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The Future of Healthcare in Somalia:

A Bold Step Towards a Nationally Funded and Transparent System

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THE CENTRAL ARGUMENT

Somalia cannot achieve state stability without a strong foundation in healthcare. The prioritization of health needs to transition from being solely dependent on donor funding to becoming an integral component of political, financial, and societal development in nation building efforts.



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A POLITICAL MOMENT

The question before Somalia's leaders is no longer whether health reform is necessary

The question is whether the country will continue to treat health as an emergency portfolio financed project by project, or recognize it as state infrastructure: part of the social contract, economic strategy, national security architecture and federal legitimacy.

For decades, Somalia's health system has absorbed the consequences of conflict, displacement, drought, recurrent epidemics, fragmented financing, workforce shortages, weak regulation and uneven institutional capacity. The extraordinary contribution of development partners and humanitarian actors has saved lives. Yet a system that depends overwhelmingly on external financing remains exposed to decisions made outside Somalia.

WHO reported in October 2025 that approximately 95% of the country's health care funding was externally supported. In 2026, the Health Cluster estimates that 5 million people need health assistance, while funding cuts, access constraints and supply disruptions continue to narrow the response space. [1,2]

This is not an argument for abruptly replacing international partnership. That would be financially unrealistic and operationally dangerous. It is an argument for changing the direction of travel: from dependency without a transition plan to partnership with increasing Somali ownership; from fragmented projects to a costed national service platform; from recurrent crisis financing to predictable domestic commitments; and from institutional ambiguity to enforceable stewardship.



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LEADERSHIP WISDOM

"A nation's sovereignty in the realm of public health is not contingent upon the presence of external donors. True sovereignty is achieved when domestic institutions can safeguard critical services, regardless of shifts in donor preferences." ✍️ : Dr Abdulrazaq Yusuf Drjalaaludiin

THE EVIDENCE AT A GLANCE

Somalia's health reality in six numbers

≈95% Health care funding externally supported WHO, October 2025; funding source definitions vary across datasets.	5.0m People needing health assistance in 2026 WHO Health Cluster Somalia, 2026.	27/100 UHC service coverage index 2024 estimate reported in the evidence brief.
≈31 45% Out of pocket share of health spending Range reflects inconsistent national estimates and absent harmonized health accounts.	3.2 Nurses + midwives per 10,000 WHO GHO estimate; far below a 44.5/10,000 SDG index reference threshold.	\$369.4m Domestic revenue collected in 2024 Up 12.1% year on year; still small relative to national needs.

Interpretation is important: the spending shares above rely on varying denominators across sources. Because Somalia still lacks a unified National Health Account baseline, ranges offer more honesty than false precision.[3]

THE DECISIVE SHIFT



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Health must be recognized as a strategic political priority rather than a matter confined solely to the Ministry of Health.

The greatest potential for reform transcends technical specifications. Although the Ministry of Health may define service packages, standards, workforce strategies, and regulatory frameworks, it lacks the independent authority to create fiscal space, protect appropriations, harmonize federal and state incentives, transform procurement, regulate harmful products, guarantee referral pathways, educate the future workforce, expand water and sanitation services, or build a national digital public infrastructure.

These responsibilities require a whole of government approach. Consequently, health must be central to the presidency's national agenda, the prime minister's coordination mechanisms, cabinet deliberations, parliamentary budgeting and oversight, the upper house's federal equity mandate, the Ministry of Finance's fiscal strategy, and implementation by federal member states. The political challenge is clear: will health remain a line item within a sectoral plan, or will it become a measurable cross governmental obligation?



THE SOCIAL CONTRACT

The intersection of health and the state represent a critical juncture for individuals, highlighting their utmost vulnerability. This encounter essentially acts as a reflection of the state's efficacy and performance.



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BEYOND THE HEALTH SECTOR

Health functions as a critical link to security, stability, and national confidence.

Somalia should avoid the false dichotomy between security and health. Security safeguards communities from violence, whereas health protects against preventable mortality, financial strain, epidemic shocks, and institutional instability; both are indispensable to national stability.

A district with effective primary care, trained community health workers, robust surveillance, safe maternity services, and reliable access to pharmaceuticals reflects not only improved health outcomes but also a strengthened state presence, enhanced early warning capacity, increased public trust, and greater resilience.

Health reform further bolsters economic and social stability. Illness removes individuals from the labor force, depletes household assets through out of pocket costs, disrupts education, and intensifies poverty.

Conversely, a well functioning health system generates skilled employment, preserves family income, reinforces confidence in public institutions, and reduces dependence on foreign medical services that should be available domestically.

The relationship to migration warrants careful framing. Health investment alone will not resolve migration, which is shaped by security, employment, education, family networks, climate, and political expectations.

Nevertheless, improved public services, local health employment, financial protection, and assurance of essential care can mitigate pressures that compel households to relocate, seek treatment abroad, or lose confidence in local institutions. Health is therefore an integral component of a broader strategy to retain opportunity, skills, and confidence within the country.



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HEALTH SECURITY NEXUS

A hospital is not equipped to address issues of insecurity. However, a government that fails to ensure the survival of mothers, provide vaccinations for children, or adequately compensate nurses will face challenges in establishing the necessary trust for long term security.

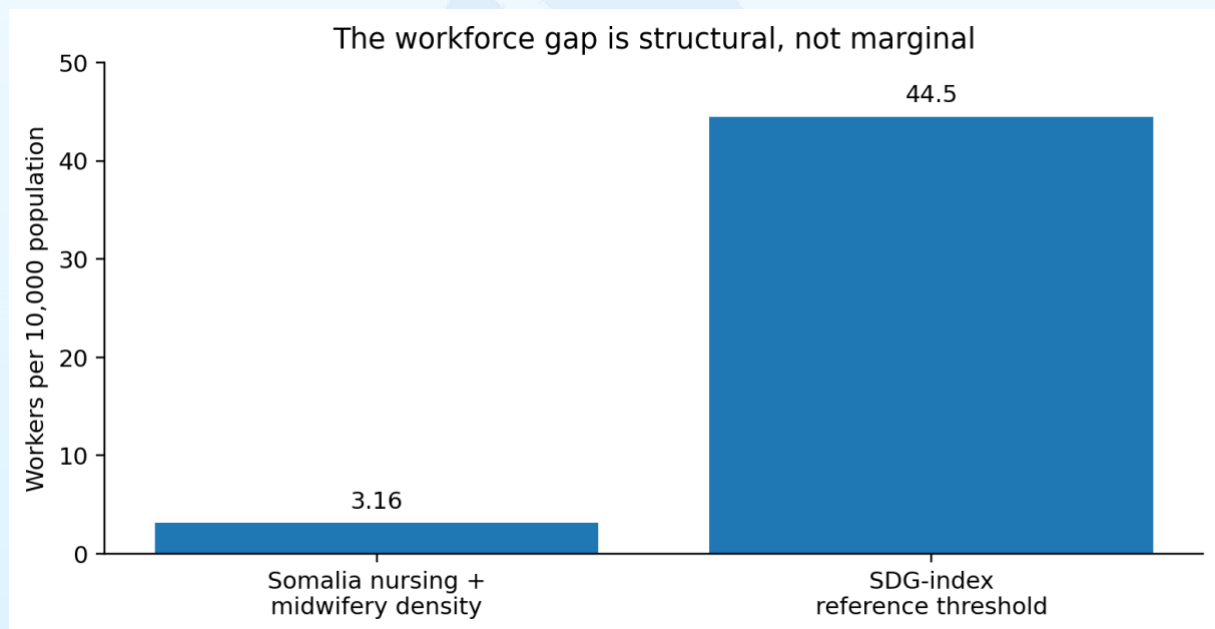


Figure 1. A minimum viable workforce strategy must prioritize task sharing, community cadres, rural retention and phased production not pretend the national gap can be closed at once.[3]

FROM DECLARATION TO DISCIPLINE



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The first transformative factor: measurable political commitment.

Political commitment is not a speech, launch, policy document or institutional name. It is the sustained willingness to make difficult choices: allocate domestic money, protect it from displacement, coordinate across ministries and levels of government, publish results, enforce standards and continue reform after attention moves elsewhere.

The Presidency and Prime Minister should establish health as a recurring national performance agenda, with a small set of indicators reviewed across Cabinet and reported publicly. The objective is not to centralize every operational decision. It is to create an unmistakable political signal that health outcomes, financing and accountability are state performance indicators

Political commitment is visible when... approved health funds are released on time; recurrent services are protected; national and state leaders use the same priorities; procurement and performance are disclosed; and poor results trigger corrective action.

Political commitment is not proven by...

new committees without authority, unfunded strategies, donor funded launches, ambitious targets without execution mechanisms, or institutional announcements that do not change what reaches patients.

FINANCING THE SOCIAL CONTRACT



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The second transformative factor: elevating domestic health financing as a central political and social priority.

WHO's global financing guidance is clear: "No country has made significant progress toward UHC without increasing reliance on public revenues." [4] For Somalia, this principle outweighs any single international spending benchmark. The fiscal base remains narrow, aid is central, and core public functions compete with security, debt service, infrastructure, and administration. The credible aim is thus a binding path toward greater domestic responsibility not an immediate fiscal jump.

Domestic revenue collection is rising. Federal revenue grew from roughly US\$329.5 million in 2023 to US\$369.4 million in 2024. [3] This growth is vital because health financing depends on the state's ability to raise, pool, and spend public resources. Post HIPC fiscal reforms offer a chance to make visible social investment part of the dividend from stronger public finance.

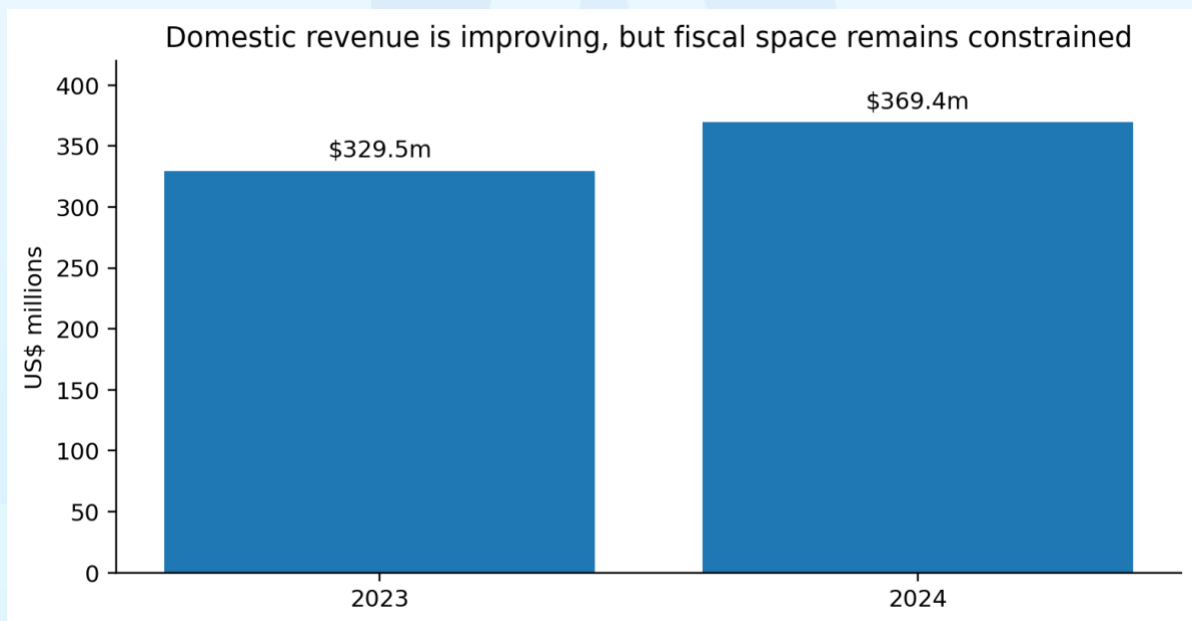


Figure 2. Revenue growth creates opportunity, not automatic health spending. Health gains require explicit political allocation and credible execution. [3]



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A pragmatic financing framework should commence with seven strategic actions:

1. Safeguard existing recurrent health expenditures prior to expansion. Core allocations including salaries, surveillance, essential medicines, district administration, and facility operations must remain secure beyond project lifecycles.
2. Evaluate budget execution rather than allocation alone. Approved funds that are not disbursed cannot procure medicines, compensate personnel, or sustain infrastructure.
3. Establish an annual domestic financing growth rule aligned with realistic fiscal performance. As domestic revenue increases, a transparent proportion of incremental fiscal space should be allocated to essential health functions.
4. Pilot targeted revenue instruments where administratively viable. A 2026 Somalia specific assessment identifies tobacco taxation as a feasible initial measure, contingent upon political consensus, enforcement capacity, equity protections, and transparent revenue utilization.
5. Phase in prepayment and risk pooling. The development of social or national health insurance should be sequenced with enrollment mechanisms, provider accreditation, claims management, subsidy design for vulnerable populations, and a realistic benefit package.
6. Implement strategic purchasing. Public funds should increasingly procure verified outcomes, quality, and equity rather than financing inputs without performance criteria. Somalia's Damal Caafimaad initiative offers a domestic proof of concept for performance based contracting.
7. Negotiate donor transitions function by function. Governments need not assume full project responsibility simultaneously; they may progressively assume specific recurrent functions while partners finance scale up, capital investments, commodities, and technical assistance.



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A realistic financing transition: sequence before scale

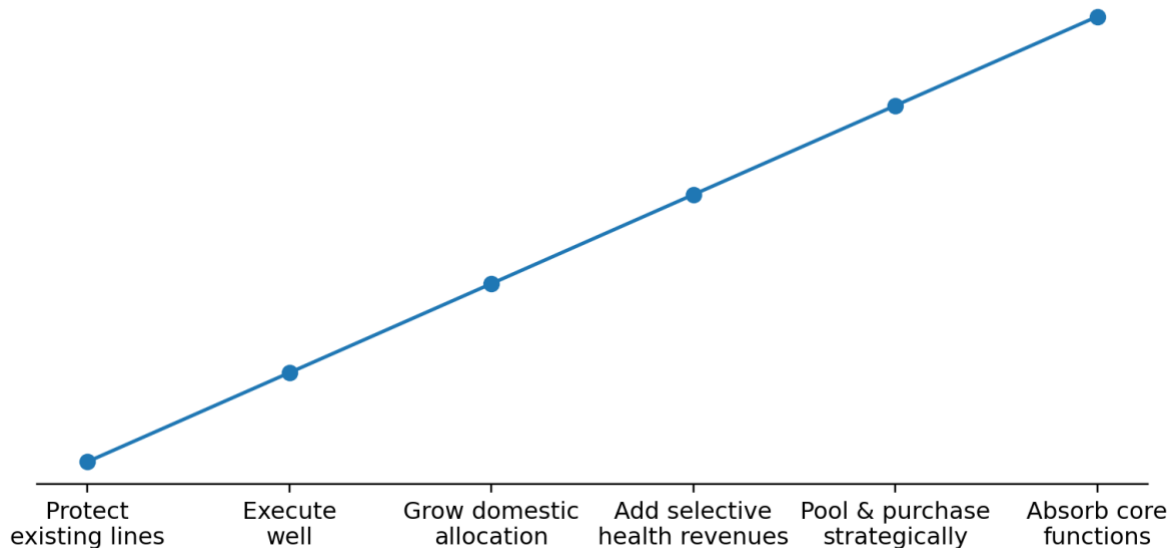


Figure 3. The order of reforms matters. Pooling and insurance should follow stronger budget discipline, purchasing systems, provider standards and data not substitute for them.



FISCAL WISDOM

“The question is not whether Somalia can finance the whole health system today. The question is whether Somalia can finance more of the essentials next year than it finances this year and prove where the money went.”

THE EXECUTION CHALLENGE



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The third transformative factor: governance and stewardship that translate financial investment into health outcomes.

Higher funding without stronger governance may worsen institutional division. Good stewardship turns financial pledges into fair service delivery. In Somalia, this means recognizing key weaknesses such as divided authority, procurement gaps, regulatory limits, incomplete data, uneven local capacity, and donor overlap while applying layered controls instead of waiting for perfect institutions.

The evidence brief notes existing safeguards that can be improved: public financial management systems, Auditor General oversight, high value contract review, third party monitoring, citizen feedback mechanisms, performance based contracting, and digital financial controls.[3] The policy goal is a health sector where all major public or pooled funding flows are fully traceable from allocation through purchaser, provider, and population served.

Governance layer	Minimum rule	Public evidence	Consequence
Budget	Protected lines, timely release, realistic costing	Quarterly allocation and execution dashboard	Correct under execution; protect essential services
Procurement	Competitive, transparent purchasing with conflict controls	Contracts, prices, suppliers, delivery status	Audit, sanction and supplier performance action



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WHOLE OF GOVERNMENT REFORM

Health in All Policies: build health into the machinery of government

Somalia's disease burden is produced far beyond hospitals. Cholera is shaped by water and sanitation. Maternal mortality is influenced by roads, referral transport, female education, household income and security. Malnutrition is linked to food systems, climate and social protection. Workforce supply depends on education, licensing, labour policy and payroll. Financial protection depends on taxation, public expenditure, insurance design and poverty policy. For that reason, "Health in All Policies" should become a practical Cabinet discipline rather than a slogan.

Government portfolio	Health contribution	A measurable cross government commitment
Finance & Revenue	Fiscal space, cash release, pooled financing	Publish domestic health allocation and execution; assess health revenue options
Planning	National priorities and investment alignment	Include UHC, PHC and health security milestones in national performance reporting
Interior & Security	Safe access, referral corridors, protection of facilities	Monitor service interruptions linked to insecurity and protect critical routes



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Government portfolio	Health contribution	A measurable cross government commitment
Water & Local Government	Cholera and environmental health prevention	Link high risk districts to WASH and outbreak prevention investments
Education	Health workforce pipeline and health literacy	Accredit training, align graduate production with national workforce needs
Labour & Social Protection	Formalization, employer contributions, poverty protection	Design contribution/subsidy mechanisms that do not exclude informal or poor households
ICT / Digital Government	Identity, interoperability, claims and surveillance	Adopt common health data standards and secure digital verification
Justice & Oversight	Regulation, procurement integrity, anti fraud enforcement	Operationalize sanctions and public reporting for major breaches

SEQUENCE BEFORE SCALE

A streamlined health system for a delicate and decentralized environment



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Somalia cannot deliver every service everywhere with equal quality at once. This reality should not be seen as failure; instead, it should guide a clear prioritization plan. The EPHS 2020, Damal Caafimaad, and global experience with essential service packages offer a stronger path than spreading limited funds across too many commitments.[3]

A minimum viable approach is to secure a defined set of high value services in selected districts, then expand as financing, staffing, and governance improve. Priorities should reflect population need, geographic access, disease burden, maternal and child risk, displacement, insecurity, current facility readiness, and the practicality of sustaining recurring costs.

Protect first

Maternal and newborn care; immunization; communicable disease prevention and treatment; nutrition; emergency and referral care; essential medicines; community health; surveillance and laboratory functions; high burden chronic disease services that can be reliably delivered at PHC level.

Build the platform

District management; supply chain; workforce supervision; digital reporting; referral systems; procurement integrity; provider standards; patient feedback; and financing arrangements that keep facilities functional between donor cycles.

PEOPLE ARE THE SYSTEM

Reforming the workforce: Prioritize bridging the service gap over solely focusing on numerical targets.

Somalia's health worker deficit is too large for a single recruitment campaign. The evidence suggests a combined approach: task sharing, community health workers, rural retention policies, targeted production of scarce cadres, supportive supervision, stronger licensing and gradual absorption of project funded personnel.[3]

The most politically useful workforce metric is not the number of graduates produced. It is the number of verified, competent workers delivering priority services in underserved districts, with regular pay, supervision, supplies and a defined scope of practice. Training without employment planning can create frustration and migration; employment without quality assurance creates risk. Workforce planning must link education, regulation, financing and deployment.



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WORKFORCE WISDOM

“A health worker who is trained but unpaid is not system capacity. A health worker who is paid but unsupported is not quality. Leadership must finance the conditions in which competence becomes care.”

THE ACCOUNTABILITY MAP

Measures that can be implemented by each national leadership institution at this current juncture.

Leadership actor	Decisions now	How to measure commitment
President / Presidency	Declare health, UHC and financial protection a national political priority; require an annual national health performance review.	Visible national targets, annual report, sustained high level review and corrective decisions.
Prime Minister / Cabinet	Create a Cabinet level Health in All Policies and Financing Compact; resolve	Quarterly decisions on financing, workforce,



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Leadership actor	Decisions now	How to measure commitment
	cross ministerial bottlenecks; align partners with national priorities.	medicines, WASH, security access and digital systems.
House of the People	Protect health appropriations; legislate financing, regulation and accountability; hold budget execution hearings.	Approved versus released versus spent health funds; audit follow up; law implementation.
Upper House	Use federal representation to strengthen equitable allocation, FGS FMS role clarity and national minimum service commitments.	District coverage equity, intergovernmental agreements and reduced duplication.
Ministry of Finance	Integrate health into medium term fiscal planning; protect recurrent lines; strengthen execution and transparency.	Domestic share, execution rate, predictable releases, public expenditure tracking.
Ministry of Health	Set the service package, standards, purchasing rules, workforce priorities, quality and data architecture.	Coverage, quality, stockouts, workforce deployment, provider performance and financial protection.
Federal Member States	Translate national priorities into district delivery,	Priority districts operational, verified staff, local scorecards and referral functionality.



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Leadership actor	Decisions now	How to measure commitment
	workforce supervision and community accountability.	
Private sector, diaspora & civil society	Co finance, innovate and deliver within common standards; support transparent public private mechanisms and citizen oversight.	Accredited participation, reported outcomes, co investment and grievance resolution.

STRATEGIC SUPERVISION LEADING TO BEHAVIOR MODIFICATION

Ten inquiries that Parliament and Cabinet ought to pose each quarter.

1. How much of the approved health budget was financed domestically, released and actually spent?
2. Which essential recurrent functions remain dependent on a single external donor or project?
3. Which districts have the lowest access to the minimum service package, and what changed this quarter?
4. Which facilities experienced stockouts of essential medicines, oxygen, vaccines or diagnostics and why?
5. How many verified health workers are deployed in underserved districts, and how many payroll gaps remain?
6. What are the largest health contracts, who won them, what was delivered, and what independent verification exists?
7. What proportion of public or pooled financing is tied to measurable provider outputs and quality?



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8. What patient complaints recur most frequently, and what corrective actions were completed?
9. Which donor funded functions have an agreed transition or co financing plan?
10. Which indicators show that households are becoming better protected from catastrophic health spending?

AVOIDABLE REFORM FAILURES

What must not happen

1. Do not create an insurance scheme that promises more than the provider network can deliver. Pooling money cannot substitute for functioning services.
2. Do not expand benefits faster than revenue, purchasing systems, fraud controls and provider accreditation can support.
3. Do not measure health political commitment only by budget allocation. Measure release, execution, outputs and outcomes.
4. Do not replace donor fragmentation with government fragmentation. A national package needs common rules across financing streams.
5. Do not nationalize donor funded functions abruptly. Transition should be phased and explicitly costed.
6. Do not hide uncertainty in the data. Somalia needs a National Health Accounts process, stronger expenditure tracking and a single set of agreed metric definitions.
7. Do not treat governance as a reputational issue. Procurement, payroll, contracting, regulation and audit are clinical quality and survival issues.



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Key proposition

In Somalia, UHC is primarily a governance and trust challenge before it becomes a financing challenge.



Why sequence matters

- Expanding services without fixing stewardship can deepen fragmentation.
- Pooling funds without trust can fail to change care-seeking behavior.
- The fastest near-term wins come from primary care, CHWs, mobile outreach, and digital basics.
- The sustainable end-state is national pooling — but only after institutional foundations improve.



REFORM WISDOM

“In delicate systems, ambition without proper planning can lead to additional vulnerabilities. The most effective reform is one that remains operational during budget constraints, shifts in leadership, and unforeseen crises.”

THE CALL TO LEADERSHIP

A national compact for health, security and stabilization

Somalia's health system has reached a strategic crossroads. The country has accumulated policy frameworks, partner investments, health worker experience, community networks and lessons from repeated emergencies. It also has a growing domestic revenue base and a post HIPC reform environment. What is missing is not knowledge of the problems. What is missing is the political conversion of that knowledge into predictable money, accountable institutions and an implementation sequence that survives beyond individual projects.

The Presidency can make health a national political priority. The Prime Minister and Cabinet can make it a whole of government agenda. Parliament can protect funding and demand execution. The Upper House can ensure federal equity. The Ministry of Finance can convert revenue growth into visible social investment. The Ministry of Health can steward a



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minimum package with quality, data and accountability. Federal Member States can make the national commitment real in districts and facilities. Development partners can shift from parallel delivery toward co financed transition. Communities can become partners in oversight rather than passive recipients.

The core political proposition is therefore straightforward: health financing should sit at the top of Somalia's political and social agenda because it is simultaneously an investment in human capital, household protection, state legitimacy, emergency resilience, productivity, security and stabilization. Health is not the residual sector to be financed after every other national priority. It is one of the foundations that makes every other priority more sustainable.



FINAL LEADERSHIP MESSAGE

“The trajectory of Somalia's healthcare system will not be dictated by the forthcoming policy paper. Rather, it will be shaped by the allocation of financial resources, the enforcement of institutional policies, and the protection of key priorities by the nation's leaders in times of scarcity.”

HEALTH IS THE BRIDGE

From survival to stability. From dependency to partnership. From projects to institutions. From promises to protection.

FOR RESPONSIBLE PUBLIC COMMUNICATION



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Scholarly articles, data analysis, and suggestions for further study.

Several health financing estimates for Somalia displays definitional inconsistencies. Out of pocket expenditure is reported at approximately 31% to 45% of current health expenditure across sources; external financing varies depending on whether the denominator is total current health expenditure or health service delivery costs. Accordingly, the evidence brief recommends reporting ranges and denominators rather than a single figure.[3]

Workforce data sources utilize divergent cadre definitions and update cycles; consequently, the 2021 national estimates and subsequent WHO data should not be interpreted as a longitudinal trend. Maternal and child mortality figures represent modeled estimates rather than complete civil registration counts. These limitations underscore rather than diminish the necessity for national health accounts, a consolidated workforce registry, and routine public reporting.[3]

The proposition that health investment may support stabilization and mitigate certain migration pressures should be regarded as a systemic pathway rather than a direct causal relationship. Security, livelihoods, education, governance, climate, and family networks remain principal determinants of migration and displacement.

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Dr. Abdulrazaq Yusuf Ahmed is a physician and senior public sector leader with more than two decades of experience transforming health systems in fragile and post-conflict environments. He blends clinical practice with advanced training in public health, health economics, and demography to design pragmatic, sustainable reforms that expand access, improve quality, and strengthen financial protection. Dr. Ahmed has led national policy development, fiscal and governance reforms, and institutional turnarounds, and he advises governments, UN agencies, and donors on pathways to Universal Health Coverage. He is recognized for aligning diverse



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stakeholders around a single national vision and for mentoring the next generation of health leaders.

