a binary definition of fragility. Within this, countries are either labelled fragile or not. However, the COVID-19 pandemic has thrown this distinction into question. Many settings previously thought of as fragile are now outperforming others.[1]

The World Bank has seen this binary designation as fundamental to its strategy. Using the Country Policy and Institutional Assessment (CIPA), the Bank evaluates performance across domains of economic management, social inclusion, equity and structural policy. Poor-performers are included in the 'fragile situations' list.[2] Most situations so identified are conflict affected.

The OECD had applied similar definitions until 2016, when the organization proposed a more nuanced understanding:

> "Fragility is defined as the combination of exposure to risk and insufficient coping capacity of the state, system and/or communities to manage, absorb or mitigate those risks. The new OECD fragility framework is built on five dimensions of fragility - economic, environmental, political, societal and security - and measures each of these dimensions through the accumulation and combination of risks and capacity".[3]

The concept of fragility has thus evolved. The OECD has continued to publish on the multi-dimensional nature of fragility with landmark reports every two years.[4,5] A sixth dimension of the framework – human fragility – was added in 2022 in recognition of factors affecting the realisation of people's well-being and potential. The breadth of this evolving conceptualization is emphasized in the overview of all reports: 'fragility is a global phenomenon, felt across multiple dimensions to varying degrees in all contexts'.[5]

However, how much of this approach has trickled down to global health? In 2020, Diaconu et al.[6] published a review of how fragility was used across global health literature. The term continues to be frequently applied in relation to the designation of contexts (either countries or regions, or even within-country areas) as 'fragile and conflict affected'. Increasingly, however, fragility is also being used to describe performance of the health system (or wider 'systems for health'[7]) and the way such systems connect with communities. The latter are also frequently recognised as fragile themselves, with discussions on vulnerable populations abounding.[8] These trends chime with the OECD's multidimensional understanding of fragility.

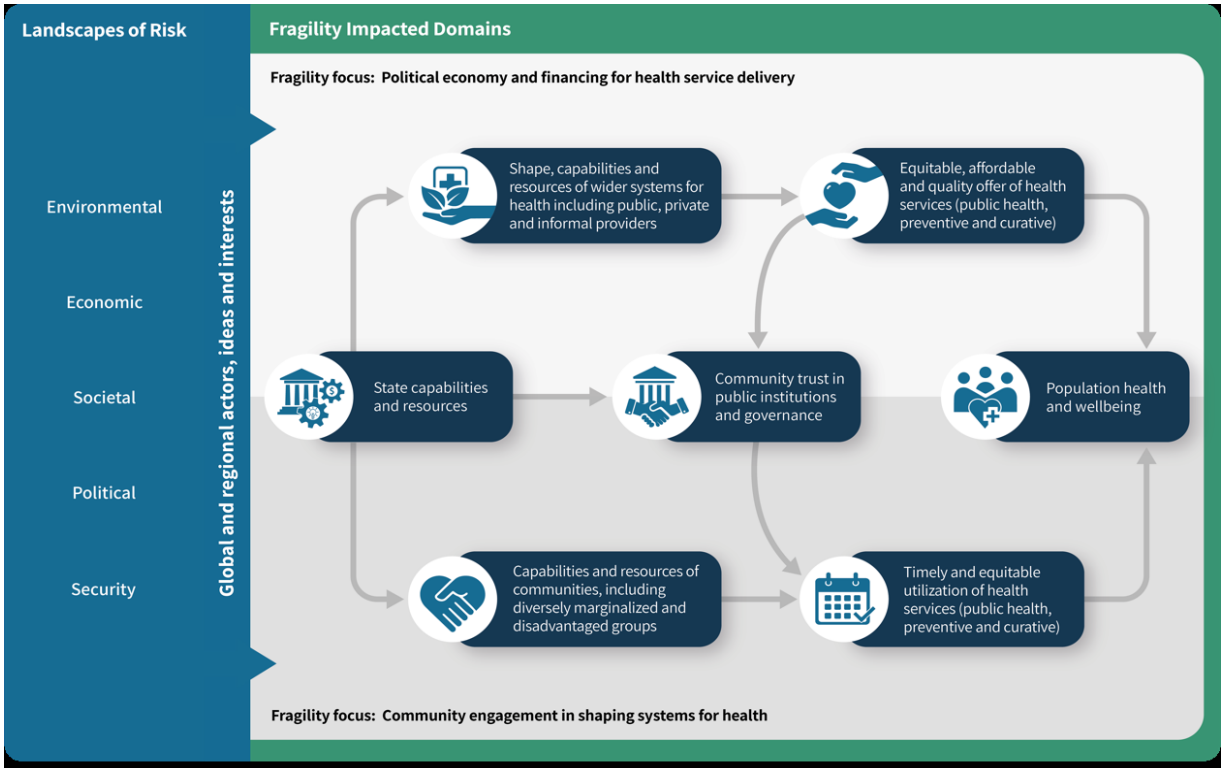
Since 2017, the Research Unit on Health in Situations of Fragility (RUHF) [9] has studied aspects of fragility and their impact on population health. Our research focused particularly on non-communicable diseases and mental health. These disease categories require continuity of care and long-term investments into health service delivery and capacity and, as such, offer an ideal tracer for studying fragility as it relates to health. We worked across Sierra Leone, Lebanon, Nepal, El Salvador and Nigeria: all contexts with escalating risk in relation to at least one fragility related dimension of the OECD framework.

Adopting the OECD's fragility definition, our work explored the capacity of the broader systems for health[7] to deliver care in each setting. We considered the capacities of public, private and not for profit, as well as formal and informal, care providers to deliver NCD and mental health care, subject to the diverse contextual risks and state, system and community capacities present. We examined how communities sought help and health care and perceived care quality of different providers.

Findings across this body of work helped us identify common themes more explicitly linking fragility and health. Based on these, we have formulated a 'fragility for health'

framework (Figure 1). Read from left to right, the framework prompts us to interrogate how diverse risks work to shape two particular domains.

Figure 1: Fragility for Health Framework



First, diverse and interacting risks shape ***the political economy and financing of health service delivery.*** As per the OECD, risks and coping capacities need to be assessed across multiple aspects. For example, this means considering the risk associated with climatic, security and economic shocks and more slow-acting stressors, such as societal discontent and urbanisation, and how these suddenly deplete - or slowly erode - the coping capacities of the state and other institutions over time. For health in fragile contexts, this means that non-state actors and private and not-for-profit entities become increasingly important in determining who delivers health services, when and to whom. Similarly, global and regional actors, including donors and commercial entities, have their own priorities and

interests. Given their influence over state - and consequently health - financing, these priorities and interests substantially shape what care is delivered.[10]

RUHF work in Lebanon illustrated how regional political dynamics and cross-border risks (e.g. conflict and displacement of Syrian refugees into Lebanon) prompted the engagement of donor, humanitarian and private stakeholders, which shaped state and health system capabilities.[11] Public (Ministry of Health) and private health providers (either profit-based or civil society endorsed), and international actors such as the United Nations High Commission for Refugees (UNHCR) and the World Bank, shape who is able to deliver care, where and for whom.[11,12] Financing for service delivery is highly fragmented, with social insurance covering only populations employed in specific sectors, and augmented by the World Bank and UNHCR to ensure coverage for vulnerable host and refugee communities respectively. Strong sectarian political influences, and a relatively weak coordinating capacity at the Ministry of Health,[13] contribute to un-coordinated health planning, including in relation to financing, and result in inequitable and variable quality care delivery.[11,12,13]

A second important focus of inquiry relates to how both the landscapes of risk and institutional capacities within a specific context, and the resulting political economy of health service delivery, shape ***community capacities and their interactions with health actors.*** Our work illustrates how the civil war in Sierra Leone depleted state capacities and resources, including loss of life and infrastructure; over time, this has resulted in an acutely weak resource base for both state and health system functioning, severely restricting the state's ability to introduce needed services to manage chronic conditions.[14] A large part of care for common chronic conditions such as diabetes and hypertension therefore occur beyond formal facilities. Informal local stakeholders – ranging from teachers, through faith

leaders to traditional healers – play an important role in health-seeking journeys.[8,15] Deep-seated spiritual and cultural beliefs, but also the relative convenience and perceived affordability of obtaining care from local traditional healers or medicine sellers, influence who communities seek care from. Mistrust in local health systems – as linked to previous actions during the Ebola Virus Disease outbreak – further reinforce such patterns. [8,9]

COVID-19, climate change, conflict as well as extended economic crises and insidious roll back of freedoms and rights across many countries globally are all protracted risks prompting us to think carefully about how fragility affects individual, population and planetary health. Our work highlights how the pejorative development and global health discourse that associates fragility solely with 'fragile and conflict affected states' is not helpful in achieving this aim. In line with the OECD, we therefore recommend that health actors adopt a more contextually and politically sensitive analysis of fragility and use this in relation to wider systems for health. The proposed 'fragility for health' framing of Figure 1 highlights key areas and linkages to be studies in such analyses.

Summary box

- In the development sphere, the term ‘fragile’ has generally been used as a pejorative label to represent ‘fragile and conflict-affected states’ with chronic governance challenges;
- Beginning with the formulation of the OECD’s multi-dimensional framing of fragility, a broader use of the term is emerging, which is of potential utility in the field of global health;
- Evidence from a series of studies addressing non-communicable disease and mental health provision – both of which require continuity of care and long-term investments into health service delivery and capacity – informs a ‘fragility for health’ framework consistent with this evolving understanding of fragility.
- This framework identifies two domains that warrant more intense, politically sensitive study: political economy and financing for health services delivery and community engagement in shaping systems for health.
- Consideration of these domains will critically inform health interventions in contexts of fragility.

Data availability statement

Data sharing not applicable as no datasets generated and/or analysed for this analysis.

Ethics statements

Patient consent for publication

Not applicable.

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