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Strengthening Somalia's Healthcare Sector

Decentralization in a Federal System

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i. Abbreviations and Acronyms

AAH:	Action Against Hunger
CBO:	Community-Based Organizations
EDPs:	External Development Partners
EPHS:	Essential Package of Health Services
FGS:	Federal Government of Somalia
FMOH:	Federal Ministry of Health
FMS:	Federal Member States
FMS-MOH:	Federal Member States-Ministry of Health
GRM:	Grievance Redress Mechanism
IMNCI:	Integrated Management of Neonatal and Childhood Illness
LSC:	Local Service Commission
MoH&HS:	Ministry of Health and Human Services
MOI FAR:	Ministry of Interior, Federal Affairs and Reconciliation
MOJ&CA:	Ministry of Justice and Constitutional Affairs
NGO:	Non-Governmental Organizations
NHPC:	National Health Professional Council
NIH:	National Institute of Health
NRA:	Newly-Recovered Areas
PPP:	Public Private Partnership
PSI:	Population Services International
PSI:	Public Services International
RCRSF:	Recurrent Cost and Reform Financing
SCF:	Save the Children Fund
SDG:	Sustainable Development Goals
SMA:	Somali Medical Association
TFG:	Transitional Federal Government
UHC:	Universal Health Coverage
UNICEF:	United Nations Children Fund
VSM:	Viable System Model
WHO:	World Health Organization

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Part One:
Executive Summary

In September 2024, the Heritage Institute for Policy Studies (HIPS) commissioned a strategic study to assess the structural and capacity challenges within Somalia's federal and state ministries of health. The objective was to inform the development of a resilient, decentralized healthcare system aligned with Somalia's federal governance framework and responsive to both national priorities and local needs.

Objectives and methodology

This study provides actionable insights to to improve health and healthcare in Somalia by strengthening the Federal Ministry of Health's (FMoH) capacity for policy analysis on health sector decentralization, and by developing a forward-looking agenda to guide the decentralization of the health sector. —in shaping a health sector that is:

- Equitable in service delivery
- Efficient in resource use
- Accountable to citizens
- Sustainable in governance and financing

Researchers used key informant interviews, semi-structured interviews and documentary analysis to carryout an initial assessment of health sector decentralization in a federal system review of international experience developing an agenda for an effective health system in Somalia.

Strategic insights

Policy and Governance Gaps: Somalia lacks a unified policy framework for health sector decentralization. There is no shared understanding of roles, responsibilities, or implementation pathways across federal, state, and local levels.

Weak Institutional Structures: Overlapping mandates and unclear functions hinder coordination and service delivery. The FMoH's role in planning, regulation, and oversight needs to be redefined and strengthened.

Underdeveloped Fiscal Systems: Local bodies are heavily reliant on central and donor funding, with limited capacity for revenue generation. Without robust fiscal frameworks, decentralization risks deepening regional inequities.

Fragmented Planning and Resource Management: Health planning is donor-driven and poorly aligned across governance levels. Workforce management and financial governance remain weak and inconsistent.

Limited Accountability and Community Engagement: While decentralization offers opportunities for improved accountability, mechanisms to ensure transparency and citizen participation are underdeveloped.

Capacity Building Challenges: Current efforts are fragmented and project-based, lacking integration into broader health system reforms.

Neglected Public–Private Collaboration: Despite high household health expenditures, structured engagement with the private sector is minimal.

Weak Intersectoral Coordination: Health outcomes are closely tied to other sectors (e.g., water, education, agriculture), yet collaboration remains limited.

Key highlights of recommendations and action

Policy and Planning

- Support the FMoH in developing a comprehensive decentralization policy with clear objectives, stakeholder engagement, and evidence-based monitoring.
- Invest in strengthening the FMoH's planning and policy analysis capacity.

Structural Reform

- Clarify and align roles across federal, state, and local levels to reduce duplication and improve accountability.
- Recognize states, regions, and districts as key governance units for health service delivery.

Resource Allocation

- Develop transparent, equitable, and performance-based funding formulas.
- Link resource allocation to clearly defined responsibilities and measurable outcomes.

Capacity Development

- Fund long-term, integrated capacity-building programs targeting both central and local institutions.
- Promote inclusive training and institutional strengthening aligned with decentralization goals.

Accountability and Community Engagement

- Embed accountability mechanisms into operational policies.
- Support civil society engagement in planning, service delivery, and oversight.

Public–Private Partnerships

- Facilitate structured collaboration between government and private health providers.
- Develop regulatory frameworks to guide service provision and quality assurance.

Intersectoral Collaboration

- Encourage joint planning and implementation across health-related sectors.
- Support cross-sectoral capacity building and coordination platforms.

Call to Action

This study presents a roadmap for transforming Somalia's health sector through strategic decentralization. Government leaders and donor partners are urged to:

- **Invest in systems strengthening** to build institutional resilience.
- **Support policy coherence and alignment** across governance levels.
- **Promote inclusive, evidence-based planning** that reflects community needs.
- **Ensure sustainability** by embedding reforms into national development frameworks.

By acting on these recommendations, stakeholders can help build a health system that is responsive, equitable, and capable of delivering quality care to all Somalis.

Part Two:
Background and Objectives

Background

Somalia lacked a viable and functional government for over 20 years [1]. State governance and the system to deliver public services ceased to operate. The Ministry of Health and the entire health care system were destroyed along with sanitation and safe drinking-water systems.

Under international pressure in 2004 warring factions agreed on transitional federal charter and transitional federal government (TFG). In the place of the TFG, a permanent Federal Government of Somalia (FGS) emerged in 2012 [2].

However, public health service delivery remains limited. A large private sector has emerged to fill the gaps, which delivers an estimated 60 per cent of health services especially in urban areas. Humanitarian health services are provided by numerous international and national NGOs with funding from the UN, donor organizations, the diaspora and other private sources [3].

More than three million Somalis are in need of healthcare assistance from donors. Natural and man-made disasters have contributed to the spread of malnutrition and disease outbreaks, and lack of access to healthcare has resulted in Somalia having some of the lowest health indicators in the world [4]. The population of Somalia was 18,358,615 as of 2023 with a projected increase of 100% to 37,206,512 by 2050 as illustrated in figures 1, 2 and 3.

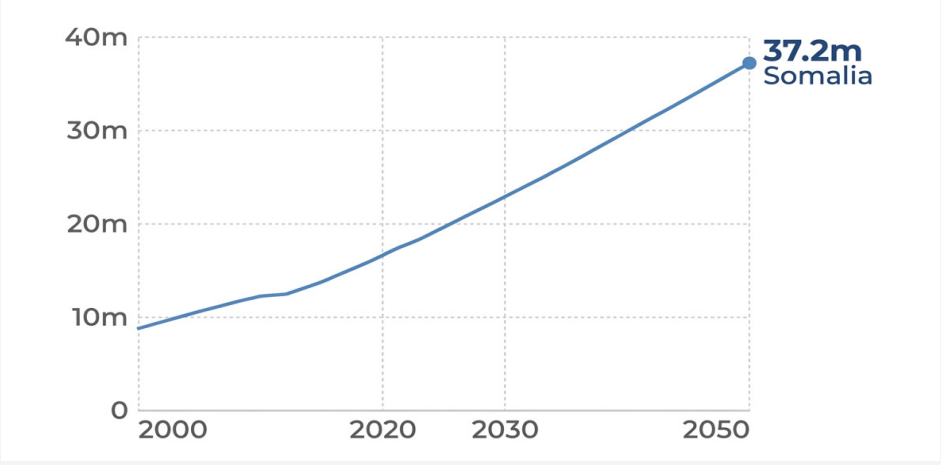

Figure 1: Population trends and projections
Source: https://data.who.int/countries/706 (WHO)

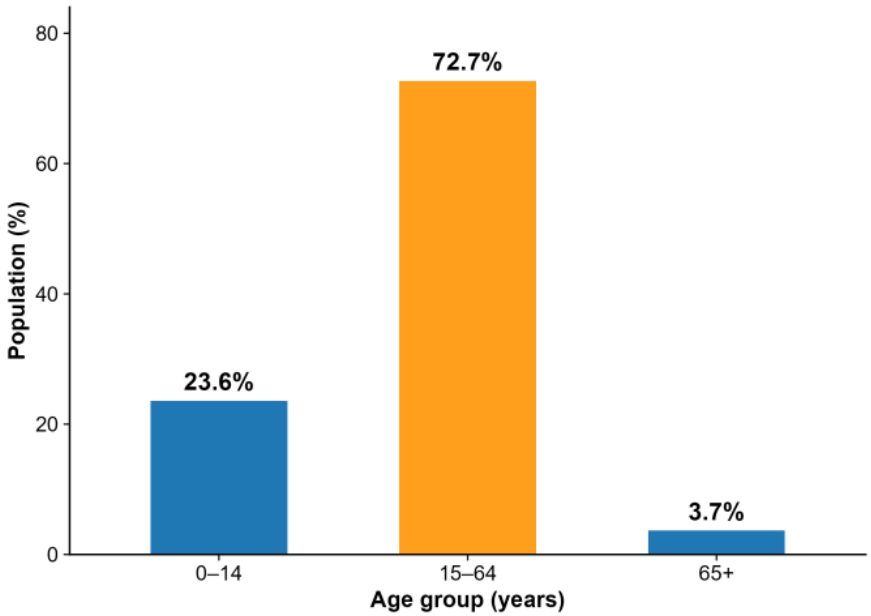

Figure 2: Age distribution of population
Source: https://data.who.int/countries/706 (WHO)

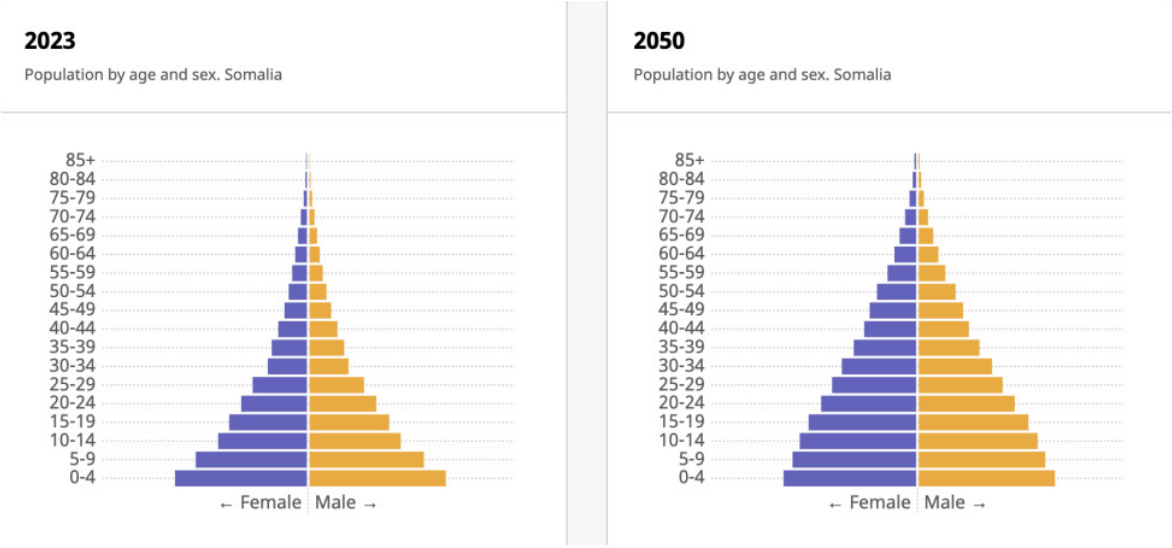

Figure 3: Demographic changes 2023–2050
Source: https://data.who.int/countries/706 (WHO)

The Federal Ministry of Health (FMoH), with the support of its partners, has developed the Health Sector Strategic Plan (HSSP III) for 2022-26 that was informed by the national health policy and the ninth National Development Plan (NDP-9). The aim of the plan is to achieve universal health coverage (UHC) by improving the health of the population through health system strengthening interventions and providing quality, accessible, acceptable and affordable health services [4].

The key components of HSSP III strengthen the foundation for achieving Universal Health Coverage (UHC). These include:

- Enhancing leadership and governance
- Advancing health information systems
- Developing human resources for health
- Expanding health institutions (health service delivery systems)
- Increasing health facility density and service availability

The strategic plan also establishes a comprehensive framework that steers the development of the health sector, aligning national efforts to achieve UHC and bolster health security.

Another policy developed by the FMoH includes the National Reproductive Maternal, Newborn, Child and Adolescent Health (RMNCAH) strategy which ensures "that every Somali woman of childbearing age, newborn child and adolescent realize their rights and enjoy the highest attainable standards of health and wellbeing" [5].

The strategy aimed to promote and provide quality RMNCAH services to all women, neonates, young children and adolescents to achieve better health outcomes and reduce all preventable maternal and child deaths. It focuses on key interventions such as antenatal, postnatal and delivery care, Integrated Management of Neonatal and Childhood Illness (IMNCI) and essential newborn care [5]. However, there are challenges in implementing these strategies including the transitional and evolving nature of governance systems, lack of resources, a shortage of skilled workers especially in rural and hard-to-reach areas, unequal distribution of health facilities, and lack of essential equipment and medicines.

As shown in table 1, maternal, neonatal and nutritional diseases are among the leading causes of death in Somalia. One in 1,000 women aged 15 to 49 die due to pregnancy or birth-related complications, and one in 20 women is expected to die from pregnancy-related causes during their reproductive lifetime. Similarly, the under-five mortality rate is the highest in the eastern Mediterranean region [6].

Table 1: Key maternal, newborn and child health indicators

Maternal mortality ratio	692/100,000 live births* 621/100,000 live births*
Newborn mortality rate	37 per 1,000 live births**
Under five mortality rate	117 per 1,000 live births***
Maternal mortality ratio	1,044 per 100,000 live births***
Life expectancy at birth	52 (male) 59.2 (female) 56.5 (both sexes)****
Hospital beds	8.7 per 10,000 population****

Sources: * Somalia Health Demographic Survey report, 2020; ** Trends in maternal mortality 2000 to 2020; *** Country Cooperative Strategy Somalia, 2021-2025; **** Global Observatory on eHealth

Decentralization and federalization

Decentralization is defined as the transfer of part of the powers of the central government to regional or district authorities in response to demands for diversity [7].

The terms decentralization, multi-level governance, and federalism [8] all relate to how the public sector organizes itself across different government levels or administrative tiers. However, federalism denotes a specific type of vertical governance arrangement. Although unitary (non-federal) countries can choose to pursue a wide variety of decentralization reforms, decentralization and multilevel governance are by definition important features in federal countries such as Somalia [9].

According to Riker (1975, 101), "Federalism is a political organization in which the activities of government are divided between regional governments and a central government in such a way that each kind of government has some activities on which it makes final decisions."

Federalism involves some of the following characteristics:

- Shared rule but the central government typically has powers over defence and foreign policy
- A decentralized system which can bring services closer to people and increase citizen participation

- There are at least two levels of government, each with final authority
- The division of power is often constitutionally established

Federations therefore consist of constituent governments (regional governments) and one central government and both levels of government are endowed with final decision-making power in some areas [10]. Therefore, federalism is a governance system of self-rule and shared rule in which governance powers are divided and shared between central government and regional governments. This division of powers is combined with the authority to carry out those responsibilities on behalf of the people of the federal body [11].

In federal systems, an overarching national government is generally responsible for broader governance of larger territorial areas, while the regions govern the issues of local concern [12]. A constitution protects the division of power and responsibilities [13].

Federalism allows different groups of people to live together and share power over common areas of interest. However, according to Gamper (2005) it can present challenges such as: protecting minorities, the cost of building institutions at the central and state levels, and difficulty in coordinating policies across levels, especially in response to natural disasters or pandemics [14].

Figure 4 provides a conceptual framework that is used for the analysis of organizational issues and development of health sector decentralization in a federal system of Somalia. This is further illustrated in table 3.

Figure 4: Analytical framework of organizational issues in a federal system

Somalia adopted federalism in 2004 and embarked on its implementation in 2012 under the framework of a federal parliamentary republic. According to the constitution, the President is the head of state, and the Prime Minister is the head of government, appointed by the President with the parliament's approval [15-17]. Somalia has a bicameral legislature, which consists of the Senate (upper house) and the National Assembly (lower house). Together, they make up the Federal Parliament. The country has a two-level federal system made up of the national government—called the Federal Government of Somalia (FGS) and six Federal Member States (FMS) (Figure 5): Puntland, Jubaland, Southwest, Galmudug, Hirshabelle and North East[1]. There is also the Banadir Regional Administration whose status has not yet been resolved. This system is outlined in the country's Provisional Constitution, but putting it into practice has been difficult due to ongoing disagreements over how power and resources should be shared.

Article 50 of Somalia's Provisional Constitution laid down the principles of federalism including clan power-sharing, regular elections, and a spirit of inclusivity. "The various levels of government, in all interactions between themselves and in the exercise of their legislative functions and other powers, shall observe the principles of federalism, which are: (a) Every level of government shall enjoy the confidence and support of the people (b) Power is given to the level of government where it is likely to be most effectively exercised (c) The existence and sustainability of a relationship of mutual cooperation and support between the governments of the Federal Member States, and between the governments of the Federal Member States and the Federal Government, in the spirit of national unity (d) Every part of the Federal Republic of Somalia shall enjoy similar levels of services and a similar level of support from the Federal Government (e) Fair distribution of resources (f) The responsibility for the raising of revenue shall be given to the level of government where it is likely to be most effectively exercised and (g) The resolution of disputes through dialogue and reconciliation" [18].

Main Issues:

- The constitution doesn't clearly define how federalism should work in practice.
- There's no agreement between the national and state governments on who controls what.
- Some states want more independence, while others support a stronger central government.

1| The North East state was formed after the completion of the study.

- Tensions often arise when states try to take on roles meant for the national government.
- A final version of the constitution is still needed to settle these disputes and build trust.
- Somaliland, which declared independence in 1991, does not recognize the federal system and is not part of it. It is also not internationally recognized as a separate country.

Somalia's federal system is still a work in progress. Leaders continue to negotiate and work toward a political agreement that can help improve governance, reduce conflict, and strengthen the country's institutions.

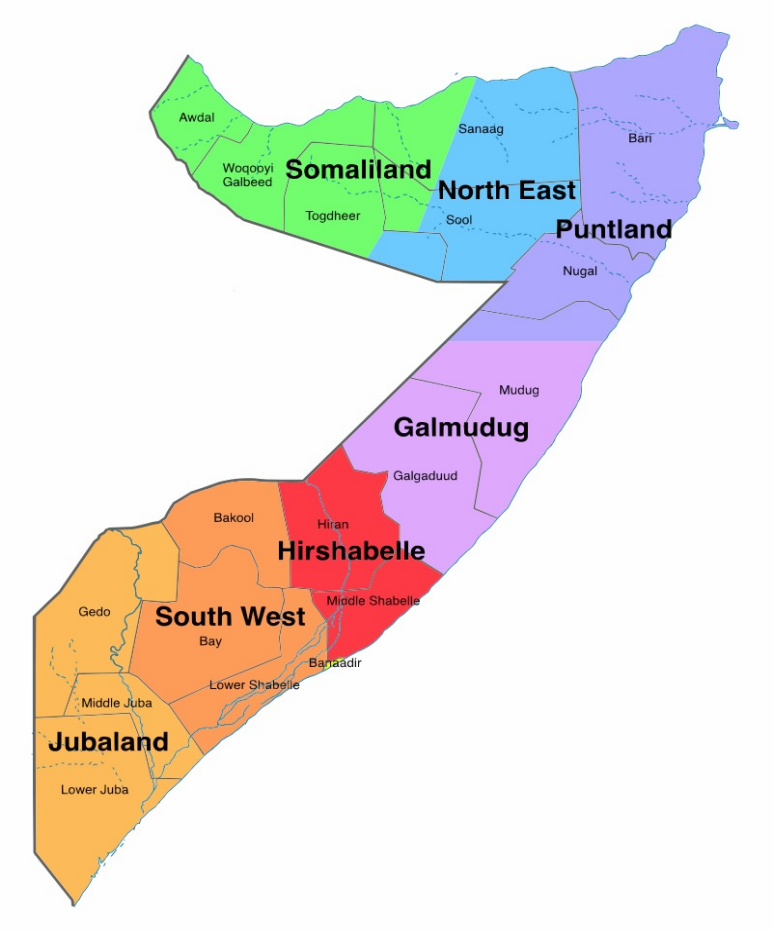

Figure 5: Federal Member States
Source: https://en.wikipedia.org/wiki/States_and_regions_of_Somalia

Objectives of the Study

1. Analyze the situation of and conditions for the functioning of a decentralized healthcare system in the specific context of federal governance of Somalia.

2. Analyze the situation of and conditions for health system governance considering international and regional experience.

3. Identify the roles and responsibilities of federal and federal member state (FMS) ministries of health. Explore the changing roles and responsibilities of the federal and state ministries of health to avoid duplication, confusion and enhance efficiency and effectiveness.

4. Investigate structural variations. Explore the structural similarities and variations between the federal and state ministries of health, investigating their changing roles and assessing the effects on healthcare delivery and governance.

5. Examine capacity gaps and structural challenges. Conduct a comprehensive examination of the structural challenges and capacity gaps plaguing the health ministries and analyze their impact on healthcare service delivery.

6. Develop policy recommendations. Formulate actionable policy recommendations to address the identified gaps and challenges. These recommendations will catalyse the revitalisation of Somalia's healthcare system to provide clarity of roles and promote collaboration between the federal and state ministries.

7. Assess partnership frameworks and propose key actions. Examine the collaboration frameworks between the private sector and development partners at both the state and federal levels to identify exemplary practices and propose recommendations for enhanced cooperation and operational efficiency.

8. Disseminate the findings to key stakeholders.

Research Questions

1. What are the primary structural challenges confronting the ministry, and how do they impede the effective coordination and delivery of healthcare services across Somalia?

2. How can collaboration between the Federal Health Ministry and member states' health ministries be enhanced to overcome these challenges?

3. What are the structural variations between the federal and member state ministries of health, and how do these differences impact the overall healthcare system?

4. What are the key capacity gaps (structural, technical, governance and financial) within the ministries of health at the federal and state levels, which undermine their ability to provide essential healthcare services to the Somali population?

5. How do the private, for-profit and non-profit sectors and development partners currently collaborate with the federal and state ministries of health, and what could enhance these partnerships for more effective health service delivery?

Table 2: Link between research objectives and research questions

RESEARCH OBJECTIVES	RESEARCH QUESTIONS
Analyze the situation of and conditions for the functioning of a health system in the specific context of federal governance of Somalia.	What are the primary structural challenges confronting the ministry, and how do they impede the effective coordination and delivery of healthcare services across Somalia? How can collaboration between the federal health ministry and member states' health ministries be enhanced to overcome these challenges?
Analyze the situation of and conditions for health system governance in Somalia considering international and regional experience.	
Identify the roles and responsibilities of federal and federal member state (FMS) ministries of health. Explore the changing roles and responsibilities of the federal and state ministries of health to avoid duplication, confusion and enhance efficiency and effectiveness.	
Investigate structural variations. Explore the structural similarities and variations between the federal and state ministries of health, investigating their changing roles and assessing the effects on healthcare delivery and governance.	What are the structural variations between the Federal Ministry of Health and the state ministries of health, and how do these differences impact the overall healthcare system in Somalia?
Examine capacity gaps and structural challenges. Conduct a comprehensive examination of the structural challenges and capacity gaps plaguing the health ministries and analyze their impact on healthcare service delivery.	What are the key capacity gaps (structural, technical, governance and financial) within the Ministry of Health at both federal and state levels which undermine their ability to provide essential healthcare services to the Somali population?

Develop policy recommendations. Formulate actionable policy recommendations to address the identified gaps and challenges. These recommendations will catalyse the revitalisation of Somalia's healthcare system to provide clarity of roles and promote collaboration between the federal and state ministries.	How do the private, for–profit and non–profit sectors and development partners currently collaborate with the federal and state ministries of health, and what recommendations can be made to enhance these partnerships for more effective health service delivery?
Assess partnership frameworks and propose key actions. Examine the collaboration frameworks between the private sector and development partners at both the state and federal levels to identify exemplary practices and propose recommendations for enhanced cooperation and operational efficiency.	
Disseminate the findings to key stakeholders.	

Part Three:
Methodology

It was necessary to take into account two factors in the formulation and implementation of the methodology. The study was designed to explain a contemporary phenomenon and produce recommendations for development and the proper functioning of the health sector at all levels. The study may also be seen as policy analysis in the sense that the FMoH needs to develop a policy for the effective implementation of decentralization in federal governance of the health sector. This study was designed to respond to this need.

The outbreak of internal hostilities is an ongoing phenomena and was likely to have an impact on the study. It therefore made it more vital in that the study was designed to assess the present process of change and suggest ways forward. The study therefore involved four phases as illustrated in figure 6.

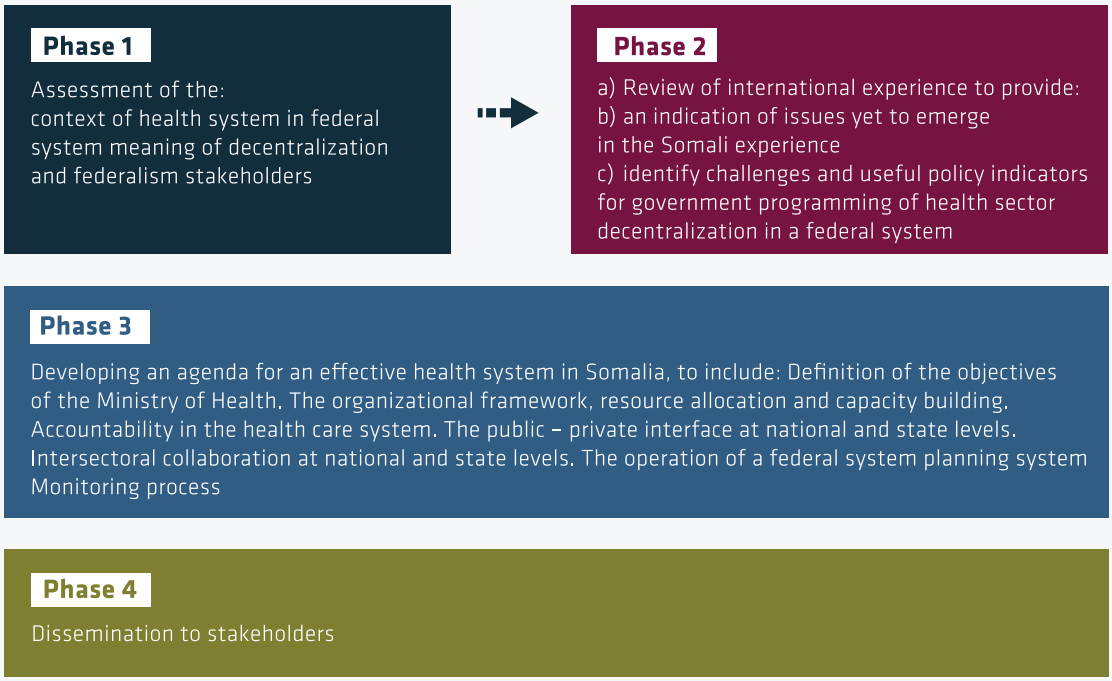

Figure 6: Four phases of the study

These factors were important in selecting a methodology that was responsive to the study objectives and questions while offering flexiblity. A trade-off was required between the application of best methodological practice and the practical necessities of quick policy/organizational analysis, training and political reality. In order to meet the time requirements for the organizational and policy analysis, carry out capacity development activities and undertake the study in an unstable context, it was necessary to reduce the number of methodological requirements typically recognised as best practice.

To facilitate a comprehensive analysis, this study adopted a qualitative approach for data collection, combining document reviews and key informant interviews As illustrated in figure 4, the key issues reviewed were:

- Aims and objectives of the FMoH – including the extent to which the FMoH articulates clear objectives and is focused on health development.
- The responsibilities of the FMoH and FMS-MOH – including poverty reduction strategies, federalism and the growth of the private sector.
- Autonomy of the FMoH – including the capacity of the FMoH to operate in a relatively autonomous fashion in the development of the health care system.
- Policy making and planning capacity of the FMoH – including the extent to which the FMoH has the system, skills and structures to operate a policy making and health planning capacity.
- Financing capacity of the FMoH – including the capacity of the FMoH and FMS-MOH to generate and obtain funds for the development of the health system.
- Management capacity of the FMoH – including the organizational structure of the MoH, the management systems it operates, and its management values. Particular attention was paid to the relationship between the FMoH and FMS-MoH and the management values and practices of the public sector.
- Center/state relations –including the ongoing system of federalism in Somalia and its impact on the FMoH and FMS-MoH
- Intersectoral and inter-organizational links – including collaboration between the FMoH and FMS-MoH and their relationships with other sectors in relation to health..
- Public/private relationships – including regulatory role of the FMoH and FMS-MoH has with respect to the private sector.
- Accountability – including managerial, professional, political and community-based accountability.

Table 3: Framework of organizational issues and related questions

Organizational issues	Related questions
1. Aims and objectives of the FMoH	Does the MoH articulate clear aims and objectives? Does the MoH focus on health of the population or the provision of health care services to the population? To what extent does the MoH meet the health and health care needs of the population?
2. Responsibilities of the FMoH and FMS-MOH	How are the responsibilities of FMoH and FMS-MOH changing in the context of the federal system and other health sector reforms?
3. Degree of FMoH and FMS-MOH autonomy	To what extent does the MoH have control over health care and how does it relate to other providers? What relationships exist between the FMoH and international organizations?
4. Planning capacity of the FMoH and FMS-MOH	Do the FMoH and FMS-MOH have the capacity to conduct health policy making/development planning? ?
5. Financing capacity of the FMoH and FMS-MOH	Do the FMoH and FMS-MOH have the financial capacity to pursue their aims and objectives? What is the relationship between tax-based and user charge-based systems? What is the impact of international aid financing on the health care system?
6. Management capacity of the FMoH and FMS-MOH	What is the management capacity of the ministries of health?
7. Center/state relations	What are the relationships between the federal ministry and federal member state ministries of health? What is the impact of the federal system on the aims and objectives of the ministries? Do the conditions exist for the effective distribution of responsibilities between the FMoH and FMS-MOH?
8. Intersectoral and inter-organizational links	How effective are the links between the MoH and other sectors in pursuit of the One Health agenda/goal? What form do these relations take: e.g. advocacy, co-ordination, co-operation?
9. Public – private relations	What information do the FMoH and FMS-MOH have about the private sector? What capacity do the FMoH and FMS-MOH have to regulate the private sector? What collaborations exist between the FMoH and FMS-MOH and the private sector?
10. Accountability	What are the different forms of accountability in the operation of the FMoH? How do they interrelate and how are they changing? What are the implications of these changes on health and health care?

Methods of Data Collection

Document review and analysis: Federal and state reports and documents, international literature and regional publications from countries with similar systems of governance as well as international organizations like the WHO and World Bank were consulted and cited accordingly.

Semi-structured interviews: In-depth interviews using a questionnaire guide were conducted with key informants and stakeholders including: members of parliament; FMoH and FMS-MOH representatives; members of state parliaments and related ministries such as planning; healthcare experts; academics; donor organizations; and representatives from local and international NGOs engaged in healthcare service provision.

Purposive sampling was used in the selection of respondents based on their roles and responsibilities as well as areas of expertise. Participation in the study was voluntary and information about the objectives and potential benefits of the study was provided to all respondents

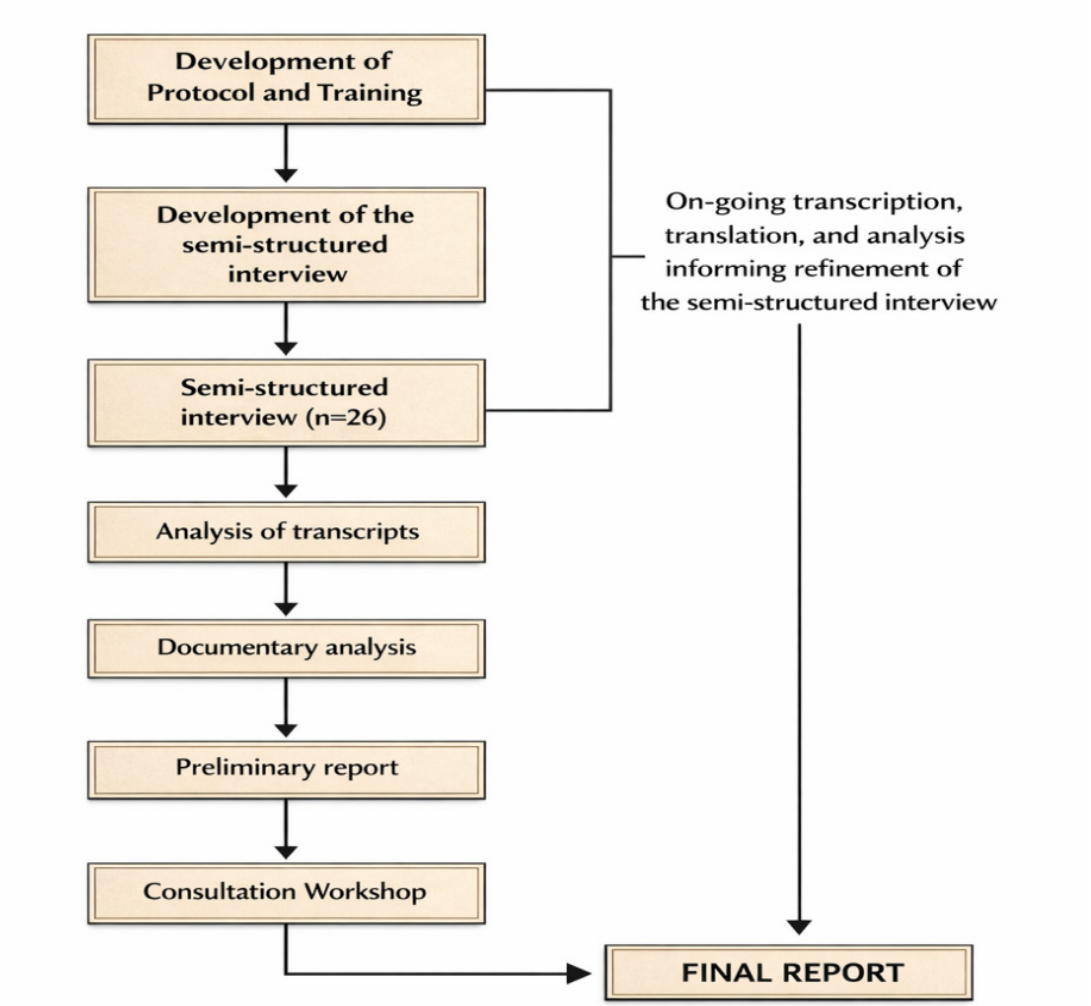

Figure 7: An overview of the methods used in study

Phase one

Training and semi-structured interviews. The methods applied were qualitative and preceeded by the Zoom training of four local researchers in Mogadishu and Burao [18]. Twenty-six semi-structured interviews elicited opinions from respondents about their perceptions of decentralization and federalization using a detailed format of principle and follow-up questions.

Table 4: Affiliation of respondents in phase one

Affiliation of respondents	Number interviewed
Federal Ministry of Health officials	3
Federal level line ministries	2
Federal level members of parliament	1
Former federal ministers (politicians)	2
Health policy makers	1
Civil society	2
External development partners	1
Other government officials (advisors)	2
FMS Ministry of Health	3
FMS ministries (non–health)	2
FMS members of parliament	1
Academics	4
Private sector health care providers	2
Total	**26**

Twelve of the 26 interviews (46%) were conducted in Mogadishu, 11 in the member states and three outside the country.

Most of the interviews were digitally recorded except two for technical reasons. Notes were also taken. The recorded interviews were transcribed and translated by HIPS translators. The research team compared tapes with the transcription and made amendments where necessary. All transcription attempted to capture Somali intonation [19].

The interview format was developed during the online training held at the beginning of the research (see below). A brainstorming session was held with all members of the research team and the trainer, from which an initial draft of the semi-structured interview was developed.

Data was coded [20] to the theme headings in the interviews. All coding was done manually by the principal investigator (PI). Further codes were generated to capture themes emerging in the research.

Phase two

Literature review and analysis of international experience

Analysis of literature on Somalia was part of the triangulation process. This enabled building on the key points raised during phase 1. The information gathered was also used during the third phase of the research.

Analysis of the international experience of decentralization and whether it was relevant to Somalia. The review of international experience also provided an indication of issues yet to emerge in Somalia and therefore provided useful policy indicators for government programing of decentralization in the context of a federal system.

Phase three

Analysis

Research findings were analyzed to develop an agenda for effective health sector decentralization in Somalia.

Phase four

The final report

Particular attention was paid to the development of an agenda for effective health sector decentralization in Somalia. Stakeholders were consulted about the report at a one-day meeting in Mogadishu in August 2025.

Study Limitations

The study was limited to three states and Mogadishu because of the security situation in the country at the time. Approximately 12 of the 26 interviews were conducted in Mogadishu, an indicator of the number of interviews conducted with central government officials, civil society and external development partners. However, this also reflected the limitations imposed on the study by the on-going conflict.

No systematic stakeholder analysis was carried out. In retrospect, the researchers realized that this could have been useful and could be adopted for future studies.

To the extent that it was possible, triangulation of data was conducted. Interviews were checked with each other and with documentary evidence. However, the characteristics of policy analysis and the need to produce policy-relevant results in the shortest time possible, meant that the detailed points of best practice could not all be used [21]. However, the data was interpreted through the lens of the PI's extensive Somali and international experience to assess its relevance and appropriateness."

Part Four:
Key Findings

Health sector decentralization in Somalia lacks a clear policy framework, shared understanding, and evidence base

Respondents pointed out there has been no in-depth policy analysis of health sector decentralization. They said there is a limited historical and international evidence base for the development of health sector decentralization.

They saw the objectives of decentralization/federalism as focused around constitutional and citizens rights; efficiency and effectiveness; and people's participation in local development. This indicated a social development approach to health sector decentralization with its emphasis on rights and participation rather than a more market driven approach which links decentralization with privatisation.

Respondents expressed concern over the absence of a common understanding of the definition of decentralization/federalism; its politically selective origins; the lack of a monitoring system; the contested nature of its implementation; and the lack of a full consultation and discussion around the implications of decentralization for the health sector.

The structure of health sector decentralization in Somalia is poorly defined, leading to overlaps, unclear roles, and weak coordination

The health and health care roles of the federal government, federal member states, and local bodies remain undefined. Functions are not classified by specific characteristics, and there is significant overlap between the center and the states.

Greater care is needed in aligning decentralization processes with the operation of national health programmes to avoid fragmentation and duplication.

The relationship between the FMoH and the federal member states requires clarification, especially in the areas of national planning, the FMoH's central support functions, and its regulatory responsibilities. This points to the need for a redefined role for the central FMoH within a decentralized system.

Fiscal decentralization in Somalia remains underdeveloped, with weak revenue generation, heavy dependence on central/donor funding, and risks of inequity

As regions and districts have only recently begun functioning, mechanisms for developing fiscal decentralization remain largely undeveloped.

There are concerns about whether local bodies will be able to generate sufficient income to meet their responsibilities.

While there is diversity in income sources across local bodies - some relying more on locally generated revenues, others on centrally allocated funds - overall, they remain highly dependent on the federal government and donors for resource allocation.

Significant work is still required to develop fair and effective resource allocation formulas. Respondents questioned whether emerging approaches are sufficiently poverty-sensitive, transparent, and capable of incentivizing local resource generation.

Financial management systems at the local level are poorly developed, and revenue collection is generally low, with the exception of Mogadishu.

Without stronger fiscal frameworks, decentralization risks reinforcing inequities between regions and districts.

Local bodies struggle to ensure that spending translates into sustained improvements in service delivery. Weak systems and the influence of local politics further undermine performance.

Health planning in Somalia is fragmented, donor-driven, and poorly aligned across national and local levels.

While a number of planning exercises exist across all levels, they are often driven by donor priorities and funding rather than being based on nationally or locally articulated needs.

There is little coherence or coordination between national health plans and those developed at regional and local levels, resulting in fragmentation and reduced effectiveness.

Resource management under decentralization is constrained by unclear workforce roles, weak financial governance, and misalignment with planning

Decentralization has created uncertainty in managing the health workforce, particularly at district level. Key issues remain unresolved, including the respective roles of local authorities and regional governments, recruitment practices, career development pathways, staff deployment during decentralization, authority over transfers, and local recruitment policies.

Respondents expressed doubts about whether sufficient financial resources will be allocated to local bodies, whether funds will be managed correctly, and how effectively budgets will link to health planning processes.

Decentralization presents an opportunity to strengthen accountability in Somalia's health sector, but frameworks remain underdeveloped

Accountability in the health sector spans ethical, legal, and financial responsibilities.

Strengthened accountability is vital for improving the quality of care, preventing harmful mistakes, building trust between patients and providers, and reducing the misuse of scarce resources.

Decentralization creates potential to enhance community-level accountability by bringing decision-making closer to citizens. However, concrete mechanisms to realise this potential remain limited.

Capacity building is essential for decentralization but remains fragmented, project-driven, and poorly integrated

The link between capacity building and the transfer of responsibilities and resources is highly contested. Many respondents advocated a phased approach, where responsibilities are transferred only as capacity develops.

Capacity building must also include the center, not just local authorities. Training and mass awareness are critical for local authority members. Current initiatives have been implemented through parallel systems, and marked by exclusiveness, weak community engagement, poor sustainability, limited coverage, and coordination challenges.

Public–private relations in Somalia's health sector are underdeveloped, despite the dominance of out-of-pocket expenditure

Although around 80% of health expenditure comes from households, respondents warned against overstating the private sector's role.

Three key avenues for development were identified: (1) a regulatory role for the ministries of health at both the central and state levels; (2) collaboration in service provision; and (3) structured public–private linkages in decentralized planning, management, and policymaking.

International experience underscores both the importance and complexity of these processes, highlighting the need for context-specific policy analysis.

Intersectoral collaboration is vital for effective decentralization but remains weak in practice

Health sector development requires an intersectoral approach that links health with other sectors influencing well-being.

While decentralization provides a structural basis for intersectoral collaboration, it does not guarantee it.

Somalia's periodic development plans—such as the five-year strategic and annual plans—offer important opportunities to embed intersectoral approaches into planning and implementation.

Part Five:
Discussion of Key Findings

Challenges of Health Sector Decentralization Within Somalia's Federal System

This section examines the process and content of health sector decentralization in Somalia, with the aim of identifying the principal problems and challenges it entails. The analysis draws on three main sources: semi-structured interviews; document analysis; and the analysis of the challenges. This analysis will form the basis of policy proposals to meet these challenges. The discussion items is based on the framework presented in figure 4 that are analysed along with more specific issues as outlined in table 5.

Table 5: Themes and issues

Themes	Specific issues
1. Policies shaping health sector decentralization	Context of decentralization Objectives of decentralization Stakeholders and consultation Evidence base Legislative compatibility Monitoring decentralization
2. Organizational structures	Definition of central and district responsibilities Relations between the levels Relations between the local bodies Number of local bodies Classification of local bodies
3. Resource generation and allocation	Overall position of income Local bodies'own sources of income Central grants Performance and capacity Equity issues
4. Planning	Planning process
5. Resource management	Staff management Financial management

6. Accountability	Accountability Participation
7. Capacity for decentralization	Central level capacity Training and orientation Mass awareness Responsibility and planning for capacity building
8. Decentralization and public–private relations	Local bodies and regulation Local bodies and linking
9. Intersectoral linking	Collaboration with other sectors at national level Partnership with other sectors at local level

Policies Processes Shaping Health Sector Decentralization

There is increased interest both internationally and within Somalia in understanding the policies of health sector decentralization as well as how and why they were developed [22-24]. It is a matter of some concern that an in-depth analysis has not previously been undertaken. There are studies on decentralization options [25], federalism in post-conflict Somalia [1], the concept of decentralization [26], and resource scarcity and conflict [27]. However, these need to be analyzed to see how they relate to each other and their impact on health sector federalization/decentralization.

Aims and Objectives of the Healthcare Sector

Primary health care is considered the foundation of the country's health system, with a focus on essential, life-saving services for the poor and vulnerable and protecting households from the risk of impoverishment due to out-of-pocket spending on health care [28, 29].

The overall aim of the federal health ministry is to strengthen health care delivery and to ensure equitable access to basic health care for all men, women, and children across Somalia. The FMoH has developed an Essential Package of Health Services (EPHS), which serves as a framework for delivering quality and accessible healthcare services to all the population.

The official objective of health sector decentralization in the Health Sector Strategic Plan, 2022-2026 [30] states that *"decision-makers with a shared strategic direction for health system development will be capable of responding to the health needs of the Somali population and its desire in achieving UHC and health security"*

A number of respondents re-affirmed that the FMoH has clear aims and objectives focused on improving population health outcomes and providing access to quality healthcare services. A senior Federal Ministry of Health Official stated:

"The Ministry of Health of Somalia has clear aims and objectives that are in line with its broader goal of improving the health and well-being of the population."

"The MoH health sector strategic plan provides a roadmap to strengthening and improving the health system."

However, concerns were raised about how the objectives and commitments are being translated into tangible outcomes.

"Although the FMoH is committed to meeting the population's health care needs, still there is an existing huge gap as the resources and funds to invest in the healthcare services are limited."

FMoH Advisor

Reasons for Decentralization

Civil war

Respondents were asked why the government supports a federal/decentralized system. Some believed that the federal system did not come out of choice but as a result of dictatorship, centralized authority and the prolonged civil war which led to the destruction of governance systems, structures and resources.

Constitutional and civil rights

Some respondents linked the shift to federalism and decentralization as being related to rights. One described it as a right "that is mentioned in the draft constitution of the country".

Others made the link with civil or citizen rights and saw no alternative to decentralization and federalism in the democratic context. "Federalism or decentralization gives rights to the people to evaluate the work carried out by the government for them."

Efficiency and effectiveness

One respondent said, "The main objective of a federal system is to build the capacity and to increase work efficiency and operational level through the delegation of authority."

It was pointed out that there can be delays in the implementation of programs when the center retains this responsibility. Decentralization enables implementation of programs in more cost-effective manner by local people. Resources can be used more efficiently to benefit the people at the lowest level.

Respondents said that decentralization aims to reduce bureaucratic and administrative layers in decision making, ensuring efficient service delivery by bridging the gap between service providers and users, making services accessible to people at the local local level.

Local authorities have the ability to make decisions that improve how services are provided. A key factor in this is acknowledging the diversity within communities and adjusting policies to meet their varied needs. Many respondents emphasized that people living in the area understand their own challenges better than distant, centralized decision-makers, and are therefore more capable of creating effective solutions.

"It will not be possible to carry out all the programs from Mogadishu especially in a country like ours that has a great geographical diversity. It is not possible to implement programs at the local levels from the center. The authority and the responsibilities regarding staffing arrangement, budget allocation or whatever is needed should be delegated to the local bodies."

Regional Assembly Member

Some respondents felt that decentralization facilitates the information flow between the government and the people, as well as ensuring transparency and accountability when local organizations and civil society are involved in providing services.

Citizen participation in local development

A number of respondents stressed the importance of citizen participation through decentralization, as representatives of local communities are more familiar with local problems and needs than those from the center. When citizens are involved in identifying their own needs, they are able to identify real priorities and develop plans relevant to the local needs which are feasible to implement. As one respondent said:

"You cannot run health services in Xarardheere, Hobyo, Dhuusamareeb from Mogadishu, nor can you recruit people for these places from the capital. It has to be done from the districts and the regions."

FMS-MoH Official

Some respondents saw decentralization as important for strengthening democracy and governance and making local institutions more functional. One of the academics felt decentralization would strengthen democracy and allow people to be involved in the development process.

"Direct access to the ruling system means an effective tool for the local development."

In contrast, it was interesting to note another respondent from the private sector who linked decentralization to privatization.

"In the context of 21st century and the concept of free economy, decentralization should focus on privatization because the government alone cannot do everything."

This contrasted with other study respondents but was in line with international reports [31, 32] as well as the World Bank, which often uses the terms privatization and decentralization interchangeably or sees privatization as a form of decentralization [33].

Internal/external pressure

Some respondents cited pressures exerted on the government from the civil war factions as initiating the process of federalism, as well as from tribal and political leaders who wanted more authority to manage local affairs.

A number of respondents expressed concern over the lack of a federalism strategy and the lack of consensus on the issue.

"It is important for us to first think about whether Somalia needs a federal system or not. When federalism is adopted, there must be something that compels that federalism."

"Before federalism was adopted, it was important to conduct research and determine the type of decentralization system that is needed."

"We must clarify what everyone wants, and we must all agree. Federalism has not been accepted by all."

Stakeholder Involvement in Federalism/Decentralization

A document review and interviews with study respondents suggested a number of important issues and concerns around stakeholder involvement in the federalism/decentralization process.

Lack of understanding

According to a member of federal parliament, there is no common interpretation among citizens or politicians about what federalism actually is and how it works.

"There is no common understanding about the concepts of federalism and decentralization. It varies from ministry to ministry and from person to person. Even the interpretation of key officials, government advisors and local leaders varies on the basis of what they represent."

Selective origins

Some respondents were concerned about the origins of federalism in Somalia and the lack of overall support for it within government and society.

A former member of cabinet said: "the whole idea of federalism emanated from certain parts of government but was not supported by all parts. Regional entities and tribal leaders that formed during the civil war in Somalia and donors [were supportive]. It was not an original movement from the government itself."

Opposition and approval

There were a wide range of views on federalism among respondents. They referred to stakeholders in favour of federalism such as the Ministry of Justice and Constitutional Affairs (MOJ&CA), the Ministry of Interior, Federal Affairs and Reconciliation (MOI FAR), donors, the FMS MOH) and NGOs.

The role of NGOs was criticised by one key informant:

"Although the NGOs are considered to have been working for the promotion of health services in a federal system, they are actually working for their vested interests. In reality, they work not to give something to the communities but to take benefits in their names."

Other respondents also expressed concerns.

"Somalia believes that its people have the same religion, the same language, the same culture. We are one people who come from one place, not different ethnic groups. I am not sure if a federal system is appropriate for our country."

"The health sector is not committed to decentralization at all. The biggest opponents are the head of departments who have programs with money."

"The center or higher–level officials (both federal and regional) do not want to delegate responsibilities and authorities to the local levels. These people do not have the inner desire for decentralization. At the most they may delegate some authorities with a motive to seize or take back whenever they want."

The interviews also revealed an ambiguity around whether respondents actually oppose decentralization or whether it is too complex an issue to be simply divided into for or against. This was explained by one respondent who did not see opposition but instead confusion and a lack of willingness to implement decentralization in a federal system.

A former member of parliament stated: *the central government is in a state of confusion regarding federalism. It cannot openly deny federalism but doesn't show willingness to devolve authority and responsibility to regional governments. The central government is creating an unfavorable environment by making different excuses for decentralization to be fully implemented."*

The complexity of the issue of supporting or opposing decentralization was characterised by one academic.

"The theoretical part of decentralization has not been opposed by anyone yet. However, there are those who oppose the practical part. For an example, there are those people who do not directly/explicitly oppose decentralization but tend to mould the definition of decentralization to their own perspectives."

This was similar to the contradiction noted by another respondent from civil society organization:

"There is a contradiction among the people at the central level in saying and doing. They talk in favor of federalism or decentralization but in practice they contradict it."

All government documents state that Somalia is a federal state consisting of central and regional governments. The country has adopted a provisional constitution that defines the functions of each. Regional governments also have their own constitutions and administrative systems which contradicts the federal one. A former member of parliament stated:

"Some regional governments call themselves the self-governing government and do not accept that they are a regional governments under the federal system".

The same respondent went further.

"They have all the institutions that the federal government has such as a parliament, a Council of Ministers, as well as judicial institutions such as the Constitutional Court, which the federal government does not have. Somalia is only a federal state in theory. They are independent states or emirates."

Consultation and Discussion

Many consultations and multi-stakeholder meetings were held to agree on the political structure of the country including:

- the first national constitutional conference in Garowe in December 2011[34].
- the second Garowe meeting in February 2012 [35] at which the signatories reaffirmed the Garowe One Principles and agreed to establish federal states as referenced in the 2004 Transitional Federal Charter.
- the London Conference held in February 2012 [36] which was attended by 55 delegations from Somalia and the international community. In its communiqué, the conference agreed that the mandate of the Transitional Federal Institutions ends in August 2012, as planned, and endorsed the Garowe I and Garowe II Principles.

Some respondents mentioned this extensive consultative process but some had concerns about the lack of consultation and discussion in the process of policy formulation at the FMS-MoH levels.

One respondent noted that the cooperation between the center and regions in the past had been good, citing forums and functional reviews. Another respondent made a distinction between the general discussions on federalism and its application to the health sector.

"No adequate discussions have been held on the decentralization of the authority in the health sector."

Systematic consultation about how decentralization can be incorporated into national health programs is not well developed. International experience suggests that this is a very important area for consultation and discussion that needs to be on the policy process agenda [37, 38].

Consultation Versus Implementation

The distinction between discussion/consultations and implementation was highlighted by several respondents.

"Some discussions have been held, however, the issues raised from the discussions have not been incorporated in the rules and regulations. Although many issues have been clarified from the discussions the main issue is of implementation."

A senior government official stated:

"Our plans are not our own and are being prepared by the concerned ministries. They are plans for the districts and regions where the ministry works".

"We submit most of the plans there. We make sure that the ministers and directors-general participate in the consultation and submit the plan in detail. We prepare the field service delivery aspects for them and they work out the details".

According to one key informant, *"strategies, plans, and policy documents developed at the federal level often fail to translate into effective implementation in Newly Recovered Areas (NRAs) as current interventions tend to be reactive, focusing on immediate needs without a well-structured, long-term strategy."*

This reactive approach may result in fragmented efforts that address isolated issues without linking them to broader, sustained development goals.

Use of Evidence

There is little available international evidence on the clear impact of decentralization on service quality, equity and responsiveness [39, 40]. Nevertheless, there is literature, albeit fragmented, that provides useful evidence on specific aspects of decentralization [37, 41, 42]. Policy-makers need to be aware of this literature and know how to analyze it in relation to the specific conditions in Somalia.

The need for an evidence-based decentralization strategy was an issue raised by a number of respondents. For some, this referred to the need to look internationally and regionally, although respondents had differing views on the extent to which this had been done.

Another respondent emphasized the need *"to look back at the past experiences and past records before deciding upon the strategies. Strategies should be evidence based." The same respondent said strategies need to be based on consultations with local stakeholders.*

However, It is not clear the extent to which those working on health system decentralization in Somalia have made use of international experience including reports by international consultants.

Given the importance of decentralization in the health sector—and its influence on service quality, efficiency, responsiveness, and fairness—it is essential to have a robust system for monitoring programs. Decentralization allows local health authorities to tailor services to community needs, but without proper oversight, it's difficult to assess performance or ensure accountability. Despite this need, no comprehensive monitoring system has yet been developed for the health sector that will make it hard to know whether decentralization is actually working or where adjustments are needed.

Organizational Structures

In this section we focus on the organizational structures that are needed to overcome the challenges of health sector decentralization within Somalia's federal system four main issues emerged in the research:

- Central and local responsibilities
- Relations between central government and the federal states
- Relations between the local bodies

Current structure

Decentralization is the process of shifting decision-making power from central to local authorities [43]. It therefore sparks diverse views on optimal governance structures.

Some argue for stronger local autonomy to enhance responsiveness to diverse needs and boost participation. Others emphasize the potential pitfalls of decentralization such as increased risk of corruption and elite capture, advocating for centralized oversight to ensure accountability and equity.

This leads to debates about the ideal balance between local control and central coordination, with considerations like capacity, accountability and the specific context playing crucial roles.

These diverse views on decentralization revolve around its potential benefits and drawbacks, with strong arguments both for and against transferring power from central to regional governments and below.

Some see decentralization as a way to improve service delivery, enhance citizen participation, and foster democratic practices. Others worry about potential inefficiencies, inequalities and the risk of local elites capturing power. Ultimately, the effectiveness of decentralization depends on various factors including the specific context, the design of the decentralization process, and the capacity of state, regional and local governments [44].

Respondents in this study were of the view that the situation in Somalia is especially complex due to the different relationships each individual state has with the FGS (Table 6).

Table 6: Summary of Key Health Governance Issues

Governance Issue	Description	Example
Weak Coordination Structures	Poor collaboration among federal, state, and partners.	Inter-ministerial coordination between FMoH and FMS-MoH exists but is not functioning well.
Fragmented Authority	Overlapping or unclear responsibilities across government levels.	Each Somali state has a different relationship with the FGS, complicating unified health policy.
Limited Accountability & Transparency	Lack of systems to track performance and spending.	Health budgets and donor funds are not consistently reported or publicly accessible.
Insufficient Monitoring & Evaluation	No comprehensive system to assess health program effectiveness.	Somalia lacks a national health monitoring framework despite decentralization.
Resource Constraints	Shortages in funding, infrastructure, and skilled personnel.	Rural clinics lack basic supplies and trained staff; urban centers are overwhelmed.
Inequitable Service Delivery	Uneven access to healthcare across regions and populations.	IDPs and remote communities receive minimal health services compared to urban areas.
Policy and Legal Gaps	Outdated or missing regulations and weak enforcement.	No clear legal framework for regulating private health providers, leading to inconsistent standards.

Diverse pathways to decentralization

There is no universal structure of decentralization that applies to all country health systems [45].

For example, in Brazil, the Philippines and Uganda, health services authority has been given to municipal and local governments which are separate from the central ministry of health [46, 47]. In Nigeria, responsibility for hospitals was handed to the states while power over primary health care and family planning was given to the local government authority. In Chile, both hospitals and public health programs were given to autonomous health service areas while basic health services went to municipalities [48-51].

Forms of decentralization and overlapping responsibilities

Decentralization can be categorised into political, administrative and fiscal.[41]

Political decentralization – involves transferring power to democratically-elected local governments, allowing them to make decisions and shape policies which can lead to greater citizen participation and responsiveness to local needs.

Administrative decentralization – focuses on shifting the responsibility for implementing policies and delivering services to local administrative units. This can improve efficiency and responsiveness by placing decision making closer to the point of service delivery.

Fiscal decentralization – involves transferring financial resources and authority to raise revenue to local governments. This empowers local authorities to manage their own budget and fund local priorities.

In Somalia, health governance involves three main levels of government:

- Federal Government of Somalia (FGS)

Through the Federal Ministry of Health (FMoH), the FGS is responsible for setting national health policies, coordinating donor support, and overseeing strategic planning. However, its authority is often limited by political dynamics and varying degrees of cooperation from member states.

Federal Member States (FMS)

Each FMS has its own Ministry of Health (FMS-MoH), which manages health service delivery within its territory.

These ministries often operate independently, with limited alignment to federal policies, leading to fragmented service provision.

- Local Governments / District Authorities

Local bodies are closest to the communities and are expected to implement health programs and manage facilities. However, they often lack clear mandates, resources, and technical capacity, and their role is not well defined in the broader health governance framework.

However, respondents were concerned that the division of responsibilities between local bodies and the center is unclear.

A senior government officials said: "Although the draft constitution is not yet complete, there has been a review to clarify their respective roles. For example, in a discussion I participated in, it was discussed that the three levels of government have their respective responsibilities, whether it was the central government, the regional government, and the local governments, and some are separate, some are shared."

Respondents also cited the overlap between the various FMS-MoH and the FMoH. According to a respondent, "the FMoH continues to do many activities that are more appropriate for the local bodies."

Further concerns were raised by another respondent who highlighted "profound structural challenges including the unclear delineation of roles and responsibilities between the Federal Government of Somalia and Federal Member States, as well as inefficiencies in leadership frameworks and resource distribution mechanisms."

Respondents have further highlighted that the unclear division of responsibilities across the three levels of government—federal, state, and local—only worsens inefficiencies in healthcare delivery. These governance challenges hinder effective coordination, planning, and implementation of health services.

In Somalia, the Federal Ministry of Health (FMoH) operates in a highly complex and conflict-affected environment, where political tensions, insecurity, and fragmented authority structures make coordination extremely difficult. This is especially evident in areas related to:

- Civilian protection, where health services must be integrated with humanitarian and security responses.
- Post-liberation efforts, where newly accessible areas require urgent health interventions, but coordination between federal and state actors is often weak or absent.

Despite the existence of coordination mechanisms—such as the health sector coordination forum and inter-ministerial platforms—their effectiveness is limited due to:

- Inconsistent engagement from federal member states.
- Lack of trust and shared priorities between levels of government.
- Insufficient resources and technical capacity at the local level.

Table 7: Roles the three levels of government should play (according to respondents)

Center	State/Region	District
▪ Policy formulation on national issues ▪ Strategic planning ▪ Resource generation ▪ Resource allocation ▪ Developing guidelines and technical and policy related directives ▪ Research and technology development ▪ Playing a supportive role in strengthening capacity at the subnational level ▪ Developing mechanisms for monitoring and evaluation ▪ Providing logistics and medical technology ▪ Operational responsibilities, such as the management of large tertiary and referral hospitals ▪ Data collection, analysis and sharing	▪ Co-ordinating/ bridging role between center and local levels ▪ Developing local policies and plans ▪ Translating national policy guidelines into implementation plans ▪ Operational responsibilities ▪ Management of resources and health services ▪ Developing appropriate tools and conducting supervision, monitoring, planning and capacity building ▪ Data collection, analysis and sharing	▪ Assessing and prioritizing ▪ Promoting community participation and bottom up planning processes ▪ Implementing programs ▪ Supervising health facilities and staff ▪ Identifying training needs. ▪ Data collection, analysis and sharing

As shown in table 7, respondents were aware of the need to change the role of the center from one of operational control to one of stewardship, responsible for "facilitating", "steering" and "supporting". The views expressed were similar to those put forward in the literature which referred to central responsibilities such as strategic direction, support and regulation [52].

Respondents acknowledged that the federal health ministries' responsibilities were changing with the adoption of federalism and decentralization aimed at distributing power and resources between the federal government and the member states.

A former member of cabinet pointed out that:

"The federal Ministry of Health is responsible for developing national health policies, strategies and regulatory frameworks. It also coordinates and oversees the health services delivery across the country. With all the challenges of resources, infrastructure, and coordination, the federal ministry remains critical in building a resilient healthcare system in Somalia in collaboration with other government institutions."

"As the governing structure is fragmented, the FMoH does not have overall control of the healthcare system. Other stakeholders, namely the private sector, bilateral and multilateral healthcare donors, implement vertical healthcare programs independently and do not have a strong coordination with the ministry."

Center-local relations

Respondents used words such as "harmony", "co-ordination", "working together" and "dialogue" when describing the appropriate center-local relations.

"If there are differences in matters related to the national and the local priorities, there should be a co-ordination and dialogue to resolve the differences."

However, central-local relationships are often problematic and are in need of greater development. Issues include:

- The national planning system has to develop mechanisms to transmit to the states the broad strategic direction and national goals plus the allocation of resources. The local bodies need to express particular and important health needs. The planning system needs to place special emphasis on the development of dialogue between the central and state levels of government.
- Central support is needed to provide the states with expertise in technical supervision and developing management and planning systems at the local level.
- The regulatory role of the center is of particular importance in ensuring the quality of health care standards.

Resource Generation and Allocation

In this section, resource generation and resource allocation will be analyzed, including:

- overall income of the local bodies
- central resource allocation
- local bodies performance and capacity
- implications for equity of resource generation and allocation

Domestic healthcare financing

According to the Global Health Observatory, "…. experience demonstrates that real progress is possible in countries at all income levels. Each country's pathway will differ depending on the local context, however the above lessons are essential for equitable and effective progress.

Country experience should therefore be looked at through the lens of the health financing functions, rather than labels, and can provide valuable lessons. Labels such as "social health insurance," "community insurance," or "tax-funded systems" have little meaning by themselves and hide the complex choices and options available to countries as they raise, pool, and use funds to ensure the availability and use of quality services.

"Health system financing is an essential component of UHC but progress toward UHC also requires coordinated actions across the pillars of the health system with particular attention to strengthening human resources for health."

Donor representative

According to the Global Health Observatory, spending on health in 2022 was only 2.5% of general government expenditure. The budget allocated in 2024 was estimated as $1.08 billion. 66.7% of this budget ($694.6 million) was expected to come from donor support, while 33.3% ($346.2 million) was projected from domestic revenue, which is very limited [53] and plays a limited role in financing the health sector, with the government struggling to generate sufficient revenue and allocate a significant portion to healthcare. This leads to heavy reliance on international aid and out-of-pocket payments by individuals. While there have been efforts to strengthen domestic revenue mobilization, challenges like a weak tax base, security concerns and corruption hinder progress.

According to the Providing for Health (P4H) Network [54], the government of Somalia faces challenges in collecting taxes and allocating sufficient funds for public services including healthcare. For example, government expenditure on health was estimated at only 1.3% of total spending. Therefore, a significant portion of healthcare costs are covered by individuals through out-of-pocket payments to private healthcare providers. This creates barriers in accessing healthcare services to vulnerable populations and potentially leads to financial hardship and catastrophic health spending, particularly for those with low incomes.

Other challenges include insecurity which limits the government's ability to expand its tax base and effectively collect revenue [55]; and corruption, potentially leading to mismanagement and discrepancies between allocated budgets and actual spending, according to Amnesty International [56].

Donor representative

International aid funds a significant portion of healthcare in Somalia, with major donors like the UK, the European Union, and the World Bank channelling funds through NGOs and UN agencies for services such as immunization, maternal and newborn care, malnutrition treatment and disease prevention. This "off-budget" approach, though effective for immediate delivery, bypasses government systems and presents challenges for long-term national ownership and sustainability [57].

In 2022, the World Bank reported net official development assistance to Somalia of $1.94 billion [58]. International aid funded approximately 40% of overall health expenditure in Somalia in 2022.

This heavy reliance on foreign aid is not sustainable in the long term, as it can hinder the development of a robust and self-sufficient health system within Somalia. It also limits the government's ability to make its own decisions about resource allocation and priorities within the health sector as funding often aligns with donor priorities rather than the specific needs identified by Somali health authorities.

Respondents were aware that international aid has significantly expanded access to healthcare services. Many healthcare facilities, especially in rural and conflict-affected areas, rely heavily on funding from international organizations and NGOs. Major donor-funded health projects include the Damal Caafimaad project, funded by the World Bank with a total of $100,000,000 that is designed to strengthen Somalia's health system and expand access to essential health and nutrition services, particularly in underserved regions such as Puntland, Southwest State, and Hirshabelle. The FMoH is leading the prioritisation of services, managing the available resources and monitoring the overall results and outcome of the project.

With the winding down of emergency COVID-19 response activities, the World Bank has begun reallocating remaining funds from its COVID-19 Emergency Vaccination Project to support broader health system strengthening in Somalia. The reallocated funds are being directed to: Banadir, Galmudug and Jubaland regions to:

- Rehabilitate health infrastructure, including hospitals and clinics.
- Expand access to essential health services, especially for vulnerable populations.
- Improve emergency response capacity and climate resilience in health facilities.
- Continue immunization and public health programs, including reaching zero-dose children under the Big Catch-Up initiative.

The Recurrent Cost and Reform Financing (RCRF) Project, funded by the World Bank and implemented by Somalia's Ministry of Finance, is a national initiative aimed at strengthening public financial management (PFM), improving intergovernmental fiscal relations, and supporting service delivery in key sectors such as health and education.

The project has gone through multiple phases:

- RCRF I: Initiated in 2014.
- RCRF II: Expanded in 2015.
- RCRF III: Launched in 2020 with a focus on deeper reform and service deliver

Some key informants believed that the federal Ministry of Health struggles with aligning available resources with the actual needs of the population due to a lack of proactive engagement with the donor community, leading to a disconnect between funding availability and the healthcare needs of the population.

The reactive nature of funding and resource allocation also forces international partners and the donor community to respond without sufficient preparation. This lack of clarity around roles and responsibilities among multiple actors exacerbates inefficiencies within the system.

A key informant suggested:

"To help tackle some of the challenges, I suggest using the Viable System Model (VSM) in the research. It's a practical tool that helps spot weaknesses in how an organization is set up and how it communicates. By applying VSM, we can better understand how the Ministry of Health works and make sure its structure supports quick and effective responses to changing needs."

According to one respondent, the assistance that comes from abroad is not something Somalis asked for, but was given by donors who came and said, "Okay, this is what you need. We will give it to you." Since the donors provided the money, they have full control over how it is spent. As a result, they are seen by some respondents "as managing the funds without any transparency."

Donor dependency was seen as having a negative impact in the long term and some respondents said Somalia should gradually withdraw from relying on international aid over the next 5-10 years.

Though the central and regional ministries of health currently lack the funding to pursue their aims and objectives, one respondent said there was plenty that could be done to decrease donor dependency such as health taxes. Participants from dissemination made the following remarks:

"The government could introduce targeted taxes, for example on tobacco. Khat, alcohol and sugary drinks, to raise additional revenue for health-related activities.

"Another revenue-generating method is charging for licenses for private healthcare providers, pharmaceutical companies and importers of medical equipment and drugs."

Despite the importance of financial transparency and accountability at the local government level, there is currently no comprehensive dataset available on the finances of local bodies in Somalia. This lack of centralized and reliable financial information presents a significant challenge for planning, monitoring, and evaluating public service delivery. Nevertheless, a number of partial studies and fragmented sources do exist, offering a limited but useful glimpse into how resources are generated and allocated across different regions. These sources can help inform preliminary analysis, though they fall short of providing a complete picture. The World Bank Group [27, 59] has also emphasized the critical role of government institutions in establishing a national data bank. Such a system would not only consolidate financial data from local bodies but also enhance transparency, support evidence-based decision-making, and improve coordination across sectors.

Although the FGS has been strengthening its revenue systems since 2012, it collected only around three percent of GDP in tax revenue—far below the sub-Saharan Africa regional average of 19% [60].

This inability to mobilize sufficient revenues means that the government maintains a relatively small financing envelope for public services and investments including health.

Respondents were concerned about the imbalance between the responsibilities assigned to the local bodies and the resources allocated to them [61, 62]. They were critical of the low level and irregular provision of resources actually managed by the local level, limiting their performance capacity.

"The local organizations are capable of accomplishing the task if they are provided with adequate resources."

"Money arrives too late and is not enough."

Federal government transfers to member states

As shown in table 8 Somalia's fiscal system involves both the Federal Government (FGS) and Federal Member States (FMS) raising revenues, with FMS relying partly on transfers from the FGS. However, all FGS revenues are currently collected from the Mogadishu (Banadir) region [60], indicating a centralized revenue base. While some tax instruments are transitional for FMS, many are shared between both levels of government, creating risks of overlapping taxation and potential inefficiencies in the fiscal framework.

Table 8: Breakdown of total revenues for the Federal Government of Somalia, Federal Member States and Somaliland (US$ millions)

					Federal Member States					
			Consolidated	FGS	Galmudug	Hirshabelle	Jubbaland	Puntland	South West	Somaliland
Domestic revenue			531.8	229.8	2.7	2.7	20.2	58.8	3.7	213.9
	Tax Revenue		419.6	173.3	2.7	2.7	19.3	43.5	3.5	174.6
		Tax on Incomes Profits and Capital Gains	31.8	11.7	0	0	1.3	0.5	0	18.3
		Tax on Goods and Services	128.2	47.1	2.7	2.7	8.3	6.1	2.2	59.1
		Tax on International Trade and Transactions	253.6	109	0	0	9.6	36.5	1.3	97.2
		Other Taxes	6	5.5	0	0	0.1	0.4	0	0
	Non-Tax Revenue		112.2	56.5	0	0	0.9	15.3	0.2	39.3

Source: Ministry of Finance 2021 [60]

A 2017 World Bank study [63] identified promising avenues for local revenue generation in Somalia, but significant structural and capacity-related challenges persist. Even in relatively urbanized areas like Mogadishu, local governments struggle with inadequate institutional capacity, limited technical infrastructure, and a shortage of qualified personnel. Many staff members lack the academic and professional training required to manage complex revenue systems, including tax collection, financial reporting, and enforcement [64]. These limitations hinder the effective implementation of fiscal decentralization and reduce the potential for sustainable local governance. Without targeted investments in human capital, training, and administrative systems, local governments may remain dependent on central transfers and unable to fully leverage their revenue-generating potential.

Budgets to member states were estimated to have increased by $19.6 million in 2025, up 9% from 2024 [65].

Table 9: Planned transfers to FMS in 2025

Recipient	2024 Budget in US$	2025 Budget in US$
Grants from FGS to FMS	65.87	80.51
Puntland	10.33	10.35
Jubbaland	8.26	9.72
South West	7.50	9.02
Galmudug	7.54	9.52
Hirshabelle	7.51	10.25
Banadir Regional Administration	24.73	31.64
Grant from Donor Projects to FMS	116.40	147.01
Puntland	11.35	6.745
Jubbaland	30.19	30.10
South West	27.16	31.41
Galmudug	14.70	21.50
Hirshabelle	20.10	26.76
Banadir Regional Administration	10.71	30.49

Source: Federal Government of Somalia – Budget 2025 Policy Framework

Transfers allocated by central government to the FMS are set out in Table 9. However, there is the issue of inequity in resource allocation. The distribution of these funds is not based on the application of an equity based criteria but is much more on the nature of the contacts established between donors and specific districts. One respondent made an interesting point: "Some FMS are capable and have access to donor partners whereas some FMS do not because of security and other issues."

Performance and capacity

One respondent noted that the problem is not that of funding, but of working modalities and the way programs operate. The respondent believed that if the available funds had been used effectively, then the outcomes or results would have been 10 times better. This view is linked to other suggestions that increased resources at the local level have to be matched by improved implementation.

"There is a need to make provision of adequate resources, appropriate training, effective monitoring mechanisms and a concrete legal structure."

"The regional (state) government cannot handle the big projects for which a high level of technical and financial inputs are required."

Equity issues

There is a growing concern that decentralization and federalism is associated with inequity [37, 38, 66, 67]. While this might sound paradoxical in that decentralization and federalism are often justified in the name of equity, three contrary processes can result in the opposite.

Firstly, there is the potential problem that too much reliance on locally-generated resources can lead to geographical inequity. Richer areas are able to generate more resources than poorer areas. There is certainly the potential for this to happen in Somalia.

Secondly, there is the danger that local bodies will not spend and develop programs that are pro-poor and are directed against poverty. Referring to a number of research studies, it may be suggested that in many cases it is the relatively better-off population which has benefited most from locally implemented programs [68].

Thirdly, there is concern over the equity implications of how the FMS and local bodies generate their own income. For example, reliance on local user fees would have a negative effect on access to local services for the poor.

Health Planning in a decentralized federal system

Planning roles of the center

While planning roles may be relatively straightforward to define, a key challenge lies in the capacity of the central authority to effectively carry them out, particularly in the context of a decentralised health systems. This raises important questions about how central health planning functions interact with the resource allocation process, as successful implementation depends not only on clear roles but also on the availability of skilled personnel, data infrastructure, and coordination mechanisms that link planning with budgeting and service delivery.

Planning roles of the state

The definition of state and regional roles in health planning is closely tied to a broader understanding of their overall responsibilities within the health sector. Without a clear and comprehensive view of what these entities are expected to achieve—whether in service delivery, policy implementation, or system oversight—it becomes difficult to delineate their planning functions effectively. This broader definition provides the necessary context for assigning roles, coordinating efforts, and ensuring that planning aligns with both local needs and national health priorities

Planning roles of the district

The capacity of the district to carry out its planning and implementation responsibilities, along with the level of support it receives from higher levels of government or health administration, are critical factors in the success of local health initiatives. Without adequate resources, skilled personnel, and technical assistance, districts may struggle to translate plans into effective action. Moreover, consistent and coordinated support from regional or national bodies is essential to strengthen local capacity, ensure alignment with broader health strategies, and foster a more integrated and responsive health system.

Interactions of the different levels

Ideally, health planning should prioritize the expression of needs at the local level, ensuring that community-specific concerns and priorities are clearly articulated and addressed. At the same time, the central and regional authorities play a crucial role in guiding the overall strategic direction and managing resource allocation, creating a balanced system where local insights inform broader policy decisions and funding flows support equitable and effective service delivery.

Determining planning needs

Determining planning needs relies heavily on the capacity of both regional and local levels to engage in effective planning, which includes having the necessary skills, resources, and institutional frameworks. Equally important is the active involvement of community members, whose insights and lived experiences help shape priorities and ensure that plans are responsive to actual needs. Without strong local capacity and meaningful community participation, planning risks becoming disconnected from the realities on the ground.

Community involvement in planning

Local health planning must actively integrate community involvement into its processes to ensure that plans are responsive, inclusive, and grounded in the lived experiences of the population. By mainstreaming community participation, planning becomes more transparent and accountable, allowing local voices to shape priorities, identify gaps, and contribute to solutions. This approach not only strengthens the relevance and effectiveness of health interventions but also fosters trust and ownership among community members.

Planning and sustainability

Long-term planning is a vital component of local-level operations, as it enables strategic alignment with broader goals, optimizes resource allocation, fosters meaningful community engagement, and enhances resilience to future challenges such as climate change or economic shifts. By looking beyond immediate needs, local authorities can ensure policy continuity across political cycles, make informed decisions that prevent waste, and build trust through transparent, inclusive processes that reflect the community's evolving priorities.

Some respondents believed that the FMoH had gained significant capacity in terms of policy development and planning. They cited the development of the current health sector strategic plan, the third HSSP which covers 2022-2026 and was led by a team from the FMoH.

In particular, a senior planning officer highlighted the involvement of Federal Ministry of Health (FMoH) authorities in the development of most recent national transformation plan, indicating a level of central engagement that could be crucial for aligning national priorities with local implementation. This participation suggests an effort to ensure coherence across planning levels and may reflect a commitment to supporting districts and regions through strategic guidance, resource allocation, and policy oversight.

"Currently, the FMoH team are part of the national team working on the national transformation plan, where they are leading the health component of the social and human capital transformation.This shows the strengthened capacity of FMoH's team for policy development and strategic planning."

However, the present system of planning was strongly criticised by a former member of cabinet particularly the impact of donor funding on the process:

"As planning funds are donor driven, there are international consultants embedded within the FMoH to assist in its planning exercises, who seem to influence the outputs of the exercise to a large extent."

Senior academics

"A country's healthcare system cannot be run by donors. That is not right. This was okay when we were in the war, donors were just taking care of us. There was no government. They were the only ones managing things. Now that the government has come to the country, we need to decide on what we need."

A member of regional assembly

"Strategies, plans and policy documents developed at the federal level often fail to translate into effective implementation in Newly Recovered Areas (NRAs). Current interventions tend to be reactive, focusing on immediate needs without a well-structured, long-term strategy."

Respondents also thought this reactive approach would result in fragmented efforts that address isolated issues without linking them to broader, sustained development goals. Furthermore, engagement with international partners was seen to be inconsistent, leading to unpredictable funding and support, which further undermines the strategic planning and coordination process, as illustrated by a senior civil servant:

"In the planning process, the local stakeholders are involved only in simple discussions and all the programs and activities are being implemented as per the direction from the center/donor. The discussions at the local levels are held just for the sake of formality."

"The planning done at the central level is just to deceive/cheat the people. It is quite impossible to understand the core problems and issues of the districts and lower levels from the state and central levels. Therefore, the planning done at those levels will not be effective. No programs can be developed or planned without understanding or grasping the situation of the districts in micro-level planning. Planning that is carried out without identifying the real needs of the local population will not result in the desired changes."

Respondents from both the federal and state governments pointed to the lack of integration of the sectoral plans into the government planning cycle. Plans developed by different sectors such as agriculture, education and livestock, for example, are done in silos. The integration of these sectoral plans into one local area plan which is incorporated into the budget process was seen to be essential in achieving universal health coverage (UHC) and meeting the sustainable development goals (SDGs).

Other respondents pointed out the lack of involvement of the district and regional level authorities in overall developmental planning and co-ordination of government and non-government activities in their regions and districts:

With respect to the management of allocated resources, among the challenges pointed out by a donor representative was that most of the projects are owned by funding agencies. For example Damal Caafimaad Project is funded by the World Bank and the people working on it were assigned by the ministry.

A senior staff from international development partners (donors) stated:

"The people in charge of the departments working on this project should have had the decision-making power in developing policies and guidelines and can say what is wrong, but in practice that is not the case."

There are formal provisions for local health planning, such as the requirement for federal member states to develop strategic and annual activity plans. However, as one respondent noted, some of the federal member states have only been able to produce these plans with support from donor agencies due to limited internal capacity and constrained funding arrangements. This highlights the ongoing need for external assistance and capacity-building efforts to ensure that planning processes are both sustainable and locally driven.

Another respondent emphasized the lack of involvement of local stakeholders in broader developmental planning and in coordinating government and non-government activities within their areas, noting that "they have done little to make use of their existing potentialities." This limited engagement has several consequences: it impedes appropriate and effective resource allocation, contributing to poor management of health facilities; it undermines the morale and sense of ownership among local-level managers; and it inhibits the ability of local health services to respond effectively to the needs and demands of the communities they serve.

A senior government official noted that in decentralized systems, the limited power that remains is often concentrated in regional capitals, leaving district-level authorities without their own budgets and reliant on in-kind resource provision. As one respondent put it, "The district has no authority to identify and address unmet needs," highlighting the lack of autonomy at the local level. This situation severely restricts opportunities for communities to contribute input into the services they require, which can lead to low service utilization. Furthermore, the absence of local decision-making authority and community engagement undermines the development of a sense of ownership among staff and beneficiaries—an essential factor for the sustainability of health projects [69, 70].

RESOURCE MANAGEMENT

This section analyzes the important issue of how decentralization will impact on health workforce, and financial, management.

Health workforce management

Human resources are an important determinant of the quantity and quality of health care provided. International experience indicates that decentralization can have an important impact on staff and how they work [71-73].

Key issues raised by respondents included staff recruitment, transfer, remuneration and career development. They were asked how the existing staffing arrangements will change with decentralization, particularly at state levels. They were also asked about the implications for existing roles and new roles.

Authority over staff

Within the context of decentralization, a change in the allocation of health workforce management responsibilities is required. Exactly how this works and the precise role of regional and local governments is not yet clear. Respondents, however, had some suggestions.

A FMS-MoH official stated:

"The regional government should hand over the authority of personnel management to the local bodies. In doing so, the local bodies will be responsible for the recruitment and payment of staff".

A respondent from Ministry of Justice and Constitutional Affairs suggested that, "a separate local service commission or equivalent body should be set up for human resources management like recruitment, promotion and career development."

Another official from State Ministry of Planning said: "The local levels should be given the responsibility of monitoring whether staff attend their duties or not."

The shift towards local control over staff was seen by respondents as leading to greater responsibilities but also improved staff retention.

"A local level recruitment system is needed … so that local staff become more responsible to people."

"In a decentralized situation, if the overall personnel management, supervision and evaluation is done at the local levels, the staff would be compelled to stay at the health facilities."

One respondent identified a dilemma regarding local human resource management. They noted that establishing a local public service commission or equivalent body could be beneficial, as it would encourage local competition and increase the likelihood that individuals remain in posts near their home, fostering stability and continuity. However, they also cautioned that fully transferring human resource management to the district level could pose risks—potentially threatening job security for local employees and leading to demotivation and increased vulnerability. This highlights the need for a balanced approach that promotes local recruitment while safeguarding staff welfare through clear policies and oversight.

The role of regional governments in staff management was also raised, particularly in relation to their responsibility for developing normative, legislative, and monitoring frameworks. These functions are essential for setting standards, ensuring compliance, and guiding human resource practices across districts. By establishing clear policies and oversight mechanisms, regional authorities can help balance local autonomy with accountability, support staff development, and promote consistency in service delivery across different areas.

Local recruitment

Respondents had a variety of views on where staff should be recruited from – some said within the district while others said outside.

"From the experience of some districts it could be observed that the personnel from outside have worked more effectively than the staff from the area. These local level staff are negligent in their work because they think that they do not have to work as they are local residents." (Member of civil society organization)

Decentralization is often based on the assumption that it will foster greater political accountability, but several respondents expressed concern that it could also lead to the politicization of staff management. When local authorities gain more control over human resources without adequate checks and balances, there is a risk that employment decisions may be influenced by political affiliations or favoritism rather than merit. This could undermine professionalism, reduce staff morale, and compromise the effectiveness of service delivery, highlighting the need for transparent and accountable systems to manage personnel at the local level.

Career development

One respondent from Regional Assembly said, "Local staff should be provided with better opportunities for career development only after they have worked at the local levels for a certain period of time. Therefore the eligibility of a staff for transfer to the higher levels should be based on the provision that he/she has worked at the local level for a certain period of time."

A planning officer from one of the Federal Member States' Ministries of Health expressed concern that district-level employees often prefer to be centrally appointed due to career advancement opportunities. They noted that "there will not be job security at district level," and that local posts are perceived as temporary because employees cannot progress beyond district positions. This perception discourages long-term commitment and professional growth, reinforcing a preference for central appointments where career pathways are clearer and more secure. It underscores the need to strengthen district-level career structures and job security to retain skilled personnel locally.

Human resources planning

Several respondents raised important concerns around health workforce planning in the context of decentralization.

One respondent noted that decentralization requires a redefinition of resource needs, qualifications, and roles to ensure that staffing aligns with local priorities and service demands.

Another respondent emphasized that staffing patterns should be based on actual needs rather than fixed formulas.

A third respondent stressed the importance of assessing what people are doing, where they are based, and what services they are providing at the local level, in order to better target interventions and reduce the burden of disease.

These insights highlight the need for a dynamic, data-informed approach to workforce planning that is responsive to local realities.

Staff transfers

Some respondents suggested that the local level should be authorised for intra district transfers, while other respondents went further to suggest inter-district (to another districts), but not to the center or region.

A number of respondents suggested the need to develop a separate arrangement of recruitment and transfer for remote areas of the region.

Financial management

The FMoH has limited capacity to finance the health system and the budget allocated in 2024 was an estimated 5% of $1.08 billion. Domestic revenues are limited, and the FMoH relies on donor funds to finance its operations and public healthcare services. Out-of-pocket payments are high as many Somalis seek services from private healthcare providers. This creates barriers for vulnerable populations in accessing healthcare services.

A former cabinet member underscored the difficulty of making informed decisions about health workforce planning without access to up-to-date data on staffing and funding. This issue is particularly pronounced in newly recovered areas (NRAs), where internal communication breakdowns within the Ministry of Health hinder effective coordination. The Federal Ministry of Health (FMoH) faces challenges in aligning available resources with the actual health needs of local populations, largely due to insufficient proactive engagement with donors. Instead of anticipating needs and securing resources in advance, the Ministry often responds reactively, which leads to mismatches between funding availability and service delivery requirements. This disconnect undermines efforts to build resilient health systems in post-conflict or underserved regions.

There was a consensus among all respondents at all levels that Somalia is heavily dependent on donor assistance and foreign aid. They felt this was reasonable and acceptable when there was no government in place but that Somalia's health care system should no longer be run by donors, as donor dependency has a negative impact and affects the goal of achieving self-reliance and development in all sectors including health.

One respondent said: "It is better for us to gradually withdraw from it."

Another respondent mentioned that, "Somalis should be put through a transition period and learn to always pay for their own health, whether the government pays for it or the people pay themselves. In order to achieve this, it is important to have a plan in place for the next five years."

On the issue of financial management, respondents were critical of the low level and irregular provision of resources actually managed at the local level. A former member of parliament stated:

"We have adopted federalism, but many things are needed. In a federal world, autonomy is important and we must have it. The region and the district must be built and strengthened to manage themselves."

"The local organizations are capable of accomplishing the task if they are provided with adequate resources."

A senior civil servant emphasized that the core issue is not a lack of funding, but rather inefficiencies in operational modalities and program implementation. International experience shows that planning efforts tend to fall short when they are not integrated with the budgeting process, leading to misalignment between strategic goals and financial realities [74-76]. In decentralized systems, this challenge is compounded by the added responsibility placed on local bodies to manage funds effectively. Without strong financial management capacity and coordination at the local level, even well-funded programs may fail to meet community health needs. This underscores the importance of aligning planning, budgeting, and implementation processes within decentralized health systems.

ACCOUNTABILITY

Accountability in healthcare is the process of taking responsibility for actions and outcomes [77]. It involves a combination of ethical, legal and financial considerations but is important[78] as it:

- improves the quality of care
- helps prevent mistakes that could harm patients
- helps build trust between patients and doctors
- helps reduce the misuse of resources

Accountability, as defined in this study, refers to the mechanisms through which individuals and organizations report to recognized authorities and are held responsible for their actions [79]. International experience demonstrates that decentralization often reshapes accountability relationships and structures, introducing new dynamics between central and local actors [80]. These changes can create both opportunities and challenges in ensuring transparency and responsibility in health system governance [81]. Therefore, it is essential to develop clear, context-specific policies on accountability that reflect the realities of decentralized systems, ensuring that local bodies are not only empowered but also held to appropriate standards in managing resources and delivering services.

Accountability was an important issue raised in the interviews. Respondents shared a few examples of intergovernmental accountability in Somalia such as the policy and budgetary accountability mechanism through the Council of Ministers led by the prime minister and the Social Committee which provides parliamentary oversight. Likewise, there are government watchdogs that scrutinize the operations and financial integrity of the FMoH.

Some respondents expressed concern about government accountability. One said, "The social and community accountability of the MoH's work at all levels is non-existent as there is no community-led platform to hold them to account."

Others were critical of the existing processes of accountability in the health system. "There is a need to take actions against those who show insincerity towards their responsibilities. The existing system is not an appropriate one because there is no such system of punishing and rewarding."

However, respondents saw decentralization as an opportunity to develop community accountability. According to FMoH senior civil servant "The ongoing National Transformation Plan envisages to change the narrative and prioritize localization of the healthcare services to district and community levels. This community-owned multisectoral approach aims to enhance accountability of the healthcare services in Somalia."

A senior government official linked accountability directly to the issue of corruption, highlighting how weak accountability mechanisms can enable misuse of resources and undermine trust in the health system. Others emphasized that accountability also fosters a sense of ownership, particularly within decentralized systems, where local actors are empowered to make decisions and manage resources.

In this context, accountability is not only about oversight and enforcement but also about building commitment and responsibility among stakeholders. These perspectives suggest that effective accountability frameworks in decentralized health systems must address both integrity and engagement, ensuring transparency while strengthening local ownership and responsiveness.

Forms of accountability

Table 10 briefly defines the different forms of accountability – managerial, professional, community and political – and relates them to decentralization in a federal system [82].

Decentralization is characterised by major changes in the form of managerial accountability. Local body officials will no longer be line managed by the center but will be politically accountable to local political bodies.

Table 10: Forms of accountability and possible impact of decentralization in a federal system

Type of accountability	Description	Possible implications
Managerial accountability	Superior in hierarchy exercises line management authority over subordinate	Chain of accountability from center to periphery through the ministerial hierarchy will be broken. Accountability links of service providers to local senior officers will be strengthened.
Professional accountability	Reporting and responsibility relations within professional hierarchies or between professions	Professional lines of accountability that operate through the ministerial hierarchy will be broken. Non-medical groups at decentralized level may increase accountability to medical professional at decentralized level.
Community accountability	Service providers are required to report to and are held responsible by communities	Decentralization may increase forms of community accountability, but there may be tension between community and political accountability.
Political accountability	Political representatives require service providers to report to them and hold them responsible for service performance	Decentralization should increase political accountability, but there may be tension with other forms of accountability.

Adapted from: Nargesian A, Esfahani SA. Shifting conceptualization of accountability in light of shifting governance patterns [82]

On the other hand, it could be argued that with decentralization, the health workforce in the districts and levels below will be under closer managerial accountability of the senior local health officers. One respondent referred to the need for improved supervision and monitoring of health programs.

The shift in managerial accountability brought about by decentralization can significantly impact professional accountability within health systems. In countries like Indonesia and Kenya, devolution to counties and rural district councils strengthened the authority of medically-trained District Medical Officers [83]. While this may have improved managerial oversight, it also led to concerns among other health professionals who felt marginalized, as doctors assumed leadership roles in all institutions above the health center level—regardless of the training and experience of other cadres. This dynamic can create professional hierarchies that demoralize non-physician health workers and undermine collaborative practice. Although Somalia's context may differ, similar tensions could arise if decentralization leads to accountability structures that disproportionately favor one professional group over others. Therefore, it is crucial to design accountability systems that recognize and respect the diverse expertise within the health workforce, promoting inclusive leadership and equitable recognition of all health professionals.

Several respondents highlighted the importance of community accountability in the context of decentralization, noting its strong connection to community participation. When local populations are actively involved in decision-making and oversight, they are more likely to hold health authorities accountable and advocate for services that reflect their needs. This sense of ownership strengthens the legitimacy and responsiveness of decentralized systems. Additionally, political accountability was recognized as a key factor, as decentralization often shifts power to local political actors. Ensuring that these actors are answerable to both the public and higher authorities is essential for maintaining transparency, equity, and effectiveness in health service delivery. Together, these insights underscore the need for comprehensive accountability frameworks that integrate managerial, professional, community, and political dimensions within decentralized health systems.

Key informants stressed the need for clarity in accountability relationships within decentralized health systems. A central issue raised was whether accountability should primarily be directed toward district authorities—reflecting political accountability—or maintained through the FMoH hierarchy, representing managerial accountability.

This tension highlights the importance of clearly defining roles and reporting lines to avoid confusion, duplication, or gaps in oversight. Without such clarity, health care providers and managers may struggle to understand to whom they are answerable, which can undermine both performance and trust in the system. Establishing well-defined accountability structures that balance local autonomy with national oversight is essential for effective governance in decentralized contexts.

Respondents often linked community accountability with the broader process of decentralization. However, some questioned whether district authorities—such as district councils—are truly representative. Without this representative character, the ability of district authorities to serve as effective mechanisms for community and political accountability is limited.

Overall, there was consensus on several points:

- accountability is important,
- some mechanisms already exist,
- these mechanisms need strengthening,
- decentralization offers an opportunity to do so, and
- clearer roles and responsibilities are essential for accountability at different levels.

CAPACITY FOR DECENTRALIZATION

Almost all respondents expressed concerns about capacity—both at the federal level and at the state, regional, and district levels. This section examines their perspectives and reviews the ongoing capacity-building efforts currently underway.

The international literature underscores the growing importance of management reform in the health sector, especially at the sub-national level, as a critical component of successful decentralization. Studies by Brennan and Abimbola (2023), Panda and Thakur (2016), and Sapkota et al. (2023) highlight how decentralization demands new managerial capacities and structures to ensure effective service delivery.

A related study by Rosalind et al. (2018) draws attention to the lack of management capacity at the district level in countries like Indonesia and Kenya, identifying it as a key barrier to the success of decentralization programs [38, 84-86]. These findings suggest that without adequate investment in local management skills and systems, decentralization may lead to inefficiencies, poor coordination, and weakened accountability—issues that are highly relevant for countries like Somalia considering or implementing similar reforms.

Capacity building proved to be a controversial with relatively clear divides among the respondents. Those from the federal level showed concern about the level of capacity at the member state levels. "The human resources have not been fully developed at the local levels to make appropriate use of their decentralized authority."

This concern over capacity led some respondents to question the very process of decentralization. "The federal or state should not delegate the authority to the districts if they do not have the capacity to carry out the programs."

"The federal and state governments have a strong belief that the districts are not capable of carrying out the programs."

However, respondents from the member states questioned whether local capacity was a major problem. They suggested that the federal government should not make excuses for not handing over the authority by saying that the regions and districts are incapable. They said if a gaps were identified, then capacity building organized by the government should be undertaken. A civil servant from FMS-MoH stated:

"The local bodies would be able to carry out the tasks efficiently if their capacity in technical matters was enhanced. Local bodies have appropriate organizational structure and capacity to undertake the work, however, their understanding is not compatible to it."

Respondents from FMS argued that lack of capacity at the local level should not mean a delay in transferring power, authority and resources.

"The very idea of implementing decentralization only after capacity development at the local levels is not appropriate. Capacity will be developed after the hand over of the authority to the district or local bodies as they become experienced by actually working."

Another respondent from FMS Ministry of Planning believed it was only by giving local bodies some autonomy that capacity would be allowed to develop:

"If we always carry a baby on our back and never let him walk on his own, then that baby might never be able to walk. The baby should be allowed to learn to walk through its own struggles so that its capacity builds up. It is also the responsibility of the parents to help the baby to build its capacity."

A respondent from FMoH argued that the central level does not oppose transferring resources and authority but is reluctant at the moment:

"They think that the local people are not educated and capable enough to handle decentralization properly. But even the uneducated are found to be well aware about their local situation and can make wise decision and handle their decisions wisely enough. The thing that is needed is to provide them with appropriate training and orientation on decentralization."

The timing dilemma: capacity building and the transfer of responsibilities

An issue raised by respondents was around the timing of the transfer of responsibilities and how this related to capacity building. Some respondents believed capacity building should come before any transfer. Others advocated a phased approach with more advanced districts leading the way and those lacking capacity having the transfer of responsibilities delayed until they were ready.

"Capacity development and service delivery should both be carried out hand in hand."

"The center should not just give the authority only but also focus on capacity building of the authorities of the local government."

"Capacity is not the main issue. The most important thing is the system. Capacity is developed automatically as people work within the system once a good system is institutionalized."

One respondent took this argument further, saying that the transfer of responsibilities should come prior to the process of capacity building.

"Without giving the responsibilities to local bodies, it may not be appropriate to generalize them as being incapable. First, they should be given the responsibility. They should only be evaluated based on their performance."

Central-level capacity building

A senior civil servant from FMoH also saw the need for central level capacity building:

"The capacity of the central level should continuously be developed and updated. We need to update ourselves with the international experiences and learn from the things which have been proven from research at the international levels. Similarly, we should be able to develop a mechanism of handing over the technologies."

"The center should involve itself in matters related to policy formulation and issues of international concern."

"Reorientation is needed for the managers of the central level."

The statement that "reorientation is needed for the managers of the federal level" reflects a critical insight into the challenges of decentralization. As responsibilities shift to sub-national entities, federal-level managers must adapt their roles from direct control to strategic oversight, support, and coordination. This reorientation involves:

- Understanding new accountability structures, where authority is shared or delegated.
- Developing facilitative leadership skills, focusing on enabling rather than directing.
- Strengthening communication and collaboration with local authorities.
- Building capacity to support decentralized units, including technical assistance, policy guidance, and resource mobilization.

Without this shift, federal level managers may inadvertently hinder decentralization efforts by clinging to outdated hierarchical models. Reorientation is therefore essential to ensure that federal level leadership aligns with the goals of decentralization and supports effective, locally-driven health system management.

Training and mass awareness

Training was widely recognized by respondents as a critical component for strengthening decentralization efforts, particularly at the state and lower levels. This includes targeted capacity-building for political leaders, health care professionals, and community representatives. Respondents emphasized that:

- Political leaders at all levels—central, regional, and local—must be educated to uphold the rule of law, which in turn enhances their responsiveness and accountability.
- Local health personnel and people's representatives require training to effectively manage delegated responsibilities and contribute to decision-making processes.
- Training should be phased and context-specific, ensuring that authority is transferred gradually and with adequate preparation.

The federal government has a key role in providing ongoing training, orientation, guidance, and support tailored to the needs of regional and local governments.

These insights highlight that decentralization is not just a structural reform but a transformational process that depends heavily on human capacity. Without robust training and orientation, the goals of decentralization—improved accountability, responsiveness, and service delivery—may not be fully realized.

A significant number of respondents also emphasized the urgent need for mass capacity-building training to support the decentralization process. This includes not only technical training but also awareness-raising on the federal system and the principles of decentralization. Key areas identified include:

- Two-way communication and visits between district headquarters and villages were seen as essential for building trust and mutual understanding.
- Local bodies should be familiarized with health-related responsibilities and mobilized to conduct mass awareness programs.
- Both service providers and recipients must be included in capacity development efforts to ensure inclusive and sustainable progress.

These insights point to the need for a comprehensive, inclusive, and phased training strategy that builds capacity across all levels of governance and society, ensuring that decentralization is not only structurally implemented but also socially and institutionally supported.

Responsibility and planning for capacity building

There have been a wide range of donor-supported programs to develop capacity at both central and local levels. However, respondents were critical of many of these projects. Some felt they had operated with top-down rigidity rather than focusing on institutional development [87].

Respondents said that donors often built parallel structures instead of rebuilding what is already in place. "What we need is transfer of power and resources to local government [rather than] another local bureaucracy being built."

They believed that local capacity development programs have often excluded the local authorities, women and the poor, and at times lacked relevance. There was also criticism about a lack of coordination, leading to unfocused efforts.

Focus has been given to participatory planning which respondents believed is a good democratic practice. However they said local teams repeatedly visiting communities for discussions without fulfilling previously advocated development needs has resulted in frustration among the local people [88].

Many capacity development initiatives have been expensive and therefore unsustainable [89, 90] and operate in a restricted number of local areas partly due to insecurity in parts of the country.

Poor institutional linking—particularly between NGOs and federal government agencies—was identified by respondents as a recurring challenge in decentralized health systems. This disconnect often results in fragmented service delivery, duplication of efforts, and missed opportunities for coordination and resource sharing. NGOs may operate independently without aligning their programs with national health priorities or reporting structures, which weakens accountability and reduces the overall effectiveness of interventions. Strengthening institutional linkages requires establishing clear communication channels, formal collaboration frameworks, and shared planning mechanisms to ensure that all actors—governmental and non-governmental—work toward common goals within a coherent system.

One respondent saw it as the responsibility of the Federal Ministry of Health to take capacity building forward. "The Federal Ministry of Health should manage training to the personnel working under the ministry. The ministry should also manage the career development of the personnel."

Several respondents both from federal and regional levels emphasized that capacity building must be carefully planned and sustained over the long term, rather than delivered as a one-off intervention. They stressed the importance of developing a strategic plan that supports local bodies gradually, with the central government providing training, orientation, and guidance until these entities become self-reliant. This phased approach ensures that local institutions are not overwhelmed and can build the necessary skills and systems to manage responsibilities effectively. Respondents also called for special programs focused on enhancing management capabilities, highlighting the need to equip local leaders and staff with the knowledge and tools to address emerging challenges confidently. Overall, long-term, structured capacity development is seen as essential for the success and sustainability of decentralization efforts.

THE ROLE OF THE PRIVATE SECTOR

Public–Private Relationships in Healthcare Delivery

The relationship between the public and private sectors has been an important international issue, particularly in the light of health sector reform.

As the Somali government contributes a minimal amount towards healthcare, the majority of citizens pay privately for their healthcare needs, with estimates suggesting that nearly half of total health expenditure comes from out-of-pocket payments [91]. A significant portion of healthcare funding also comes from international donors, which can limit access to healthcare, particularly for vulnerable populations.

Both the document review and respondent feedback highlight significant concerns about the limitations of private markets in health service delivery and the fragmentation of the overall health system. Across various health services, private markets often fail to meet socially desirable levels of provision—particularly in areas like disease control, where relying solely on private valuations would result in underinvestment [92]. In curative care, challenges such as high costs, limited insurance coverage, and information asymmetry for consumers further restrict the effectiveness and growth of private sector solutions [93].

Moreover, the health system is described as fragmented, with the Federal Ministry of Health (FMoH) and Federal Member State Ministry of Health (FMS-MoH) are primarily responsible for primary and preventive services, while private hospitals dominate secondary and tertiary care. Critically, the MoH lacks the capacity and mechanisms to regulate the private sector, leading to gaps in oversight, coordination, and quality assurance. This fragmentation undermines efforts to build a cohesive and equitable health system, especially in the context of decentralization.

As private providers operate independently and don't report to either the state or federal governments, the FMoH established the National Health Professional Council to oversee and regulate the quality and standards of private healthcare services. However, it is not yet fully functional and its enforcement and regulatory capacity is weak.

One respondent said: "In past years, it was not easy to collaborate with private entities. Obtaining data or information from the private sector was challenging. The private sector is unregulated and has less trust in the government. Lately, the government has made slow efforts to engage with private entities."

Collaboration within the private sector

One respondent mentioned the importance of collaboration between local bodies and the private sector. "All the development-related government agencies of the regions and districts and the NGOs need to be brought under the umbrella of the local authorities, and they should work collaboratively."

Respondents suggested local bodies could take on a regulatory role in relation to the private sector; or collaborate with NGOs and for-profit organizations on local service provision. This could be achieved by joint ventures or contracts with the private sector for service provision.

In Somalia, there is growing experience of contracting NGOs for service delivery especially with the Damal Caafimaad project, as explained by a former Minister of Health who said, "Since the Damal Caafimaad project came into effect in 2022, the Ministry of Health, for the first time, has been contracting NGOs for service delivery."

Public sector contracting of the private sector, be this not-for-profit or for-profit organizations, is increasingly used in a wide range of low, middle and high income countries [94]. However, there are a large number of conditions and requirements for this type of contracting to operate effectively.

However, this is a highly complex area and at an early stage of decentralization it may put to heavy a burden on the public sector to organize and manage contracting processes. According to respondents, important consideration include:

Larger districts may be in a better position to develop public contracting of the private sector given their greater capacity and resources.

There are useful international examples of public contracting of NGOs to provide district hospital services in Tanzania and Ghana [95, 96].

There are specific areas in which collaboration with the private sector is an important area which will need to be explored in a decentralized setting. In particular, work on public-private partnerships for TB control involving private practitioners [97, 98] have proved successful in in Bangladesh and India.

There is the possibility of local bodies linking up with the private sector, as part of the general management and planning process in the district. This could take the form of consultation with NGOs in the district health planning process.

INTERSECTORAL LINKING

In this study, intersectoral linking includes collaboration between governments, donors and civil society. It is central to the development of a health strategy and needs to be recognized in any program for health sector development in the context of a federal system. Despite this, it should be noted that intersectoral collaboration was not an issue raised by many respondents, nor was it dealt with in the documentary evidence and key informant interviews.

There is some existing inter-ministerial coordination at the federal level in Somalia, facilitated through the social pillar at the Prime Minister's Office, which serves as a platform for aligning efforts across ministries. Additionally, health sector and cluster coordination mechanisms operate at both the federal and state levels, helping to link government entities with non-governmental organizations (NGOs). These structures are important for improving collaboration, reducing fragmentation, and ensuring that health interventions are aligned with national priorities.

However, as noted earlier, challenges such as poor institutional linking, especially between NGOs and central government agencies, still persist. Strengthening these coordination mechanisms—by clarifying roles, improving communication, and integrating planning processes—will be essential for enhancing the effectiveness of decentralized health governance.

Kenya's experience with decentralization offers a robust model for coordination between federal, county, and non-governmental actors :

- Inter-County HRH Coordination Forums: After devolving health services to 47 counties, Kenya established inter-county cluster forums to address human resources for health (HRH) challenges. These forums, hosted by rotating county secretariats, meet quarterly to share best practices, validate policies, and track implementation.

- National HRH Inter-Agency Coordinating Committee (HRH-ICC): This committee includes the Ministry of Health, donors, training institutions, unions, and private sector representatives. It provides strategic oversight and links national policy to county-level implementation.

Kenya Health Sector Partnership and Coordination Framework (2018–2030):
This framework outlines structures such as the Health Sector Intergovernmental Consultative Forum and Interagency Steering Committees to harmonize efforts across stakeholders. It promotes joint planning, budgeting, and monitoring among government, NGOs, and development partners . Somalia could adopt a similar multi-level coordination framework, with regional health authorities forming clusters based on geographic and service delivery similarities. A national coordinating body could ensure alignment with federal health priorities while supporting local autonomy.

A key informant identified the 'One Health' agenda in Somalia as a strategic opportunity to strengthen intersectoral collaboration, particularly among the human health, animal health, and environmental sectors. This perspective is especially relevant given Somalia's complex health landscape, which is shaped by protracted conflict, recurrent climate shocks (droughts and floods), disease outbreaks, and widespread poverty. These overlapping crises have led to one of the highest maternal mortality rates in the world, widespread malnutrition, and limited access to essential health services.

The One Health approach, which recognizes the interconnectedness of human, animal, and environmental health, is particularly suited to Somalia's context, where livestock contributes around 60% of GDP and zoonotic diseases like Rift Valley Fever and anthrax pose significant threats to both livelihoods and public health.

Despite its relevance, the institutionalization of One Health in Somalia remains limited due to insufficient infrastructure, fragmented governance, and overreliance on external donor support. However, recent initiatives—such as the One Health Zoonotic Disease Prioritization workshop and the establishment of technical working groups—signal growing momentum. By leveraging the One Health framework, Somalia has the potential to build resilient, multisectoral systems that can more effectively respond to health emergencies and promote sustainable development

DONORS

The World Bank plays a significant role in supporting Somalia's health sector through multiple initiatives. One of its flagship efforts is the Damal Caafimaad pilot project, currently being implemented in Puntland, Southwest, and Hirshabelle. This project aims to improve access to essential health services and strengthen the delivery of primary healthcare. In addition, the World Bank is utilizing remaining COVID-19 response funds to invest in critical infrastructure, including the construction of new hospitals and the upgrading of cold chain systems and other health facilities.

Beyond the World Bank, other donor-funded initiatives are also contributing to health system strengthening. Notably, the Recurrent Cost and Reform Financing (RCRF) project, managed under the Ministry of Finance, provides partial support to the health sector. This project is particularly significant as it represents the first healthcare initiative for which the Somali government has assumed full responsibility in terms of oversight and implementation. As one key informant noted:

"In the past, projects were funded by the UN or other organizations, but with this project, the government is accountable and responsible for its oversight and implementation."

This shift toward greater national ownership marks a critical step in Somalia's journey toward sustainable health governance and provides a foundation for integrating broader frameworks like One Health, which require strong intersectoral coordination and institutional leadership.

A respondent from a donor agency supported the idea of allowing the government at all levels to be responsible for managing projects being implemented in the country.

A key informant emphasized the importance of government ownership and accountability in health sector projects, particularly in the context of Somalia's evolving governance landscape. Reflecting on the shift from donor-led to government-led implementation, the informant noted:

"It is better for the government to manage the projects and be held accountable to the agencies implementing the projects. However, when UN agencies are implementing them, the government can only be held accountable and observe them and cannot interfere."

Other respondents said that UN agencies don't want to transfer resources and authority to the government as in the case with Damal Caafimaad. "It is in their own interest for UN agencies to think like this because if they say Somalia is self-sufficient, it means that they are not needed and they should leave."

While donor-supported projects have played a crucial role in strengthening Somalia's health system, many respondents expressed concern that these initiatives tend to focus primarily on public health interventions and primary health care services, often neglecting secondary and tertiary care, which are equally essential. For instance, although the Damal Caafimaad project is widely appreciated for its focus on expanding access to primary care, it does not include the construction of new health facilities, which limits its ability to address critical infrastructure gaps.

One respondent highlighted the stark reality on the ground:

"The reality of our country is that there are no health services available. Primary health care and health centers do not have services. Basic things are not available. For example, hospitals do not have rehabilitation centers. I hope that many missing things will be included in other parts of this project."

This reflects a broader sentiment that while primary care is foundational, a more comprehensive approach is needed—one that includes investments in hospital infrastructure, specialized services, and rehabilitation centers. Without these, the health system remains fragmented and unable to meet the full spectrum of population health needs. As Somalia moves toward greater national ownership of health projects, there is a growing call for donors and government alike to adopt a more holistic vision that includes all levels of care.

The current state of Somalia's health system is often described as heavily reliant on donor funding, a sentiment echoed by many respondents. A senior official from FMS-MOH succinctly captured this dynamic, stating:

"As Somalis, we have become donor dependent. But I believe that the money that was started for this health care project will run out. Among the things that have been started is an innovation that the community will contribute, for example, the construction of a hospital or health center by adding more rooms, so the community will feel ownership. Areas where this community-based project has been implemented include Puntland where the community has expanded several hospitals, and others have started."

This quote reflects both a realistic concern about the sustainability of donor-funded projects and a hopeful shift toward community-driven solutions. While external support remains vital, there is growing recognition that local ownership and participation—such as community-led expansion of health facilities—can enhance sustainability, accountability, and relevance. The example from Puntland, where communities have taken the initiative to expand hospitals, illustrates the potential of blended models that combine donor support with grassroots engagement. This approach not only builds resilience but also fosters a sense of shared responsibility for health system development.

NON-GOVERNMENTAL ORGANIZATIONS (NGOS)

The current state of Somalia's health system reflects a broader tension between donor dependency and the need for local ownership and sustainability. As one respondent aptly summarized:

"As Somalis, we have become donor dependent. But I believe that the money that was started for this health care project will run out. Among the things that have been started is an innovation that the community will contribute, for example, the construction of a hospital or health center by adding more rooms, so the community will feel ownership. Areas where this community-based project has been implemented include Puntland where the community has expanded several hospitals, and others have started."

This perspective aligns with longstanding critiques of international aid and NGO expansion in the Global South. Banks, Hulme, and Edwards (2015) argue that despite the proliferation of NGOs, their impact on strengthening indigenous civil society has been limited due to weak grassroots connections, political constraints, and the over-professionalisation of aid delivery, which often undermines their legitimacy [99].

These structural issues have persisted, leaving many NGOs poorly positioned to drive transformative change [100]. In Somalia, this dynamic is particularly acute. While donor-funded projects have provided critical support for humanitarian relief and basic health services, they have also entrenched a culture of dependency that limits the development of sustainable, locally driven systems. As one analysis notes, Somalia's reliance on foreign aid has stifled its economic and political self-determination, discouraged investment in domestic institutions, and left the country vulnerable to shifting donor priorities.

Moreover, the professionalization and technocratization of aid—often driven by donor reporting requirements—can marginalize community voices and reduce accountability to local populations. This phenomenon, sometimes referred to as "NGO-ization", has been shown to weaken civic engagement and create organizations more responsive to donors than to the communities they serve [99].

However, examples of community-led initiatives, such as those in Puntland where local populations have contributed to hospital expansions, offer a promising alternative. These efforts reflect a shift toward shared responsibility and local ownership, which are essential for building resilient health systems. They also resonate with broader calls for decolonizing global health, which emphasize the need to rebalance power, promote equity, and center local knowledge and leadership in health development efforts [101].

Damal Caafimaad was supported by a number of NGOs including Save the Children in Hiiraan; ALIGHT in Middle Shabelle; Action Against Hunger (AAH); in Southwest Bay and Bakool; and Population Services International (PSI), in Puntland.

However, there is a notable absence of a clear and structured methodology for engaging non-state development partners—such as NGOs, civil society organizations, and the private sector—in Somalia's development planning and programming processes. Their involvement is largely limited to the implementation phase of projects, which restricts their potential contributions to strategic decision-making and policy formulation. While the private sector is acknowledged as an active development partner, its role remains poorly defined at the operational level, resulting in limited integration into national development frameworks.

Local NGOs, particularly those working in relief, health, and social sectors, are heavily dependent on external funding from non-traditional donors and international NGOs. This reliance poses challenges to their sustainability and autonomy, and often limits their ability to engage in long-term development initiatives. Despite these constraints, NGOs retain significant potential to support broader civil society efforts. Their deep understanding of local contexts and established community networks position them well to act as intermediaries between grassroots organizations and national-level structures.

Moreover, NGOs can play a transformative role by fostering empowerment and social change. Their traditional strengths in advocacy, community mobilization, and service delivery enable them to build bridges between marginalized communities and formal institutions. However, without formal mechanisms to incorporate their insights and capacities into planning processes, much of this potential remains untapped. The lack of structured collaboration with non-state actors represents a missed opportunity to enhance the inclusivity, effectiveness, and sustainability of Somalia's development efforts.

A member of civil society organization is of the opinion that collaboration between NGOs and the government in Somalia can be significantly improved by:

Establishing formal coordination mechanisms such as joint planning committees and sectoral working groups that facilitate regular dialogue and shared decision-making.

Developing clear partnership frameworks that define roles, responsibilities, and expectations can help align efforts and build mutual accountability.

Enhanced communication and information sharing through centralized platforms would ensure transparency and better access to policy documents, data, and funding opportunities.

Capacity-building initiatives should be mutual, with governments supporting NGOs in areas like compliance and strategic planning, while NGOs contribute their expertise in community engagement and service delivery.

A key informant from FMoH suggested that "joint monitoring and evaluation systems can foster shared learning and accountability, while promoting local ownership of development initiatives ensures that programs are culturally relevant and sustainable".

The above measures could potentially foster trust, improve coordination, and unlock the full potential of NGOs as strategic partners in national development.

Part Six:

A Program for Developing an Effective Healthcare Sector in a Federal System

In this section the components of a program for developing an effective healthcare sector in the context of federal system will be explained. This program is based on the context, analysis and key informant interviews presented in this study as well as the accumulated experience of the principal investigator.

The overall structure of the program is outlined in table 11 which corresponds with the analysis of problems and challenges set out in table 3.

Table 11: Program for effective health sector decentralization in a federal system

Program components	Specific issues
1. Process of change	Policy analysis Policy consultation Policy monitoring Policy phasing of implementation
2. Organizing the structure	Defining decentralization and federalization Determining federal level responsibilities Determining central level responsibilities
3. Resource generation and allocation	MoH responsibilities General principles Resource generation Resource allocation
4. Planning	Linking plans with budgets Articulating plans to respond to local needs Definition of planning roles and responsibilities Community involvement in planning
5. Resource management	Operational policies Staff management Financial management Supply management Transport management

6. Accountability and participation	Accountability Community participation
7. Capacity development	Preconditions for capacity building Diagnosing the problems Programing the areas and means of capacity building Conducting, diffusing and sustaining capacity building
8. Decentralization and public-private relations	Local bodies and regulation Local bodies and public-private collaboration
9. Intersectoral linking	Decentralization and an intersectoral approach Devolving collaborative processes between sectors Structures and systems for an intersectoral approach Introducing an intersectoral approach

In developing this program, some initial points need to be taken into account.

Firstly, the focus is on the health sector decentralization in a federal system. It is not a general review of decentralization and federalization in Somalia. However, both decentralization and federalism are a cross–sector process that is changing the overall structure of the public sector in the country. This means that the recommendations in this section will consist of:

Actions that the FMoH, state ministries of health, international partners and related institutions can do with a certain degree of autonomy and focus specifically on the health sector;

Advocacy in favor of changes that will not only affect the health sector but also other sectors. The FMoH, state ministries of health, international partners and related organizations may have limited authority over these changes.

Secondly, this program is based on the notion that for decentralization to be effective the necessary conditions for its effectiveness need to be developed. As one respondent stated, "Decentralization in a federal system takes time but we have to prepare the ground for this process."

Thirdly, the program is a set of guidelines designed to provide a comprehensive process of change. Where possible, details on the content, timing and resources for change are specified. Where this is not possible, these are not identified.

The program is not a detailed blueprint for the following reasons:

- It is based on evidence and understanding of respondents and stakeholders. This can only be achieved over an extended period and goes beyond the limited resource base of this study.
- To be effective the program has to be based on consultation with stakeholders. While many have been consulted in this study, the consultation needs to develop in both breadth and depth.
- Change has to be taken into account. Decentralization/federalization is an unstable process with unpredictable outcomes. At the same time, the nature of many problems can only be understood in the process of implementation. Flexibility and understanding are required in the process of change [102] [103].

Component One: Process of Change

The way in which policy on the healthcare sector is formulated and implemented will have an important bearing on the effectiveness of the policy. In this report, the importance of interpreting the context of change was emphasized along with specific issues concerning the way in which decisions on health sector are actually being made such as policy analysis, consultation and implementation. Therefore, extensive policy consultation needs to be carried out in four key areas: cross governmental; within health sector functions; with local stakeholders; and with health sector staff [104].

In developing the process of health sector decentralization in a federal system, the following points should inform the process of policy making and decision making.

Policy analysis

There is an urgent need to strengthen the capacity to develop effective health policies within Somalia's federal context. While broader policies on federalism and decentralization are formulated at the government-wide level and largely outside the remit of the FMoH, the ministry and its associated policy-making bodies have a critical role to play in:

- Articulating the health sector perspective within government deliberations on the implementation of federalism and decentralization; and
- Strengthening the federal system from within by advancing policies and actions that enhance the ministry's regulatory, planning, and coordination functions as a key line ministry.

The development of policy making capacity needs to take place at four levels: understanding the characteristics and country situation; policy objectives; policy contents; and impact assessment. This recognizes the simple fact that the effectiveness of the health sector in a federal system will depend on the choice of how it is implemented within a particular but changing context.

Understanding why decentralization is on the policy-making agenda for the health sector; the feasibility of its implementation taking into account the constraints and opportunities of implementation; and the position of stakeholders in relation to health sector. Existing studies on the relevance of decentralisation have to be brought together and related to health sector decentralization in a federal system.

Respondents views on the policy objectives of the health sector provide a useful starting point for discussions with stakeholders, and are categorized in table 12. Often their objectives are over-lapping, meaning the FMoH must work with stakeholders to develop consensus. This should go some way to overcoming the view that there has been a lack of commitment to federalism at the central level. Defining objectives will also provide a broad direction to the process, facilitate understanding among stakeholders and allow for impact monitoring.

Table 12: Objectives of health sector decentralization: A starting point for consultation

Policy objective	Elements of policy objective
Improve cost efficiency	To reduce costs of government action by implementing policy through local people To remove central/regional bureaucratic constraints
Improve effectiveness of government action	To allow for greater adaptability and flexibility in local conditions To recognize and meet local needs
Improve governance	To facilitate better transparency, accountability, improve information flow between government and citiizens and community participation
Strengthen community approach	To allow for improved understanding and meeting of local needs

There are different forms of decentralization and different ways of implementation. The FMoH and policy-making bodies need to be fully conversant with the different forms and how they can be implemented. International experience will be useful here, in particular Ethiopia, Kenya and Uganda which offer important institutional parallels for Somalia [[105-107].

There is a growing body of international experience concerning the impact of decentralization on health sector inputs, outputs and outcomes. This provides useful lessons to guide policy makers. However, a bespoke monitoring and evaluation process is needed for Somalia.

The means for achieving this policy-making capacity, particularly in the FMoH include: strengthening the Policy and Planning Department; using policy circles and developing links with universities and research institutions; developing links with training and academic institutions; and strengthening policy analysis.

It is important to have a focal point for policy analysis. The Department of Policy and Planning, if strengthened, could provide that focus given its system-wide responsibilities for policy, financing, planning and capacity development. The department could develop a network of interested agencies; liaise with the ministry of interior, constitution and federalism and key cross-sector decision-making bodies; channel international experience on health sector decentralization; promote policy discussions among stakeholders; propose actions to to ensure that the conditions for effective decentralization in a federal system are developed; and service the decision-making bodies within the FMoH.

Policy circles are organized groups of stakeholder representatives taking on the role of policy analysts. They would work across the FMoH as well as their stakeholder bodies. Policy circles would be co-ordinated from the Policy and Planning Department and the FMoH and undertake specific areas of policy analysis structured around the components of this program. Policy circles are needed in order to:

Develop a sense of ownership of health sector policy among the FMoH and the stakeholders
Maximize the expertise and knowledge of persons working within the system
Establish the basis, through analysis, for consultation and consensus among stakeholders

A policy circle could be established on the development of One Health in a federal health system. This could be made up of officers from different dependencies in the central FMoH and FMS-MOH, in addition to representatives from local bodies and civil societies. Coordination by the Policy and Planning Department could ensure that the policy circles were adequately serviced with data and and agreed terms of reference.

Developing links with training and academic institutions highlighted in table 13 would provide access to important research bodies at universities in Somalia. These training and academic institutions could undertake applied and action research on specific issues related to health sector roles and responsibilities in a federal system; and undertake social and political analysis of regions and districts with a view to understanding the social conditions for effective local health systems.

Table 13: Training and academic institutions: opportunities and challenges

Institution	Opportunities	Challenges
Faculty of Public Health, Somali National University	Has a core staff with postgraduate qualifications in public health subjects, who have a track record of research work in their own fields. Produces trained health workers to respond to the needs of the country.	Lacks core members with health policy, planning and management qualifications and expertise. The need to link and coordinate with FMoH and other relevant bodies
Banadir University, Mogadishu	Has a network of international research and development partners. Engages in research activities aimed at addressing local health challenges and finding innovative solutions. Research conducted at Benadir University may lead to advancements in healthcare practices, disease prevention, and treatment strategies, benefiting both the local	Needs to enhance capacity and resources in management, planning and policy issues.
	community and the broader medical field. Conducted a relevant study on the role of political decentralization on service delivery in the Banadir Regional Administratio. [108]	
National Institute of Health, Mogadishu	NIH contributes to improving the health of the Somali people through innovative integration of research, surveillance, training, and prevention and control of diseases. Aims to build resilient systems that can prevent, promptly detect, and effectively respond to public health risks and emergencies through attaining and sustaining IHR (2005) core capacities. Works closely with AFNET and Africa CDC along with WHO and other health partners.	Though NIH has the potential to engage with policy development issues, it lacks capacity in terms of adequate and trained human resources.

Somali Research and Development Institute (SORDI)	An independent think tank and multidisciplinary research and capacity development institute specializing in addressing complex health, education, disaster climate resilience and humanitarian crisis in Somalia. SORDI focuses on institutional capacity development and the comprehensive study of disaster resilience, climate change adaption, natural resources management and water, nutrition and food security, health systems, sustainable and quality education, public financial management and media and governance.	SORDI faces significant challenges, including inadequate funding, a shortage of qualified and experienced researchers due to a brain drain caused by conflict, and the inherent complexities of conducting research in a post-conflict environment, which include instability, security risks, limited infrastructure, and difficulties with data collection and community engagemen.
The Somali Institute for Development Research and Analysis (SIDRA)	SIDRA provide research and development services to public and private entities in Somalia. It offers technical innovative solutions to key development issues through knowledge-based dialogue, research, independent analysis, insight and expertise in development projects from needs assessment, planning, design and implementation to output monitoring and impact evaluation.	Limited access to funding, inadequate research capacity within local institutions, andsecurity constraints pose significant hurdles for SIDRA in fulfilling its mission to provide technical and intellectual support for ustainable development in Somalia.
Heritage Institute for Policy Studies (HIPS)	An independent, nonpartisan, nonprofit policy research and analysis institute based in Mogadishu.n.	HIPS faces challenges including funding and the impact of prolonged conflict and instability on security and access to services. HIPS's work on public service reform, security sector reform, and other development areas is directly affected by these overarching national challenges, requiring solutions that address deep-rooted issues like clan politics, resource competition, and the need for effective governance and development.

The process of reform and transformation must be informed by international experiences. This will help policy makers to understand the different forms of decentralization in federal systems and how they function along with the specific contexts in which they operate, their impact on equity and the appropriateness of this experience to Somalia.

To make this happen, the the Policy and Planning Department of the FMoH must establish strong relationships with: similar agencies in countries such as Uganda, Ethiopia, Kenya, Nigeria and Pakistan; and research institutions interested in international health systems and which specialize in health sector reforms, decentralization and federalism.

There is a need for donor funding to support the strengthening of the Department of Policy and Planning; the operation of the policy circles; developing links with research agencies; and developing international links. This support should not be seen as a short project but a medium to long term commitment. Sustainability needs to be the key word in developing this policy analysis.

Policy consultation

Consultation needs to be a fundamental part of the policy process for two main reasons: it leads to a greater sense of ownership in the process of change, setting in process the mechanisms by which affected interests can be discussed and levels of consensus achieved; and allows for the necessary expertise and knowledge of stakeholders to be taken into account.

The implementation of decentralization in a federal system is a complex and problematic process involving change in many areas and affecting the views and interests of a wide range of groups. In this report, we noted concerns over the selective origins of federalism and the lack of understanding around its actual meaning. Broad policy consultation should be seen as a way of overcoming these problems.

Four important areas in which the process of policy consultation needs to be strengthened are explained in table 14

Table 14: Policy consultation for health sector decentralization: areas of consultation, commentary and key stakeholders

Area of consultation	Comments	Key stakeholders
Cross governmental	The fundamental push for federalism in Somalia comes from outside the health sector. It is a cross-governmental process. Respondents in this report expressed concerns about the extent to which the specific characteristics of the health sector are respected in this process. It is important that a dialogue be established and nurtured between the cross governmental reformers of the public sector and those stakeholders involved in improved health and the delivery of health care.	FMoH and FMS-MoH; Ministry of Interior and Fedral Affairs; Ministry of Finance; Ministry of Justice and Constitutional Affairs
Within health sector functions	The importance of ensuring the federal system is compatible with continued, uninterrupted and sustained health interventions was emphasised by respondents. This applies to the development of support functions, such	Federal Ministry of Health (national health programs); Deptartment of Policy and Planning; Federal Member State Ministries of Health)
	as drug supplies, equipment maintenance and transport.	
Local stakeholders	The whole way and process by which the states take on health sector responsibilities needs to be the subject of consultation. Intersectoral collaboration, community participation and links with civil socoieties and NGOs also need to be discussed.	Federal and Federal Member State Ministries of Health; local bodies; local civil society organizations; NGOs; community representatives
Health sector staff	Decentralization can affect the interests of health sector staff not only in terms of their job responsibilities, supervision and management control but also in terms of salaries, pensions and career development.	FMoH, Public Service Commission (or equivalent body, i.e. Ministry of Labor); occupational and professional groups; trade unions

Establish monitoring and evaluation systems

Given the complex, broad ranging and problematic character of decentralization in the healthcare sector, policy monitoring needs to be recognised as important. Two forms of monitoring are particularly recommended – monitoring decision space and monitoring impact.

Monitoring decision space

One of the key challenges of any process of health sector is to achieve the appropriate degree of health service delivery in a federated/decentralized system. A minimum of transfer to the local bodies will not allow for the desired objectives of federalization/ decentralization to be realised. Too much transfer, however, can lead to a fragmentation of the health care system.

There are a number of reasons why an adequate tool for measuring the extent of transfer of power, resources and authority is required in policy making.

Firstly, and despite the existence of legislation and subsequent action plans for a federal system, it is still unclear the direction that federalism and decentralization will take in Somalia. An adequate measure of decentralization on key variables and indicators would certainly help in clarifying the actual direction taken.

Secondly, policymakers need to know the starting point and to the degree to which decentralization has actually taken place. This is vital to any form of monitoring and evaluation and would play an important role in determining the extent to which a federal system actually leads to improvements in health and health care.

Thirdly, it is not unusual for governments to proclaim policies of decentralization without actually transferring power, resources and decision making. Perversely, some policies can actually lead to increased central/regional control. An adequate tool to measure the implementation would allow for a more realistic picture of the extent of decentralization in Somalia's federal system.

To monitor the extent of decentralization, a process of monitoring decision space should be introduced. Decision space is defined as "the range of effective choice that is allowed by the central authorities (the principal) to be utilised by local authorities (the agents)."[109]

Monitoring decision space is designed to identify the extent of decentralization or rather the degree to which authority, resources and responsibilities will, and should be, transferred from the central level to the states and local bodies. This will provide information about the changes resulting from a decentralized system and will allow for monitoring of any re-centralization, as often is the case.

As Bossert (1998) points out, the use of such a matrix allows the policy-maker "to disaggregate the functions over which local officials have a defined range of discretion, rather than seeing decentralization as a single transfer of a block of authority and responsibility." The notion of decision space used here builds on that developed by Bossert (1998:1518) of discretion "which normally distinguishes between political and technical choice within parameters set by legislation." Bossert (idem) specifies "the degree of discretion allowed for specific functions with high technocratic content" [110].

Although the use of a common matrix for international comparative studies on shift of power and resources to the periphery makes sense for the development of a specific matrix adapted to the characteristics of Somalia's federal system. Table 15 builds on the framework presented by Bossert (1998), adapting it to the situation in Somalia. It widens the number of categories and provides more details for categories used.

Table 15: Categories and indicators in measuring decentralization

Category	Items in category
Governance and organization	Clarity of roles and authority of FMoH structure Clarity of roles and authority FMS MOH structure Availability of tools of community participation in decision making
Finance: Resource generation and budget management	Degree of central allocations to local level Degree of local discretion for generating local sources of finance Degree of local discretion in formulating budget Degree of local discretion in virement
Policy making, planning and resource allocation	Existence of state-level health planning Form of relationship between state and national health planning Percentage of central controls on grants
Human resources	Degree of local discretion on job design Degree of local discretion on staff appointments and staff changes Degree of local discretion on staff terms and conditions
Logistics and supplies	Degree of local discretion on purchasing Degree of local discretion on logistics management
Inter-organizational links	Degree of local discretion on inter-organizational links
Service organization and access	Degree of local discretion in public contracting of private providers Scope of local program integration and management Form of local relationship between health authority and local hospitals Degree of local discretion on type and form of service provision Degree of local discretion on forms of insurance financing Degree of local discretion in targeting of groups

Table 15 incorporates two interrelated items. Firstly, there is the notion of administrative and managerial discretion within the bounds of legislation [111]. This is expressed in the points related to local discretion in, for example, the appointment of staff or logistics management. Secondly, it incorporates the notion of the effective operation of a decentralized/federated system which is expressed in the form of, for example, the extent of local program integration.

Monitoring impact

A theme throughout this study has been that there is no guarantee that decentralization or federalization will have a positive impact on health and health care. It has even been suggested that decentralization is an act of faith for which there is no concrete evidence. In this situation, monitoring the impact of decentralization takes on great importance. Any monitoring process should include:

Monitoring bodies – This should be co-ordinated from a strengthened Department of Policy and Planning at the FMoH and involve a wide network of agencies, typically those involved in the policy analysis mentioned above.

Indicators – These should include a range of inputs, outputs and outcomes, as listed in Table 16. Baseline data should be gathered at selected sites to help determine the appropriate indicators.

Time span – Monitoring is not a short-term, one-off process but a medium to long term one. It must take into account the time it takes for the new system to impact on outputs and outcomes.

Attribution – This will be one of the major problems facing the monitoring process. While changes in the indicators might well be signalled, it is important that researchers know the extent to which these changes can be attributed to a federal or decentralized system. Clearly, the further one moves from inputs to outcomes, the more difficult the problem of attribution becomes.

Decision making – The means by which the monitoring data is channelled to the points of decision making needs to be established from the beginning.

Table 16: Examples of inputs, outputs and outcomes for monitoring in a decentralized health system

Inputs	Extent of technical capacity and form of skill mix among local (state and below) health staff
Outputs	Quality of care Community involvement Access of poor to health services
Outcomes	Health status change in terms of morbidity and mortality

Phasing in implementation

Phasing in the implementation of decentralized healthcare needs to be an essential part of the process. This makes sense for two reasons:

Some local bodies clearly have a capacity problem. Phasing in allows the local bodies to build up their capacity in the implementation process. The lack of capacity applies also to the central level, which needs to develop new skills and systems to facilitate the implementation of reforms and transformations. As one senior government official said: "Decentralization should not be adopted in blanket form to all. We should first assess the existing situation in terms of human and organizational structure, programs, health priorities, capacity of local institutions, and the social characteristics of different districts."

Phasing in allows for a learning approach to be adopted. As the process of implementation progresses, new and unforeseen challenges will appear and new ways of proceeding will emerge.

Component Two: Organizing the Structure

This section discusses the development of the overall structure of the healthcare sector in a decentralized federal system.

Defining decentralization in a federal system

The extent to which a decentralized system of government is to be introduced is basically a political decision. Decisions which must be made include:

- The range of government responsibilities to be transferred to the state and local bodies
- The extent to which resources will be generated locally and/or centrally allocated
- The authority the local bodies will have to determine priorities and manage their own resources.

However, these decisions go beyond the boundaries of this study, as they are broad strategic decisions which will affect all sectors and not just healthcare. However, there are two key considerations. First, in the strategic areas noted above, the FMoH should take an advocacy role, proposing actions from the health sector's perspective. Second, it must seek maximum clarity from government on how decentralization will be implemented and what it will mean for health services. This requires regular and structured engagement – particularly with the ministries of finance, interior, and constitutional affairs. Such engagement must go beyond simply assigning a representative to a committee; the FMoH needs to take a proactive stance, defining clearly what information it requires and how new legislation will affect the health sector.

Determining state (local) level responsibilities

At the state level, the following roles should be undertaken:

- **Health planning** - The formulation and implementation of a state health plan is a fundamental responsibility, linking local and national planning. This will involve the development of processes and mechanisms for priority setting and a health information system.
- **Health information** – The development of a health information system includes collecting, compiling, forwarding and analyzsing health information.
- **Community health programs** – The state and district levels will be responsible for carrying out community health programs, principally for non-communicable diseases. This will include activities to promote healthy living and control diabetes and cardiovascular diseases.
- **Management of government health units** – In time, local bodies will control and manage all state and local level hospitals, health centers and health facilities.
- **Staff management, planning and development** - Local bodies will be responsible for the management and development of the health workforce through recruitment, deployment, supervision, control and in-service training.
- **Financial management** – Local bodies will be responsible for generating their own resources, receiving central funds and budget management of local health funds.
- **Supplies management** – This refers to the process of ordering, receiving, storing and distributing items ranging from drugs to medical equipment. Purchasing and regulating will be shared with higher levels of government.

- **Logistics management** – This includes local bodies taking responsibility for the management of buildings, equipment and transport.
- **Public–private links** – Local bodies will be responsible for developing constructive links with the private sector (for-profit and not-for-profit) including the co-ordination, regulation, support and supervision of all non-governmental health facilities.
- **Inter–sector links** – This refers to the development of links with sectors such as education, agriculture, livestock, environment, water and transport with a view to health development under the One Health concept.
- **Community participation** –This should be made a priority by incorporating it into other processes such as health planning and resource management.

Determining central level responsibilities

Decentralization is not about weakening the central, state or regional levels but changing what they are responsible for. This means that the FMoH will transfer many of its operational, management and planning responsibilities to the states which in turn devolve certain responsibilities to districts and local bodies. Considerations should include:

The capacity of the FMoH to conduct strategic management and planning of the health sector, to help it develop a national health plan and allocate resources through the national budget, needs to be improved. Developing a national health information system and policy-making systems are areas which will require particular support.

The FMoH is responsible for setting and monitoring the standards of quantity and quality of health and health care. This should operate through regulatory processes – setting the limits to, and monitoring the process of, decentralized responsibilities.

Key operational responsibilities for the MoH should include the supply system, as well as drug purchasing and distribution. However, the FMoH needs to take on a support role, acting as a center of expertise on health and health care and backing a process of capacity development for the states and local bodies.

Component Three: Resource Generation and Allocation

General principles

In developing the new system of resource generation and allocation there are a number of guiding principles to be taken into account. These are expressed in the Ministry of Health Strategic Plan, 2021-26 and WHO's Country Cooperation Strategy [3, 112] as well as in the international literature. The five points highlighted here form a basis for discussion within the FMoH and among stakeholders.

The system of resource generation and allocation needs to take into account the guiding principle that the overall aim of the FMoH is to improve health in an equitable manner. This raises particular issues around the criteria used for resource allocation to local bodies and the extent to which it channels resources to meet health needs and equity.

The transfer of responsibilities from the center to local bodies has to be linked to the transfer of authority and resources. To transfer responsibilities without the corresponding resources weakens the public sector and the impoverished local bodies.

A health economics and financing unit could be established under the Department of Policy and Planning. A task force on costing and decentralization (transference) of health services also needs to be formed.

Openness about resource generation and allocation is an important principle.

Omar (2021) proposed a network of organizations, including line ministries and local bodies, developing strategies to enhance data collection on finance and statistics [113]. The FMoH could join in this sharing of data and play an important role in providing and analysing health data.

Sanjir (2017) raised the need for system to monitor performance of local bodies. This cannot be a separate system for each line ministry and Sanjr (2017) correctly advocated against parallel initiatives. Line ministries and local bodies need to coordinate in determining relevant indicators, on data analysis and on recommendations to improve performance [114]. The FMoH should liaise with relevant bodies to provide the health component of a performance monitoring system.

Defining and clarifying the responsibilities of the FMoH

Proposals for general resource generation and resource allocation were outlined in the Ministry of Health Strategic Plan, 2021-26.[3] The FMoH will therefore play an important role in recommending how proposals for change will affect the health sector and should play a major role in the policy-making process.

Developing a policy of resource generation

Approaches to resource generation by state and local governments must be carefully examined as a matter of urgency (if not already done). Once again, the FMoH has an important role to play in submitting, from the point of view of the health sector, considerations on local body resource generation. It also has oversight on local taxes, local fees and community health insurance schemes (if and when established).

As stated by one respondent *"The funding to the federal states should gradually be reduced in the phase wise basis." Another said, "It will be more effective and sustainable if they collect tax revenue because it will be their own resources. When these states become independent and capable in funding, the center can gradually stop providing funding."*

While local bodies will develop their own sources of revenue over time, some caution is required, particularly regarding local taxes and the funding of local health systems. There are important issues of inequity that the FMoH needs to be aware of when developing appropriate policies in this regard together with the Ministry of Interior, Federal Affairs and Reconciliation (MoIFC) and Ministry of Finance (MoF).

Health taxes

The government can introduce targeted taxes (on tobacco, khat, or sugary drinks) to raise additional revenue for health-related activities. Licenses for private health care providers, pharmaceutical companies and importers of medical equipment and supplies could generate additional revenue for the health sector. However, this would require a system of taxation be developed by the Ministry of Finance.

User charges

The FMoH needs to pay particular attention to five issues when developing its guidance on user charges. They include:

Equity and health

As some of the regions and districts are much stronger in funding and financial resources while others have no adequate funding or financial resources, the government should consider while allocating/distributing its investment to the local level on the basis of the available resources, geographical condition, the infrastructure and the capacity of these local bodies. In this regard, a senior civil servant suggested that: *the federal government should provide health and related services free of costs. There must be a system of charging fees as per the user's economic capacity/status at the local level."*

Corruption controls - Questions were raised by some respondents about whether users were ready to pay fees or may use political influences to avoid payment. They suggested that in order to make a system of local contributions work there would need to be controls on embezzlement and the provision of capable staff and infrastructure for resource generation.

Local ownership – A member of regional assembly said: "If people have an ownership feeling over health-related programs and are aware of the benefits, they could be ready to make a financial contribution,"

Trust – A senior civil servant said: "We have to generate and develop our own resources. Another very important aspect in decentralization is transparency. Trust can also be increased through transparency".

International experience points to problems with the **efficiency of collection systems.** It makes little sense to collect fees if all or a substantial part of the sums collected are lost in administrative costs.

Internal allocation of resources

This raises the question of the extent to which local bodies will use their own resources for health. This will clearly depend on local priority setting.

Developing a policy and formula for resource allocation

There are important issues for the FMoH consider around the system of resource allocation to local bodies. In terms of health sector decentralization, resources allocated may come from block grants, sectoral grants and donor-funded development grants. The FMoH needs to consider all three resource channels, particularly the proportion to be dedicated to health and health care and the criteria for distribution among states.

Block transfers

This was illustrated by a member of FMS Ministry of Planning: "There should be a system of providing a lump sum amount to the states in which they can spend the amount with full flexibility and as per the priorities set by them (the local levels). The transfer should be both conditional and unconditional."

Work surrounding block grants needs to come from the central treasury using an agreed formula which could include the criteria such as size the local population; area size; the Human Development Index; costs; and tax revenues.

Respondents came up with different options on financing the local health system, taking int consideration the population and capacity of the district. The FMoH must participate fully in this process of policy-making, paying particular attention to the potential impact of different formulas on health and health care. If health care is to be funded out of general local income, then the allocation of these funds is of the utmost importance to the FMoH. Equity will clearly be affected, according to one respondent: "There needs to be an arrangement of giving subsidies to the areas that have low funding or financial capacity."

Similarly, the use of allocated funds for general development expenditure in the state, region and district will affect the process of intersectoral collaboration.

Health sector budget transfers

As primary care facilities are progressively transferred to local bodies, the FMoH will have to pay increasing attention to resource allocation mechanisms. It will need to establish some form of health sector fund for allocating resources to the local bodies. There are key questions to be answered, some of which are applicable to the health spend from the block grant. An introduction to some of the issues is provided by the World Bank [27]. The questions are essential to future policy analysis for effective health sector reorganization [115]. They include:

1. Initial size of the health sector fund. This will depend on the range and number of services that are transferred to the local bodies. Any shortfall in allocated resources will effectively mean an abandonment of the services.

2. Criteria included in the allocation formula. In the shift to a more needs-based formula in pursuit of better and more equitable health and health care, criteria such as population, demographic profile and poverty indices need to be included. The FMoH will also have to take into account differing costs of providing services between regions and districts and the availability of other funding sources (own tax and fees and donor funding). In order for the criteria to be applied, there needs to be reliable and available data.

3. Services provided by local bodies. There has to be a correlation between the responsibilities held by the local bodies and the funds received. For example, the FMoH may wish to make the allocations to hospitals a separate item.

4. Conditional or unconditional allocations. Allocations through a Health Sector Fund are conditional in the sense that resources would have to be allocated to health sector activities. However, the issue is the extent to which there are conditional sums within the overall packet.

5. Shift from sectoral allocations to block grants. The shift to unconditional block grants would be more consistent with the process of decentralization in a federal system, as it would allowing the local bodies to make their own priorities related to the resources received. On the other hand, some respondents were concerned there would be no guarantee that local bodies would provide a minimum of health care.

6. Transition process. Any shift from a service-based formula to a more needs based one cannot be done overnight and will take time to achieve.

7. Administrative mechanisms ensuring the efficient and timely receipt of funds by the local bodies. Given the importance of ensuring continuity and sustainability in service delivery, administrative mechanisms would need to be in place to ensure the efficient and timely receipt of resources.

8. Incorporating donor funds into the system of resource allocation. Essential to answering how this will be done is developing a policy on donor funding and the balance between donor funding of specific projects and on-line budget support. Support for the former was presented by one respondent: "If the federal government does not want to provide the grants to us, we should have freedom to receive money directly from the donors. The donors will not deny giving grants if they are requested from the state government."

However, the development of a sector-wide approach (SWAp) arrangement would change this. Interest in moving to a SWAp was signalled by a number of respondents and there was general agreement among external development partners that a move towards joint programming and planning makes sense as seen in other countries [116].

Component Four: Health Planning

This section will discuss how decentralized planning fits into the national health planning system; and the characteristics of a decentralized health planning system.

Linking plans with budgets

International experience highlights the poor record of planning when it is not carried out alongside the budget process [117]. In Somalia the current situation reflects a historical incrementalist budget process with no link with the plans prepared by either the federal or state levels. Any effort to improve planning will fail if it is isolated from its financial counterpart.

Planning to respond to local needs

In Somalia, there are a vast array of plans dealing with national health programs which could be made more meaningful if they articulated local needs. Green et al (2007) suggested creating conditions for national health programming to be carried out at the local level by the people in close contact with the local needs and conditions [118]. This approach puts more emphasis on local health programming than on detailed planning of large national health programs. This approach is based on the need for equity:

- Involving communities in decision-making processes
- Recognition of the multi-sectoral nature of factors affecting health
- Ensuring that the interventions adopted are appropriate
- Emphasizing health promoting activities

There may be conflict between different principles which require political resolution in the planning processes. Figure 8 sets out some possible planning values.

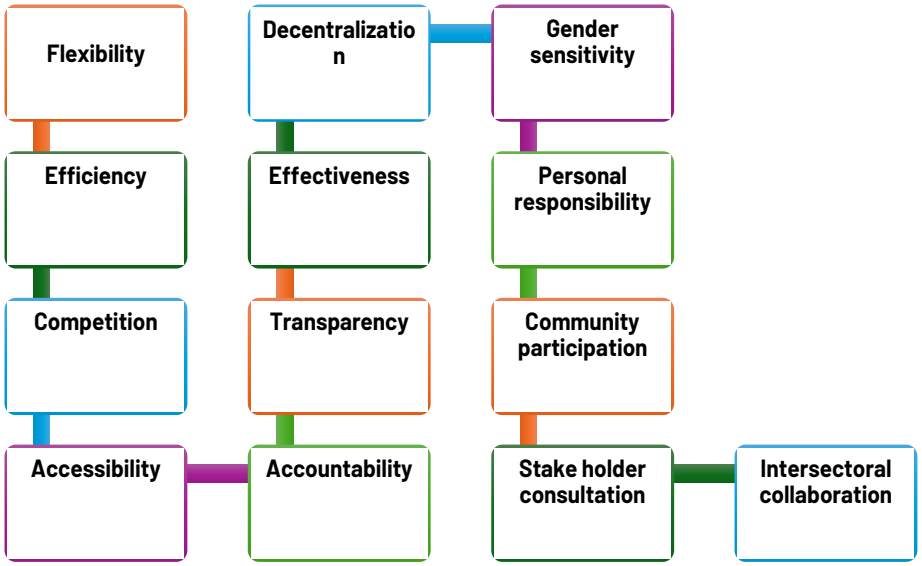

Figure 8: *Planning values and principles*
Source: Green, Collins, Stefanini *et al.*, 2007 [118]

Defining planning roles and responsibilities

The federal system of governance in Somalia will affect how plans are developed and the relationship between the national and state levels. Figure 9 demonstrates the relationships in decentralized systems and the more complex relationships that exist under federalization.

According to two respondents, the center should set national strategic priorities and measuring the overall impact and long-term trends of a program or project rather than short-term outputs.

State-level planning should reflect the needs expressed in the regions and districts. According to a respondent, *"In the federal system, planning at the state level should give due consideration to the real needs of different places within the state."*

Another respondent from FMoH said: *"Central people should work in close co-ordination with the state level and local people for better planning."*

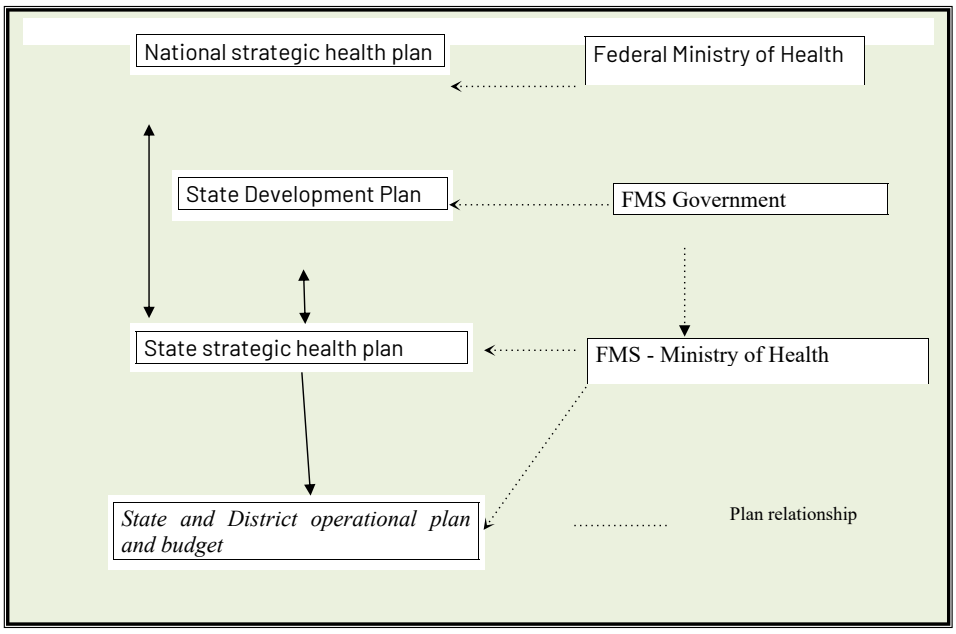

Figure 9: Relationship between plans in a federal (decentralized) system

Table 17 proposes the division of responsibilities between the state and the center.

Table 17: Division of planning responsibilities between FMoH and FMS-MoH

Central functions	Joint activities	State and local functions
broad policy leadership resource generation and allocation donor co-ordination liaison with central ministries co-ordination of local plans planning of central specialist services human resource planning technical planning support legislation		local needs assessment local resource generation and allocation liaison with state-level ministries planning of state specialist services state and local human resources planning and development development of state plans implementation of local plans
monitoring and evaluation jointly with central level		

Planning should not be done in isolation. The groups shown in figure 10 should be involved. They include:

- Communities
- Users
- Health care providing agencies
- Health care managers
- Health care professionals and workers

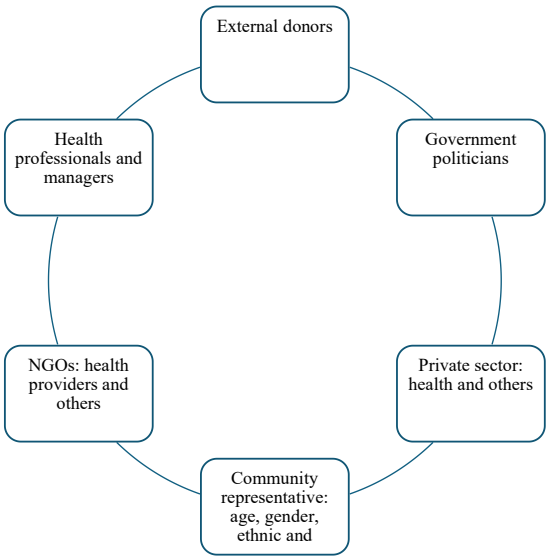

Figure 10: *Stakeholders involved in decentralized health planning*

How different groups are involved in planning is likely to affect the quality of the plan, the speed of decision making and ownership of the plan. Consultation may take place at different points in the planning processon on topics including:

Priorities and strategies (at the beginning of the process)
Alternative options (once priorities and strategies have been formulated)
The final plan (at the end of the process)

Linking state and national plans

Respondents advocated a needs-based approach, community involvement and sustainability to ensure state and national healthcare plans are linked.

"The policy of federalism is mainly to focus on a bottom-up approach rather than concentrating the resources and programs in the center. There should be bottom-up-planning so that the people at the bottom level can identify their problems and plan for their resolution."

The linkage between national (Federal Government) and state (FMS) plans can be illustrated by developing planning time scales such as: long-term (10-20 years); medium-term (five years); and annual activities/operational plans (figure 11).

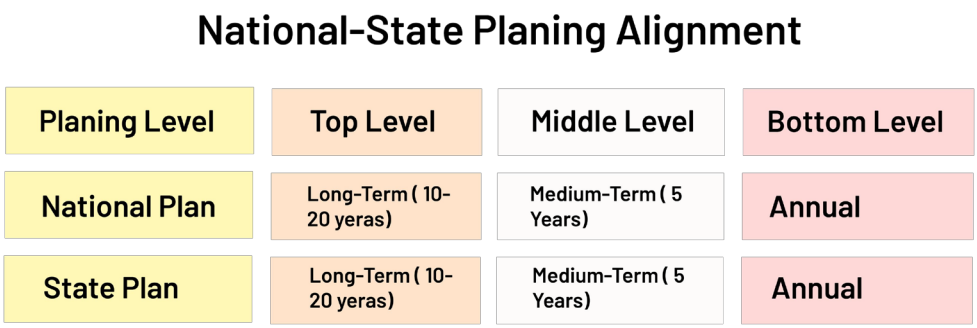

Figure 11: linkages between long, medium and annual plans

Planning schedules must allow time for broad consultation at each stage, and ensure that plans at every level (e.g., state health plans) are aligned with both higher- and lower-level plans as well as other parts of the wider system (e.g., state government plans).

Involving community in planning

The existing planning system assumes that identification of health needs is a technical process centered in epidemiological and clinical data. This has produced a narrow understanding, often resulting in poor utilization of available services.

Involving local communities in the planning process at the state, region, district and village levels would enhance the effectiveness of health programs. According to one respondent, "There is a need to involve representatives of local communities in all the steps of the planning cycle, so that health services would benefit those in need, the most vulnerable, and the poor".

The creation of well-trained committees of both community members and health professionals is a pre-requisite for the successful involvement of communities. Representatives of all sections within the community should be empowered to play a role in planning for state, region and district health, mobilizing resources and overseeing the implementation of agreed plans. Committees should have: a degree of autonomy; broad involvement of all community groups including women, the voiceless and ethnic minorities; and representation from other sectors and civil societies.

Community participation in the planning process needs to begin with the identification of health needs and priority setting, continuing all the way through the monitoring and evaluation of health plans.

As highlighted in figure 12 community participation in the health planning process should begin with the identification of health needs and the setting of priorities. It must continue through every stage, including the design, implementation, monitoring, and evaluation of health plans. This inclusive approach ensures that health interventions are relevant, effective, and aligned with the real needs of the population.

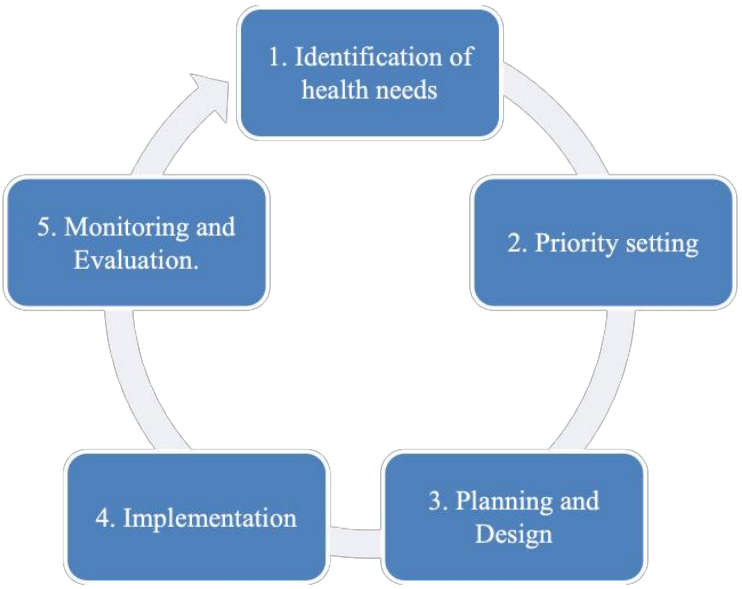

Figure 12: stages of community involvement in health planning

Component Five: Managing Resources

This section examines how health resources are to be managed within the decentralized federal system.

In this report, decentralized health management refers to the way in which resources are brought together and combined by local bodies to achieve health care objectives.

To indicate how all resources are to be managed goes beyond the scope of this report. We will, however, focus on two resources – people and finance –to better understand the key factors guiding resource management in the decentralized setting.

Format for decentralized resource management

Though there are no ready-made recipes for developing resource management in a federal system, table 18 provides a broad framework for the FMoH.

Table 18: Format for decentralized resource management

Policy question	Explanations
Is management of the resource recognized as key to decentralization in a federal system?	The issue here is whether the stakeholders recognize that health workforce management, for example, is essential to the development of the decentralized health service
What is the information base of resource management?	This may not be readily available and has to be built up as a basis for policy change
Who are the stakeholders?	Consultation among stakeholders is fundamental for ensuring appropriate data and ownership
What are the problems of resource management and how will decentralization affect them?	These need to be identified in a general sense and then understood in terms of the negative, positive or neutral impact decentralization will have on them
What new issues will decentralization generate?	As decentralization involves the transfer of authority over resources, it will generate a whole series of issues, problems, opportunities and challenges
What are the options for developing resource management?	This requires a scanning of international experiences and the generation of new ideas among stakeholders
What are the constraints?	These refer to constraints that will hinder the adoption of appropriate answers to the challenges raised by decentralization in a federal system in particular areas of resource management
How can the transition be made?	We have already raised the issue of consultation in the process of the transition. There are additional issues referring to the timing of change and the use of an evidence base

Operational policies

Operational policies are a set of guidelines for the management of resources. A local body – state, region and/or district – could develop operational policies for the management of staff, money, planning or developing community participation. The guidelines, which may be linked to a management system, would be made up of the 'why', 'who', 'what', 'how' and 'when' of managing resources. That includes staff, money, supplies and transport. Serious attention should be paid to the development of operational policies for and by local bodies.

A format for these operational policies is set out in table 19 including the basic elements of the policies – documents of 10-15 pages. Also provided are the key guidelines on how a particular resource is to be managed by the local levels.

Table 19: Basic format for an operational policy on staff management (States, Regions, and Districts)

Area of local management and planning: For example, staff management.

Context: This should include the basic factors to be taken into account in the formulation and implementation of the operational policy. For example, reference to FMoH policy, the role of the State Level Service Commission (when established), or recent reports on staff problems such as de-motivation.

Areas covered: This should include the specific areas of management in the operational policy, for example an operational policy on staff management would cover supervision, performance appraisal, recruitment and selection, and policies on rewards and motivation.

Aims and objectives: This refers to the general goal of the operational policy which may be broken down into objectives leading to the stated aim.

Responsibility: This refers to the person responsible for formulating and implementing the operational policy, as well as the units and institutions involved in its management. For staff management, this would involve the HR department in the FMoH, the state, the regional level, the district, the Local Service Commission (when established), the trade unions and professional / occupational groups, and local health managers.

Processes and agreed procedures: This is the main part of the operational policy and may require subdividing into particular areas such as supervision, rewards and motivation. Attention here should be on the component parts and actions required to carry out the operational policy, together with who is responsible. This section will be a mixture of national and local rules and procedures along with good practice.

Links with other operational policies: This should show the implications on other operational policies. For staff management, particular attention should be paid to:
Finance (show where staff incentives come from within the finance operational policy)
Human resource planning and production (linking how staff are managed with how their numbers are planned)
Supplies (show how staff are given proper logistical back-up)
Information (show how information on staff distribution in the district is to be found in the information system)

Links with other levels of government: Linking up management by local bodies with staff management responsibilities at the national, state, regional and district levels.

Monitoring and evaluation: The policy should indicate how it will be monitored and evaluated, as well as revised.

Staff management

The report has already stressed the importance of ensuring a positive relationship between decentralization and staff management and planning. This section will identify a range of actions to be taken in order to ensure this happens.

Ensure staff management is recognized as a key to federal system. The first and most important point is to recognize the importance of the health workforce in the process of decentralization. Failure to ensure a high level of staff management and planning that is compatible with the process of decentralization could have a significant impact on service provision to health care users. The first step therefore is to establish human resource management and planning as a key item on the agenda of the FMoH, state government and local authorities (regions and districts). This needs to be expressed in the decisions taken by the institutions concerned, the attention given to policy analysis in this area, monitoring of the impact of decentralization on staff and policy consultation with the stakeholders.

International literature and experience can help in developing the data base for human resource management [119, 120]. This can be used to monitor staff management together with the results of policy analysis and action research.

Identify the stakeholders. They include the stakeholders indicated in the consultation process, such as local health managers, local leaders, civil society, training institutions and labour union.

Identify the problems of human resource management and how decentralization will affect them. They include:

- HR units existing in name only
- Staff unwilling to accept postings because of inconsistency in applying policy
- No rewards for merit and performance
- Staff allocation not based on staffing norms or workload
- Staff recruitment is not matched to needs
- No institutional performance measures
- Training of high level staff not based on any health or health care objectives
- No institutional plans available to guide staff development and deployment
- Staff salary differentials not sufficiently demarcated
- No transparent career systems in place and the current system is de-motivating
- Strategic HR plan not being followed or assessed

Consider new issues generated by decentralization. They include career development, job security and staff appointment to different positions as well as:

Human resources needs. It is important that two extreme situations are avoided. Firstly, decentralization should not be taken to the extreme of stripping the center of its key role in the development of national human resource planning [73]. This happened in a number of countries during the 1980s when the center lost out to the regional level, essentially cutting the important national perspective in health planning [39]. Secondly, the decentralized level should not ignore its important role in staff planning. Health workforce planning has to be an integrated center-local process in which the decentralized level develops specific techniques to estimate staff need. As part of capacity development, staff planning should be instituted within the districts.

Accountability, supervision, authority and staff. New relations of accountability and authority will emerge as federalism progresses. For example, the local service commission, once established, would be responsible for appointing local staff within the structure and lines of managerial authority established within the state level health system. Lines of supervision will need to be established within the local health system.

Development of staff – The FMoH must take on an important role in staff development by ensuring an appropriate system of national staff training, linked to national health system needs. The states will also have a role to play through, i) the identification of staff development needs as part of the state and local based planning system and, ii) the identification of individual staff development needs as part of the individual performance review of staff. FMS-MOH, in collaboration with the regions and districts, will need to be proactive in contracting training institutions to provide formal training courses, as appropriate. They will also have to recognize that a great deal of staff training takes place not through formal training courses, but through on-going management practice. These include supervision, mentoring, and shadowing.

Options for developing human resource management. They include specifying the designation of authority to the FMS-MOH, the role of the regions and districts in staff transfers, separate arrangements for staff transfers to remote areas and continued employment of existing staff.

Consider the constraints. These must be identified and related to the stakeholder analysis and the process of transition.

Consider how the transition to a decentralized federal system may affect the interests health workers in areas such as promotion and career development, salaries, terms and conditions of employment, pensions, trade union and professional representation. These can be de-motivating factors for health staff with negative effects on health care. It is important that the transition be based on:

A process of consultation with the representatives of affected groups around the key issues. One respondent suggested rapid appraisal in the districts to find out the aspirations and interests of district-based health personnel, which include:

- A full dissemination of information on the changes
- An understanding of the different options available to ensure informed choice
- A phased approach which allows for a full consultation on the changes
- A close monitoring of the change to ensure corrective action when necessary

International experience is full of horror stories [121-124] about how health staff and service providers felt as a result of poor staff management during the transition to decentralization. Somalia should avoid, as far as possible, these problems. Among the critical issues for negotiation are:

- Career development
- Arrangements for existing staff
- Staff motivation
- Incentives for staff in remote areas.

Decentralization or federalization is not about weakening the role of the center but strengthening a new set of responsibilities in staff planning and management [125].

The report has discussed the important role for the FMoH in national human resource planning. This needs to be conducted in an integrated fashion with staff planning done at the decentralized level.

Setting out the management and regulatory framework in which the states and local bodies will employ staff is also the responsibility of the FMoH. This should include the structure of staff grading and national salary systems to operate throughout the country, and the formulation of career development paths for occupational and professional groups working in the health care system, Given the weak nature of finances, the central level will need to take responsibility for transferring payments to the states for staff salaries.

Financial Management

There are two main financial management tasks at the decentralized level: the local collection of revenue and the management of the resource allocation and budgeting system controlled by central/federal administrative levels.

The former may provide useful additional revenue for the local health system. Both state governments and FMS-MOH must ensure that there are adequate safeguards on the collection and expenditure of these funds.

The rules regulating the budgets allocated from higher levels might influence the extent of local flexibility in the use of funds. Table 20 provides a check list for financial management in a decentralized system [126].

Table 20: Checklist for financial management in a decentralized system

Can revenue be raised locally?
If so, is the system working well?
Do FMS-MOH and levels below have an identifiable budget?
Can they submit an annual budget request?
Can budget allocation be adapted to local circumstances?
Can expenditure be transferred between budget heads?
Is there a ceiling on the FMS-MOH's ability to spend within its budget without reference to higher levels?
Is there a ceiling on the regional and district ability to spend within its budget without reference to higher levels such as the FMS-MOH?
How does actual expenditure compare with budget allocations?
Can state level and FMS-MOH expenditure on essential service package be identified and trends over time be monitored?

In a decentralized setup:

- Central government needs to formulate guidelines and provide direction to the states, regions or districts on resource generation.
- If user fees are to be charged, it is important to consider the economic situation of different states, regions or districts and the ability of users to pay.
- Local bodies need to be able to allocate the resources received in the form of grant on the basis of clearly agreed priority.

Financial management is an essential component of resource management under a decentralized system, as health officials at state, region or district will be increasingly expected to manage budgets in situations of severe resource constraints. In Somalia, local health systems operate on the basis of limited cash. The responsibilities of managers to deal with financial resources management will therefore need to be reviewed in context.

Decentralization in Somalia's federal system presents both opportunities and challenges for financial resource management in the health sector. Green et al. (2007) emphasize that multi-level coordination is essential, especially in fragile or transitioning states like Somalia [118].

Here's a breakdown of how different actors—particularly the government and Ministry of Health (MoH)—can respond effectively:

National Government Responsibilities

1. Policy and Legal Frameworks: Establish clear laws and policies that define roles and responsibilities across federal and state levels.
2. Equity and Redistribution: Ensure equitable allocation of resources to avoid disparities between regions.
3. Capacity Building: Support training and institutional development at sub-national levels.
4. Monitoring and Accountability: Develop systems to track financial flows and health outcomes across all regions.

Ministry of Health (Federal and State Levels)

1. Strategic Planning: Align national health strategies with local needs and capacities.
2. Budgeting and Financial Oversight: Improve transparency and efficiency in health budgeting processes.
3. Technical Support: Provide guidance and tools for local health authorities to manage funds effectively.
4. Data Systems: Strengthen health information systems to inform resource allocation and policy decisions.

Green et al. argue that decentralization requires [118]:

- Adaptive leadership: Ministries must be flexible and responsive to local contexts.
- Collaborative governance: Encourage partnerships between federal, state, and local actors.
- Resource mobilization: Diversify funding sources, including donor coordination and community contributions.

Component Six: Accountability

In this context, accountability means that the Federal Member State Ministries of Health (FMS-MoHs) have a duty to be transparent, responsive, and answerable to local stakeholders—including civil society organizations and community members—who are involved in the planning and management of health services. It involves integrating these stakeholders into the core functions of the health system, rather than treating them as external or optional participants. This process, often referred to as "internalising" or "mainstreaming," ensures that local voices are not only heard but actively shape decisions, monitor performance, and hold authorities responsible for the effective and equitable use of resources.

The development of new forms of accountability in Somalia's decentralized health system is inherently cross-sectoral, reflecting the broader nature of decentralization in a federal system. However, this does not exempt the health sector from its responsibility to lead and contribute meaningfully. The Federal Ministry of Health (FMoH) and the Federal Member State Ministries of Health (FMS-MoHs) must take proactive steps to clarify the potential for new accountability relationships with civil society and community-based organizations (CBOs).

This includes:

- engaging relevant stakeholders in policy discussions,
- recognizing these relationships as essential to effective governance, and
- embedding them into the core management and planning processes of the health system.

Furthermore, they must monitor how these accountability mechanisms evolve to ensure they are meaningful, inclusive, and sustainable.

Accountability

Improved accountability in health care is a central objective of decentralization and federalism, and it is essential that both the Federal Ministry of Health (FMoH) and the Federal Member State Ministries of Health (FMS-MoHs) explicitly integrate this goal into the ongoing process of health sector decentralization. This means embedding accountability into the decision-making structures of decentralized district health systems through operational policies, job descriptions, and training programs. It also requires active monitoring to ensure that accountability mechanisms are functioning effectively. The FMoH and FMS-MoHs should advocate for systemic changes that support new and more inclusive forms of accountability, particularly those that enhance the political and community representation of women, which is vital for the equitable and effective delivery of community health services.

Secondly, the FMoH, FMS-MoHs, and other stakeholders must carefully manage the evolving forms of accountability introduced by decentralization. As authority and responsibility shift across different levels of the health system, four key types of accountability—managerial, political, professional, and community—are being reshaped. These changes can lead to tensions, particularly when new managerial structures disrupt established professional norms or when political and community expectations diverge from technical priorities. It is therefore essential that these shifts are actively monitored and managed to ensure that accountability remains balanced, inclusive, and aligned with the goals of equitable and effective health service delivery.

To address this, the FMoH and FMS-MOH should lead efforts to explain the reasons for change, engage affected groups in dialogue, and develop new approaches that respect both managerial oversight and professional integrity. For example, if doctors feel that stronger local-level managerial controls undermine their professional accountability, health authorities should work with them to safeguard professional standards while maintaining effective management.

Decentralization can also generate uncertainty about roles and reporting lines. Clear organizational charts, updated job descriptions, and revised operational policies are essential to clarify responsibilities and chains of accountability. Sensitization sessions, joint training, and formal recognition of these changes within the broader health system will help embed the new arrangements and reduce conflict.

Civil society organizations

The extent to which civil societies and CBOs take on health and health-related issues is an important point. There is a role here for the FMoH and FMS-MOH to conduct sensitization of local bodies and CBOs around health and health care issues. The FMoH should carry out action research with CBOs with a view to developing their potential to take on provider roles in health and health care responsibilities.

There is also an important area around the relationships between civil societies and the local bodies. This relationship has an important impact on local governance. It is important that the relations between the local bodies and the CBOs should be built into the operational policies, particularly that of human resources management and district health planning.

Component Seven: Capacity Development

Many respondents were concerned about the lack of capacity at the center, state, regional and district levels and some considered this a major constraint to the process of decentralization, especially in an unstable setting or situation of conflict. These concerns were backed up internationally [84, 127]. Questions were also raised about the attempts to develop capacity building initiatives. This section will develop a framework for capacity building in local bodies with a view to addressing the concerns.

Preconditions for capacity building

For capacity building to be successful in Somalia's decentralized health system, several key preconditions must be met.

Foremost among them is a clear national political commitment. This commitment should be demonstrated through the allocation of both donor and government resources to support capacity development initiatives. Such political backing is essential, as capacity building often requires changes to established practices and may face resistance at various levels—regional, state, or central.

A strong and visible commitment from the Federal Ministry of Health (FMoH) can help dispel concerns that capacity building is being used as a pretext to undermine health sector decentralization. Instead, it should be positioned as a necessary and constructive process to strengthen decentralized governance and service delivery.

Capacity building needs to be linked to the national program of decentralization with the transfer of authority, functions and resources to the local bodies. The issue of what comes first – capacity building or the transfer of authority – was an important one in the interviews. Diverse views were put forward by respondents. The lack of capacity at the local level cannot be seen as a reason for not decentralizing. It is a reason for linking capacity building to decentralization and the transfer of authority. This requires a synchronised and co-ordinated program in which the two go together. Once again, it is recommended that the FMoH show a commitment to this process.

To effectively formulate and implement capacity building in Somalia's decentralized health system, both adequate infrastructure and resources are essential. Given the scale and complexity of the task, no single organization can manage it alone. While capacity building in the health sector must be part of a broader, cross-sectoral effort—especially under the leadership of the Ministry of Interior, Federal Affairs and Reconciliation—there is a critical need for one health sector institution to take strategic leadership. This lead organization would coordinate the efforts of various actors involved in capacity building and serve as the primary liaison with the Ministry of Interior. To reflect political commitment and ensure alignment with the broader decentralization agenda, this role should be housed within a high-level unit of the Federal Ministry of Health (FMoH). It is therefore recommended that the Planning and Policy Department of the FMoH assume this responsibility, guiding and harmonizing capacity building efforts across the decentralized health system.

Diagnosing the problems

Before embarking on the actual activities of capacity building, there is a need to understand the nature and scope of the problems faced by the local bodies. While it is possible that some of these problems might only be understood as the process of change progresses, an initial picture may be drawn which could form the basis of the program of action. Table 21 sets out the typical issues and techniques involved in the initial diagnosis of the problems.

Table 21: Key issues and techniques in initial diagnosis of problems

The initial diagnosis of problems involves:

Identifying the problems
Clarifying the symptoms of weak management
Charting the scope of the problem
temporary or recurrent problems
level in the health service where the problem is located
geographical scope of the problem
Understanding the causes of the problem
Using the techniques to identify these problems

The typical techniques for identifying and analysing the problems are:

Documentary analysis of existing studies on local body problems [128]
Focus group discussions at the level of the local bodies and with users [129]
Key informant semi-structured interviews [130]
Problem analysis techniques such as problem trees, delphi techniques [131]

Programming the areas and means of capacity building

Based on respondent interviews, there are three main areas of concern to be addressed through capacity building:

1. **Awareness of health priorities:** The degree to which local bodies understand health issues and recognize the importance of prioritizing action in this field.

2. **Technical knowledge:** Understanding of specific diseases (e.g., TB, HIV/AIDS, malaria, diabetes) and the appropriate health interventions required.

3. **Management and governance skills:** Competence in planning, policy-making, and overall health system management.

The extent to which these areas need to be developed will depend on the capacity deficit identified. This will be analyzed in terms of a realistic understanding of what the local bodies are supposed to do and the extent to which they need to improve capacity (table 22). Local bodies should be receiving central support and should not have to develop their own in-house capacity.

Table 22: Possible aeas of capacity building

Areas of capacity building	FMS - Ministry of Health	Regions	Districts
Sensitization to health and health care			
Strategic and Regulatory	Develop state-level sanitation and health policies aligned with national frameworks. Allocate resources and provide technical guidance to regions and districts. Coordinate with other sectors (e.g., water, education, environment) for integrated sanitation planning. Monitor and evaluate sanitation and health outcomes across the state. Lead capacity building and training programs for regional and district health staff.		
Coordination and Oversight		Adapt FMS-MoH policies to regional contexts and	

		priorities. Supervise and support district health offices in implementing sanitation and health programs. Coordinate regional-level health campaigns and emergency responses. Facilitate data collection and reporting from districts to the FMS-MoH. Ensure inter-district collaboration and knowledge sharing.	
Implementation and Community Engagement			Deliver primary health care and sanitation services at the community level. Engage with local councils, civil society, and community-based organizations (CBOs). Monitor local sanitation infrastructure (e.g., latrines, waste disposal) and hygiene promotion. Collect and report health and sanitation data to regional authorities. Conduct community health education and behavior change campaigns.
Technical areas			
TB Malaria HIV/AIDS Diabetes	Relations with development partners, private sectors	Developing a multisectoral approach	Developing a multisectoral approach

Management, planning and policy-making			
Human resource management	Recruitment and selection Supervision	Recruitment and selection Supervision	Recruitment and selection Supervision
Health planning	Situation analysis Priority setting Programming Monitoring and Evaluation	Situation analysis Priority setting Programming Monitoring and Evaluation	Situational analysis Priority setting

A capacity-development program should identify each local body's priority capacity gaps and outline how efforts in these areas will be integrated into a coordinated capacity-building process. To achieve this, priority capacity areas must first be identified, along with a clear, logical sequence showing how work on these initial priorities will progress to subsequent stages of capacity building.

Linked to identifying capacity-building areas is the need to determine how change will be achieved and the entry points for each area. For every management area, we should ask: what are the primary and supporting entry points for effecting change? These can be grouped into six broad categories: resources, policies, structures, systems, knowledge and skills, and values [133].

Capacity in any area can be strengthened through one or more of these categories. Effective programming therefore requires pinpointing which of these need reinforcement. Table 23 illustrates this by taking human resource management—a specific aspect of management and planning capacity—and mapping the ways it should be strengthened across the six categories, with examples for each.

Table 23: Capacity strengthening in human resource management

Means of capacity building	Examples
Resources	Money to finance in-service training Money to provide incentive payments to staff Expert trainers Human resource managers
Policies	Policies on supervision Policies on recruitment and selection of local staff
Structures	Formation of health teams Lines of authority established in the organization Conducting job analysis and re-writing of job descriptions
Systems	Written operational policies on supervision Written operational policies on recruitment and selection
Knowledge and skills	Team leadership skills Selection interview skills Supervision and staff appraisal
Values	Team working values Appreciation of supervision Staff appreciate using initiative

Of particular interest are the systems, which we refer to here as operational policies. These are written documents showing the why, who, where and how of particular areas of management and planning. Table 19 sets out the basic parts of an operational policy. The suggestion is that every level (state, region and district) should develop its operational policies on, for example, health planning and human resource management. There would, of course, be a considerable amount of similarity as they would incorporate the way things are done in all local bodies in the country. For this reason, the FMoH should be involved in the development of the operational policies. However, there would be a degree of variation, as local bodies develop their own way of conducting local health planning and human resource management.

Conducting, diffusing and sustaining capacity building

A number of key issues must be considered when deciding how the program of capacity building should be conducted.

A strict blueprint approach is frequently used in management development work in the health sector, despite its limitations in failing to achieve sustained changes in management and planning [132]. A more flexible approach is suggested here in which the adaptation, flexibility and learning are incorporated into a broad framework of structured changes.

To take advantage of local knowledge and develop a sense of ownership in the process of capacity building, consultation with, and participation of, the local bodies in the formulation and implementation of capacity building needs to be promoted.

In developing the time span for capacity building, it needs to be recognised that this is not a one-off project but a long term effort to constantly build up the capacity of the local bodies to operate sustainable local health systems.

Where appropriate, use should be made of pilot projects of capacity building and district action learning.

Monitoring of the process of capacity strengthening needs to be integrated using a range of input and output indicators.

Component Eight: Public-Private Relations

In this section, we will discuss the extent to which policy on decentralization in a federal system needs to take into account the public–private mix in the health sector particularly: the role of regional governments and local bodies in the regulation of the private sector and the extent to which public–private linkages need to be developed by local bodies.

Regional governments, local bodies and regulation

The emergence of a decentralized regulatory role needs to be linked to national regulatory processes and will require capacity development in the local bodies.

Regional governments, local bodies and public–private collaboration

Collaboration in service provision through contracting and collaboration in the area of local body health management and planning were discussed earlier in the report.

Service provision – The complexities of public–private collaboration in this area were explained earlier in the report. Public contracting of the private sector is especially complex. Three areas for further policy analysis by the FMoH and FMS MOH are recommended including:

Local body contracting of the private for profit sector

The experience of selected African countries in the contracting of NGO and private sectors to deliver primary health and to operate as district hospitals [133-135] by identifying where collaboration with the private sector is important by reviewing specific areas of community health services.

Management, planning and policy – A theme running through this report on effective health sector decentralization in the context of federal system is that of consultation and working with stakeholders. NGOs and for-profit organizations and actors are among these stakeholders. This consultation has to be conducted in the policy process of transition to a decentralized system and in its eventual operation.

Component Nine: Intersectoral Links

The ultimate aim of decentralization in a federal system in Somalia is to improve health. The development of intersectoral links is fundamental to moving in this direction. Health is not the preserve of health care but requires an intersectoral approach. Links and joint action are needed in order to have an impact on the determinants of health and causes of ill-health in areas such as education, transport, incomes and agriculture [136]. This is equally important in the design and implementation of the One Health approach which is a collaborative strategy where different sectors, such as public health, animal health, environmental protection, agriculture, and even social services, work together to address health issues that impact humans, animals, and the environment [137].

Decentralization and an intersectoral approach in a federal system

Decentralization offers important opportunities for the development of an intersectoral approach in two ways.

Firstly, the structure of government is no longer formed by vertical silos that channel decision making and resource along isolated routes. Decentralization introduces a horizontal approach to government, through the use of multisectoral state and local governments that operate in a cross governmental fashion.

Secondly, decentralization transfers decision space to the local level. Joint action across sectors requires decision-making authority be put in the hands of people at the point of service delivery. They can then make the decisions on resource use and action to allow for an intersectoral approach.

There is, however, an important cautionary note at this point. This link between decentralization and the intersectoral approach is easy to make in theory. In practice, however, it is more complicated.

There are two problems here. Firstly, depending on how decentralization is introduced, it can be a sham. Although it looks good on paper, in reality central government can control regional and local governments through central government expenditure controls, regulations and planning. Lacking decision space, regional and state governments are unable to practice an intersectoral approach.

Secondly, local decision space and autonomy are not the only determinants of intersectoral collaboration. There are professional, personal, administrative, planning and budget constraints which can make collaboration so elusive. For this reason, developed regional and local governments have also found intersectoral collaboration elusive.

Developing collaborative processes between sectors

Health officers at the periphery need to develop collaborative processes in order to promote the intersectoral approach. A summary of an intersectoral approach is presented in table 24. This takes the form of a set of basic questions that, for example, a health team can develop as an approach to intersectoral collaboration [138].

Table 24: Key questions for the development of an intersectoral approach

Key questions	Comments
Why are we collaborating? What are the reasons for doing the collaboration?	The health team and other sector teams need to have clarity of purpose as to why they are seeking collaboration. This means asking whether collaboration is possible and desirable.
Which organizations and people have to be included in the collaboration process?	The health team needs to do a scoping exercise to see who should be involved in the collaborative process.
What form of collaboration is most appropriate?	The health team has to decide on the type of collaboration to be used. Table 25, for example, shows the difference between coordination and cooperation.
What should we be collaborating about?	Health and other teams will need to ask whether they are collaborating in, for example, joint planning, joint financing, joint
	logistics, and/or joint service delivery.
What are the constraints to collaboration?	The health team will find that these vary a great deal from one situation to another. One example could be professional differences between health professions and educational experts. Another could be that the health and educational teams are using different planning, information and budgeting systems.
What resources are required for collaboration?	The teams will find that collaboration costs. It is not cheap and this has to be set against the potential benefits.
What mechanisms and approaches are involved in collaboration?	This is an extensive issue and is explained in the next section

Table 25 picks up on the forms of collaboration and their appropriateness in regard to cooperation and coordination [139].

Table 25: The characteristics of co-operation and co-ordination as forms of collaboration

Characteristics	Co-operation	Co-ordination
Rules and formality	No formal rules	More formal rules
Goals and activities	Organizations maintain own goals and activities	Joint goals and activities
Linkages	Not important	Important
Resources involved	Relatively few	More resources involved
Autonomy	Little threat	More threat to autonomy

Structures and systems for intersectoral collaboration

In order to develop the approach outlined above, the necessary structures and systems have to be in place. These are set out, in summarised form, in Table 26 with particular attention being paid to their relevance to federalization in Somalia [140].

Table 26: Key structures and systems for developing a collaborative approach

Structures and systems	Commentary for federalization in Somalia
Regional and district level comprehensive planning / integrated area planning	Vital to the development of an intersectoral approach are, for example, annual development plans
Health information systems	The health information system needs to adopt intersectoral content, particularly in the area of intersectoral indicators for health status and quality of life.[141] The local bodies can play an integrating role in developing this type of information system
Rules and procedures	This may include collaboration responsibilities in job descriptions, including intersectoral consultations in deciding, for example, transport programing, joint purchasing requirements, and consultation requirements in priority setting
Political and management structures	The regional government and district councils are the obvious political structures for the promotion of an intersectoral approach. However, management structures may also be considered, such as regional health boards or district development committees.
Operational policies	Operational policies allow intersectoral collaboration to be built into the way in which decisions are made and resources used. This is certainly the case with operational policies for planning, staff supervision, information systems and community participation.

Table 26 highlights the importance of integrated area planning, for example regional development plans or district development plans. Through these plans, the functional sectors within local bodies are brought together in a planning process. This is a planning exercise which involves all sectors and agencies in the area and which attempts to integrate their activities within a general framework for the development of the area as a whole [142].

Recognizing the interconnectedness of these elements, essentially means coordinating efforts across various sectors to achieve optimal health outcomes for all living beings through a One Health framework. The onus here is on the 'integrated' and 'comprehensive' - the plan is not just the sum of the separate sectors but looks to achieve a functional and spatial harmony" etween the activities of different sectors and the most effective distribution of resources between agencies [142].

Introducing intersectoral collaboration

This component focuses on the structures, systems and processes with a view to developing intersectoral collaboration compatible with the system of decentralization. We now have to consider practical steps that will back up its emergence. Three points may be made here.

The processes, structures and systems mentioned so far in this component also depend on the emergence of values that back up collaborative behavior within the local bodies. The most obvious one is to believe in the importance of collaboration between different sectors as a basis for health development. Added to this is the value of trust. Trust between staff in different sectors and institutions has to be supported and developed. Trust is an essential component of effective collaboration, although how we develop it is no easy matter. It is suggested that we calculate the risk involved in trusting and begin with small ventures to build up confidence; keep to 'principled conduct'; and develop personal and more stable relations [143].

Ideas to promote intersectoral collaboration have so far focused on the periphery. This local level collaboration has to be backed up by similar collaborative strategies at both the regional and national levels.

Research also suggests the importance of a learning approach.[144] There is no blueprint for establishing intersectoral collaboration. Rather, organizations have to learn how to do it over a period of time.

Part Seven: Recommendations and Way Forward

In developing a program for effective health sector development, some initial points need to be considered:

Firstly, the focus must be on the health sector, not a general review of decentralization in a federal system. However, decentralization is a cross-sector process that will change the overall structure of the public sector.

Secondly, this program is based on the notion that for decentralization to be effective the necessary conditions for its effectiveness need to be developed.

Thirdly, the program is a set of guidelines designed to provide a comprehensive process of change. It is not a detailed blueprint as it is based on evidence and understanding which can only be achieved over an extended period and goes beyond the limited resource base of this study. To be effective the program has to be based on a wider and deeper range of stakeholder consultations.

Finally, decentralization is a process taking place in an unstable environment with unpredictable outcomes. The nature of some problems can only be understood in the process of implementation. Flexibility and understanding are required in the process of change.

Policy Processes

Attention must be paid to defining policy objectives, clarifying policy content and using impact evidence. This must take place alongside the strengthening of the planning department of the FMoH, developing policy circles, strengthening links with research bodies and using international links. Sustainability and external funding are also important.

Extensive policy consultation needs to be carried out in four key areas: cross governmental; within health sector functions; with local stakeholders; and with health sector staff.

To ensure that decentralization in the health sector leads to meaningful improvements, it is recommended that the Federal Ministry of Health (FMoH), through its Department of Planning, establish a comprehensive monitoring system. This system should:

- Be coordinated across a network of relevant institutions.
- Use a balanced set of input, output, and outcome indicators to track progress.
- Operate over the medium to long term to capture sustained impacts.
- Address attribution challenges, ensuring that observed changes can be linked to decentralization efforts.
- Be integrated into decision-making processes, enabling evidence-based adjustments to policy and implementation.

Structural Organization

There must be a clear understanding among the stakeholders as to what decentralization and federalism mean in the context of Somalia and how it affects the health sector. The FMoH must participate in this as well as advocate for it.

To strengthen the effectiveness and coordination of the health system, it is recommended that the responsibilities of federal, state, and local authorities be clearly defined and aligned. These responsibilities should comprehensively cover the following areas:

- Health planning and policy development
- Health information systems and data management
- Management of public health facilities and services
- Human resource planning and staff management
- Infrastructure planning and service development
- Financial planning, budgeting, and expenditure tracking
- Procurement and supply chain management
- Public–private partnerships and collaboration
- Intersectoral coordination with other government sectors
- Community engagement and participation in health governance

Clearly delineating these roles will reduce duplication, improve accountability, and ensure that all levels of government contribute effectively to national health goals.

To strengthen the effectiveness of health sector decentralization, it is recommended that states, regions and districts be formally recognized as the primary and intermediary levels of governance. These levels are best positioned to:

- Respond to local health needs and priorities.
- Coordinate service delivery across communities.
- Facilitate intersectoral collaboration at the operational level.
- Manage resources, personnel, and infrastructure more efficiently.
- Engage communities in planning and decision-making.

Empowering local authorities with clear mandates, adequate resources, and technical support will help build a more responsive, equitable, and accountable health system.

To effectively lead and coordinate a decentralized health system, it is recommended that the **Federal Ministry of Health (FMoH)** be strengthened in three key areas:

- Enhance the Ministry's capacity to set national health priorities, allocate resources equitably, and guide long-term sector development.
- Develop robust mechanisms to provide technical, financial, and operational support to state and district-level health authorities, ensuring consistency and quality across regions.
- Reinforce the Ministry's role in setting standards, monitoring compliance, and ensuring accountability across public and private health actors.
- Investing in these areas will enable the FMoH to play a more effective leadership role, ensuring coherence, equity, and sustainability in health sector reforms.

Resource Generation And Allocation

The FMoH must play an important role in presenting the perspectives of the health sector in the formulation and implementation of a decentralization policy on resource generation and allocation. It also has a more direct role in relation to resource generation and allocation.

To ensure that resource generation and allocation within the health sector is effective, equitable, and sustainable, it is recommended that the Federal Ministry of Health (FMoH) adopt the following guiding principles in its policy development:

- Link Resources to Responsibilities - Ensure that financial and human resources are allocated in alignment with clearly defined roles and responsibilities at all levels of the health system.
- Promote Transparency - Establish open and accountable processes for budgeting, allocation, and expenditure tracking to build trust and improve efficiency.
- Strengthen Data Collection Systems - Invest in reliable and timely data collection to inform resource needs, monitor usage, and support evidence-based decision-making.

By embedding these principles into policy, the FMoH can enhance the effectiveness of resource management and support the broader goals of health sector reform.

It may be expected that local bodies (states, regions, districts) will develop their own sources of revenue as time passes such as the authority to impose user fees. However, the FMoH needs to be cautious here as this raises critical issues of equity, politics, accountability, ownership and efficiency.

The FMoH needs to play an important part in proposals for changing the resource allocation formula for development grants to local bodies. In particular, it should simulate the impact of these changes on the funding of health care in a federal system.

To ensure that resources are allocated effectively and equitably across the decentralized health system, it is recommended that the Federal Ministry of Health (FMoH) take a leading role in reviewing and guiding the process of sectoral resource allocation to local bodies. This should include the development of a structured policy framework that addresses the following key issues:

- Define the total amount of resources available for distribution.
- Establish transparent and evidence-based criteria for distributing funds, such as population health needs, service coverage gaps, and performance metrics.
- Clarify whether allocations are conditional (linked to specific outcomes or uses) or unconditional (flexible use by local bodies).

- Explore the feasibility and implications of shifting from sector-specific grants to broader development block grants.
- Design efficient systems for fund disbursement, monitoring, and reporting.
- Ensure that external funding is aligned with national priorities and incorporated into the overall allocation framework.

By addressing these components, the FMoH can promote a more coherent, accountable, and responsive approach to resource allocation that supports local health system strengthening.

Health Planning

Effective decentralized health planning requires more than just transferring responsibilities—it demands a strong connection between planning authority and budgetary control at each level of government. It is recommended that the Federal Ministry of Health (FMoH) ensure that:

- Local bodies have both the mandate to plan and the authority to allocate resources in line with those plans.
- Budgetary processes are aligned with health priorities identified through local planning.
- Capacity-building efforts support local institutions in managing both planning and financial functions.
- Oversight mechanisms are in place to ensure accountability and performance across decentralized units.

In a federal system, this linkage is essential to empower local decision-makers, improve responsiveness to community health needs, and ensure that planning translates into action.

To ensure that health sector planning is responsive and equitable, it is recommended that the **Federal** Ministry of Health (FMoH) ensure that national health plans are clearly articulated to reflect the specific needs of states, regions, and districts. This includes:

- Engaging local stakeholders in the planning process to identify priority health issues.
- Customizing interventions and targets based on local epidemiological profiles, service delivery gaps, and resource availability.

- Ensuring flexibility within national frameworks to allow for regional adaptation.
- Strengthening coordination mechanisms between federal, state, and district levels to align goals and implementation strategies.

By tailoring health plans to local contexts, the health system can become more responsive, efficient, and impactful in addressing diverse population needs.

To improve the effectiveness of decentralized health planning within a federal system, it is recommended that the Federal Ministry of Health (FMoH) conduct a structured assessment to determine which planning functions are best carried out at the central level and which are more effectively managed at the local level. This should include:

- **Central Level Functions:** Strategic policy development, national health priorities, standard-setting, regulatory oversight, and coordination of donor support.
- **Local Level Functions:** Operational planning, service delivery management, community engagement, and adaptation of national strategies to local contexts.

Clearly defining these roles will reduce duplication, improve coordination, and ensure that planning is both responsive to local needs and aligned with national health goals.

To ensure coherence and responsiveness in health sector planning, it is recommended that the Federal Ministry of Health (FMoH) promote stronger alignment between local health plans and national-level strategies. This should be accompanied by meaningful community involvement in the planning process. Specifically:

- Local health plans should reflect national priorities while addressing the unique needs and challenges of states, regions, and districts.
- Planning processes should include mechanisms for community consultation and participation, ensuring that local voices shape health priorities and service delivery.
- Feedback loops should be established to allow local insights to inform national policy adjustments.
- Capacity-building should be provided to local bodies to support inclusive and evidence-based planning.

This approach will foster ownership, improve relevance, and enhance the effectiveness of health interventions across all levels of the system.

Managing Resources

To guide effective decision-making in a decentralized health system, it is recommended that the Federal Ministry of Health (FMoH) undertake targeted policy analysis to assess the impact of decentralization on resource management. This analysis should:

- Examine how decentralization affects the allocation, utilization, and oversight of financial, human, and material resources at local levels.
- Identify gaps and inefficiencies in current resource flows and management practices.
- Evaluate the capacity of local bodies to manage resources effectively under decentralized arrangements.
- Provide evidence-based recommendations to improve equity, accountability, and performance in resource distribution.

This analysis will help ensure that decentralization strengthens—not weakens—health system efficiency and responsiveness.

To support effective and accountable resource management at the local level, it is recommended that the Federal Ministry of Health (FMoH), in collaboration with key stakeholders and local bodies, develop operational policies and guidelines tailored to the needs of decentralized health systems. These guidelines should:

- Provide clear standards and procedures for financial, human, and material resource management.
- Be context-sensitive, allowing flexibility for local adaptation while maintaining national consistency.
- Include capacity-building components to strengthen local institutions in implementing and monitoring resource use.
- Promote transparency and accountability through reporting mechanisms and performance benchmarks.
- Ensure alignment with national health priorities and integration of donor contributions.

By establishing these operational policies, the FMoH can help local bodies manage resources more effectively, improve service delivery, and enhance trust in the health system.

Accountability

To ensure that decentralization leads to improved governance and service delivery, it is recommended that accountability be explicitly recognized as a central goal of health sector reform. The Federal Ministry of Health (FMoH) and Federal Member State Ministries of Health (FMS-MOH) should:

- Develop new operational policies and job descriptions that clearly define roles, responsibilities, and performance expectations at all levels.
- Promote mechanisms for community and political accountability, including public reporting, citizen engagement, and participatory planning.
- Advocate for broader governance reforms that support transparency, responsiveness, and oversight in decentralized systems.
- Strengthen monitoring and evaluation systems to track performance and ensure that decentralization delivers measurable improvements in health outcomes.

By embedding accountability into the structure and culture of decentralized health systems, the FMoH and FMS-MOH can help build public trust and drive continuous improvement.

To support effective governance in a decentralized health system, it is recommended that the Federal Ministry of Health (FMoH) and Federal Member State Ministries of Health (FMS-MOH) take proactive steps to clarify and communicate the evolving forms of accountability. This includes:

- Defining new accountability relationships between central, state, and local levels, and ensuring these are clearly understood by all stakeholders.
- Developing communication strategies to explain roles, responsibilities, and expectations under the decentralized framework.
- Facilitating dialogue to identify and address tensions that may arise from overlapping or mixed accountability structures.
- Promoting collaborative problem-solving among stakeholders to ensure accountability mechanisms are practical, fair, and aligned with health system goals.

By fostering transparency and open communication, the FMoH and FMS-MOH can help build trust, reduce confusion, and strengthen accountability across all levels of the health system.

To build stronger, community-responsive health systems, it is recommended that the **Federal Ministry of Health (FMoH) and Federal Member State Ministries of Health (FMS-MOH)** take the lead in:

- Raise awareness among local authorities about key health and healthcare issues, including their roles in planning, service delivery, and accountability.
- Partner with community-based organizations (CBOs) to explore innovative approaches to health service delivery and assess their potential to take on provider roles. This research should be participatory, evidence-driven, and focused on building local capacity.
- Use insights from action research to create practical guidelines that support CBOs and local bodies in contributing effectively to health system goals.

By investing in local engagement and evidence-based capacity-building, the FMoH and FMS-MOH can foster inclusive, sustainable, and community-driven health sector development.

To strengthen community participation and improve the responsiveness of decentralized health systems, it is recommended that the Federal Ministry of Health (FMoH) and Federal Member State Ministries of Health (FMS-MOH) ensure that relationships between local bodies and civil society organizations (CSOs) are formally built into **operational policies.** This should include:

- Embedding civil society engagement in district health planning processes to ensure that local priorities and community voices are reflected in service delivery.
- Incorporating CSO collaboration into human resource management policies, particularly in areas such as recruitment, training, and community health worker support.
- Establishing formal mechanisms for consultation, partnership, and accountability between local authorities and civil society actors.
- Promoting inclusive governance by recognizing the role of CSOs in advocacy, service provision, and monitoring.

By institutionalizing these relationships, the health system can become more participatory, transparent, and responsive to the needs of the population.

Capacity Development

To ensure that capacity building efforts are successful and sustainable, it is recommended that the Federal Ministry of Health (FMoH) and Federal Member State Ministries of Health (FMS-MOH) work to establish the necessary preconditions. These should include:

- Secure high-level support for decentralization and capacity development across all levels of government.
- Ensure that health sector capacity building is integrated into broader federal decentralization strategies to promote coherence and coordination.
- Guarantee adequate financial, human, and physical resources to support training, systems development, and institutional strengthening at local levels.

By laying this foundation, the health sector can build the institutional and human capacity needed to deliver quality services and manage decentralized responsibilities effectively.

To ensure that health sector reforms under decentralization are effective and sustainable, it is recommended that the Federal Ministry of Health (FMoH) and Federal Member State Ministries of Health (FMS-MOH):

- Clearly identify and prioritize areas of change, such as governance, resource management, service delivery, and accountability.
- Develop structured implementation plans that link each area of change to specific tools, processes, and institutional mechanisms capable of driving transformation.
- Ensure that change strategies are realistic and context-sensitive, with timelines, responsibilities, and resource requirements clearly defined.
- Monitor and evaluate progress, adjusting approaches as needed to maintain momentum and respond to emerging challenges.

By programming change areas and aligning them with capacity strengthening and practical means for implementation, the health sector can move from policy intent to measurable impact.

To build lasting capacity within decentralized health systems, it is recommended that the Federal Ministry of Health (FMoH) and Federal Member State Ministries of Health (FMS-MOH) adopt a structured yet flexible approach to capacity strengthening. This should include:

- Apply a structured framework that allows for adaptation to local contexts and evolving needs.
- Engage local bodies actively in the design, implementation, and evaluation of capacity-building initiatives.
- Focus on sustained capacity development rather than short-term interventions, with clear milestones and follow-up mechanisms.
- Test new approaches through pilot programs, monitor their effectiveness, and scale up successful models.
- Ensure that capacity gains are shared across regions and embedded into institutional practices.
- Establish systems to track progress, identify gaps, and provide continuous support to maintain improvements.

This approach will help ensure that capacity strengthening efforts are inclusive, adaptable, and capable of supporting long-term health system transformation.

Public-Private Relations

To support effective decentralization and strengthen health governance in Somalia, it is recommended that regulatory responsibilities be gradually developed and delegated to regional and district-level bodies. This process should begin as a priority in larger and more developed regions, where institutional capacity is relatively stronger. Key actions include:

- Defining clear regulatory roles for subnational entities in areas such as licensing, quality assurance, and compliance monitoring.
- Providing targeted capacity building to equip local bodies with the skills and tools needed to carry out regulatory functions effectively.
- Developing legal and policy frameworks that support decentralization of regulatory authority while maintaining national standards.

- Piloting regulatory functions in selected regions to inform broader rollout and ensure lessons are captured for scaling.

To improve coordination and effectiveness in Somalia's health system, it is recommended that a comprehensive policy analysis be undertaken to examine the relationship between local government bodies and the private health sector, particularly in the areas of service provision, planning, and management. This analysis should aim to:

- Identify existing gaps and overlaps in roles, responsibilities, and service coverage between public and private actors.
- Assess the regulatory and operational frameworks governing public–private interactions at the local level.
- Inform the development of policies and guidelines that promote effective collaboration, accountability, and alignment with national health priorities.
- Support evidence-based decision-making for integrating private sector contributions into local health planning and service delivery.

Intersectoral Links

The Federal Ministry of Health (FMoH), Federal Member State Ministries of Health (FMS-MoH), and local health authorities should actively leverage the decentralization process to develop and strengthen intersectoral approaches to health. To achieve this, it is recommended that:

- Health planning and implementation be coordinated across sectors, including education, water and sanitation, agriculture, and social services, to address the broader determinants of health.
- Joint capacity building initiatives be designed to include stakeholders from multiple sectors, fostering shared understanding and collaboration.
- Decentralization frameworks explicitly incorporate intersectoral mechanisms, such as multi-sectoral committees or integrated planning platforms at the local level.
- Monitoring and evaluation systems track the effectiveness of intersectoral actions in improving health outcomes.

Local health officers and governing bodies should be supported to develop structured processes for intersectoral collaboration as part of decentralization efforts. This collaboration is essential for addressing the broader determinants of health and improving service delivery. To achieve this, it is recommended that:

- Action learning approaches be adopted to build practical, context-specific collaboration skills among local authorities.
- Facilitated training and coordination be led by the Federal Ministry of Health (FMoH), in partnership with key ministries such as Interior, Federal Affairs and Reconciliation, Agriculture, Livestock, and Education.
- Local bodies be empowered to initiate and sustain cross-sectoral partnerships, with clear guidelines and support mechanisms.
- Monitoring and evaluation frameworks be established to assess the effectiveness of intersectoral collaboration in improving health outcomes

To support effective intersectoral links and health system governance in Somalia, it is recommended that structures and systems be developed through coordinated capacity building efforts. This process should be facilitated jointly by Federal Ministry of Health (FMoH), Ministries of Interior, Federal Affairs and Reconciliation, Agriculture, Livestock, and Education, and Local government bodies

Key actions include:

- Establishing cross-sectoral coordination mechanisms to guide the development of health governance structures.
- Designing joint capacity building programs that address administrative, technical, and leadership skills across all levels of government.
- Ensuring alignment of efforts with national health priorities and decentralization frameworks.
- Monitoring progress and adapting strategies based on local needs and implementation challenges.

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