

Operationalising Health Service Delivery in Somalia

Operationalising Health Service Delivery in Somalia: A Health Systems Policy Analysis Toward Universal Health Coverage

By **Dr. Abdulrazaq Yusuf Ahmed** · MPH · MSc(HM) · PhD (Health Economics) · PhD (Demography & Social Sciences)

Executive Director for, National Social Health Insurance Authority (NHIA) · Federal Ministry of Health, Somalia

Chairperson and Founder of RIYAADA Institute for Leadership & Governance

Abstract. *The primary challenge in the implementation of ambitious Universal Health Coverage (UHC) commitments within fragile health systems lies in translating policy intentions into operational reality. In Somalia, the development of national policies and packages has surpassed their operational implementation, resulting in a persistent disparity between policy objectives and service delivery. This article presents a comprehensive analysis of service delivery within the Somali health system, identifies the structural obstacles hindering its operationalization, proposes a Somali model that harmonizes federal stewardship, federated implementation, and strategic purchasing through the National Health Insurance Authority, and extracts valuable lessons applicable to other fragile and conflict-affected states striving to achieve UHC.*

1. Background

Over the past decade, the Somali health system has produced a substantial body of policy documents, including successive National Health Sector Strategic Plans, the Essential Package of Health Services (EPHS), the Somalia Health Financing Strategy, the Human Resources for Health Policy, and the Somalia National Health Policy. Each of these documents articulates significant commitments, principles, and aspirations. However, each faces the persistent challenge of translating policy into practice. The disparity between intended outcomes and operational delivery is the defining policy challenge of the sector.

Service delivery is carried out by a complex network of actors. Federal and Federal Member State ministries, public facilities, private for-profit providers, non-governmental organizations, faith-based providers, humanitarian agencies, community-level workers, and traditional practitioners operate within diverse governance structures, financing mechanisms, accountability frameworks, and standards of care. This results in fragmentation, inefficiency, variable quality, and substantial inequities in access. These dynamics are evident in health outcomes: maternal mortality remains among the highest globally; under-five mortality persists at crisis levels; communicable disease burdens are exacerbated by an increasing non-communicable disease challenge.

Operationalising Health Service Delivery in Somalia

These outcomes are not solely attributable to underinvestment; they are the consequence of fragmented, uncoordinated, and underregulated service delivery. Consequently, the unfinished agenda of Universal Health Coverage (UHC) in Somalia is not primarily concerned with the introduction of new policies but rather with the deliberate operationalization of existing ones.

2. Reform Rationale

The case for systematic operationalization is grounded in three interconnected arguments. Firstly, policy without operational mechanisms fails to achieve health outcomes; an EPHS that is inconsistently delivered, financed, monitored, and held to standard cannot reduce mortality. Secondly, fragmentation is not merely inefficient but also inequitable; it concentrates services in accessible areas while leaving remote, displaced, and marginalized populations underserved. Thirdly, the strategic moment is opportune: the establishment of the National Health Insurance Authority (NHIA), the maturation of Federal Member State health ministries, and the growing alignment of partners around national plans collectively create the institutional conditions for transformation.

International evidence substantiates this rationale. In Rwanda, Ethiopia, Ghana, and Indonesia, the operationalization of national service delivery models—anchored in clear standards, strategic purchasing, and accountability mechanisms—has consistently outperformed less coherent approaches. The lesson is generalizable: institutional architecture serves as the lever through which policy commitments translate into health outcomes.

4. Stakeholder Engagement

Operationalizing service delivery necessitates sustained engagement with a diverse coalition. The Federal Ministry of Health and Human Services assumes stewardship responsibility for national standards, regulation, and partner coordination. In contrast, Federal Member State health ministries bear operational responsibility for service delivery within their jurisdictions, encompassing district health system management. The National Health Insurance Authority (NHIA) functions as the strategic purchaser, contracting providers on behalf of the population. Implementing partners, including United Nations agencies, international and local non-governmental organizations, and faith-based providers, deliver the majority of frontline services in various regions. Private providers cater to large urban populations. Communities, encompassing elders, women's groups, religious leaders, and youth networks, simultaneously receive services and serve as indispensable partners in their design and oversight.

A robust operationalization strategy must engage these stakeholders in differentiated and complementary manners: through joint federal-state planning forums, performance-based contracting with providers, structured policy dialogue with partners, and community oversight mechanisms at the district level.

4. Governance Architecture

The proposed Somali model is based on a layered governance architecture. Federal stewardship encompasses policy direction, national standards, regulatory frameworks, and partner coordination. Federal Member State implementation entails contextually adapted service delivery and district health system management. Strategic purchasing through the NHIA positions the Authority as the population-facing purchaser that contracts providers—public, NGO, faith-based, and private—on standardized terms anchored in the EPHS. Performance and quality assurance are administered through independent supervision, accreditation, and licensing systems. Community accountability is institutionalized through community health committees, citizen feedback mechanisms, and structured grievance redress.

This architectural approach distinguishes Somalia’s model from both centralized and unregulated approaches. It deliberately builds upon federalism while maintaining national coherence; it embraces provider pluralism while subjecting it to common standards; and it aligns financial incentives with population health through strategic purchasing. The deliberate separation of stewardship (Ministry), purchasing (NHIA), and provision (multiple providers) is a constitutive design principle drawn from international experience and adapted to the Somali context.

5. Implementation Challenges

Despite a well-defined architecture, implementation encounters significant challenges. Geographic insecurity restricts access to substantial portions of the country, complicating supervision and monitoring. Workforce maldistribution concentrates skilled personnel in urban centers while rural and remote populations remain underserved. Supply chain vulnerabilities lead to stock-outs of essential medicines and commodities, eroding both service quality and public trust. Health management information systems are fragmented and incomplete, limiting the evidentiary basis for stewardship. Donor priorities can influence implementation in directions that deviate from national plans. Financing remains unpredictable and largely externally sourced. The transition from project-based to system-based delivery is a delicate process that risks short-term disruption if poorly managed.

6. Lessons Learned and the Somali Model

Several lessons emerge that may inform similar contexts. First, operationalization necessitates institutional architecture, not solely policy documents; strategic purchasing through NHIA exemplifies this. Second, federal–state coordination should be understood not as a problem to be resolved but as a productive tension to be managed through clear decision rights and structured joint planning. Third, information systems are foundational; without timely, reliable, disaggregated data, neither stewardship nor accountability can function. Fourth, performance-based contracting—when fairly priced and transparently monitored—aligns

Operationalising Health Service Delivery in Somalia

provider behavior with national priorities. Fifth, community engagement is constitutive of legitimate service delivery rather than an optional add-on.

The Somali model that emerges is integrated EPHS delivery, financed through pooled mechanisms and strategically purchased by NHIA, implemented by a regulated mix of public, NGO, faith-based, and private providers, under federal stewardship and Federal Member State operational leadership, with community accountability. Its distinctiveness lies in the deliberate integration of federalism, pluralism, and purchaser–provider separation within a coherent national framework. The model offers a generalisable template for other fragile states seeking to move beyond project-based fragmentation to systematic service delivery.

7. Recommendations

Adopt a National Service Delivery Operational Framework that translates the EPHS into costed, location-specific delivery models and accountability standards.

Strengthen the strategic purchasing capacity of NHIA through actuarial, contracting, claims, and provider-relations functions.

Invest in integrated Health Management Information Systems with routine, disaggregated performance reporting at facility, district, state, and federal levels.

Establish independent quality assurance, licensing, and accreditation mechanisms for facilities and professionals.

Institutionalize federal-FMS joint planning, performance review, and accountability forums.

Develop a sustainable health workforce strategy with deliberate rural deployment incentives and standardized competency frameworks.

Align partner financing with the national operational framework through pooled funds or compact-based arrangements.

8. Conclusion

Operationalizing service delivery remains the unfinished agenda of Universal Health Coverage (UHC) in Somalia. Policies have been articulated; the operational architecture is now being constructed. The model emerging from Somalia—federated yet coherent, plural yet regulated, ambitious yet phased—offers both a domestic agenda for action and a generalizable lesson for other fragile states: that the path from policy to outcome passes through institutions, and that the deliberate investment in institutional architecture is itself the most strategic act of health systems policy.

References

Dr Abdulrazaq Yusuf Ahmed Health systems Expert; www.drjalaaludiin.com
www.riyaadaacademy.com drjalaal@hotmail.com drjalaal@nhia.gov.so

Operationalising Health Service Delivery in Somalia

- Kruk, M. E., Gage, A. D., Arsenault, C., et al. (2018). High-quality health systems in the Sustainable Development Goals era. *The Lancet Global Health*, 6(11), e1196–e1252.
- Kutzin, J. (2013). Health financing for universal coverage and health system performance. *Bulletin of the WHO*, 91(8), 602–611.
- Witter, S., Hunter, B., & Bertone, M. P. (2019). Health financing in fragile and conflict-affected settings. *Social Science & Medicine*.
- World Health Organization. (2019). *Primary Health Care on the Road to UHC: Global Monitoring Report*. Geneva: WHO.
- World Health Organization. (2010). *The World Health Report 2010 — Health Systems Financing*. Geneva: WHO.



Dr Abdulrazaq Yusuf Ahmed
MPH, MSc(HM), PhD (Health Economics), PhD (Demography & Social Sciences)
Health Systems Expert | Public Sector Transformer | Global Health Leader | Academic Researcher
Director General, National Health Insurance Authority (NHIA)
Federal Ministry of Health, Somalia

Email: drjalaal@nhia.gov.so | drjalaal@hotmail.com
drjalaal@rugsan.org | drjalaal@riyaadaacademy.org

Phone: +252 615 572 605

Web: drjalaaludiin.com | drjalaaludiin.link

Research: ORCID | Scopus: 57222062380 | WoS: ADD-3214-2022

Affiliations: RUGSAN | RIYAADA | LinkedIn



Global health leadership • Health systems strengthening • Policy, governance, and financing