

PERSPECTIVE · HEALTH SYSTEMS · HEALTH FINANCING · STEWARDSHIP

From Fundraising to Financing

Bringing quality cardiac care home through domestic financing and social health insurance in Somalia

Qaaraan ilaa Caymis: daryeel wadne oo tayo leh oo dalka gudihiisa laga helo

Dr Abdulrazaq Yusuf Ahmed (Dr Jalaaludiin)

Physician · Health Economist · Demographer

Reflections on the keynote delivered at the 2nd National Cardiac Conference of the Somali Cardiac Society, Mogadishu, 29 October 2026

IN BRIEF

A child's heart operation should not depend on how fast a family can raise money.

FIVE KEY MESSAGES

1. **Somalia has crossed a clinical threshold.** Adult open heart surgery (March 2024), paediatric open heart surgery (January 2025) and paediatric catheter interventions are now performed in Mogadishu.
2. **Financing has not crossed with it.** Almost every procedure is paid for by households, charities, foreign partners or travel abroad; Somali households spent an estimated US$219 million on treatment abroad in 2024.
3. **Fundraising and medical evacuation are not a financing model.** They are slow, unequal, volatile and blind to quality, and the external money they lean on fell by 61% between 2025 and 2026.
4. **The alternative is institutional:** one cardiac window within social health insurance, many domestic sources (public budget, contributions, zakat, waqf, takaful and a Somali Diaspora Heart Fund), and purchasing that pays for verified quality.
5. **Quality is the lever that brings patients home.** Accreditation, a national cardiac registry and published outcomes close the confidence gap that drives medical travel.

AT A GLANCE

Somalia's heart in numbers



Figure 1. Somalia's heart in numbers. Eight figures that frame the argument.

Source: references 1–7.

© 2026 Dr. Abdulrazaq Yusuf Ahmed · The text and original figures are licensed under CC BY 4.0, with the exception of photographs · This document reflects a personal academic viewpoint and does not represent an official stance of SHIA.

SOO KOOBID · SOMALI SUMMARY

Soomaaliya waxay gudubtay marxalad caafimaad oo taariikhi ah: qalliinka wadnaha furan ee dadka waaweyn (Maarso 2024) iyo kan carruurta (Janaayo 2025), iyo daaweynta kateetarka ee carruurta, ayaa hadda lagu sameeyaa Muqdisho. Hase yeeshee maalgelintu lama gudbin: qalliin kasta wuxuu weli ku tiirsan yahay kaydka qoyska, qaaraanka, ololeyaal samafal ama u safridda dibadda, halkaas oo qoysaska Soomaaliyeed ku bixiyeen qiyaastii US$219 milyan sannadkii 2024. Maqaalkani wuxuu soo jeedinayaa in qaaraanka loo beddelo caymis: daaqad wadne oo mideysan oo ku dhex jirta caymiska caafimaadka bulshada, ilo badan oo gudaha ah (miisaaniyadda dawladda, wax ku biirinta, sakada, waqfiga, takaafulka iyo Sanduuqa Wadnaha ee Qurbajoogta), iyo iibsasho ku xiran tayada la xaqiijiyay.

01 · THE CLINICAL THRESHOLD

Somalia has crossed a clinical threshold

On 29 October 2026 I had the privilege of delivering the keynote address at the 2nd National Cardiac Conference of the Somali Cardiac Society in Mogadishu, held under the theme “Building Resilient Cardiovascular Care in Somalia”, and of joining the panel that followed. This perspective develops the argument I made there for a wider audience of scholars, clinicians, policymakers, funders and members of the Somali diaspora.

The clinical facts deserve to be stated precisely, because they are a national achievement. A cardiac surgery department opened at the Recep Tayyip Erdoğan Training and Research Hospital in Mogadishu on 4 March 2024 [8]. One week later, on 11 March 2024, a joint Somali Turkish team that included the Somali cardiovascular surgeon Dr Abdinafic Mohamud Hussein performed the first open heart operation in the country, a coronary bypass for a 74 year old man [1,9]. On 25 January 2025 the first paediatric open heart operations followed at Kalkaal Hospital, performed with a visiting Italian team and sponsored by the Hormuud Salaam Foundation [2,10]. In October 2026 a campaign led by Qatar Charity with the Ministry of Health, the Somali Sudanese Specialised Hospital and the Mogadishu Heart Centre screened 144 children and delivered catheter interventions to 40 of them [11,12]. The Mogadishu Heart Centre now reports 559 children with heart defects treated in about three years [3].

> *“The science has arrived in Mogadishu. The money has not yet followed.”*

© 2026 Dr. Abdulrazaq Yusuf Ahmed · The text and original figures are licensed under CC BY 4.0, with the exception of photographs · This document reflects a personal academic viewpoint and does not represent an official stance of SHIA.



Figure 2. Somalia's cardiac milestones, 2024 2026, and who paid for them. Green markers show the first adult and paediatric open heart operations and the latest centre report.

Source: references 1 3, 8, 10, 11, 13; Somali Cardiac Society conference materials.



From the conference. The author delivering the keynote (left) and on the panel "Building Resilient Cardiovascular Care in Somalia From Challenges to a National Roadmap" (right). Décalé Airport Hotel, Mogadishu, 29 October 2026.

02 · THE NEED

A young nation with a heavy and rising cardiac burden

Somalia is one of the youngest nations on earth. Its population was an estimated 19.65 million in 2025, and nearly half are children [14]. That demography shapes the cardiac agenda in two ways. First, congenital and rheumatic heart disease, the conditions of childhood and youth, dominate the years of life at stake: about 6,000 babies are estimated to be born each year with a congenital heart defect [2]. Second, as a demographer I read the slow retreat of infectious disease as a forecast. As children survive and adults age, non communicable disease moves to the front of the queue. Non communicable diseases already account for about a quarter of all deaths [15]; the epidemiological transition is not a distant theory but is arriving in our wards.

Somali clinical evidence confirms the breadth of the need. Of 6,782 people examined by echocardiography at a Mogadishu referral hospital, 1,140 had abnormal findings. Hypertensive heart disease was present in 39.8%, valvular heart disease in 34.6% and heart failure with reduced ejection fraction in 30.8%. Congenital heart disease, found in 13.2%, was present in 90.3% of children with

© 2026 Dr. Abdulrazaq Yusuf Ahmed · The text and original figures are licensed under CC BY 4.0, with the exception of photographs · This document reflects a personal academic viewpoint and does not represent an official stance of SHIA.

abnormal findings, and rheumatic heart disease, found in 7.4%, was most common among people aged 16 30 [16]. The first Somali series of rheumatic heart disease, 433 patients identified among 8,526 echocardiograms, shows how late the disease reaches care: two thirds were women, the mean age was 46.5 years, more than half had severe mitral regurgitation and nearly a quarter already had pulmonary hypertension [17].

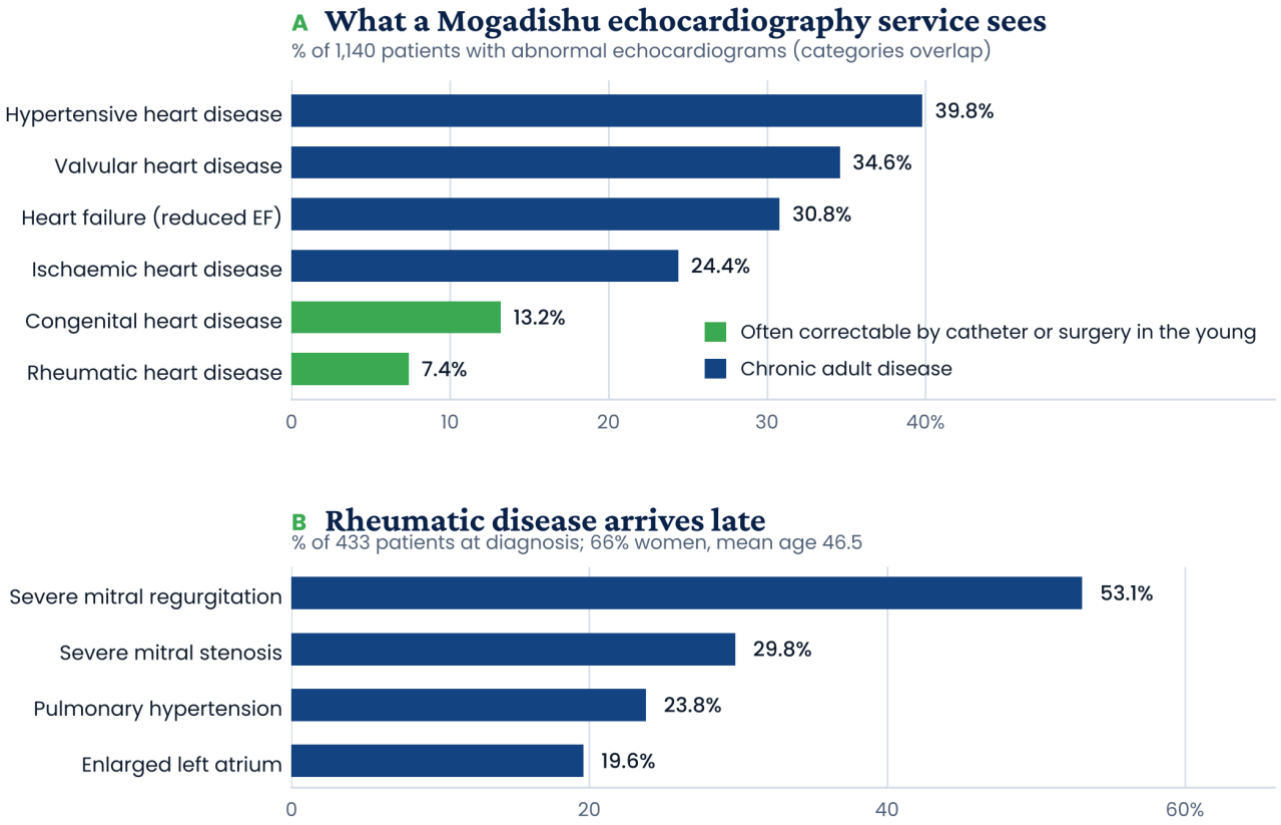


Figure 3. The spectrum of heart disease seen in Mogadishu. Panel A: share of abnormal echocardiograms by diagnosis. Panel B: severity of rheumatic heart disease at diagnosis.

Source: references 16, 17.

Hypertension is the largest single driver. WHO estimates that 26% of Somali adults aged 30 79, about 1.3 million people, live with hypertension and that only about one in ten has it controlled. High blood pressure accounts for about 57% of cardiovascular deaths, and reaching 50% control would avert an estimated 55,000 deaths by 2040. WHO also records that Somalia has no national hypertension treatment guideline [4]. Modelled estimates of cardiovascular deaths range from about 11,000 (IHME, 2021) to about 18,000 (WHO, 2021) a year [18]. The range is itself a finding: Somalia does not yet register deaths by cause, so its cardiac burden is estimated rather than counted.

© 2026 Dr. Abdulrazaq Yusuf Ahmed · The text and original figures are licensed under CC BY 4.0, with the exception of photographs · This document reflects a personal academic viewpoint and does not represent an official stance of SHIA.

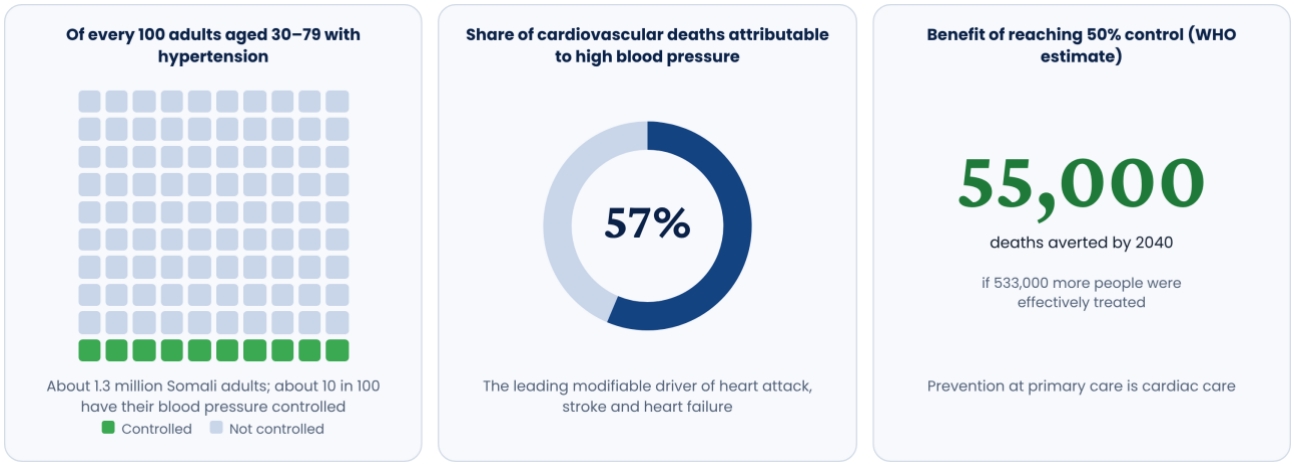


Figure 4. Hypertension: the largest and most preventable driver. Modelled WHO estimates for adults aged 30 79.
Source: reference 4.

A continuum, not a single operation

A national cardiac service is therefore not one operation but a continuum across the life course, from the newborn with a septal defect to the grandparent with a failing valve or a slow heart, and into the chest. In a country that still carries a heavy tuberculosis burden, thoracic surgery for post tuberculous lung disease, empyema and trauma belongs in the same network. Each condition has a treatment window. A shunt closed late leaves irreversible pulmonary hypertension; untreated rheumatic stenosis brings heart failure, atrial fibrillation, stroke and danger in pregnancy; in a heart attack, time is muscle; in complete heart block, one pacemaker prevents sudden death. Fundraising consumes precisely the time these patients do not have.

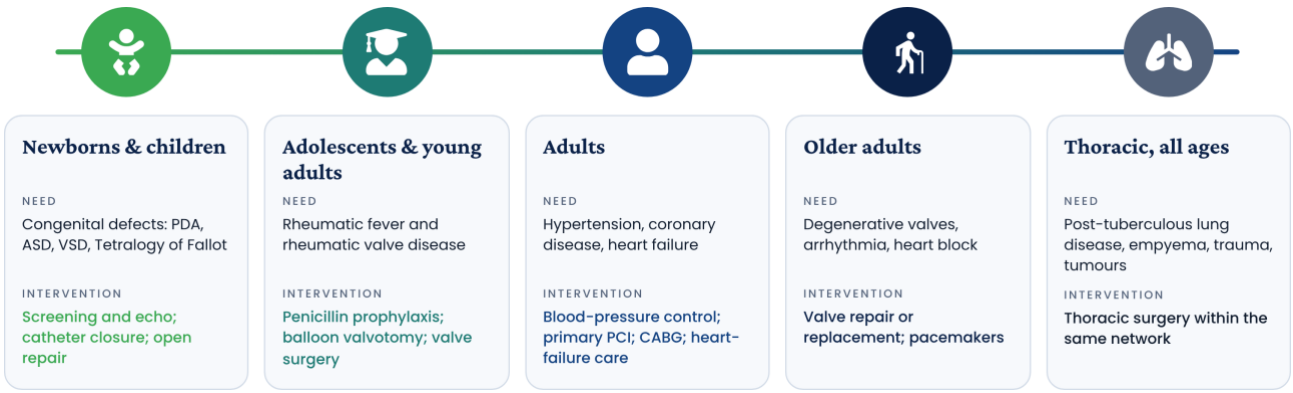


Figure 5. Cardiothoracic care across the life course. The benefit package and the provider network must be designed for all five groups.

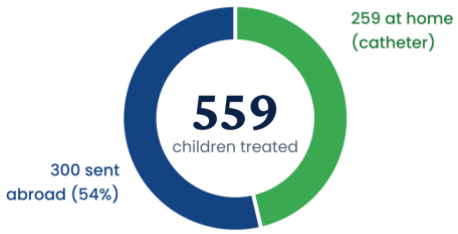
03 · THE FINANCING GAP

Financing has not crossed with it

Every milestone above was paid for by philanthropy, foreign partners or households; none was financed through a public budget line or an insurance pool. The Mogadishu Heart Centre treats children free of charge thanks to donors, yet 300 of its 559 children, 54%, still had to be sent abroad for surgery, and the centre's leadership has said that outside support is very limited [3]. Before the first paediatric operations at

© 2026 Dr. Abdulrazaq Yusuf Ahmed · The text and original figures are licensed under CC BY 4.0, with the exception of photographs · This document reflects a personal academic viewpoint and does not represent an official stance of SHIA.

home, families had spent US$6,000 7,000 on travel, visas and medical fees in India or Türkiye [10]. When the adult cardiac unit opened in 2024, the then Minister of Health, Ali Haji Adan, observed that many patients who need open heart surgery lose their lives while dealing with high surgery and treatment costs and visa procedures [8]. The first adult patient operated on at home had planned to travel to Malaysia but stayed for financial reasons [1].



WHAT 54% MEANS

Catheter capacity has come home; paediatric surgical capacity has not. Every child sent abroad is a cost to a donor or a family, a delay in treatment and a gap in follow up, and every case treated abroad is clinical volume that Somali teams need in order to build skill.

Figure 6. Children treated by the Mogadishu Heart Centre in about three years. *Source: reference 3.*

The financing architecture explains why. Somalia spent about US$22 per person on health in 2023. Of current health expenditure, 54.4% came from external sources, 30.8% from out of pocket payments and 14.2% from domestic government sources [19]; general government health spending is about 0.5% of general government expenditure [20]. External financing is now contracting sharply: committed external health financing fell from US$320 million in 2025 to US$125 million in 2026, a 61% drop, while government health financing rose from US$2.7 million to US$9.3 million [6]. The direction is right; the scale cannot yet carry tertiary care. Humanitarian health funding tells the same story: the Somalia Health Cluster received US$26.7 million of the US$122.4 million it sought in 2025 [21].

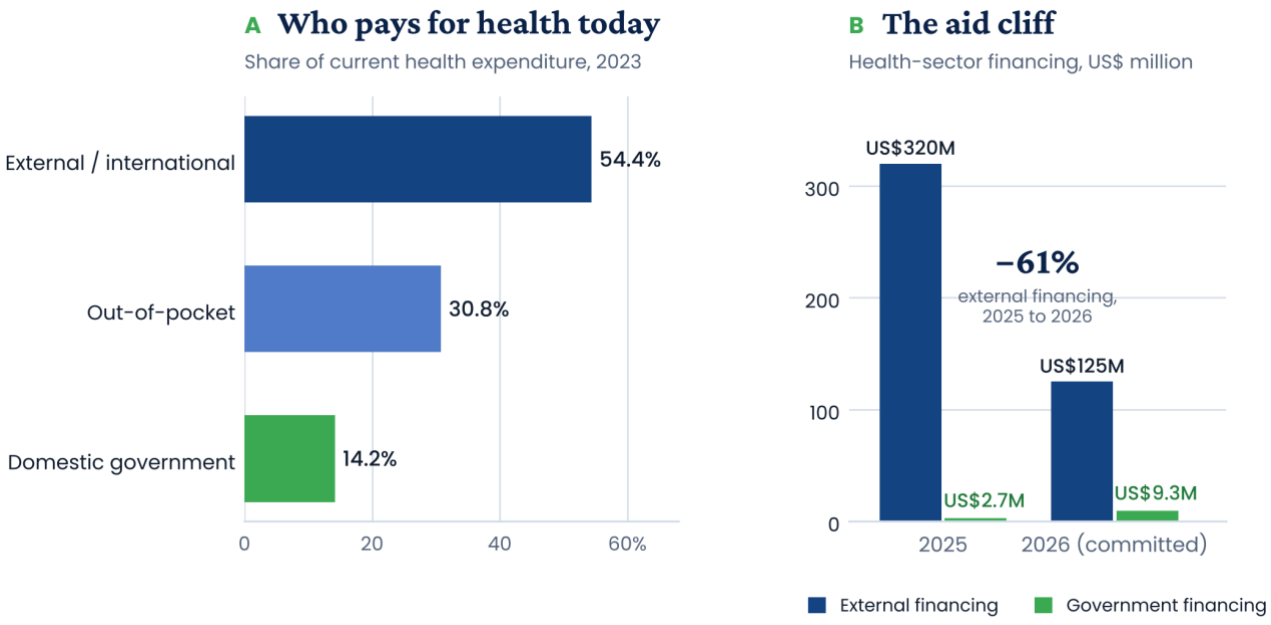


Figure 7. Thin, external and contracting. Panel A: who pays for health. Panel B: external and government health financing, 2025 and 2026.

Source: references 19 and 6 (preprint).

© 2026 Dr. Abdulrazaq Yusuf Ahmed · The text and original figures are licensed under CC BY 4.0, with the exception of photographs · This document reflects a personal academic viewpoint and does not represent an official stance of SHIA.

Households absorb the shock. By the official SDG 3.8.2 measure, 38.8% of Somalis, about 6.8 million people, faced financial hardship from health spending in 2022 [22]. In the 2023 24 household survey evidence synthesised in our study, out of pocket payments made up 44.9% of household health spending, only 3.5% of people were insured and 24% of households spent more than a tenth of their income on health [5]. The two out of pocket figures use different denominators, current health expenditure and household health spending, but they point the same way.

04 · THE CASE AGAINST FUNDRAISING

Why fundraising and medical evacuation cannot be the financing model

Every clinician in Somalia knows the cascade a family descends when a heart operation is needed: savings first, then *qaaraan* from relatives and clan, then the sale of livestock, land or gold, or borrowing; then travel abroad; and, when all else fails, waiting for a charity mission. *Qaaraan* is one of the most admirable institutions in Somali life. As a financing system for cardiac care, however, it fails on five counts.

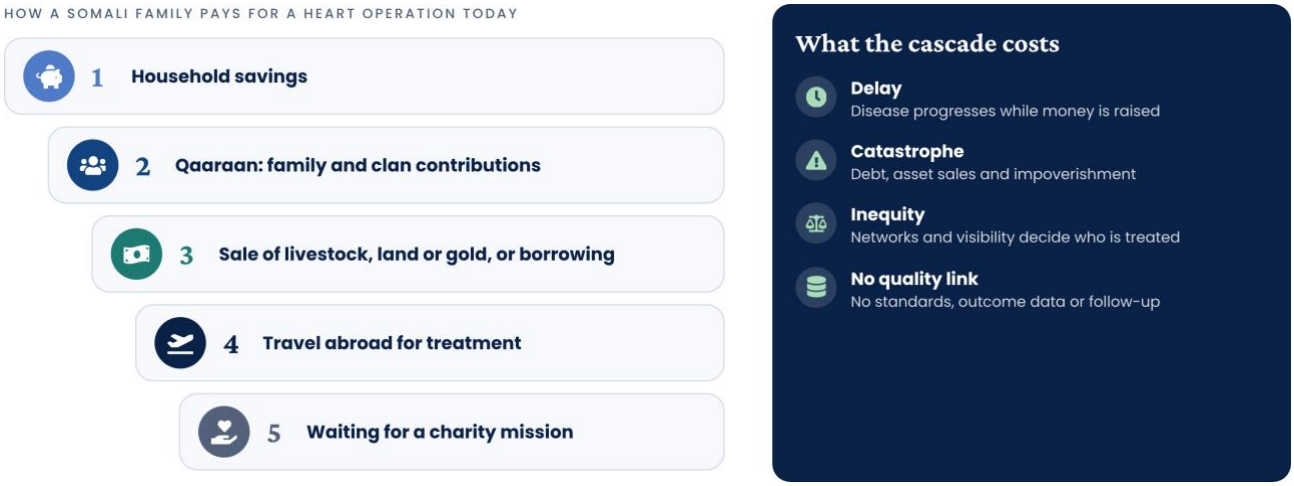


Figure 8. The fundraising cascade. How Somali families pay for a heart operation today, and what it costs them and the system.

1 **It is too late.** Money is raised after diagnosis, and cardiac disease does not wait. Weeks spent fundraising are weeks of progressing disease.

2 **It is unequal.** It allocates surgery by the size and wealth of a family's network rather than by clinical need. International evidence is sobering: of 437,596 medical crowdfunding campaigns in the United States in 2016 2020, fewer than 12% met their goals and 16% received no donations at all, and campaigns from poorer, less insured areas raised less [23].

3 **It is volatile.** Charitable campaigns and missions are episodic by design, and the external money behind them fell by 61% in a single year [6].

4 **It is blind to quality.** Money flows without standards, registration or follow up. Our synthesis found that no defensible complication or mortality rate can be derived for Somali patients treated abroad, because no system links a trip abroad to its outcome [5].

© 2026 Dr. Abdulrazaq Yusuf Ahmed · The text and original figures are licensed under CC BY 4.0, with the exception of photographs · This document reflects a personal academic viewpoint and does not represent an official stance of SHIA.

5 **It drains the nation.** Medical evacuation exports demand, foreign exchange and the clinical volume Somali teams need to build skill.

The outbound bill

My co authors and I have estimated what that last point costs [5]. In 2024 Somali households spent about US$219.3 million on treatment abroad across four corridors (India, Türkiye, Ethiopia and Egypt), about 1.8% of GDP, at a mean direct cost of US$8,543 per episode. India alone issued 16,411 medical visas to Somalis in 2023 and 12,261 in 2024: at least 61,465 recorded episodes since 2015 in that one corridor. Cardiovascular disease is among the principal drivers, alongside cancer, kidney failure and transplantation. Research presented in Mogadishu in October 2026 reported a similar total, which the chairman of the Somali Chamber of Commerce described as a financial drain on the country [24]. The scale is striking: the outbound bill is about 1.75 times all committed external health financing for 2026, and about 24 times the government's health financing in that year.

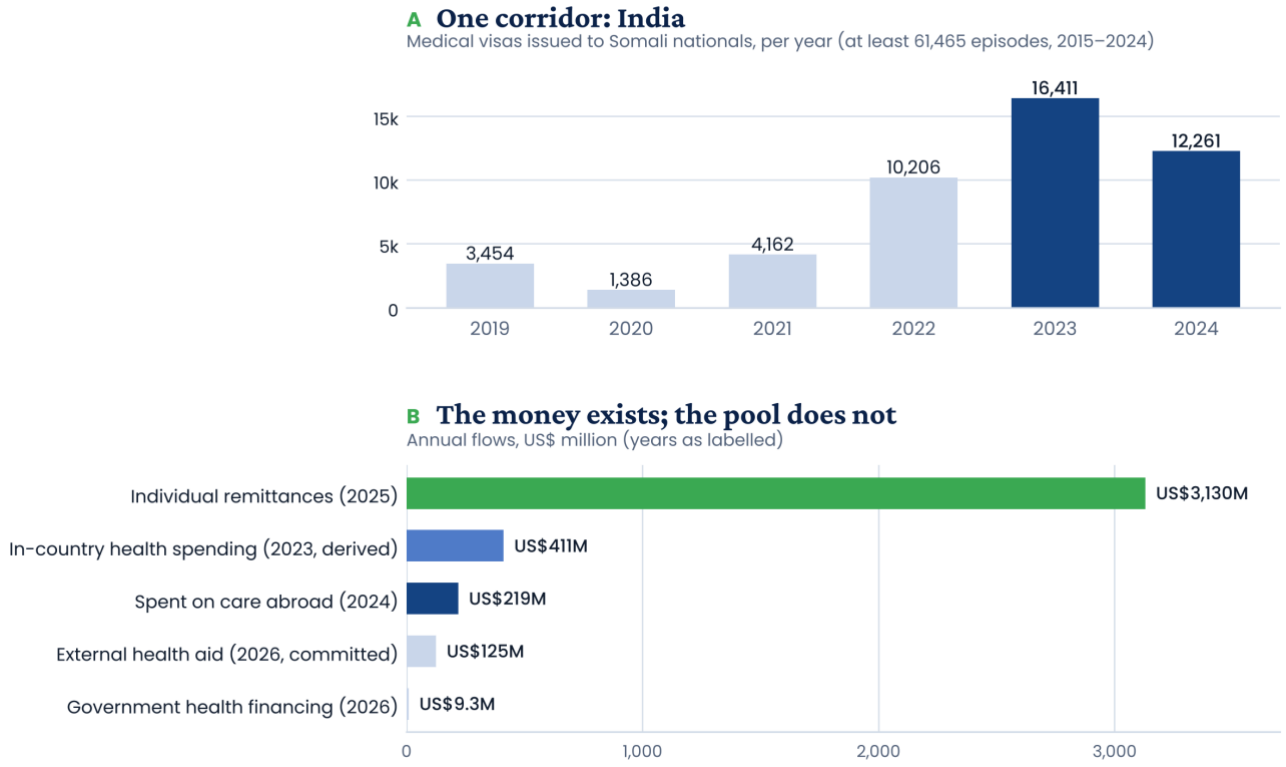


Figure 9. The outbound bill and the money that could pool. Panel A: Indian medical visas issued to Somali nationals. Panel B: annual flows; in country health spending is derived from WHO per capita expenditure and UN population.
Source: references 5, 6 (preprints) and 7, 19.

A NOTE ON THE YEAR

Press coverage in October 2026 dated the US$219 million to 2025 [24]. The underlying estimate in our study refers to 2024. The National Bureau of Statistics' planned study of outbound health expenditure should provide an official annual series.

Read the evidence synthesis (preprint): doi.org/10.21203/rs.3.rs 11100686/v1

Scan for the study

© 2026 Dr. Abdulrazaq Yusuf Ahmed · The text and original figures are licensed under CC BY 4.0, with the exception of photographs · This document reflects a personal academic viewpoint and does not represent an official stance of SHIA.

Outbound care is also a question of trust, not only of capacity. The chairperson of the Somali Medical Association, Luul Mohamud Mohamed, noted that not all Somalis who travel do so because services are unavailable at home; some lack full confidence in the country's health services [24]. Capacity alone will not bring patients home. Verified, published quality will.

Table 1. Fundraising and financing compared. Why generosity needs an institution.

Dimension	Fundraising (qaaraan, charity, evacuation)	Financing (pooled and purchased)
Timing	Money is raised after diagnosis, often too late	**Pre paid: funds are ready before illness strikes**
Equity	Networks and visibility decide who is treated	**Entitlement follows clinical need**
Predictability	Episodic campaigns; providers cannot plan	**Predictable revenue sustains teams and equipment**
Quality	No standards attached to the money	**Payment tied to accreditation and outcomes**
Data	Cases are invisible to the system	**Every case registered and audited**

"Medical evacuation is a symptom of a missing purchaser, not a strategy."

05 · STEWARDSHIP

A stewardship diagnosis: rich in solidarity, poor in pooling

Seen through the lens of governance and leadership, Somalia's cardiac problem is not a shortage of generosity but an absence of architecture. In 2025 Somalis abroad sent home US$3.13 billion in individual remittances, equal to 24% of GDP and 15% more than a year earlier [7]: by my calculation, roughly seven times everything spent on health inside the country. The resources exist. What is missing are the stewardship functions that turn private solidarity into protection:

- **A purchaser.** Money follows campaigns and cases, not patients and outcomes; no institution yet buys cardiac care on behalf of the population.
- **Standards.** To my knowledge, Somalia has no national accreditation programme for cardiac centres, no national cardiac registry and no published cardiac outcome series.
- **Regulation of medical travel.** Facilitators, referral agents and foreign providers operate without licensing, price transparency or follow up obligations.

© 2026 Dr. Abdulrazaq Yusuf Ahmed · The text and original figures are licensed under CC BY 4.0, with the exception of photographs · This document reflects a personal academic viewpoint and does not represent an official stance of SHIA.

- **Coherence.** Missions, charities and partners each bring their own rules, equipment and eligibility criteria, which fragments a small system.
- **Data.** Workforce counts, catheterisation laboratory numbers and procedure prices are not published, so budgets cannot be planned against need.

Stewardship means the careful and responsible management of a population's health on its behalf. In cardiac care it means deciding what is covered, who may provide it, at what price and to what standard, and then publishing the results. Social health insurance is the instrument that can carry those functions.

06 · THE PROPOSAL

From fundraising to financing: a quality linked purchasing model

I propose to treat cardiac intervention as the stress test of Somalia's social health insurance. Because it is high cost, time critical and quality sensitive, it reveals whether pooled financing can protect households and whether purchasing can reward outcomes rather than volume. The model rests on four pillars, set out below as proposals for dialogue with clinicians, government, partners and communities, not as announced policy.

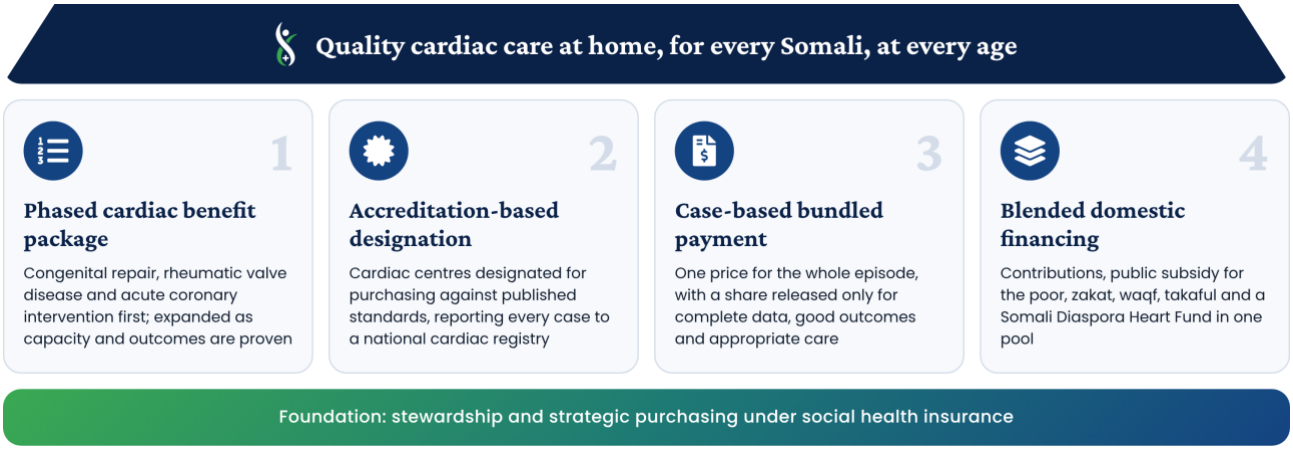


Figure 10. A quality linked purchasing model on four pillars. The author's proposal for dialogue.

Pillar 1. A phased cardiac benefit package

The package should be phased by burden, effectiveness, cost effectiveness, local capacity and financial protection, through an explicit and published health technology assessment, with its clinical content owned by the Somali Cardiac Society.

© 2026 Dr. Abdulrazaq Yusuf Ahmed · The text and original figures are licensed under CC BY 4.0, with the exception of photographs · This document reflects a personal academic viewpoint and does not represent an official stance of SHIA.

Table 2. A phased cardiac benefit package (proposed). Phases expand as domestic volumes and outcomes are documented.

PHASE 1 **Foundation**	Child cardiac screening and echocardiography ▪ Secondary penicillin prophylaxis for rheumatic heart disease ▪ Catheter closure of PDA, ASD and VSD ▪ Balloon mitral valvotomy ▪ Primary PCI for heart attack ▪ Permanent pacemakers
PHASE 2 **Expansion**	Open repair of congenital defects ▪ Valve repair and replacement ▪ Coronary bypass surgery (CABG) ▪ Structured heart failure care ▪ Cardiac rehabilitation
PHASE 3 **Comprehensive**	Complex neonatal heart surgery ▪ Thoracic and oncological surgery ▪ Advanced structural interventions ▪ Electrophysiology procedures

Pillar 2. Accreditation based designation and a national cardiac registry

Centres should be designated for purchasing only against published standards: a complete team (surgeon, cardiologist, cardiac anaesthetist, perfusionist, intensivist and nurses), infrastructure (catheterisation laboratory, cardiac theatre, intensive care, blood bank), safety protocols, minimum volumes and outcome reporting. The same standards must apply to public, private and partnership hospitals. Every case, whether treated at home or referred abroad, should be entered in a national cardiac registry with a minimum dataset: diagnosis, procedure, centre, cost, and 30 day and one year outcomes. Quality that is measured and published is quality that patients can trust.

Pillar 3. Case based bundled payment tied to quality and appropriateness

One case based price should cover the whole episode, from work up to 30 day follow up, with a share released only when registry data are complete and outcomes are within benchmark. India's experience is instructive in both directions. Its national scheme, PM JAY, purchases cardiac care through about 130 case based packages and has widened access [25]; yet after two patients died in 2024 following angioplasties later found to be unnecessary, India made additional pre authorisation documents mandatory for cardiology procedures in the affected state [26]. Bundles bring care within reach; without appropriateness criteria, pre authorisation and audit, they reward volume.

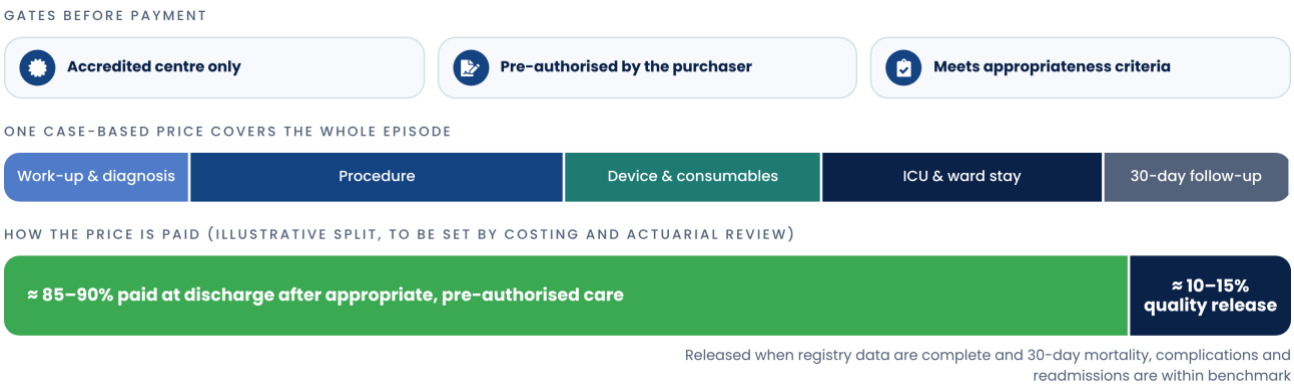


Figure 11. How a quality linked bundle pays. Shares are illustrative and would be set through Somali costing studies and actuarial review.

© 2026 Dr. Abdulrazaq Yusuf Ahmed · The text and original figures are licensed under CC BY 4.0, with the exception of photographs · This document reflects a personal academic viewpoint and does not represent an official stance of SHIA.

Pillar 4. Blended domestic financing in one pool

Six sources should flow into a dedicated cardiac window inside the national social health insurance fund: the government budget, subsidising contributions for the poor; payroll contributions from the formal sector; zakat; waqf capital and its returns; Somali diaspora contributions; and partner and philanthropic funds, brought on budget and through the pool. The organising principle is one pool with many sources, not many pools around one patient.

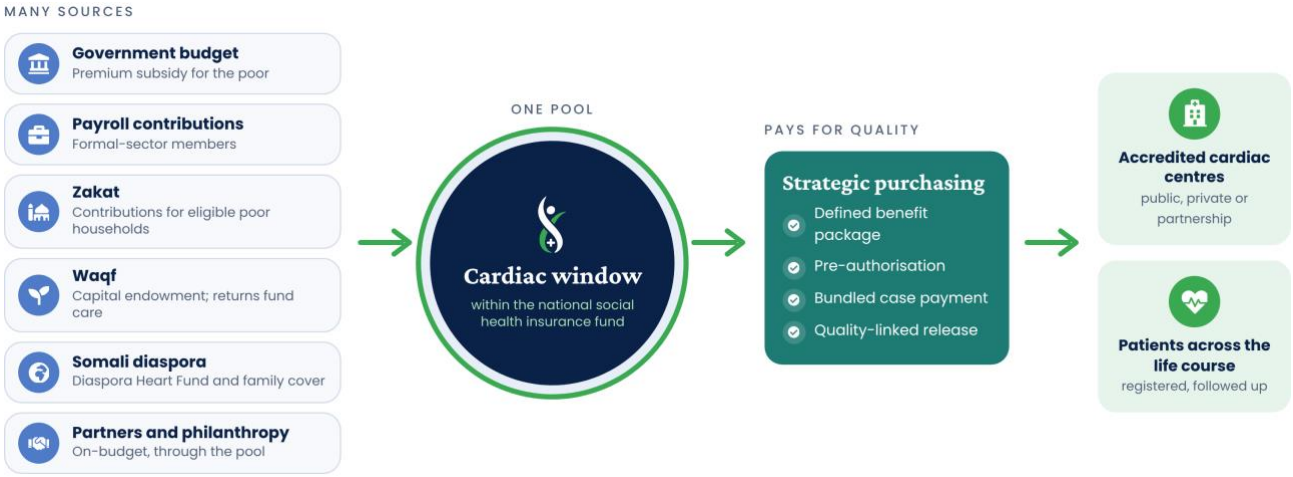


Figure 12. One pool, many sources, quality linked purchasing. Proposed financing architecture for cardiac care under social health insurance.

For the patient, the model becomes a single pathway and a single record, from detection in primary care to learning through the registry.



Figure 13. One pathway, one record. The patient journey under the proposed model.

07 · SOLIDARITY, INSTITUTIONALISED

Islamic social finance and a Somali Diaspora Heart Fund

For a Somali health system, the most sustainable money may be the oldest. The Qur'an names the poor and the needy first among those entitled to zakat [27]. The Prophet, peace be upon him, taught that when a person dies their deeds come to an end except three, the first of which is continuing charity, *ṣadaqah jāriyah* [28]. A catheterisation laboratory endowed as waqf is continuing charity in its purest form: every child it treats is a reward that does not end. The great hospitals of medieval Damascus and Cairo were financed in exactly this way.

© 2026 Dr. Abdulrazaq Yusuf Ahmed · The text and original figures are licensed under CC BY 4.0, with the exception of photographs · This document reflects a personal academic viewpoint and does not represent an official stance of SHIA.

Sudan shows how Islamic finance can work inside a modern insurance system. Its Zakat Chamber and Ministry of Finance pay National Health Insurance Fund contributions for poor households; in 2016, 8.78 million poor people were among the 16.41 million insured [29]. Sudan also shows the conditions for success: beneficiary databases must be linked and transfers made regularly across states [30]. The lesson for Somalia is to use zakat as a premium payer inside one pool rather than as a parallel charity.

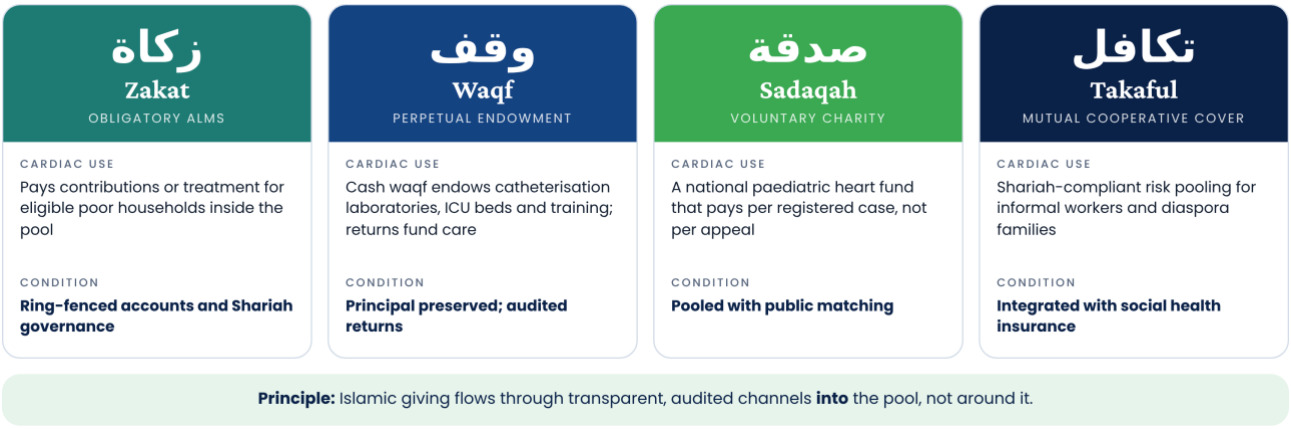


Figure 14. Four instruments of Islamic social finance for cardiac care. Each works best inside the pool, under transparent Shariah governance.

A Somali Diaspora Heart Fund

The Somali diaspora already finances Somali health care, usually after a crisis and at the highest price. The question is whether it pays before illness or after. Illustratively, if 1% of 2025 individual remittances were pre paid into a dedicated fund, it would yield about US$31.3 million a year; at 2%, about US$62.6 million, more than a quarter of the outbound bill. These are scenarios, not projections. The channel already exists: during Ramadan 2026, Dahabshiil customers donated US$54,361 at the point of transfer, which the company matched to raise US$108,722 for drought relief [31]. In June 2026 the Prime Minister opened the Somalia Diaspora Centre to support implementation of the National Diaspora Policy, and the Foreign Minister stressed building the confidence and trust of diaspora communities [32].

Trust is therefore the design brief. A Somali Diaspora Heart Fund should be ring fenced to registered cardiac episodes at accredited centres; matched by public, zakat or corporate money; results based, paying per registry verified case; transparent, with a quarterly public dashboard and independent audit; inclusive, offering diaspora families “heart cover” for relatives at home that is pooled with social health insurance rather than run as a parallel scheme; and low friction, collected through licensed banks and mobile money. Bank or card funded contributions would also avoid the 1% United States excise tax on cash funded remittance transfers in force since January 2026 [33]. Diaspora cardiologists, surgeons, anaesthetists and nurses are the fund’s second asset: structured twinning and temporary return can turn goodwill into Somali teams.

© 2026 Dr. Abdulrazaq Yusuf Ahmed · The text and original figures are licensed under CC BY 4.0, with the exception of photographs · This document reflects a personal academic viewpoint and does not represent an official stance of SHIA.



Figure 15. Designing a Somali Diaspora Heart Fund. Illustrative yields and six design features proposed by the author.
Source: reference 7; author's scenarios and proposal.

08 · LESSONS FROM ELSEWHERE

What other countries teach us

Three countries offer transferable lessons, and Somalia already has its own proof of concept. Tanzania's government owned Jakaya Kikwete Cardiac Institute treated 2,760 patients in 2022/23 for TSh 31 billion, against an estimated TSh 62 billion had they been treated abroad [34]; its executive director reported TSh 172 billion (about US$69.4 million) saved in foreign treatment costs since 2015 [35]. Sudan's zakat financed premiums and India's case based packages, discussed above, show how to pay and how not to. Globally, high income countries have 7.15 adult cardiac surgeons per million people against 0.04 in low income countries [36], and some six billion people lack access to safe, timely and affordable cardiac surgery [37]. Feasibility is not the binding constraint. Financing is.

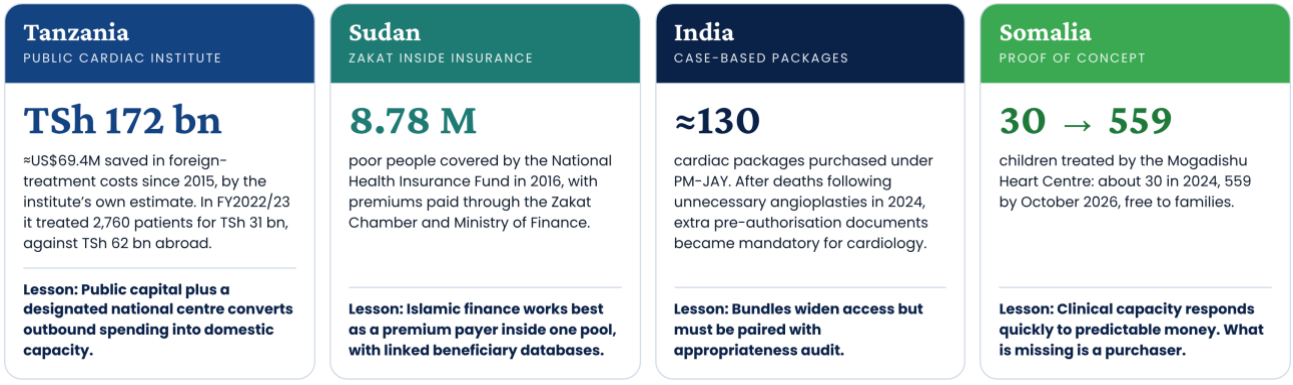


Figure 16. Four cases, four lessons.
Source: references 3, 25, 26, 29, 34, 35.

09 · THE ROAD AHEAD

A phased roadmap and the measures that matter

Reform should be sequenced so that each step earns the trust needed for the next: measure, define and designate in the first year; pool and purchase in years one to three; institutionalise in years three to five.

© 2026 Dr. Abdulrazaq Yusuf Ahmed · The text and original figures are licensed under CC BY 4.0, with the exception of photographs · This document reflects a personal academic viewpoint and does not represent an official stance of SHIA.

Progress should be judged by five indicators published every year. Workforce sits beneath all three horizons. Predictable purchasing is itself workforce policy, because teams stay where caseloads and revenue are reliable, and every visiting mission should become a structured twinning programme with a measurable transfer of skills.



Figure 17. A phased roadmap with five public indicators. The author's proposal; dates would be set with government and partners.

10 · CALLS TO ACTION

A shared responsibility

No single institution can finance a national heart programme. Each of the communities reading this has a specific contribution to make.



A shared agenda. Participants at the 2nd National Cardiac Conference (left) and the author during the panel discussion (right). Mogadishu, 29 October 2026.

Table 3. Calls to action. What each actor can do, starting now.

Academics and researchers	Confirm Somalia's cardiovascular and rheumatic burden in national data, cost the Phase 1 bundles at Somali centres, and publish the first Somali cardiac outcome series.
Clinicians and the Somali Cardiac Society	Lead the design of the national cardiac registry, the clinical content of the benefit package and the centre designation standards. Published outcomes are the most credible answer to the confidence gap.

© 2026 Dr. Abdulrazaq Yusuf Ahmed · The text and original figures are licensed under CC BY 4.0, with the exception of photographs · This document reflects a personal academic viewpoint and does not represent an official stance of SHIA.

Policymakers and decision makers	Create a ring fenced cardiac purchasing window and a budget line, however modest at first, so that domestic money leads and charity follows; license medical travel facilitators.
Fundraisers and charitable foundations	Channel campaigns into pooled, case based purchasing at designated centres, so that every dollar buys a registered, audited outcome rather than a one off mission.
Bilateral and multilateral donors	Finance the system functions charity cannot: the registry, accreditation, costing studies and the pool's start up, on budget and aligned with national plans.
The Somali diaspora	Pledge to a matched, transparent Diaspora Heart Fund, buy heart cover for relatives at home, and offer clinical skills through structured twinning.
Private sector and impact investors	Invest in catheterisation laboratory and surgical capacity against predictable case based contracts, not out of pocket demand alone.
Zakat, waqf and Islamic finance institutions	Pay contributions for poor households into the pool, as Sudan's Zakat Chamber does, and endow cash waqf for cardiac equipment and training.

11 · CONCLUSION

Solidarity into a system

Somali solidarity has sustained heart patients this far. It has funded flights to India and Türkiye, occupied hospital wards abroad, and, over the past three years, helped bring heart surgery home. The current challenge is to institutionalize that solidarity: shifting from fundraising to financing, from cases to coverage, and from missions to systems. A child's heart operation should not rely on how quickly a family can gather money.

وَمَنْ أَحْيَاهَا فَكَأَنَّمَا أَحْيَا النَّاسَ جَمِيعًا

"Whoever saves one life, it is as if he had saved all of humanity." Al Mā'idah 5:32

Qofkii naf badbaadiya, waxa uu la mid yahay qof badbaadiyay dadka oo dhan.

Let us turn qaaraan into caymis: solidarity into a system.

© 2026 Dr. Abdulrazaq Yusuf Ahmed · The text and original figures are licensed under CC BY 4.0, with the exception of photographs · This document reflects a personal academic viewpoint and does not represent an official stance of SHIA.

ABOUT THE AUTHOR

Dr Abdulrazaq Yusuf Ahmed

(Dr Jalaaludiin) · MBChB, MD, MPH, PhD, FRSPH, FRSTMH

Physician · Health Economist · Demographer



Dr Abdulrazaq Yusuf Ahmed is a Somali physician, health economist and demographer based in Mogadishu. He is the Founding Director General of the Social Health Insurance Authority (SHIA) of the Federal Republic of Somalia, an Associate Professor at Benadir University and City University of Mogadishu, and founder and chairman of the RIYAADA Institute for Leadership & Governance. He served as Director of Medical Services at the Federal Ministry of Health from 2012 to 2018. He holds doctorates in health economics and in demography and social sciences, and is a Fellow of the Royal Society for Public Health and of the Royal Society of Tropical Medicine and Hygiene (Country Ambassador for Somalia), and an ISQua Fellow. His work spans health financing, social health insurance, universal health coverage in fragile settings, Islamic social finance for health and health systems governance, across more than 50 publications.

drjalaaludiin.com · ORCID 0000 0002 6985 1087 · @drjalaal · drjalaal@riyaadaacademy.com

drjalaaludiin.com

Views and competing interests. This personal academic perspective reflects the author's own views and does not represent an official stance of the Social Health Insurance Authority or the Federal Government of Somalia; the proposals are intended for professional and academic discussion. The author serves as Founding Director General of SHIA, lead author of a cited preprint (reference 5), and board member of Mogadishu Turkish Hospital.

How to cite. Ahmed AY. From fundraising to financing: bringing quality cardiac care home through domestic financing and social health insurance in Somalia [Perspective]. drjalaaludiin.com; November 2026.

Licence. Text and original figures © 2026 Dr Abdulrazaq Yusuf Ahmed, licensed under CC BY 4.0. Photographs from the 2nd National Cardiac Conference are excluded; rights rest with their owners. The Dr Jalaaludiin name and emblem are trademarks and are not licensed.

Acknowledgements. The author thanks the Somali Cardiac Society for the invitation to deliver the keynote, and the Somali clinicians and partners whose achievements are recorded here.



Shared through RIYAADA academic platforms

REFERENCES

Preprints are marked; they have not completed peer review. Web sources were accessed in October November 2026.

1. Mogadishu24. Turkish, Somali doctors conduct successful open heart surgery [Internet]. 14 March 2024. https://mogadishu24.com/turkish somali doctors conduct successful open heart surgery/
2. Garowe Online. Hormuud Salaam Foundation sponsors first ever open heart surgery for children in Somalia [Internet]. January 2025. https://www.garoweonline.com/en/news/somalia/hormuud salaam foundation sponsors first ever open heart surgery for children in somalia
3. Dawan Africa. Somali doctors treat 559 children with heart defects in three years [Internet]. 24 October 2026. https://www.dawan.africa/news/somali doctors treat 559 children with heart defects in three years

© 2026 Dr. Abdulrazaq Yusuf Ahmed · The text and original figures are licensed under CC BY 4.0, with the exception of photographs · This document reflects a personal academic viewpoint and does not represent an official stance of SHIA.

4. World Health Organization. Hypertension Somalia 2023 country profile. Geneva: WHO; 2023. https://cdn.who.int/media/docs/default source/country profiles/hypertension/hypertension 2023/hypertension_som_2023.pdf
5. Ahmed AY, Hussein AM, Monamed MH. Cross border health care seeking among Somali nationals: a multi country evidence synthesis of determinants, outcome domains, economic burden and health system implications, 2014 2026 [preprint]. Research Square; 22 September 2026. doi:10.21203/rs.3.rs 11100686/v1 https://doi.org/10.21203/rs.3.rs 11100686/v1
6. Mohamud KM. The 2026 aid cliff: resource mapping evidence on donor withdrawal and health financing sustainability in Somalia [preprint]. Research Square; 23 September 2026. https://www.researchsquare.com/article/rs 10619602/v1
7. The EastAfrican. Diaspora steady Mogadishu economy in times of turmoil [Internet]. 2026 (reporting Central Bank of Somalia data). https://www.theeastafrican.co.ke/tea/business tech/diaspora steady mogadishu economy in times of turmoil 5558440
8. Anadolu Agency. Open heart surgery can be performed at hospital in Somalia named for Turkish president [Internet]. 4 March 2024. https://www.aa.com.tr/en/africa/open heart surgery can be performed at hospital in somalia named for turkish president/3155179
9. Somali National News Agency (SONNA). Historic day for Somalia: first successful open heart surgery at Recep Tayyip Erdoğan Hospital [Internet]. March 2024. https://sonna.so/en/historic day for somalia first successful open heart surgery at recep tayyip erdogan hospital/
10. Hiiraan Online. Landmark open heart surgeries performed in Somalia for first time [Internet]. January 2025. https://www.hiiraan.com/news4/2025/Jan/199974/landmark_open_heart_surgeries_performed_in_somalia_for_first_time.aspx
11. Dawan Africa. Qatar Charity treats 40 children for congenital heart defects in Somalia [Internet]. October 2026. https://www.dawan.africa/news/qatar charity treats 40 children for congenital heart defects in somalia
12. Qatar News Agency. Qatar Charity concludes campaign to treat heart defects in children in Somalia [Internet]. 1 November 2026. https://qna.org.qa/en/news/news details?id=qatar charity concludes campaign to treat heart defects in children in somalia&date=1%2F11%2F2026
13. SOOHA. QRCS dispatches medical convoy to Somalia [Internet]. 11 January 2025. https://sooha.org/en/2025/01/11/qrcs dispatches medical convoy to somalia/
14. United Nations, Department of Economic and Social Affairs. World Population Prospects 2024: Somalia (via StatisticsTimes) [Internet]. https://www.statisticstimes.com/demographics/country/somalia population.php
15. World Health Organization. Somalia: country health data profile [Internet]. Geneva: WHO [cited 2026 Nov]. https://srhdpeuwpubsa.blob.core.windows.net/whdh/DATADOT/COUNTRY/PDF/706_Somalia.pdf
16. Alıcı G, Genç Ö. Spectrum of cardiovascular diseases at a referral tertiary care hospital in Somalia, Mogadishu: an echocardiographic study. BMC Cardiovasc Disord. 2021;21:599. doi:10.1186/s12872 021 02417 4 https://doi.org/10.1186/s12872 021 02417 4
17. Abdi IA, Karataş M, Öcal L, Ahmed SA, Hassan MS, Atilla K, et al. Pattern of rheumatic heart disease among patients attending at a tertiary care hospital in Somalia: first report from Somalia. Am J Cardiovasc Dis. 2023;13(5):345 353. https://pmc.ncbi.nlm.nih.gov/articles/PMC10658047
18. Our World in Data. Deaths from cardiovascular diseases: Somalia (IHME Global Burden of Disease 2021; WHO Global Health Estimates) [Internet]. https://ourworldindata.org/grapher/deaths from cardiovascular disease
19. World Bank. World Development Indicators: current health expenditure per capita and by financing source, Somalia, 2023 (WHO Global Health Expenditure Database) [Internet]. https://data.worldbank.org/indicator/SH.XPD.CHEX.PC.CD?locations=SO
20. P4H Network. Country profile: Somalia [Internet]. https://p4h.world/en/countries/somalia
21. UN Office for the Coordination of Humanitarian Affairs. Somalia Humanitarian Needs and Response Plan 2026 [Internet]. 2026. https://www.unocha.org/attachments/edea4204 0921 4741 862f 203c6f75a631/Somalia_HNRP_2026.pdf
22. Mohamud KM. Hidden financial hardship and inequity in health spending: beyond SDG 3.8.2 evidence from Somalia [preprint]. Research Square; 10 September 2026. https://www.researchsquare.com/article/rs 10083322
23. Kenworthy N, Igra M. Medical crowdfunding and disparities in health care access in the United States, 2016 2020. Am J Public Health. 2022;112(3):491 498. doi:10.2105/AJPH.2021.306617 https://doi.org/10.2105/AJPH.2021.306617
24. Dawan Africa. 11,500 Somalis sought treatment in India in 2025, spending $219m abroad [Internet]. October 2026. https://www.dawan.africa/news/11500 somalis sought treatment in india in 2025 spending dollar219m abroad
25. Trends in cardiac care utilization under Ayushman Bharat Pradhan Mantri Jan Arogya Yojana. Ann Clin Cardiol. 2021;3(2). https://journals.lww.com/accd/fulltext/2021/03020/trends_in_cardiac_care_utilization_under_ayushman.4.aspx
26. ThePrint. Tighter checks for cardiac, paediatric procedures under AB PMJAY after Gujarat fraud cases [Internet]. 18 March 2025. https://theprint.in/health/tighter checks for cardiac paediatric procedures under ab pmjay after gujarat fraud cases/2553140
27. The Holy Qur'an. Sūrat Al Mā'idah 5:32 and Sūrat At Tawbah 9:60. https://quran.com/5/32

© 2026 Dr. Abdulrazaq Yusuf Ahmed · The text and original figures are licensed under CC BY 4.0, with the exception of photographs · This document reflects a personal academic viewpoint and does not represent an official stance of SHIA.

28. Ṣaḥīḥ Muslim, Book of Wills, ḥadīth 1631. https://sunnah.com/muslim:1631
29. Machado AC, Bilo C, Helmy I. The role of zakat in the provision of social protection: a comparison between Jordan, Palestine and Sudan. Working Paper 168. Brasília: International Policy Centre for Inclusive Growth; 2018. https://www.researchgate.net/publication/327201516_The_role_of_zakat_in_the_provision_of_social_protection__a_comparison_between_Jordan_Palestine_and_Sudan
30. International Labour Organization. Sudan National Health Insurance Fund (NHIF): assessment of institutional arrangements and analysis of income and expenditure as of 2022. Geneva: ILO; 17 July 2025. https://www.ilo.org/publications/sudan national health insurance fund nhif
31. Dahabshiil. Ramadan Relief 2026: thank you [Internet]. 2026. https://landing.dahabshiil.com/ramadan relief 2026 thank you
32. Somali National News Agency (SONNA). Prime Minister Hamza opens Somalia Diaspora Centre [Internet]. June 2026. https://sonna.so/en/article/Prime Minister Hamza Opens Somalia Diaspora Centre
33. US Somalia.com. Somalia economy: remittances [Internet]. 2026 (secondary source). https://us somalia.com/economy/
34. AllAfrica. [Jakaya Kikwete Cardiac Institute: patients treated and costs avoided, 2022/23] [Internet]. 20 July 2023. https://allafrica.com/stories/202307200042.html
35. African News Agency (Xinhua). Chinese built cardiac institute in Tanzania marks 10 years, saves 1 million lives [Internet]. 2025. https://africannewsagency.com/chinese built cardiac institute in tanzania marks 10 years saves 1 million lives/
36. Vervoort D, Meuris B, Meyns B, Verbrugghe P. Global cardiac surgery: access to cardiac surgical care around the world. J Thorac Cardiovasc Surg. 2020;159(3):987 996. https://pubmed.ncbi.nlm.nih.gov/31128897/
37. Vervoort D, Swain JD, Pezzella AT, Kpodonu J. Cardiac surgery in low and middle income countries: a state of the art review. Ann Thorac Surg. 2021;111(4):1394 1400. doi:10.1016/j.athoracsur.2020.05.181 https://doi.org/10.1016/j.athoracsur.2020.05.181

© 2026 Dr. Abdulrazaq Yusuf Ahmed · The text and original figures are licensed under CC BY 4.0, with the exception of photographs · This document reflects a personal academic viewpoint and does not represent an official stance of SHIA.

وَمَنْ أَحْيَاهَا فَكَأَنَّمَا أَحْيَا النَّاسَ جَمِيعًا

“Whoever saves one life, it is as if he had saved all of humanity.”

Qofkii naf badbaadiya, waxa uu la mid yahay qof badbaadiyay dadka oo dhan.

Let us turn qaaraan into caymis:

solidarity into a system.

Aan qaaraanka u beddelno caymis, wadajirkeennana u beddelno nidaam.

Dr Abdulrazaq Yusuf Ahmed (Dr Jalaaludiin)

drjalaaludiin.com · @drjalaal · ORCID 0000 0002 6985 1087

RESEARCH. POLICY. TRANSFORMATION.