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POLICY PAPER

BEYOND DONOR AID: SUSTAINABLE HEALTH FINANCING THROUGH LOCALLY DRIVEN STRATEGIES IN PUNTLAND STATE OF SOMALIA.

EXECUTIVE SUMMARY

This policy brief examines the health financing landscape of Puntland State of Somalia, highlighting current financing mechanisms and potential sources for mobilizing additional resources for the health sector. Key findings include:

- **The Government of Puntland currently lacks the domestic capacity** to mobilize adequate resources for the financing of basic healthcare services, resulting in a heavy dependence on external donor support.
- **Health financing in Somalia is overwhelmingly dominated by external actors,** who contribute more than 80 percent of total national health expenditure, underscoring the fragility and unsustainability of the system
- **Due to sustained donor investment, Puntland hosts a significant proportion of Somalia's health centers.** These facilities are largely managed by international and local non-governmental organizations, which provide critical inputs such as medical equipment, pharmaceuticals, and remuneration for health personnel. However, without the establishment of alternative and sustainable financing mechanisms, the continuity of these services remains at serious risk
- **Donor support has declined by more than 60 percent,** primarily as a result of the COVID-19 pandemic and ongoing global conflicts, including the war in Ukraine. This reduction in available funds for developing countries has placed Somalia at heightened risk, with thousands of people potentially losing access to essential health services.
- **Out-of-pocket payments remain the dominant source of health financing,** imposing a disproportionate burden on households already living in poverty. Many families are forced to liquidate assets or exhaust savings in order to meet healthcare costs, further entrenching economic vulnerability.
- **There is an urgent need for government-led reforms to strengthen health financing and diversify resource mobilization strategies.** Key measures include expanding domestic revenue generation and introducing health insurance mechanisms designed to alleviate the financial strain on households.[2]

INTRODUCTION

The attainment of universal health coverage (UHC**)** is a central goal for all countries seeking to fulfill the Sustainable Development Goals (SDGs)**.** Specifically, SDG 3 emphasizes the[3] need for accessible and affordable basic healthcare services that do not impose financial hardship on populations. To achieve UHC, countries are encouraged to increase health expenditure in line with the Abuja Declaration, which recommends allocating at least 15 percent of the national budget to health.

Financing health systems, however, remains a formidable challenge. It requires governments to dedicate substantial portions of their budgets to service provision, infrastructure, and workforce development. Many developing countries struggle to mobilize sufficient domestic resources to meet these demands. As a result, they often rely heavily on external donor support to bridge resource gaps and finance a significant share of health expenditures.

Somalia is among the countries marred by years of instability and civil war, which devastated health sector infrastructure and forced many health professionals to flee. Following the collapse of the Somali government, the healthcare system also disintegrated.

Before the civil war, healthcare services were publicly provided by the government free of charge. Although private sector involvement in health provision was gradually increasing in urban areas, the majority of the population relied heavily on government-funded services.

Since 1991, Somalia's healthcare system has depended largely on external aid—both bilateral and multilateral. Despite progress in state-building, the government's contribution to health financing remains minimal and almost invisible, accounting for less than 3 percent of the national budget, far below the levels of neighboring countries. International donors have supported the sector through various initiatives, including the Essential Package of Health Services (EPHS). However, donor support is often shaped by external priorities and interests, with a focus on vertical programs(targeted interventions) rather than horizontal approaches that strengthen the overall health system.

The Essential Package of Health Services (EPHS) has remained the primary health framework in Somalia, reaching approximately 47 of the country's 90 districts and covering an estimated 5.7 million people. External donors continue to be the main financiers of the package. The EPHS focuses on six major components: child health, maternal and reproductive health, communicable diseases, first aid, and other essential services. However, research indicates that while the package was initially limited in scope, its implementation has been uneven, with disproportionate coverage across the six components.

Moreover, the EPHS has struggled to alleviate the burden on poor communities. In practice, it has tended to benefit wealthier families, as many of its key components have been concentrated in urban areas, leaving rural and marginalized populations underserved.
In addition to donor support, the private sector has played a crucial role in the provision of health services in Somalia, accounting for an estimated 60–70 percent of service delivery. Despite its significant contribution, private healthcare faces major challenges, including poor quality of care, lack of equipment, limited capacity building, and high costs. As a result, the reliance on private providers places a heavy financial burden on households, rendering services unaffordable for the majority of the population.

Although substantial donor support to the health sector, Somalia ranks among the lowest performers in the assessment of Universal Health Coverage (UHC). With recent reductions in donor aid for health, there is growing concern that the entire healthcare system could collapse if immediate interventions and reforms are not undertaken. The Ministry of Health in Puntland has reported that more than 60 percent of health financing was cut by donors, placing hundreds of health facilities at risk of closure.

Against this backdrop, this policy brief seeks to examine the current status of health financing in Puntland, identify existing sources of finance, and highlight potential avenues that could be explored to address the looming healthcare crisis before it escalates further.

METHODOLOGY

This policy brief is the outcome of a two-day health financing conference organized by the Ministry of Health of Puntland in collaboration with international partners. During the conference, dozens of health experts delivered presentations on best practices for financing health in fragile contexts such as Somalia. These were followed by panel discussions that examined and analyzed the health status of Somalia, with particular focus on Puntland State.

In addition, a major forum was convened by the Puntland Development Research Center (PDRC), which featured a senior health expert and provided an open platform for participants to discuss key issues related to health financing.

The policy brief also draws on secondary data sources, including strategic documents, reports, and academic articles on health financing in Somalia, with specific emphasis on Puntland.

AN OVERVIEW OF SOMALIA HEALTHCARE SYSTEM.

The Somali healthcare system is ranked among the poorest in the world—fragmented, unregulated, and underfunded. Health services are organized into a four-tier structure consisting of referral hospitals, regional hospitals, health centers, and primary health units.
There are two main healthcare service providers: the public sector and the private sector. The public sector, led by the Ministry of Health, manages dozens of publicly owned hospitals, health centers, and primary health units. It is estimated that Somalia has 846 public health facilities (Said & Kicha, 2024). These facilities often charge fees like private hospitals and receive minimal government support.
In 2009, with donor assistance, the government introduced the Essential Package of Health Services (EPHS) to promote and deliver basic services nationwide. The EPHS covers six core components:

- Maternal, reproductive, and neonatal health
- Child health
- Communicable diseases, surveillance, and control
- First aid and care for critically ill and injured patients
- Treatment of common illnesses
- HIV, sexually transmitted infections (STIs), and tuberculosis (TB)

The private sector is the most important actor in the provision of health services in Somalia, covering approximately 60 percent of healthcare delivery and supplying about 70 percent of the country's medicines. It is estimated that 90 percent of the population relies on private healthcare, which is often expensive and unaffordable for the majority (Gelle, 2017).

The private health sector has expanded significantly since 1991. By 2016, there were 3,289 private health facilities across the country, with 80 percent located in urban areas (Heritage, 2018). Despite the dominance of private providers, many Somalis continue to prefer and trust public healthcare services (Gelle, 2017). In terms of health indicators, Somalia also ranks among the lowest globally. According to the Puntland Health and Demographic Survey Report (2020), life expectancy is 53 years for men and 56 years for women. Infant mortality remains alarmingly high at 85 per 1,000 live births, and one in 24 women faces a lifetime risk of maternal death. The maternal mortality ratio was estimated at 622 per 100,000 live births in 2015.

Only 9 percent of children aged 12–23 months are fully vaccinated, while malnutrition affects 25.2 percent of children under five. Although communicable diseases continue to dominate, non-communicable conditions such as hypertension, diabetes, kidney disease, and liver disease are on the rise, affecting approximately 5 percent of the population (PHDS,2020). Female genital mutilation (FGM) remains nearly universal, with a prevalence of 98 percent, contributing to long term reproductive health risks (Capobianco Emanuele & Veni Naidu, 2008).

Somalia's poor healthcare system can be attributed to multiple factors, including a shortage of health workers, weak health infrastructure, an unregulated health system, heavy donor dependency, and the complex governance structure of the health sector.

A critical shortage of health professionals remains the most pressing challenge facing Somalia's health sector. It is estimated that there are only 4.28 physicians per 10,000 people, far below the WHO standard of 22.8 health professionals per 10,000 people.

Nevertheless, there have been promising developments in recent years. Somalia now has approximately 25 medical schools, compared with only one in 1991. The number of graduating students in medical related fields has also increased, with an estimated 14 percent of graduates specializing in health sciences (MM Hasan et al. 2024). Despite these improvements, the shortage of skilled health workers continues to result in poor access to healthcare, particularly in rural and hard to reach areas (Marco Schaferhoff, 2014).

Another major challenge is **the inadequate regulatory framework.** The government has limited capacity to oversee a health sector that is largely dominated by private providers. The absence of effective regulation has led to the proliferation of health professionals with insufficient qualifications, which at times poses risks rather than solutions to health problems. This regulatory gap has also contributed to the maldistribution of skilled health workers, who overwhelmingly prefer to work in urban centers and major cities. For example, only 20 percent of private health facilities are located in rural areas (Heritage, 2018). The poor quality of healthcare services has further increased patient dissatisfaction, prompting many Somalis to seek medical treatment abroad (SIDRA, 2024).

Another major challenge is the **poor health infrastructure**. A functioning healthcare system requires well equipped facilities capable of delivering services to citizens in need. Unfortunately, much of Somalia's health infrastructure was destroyed during the civil war, leaving only a few adequately equipped hospitals in urban centers.

According to the Health Sector Strategic Plan (2022–2026), Somalia's health facility density is just 0.93 per 10,000 people, reflecting a 72 percent deficit in health infrastructure. In rural areas, health units provide only limited essential services, often lacking medical supplies and qualified personnel.

This forces patients to travel long distances in search of care and has resulted in 61.2 percent of the nomadic population not seeking medical services (PHDS, 2020).

Governance complexity is another major challenge. Studies have shown that the provision of health services is closely linked to the state capacity of government (Shaferhoff, 2014). In Somalia, the healthcare system has been heavily affected by decades of conflict, political instability, and underdevelopment. Governments at all levels—federal and state—lack the financial and technical capacity to deliver adequate health services to citizens. Weak coordination between federal and state authorities further fragments the system, making service delivery uneven.

Dependence on external donor funding has also made the country vulnerable to unpredictable and short-term financing. Donor priorities often overshadow national health priorities, focusing on narrow, vertical programs rather than comprehensive system strengthening. This reliance creates uncertainty, particularly when donor agendas shift.

Despite these challenges, Puntland has made notable progress. It currently hosts 419 health centers—half of Somalia's total—and recorded 1.4 million outpatient visits in 2024. The number of health professionals has grown to 1,935, including nurses, midwives, and doctors. However, this figure remains far below the WHO standard, which requires at least 19,290 health professionals to adequately serve Puntland's population (Puntland Ministry of Health).

WHERE DOES HEALTH FINANCING COME FROM?

Health financing sources refer to the institutions and mechanisms that provide funds to strengthen the health system. Currently, the largest share of health financing in Somalia comes from out-of-pocket payments made by households from their disposable income. It is estimated that 49 percent of Puntland's population pays health expenses directly from their income (SHDS, 2020). Per capita health financing in Somalia is estimated at USD 13–15, far below the WHO recommended USD 86 per capita. Given that poverty affects more than 70 percent of the population, approximately 37.5 percent of Puntlanders are unable to afford health bills, leading many to forgo or delay seeking healthcare services (PIHHS, 2022).

Donors also play a crucial role in financing the healthcare sector, providing more than 70 percent of total health expenditure. International funding for health has grown significantly, from USD 62 million in 2006 to USD 265 million in 2020. Donor support extends beyond health, accounting for 67 percent of the overall budgets of both Somalia and Puntland. Donors contribute 90 percent of EPHS funding (Khalid, 2025), and Puntland has received a notable share of donor resources—between 2000 and 2008, it received 19 percent of total health sector funds (Capobiano & Naidu 2008).

By contrast, the federal government of Somalia contributes less than 10 percent of national health expenditure. In 2025, the government allocated USD 91 million to the Ministry of Health, primarily for assets, equipment, and salaries (SPA,2025). At the state level, only 1 percent of Puntland's budget was allocated to its Ministry of Health. This underscores how health financing remains a low priority across different levels of government in Somalia.

ALTERNATIVE SOURCES OF HEALTH FINANCING: TOWARDS SUSTAINABLE HEALTHCARE SYSTEM

Increase tax-based financing; Tax based health financing relies on the collection of government revenues, which are then allocated to health service provision for the population. This model, used by the Somali government before its collapse, is notable for its potential to achieve universal coverage, reduce fragmentation caused by multiple stakeholders, and enhance the quality of services provided.

However, this financing approach has significant limitations. It requires dedicating a high percentage of national income to the health sector—an unrealistic expectation in a low-income country such as Somalia, which depends heavily on foreign aid to subsidize its national budget. Expanding tax-based financing also necessitates broadening the tax base, which may generate resistance among taxpayers if it involves raising tax rates.

The government nonetheless holds the primary responsibility to ensure affordable and accessible healthcare for its citizens. To meet this obligation, it must increase health budget allocations and strive to achieve the 15 percent threshold set by the Abuja Declaration. Additional revenue could be mobilized through targeted taxation on harmful products such as khat and tobacco, as well as through increased taxation of corporations that are currently undertaxed.

Social health insurance is one of the most effective and widely used models globally, particularly in middle and high income countries. It is a payroll funded scheme, typically for civil servants, which relies on a small percentage of their income to cover basic health services. Contributions are collected and deposited into a national insurance agency account for management and distribution. This model is an effective way to increase health revenues and expand coverage, often attracting less resistance when citizens are assured that the funds will be used for their own health needs. Social insurance can also improve service quality, as providers are contracted to deliver care and can be removed from the provider list if they fail to meet standards.

However, the model faces several challenges. It is costly to fund a country's health system solely through employee contributions, and administrative costs are often high. Inequalities may arise since contributions are linked to income, even though the system is intended to cover non contributors as well. Effective implementation also requires independent financial management, which can be difficult in fragile governance contexts. Over time, subscription rates may decline, further weakening the system.

Although health insurance is not yet popular in Somalia, international NGOs often require their staff to subscribe to private health insurance. The government could consider introducing mandatory health insurance for all working citizens, regardless of sector, with contributions based on income.

HOW CAN HEALTH FINANCING BE MANAGED?

The provision of health services in Somalia is highly fragmented, with numerous stakeholders involved in both financing and management. One way to enhance efficiency and strengthen financial oversight is through the introduction of National Health Accounts (NHA).
NHA is a systematic, comprehensive, and consistent tool for monitoring the flow of resources within a country's health system. It tracks and measures total health expenditure and includes several key components:

- Out of pocket financing
- Financing sources
- Financing agents
- Health providers
- Healthcare functions

By adopting NHA, Somalia could establish a more transparent and evidence-based framework for managing health financing, ensuring that resources are better aligned with national health priorities.

RECOMMENDATIONS

- Estimate the actual expenditure on healthcare: by undertaking research to find out the overall health expenditure for Puntland population. This would allow the government to plan the health financing needed to sustain the health system.
- Assess the health needs of the population and appropriate the required expenditure for primary healthcare: Although it is well known the burden of disease of the population, there is need the government to estimate the actual health needs of Puntland Population
- Introduce health financing policy: the foundation of achieving universal primary healthcare is to set solid legal foundation for initiative. Currently, Puntland does not have health financing policy; it is imperative to strengthen the legal framework guiding the health financing initiatives.
- Establish integrated health system at different levels. The local government can be represented to lead and manage the primary and secondary healthcare while the tertiary health is purely provided by the Puntland government.
- Enhance community trust and carry out awareness programs for the promotion and financing of primary health: one of the challenges Puntland health systems is facing is the lack of trust among the community in terms of quality and capacity of the system. There is need to conduct dialogue forums to inform the population of the importance of health financing and their contribution.
- Increase government expenditure on health financing to 15 percent to conform to the standards set for health financing in Sub-Saharan Africa under the Acra declaration.
- Explore potential sources for financing healthcare including Increasing taxes on goods such as tobacco, cigarettes and khat to finance the healthcare system. In addition, domestic revenue can also be collected from sectors such as livestock, fisheries and mining.
- Create national income accounts to direct all income earmarked for healthcare.
- Coordinate with diaspora community to pool funds for financing healthcare. For example, the ministry can provide salaries for health workers while diaspora can build schools.
- Keep the quality of health providers to ensure the trust of citizens on the health system by regulating the health sector and establish health centers that can provide training for female extension health workers and recently graduated health professionals.
- Encourage public-private partnership by offering incentives to private health providers to entice them to invest in the healthcare sector.
- Establish long term commitment and relationship with donors: the donor support has not faded away one time, it has been incremental, the government needs to secure long-term support from donors to strengthen the healthcare by focusing on bilateral stakeholders and remove the issue from humanitarian setting.
- Implement community health insurance programs by encouraging the community to save income for their health. Initiatives such as Medi-save can be appropriate.
- Encourage the business community to finance healthcare through social responsibility programs; the corporate taxation in Somalia is below the neighboring countries, as such, Business corporations can be encouraged to channel part of their profit to finance provision of the primary health.

Create a Puntland Health Fund; Since health financing in Puntland is fragmented and lacks coordination, there is a need to establish a Puntland Health Fund—an independent body responsible for collecting, managing, and distributing health resources. The fund could draw contributions from diverse sources, including the diaspora, donors, government allocations, businesses, and local communities. Such an entity should be co-managed by the government, community representatives, and the private sector, with distribution guided by an agreed formula.

Given the difficulty of financing health services at all levels, the government could prioritize a limited set of interventions, focusing on the ten most prevalent diseases in Puntland or channelling resources toward the Essential Package of Health Services (EPHS) to maximize impact.

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