Somalia's health system at a crossroads: Sustaining essential services in a changing financing landscape

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Key messages

Somalia's health system is under severe strain following sharp reductions in international financing. An estimated 85–90% of total health financing comes from development partners. As these resources contract, service delivery has been disrupted, coverage has narrowed, and the already fragile health system is experiencing heightened strain.

Domestic financing remains both limited and unstable. Public spending represents only 6–7% of overall health expenditure, and the health share of the national budget declined from 8.5% in 2023 to 4.8% in 2024 [1]. Meanwhile, households bear nearly half of total health costs through out-of-pocket payments (45–50%), while health insurance coverage reaches just 3.5% of the population [2]. The private sector provides more than 70% of services yet operates in a largely under-regulated environment. Although some partners, including the World Bank, engage with government systems, most external assistance remains off-budget.

Without faster progress in mobilising domestic resources, clearly prioritising and protecting a core package of essential services, strengthening financial governance, and formally integrating the private sector and diaspora within national frameworks, essential services will remain highly vulnerable to further funding declines. Importantly, political economy dynamics shape how resilient responses are pursued in Somalia's aid-dependent health service sector. Federal authorities seek greater stewardship but have limited fiscal control, while state governments prioritise keeping services operational through pragmatic arrangements with NGOs and donors, often increasing fragmentation. Donor emphasis on national ownership is constrained by concerns over fiduciary risk and short funding cycles, meaning inequitable measures, such as reduced benefit packages or higher user fees, have become rational survival strategies.

Background

Somalia's health financing structure is inherently unstable. External partners finance more than 90% of total public health expenditure, while government spending contributes approximately 6–7%. Although the government share of current health expenditure increased to 14.17% in 2023 (from 3.4% in 2015), health remains inconsistently prioritised within the national budget, with allocation declining from 8.5% of total public expenditure in 2023 to 4.8% in 2024. Domestic resource mobilisation is insufficient to absorb reductions in external support, despite debt relief facilitated by the International Monetary Fund and the World Bank [3].

Financial protection mechanisms are weak. Out-of-pocket (OOP) payments account for almost 50% of total health expenditure—above the Sub-Saharan Africa average (35.7%) and the global average (18.6%). Only 3.5% of the population is insured. Catastrophic health expenditure (≥10% of income) affects 24% of households, compared to 16.5% regionally and 11.7% globally, reflecting high vulnerability to health-related impoverishment.

This financing configuration—high external dependence, limited fiscal space, weak risk pooling, and heavy household burden—creates structural exposure to funding volatility and constrains progress toward sustainable, equitable health coverage.

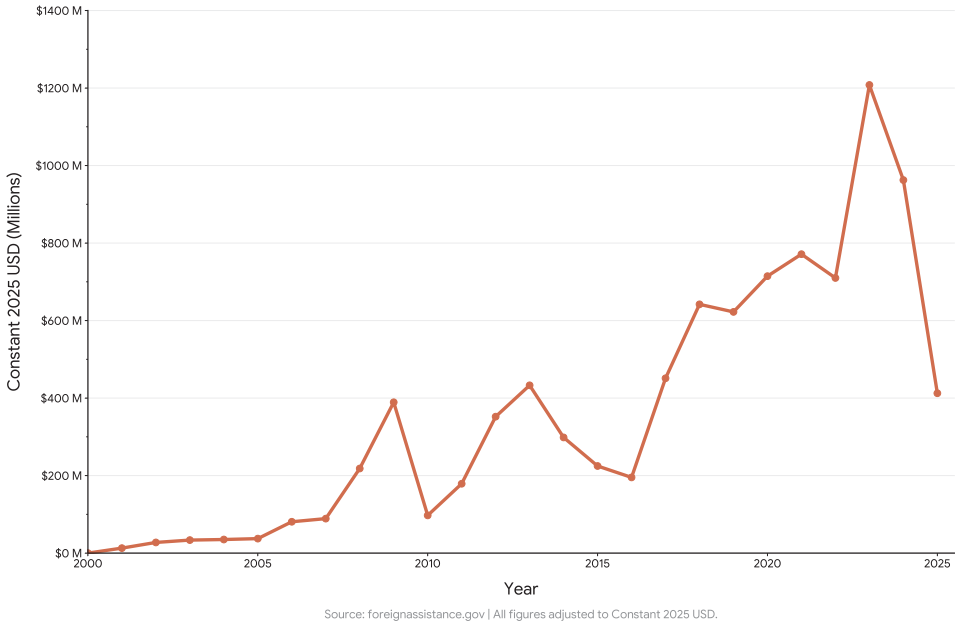

Figure 1. US Foreign Assistance to Somalia, 2000-25 (inflation adjusted)

Impact analysis: Sector consequences

Overall, humanitarian and health funding fell sharply in 2025, with only 27% of needs met and resources down by about three-quarters from 2024. Gaps forced service cuts, leaving millions without or at risk of losing access to health and nutrition care.

Following the 2025 funding cuts (see figure 1), health service capacity is contracting nationwide. In South West State [4], 40 facilities have closed and mobile outreach teams declined from 74 (2024) to 25. In Puntland, 79 facilities—including all 29 public health units—have ceased operations. In Banadir, closure of 20 supplementary feeding sites will interrupt treatment for 12,700 malnourished children, including 1,120 with severe acute malnutrition.

Funding gaps are the primary driver. By mid-2025, Health, Nutrition, Food Security, and WASH Clusters had received less than 50% of 2024 funding levels. The 2025 humanitarian response target was reduced from 4.6 million to 1.3 million people (–72%), while required funding fell from US$1.42 billion to US$367 million (–74%), despite unchanged needs [5].

Further disruptions are imminent. Support for 406 facilities has ended— for 308 financed by the World Bank in December 2025 and 98 supported by the UK government's Foreign, Commonwealth and Development Office in Q1 2026—putting services for approximately 1.5 million people at risk [6]. Following suspension of support from USAID, more than 300 nutrition centres reportedly closed, resulting in a 24% drop in treatment coverage, 59% reduction in Targeted Supplementary Feeding Programmes (TSFP), and 43% reduction in Preventive Supplementary Feeding Programmes (PSFP). Stock-outs of essential medicines and nutrition supplies are projected in 2026 [7]. Three active epidemics—acute watery diarrhoea (cholera), diphtheria, and measles—are ongoing as of March 2026. Reduced outreach, weakened surveillance, and rising malnutrition cases (reported since January 2025) heighten mortality risk, particularly in South-Central regions and among children, pregnant women, and displaced populations [8].

The system is undergoing measurable contraction in coverage, service continuity, and outbreak response capacity as financing gaps widen. While facilities have responded by increasing user fees, with households already covering 45–50% of total health spending OOP, financial protection is minimal and there is little scope for increasing OOP expenditure. In response to budget shortfalls, facilities are trimming benefit packages—scaling back preventive health programme activities including reductions in outreach activities and service delivery points.

These service reductions are compounded by workforce cuts and recurring shortages of essential medicines. Fewer staff, intermittent drug supplies, and scaled-down operations are disrupting continuity of care and lowering service quality. Rather than strengthening protection during a fiscal shock, these adjustments narrow the effective package of care and further weaken access, reliability, and system resilience.

Resilient responses: bottlenecks and leverage points

Sustaining essential health services amid declining external financing requires a sequenced and connected approach, combined with structural reform rather than isolated interventions.

First, **protecting and reprioritising essential services** is the foundation of all subsequent reforms. A revised and clearly defined and costed health service package—centred on maternal and child health, nutrition, immunisation, and epidemic control— would create a realistic baseline for financing decisions. By narrowing the focus to high-impact interventions, the government could align limited domestic resources, guide donor contributions, and prevent fragmented or duplicative investments. However, key constraints remain to achieve this, including unclear division of responsibilities between federal and state authorities, which weakens accountability and slows decision-making. A large share of donor resources is managed outside government systems, sometimes limiting national oversight and control over externally-financed programmes. During interviews for this study, some informants also noted a persistent expectation that external partners will intervene during crises, reducing the urgency to undertake difficult domestic budget reallocations and reforms.

Second, **establishing a transitional pooled financing mechanism** would operationalise these priorities. Once the core package is defined, pooled funding could channel resources directly towards agreed national priorities. Progress towards this has so far been slower than anticipated due to concerns about the strength of financial oversight systems and broader political uncertainty. Limited domestic revenue generation and overlapping fiscal responsibilities across levels of government also make it more challenging to establish a reliable pooled funding mechanism. Overall, the primary constraints relate less to technical design and more to strengthening governance systems and coordination mechanisms. However, the possibility of creating a pool fund— potentially linked to programmes supported by the World Bank— would remain a key entry point to help improve predictability of funding, reduce parallel funding streams, and strengthen coordination across federal and state levels, ensuring that financing structures reinforce service prioritisation rather than undermine it.

Bursalah Referral Health Centre, supported by International Rescue Committee with funding from GFFO, has closed due to a funding gap.
Photo credit: Mohamed Kamal

Third, **formalising private sector and diaspora engagement** would sustain service delivery within this prioritised framework. Given that private providers deliver more than 70% of services, structured regulation, contracting, and co-financing arrangements would be necessary to align market-based provision with national health objectives. However, these contributions currently remain mostly outside structured government planning and oversight frameworks. To use the private sector and diaspora more effectively as sources of resilience, clearer rules, stronger accountability arrangements, and well-designed incentives would be needed to ensure that service delivery supports national priorities and promotes equitable access. Diaspora engagement differs from private sector participation because it is largely voluntary and would require supportive measures to encourage involvement. Transparent channels for financial contributions, opportunities to collaborate with domestic health institutions, and platforms for sharing professional expertise would help direct diaspora support towards national health priorities and improve equitable access to services.

Finally, **strengthening domestic financing and governance could reduce long-term vulnerability.** Protecting health budget allocations, improving public financial management, and institutionalising expenditure tracking would be essential to sustain gains and restore donor confidence.

Political economy considerations shaping resilient responses

Beyond these considerations, the ability to sustain essential services in Somalia is shaped by how incentives, risks, and authority are distributed across actors. Federal authorities face pressure to assert stewardship over a highly aid-dependent sector but have limited fiscal leverage and incomplete control over largely off-budget resources. State governments, by contrast, are primarily accountable for keeping services operational and tend to favour pragmatic, delivery-focused arrangements with NGOs and donors, with the risk of increased fragmentation. Donors emphasise prioritisation and national ownership but in reality they remain constrained by fiduciary risk, short funding horizons, and geopolitical pressures, all of which contribute to continued parallel modalities. As a result, decisions such as reducing benefit packages or increasing user fees, are rational survival strategies, despite their inequity.

These dynamics help explain why there is broad agreement on reform objectives but persistent divergence in practice. This suggests that progress will depend not only on technical solutions—such as pooled funds or revised benefit package—but on how these instruments interact with existing incentives, political settlements, and adaptive behaviours across the system.

Bandiradley Health Centre, supported by International Rescue Committee with funding from GFFO, has closed due to a funding gap. Photo credit: Mohamed Kamal

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Front cover: K13 health facility in Bandir region closed in 2025 due to the funding gap. Photo credit: Abdi Aden