

SOMALIA HEALTH SECTOR STATUS REPORT 2026

Fragile Gains, Rising Risks

Aid contraction, health system retrenchment, and the route toward resilient universal health coverage.

SOMALIA

HEALTH SECTOR
STATUS REPORT

2026



Financing shock › System retrenchment › UHC at risk › Path to reform

✍️: Dr Abdulrazaq Yusuf Ahmed

MPH, MSc(HM), PhD (Health Economics), PhD (Demography & Social Sciences)

Health Systems Expert | Tropical Medicine; Infectious diseases; public health leadership specialist | Academic Researcher

Director General of Social Health Insurance Authority; Somalia

Chairman of the Board and Founder of RIYAADA Institute for Leadership & Governance

About this report

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Foreword

Somalia entered 2026 with a health system that had made real but fragile gains from a very low base. Over two decades the universal health coverage (UHC) service coverage index more than doubled, from 14 to 30. Under-five mortality has fallen, DTP3 immunisation coverage reached its highest recorded level, and government health spending per person roughly quadrupled between 2019 and 2023. These gains were genuine. They were also narrow, recent and heavily dependent on external finance.

The contraction of external funding since 2025 has therefore not created a new vulnerability; it has exposed and intensified an existing one. In 2026 the health sector is absorbing the largest financing shock in its recent history while drought, displacement, disease outbreaks and the threat of El Niño flooding are increasing need. The result is a measurable contraction of the system that delivers essential services.

This report assesses where the sector stands, what the evidence shows about the effects of the contraction, and what Government and its partners can do to protect essential services while building more sustainable financing and purchasing arrangements. The evidence is strongest for facility closures, reduced service coverage, halted outreach and rising admissions for severe acute malnutrition. It is weaker for post-cut national health spending, active workforce numbers and the attribution of individual disease trends to financing alone.

Maintaining that distinction is essential for credible public policy, and the report applies it throughout. Findings are graded by evidence class, divergent data series are shown with their source and reference period rather than averaged, and every recommendation is traceable to the finding it addresses. The aim is a document that Government and its partners can act on with confidence.

 **Dr Abdulrazzaq Yusuf Ahmed**

MPH, MSc(HM), PhD (Health Economics), PhD (Demography & Social Sciences)

Health Systems Expert | Tropical Medicine; Infectious diseases; public health leadership specialist | Academic Researcher

Director General of Social Health Insurance Authority; Somalia

Chairman of the Board and Founder of RIYAADA Institute for Leadership & Governance

Executive Summary

Somalia's health system has moved from prospective risk to active contraction. The defining feature of the current situation is not only that services remain insufficient, but that the platform delivering essential services is shrinking while population need is rising.

31% of the 2026 humanitarian plan funded Reported · OCHA FTS, 8 Sep 2026	380 health facilities closed or scaled back Reported operational · Jan–Jun 2026	30% reduction in health and nutrition service coverage Reported operational · UNICEF, Aug 2026
5.4 M people in IPC Phase 3 or above Projection · Oct–Dec 2026	1.92 M children aged 6–59 months acutely malnourished Projection · Jul 2026–Jun 2027	10,108 measles cases, with 36 deaths Reported · Jan–Jun 2026
30 UHC service coverage index (0–100) WHO estimate · 2023	3.81 doctors, nurses and midwives per 10,000 population WHO stock estimate · 2024 · benchmark 44.5	563 maternal deaths per 100,000 live births Modelled estimate · 2023

Figure 1. Executive dashboard: financing shock, rising need and structural baseline

Source: OCHA Financial Tracking Service, as reported in IPC (2026); IPC (2026); UNRIC (2026); UNICEF (2026a, 2026b); WHO Global Health Observatory; MMEIG (2025). Reference periods and definitions differ.

Humanitarian funding has fallen sharply from the 2022 famine-prevention peak, when 92 per cent of requirements were met. The 2026 Humanitarian Needs and Response Plan (HNRP) seeks US\$852 million to assist 2.4 million of an estimated 4.8 million people in need, 40 per cent less than was sought in 2025, a reduction driven by constrained resources rather than reduced need. By 8 September 2026 the plan was 31 per cent funded, with health at 25 per cent and nutrition at 13 per cent. UNICEF reports that 205 health and nutrition facilities have closed and that funding cuts have contributed to a 30 per cent reduction in health and nutrition service coverage. Across the sector, 380 health facilities closed or scaled back operations in the first half of 2026 and 233 nutrition sites have closed, and as many as 618 health facilities could close under a severe funding scenario.

Need is rising at the same time. The September 2026 Integrated Food Security Phase Classification (IPC) analysis projects 5.4 million people in Crisis or worse (IPC Phase 3 or above) in October–December 2026, identifies a risk of famine among displaced people in Baidoa and estimates that 1.92 million children aged 6–59 months will face acute malnutrition between July 2026 and June 2027, including 433,000 with severe acute malnutrition (SAM). Admissions for SAM with medical complications rose by 32 per cent year on year in the first half of 2026. Measles cases in the first six months of 2026 (10,108) already exceeded the total for 2025, diphtheria continues to spread, and a strong El Niño could expose 2.5–3.5 million people to flooding during the October–December Deyr season. These outcomes reflect interacting shocks — drought, flooding, conflict, displacement, low vaccination coverage, supply constraints and the financing contraction — so the report uses contribution language wherever the evidence does not support single-cause attribution.

Headline findings

- 1. Financing contraction.** The share of humanitarian requirements funded fell from 92 per cent in 2022 to 29 per cent in 2025, and stood at 31 per cent of a much smaller, hyper-prioritised plan on 8 September 2026. United States assistance to Somalia fell by about 72 per cent between fiscal years 2024 and 2025, and the World Bank-financed Damal Caafimaad project, which supported 276 health facilities, was scheduled to close in June 2026.
- 2. Service delivery contraction.** UNICEF has confirmed 205 closures of health and nutrition facilities; sector reporting records 380 health facilities closed or scaled back and a one-third fall in outpatient therapeutic sites for SAM; and UNICEF reports a 30 per cent reduction in coverage. The figure of 618 facilities is a severe-funding scenario, not an observed count.
- 3. Workforce fragility.** The 2024 WHO stock estimate records 7,226 doctors, nurses and midwifery personnel, or 3.81 per 10,000 population: 8.6 per cent of the needs-based benchmark of 44.5. A government-reported loss of more than 6,000 health jobs is an operational signal, not a post-cut census.
- 4. Nutrition and outbreak deterioration.** Famine risk has re-emerged, 1.92 million children need treatment for acute malnutrition, and measles, diphtheria and malaria are above recent levels. The 32 per cent rise in complicated SAM admissions is consistent with the loss of preventive and community services and with later presentation.
- 5. Universal health coverage under stress.** The UHC service coverage index reached 30 in 2023, up from 14 in 2000 but still indicating very low coverage. Immunisation gains have stalled: WHO/UNICEF estimates put coverage of the third dose of diphtheria–tetanus–pertussis vaccine (DTP3) at 72 per cent and of the first dose of measles-containing vaccine (MCV1) at 61 per cent in 2025, with MCV1 falling in two of the last three years.
- 6. Weak financial protection and high external dependence.** External sources financed 54.4 per cent of current health expenditure (CHE) in 2023, households 30.8 per cent and domestic government 14.2 per cent. Out-of-pocket spending per person rose between 2019 and 2023 even as its share fell; only 3.5 per cent of surveyed individuals had any health insurance, and 24 per cent of surveyed households incurred catastrophic health expenditure.

Priority actions

Five actions should be taken now:

- 1. Protect the essential service floor immediately.** Define, cost and finance a minimum package covering SAM treatment, routine immunisation, outbreak response, emergency obstetric and newborn care, referral services and acute watery diarrhoea (AWD)/cholera treatment, with flood preparedness for the Deyr season.
- 2. Verify facility and workforce status.** Establish a monthly facility status register and active-workforce roster, using unique facility identifiers and clear categories for open, reduced, closed and at-risk services.
- 3. Restore outreach in priority hotspots.** Re-establish integrated outreach for immunisation, nutrition screening and antenatal care where malnutrition, displacement, conflict, flooding and outbreak risks overlap.
- 4. Align financing behind one continuity mechanism.** Channel domestic and partner resources towards a coordinated continuity package, track funds against services monthly, and secure successor financing for expiring service-delivery projects.
- 5. Strengthen accountability and evidence discipline.** Apply standard evidence labels to all public briefs, distinguish observed findings from scenarios, and maintain one register of facility, workforce and funding data.

The immediate policy objective is to protect a minimum national essential service floor. In parallel, Government should establish the data, financing and purchasing architecture required for a more resilient health system. Insurance expansion cannot compensate for closed facilities, absent staff or unavailable medicines.

Social health insurance, led by the Social Health Insurance Authority (SHIA), can become a stabilising purchaser when it is sequenced with supply-side continuity, public subsidies for poor and displaced households, provider empanelment, transparent payment arrangements and strong accountability. Sections 10 to 12 set out the corresponding options across three time horizons, summarised in Table E1.

Table E1. Recommended actions at a glance

0–6 months: STABILISE	6–18 months: CONSOLIDATE	18–48 months: REFORM
<ul style="list-style-type: none"> ▶ Protect a costed essential service floor ▶ Prepare health services for El Niño flooding ▶ Publish a verified facility status register ▶ Verify and protect frontline posts ▶ Restore outreach in priority hotspots 	<ul style="list-style-type: none"> ▶ Align resources behind one costed package ▶ Create a continuity reserve ▶ Secure successors to expiring projects ▶ Produce post-shock health accounts ▶ Conduct an active-workforce census 	<ul style="list-style-type: none"> ▶ Sequence SHIA as a strategic purchaser ▶ Link empanelment to accreditation ▶ Shift partner funds towards pooled modalities ▶ Institutionalise one data architecture

Core policy judgement

Somalia's health system has entered a measurable phase of retrenchment. The issue is no longer prospective risk alone; it is the active contraction of service delivery capacity against a rising burden of need, at a moment when famine risk and El Niño flooding are converging.

1 Introduction

1.1 Purpose of the report

This report assesses the status of Somalia's health sector in 2026. It gives particular attention to health financing, universal health coverage (UHC), service delivery, the health workforce, maternal and child health, nutrition, immunisation, communicable disease outbreaks and the effects of rapid external aid contraction. It is designed as a decision-support document for Government, Parliament, development partners, health sector leaders, researchers and civil society.

1.2 Scope and analytical questions

The report addresses four connected questions, each answered in a defined part of the document:

1. What was the structural condition of the health system before the current aid shock? (Section 3)
2. How large and how rapid has the financing contraction been? (Section 4)
3. What operational evidence shows that service delivery capacity is contracting, and with what health consequences? (Sections 5–9)
4. Which policy and governance actions can protect essential services while Somalia builds more sustainable financing and purchasing arrangements? (Sections 10–12)

1.3 Evidence approach

The assessment draws on four bodies of evidence: national surveys and assessments, including the Somali Health and Demographic Survey (SHDS) 2020 and the national Harmonized Health Facility Assessment (HHFA); internationally comparable estimates from the World Health Organization (WHO), the United Nations Children's Fund (UNICEF) and the United Nations inter-agency estimation groups; humanitarian needs, funding and food security analyses from the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) and the IPC; and operational reporting by Government, United Nations agencies and non-governmental organisations, complemented by peer-reviewed studies. Data are current to 30 September 2026.

For each indicator, the report uses the latest available reference period and states its evidence class and limitations. Operational figures from 2026 are not treated as equivalent to modelled national statistics for 2023 or 2024. Figure 2 defines the four evidence classes used throughout.

1.4 Data conventions

The evidence base uses different denominators, definitions and reference years. Comparable national health accounts end in 2023. Workforce stock and most outcome indicators end in 2024 or 2025. Operational reporting on the shock covers 2025 and 2026. Four analytical rules follow and apply throughout the report:

- Missing data are never converted to zero.
- Reported job losses are not subtracted from a professional stock estimate.
- Closure counts are not divided by facility denominators that use different definitions.
- Where two credible sources report different values, both are presented with their source and reference period. They are neither averaged nor interpreted as a trend unless denominators and methods are comparable.

Every divergence of this kind is recorded, with the convention adopted, in Table 4 (Section 7.5). Later sections cross-refer to it rather than restating each caveat.

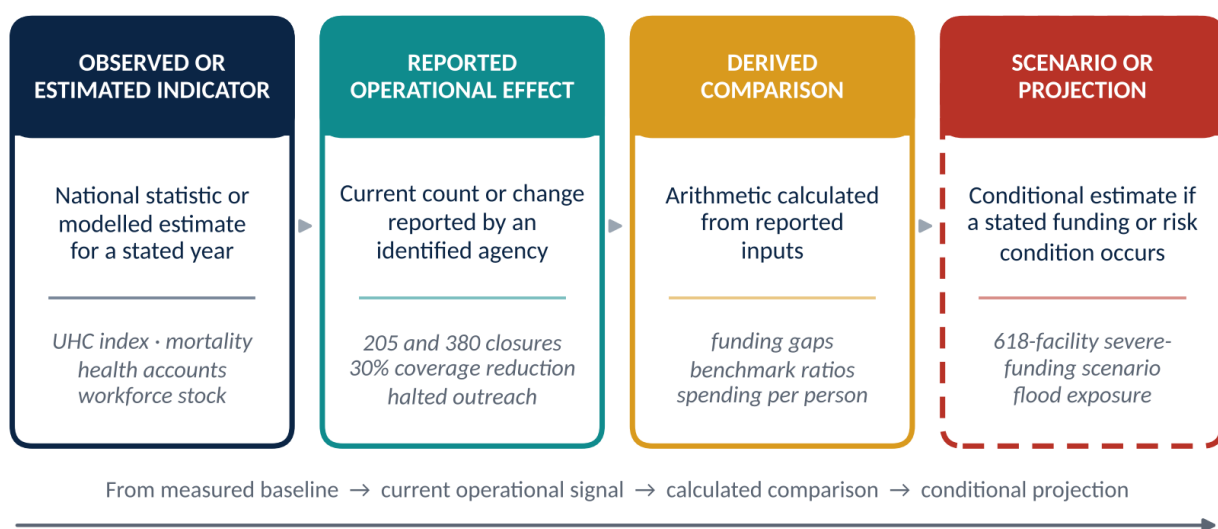


Figure 2. Evidence classes used in this report

Source: Report methodology.

2 Country Context and Risk Environment

2.1 Demographic and socio-economic vulnerability

Somalia's population was estimated at 19.7 million in 2025 and is growing by more than 3 per cent a year (World Bank, 2026b). Fertility is among the highest in the world, at 6.9 births per woman (Directorate of National Statistics, 2020), so the number of births, and with it the demand for maternal, newborn and child services, continues to rise every year.

Just under half of the population (49.5 per cent in 2025) lives below the national poverty line, and economic growth is projected to slow to 2.8 per cent in 2026 as aid inflows fall and drought and import-price shocks weigh on households (World Bank, 2026a). Fiscal space is narrow: domestic revenue is about 3 per cent of gross domestic product (GDP), and external grants are expected to finance about 60 per cent of planned federal expenditure in fiscal year 2026 (Ministry of Finance, 2025). Widespread poverty limits households' ability to compensate for service closures through private care, transport or medicine purchases, and even modest out-of-pocket payments can become a barrier to timely care.

2.2 Displacement, climate stress and conflict

About 3.3 million people are internally displaced (UNICEF, 2026b). Displacement accelerated in 2026: 728,800 people were newly displaced in the first half of the year, and a further 198,000 are estimated to have been displaced between July and September, when flooding (45 per cent), drought (28 per cent) and conflict (27 per cent) were the main drivers (IPC, 2026). The failed 2025 Deyr season left the cereal harvest in southern Somalia 83 per cent below the 1995–2025 average (FGS and United Nations, 2026a), and poor, erratic 2026 Gu rains prolonged drought in northern and central areas.

The outlook has now shifted from drought towards flood risk. Forecasts give a probability of more than 90 per cent that El Niño conditions will prevail through the second half of 2026 (UNICEF, 2026b), and the September IPC analysis cites a substantial chance of an exceptionally strong event, together with a positive Indian Ocean Dipole, during the October–December Deyr season (IPC, 2026). Government and United Nations partners estimate that 2.5–3.5 million people could be exposed to flooding and that about 1 million could be displaced (FGS and United Nations, 2026b).

The burden is concentrated in communities with limited access to water, food, transport and health care. In rural areas the price of a 200-litre barrel of water has risen from US\$2 to US\$8 (UNICEF, 2026a). Displacement also reshapes demand: dense informal settlements can experience rapid outbreaks, while remote pastoral and riverine communities lose mobile outreach and referral options.

2.3 Implications for health service delivery

The health system is being asked to deliver more with less. Drought and food insecurity increase demand for nutrition, water, maternal and child health services, and flooding adds waterborne and vector-borne disease, damaged facilities and severed referral routes. Conflict and insecurity interrupt supply routes and restrict the operations of health workers and partners. Displacement increases crowding and mobility, while the financing contraction reduces the number of functioning service points. In this setting a relatively small interruption can produce a disproportionate decline in effective coverage. Table 1 maps each risk to its health system pathway and priority response.

Table 1. Risk environment, health system pathways and priority responses

Risk environment	Health system pathway	Priority response
Drought and food insecurity	Rising acute malnutrition, unsafe water and delayed care	Protect nutrition screening, SAM treatment, WASH-linked surveillance and referral transport
Flooding (El Niño, Deyr 2026)	Waterborne and vector-borne disease, damaged facilities, cut-off referral routes and new displacement	Pre-position medicines and cholera supplies, protect the cold chain, prepare oral cholera vaccination and alternative access routes
Conflict and insecurity	Restricted facility access, staff insecurity and disrupted commodities	Use flexible financing, security-informed routing and alternative delivery platforms
Internal displacement	Crowding, transmission, lost records and high demand in IDP sites	Strengthen mobile services, vaccination, outbreak detection and continuity of care
Financing volatility	Closed facilities, unpaid staff, stock-outs and incomplete reporting	Create a continuity package, pooled funding and monthly cash-to-service tracking

Source: Report analysis drawing on United Nations in Somalia (2026), IPC (2026) and FGS and United Nations (2026b). WASH: water, sanitation and hygiene. IDP: internally displaced person.

Policy implication →

Response planning must be risk-differentiated. Drought-affected, flood-exposed, conflict-affected and displacement-affected areas require different continuity instruments (Section 10.1). These risks, however, act on a system whose baseline capacity was already limited, as Section 3 shows.

3 Health System Status Before the Aid Shock

Somalia entered the current financing shock with a system that was improving from a very low baseline but remained far from universal access. The pre-shock condition matters because it determines how much resilience exists when external funding is withdrawn. Low coverage, weak quality systems and a thin workforce leave little spare capacity to absorb closures, displacement or outbreak pressure.

3.1 Universal health coverage profile

The UHC service coverage index (Sustainable Development Goal (SDG) indicator 3.8.1) summarises coverage of essential services across reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases and service capacity. WHO estimates Somalia's index at 30 in 2023, up from 14 in 2000 and 28 in 2019 (Figure 3; WHO, 2026e). Progress has been steady but slow, at less than one point a year since 2015, and the index has not moved since 2022. A score of 30 indicates very low effective coverage of essential services.

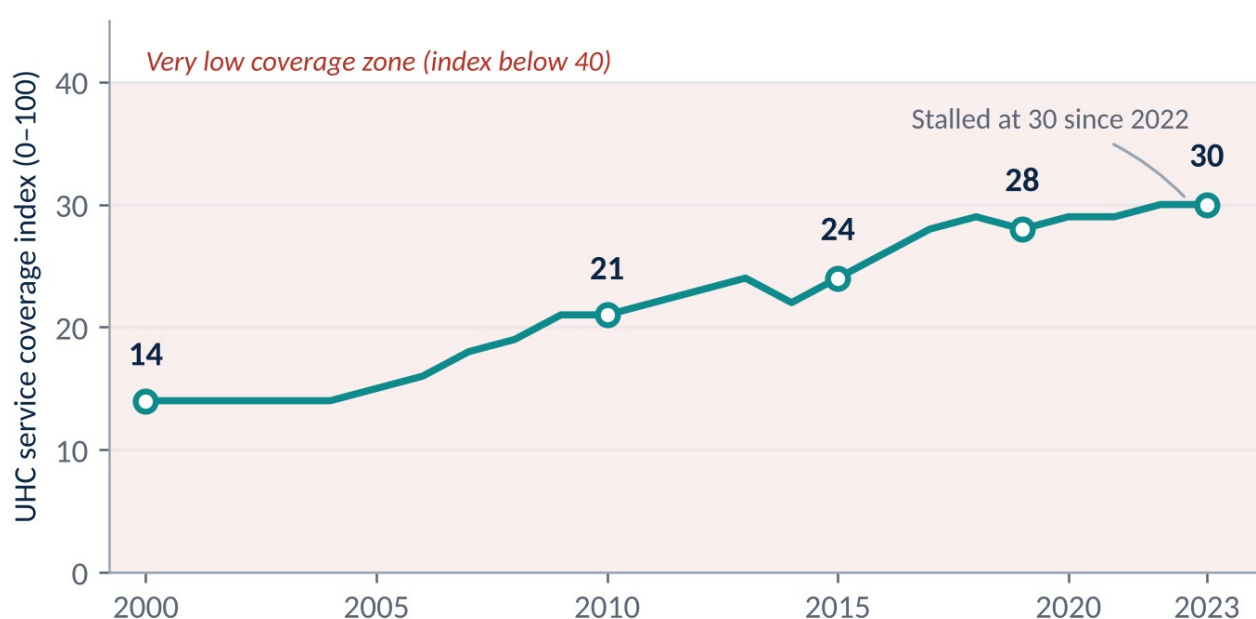


Figure 3. UHC service coverage index, 2000–2023

Source: WHO Global Health Observatory, SDG indicator 3.8.1 series (accessed 2 October 2026).

3.2 Health workforce capacity

WHO stock estimates for 2024 record 1,229 medical doctors and 5,997 nursing and midwifery personnel. Their combined density of 3.81 per 10,000 population is up from about 3.1 in 2014 but equals only 8.6 per cent of the needs-based benchmark of 44.5 doctors, nurses and midwives per 10,000 population (Figure 4; WHO, 2016). Closing the gap at the current population would require roughly 80,000 additional professionals, a derived comparison that conveys scale rather than a planning target.

The national average conceals further weaknesses, including geographic maldistribution, vacancies, inactive registrations and dual practice. There is also a material gap between a registered worker and a worker actively delivering publicly financed services, and a substantial share of frontline posts is financed through time-limited projects (Section 5.2).

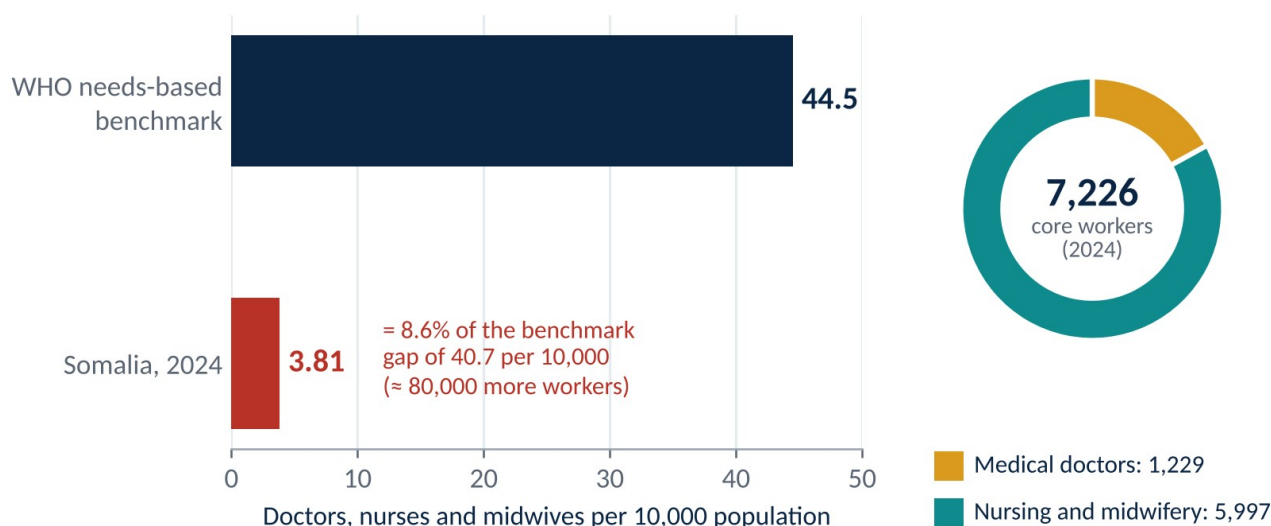


Figure 4. Core health workforce density compared with the WHO needs-based benchmark, 2024

Source: WHO National Health Workforce Accounts (2024 data), via the WHO Global Health Observatory; benchmark from WHO (2016). The additional-worker estimate is a derived comparison based on a 2025 population of 19.7 million.

3.3 Health financing structure

The latest comparable national health accounts describe the financing structure in 2023 (Figure 5). Current health expenditure (CHE) was US\$22.37 per person, equivalent to 3.74 per cent of GDP. External sources financed 54.4 per cent of CHE, households paid 30.8 per cent out of pocket, domestic government sources financed 14.2 per cent and other domestic private sources 0.6 per cent. Domestic general government health expenditure was about US\$3.17 per person and 7.9 per cent of general government expenditure (WHO, 2026e).

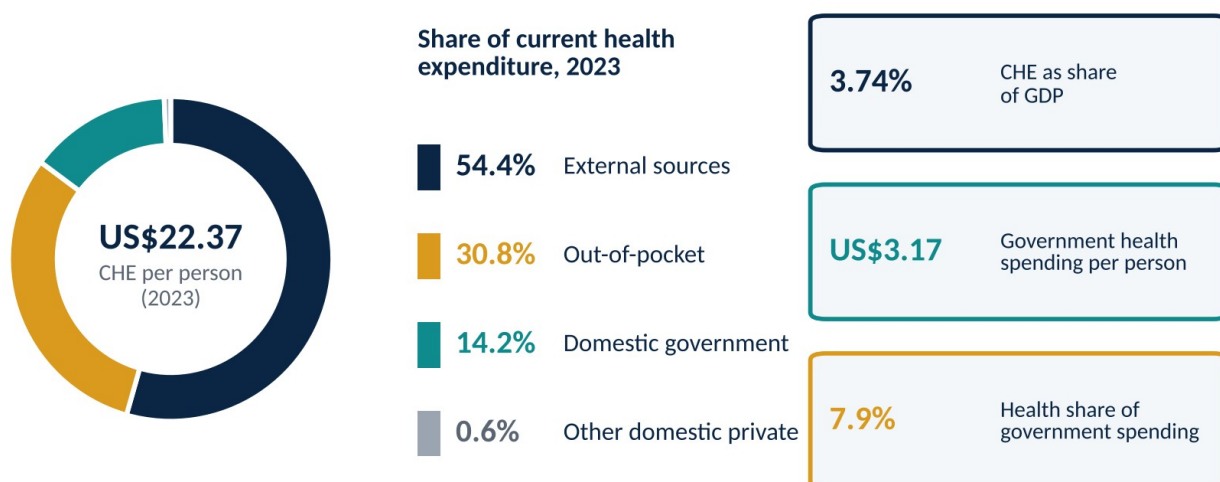


Figure 5. Current health expenditure by financing source and fiscal context, 2023

Source: WHO Global Health Expenditure Database, via the WHO Global Health Observatory (accessed 2 October 2026). Other domestic private sources are derived as domestic private expenditure less out-of-pocket spending.

The trend matters as much as the level (Figure 6). Health spending per person rose by 72 per cent between 2019 and 2023, from US\$12.99 to US\$22.37, but most of the increase came from external sources: external financing per person more than doubled between 2020 and 2023, from about US\$5.45 to US\$12.17, as the drought and famine-prevention response expanded. Government spending per person rose roughly fourfold from a very low base, from about US\$0.81 to US\$3.17. Out-of-pocket spending fell as a share of CHE, from 45.0 per cent in 2019 to 30.8 per cent in 2023, but rose in absolute terms, from about US\$5.84 to US\$6.89 per person. The falling share therefore reflects the surge in external funds rather than a lighter burden on households, and it is the externally financed layer that is now contracting.

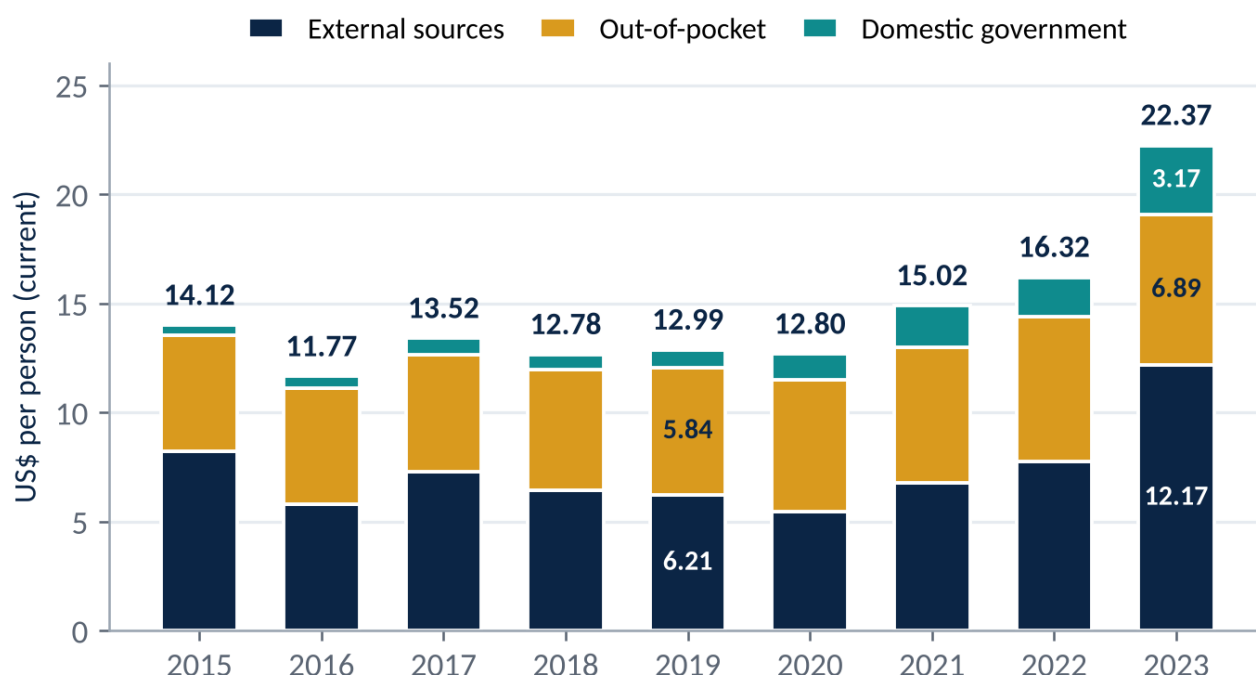


Figure 6. Current health expenditure per person by financing source, 2015–2023 (US\$)

Source: Derived from WHO Global Health Expenditure Database shares and per-person totals (accessed 2 October 2026). Other domestic private sources (US\$0.11–0.15 per person) are not shown.

The federal budget offers limited scope to absorb the shock in the short term. The fiscal year 2026 Budget Policy Framework proposes US\$42.2 million for the Ministry of Health and Human Services, about 3.1 per cent of planned federal expenditure, compared with US\$118.7 million for education and US\$264.8 million for security and defence; the social affairs sector envelope as a whole is 25 per cent below its 2025 budget level (Ministry of Finance, 2025). WHO estimates that about 95 per cent of the health budget depends on external financing (WHO, 2026b).

Two measures of donor dependence therefore appear in the evidence base. The 54.4 per cent figure uses total CHE, including household payments, as its denominator. The 95 per cent figure refers to the health budget that finances the public delivery system. Both indicate high dependence, but they measure different things and are labelled separately (Table 4).

3.4 Facility platform and quality readiness

The pre-shock facility platform was limited in both scale and readiness. The national HHFA assessed 1,219 health facilities across the five Federal Member States and the Banadir Regional Administration (Osman et al., 2026). This denominator is not interchangeable with later closure counts (Section 1.4).

Quality systems were weak (Figure 7). Only 18.5 per cent of facilities reported any accreditation, 32.8 per cent reported a routine quality assurance process and 14.5 per cent reported a quality committee meeting in the previous three months (Osman et al., 2026). Just 6.6 per cent had routine, standardised monitoring of infection prevention and control, ranging from 0.85 per cent of primary health units to 22.7 per cent of national referral hospitals (Adam et al., 2026). These are baseline vulnerabilities, not effects of the later aid cuts, but they leave the system highly exposed when surveillance and supplies are disrupted.

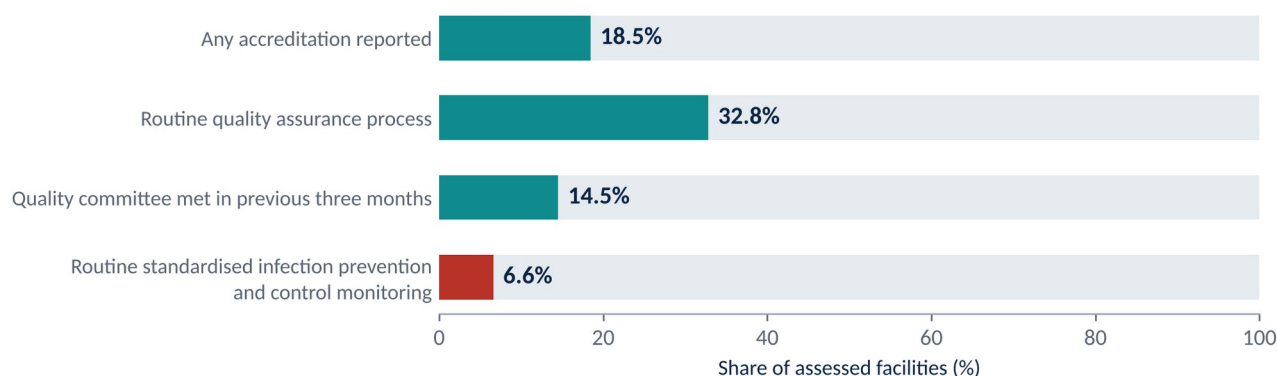


Figure 7. Facility quality readiness at baseline

Source: Osman et al. (2026) and Adam et al. (2026), analyses of the national Harmonized Health Facility Assessment covering 1,219 facilities.

3.5 Maternal, newborn and child health

Maternal and child outcomes remain far from SDG thresholds (Figure 8). The maternal mortality ratio was an estimated 563 deaths per 100,000 live births in 2023, about eight times the SDG target of fewer than 70, although the uncertainty interval is wide (244–1,089) (MMEIG, 2025). Under-five mortality was an estimated 101 deaths per 1,000 live births in 2024, about four times the target of 25, and neonatal mortality 34 per 1,000, nearly three times the target of 12 (UN IGME, 2026). The most recent national survey found that only 32 per cent of births were attended by skilled personnel and 21 per cent took place in a health facility (Directorate of National Statistics, 2020). These outcomes explain why interruptions to maternal, newborn, referral and community services can rapidly translate into preventable deaths.

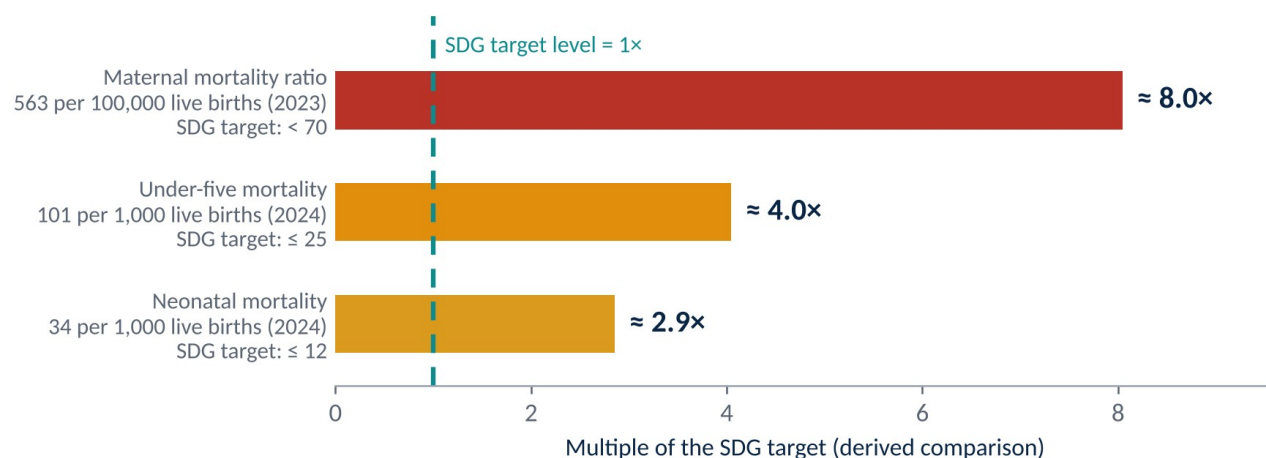


Figure 8. Maternal, under-five and neonatal mortality as multiples of SDG targets

Source: MMEIG (2025); UN IGME (2026), via the WHO Global Health Observatory. Multiples are derived comparisons.

Policy implication →

With so little baseline capacity, the system has almost no buffer: preventing further contraction costs less than rebuilding services after closure (Sections 10.1 and 13). Section 4 examines the shock itself.

4 The Aid Contraction Shock, 2022–2026

The aid contraction is the central shock examined in this report. It matters not only because it reduced the money available, but because external resources finance recurrent delivery functions, including staff incentives, commodities, mobile outreach, nutrition services, surveillance, transport and data systems. When such functions depend on short funding cycles and multiple projects, a funding freeze can reduce operating capacity before the national budget can respond.

4.1 Evolution of humanitarian financing

The share of humanitarian requirements funded fell from 92 per cent at the 2022 famine-prevention peak to 47 per cent in 2023 and 2024 and to 29 per cent in 2025 (Figure 9; Table 2). The 2026 plan was cut to US\$852 million, 40 per cent below the 2025 requirement, to concentrate on the most severe needs. Even so, it was only 31 per cent funded on 8 September 2026, with food security at 16 per cent, nutrition at 13 per cent, and health and water, sanitation and hygiene (WASH) at 25 per cent each (IPC, 2026).

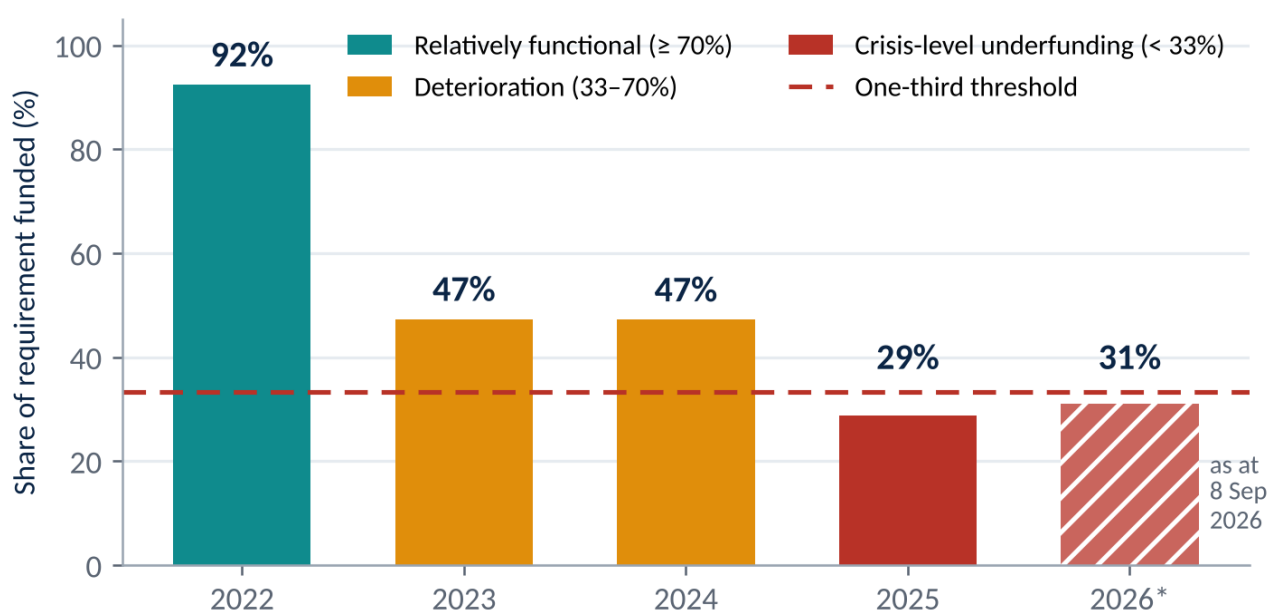


Figure 9. Share of Somalia’s humanitarian requirements funded, 2022–2026

Source: OCHA (2026), *Financial Tracking Service and Humanitarian Action platform*; IPC (2026) for the 2026 value. *2026 is a partial-year value as at 8 September 2026.

Table 2. Humanitarian requirements and funding, 2022–2026

Year	Requirement	Funding received	Share funded	Interpretation
2022	US\$2.27 billion	US\$2.10 billion	92%	Famine-prevention peak
2023	US\$2.60 billion	US\$1.23 billion	47%	Sharp decline begins
2024	US\$1.60 billion	About US\$0.76 billion	47%	Scope narrowed while needs remained high
2025	US\$1.42 billion	US\$0.41 billion	29%	Shortfall after the United States freeze and wider donor reductions
2026	US\$0.85 billion	About US\$0.26 billion (to 8 September)	31% (8 September)	Crisis-level underfunding of a reduced, hyper-prioritised plan

Source: OCHA (2026); IPC (2026); United Nations in Somalia (2026). Amounts received for 2024 and 2026 are derived from reported coverage. Amounts are rounded and are not audited health sector expenditure.

4.2 Financing gap in absolute terms

The absolute financing gap widened because needs remained high while both the requested response and the funds received fell (Figure 10). A smaller appeal does not mean lower need. The 2026 HNRP applied a stricter needs definition: its estimate of 4.8 million people in need is 20 per cent lower than in 2025, a change that reflects methodology rather than improved conditions (United Nations in Somalia, 2026). The plan targets 2.4 million people and prioritises 1.6 million facing the most severe needs in 21 districts. By mid-year, UNICEF estimated that about 6 million people required humanitarian assistance (UNICEF, 2026b). Reduced response capacity must therefore not be mistaken for reduced humanitarian need.

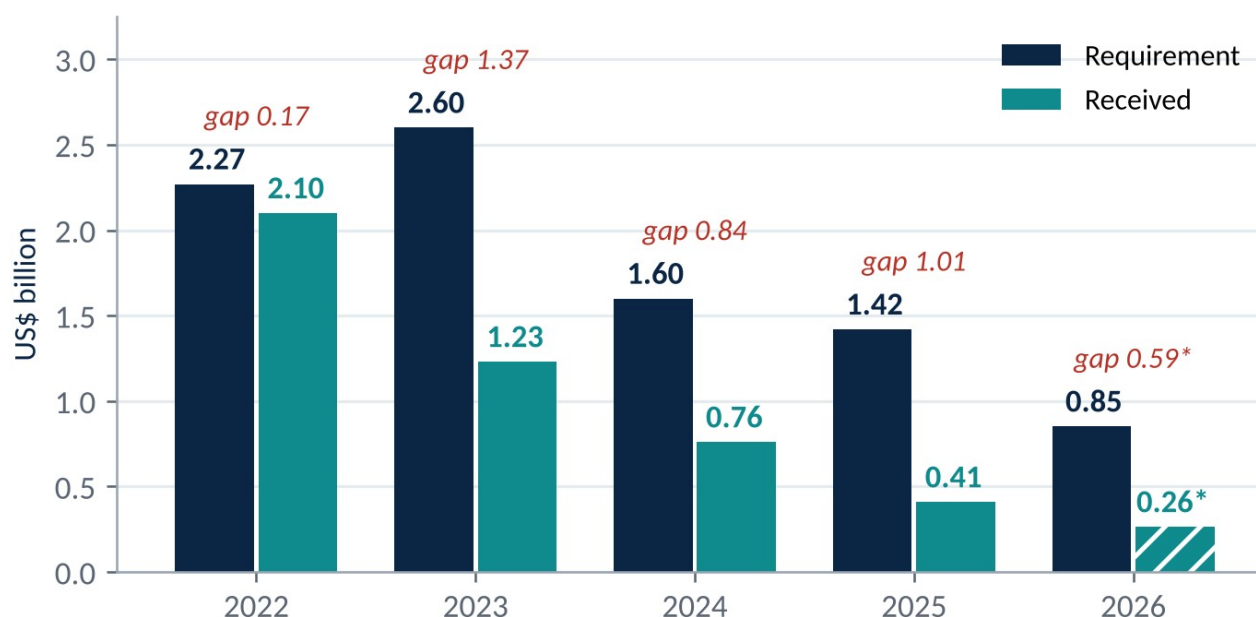


Figure 10. Humanitarian financing requirement and funding received, 2022–2026 (US\$ billion)

Source: As for Figure 9. *2026 values are as at 8 September 2026; amounts received for 2024 and 2026 are derived from reported coverage.

4.3 United States aid contraction and wider donor reductions

United States funding decisions were the largest single source of the contraction. Foreign assistance was frozen and stop-work orders were issued in January 2025, and most United States Agency for International Development (USAID) awards worldwide were terminated in March 2025. United States assistance to Somalia fell from about US\$765 million in fiscal year 2024 (Reuters, 2025) to US\$212 million obligated in fiscal year 2025, a decline of about 72 per cent (USAFacts, 2026). In January 2026 the United States suspended all assistance to the Federal Government over the alleged seizure of donor-funded food aid; World Food Programme (WFP) distributions resumed later that month, but the broader assistance posture remained under review (Al Jazeera, 2026; AllAfrica, 2026).

These figures cover sectors beyond health and are not health-specific expenditure. Their operational significance lies in shared delivery channels: health, nutrition, water, education and protection programmes often depend on the same funding streams and implementing partners. Other donors also reduced funding, and development financing for service delivery has reached a transition point (Table 3).

Table 3. Principal changes in external financing affecting health, 2025–2026

Change	Scale	Health system significance
United States assistance to Somalia	About US\$765 million (FY2024) to US\$212 million obligated (FY2025), about –72%	Loss of funding for facilities, mobile teams, nutrition services and supply chains shared across partners
United States suspension of assistance to the Federal Government	Announced 7 January 2026; WFP distributions resumed 29 January 2026; wider assistance under review	Uncertainty over government-channelled support and partner planning
European Union humanitarian allocation	€67.8 million (2025) to €63 million (2026)	Lower predictable humanitarian funding
United Nations Humanitarian Air Service (UNHAS)	Budget cut by 40% between 2025 and 2026	Reduced capacity to move life-saving cargo, including UNICEF supplies
WFP food assistance	About 2.2 million people reached in early 2025; just over 600,000 in 2026	Food assistance no longer cushions nutrition risk; humanitarian food assistance reached about 2% of the population in July–September 2026
UNICEF 2026 humanitarian appeal	24% of US\$121 million funded at mid-year	Gaps in nutrition supplies, vaccines and WASH; breaks in therapeutic food supply projected
World Bank-financed Damal Caafimaad project	US\$109.25 million; 276 facilities and 3,918 health workers supported; scheduled to close on 30 June 2026	Continuity risk for facilities and posts until a successor operation is in place

Source: Reuters (2025); USAFacts (2026); Al Jazeera (2026); AllAfrica (2026); European Commission (2026); UNICEF (2026a, 2026b); WHO (2026a); IPC (2026); World Bank (2025); Dawan (2026). FY: United States fiscal year.

The Damal Caafimaad project illustrates the exposure. By August 2025 it supported 276 health facilities, paid 3,918 health workers and had reached about 5 million people (World Bank, 2025). The Ministry of Health and Human Services reviewed the project in September 2026 in preparation for a longer-term successor operation (Dawan, 2026). Continuity of the services and posts it financed should be treated as a priority risk (Section 10).

4.4 Why Somalia was especially vulnerable

Five structural features amplified the shock:

- External sources finance more than half of current health expenditure and an estimated 95 per cent of the health budget, while domestic government health spending is about US\$3 per person.
- The primary care and outreach platform is thin, with few alternative providers in remote and insecure areas.
- Drought, displacement and conflict increased demand for services at the same time as access and operational funding deteriorated.
- Fragmented project financing leaves payroll, commodities and data functions exposed when a single grant ends or a stop-work order arrives.
- Low vaccination coverage and weak quality and surveillance systems provide little buffer against outbreaks.

Policy implication →

The core vulnerability is structural: recurrent delivery functions are financed through short, fragmented project cycles. Stabilisation therefore requires pooled, predictable financing for essential functions, not only additional funds (Sections 10.2 and 11.4). Section 5 examines how the shock has translated into operational contraction.

5 Evidence of Health System Retrenchment

The evidence supports a shift from prospective risk to observed contraction. The most defensible statement is not that aid cuts caused every adverse health outcome, but that they removed or reduced operating capacity in a system already exposed to climate stress, conflict, displacement and low baseline coverage. This section presents the evidence by function: facilities, workforce, outreach, and surveillance and supply.

5.1 Facility closures and service disruption

UNICEF reported on 21 August 2026 that 205 health and nutrition facilities had closed and that funding cuts had contributed to a 30 per cent reduction in health and nutrition service coverage (UNICEF, 2026a). Sector-wide reporting is larger: 380 health facilities closed or scaled back operations in the first half of 2026, and 233 nutrition sites have closed, reducing access to health care for an estimated 3.2 million people and to nutrition treatment for 1.1 million children and women (IPC, 2026; UNRIC, 2026). The number of outpatient therapeutic programme sites for SAM fell by a third, from 775 in late 2024 to 523 in June 2026 (UNICEF, 2026b). In November 2025 the Deputy Minister of Health reported that up to 2,000 facilities had been affected by the cuts (Associated Press, 2025), and the European Commission estimates that only about one-third of existing health facilities are functional (European Commission, 2026).

Looking ahead, as many as 618 health facilities, comprising 51 district hospitals, 413 health centres and 154 primary health units, could close in 2026 under a severe funding scenario (WHO, 2026a; UNICEF, 2026a).

These figures use different definitions and must not be added together (Figure 11). Each has a distinct use. The count of 205 is the most conservative indicator of confirmed contraction. The figure of 380 health facilities closed or scaled back is the broadest current measure of lost service points. The 30 per cent reduction is a direct signal of reduced programme reach, although its denominator is unpublished. The 618 figure is a trigger for contingency planning, and the 2,000 figure requires facility-level validation.

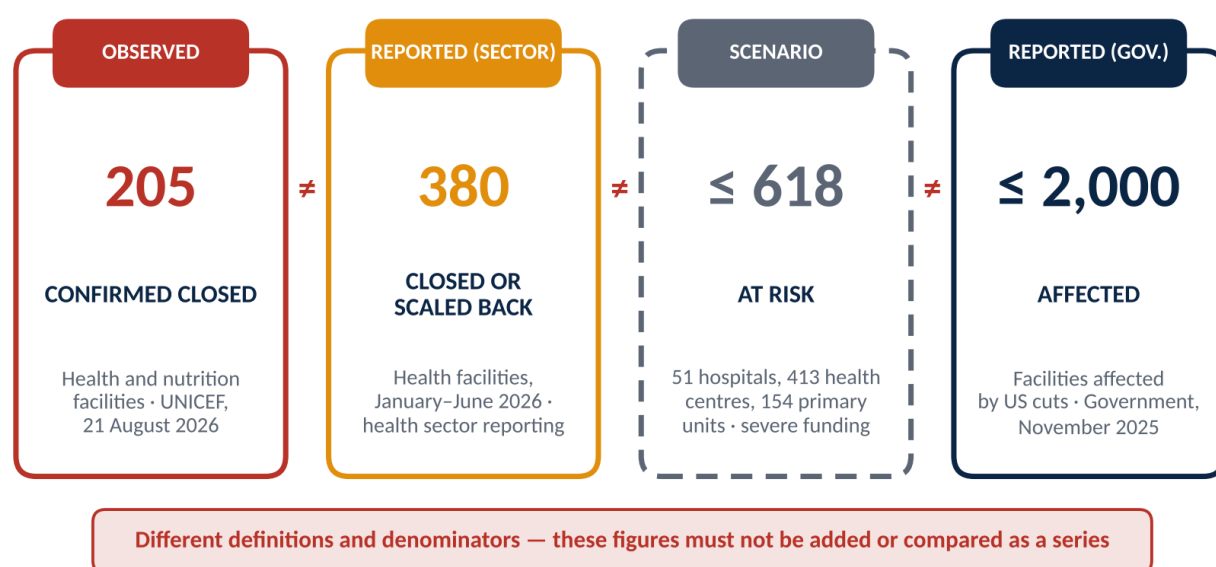


Figure 11. Facility status signals: closed, scaled back, at risk and affected are distinct categories

Source: UNICEF (2026a); IPC (2026) and UNRIC (2026) for sector reporting; WHO (2026a) for the composition of the severe-funding scenario; Associated Press (2025).

5.2 Workforce losses and operational capacity

The Deputy Minister of Health reported in November 2025 that more than 6,000 health workers had lost their jobs following the United States cuts (Associated Press, 2025). This is an important operational signal, but it is not a national post-cut payroll or licensing census. The reported group may include community, nutrition, project and support staff, whereas the WHO stock estimate covers defined professional cadres, so the two figures are not subtracted (Section 1.4). Project financing is a material share of the frontline payroll: Damal Caafimaad alone paid 3,918 health workers (World Bank, 2025), and their continuity depends on the successor arrangements described in Section 4.3.

The immediate measurement priority is a verified roster that links each funded post to cadre, active status, contract source, facility, district and essential service.

5.3 Reduction of outreach and mobile services

The Minister of Health and Human Services stated in August 2025 that mobile vaccination teams serving remote areas had lost their funding and stopped working (Reuters, 2025). CARE reported closing more than 150 health facilities in 2025, and its mobile medical vans, which had provided basic health care to about 80,000 people, were among the services lost (CARE, 2025). Coverage of treatment for moderate acute malnutrition fell from 51 per cent to 30 per cent (UNICEF, 2026b). When outreach stops, remote and pastoral communities lose one of their few routes to immunisation, screening, antenatal care, nutrition services and referral. The effect is greatest where people cannot reach fixed facilities because of distance, insecurity, transport costs or displacement, including the more than 450,000 children in south and central Somalia who were not reached during recent polio vaccination campaigns (WHO, 2026c).

5.4 Weakening surveillance and supply chains

Funding constraints threaten disease surveillance, monitoring of circulating vaccine-derived poliovirus type 2 (cVDPV2), cold-chain maintenance, commodity tracking and routine reporting. UNICEF projected breaks in the supply of ready-to-use therapeutic food (RUTF) and therapeutic milk by September 2026 without additional resources (UNICEF, 2026b). The quality baseline was already weak (Section 3.4).

One policy consequence follows directly. A decline in reported cases cannot automatically be read as an improvement; it may instead reflect reduced capacity to detect and report. The Polio International Health Regulations Emergency Committee made the same point about a recent downward trend in cVDPV2 detections in Somalia, which it said requires cautious interpretation because of persistent access gaps (WHO, 2026c).

5.5 Distinguishing observed effects from scenarios

Confirmed closures, reported coverage reductions and increased complicated SAM admissions are operational observations or estimates. The 618-facility figure, projected flood exposure and global modelled mortality projections, such as the estimate that the defunding of USAID could cause more than 14 million additional deaths worldwide by 2030 (Cavalcanti et al., 2025), are scenarios. This distinction must be preserved in all public communication, Cabinet briefs and partner appeals. Presenting a scenario as a current count would overstate certainty and weaken the credibility of the evidence.

Policy implication →

Contraction is concentrated in the functions that determine whether services reach people: outreach, surveillance, supply chains and frontline staffing. Continuity financing should target these functions explicitly, supported by a verified facility and workforce register (Sections 10.1 and 12.1). Section 6 traces the resulting health consequences.

6 Health Impact of the Contraction

The loss of operating capacity described in Section 5 is now visible in health outcomes, most clearly in nutrition and in vaccine-preventable disease. This section reviews five domains. In each, the contraction acts alongside other drivers, so the analysis assesses contribution rather than sole causation.

6.1 Malnutrition and food insecurity

Food insecurity has risen sharply over the past year (Figure 12). The number of people in Crisis or worse (IPC Phase 3 or above) peaked at 6.5 million in February–March 2026, including 2.0 million in Emergency, IPC Phase 4 (FGS and United Nations, 2026a), and stood at 6.0 million in April–June 2026, when Burhakaba District in Bay Region was identified as at risk of famine (FSNAU, 2026). After a seasonal easing to 5.1 million in July–September 2026, still 50 per cent higher than a year earlier, the number is projected to rise again to 5.4 million in October–December 2026, including 1.48 million in Phase 4 and about 25,800 displaced people in Baidoa in Catastrophe (IPC Phase 5). The September analysis is the second consecutive analysis to identify a risk of famine, this time among Baidoa's displaced population (IPC, 2026).

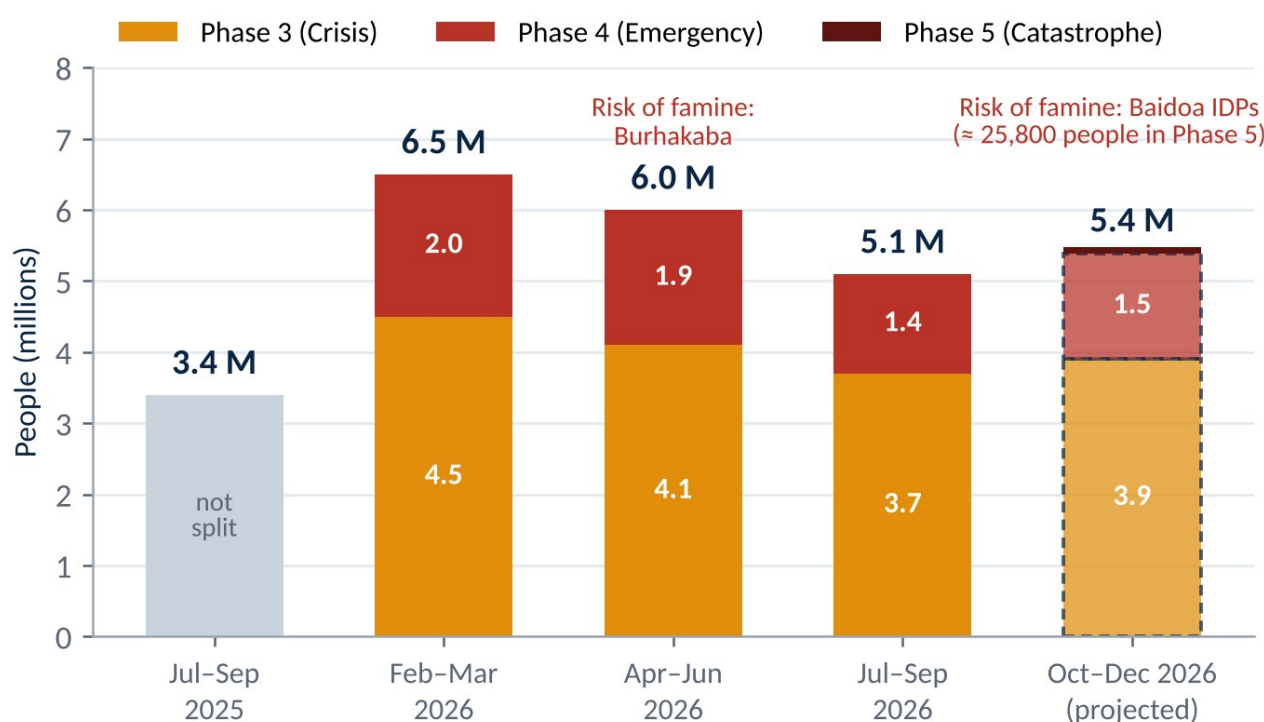


Figure 12. People in Crisis or worse (IPC Phase 3 or above), 2025–2026

Source: IPC (2026) for July–September 2025, July–September 2026 and the October–December 2026 projection; FGS and United Nations (2026a) for February–March 2026; FSNAU (2026) for April–June 2026. The July–September 2025 total is not split by phase. Values are rounded.

An estimated 1.92 million children aged 6–59 months will face acute malnutrition between July 2026 and June 2027, including 433,000 with SAM, together with 157,000 pregnant and breastfeeding women. Nineteen population groups were classified in Critical acute malnutrition (IPC Acute Malnutrition Phase 4), compared with 15 in 2022, and displaced people in Beletweyne are projected to reach Extremely Critical levels (Phase 5) (IPC, 2026). Conditions vary sharply by location. Global acute malnutrition (GAM) in Burhakaba eased from 37.1 per cent in April to 22.6 per cent in July–September 2026, still Critical, while a Médecins Sans Frontières (MSF) survey of 888 households in 14 displacement sites in Baidoa found that one child in two was acutely malnourished and one in four severely malnourished (MSF, 2026).

UNICEF reported a 32 per cent year-on-year increase, in the first half of 2026, in admissions to stabilisation centres for SAM with medical complications (UNICEF, 2026a). UNICEF's interpretation is important: the increase reflects

the loss of preventive and community-based services, so that children are identified later and arrive more severely ill. This is a direct pathway from service contraction to higher treatment intensity, cost and mortality risk. In Baidoa, MSF reported 2,890 inpatient admissions for malnutrition in 2026 by early August, 78 per cent more than in the same period of 2025 (MSF, 2026). Food assistance has contracted in parallel: humanitarian food assistance reached about 411,500 people, 2 per cent of the population, in July–September 2026 and is projected to fall to 0.5 per cent in October–December (IPC, 2026).

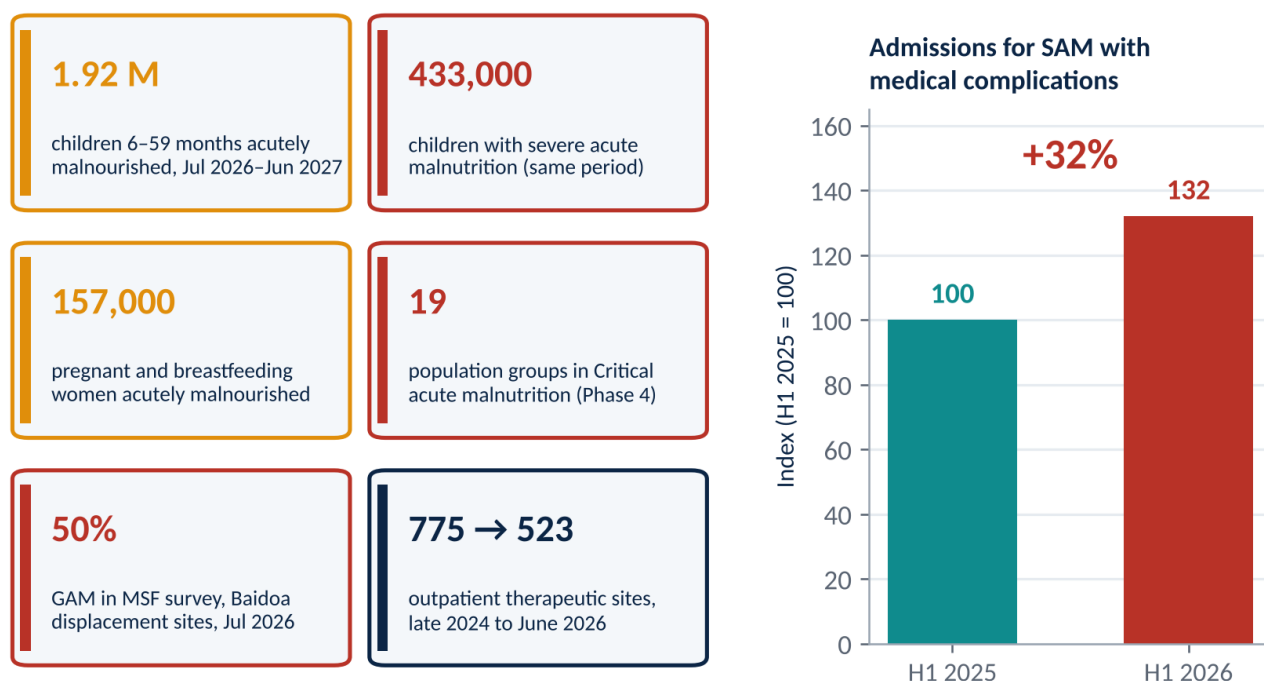


Figure 13. Acute malnutrition signals, 2026

Source: IPC (2026); MSF (2026); UNICEF (2026a, 2026b). GAM: global acute malnutrition. SAM: severe acute malnutrition.

6.2 Maternal and reproductive health

Access to skilled and emergency maternal care is limited across the continuum of care (Figure 14). In the most recent national survey, 31 per cent of women received antenatal care from a skilled provider, 32 per cent of births were attended by skilled personnel, 21 per cent of births took place in a health facility and only 11 per cent of mothers received a postnatal check within two days of birth (Directorate of National Statistics, 2020).

With a total fertility rate of 6.9 and a maternal mortality ratio of 563, facility closures, loss of midwife incentives, referral delays and supply shortages raise the probability that obstetric complications become fatal before treatment is reached.

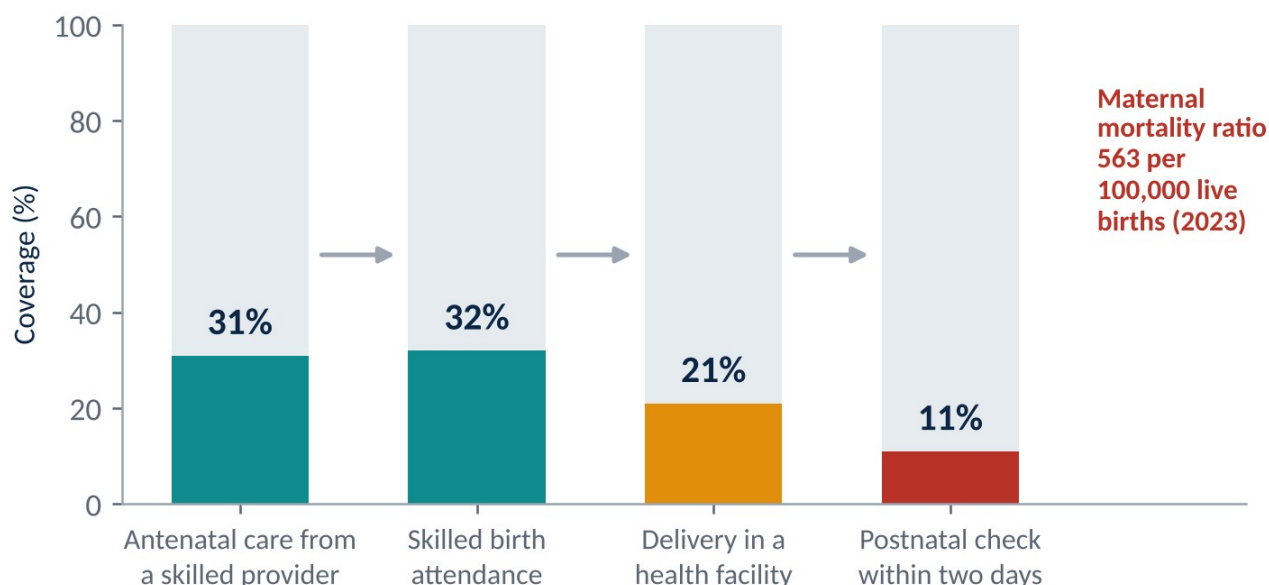


Figure 14. Coverage along the maternal and newborn continuum of care

Source: Directorate of National Statistics (2020), Somali Health and Demographic Survey 2020; MMEIG (2025) for the maternal mortality ratio.

6.3 Child health and immunisation

Routine immunisation improved markedly between 2019 and 2022 but has since plateaued below the 90 per cent programme target (Figure 15). WHO/UNICEF estimates released in July 2026 put DTP3 coverage at 72 per cent and MCV1 coverage at 61 per cent in 2025, compared with 57 per cent and 52 per cent in 2019 (WHO and UNICEF, 2026). MCV1 coverage has fallen in two of the last three years. National official estimates are higher, at 76 per cent for DTP3 and 71 per cent for MCV1 in 2024 (WHO, 2026a), and are used for programme monitoring; the WHO/UNICEF series is used in this report for trends and international comparison (Table 4).

About 1.5 million children under five were estimated to be unvaccinated in mid-2025, despite a catch-up effort that gave nearly 700,000 zero-dose children their first pentavalent dose (UNICEF Somalia, 2025). These gaps, concentrated among insecure, displaced, nomadic and hard-to-reach populations, explain why the loss of outreach (Section 5.3) carries a high outbreak risk.

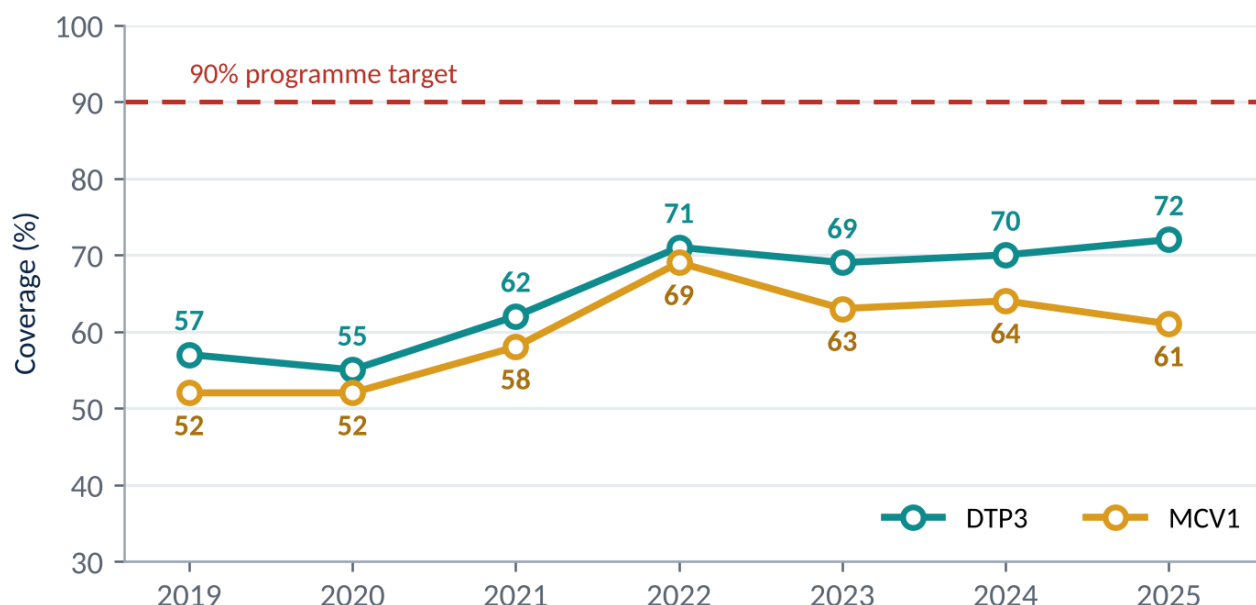


Figure 15. DTP3 and MCV1 coverage, 2019–2025, against the 90 per cent programme target

Source: WHO and UNICEF (2026), WHO/UNICEF Estimates of National Immunization Coverage, 2025 revision (released 15 July 2026), via the WHO Global Health Observatory.

6.4 Disease outbreaks

Outbreak pressure intensified in 2026 across vaccine-preventable, waterborne and vector-borne diseases (Figure 16).

Measles is the clearest current signal. Cases more than doubled between the first quarters of 2025 and 2026, from about 2,300 to 5,900 (FSNAU, 2026), and 10,108 cases with 36 deaths were reported in the first half of 2026, 77 per cent of them among children under five (UNICEF, 2026b). By mid-2026 measles was running at 259 per cent of the long-term average, with Baidoa (1,592 cases) and Burco (1,403 cases) reporting the highest numbers (IPC, 2026).

Diphtheria has spread rapidly in a largely unvaccinated population, from 838 cases and 56 deaths in 2024 (Reuters, 2025) to 3,655 cases and 143 deaths across 65 districts in 2025 (WHO, 2026a), and 2,821 cases with 73 deaths across 68 districts in the first half of 2026 alone (UNICEF, 2026b). Among cases reported up to mid-August 2025, 87 per cent had no documented diphtheria vaccination and 56 per cent were children under five (Hussein et al., 2025).

Acute watery diarrhoea (AWD) and cholera remain endemic. Reported cases fell from 18,304, with 46 deaths, in 2023 (OCHA, 2024) to 9,003, with 9 deaths, in 2025 (WHO, 2026d), but diarrhoeal disease was running at 142 per cent of the long-term average in mid-2026 (IPC, 2026), and the Deyr floods create a high risk of resurgence. **Malaria** cases rose by 59 per cent, from 8,080 in 2024 to 12,847 in 2025, and dengue cases from 355 to 1,225 (WHO, 2026a).

These changes are not attributed to funding alone. Low baseline vaccination coverage, climate stress, displacement, water insecurity, conflict and supply constraints are also material drivers.

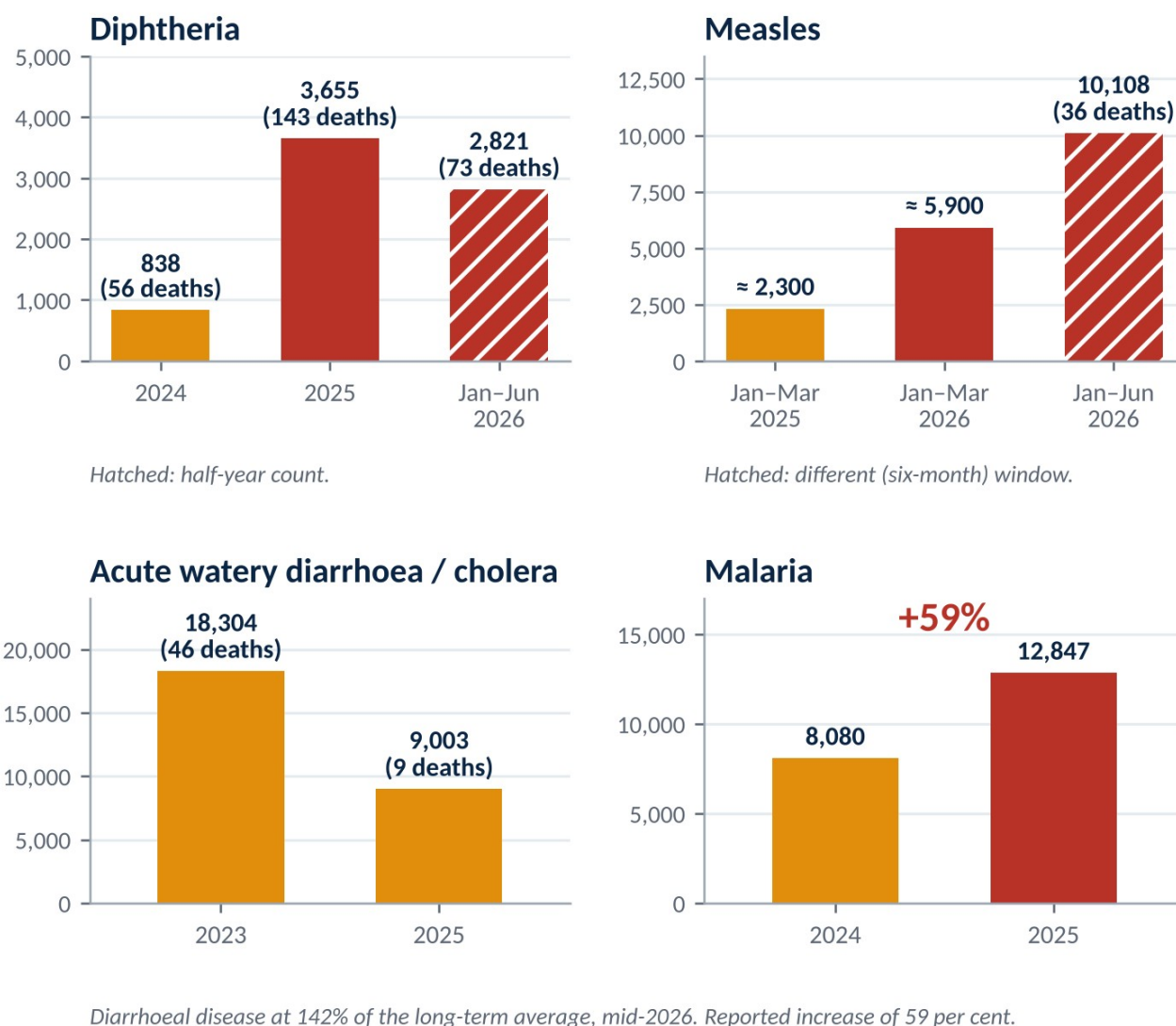


Figure 16. Disease outbreak dashboard: diphtheria, measles, AWD/cholera and malaria

Source: Reuters (2025) for diphtheria in 2024; WHO (2026a) for diphtheria and malaria in 2025; UNICEF (2026b) for January–June 2026; FSNAU (2026) for first-quarter measles; OCHA (2024) and WHO (2026d) for AWD/cholera. Time windows and case definitions differ; values are not causal estimates.

6.5 Mental health and psychosocial support

No robust national estimate of mental health prevalence or service coverage is available. This absence is a data gap, not evidence of low need. Conflict, displacement, drought, flooding, bereavement, food insecurity and lost livelihoods create a substantial psychosocial burden, and funding reductions also threaten protection services, case management and community support.

The national shock dashboard should therefore track mental health and psychosocial support (MHPSS) service points, referrals, trained providers, medicine availability and continuity of care for people with severe mental illness (Section 12.1).

Policy implication →

The heaviest health consequences fall on nutrition, maternal and newborn care, and vaccine-preventable disease. These three domains should anchor the essential service floor (Section 10.1). Section 7 assesses what these changes mean for universal health coverage.

7 Universal Health Coverage Under Stress

UHC has three linked dimensions: people receive the services they need, those services are of sufficient quality, and people are protected from financial hardship. The current crisis affects all three. Somalia entered the shock with low service coverage and high reliance on out-of-pocket payment. The aid contraction now threatens to reduce the number and reach of services while raising the cost of seeking care.

7.1 Service coverage

The UHC service coverage index stood at 30 in 2023 (Section 3.1). The 380 health facilities closed or scaled back, the 30 per cent reduction in health and nutrition coverage, the fall in treatment coverage for moderate acute malnutrition, halted mobile vaccination and rising late presentation are direct indicators of lost effective coverage in 2026.

Coverage can fall before the national index is updated. Operational changes in 2026 will appear in internationally comparable series only after reporting and validation cycles are complete.

7.2 Financial protection

Out-of-pocket spending accounted for 30.8 per cent of CHE in 2023, down from 45.0 per cent in 2019, but out-of-pocket spending per person rose over the same period (Section 3.3). A survey of 2,000 households in 2023–2024 found that only 3.5 per cent of individuals had any form of health insurance; that 24 per cent of households incurred catastrophic health expenditure above 10 per cent of income, and 6 per cent above 25 per cent; and that 70 per cent of households used coping strategies such as borrowing (50 per cent) or selling assets (30 per cent) to pay for care (Mohamud et al., 2025). As externally financed free services close, these burdens are likely to rise.

7.3 Equity and access

The burden of retrenchment is unevenly distributed. The groups at greatest risk are children under five, pregnant women, people with severe malnutrition, internally displaced persons (IDPs), rural and pastoral communities, and populations in insecure, flood-exposed or famine-risk districts.

The loss of outreach and local facilities increases travel time and transport costs. Delayed care, in turn, shifts cases from prevention and primary care towards emergency and referral services, where treatment is costlier and outcomes are worse.

7.4 Evidence of UHC reversal

The defining feature of the crisis is not only deteriorating health outcomes but the contraction of the system that delivers services. Facility closures, workforce disruption, shrinking outreach, weakened surveillance and supply chains, and rising severe presentations together indicate a reversal of underlying UHC capacity rather than simple stagnation. The mechanism is set out in Section 8.1 (Figure 17).

7.5 Divergent data series and reporting conventions

Table 4 records each case in which credible sources report different values for the same or a closely related indicator, together with the convention used in this report. It is the single reference point for the rules in Section 1.4.

Table 4. Divergent data series and the conventions used in this report

Indicator	Value or series A	Value or series B	Convention in this report
External financing	54.4% of CHE (2023, national health accounts)	About 95% of the health budget (WHO, 2026b)	Different denominators; each is labelled separately
Out-of-pocket spending	30.8% of CHE (2023)	45.0% of CHE (2019), cited as 44.9% in Mohamud et al. (2025)	Different reference years; 2023 value used; the falling share reflects higher external funding
DTP3 and MCV1 coverage	72% and 61% (2025, WHO/UNICEF estimates)	76% and 71% (2024, national official estimates)	WHO/UNICEF series used for trends and comparison; national estimates for programme monitoring
Facility status	205 closed (UNICEF, August 2026)	380 closed or scaled back (January–June 2026); up to 618 at risk (scenario); up to 2,000 affected (Government)	Not added; closed, scaled back, at risk and affected are distinct categories
Children with SAM	433,000 (July 2026–June 2027, IPC, September 2026)	483,000–493,000 (earlier 2026 projections)	Latest IPC estimate used; each figure cited with its period
People in IPC Phase 3 or above	5.1 million (July–September 2026); 5.4 million projected (October–December 2026)	6.0–6.5 million (February–June 2026)	Different analysis periods; presented as a seasonal series (Figure 12)
Diphtheria, 2025	More than 1,600 cases and 87 deaths (to mid-August 2025)	3,655 cases and 143 deaths (full year)	Full-year WHO figure used; partial counts cited with their window
Humanitarian funding, 2025	27.0% of a revised US\$1.32 billion (January 2026)	28.8% of US\$1.42 billion (May 2026)	Latest figures used; plan totals are revised as late contributions are recorded
People in need, 2026	4.8 million (HNRP, January 2026)	About 6 million (UNICEF mid-year review)	Both reported with dates; the HNRP applies a stricter definition
United States assistance, FY2025	US\$149 million (Reuters, August 2025, part-year)	US\$212 million obligated (USAFacts, September 2026)	Fully reported figure used; the decline from FY2024 is about 72%

Source: As cited in each row; OCHA (2026); IPC (2026); UNICEF (2026a, 2026b); WHO (2026a, 2026b, 2026e); WHO and UNICEF (2026); Reuters (2025); USAFacts (2026).

Policy implication →

Because 2026 effects will not appear in comparable UHC series for some time, Government needs its own near-real-time indicators of effective coverage and financial hardship (Section 12.1). Section 8 draws the evidence together into a system-level diagnosis.

8 From Humanitarian Shock to Systemic Crisis

The current pattern is best understood as a systemic crisis. The financing shock is affecting the functions that keep the whole system operating, not only individual programmes.

8.1 Causal pathway

The most credible causal interpretation is a contribution pathway (Figure 17). Donor withdrawal reduced operating resources. Those resources sustain facilities, staff, outreach, commodities and surveillance. Their loss reduced access and delayed care, and delayed care increased severity and pressure on the remaining services.

A negative feedback loop intensifies the pathway. As service points close, households travel farther and present later. More severe illness raises the cost and complexity of care. Higher costs and lower coverage reduce the number of people who can be treated, while outbreaks, malnutrition and flooding increase demand further.

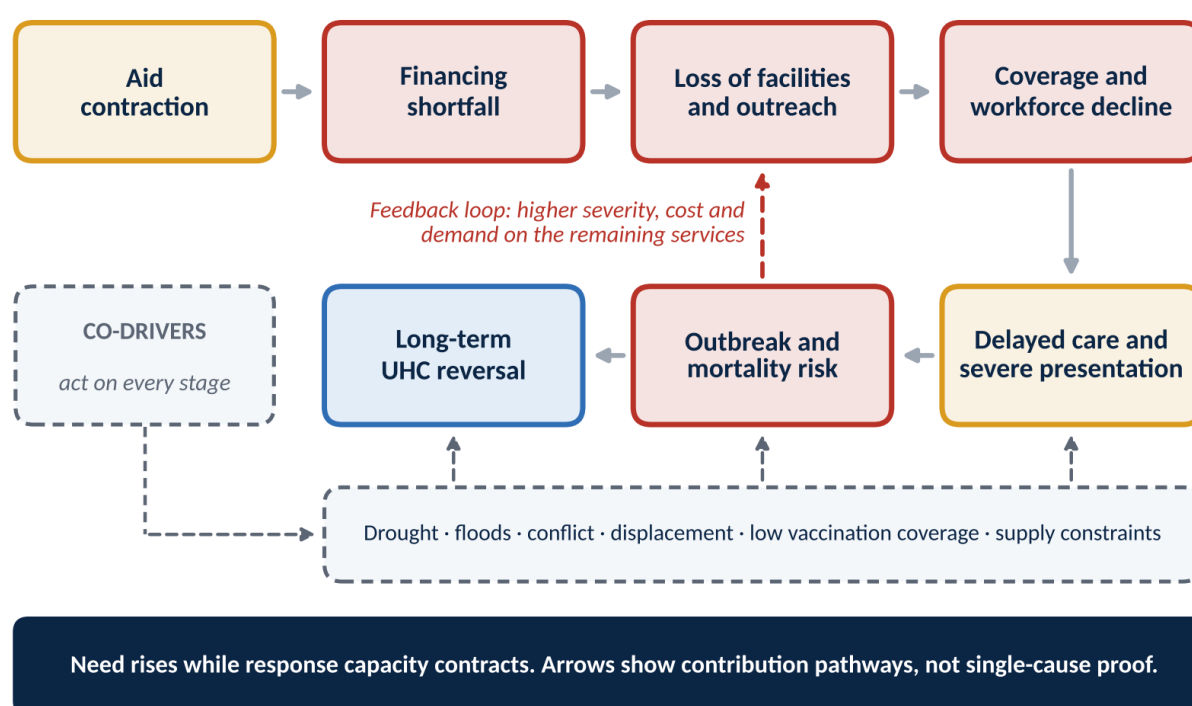


Figure 17. Operational pathway from aid contraction to UHC reversal risk

Source: Analytical synthesis of the evidence in this report. Arrows indicate contribution pathways, not single-cause proof.

8.2 What the evidence can establish

Table 5 grades the principal causal claims against the available evidence. The grading is deliberately conservative, so that policy messages remain defensible under scrutiny.

Table 5. Assessment of principal causal claims

Claim	Assessment	Supporting evidence	Limitation
Aid cuts contributed to facility closures and reduced coverage	High contribution confidence	UNICEF links the 205 closures and part of the 30% reduction to funding cuts; sector reporting links 380 health-facility closures or scale-backs to funding constraints	Exact denominators and state distribution are unpublished
Aid cuts stopped mobile vaccination outreach	High for reported operations	Statement by the Minister of Health and Human Services (Reuters, 2025); discontinued NGO mobile services	No public national count of stopped team-days
Aid cuts increased severe late presentation	Moderate to high	UNICEF links the loss of preventive services to the 32% rise in complicated SAM admissions	No national individual-level causal dataset
Aid cuts caused the measles and diphtheria surges	Not supported as sole cause	Outreach and response capacity were constrained after the cuts	Immunity gaps, displacement, conflict and vaccine shortages also matter
National health spending fell by a known percentage	Not estimable	Funding and commitment figures fell	Comparable national health accounts end in 2023
The licensed workforce fell by more than 6,000	Not established	Government statement reported by the Associated Press	Cadre scope and an active post-cut census are unavailable

Source: Report analysis; UNICEF (2026a); IPC (2026); Reuters (2025); Associated Press (2025).

8.3 Current system diagnosis

Four structural features define the system's current state:

- **Service delivery** is thin, uneven and dependent on external operating finance.
- **The workforce** is far below the needs-based benchmark, and project-funded job losses threaten both the number and the geographic distribution of workers.
- **Financing** is fragmented, with recurrent inputs often tied to short-term programmes.
- **Governance and information systems** do not yet provide a single facility-level view linking money, active staff, commodities, service volumes and outcomes.

This information gap is itself a management risk. It slows prioritisation precisely when resources are contracting.

Policy implication →

A systemic crisis requires a systemic response. Additional funding must be accompanied by changes in how resources are pooled, how services are purchased and how performance is monitored (Sections 10–12). Section 9 first identifies where the response should be concentrated.

9 Priority Geographic Hotspots

The available evidence identifies convergence zones rather than a complete district ranking. Figure 18 shows where nutrition and famine risk, outbreaks, access constraints, displacement, drought or flooding, and service disruption overlap, based on the most recent IPC, agency and surveillance reporting. These areas should be treated as priority zones for monitoring and continuity planning, subject to validation through a current facility and surveillance register. Table 6 specifies the immediate monitoring indicators for each zone.

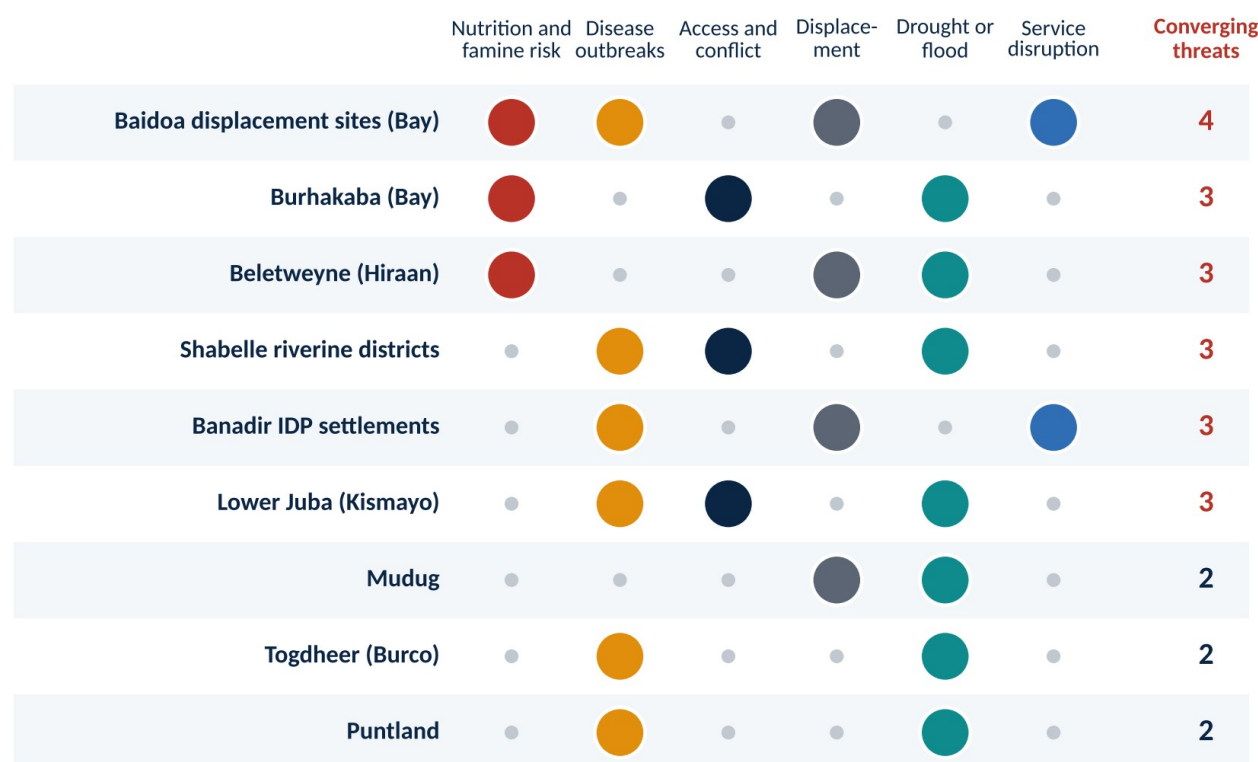


Figure 18. Threat convergence in priority geographic hotspots

Source: Derived from IPC (2026), FSNAU (2026), MSF (2026), WHO (2026a), Hussein et al. (2025) and the signals summarised in Table 6. Indicative only; requires district-level validation.

Table 6. Priority hotspots and immediate monitoring indicators

Hotspot	Current threat convergence	Immediate monitoring indicators
Baidoa displacement sites (Bay)	Risk of famine in October–December 2026, with about 25,800 people projected in IPC Phase 5; one child in two acutely malnourished in MSF survey; 1,592 measles cases; 37 health and nutrition sites closed in and around Baidoa in 2025	GAM and SAM admissions, stabilisation capacity, measles alerts, water access and facility status
Burhakaba (Bay)	GAM of 22.6% (Critical), down from 37.1% in April 2026; access constraints and agropastoral drought	GAM, SAM admissions, referral time and facility status
Beletweyne (Hiraan)	Displaced people projected to reach Extremely Critical acute malnutrition; an estimated 213,700 people likely to be displaced by flooding	Flood alerts, displacement, nutrition caseload and functional facilities
Shabelle riverine districts	Riverine flood exposure, AWD/cholera transmission and access constraints	AWD cases, water quality, outreach reach and oral cholera vaccine readiness

Hotspot	Current threat convergence	Immediate monitoring indicators
Banadir IDP settlements (including Daynile)	Population density, AWD/cholera foci, staff losses at referral hospitals and referral pressure	Water access, AWD cases, facility load and response time
Lower Juba (Kismayo)	Cholera foci, large unreached child populations, access constraints and riverine flood exposure	DTP3 and MCV1 coverage, zero-dose children, outreach sessions and outbreak alerts
Mudug	Highest displacement of any region in early 2026 (107,300 people in January–March); drought	Displacement, nutrition screening and mobile team reach
Togdheer (Burco)	Measles outbreak (1,403 cases, among the highest reported); drought and flash floods	Measles alerts, MCV coverage and facility continuity
Puntland	Among the areas most affected by diphtheria in 2025; at least four of the seven cVDPV2 cases reported nationally in 2024 were in Bari; below-average Gu rains in the north	Diphtheria alerts, vaccination coverage and surveillance completeness

Source: IPC (2026); FSNAU (2026); MSF (2026); Hussein et al. (2025); WHO (2026a); Associated Press (2025). Geographic designations follow the source documents.

Policy implication →

Continuity resources should be allocated first to zones where three or more threats converge, subject to district-level validation, and flood preparedness should be front-loaded in riverine districts before the peak of the Deyr rains (Section 10.1).

10 Strategic Policy Options

The evidence in Sections 3–9 leads to one overarching objective: halt the contraction of essential services while building a financing and purchasing system that is less exposed to external shocks. The options below are organised across three horizons (Figure 19). Each is linked to the finding it addresses, so that every recommendation remains traceable to the evidence.

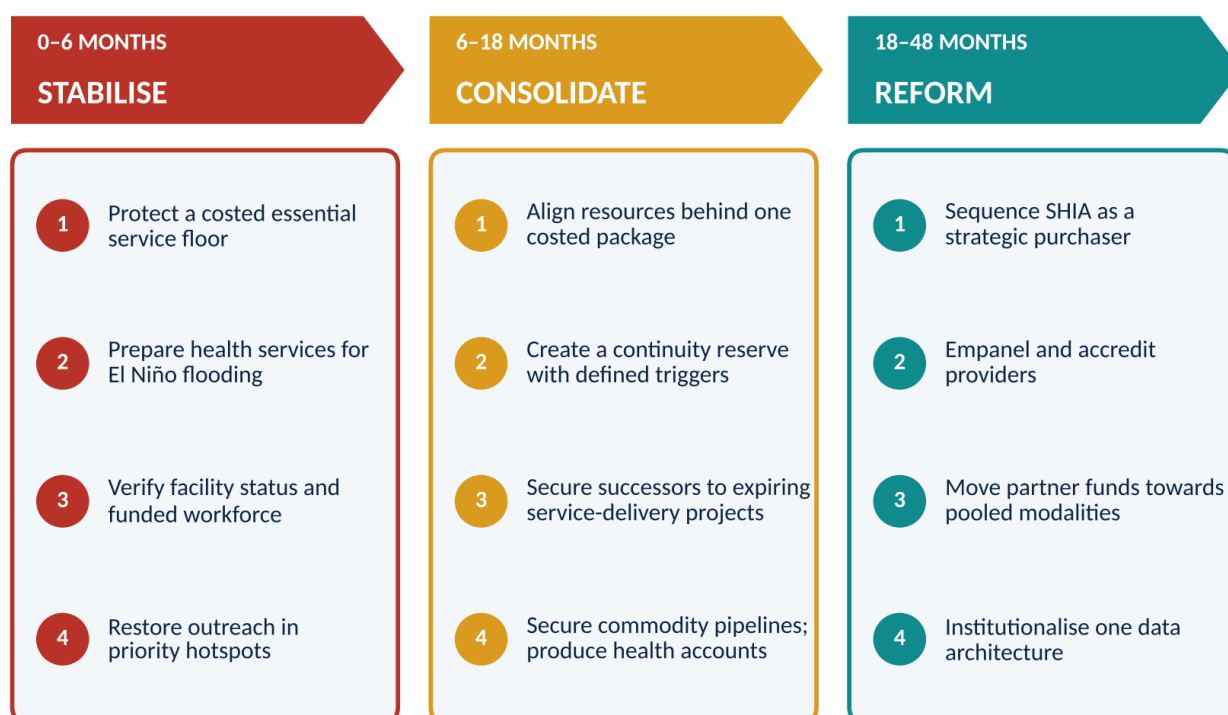


Figure 19. Policy roadmap across three time horizons

Source: Report analysis based on the findings in Sections 3–9.

10.1 Immediate priorities (0–6 months): stabilise

The first horizon focuses on preventing further loss of essential capacity, particularly in the functions and places identified in Sections 5, 6 and 9, and on preparing services for the Deyr floods.

Table 7. Immediate priorities, 0–6 months

Priority action	Evidence addressed	Milestone indicator
Define and cost a minimum national essential service floor drawn from the Essential Package of Health Services (EPHS): SAM treatment, routine immunisation and outbreak response, emergency obstetric and newborn care with referral, and AWD/cholera treatment	380 facilities closed or scaled back; +32% complicated SAM admissions; maternal mortality ratio of 563 (Sections 5.1 and 6)	Floor defined, costed and endorsed by Government and partners
Activate El Niño flood preparedness for health: pre-position cholera kits, RUTF and essential medicines, protect the cold chain and plan alternative access routes	2.5–3.5 million people exposed to flooding (Section 2.2)	Supplies pre-positioned in flood-prone districts before the peak rains

Priority action	Evidence addressed	Milestone indicator
Establish a verified facility status register (open, reduced, closed, at risk) using unique facility identifiers	Non-comparable closure figures (Section 5.1)	Monthly register published, disaggregated by state and district
Protect frontline workers delivering floor services through a verified roster of funded posts, including posts financed by closing projects	More than 6,000 reported job losses; 3.81 workers per 10,000; 3,918 project-paid posts (Sections 3.2 and 5.2)	Share of floor-service posts verified and paid on time
Restore integrated outreach (immunisation, nutrition screening and antenatal care) in priority hotspots	Halted mobile teams; MCV1 at 61%; measles surge (Sections 5.3, 6.3, 6.4 and 9)	Outreach sessions held against plan; zero-dose children reached
Channel residual and flexible partner funding through a coordinated continuity mechanism	Fragmented project financing (Section 4.4)	Share of partner funding aligned with the floor
Introduce monthly cash-to-service tracking	Post-cut spending not estimable (Section 8.2)	Monthly report linking funds received to services delivered
Apply evidence-class labelling to all Cabinet briefs and partner appeals	Risk of presenting scenarios as counts (Section 5.5)	Standard evidence labels adopted

Priorities are ordered by urgency. Milestones are proposed for adoption by the sector coordination mechanism. EPHS: Ministry of Health and Human Services (2020).

10.2 Short-term priorities (6–18 months): consolidate

The second horizon converts emergency measures into predictable arrangements and closes the most material data gaps.

Table 8. Short-term priorities, 6–18 months

Priority action	Evidence addressed	Milestone indicator
Align domestic and external resources behind one costed essential package	External sources finance 54.4% of CHE (Section 3.3)	Joint financing plan adopted
Establish a health system continuity reserve with predefined activation triggers	Funding volatility, 2022–2026 (Section 4)	Reserve capitalised; triggers approved
Increase and protect the domestic allocation to essential services through a dedicated budget line	US\$3.17 per person (2023); proposed FY2026 Ministry allocation of 3.1% of planned federal expenditure (Section 3.3)	Allocation and execution rate of the essential-service line
Secure successor financing for expiring service-delivery projects without a service gap	Damal Caafimaad scheduled to close (Section 4.3)	Successor financing approved; no break in supported services
Produce national health accounts for 2024–2025	Comparable accounts end in 2023 (Annex 3)	Health accounts published
Conduct a national active-workforce census linked to payroll and licensing	Workforce figures not comparable (Section 5.2)	Census completed; roster integrated with payroll

Priority action	Evidence addressed	Milestone indicator
Secure commodity pipelines for RUTF, vaccines and essential medicines	Projected therapeutic food pipeline breaks (Section 5.4)	Tracer-commodity stock-out rate
Strengthen surveillance completeness so that falling case reports are interpreted correctly	Detection capacity at risk (Section 5.4)	Reporting completeness and timeliness

The Abuja Declaration commitment to allocate at least 15 per cent of government expenditure to health remains the regional reference point for the health budget share (African Union, 2001).

10.3 Medium-term priorities (18–48 months): reform

The third horizon addresses the structural causes of vulnerability identified in Sections 4.4 and 8.3, with social health insurance sequenced as described in Section 11.

Table 9. Medium-term priorities, 18–48 months

Priority action	Evidence addressed	Milestone indicator
Develop SHIA as a strategic purchaser through gated stages	Low pooling; 3.5% of surveyed individuals insured (Sections 7.2 and 11)	Stage gates met and published
Link provider empanelment to accreditation and quality standards	18.5% of facilities accredited (Section 3.4)	Share of empanelled providers meeting standards
Shift external financing from projects towards pooled, on-budget or on-plan modalities	Fragmentation (Section 4.4)	Share of external health funding pooled
Finance subsidised enrolment for poor and displaced households	24% of surveyed households face catastrophic spending (Section 7.2)	Coverage of subsidised priority groups
Implement a costed human resources for health strategy	Workforce density at 8.6% of the benchmark (Section 3.2)	Density trend by state
Institutionalise one operational data architecture	Information gap (Section 8.3)	Integrated dashboard in routine use (Section 12)

10.4 Risk heat map

Figure 20 presents an indicative assessment of the principal risks to essential service continuity over the next 12 months. Ratings are expert judgements derived from the evidence in this report and should be validated and updated quarterly through the national sector coordination mechanism.

Six risks score 16 or more on the five-by-five scale: further closures towards the 618-facility scenario (R1), escalating outbreaks (R2), El Niño flooding and displacement (R9), a break in the nutrition, vaccine or medicine pipeline (R3), the loss of frontline workers (R4) and surveillance blind spots (R5). Flood risk has risen sharply since mid-2026 and should drive the immediate preparedness measures in Table 7.

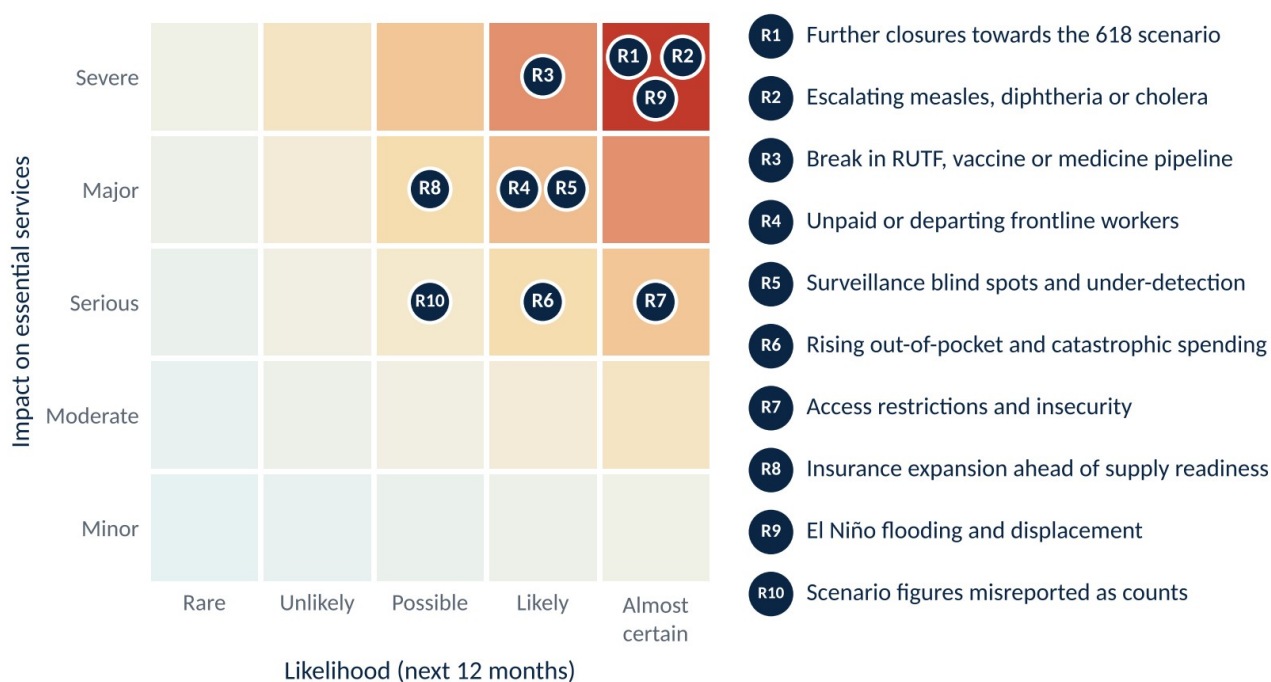


Figure 20. Indicative risk heat map for essential service continuity

Source: Report analysis. Likelihood and impact are rated on five-point scales; ratings require validation.

11 Social Health Insurance and Health Financing Reform

Social health insurance (SHI) is a medium-term instrument for pooling resources, purchasing services strategically and protecting households from financial hardship. It is not a substitute for the immediate continuity measures in Section 10.1. Insurance cannot compensate for closed facilities, absent staff or empty medicine shelves; its value depends on the supply side from which it purchases.

11.1 Current status and legal basis

The **Social Health Insurance Authority (SHIA)** is the legal name of the national social health insurance institution under Prime Minister's Decree Lr206. The decree supersedes earlier designations (NSHIA and NHIA), which this report uses only for historical reference.

Within national planning, SHIA leads five health-financing outputs under Enabler 6 (Health Financing) of the operationalisation logframe for the National Transformation Plan (NTP) 2025–2029, being developed with the Office of the Prime Minister (Federal Government of Somalia, 2025):

- health insurance schemes piloted, scaled and integrated with humanitarian financing;
- a national health financing and UHC coordination platform;
- a Shariah-compliant Islamic social finance framework;
- primary health care financing and strategic purchasing, co-led with the planning and policy function; and
- diaspora health financing mechanisms.

Population coverage remains very low: only 3.5 per cent of individuals in a 2023–2024 household survey reported any form of health insurance (Section 7.2).

11.2 Sequencing strategy

SHI should be introduced through five gated stages (Figure 21). Progression to each stage depends on meeting explicit conditions in the stage before, so that coverage never runs ahead of the capacity to deliver and pay for services.

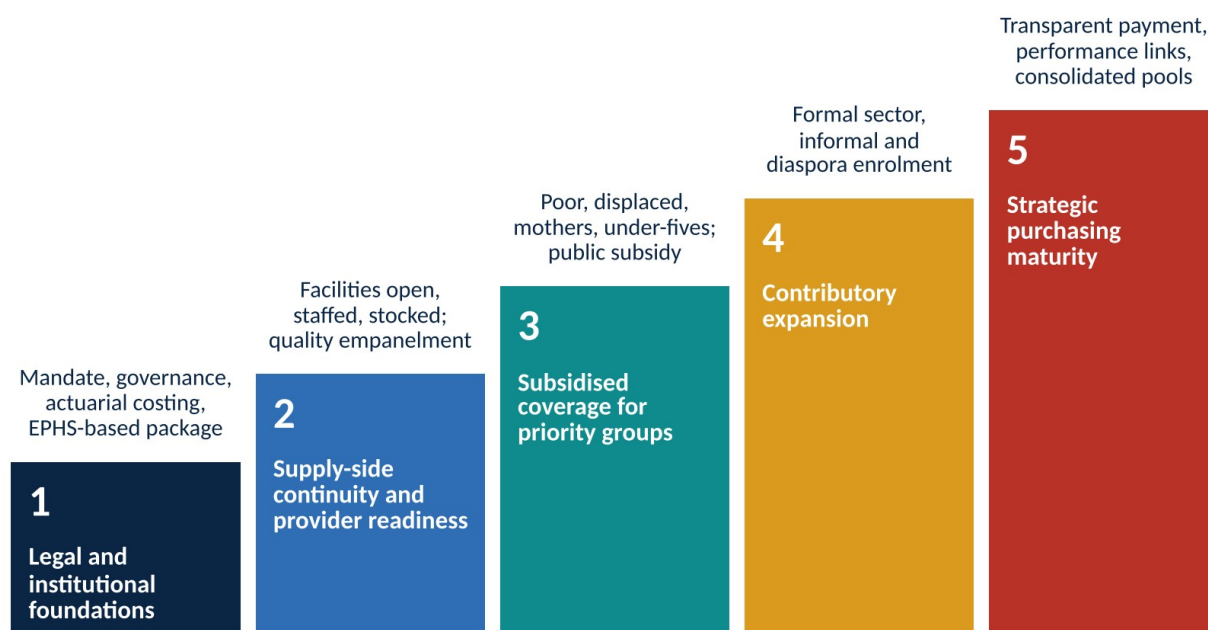


Figure 21. Gated sequencing of social health insurance

Source: Report analysis consistent with the priority actions in the Executive Summary.

- 1. Legal and institutional foundations:** mandate, governance, actuarial costing and a benefit package derived from the EPHS. *Gate:* regulations approved and benefit package costed.
- 2. Supply-side continuity and provider readiness:** facilities open, staffed and stocked, with empanelment against quality criteria. *Gate:* sufficient empanelled providers in pilot areas.
- 3. Subsidised coverage for priority groups:** poor and displaced households, pregnant women and children under five, financed through public and pooled partner subsidies. *Gate:* verified enrolment and claims-processing capacity.
- 4. Contributory expansion:** mandatory formal-sector contributions, with voluntary and subsidised enrolment for informal-sector and diaspora-linked households. *Gate:* contribution compliance and fund sustainability.
- 5. Strategic purchasing maturity:** transparent provider payment, performance links and consolidated pools.

11.3 Governance requirements

Public confidence in SHI will depend on governance being visible from the outset. The minimum requirements are:

- clear separation of purchaser, provider and regulator functions;
- board oversight, fiduciary controls and independent external audit;
- published provider payment rules, tariffs and claims performance;
- accreditation-linked empanelment building on the HHFA quality baseline;
- grievance redress and beneficiary feedback mechanisms;
- protection of member and claims data;
- defined coordination arrangements between the Federal Government and Federal Member States; and
- Shariah governance for Islamic social finance instruments.

11.4 Financing reform priorities

- **Domestic financing:** raise and protect public financing for health, which stood at US\$3.17 per person and 7.9 per cent of general government expenditure in 2023; the proposed FY2026 allocation to the Ministry of Health and Human Services is 3.1 per cent of planned federal expenditure.
- **Pooling:** consolidate fragmented pools and channel partner resources through common purchasing arrangements where feasible.
- **Subsidies:** ring-fence subsidies for poor, displaced and other priority groups.
- **Islamic social finance:** mobilise zakat, waqf and takaful as complementary resources under a Shariah-compliant framework, not as substitutes for public financing.
- **Diaspora:** develop diaspora health financing mechanisms.
- **Financial protection:** reduce reliance on out-of-pocket payments (30.8 per cent of CHE in 2023) as pooled coverage expands.
- **Public financial management:** ensure that allocations translate into timely budget execution at facility level.

Policy implication →

SHIA's credibility will rest on sequencing. The Authority should purchase services that exist, for populations it can verify, under rules it publishes.

12 Monitoring, Accountability and Data Architecture

Effective prioritisation during a contraction requires timely, comparable information. This section sets out a minimum dashboard, the data quality rules that govern it and the accountability mechanisms that give it force.

12.1 Minimum National Shock Dashboard

The dashboard should be built around a single facility master list with unique identifiers, to which funding, staffing, commodity, service and surveillance data are linked (Figure 22). Table 10 specifies the minimum indicator set.

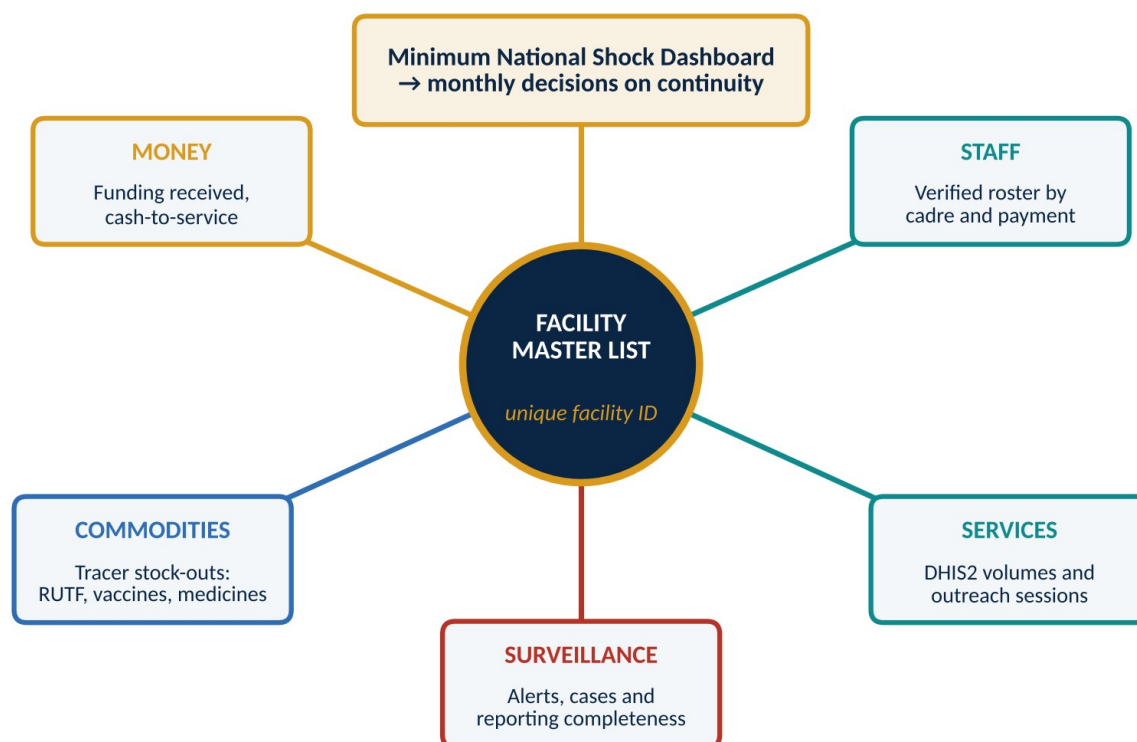


Figure 22. Proposed facility-centred data architecture

Source: Report analysis. DHIS2: District Health Information Software 2. RUTF: ready-to-use therapeutic food.

Table 10. Minimum National Shock Dashboard: indicator set

Domain	Indicator	Frequency	Primary source
Facilities	Operating status: open, reduced, closed, at risk	Monthly	Facility master list
Services	Outpatient visits, antenatal visits, deliveries and SAM admissions	Monthly	DHIS2
Nutrition	Complicated SAM admissions and stabilisation-centre capacity	Monthly	Nutrition Cluster
Outreach	Outreach sessions held against plan; zero-dose children reached	Monthly	Expanded Programme on Immunization

Domain	Indicator	Frequency	Primary source
Immunisation	DTP3 and MCV1 administrative coverage	Monthly	DHIS2 and immunisation programme
Surveillance	Alerts and response time for measles, diphtheria and AWD/cholera; reporting completeness	Weekly	IDSR
Climate and flooding	Flood alerts, facilities affected and displacement in flood-prone districts	Weekly in season	Somali Disaster Management Agency (SoDMA) and Health Cluster
Workforce	Active funded posts by cadre and payment status	Monthly	Verified roster and payroll
Commodities	Stock-outs of tracer items (RUTF, vaccines, essential medicines)	Monthly	LMIS
Finance	Funds received against requirement; cash-to-service ratio	Monthly	OCHA FTS; Ministry of Finance
Financial protection	Out-of-pocket share; catastrophic health spending	Annual	Household survey; health accounts
MHPSS	Service points, referrals and trained providers	Quarterly	Programme reporting

IDSR: Integrated Disease Surveillance and Response. LMIS: logistics management information system. FTS: Financial Tracking Service.

12.2 Data quality rules

The following rules extend the conventions in Section 1.4 to routine monitoring:

1. Every value carries its source, reference period and evidence class.
2. Divergent series are shown side by side, never averaged.
3. Non-comparable figures are neither added nor subtracted.
4. Missing data are reported as missing, not as zero.
5. Scenarios are labelled as scenarios in every table, chart and brief.
6. Case counts are always accompanied by reporting completeness.
7. Facility definitions are harmonised across sources through the master list.
8. Denominators are published alongside every coverage estimate.

12.3 Accountability mechanisms

- A quarterly public health system continuity report, presented to the Council of Ministers and the relevant parliamentary committee.
- A joint Government-partner review of the essential service floor and the continuity reserve.
- Independent verification of reported closures and workforce figures.
- Publication of funding flows by source, channel and state.
- Community scorecards and feedback mechanisms in priority hotspots.
- SHIA purchasing and claims reports, once operations begin.

13 Conclusion

Somalia's health sector is experiencing not simply a humanitarian funding shortfall but a progressive contraction of essential health system capacity. The simultaneous occurrence of a financing collapse, facility closures, reduced service coverage, workforce disruption, severe malnutrition, renewed famine risk and disease resurgence points to systemic retrenchment, and the approaching Deyr floods add a further, foreseeable shock.

The evidence is strongest for the loss of operational capacity. It is weaker for attributing every outcome to financing alone: drought, flooding, conflict, displacement, vaccine gaps and supply constraints are significant co-drivers. This distinction does not weaken the case for action; it makes the case more credible.

Without rapid stabilisation, Somalia risks losing the fragile gains in service coverage of the past two decades and deepening household financial hardship. The immediate response should protect an essential service floor and the populations most exposed to preventable mortality, and prepare health services for flooding. The medium-term response should align domestic and external resources behind a costed package, establish a continuity reserve, secure successors to expiring projects and create one operational data architecture. In the longer term, social health insurance should serve as a strategic purchaser and an instrument of financial protection, sequenced only once its legal, financing, provider and accountability foundations are credible.

Final policy message

Somalia should treat health system continuity as a national resilience and social protection priority. Preventing further contraction is less costly and more equitable than rebuilding services after closures, workforce losses and outbreaks have become entrenched.

Annex 1 Executive Indicator Register

This register brings together the headline indicators used in the report. Each value retains its reference period and evidence status.

Table A1. Executive indicator register

Domain	Indicator	Latest value	Period	Evidence status
Population	Total population	19.7 million	2025	Estimated
Poverty	Population below the national poverty line	49.5%	2025	Estimated
Displacement	Internally displaced persons	About 3.3 million	June 2026	Reported
Displacement	People newly displaced	728,800	Jan–Jun 2026	Reported
Food security	People in IPC Phase 3 or above	5.1 million (5.4 million projected)	Jul–Sep 2026 (Oct–Dec 2026)	Estimated; projection
Food security	People in IPC Phase 5 (Baidoa IDPs)	About 25,800	Oct–Dec 2026	Projection
Nutrition	Children aged 6–59 months acutely malnourished	1.92 million	Jul 2026–Jun 2027	Projection
Nutrition	Children with SAM	433,000	Jul 2026–Jun 2027	Projection
Nutrition	Complicated SAM admissions	+32% year on year	H1 2026	Observed
Nutrition	Outpatient therapeutic programme sites	523 (775 in late 2024)	June 2026	Reported
Financing	Humanitarian plan funded	31% of US\$852 million	8 Sep 2026	Reported
Financing	External share of CHE	54.4%	2023	Estimated (health accounts)
Financing	Out-of-pocket share of CHE	30.8%	2023	Estimated (health accounts)
Financing	Domestic government health spending per person	US\$3.17	2023	Derived
Financing	Health share of general government expenditure	7.9%	2023	Estimated (health accounts)
Financing	Proposed Ministry of Health allocation	US\$42.2 million (3.1% of planned expenditure)	FY2026	Reported (proposed)
Financing	Health budget dependent on external financing	About 95%	2026	Reported

Domain	Indicator	Latest value	Period	Evidence status
Service delivery	Health and nutrition facilities confirmed closed	205	21 Aug 2026	Observed
Service delivery	Health facilities closed or scaled back	380	Jan–Jun 2026	Reported
Service delivery	Health facilities at risk under severe funding	Up to 618	2026	Scenario
Service delivery	Health and nutrition coverage reduction	30%	2026	Reported
Workforce	Doctors, nurses and midwifery personnel	7,226; 3.81 per 10,000	2024	Estimated; derived density
Maternal health	Maternal mortality ratio	563 per 100,000 live births	2023	Modelled
Maternal health	Births attended by skilled personnel	32%	SHDS 2020	Observed (survey)
Child health	Under-five mortality rate	101 per 1,000 live births	2024	Modelled
Newborn health	Neonatal mortality rate	34 per 1,000 live births	2024	Modelled
Immunisation	DTP3 and MCV1 coverage	72% and 61%	2025	Estimated (WHO/UNICEF)
Outbreaks	Measles cases (deaths)	10,108 (36)	Jan–Jun 2026	Reported
Outbreaks	Diphtheria cases (deaths)	2,821 (73)	Jan–Jun 2026	Reported
UHC	UHC service coverage index	30	2023	Estimated
Insurance	Individuals with any health insurance	3.5%	2023–2024 survey	Observed (survey)
Financial protection	Households with catastrophic spending (above 10% of income)	24%	2023–2024 survey	Observed (survey)
Climate	People exposed to El Niño flooding	2.5–3.5 million	Oct–Dec 2026	Scenario

Evidence status shading: teal = observed or estimated; gold = reported operational figure; red = projection or scenario; blue-grey = derived comparison. Sources as cited in the main text.

Annex 2 Standardised Terminology and Abbreviations

A2.1 Defined terms

Table A2. Standard use of defined terms

Term	Standard use in this report
Health system retrenchment	Measurable contraction of the service delivery platform, workforce, outreach, commodities or surveillance capacity
Service delivery contraction	Reduced availability, reach, operating days or coverage of health and nutrition services
Essential service floor	The minimum costed set of services, drawn from the EPHS, that must be protected during a financing shock
Universal health coverage (UHC)	People receive the quality services they need without financial hardship; includes service coverage and financial protection
Financial protection	Protection from unaffordable direct payments and from impoverishing or catastrophic health spending
Confirmed closure	A closure reported by an identified source as an operational count for a stated period
Scaled-back facility	A facility that remains open with reduced services, staff or operating days
Affected facility	A facility experiencing some disruption; broader than a confirmed closure
At-risk facility	A facility projected to close under a stated scenario; not an observed outcome
Risk of famine	An IPC statement that famine (IPC Phase 5) is a reasonable possibility under a plausible worst-case scenario; not a famine classification
Hyper-prioritised plan	A humanitarian plan reduced to the most severe needs because of funding constraints, not because need has fallen
Scenario	A conditional projection under specified assumptions; never presented as an observed outcome
Contribution pathway	A causal chain in which a factor contributes to an outcome alongside other drivers, without sole attribution
Continuity reserve	Pre-positioned financing released against predefined triggers to keep essential services operating
Strategic purchasing	Active use of payment and contracting rules to buy defined services from qualified providers on behalf of a population
IPC	Used only for the Integrated Food Security Phase Classification; 'infection prevention and control' is always written in full
SHIA	Social Health Insurance Authority, the legal name under Prime Minister's Decree Lr206; earlier designations are historical only

A2.2 Abbreviations

Table A3. Abbreviations

Abbreviation	Full term
AWD	Acute watery diarrhoea
CHE	Current health expenditure
cVDPV2	Circulating vaccine-derived poliovirus type 2
DHIS2	District Health Information Software 2
DTP3	Third dose of diphtheria, tetanus and pertussis-containing vaccine
EPHS	Essential Package of Health Services
FSNAU	Food Security and Nutrition Analysis Unit – Somalia
FTS	Financial Tracking Service
FY	Fiscal year
GAM	Global acute malnutrition
GDP	Gross domestic product
HHFA	Harmonized Health Facility Assessment
HNRP	Humanitarian Needs and Response Plan
IDP	Internally displaced person
IDSR	Integrated Disease Surveillance and Response
IPC	Integrated Food Security Phase Classification
LMIS	Logistics management information system
MCV1	First dose of measles-containing vaccine
MHPSS	Mental health and psychosocial support
MMEIG	United Nations Maternal Mortality Estimation Inter-Agency Group
MSF	Médecins Sans Frontières
NTP	National Transformation Plan
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
RUTF	Ready-to-use therapeutic food

Abbreviation	Full term
SAM	Severe acute malnutrition
SDG	Sustainable Development Goal
SHDS	Somali Health and Demographic Survey
SHI	Social health insurance
SHIA	Social Health Insurance Authority
SoDMA	Somali Disaster Management Agency
UHC	Universal health coverage
UN IGME	United Nations Inter-agency Group for Child Mortality Estimation
UNHAS	United Nations Humanitarian Air Service
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WASH	Water, sanitation and hygiene
WFP	World Food Programme
WHO	World Health Organization

Proper names of instruments and organisations (for example, Harmonized Health Facility Assessment; WHO/UNICEF Estimates of National Immunization Coverage; World Health Organization) retain their official spelling.

Annex 3 Limitations and Priority Research Gaps

- No post-cut national health accounts estimate is available; the 2023 accounts describe the pre-shock structure, and the 2023 figures are themselves inflated by temporary drought-response funding.
- No verified national post-cut census of the active workforce exists; reported job losses are not directly comparable with WHO professional stock estimates.
- Facility closure and coverage figures are not yet consolidated in a single, publicly available register disaggregated by state and district.
- IPC projections are conditional on rainfall, prices and the level of humanitarian assistance, and may change with the Deyr season outcome.
- Immunisation coverage differs between WHO/UNICEF estimates and national official estimates; denominators should be reconciled through the national immunisation programme.
- Mental health prevalence and service coverage data are insufficient for a national estimate; routine reporting should be strengthened.
- Measles, diphtheria, AWD/cholera and malaria counts use different case definitions and reporting windows; trend interpretation should remain cautious.
- Priority research: a facility-level panel linking funding, staffing and service volumes before and after the cuts; district-level estimates of effective coverage loss; household surveys of financial hardship in hotspot areas; and an evaluation of the health effects of the 2026 Deyr floods.

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