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The 2026 aid cliff: resource mapping evidence on donor withdrawal and health financing sustainability in Somalia

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Abstract

Introduction. Official development assistance (ODA) for health is projected to fall by 29–46% between 2024 and 2026, with fragile and conflict-affected states most exposed. Country-level primary evidence on the magnitude and structure of this shock remains scarce. We quantify it for Somalia, whose health sector is among the most donor-dependent in the world.

Methods. We analysed Somalia's government-led Resource Mapping and Expenditure Tracking (RMET) exercise covering 2022–2026: a census of 28 external financing partners (19 direct responses; four captured through implementing partners and secondary sources) combined with government budget data, consolidated and triangulated to eliminate double counting. Financing was classified by source, budget channel, health system strengthening (HSS) and Essential Package of Health Services (EPHS) priority, level of care and disease programme, and compared against costed EPHS coverage scenarios. Figures for 2026 reflect commitments confirmed at data collection (December 2025–February 2026).

Results. Total health-sector resources were US$1.30 billion over 2022–2026 — US$12.50 per capita per year, of which US$0.18 was government financing. External funding rose from US$223 million (2022) to US$320 million (2025), then fell to US$125 million committed for 2026, a 61% single-year contraction driven by the United States' bilateral exit and wider donor pullbacks; humanitarian assistance fell 81% from its 2023 peak. Government financing moved counter-cyclically, rising 239% in 2026 (US$2.7 million to US$9.3 million) and lifting the government share of total financing from under 1% to 6.9%, though this offsets less than 5% of the external decline. Concentration intensified: four financiers provide 59% of cumulative external funding, and the World Bank/Global Financing Facility share of annual commitments rose from 8% to 40%. Of external financing, 78% supports service delivery and 22% system strengthening, within which pharmaceutical and vaccine supply absorbs 76% while health financing capacity receives 1.3%. Available 2026 financing (US$126 million) funds the EPHS at roughly 20% population coverage; 50–80% coverage would require US$355–655 million per year.

Conclusion. The 2026 contraction is a structural break, not a cyclical dip. In maximally donor-dependent settings, financing sustainability now depends on consolidated pooled financing under government stewardship, explicit prioritisation, and domestic revenue instruments — with institutionalised annual resource mapping as the monitoring backbone.

Key message

What is already known on this topic - Official development assistance for health is projected to fall by 29–46% between 2024 and 2026, reversing two decades of growth, with reductions concentrated in bilateral programmes on which fragile and conflict-affected states depend most. - Existing evidence on the shock consists largely of global projections, cross-country vulnerability frameworks and commentary; primary, country-level quantification of its magnitude and structure within a national health sector remains scarce.

What this study adds - Using a government-led census of all external health financiers, this study quantifies the shock in one of the world's most donor-dependent health systems: Somalia's US$1.30 billion health financing envelope for 2022–2026 was 99% externally financed, and committed external financing for 2026 stood 61% below the 2025 level at the time of data collection. - Government health financing moved counter-cyclically, rising 239% in 2026 (US$2.7 million to US$9.3 million) — the largest year-on-year increase in the series — and lifting the government share of total health financing from under 1% to 6.9%, although this offsets less than 5% of the external decline. - The contraction is accompanied by intensifying concentration — four financiers already provide close to 60% of external funding, and the World Bank/Global Financing Facility share of annual commitments rose from 8% to 40% — leaving available financing sufficient to deliver the Essential Package of Health Services at only around 20% population coverage.

How this study might affect research, practice or policy - The findings define a transition agenda for maximally aid-dependent settings — pooled financing under government stewardship, explicit service prioritisation, and new domestic revenue instruments — and demonstrate that an institutionalised, annual resource mapping exercise can supply the monitoring backbone such a transition requires.

Introduction

The architecture of development assistance for health entered its sharpest contraction in a generation in 2025. Following the abrupt withdrawal of United States bilateral health assistance and successive reductions announced by other major providers, the OECD projects that ODA for health and population will fall by 29–46% between 2024 and 2026 — a reduction of US$5–8 billion that would return health aid to levels last seen in 2008, with further multi-year cuts already legislated to at least 2028 [1]. The retrenchment extends to the multilateral system: the Global Fund's eighth replenishment secured roughly two-thirds of its US$18 billion target, with nine of its ten largest donors reducing their pledges [2]. Bilateral assistance to sub-Saharan Africa and to the least developed countries is projected to fall for a third consecutive year [1].

A rapidly growing literature has mapped the exposure this creates. Cross-country analyses have proposed vulnerability indices identifying the states least able to absorb external financing shocks [3], regional syntheses have sketched post-aid financing frameworks for Africa [4], and policy institutes have begun tracing the security consequences of health-system disruption in the Sahel and the Horn of Africa [5]. Commentaries have canvassed substitution options from debt-for-health swaps to accelerated domestic resource mobilisation [6]. What this literature largely lacks is primary, country-level quantification: how large, exactly, is the shock inside a single national health sector; through which channels does it arrive; which functions and services does it strip out first; and what does it leave behind?

This study answers those questions for the setting where the answers matter most. Somalia's health sector is among the most donor-dependent in the world, rebuilt over the past decade almost entirely on

external financing after prolonged state collapse, and financed at levels far below every benchmark for essential service delivery [7–9]. It is also — unusually for a fragile and conflict-affected state — a setting with a government-led instrument capable of measuring the shock. Since 2022, the Federal Ministry of Health and Human Services, with technical support from the Global Financing Facility and the World Bank, has institutionalised a Resource Mapping and Expenditure Tracking (RMET) exercise: a census of all external financing partners and government allocations, classified against the national Essential Package of Health Services (EPHS) and health system strengthening (HSS) frameworks of the Health Sector Strategic Plan III [10, 11].

Drawing on the 2022–2026 RMET, this paper pursues four objectives: to quantify the level, composition and trajectory of health-sector financing over 2022–2026, including the 2026 contraction; to characterise the structure of external financing — donor concentration, budget channels and allocation across services, system functions and levels of care; to measure the resulting gap against costed EPHS coverage scenarios; and to draw out the implications for financing sustainability in Somalia and for other maximally aid-dependent settings entering the post-2025 aid landscape. The analysis is situated within Somalia's decade-long sequence of aid-alignment reforms — the 2021 Roadmap for Enhanced Use of Country Systems, the 2023 Alignment and Sector Coordination Roadmap, and the 2026 pooled financing proposal — whose fuller assessment is reported elsewhere [12–14]; here they form the policy context within which the financing shock lands. Because the post-2025 landscape confronts every maximally aid-dependent health system at once, the Discussion places the Somali evidence in structured comparison with five fragile-state transitions — Afghanistan, South Sudan, the Democratic Republic of the Congo, Yemen and Sudan — and draws out what the case contributes to global health financing knowledge and to the agencies now deciding how the transition is financed.

Methods

Setting

Somalia is a federal, low-income, conflict-affected state of approximately 20 million people, comprising the Federal Government and Federal Member States. Government revenue remains among the lowest in the world relative to GDP, and the national health system delivers services through a mixed public, private and non-governmental provider landscape coordinated under the Health Sector Strategic Plan III (HSSP III) and its costed EPHS [10]. Out-of-pocket payment dominates household-level health spending — 38.8% of the population experienced financial hardship due to out-of-pocket health spending in 2022 [15, 23], while institutional financing — the subject of this paper — is overwhelmingly external.

Study design and instrument

The RMET is a government-led census of institutional health financing, adapted from the resource mapping methodology promoted by the Global Financing Facility and customised to Somalia's health

system frameworks [11]. The data collection instrument was aligned to the HSSP III's HSS priority areas and the EPHS service structure during a preparatory phase (September–December 2025) involving the Ministry and the World Bank, followed by partner-alignment sessions to standardise interpretation of budget lines across organisations [11].

Data collection

Between December 2025 and February 2026, the instrument and completion guidelines were distributed to all 28 identified external financing partners — bilateral donors, multilateral agencies, United Nations organisations, foundations and international non-governmental implementers — supported by one-to-one technical sessions. Nineteen partners (68%) returned direct responses. For four partners that did not respond directly — including the United States (BHA/USAID), EU/ECHO, WHO and one foundation — data were captured indirectly through their implementing partners (principally UNICEF and UNFPA) and verified secondary sources. Three partners provided no usable data, and two Gulf-state supporters provide in-kind assistance that is not financially recorded; both groups are treated as excluded coverage and discussed under limitations. Government financing was compiled from federal budget documentation. The full response matrix is provided in Supplementary Table S1.

Data processing and classification

Returns were consolidated, cleaned and triangulated against implementing-partner reports to eliminate double counting where a single project is financed by multiple donors or delivered through multiple agencies [11]. Each financing line was classified by: source (external development assistance, external humanitarian assistance, government); budget channel (on-budget — reflected in government budget documentation — versus off-budget parallel delivery); HSS versus EPHS priority; HSS priority area; level of care (community, primary and secondary, tertiary, central administration); and disease programme. Commitments and disbursements were distinguished throughout. Figures for 2026 represent commitments confirmed at the time of data collection; because several major donors operate July–June fiscal years beginning mid-2026 and others had unsigned budgets during strategic planning cycles, the 2026 figure is a floor estimate of committed resources rather than a projection of final flows, and is interpreted as such throughout.

Gap analysis

Available EPHS financing by year was compared against the Ministry's costed scenarios for delivering the EPHS at 20%, 50%, 70% and 80% population coverage, generating implied financing gaps for 2026 [11, 12].

Validation and analysis

Preliminary results underwent bilateral validation with individual donors (February–March 2026) and a multi-stakeholder validation workshop on 28 April 2026; this paper reports the validated preliminary series, and any residual revisions in the final RMET report are expected to affect point estimates rather than direction or magnitude of the findings. Analysis is descriptive: levels, shares, growth rates and concentration (share of the largest financiers), computed in the Ministry's consolidated RMET database.

Ethics and permissions

The study analyses aggregate institutional financial and administrative data collected by the Ministry under its sector-coordination mandate; no human subjects, patient data or individual-level records were involved, and ethics committee review was therefore not required. The Ministry of Health and Human Services approved the use of the RMET data for publication.

Patient and public involvement

Patients and the public were not involved in the design, conduct, reporting or dissemination of this research, which analyses institutional financing data.

Results

A US$1.3 billion envelope, 99% externally financed

Total institutional health-sector financing over 2022–2026 amounted to US$1.302 billion (Table 1). External sources supplied 99% — development assistance US$870.7 million (67%) and humanitarian assistance US$411.8 million (32%) — against government financing of US$19.2 million (1%). Annualised, total resources averaged US$12.50 per capita, of which government financing contributed US$0.18 per capita per year. Total funding rose steadily from US$225 million in 2022 to US$322 million in 2025, averaging approximately US$292 million per year over 2022–2025, before contracting to US$134 million in committed resources for 2026.

Table 1
Somalia health-sector financing by source and year, 2022–2026 (US$ millions, current).

Year	External financing	Government financing	Total	Of which: development assistance	Of which: humanitarian assistance
2022	223	2.4	225	148.3	74.3
2023	303	2.4	305	192.5	110.4
2024	312	2.5	315	206.3	106.0
2025	320	2.7	322	220.1	99.6
2026*	125	9.3	134	103.6	21.5
Total	**1,283**	**19.2**	**1,302**	**870.7**	**411.8**

2026 reflects commitments confirmed at data collection (December 2025–February 2026); several donors' July–June fiscal cycles begin mid-2026, so the final figure is expected to rise while remaining far below trend. Source: Somalia RMET, preliminary validated series [11].

Figure 1. **Total health-sector financing by source, 2022–2026.** *External financing (stacked bars, left axis) and government financing (line, right axis), US$ millions. 2026 = committed at data collection.*

The 2026 contraction: a structural break

Committed external financing for 2026 stood at US$125 million — 61% below the 2025 level of US$320 million — at the time of data collection (Fig. 1). Both external channels contracted, but asymmetrically (Fig. 2). Development assistance fell from US$220.1 million (2025) to US$103.6 million committed (53%), driven principally by the exit of United States bilateral assistance and pullbacks by other bilateral providers. Humanitarian assistance collapsed from its 2023 peak of US$110.4 million to US$21.5 million committed for 2026 — an 81% decline from peak — removing the channel that had cushioned the sector through 2022–2025. Government health expenditure moved sharply in the opposite direction — examined in the next section.

The 2026 figure is, by construction, a floor: mid-year donor fiscal cycles and unsigned budgets mean additional commitments will materialise. Three features nonetheless mark the contraction as structural rather than cyclical. First, the largest single financier of the preceding period, the United States, exited bilaterally rather than reducing — its share of annual external financing fell from 12% (2022) and a peak of 17% (2023) to zero. Second, the humanitarian channel contracted in parallel rather than counter-cyclically. Third, the providers that remain had, at validation, confirmed no offsetting scale-up beyond one financier's existing multi-year commitments.

Figure 2. **Composition of external financing, 2022–2026.** *Development assistance and humanitarian assistance, US$ millions per year.*

Government financing: a 239% increase from a 1% base

Government health expenditure moved decisively against the external trend. Having risen only incrementally from US$2.36 million (2022) to US$2.73 million (2025), the government allocation for 2026 reached US$9.25 million — an increase of 239% in a single year, and 293% above the 2022 level, by an order of magnitude the largest year-on-year rise in the series. As a result, the government share of total health-sector financing, which never exceeded 1.0% during 2022–2025, rose to 6.9% of the committed 2026 envelope, against 93.1% supplied by external partners (Table 2).

Two forces produce this shift, and they must be read together. The first is a genuine and unprecedented expansion of the domestic health budget — a material fiscal signal that the federal budget can move for health when political commitment crystallises, which is precisely the feasibility question hanging over the domestic revenue instruments discussed below. The second is the simultaneous collapse of the external denominator, which mechanically raises any domestic share. On the most cautious reading, US$9.25 million offsets less than 5% of the US$195 million external decline and leaves government financing below US$0.50 per capita per year. Both readings are correct, and the policy conclusion comes from holding them together: the 2026 increase is the proof of concept for domestic commitment; the proposed revenue instruments are the mechanism for scaling it.

Table 2

Government versus external partner contributions to health-sector financing: 2026 (committed) against reference years. *Panel A — Government versus external financing*

Year	Government (US $M) | External partners (US M)	Total (US$M)	Government share (%)	External share (%)	
2022	2.36	223	225	1.0	99.0
2025	2.73	320	322	0.8	99.2
2026*	9.25	125	134	6.9	93.1
Change, 2025→2026	+ 239%	−61%	−58%	+ 6.1 pp	−6.1 pp

Panel B — Composition of committed 2026 external financing, by partner

Partner	Share of 2026 committed external financing (%)
World Bank / GFF	40
Global Fund (GFATM)	18
Gavi	15
Other donors (combined)	10
Canada	5
USAID	0
All remaining partners (FCDO, Gates Foundation, European Commission, Sida, KfW and others, combined)	~ 12

2026 reflects commitments confirmed at data collection. Panel B shares are drawn from the RMET annual donor series; remaining partners' individual shares are small and reported in aggregate pending final validation. Source: Somalia RMET, preliminary validated series [11].

Channel shift: the on-budget share rises as the envelope falls

Within external financing, a marked channel shift preceded the contraction (Fig. 3). On-budget external financing — resources reflected in government budget documentation — rose more than five-fold in absolute terms, from US$19.4 million (2022) to US$105.4 million (2025), lifting the on-budget share of external financing from 9% to 33%. Off-budget parallel financing contracted from a 2023 peak of US$265.0 million to US$214.3 million (2025) and US$66.5 million committed for 2026. Because the contraction fell disproportionately on off-budget bilateral and humanitarian flows, the on-budget share of committed 2026 external financing reached 47% — a compositional improvement produced substantially by the withdrawal of off-budget financiers rather than by new alignment decisions, and driven overwhelmingly by a single financier's operating model, as the concentration analysis below shows.

Figure 3. **On-budget share of external financing, 2022–2026.** *Reported years shown; 2024 not reported in the validated preliminary series. On-budget = reflected in government budget documentation.*

Concentration: four financiers, and increasingly one

External financing is highly concentrated (Table 3). Four financiers — the World Bank/Global Financing Facility (20.2% of cumulative 2022–2026 external funding), the Global Fund (14.5%), Gavi (13.4%) and USAID (10.6%) — together supplied 59% of the total, while sixteen financiers contributed roughly 2% or less each. Concentration intensified sharply across the period: the World Bank/GFF share of annual commitments rose from 8% (2022) to 30% (2025) and 40% (2026), even as its absolute financing grew, so that by 2026 the sector's largest financier accounts for two-fifths of all committed external resources and is the only financier channelling funds through government treasury systems. The mirror image is

the disappearance of the second pillar: USAID's annual share fell from 12–17% to zero. A residual 4.5% of cumulative funding could not be attributed to a specific financier where multiple donors co-finance single projects ("unspecified donors"), a categorisation limitation discussed below.

Table 3
Cumulative external health financing by financier, Somalia, 2022–2026.

Financier	Share of external financing (%)	Financier	Share (%)
World Bank / GFF	20.2	Gates Foundation	5.6
Global Fund (GFATM)	14.5	Unspecified donors	4.5
Gavi	13.4	Sida (Sweden)	2.6
USAID	10.6	KfW (Germany)	2.5
BHA (US humanitarian)	7.1	Canada	2.4
FCDO (UK)	6.3	European Commission	2.3
Top four combined	**58.7**	Remaining 12 financiers	≤ 2.0 each

Source: Somalia RMET, preliminary validated series [11]. *BHA is reported separately from USAID development assistance in the RMET classification.*

Figure 4. **Annual external financing shares of the rising anchor financier and the exiting pillar (reported years).** *World Bank/GFF share rises from 8% to 40%; USAID share falls from a 17% peak to 0%.*

Allocation: service delivery funded eleven times over system-building

Across 2022–2026, 78% of financing supported EPHS service delivery and 22% health system strengthening, a split broadly stable over time. By level of care, primary and secondary services absorbed approximately 65% of resources and community-based interventions 24%, with tertiary care and central administration together accounting for roughly 10% — a distribution consistent with the EPHS's primary-care orientation. Within the HSS envelope, however, allocation is severely skewed toward commodities: pharmaceutical and vaccine supply chains absorbed 76.4% of HSS financing, health information systems 10.1% and cross-cutting areas 9.7%, while the functions on which a self-governing system depends received residual amounts — health workforce restructuring 1.8%, health financing and financial management 1.3%, and private-sector engagement 0.6%. Disease-programme mapping shows reproductive, maternal, newborn and child health financed by 20 separate funders, nutrition by 15 and immunisation by 11 — the programmes where coordination burdens concentrate — alongside minimal investment in non-communicable and neglected tropical diseases and none identified for mental health or injuries (Supplementary Tables S2–S4).

The coverage gap: financing one-fifth of the essential package

Financing available for the EPHS peaked at US$258 million in 2024 and fell to a preliminary US$126 million for 2026. The Ministry's EPHS costing, prepared in the OneHealth Tool across 412 interventions, prices the package at US$251.8 million for 2026 under its least expensive investment scenario and US$295.4 million under its most expensive — US$14.97 and US$17.56 per capita respectively for a projected population of 16.82 million [11, 23]. Available financing therefore covers 50% of the lower figure and 43% of the higher, against more than 100% of the corresponding 2025 requirement (US$215.4–247.8 million) a year earlier. Per capita, external financing falls to US$7.49 against a costed need of US$14.97.

The coverage-scenario figures reported in resource-mapping outputs correspond to years of this same costing trajectory rather than to independent scenarios: US$355 million is the 2027 requirement, US$528 million the 2029 requirement and US$655 million the 2030 endline at 80% coverage (Table 4). Read correctly, the series shows the requirement rising along the planned coverage path precisely as the envelope contracts, so the financing gap widens from both directions.

Table 4
EPHS coverage scenarios against available 2026 financing (US$ millions).

Coverage attained	Year attained in the costing	Funding required	2026 available financing	Implied gap
Current (2026 plan)	2026	251.8–295.4	126	126–169
50%	2027	355.4	126	229
70%	2029	528.8	126	403
80% (endline)	2030	655.2	126	529

Source: Somalia RMET preliminary validated series and Ministry EPHS costing [11, 12]. *2026 available financing is preliminary (committed at data collection).*

Discussion

Principal findings

Four findings define Somalia's position at the 2026 aid cliff. First, dependence: over 2022–2026 the health sector ran on US$12.50 per capita per year, 99% of it external, with government financing at US$0.18 per capita — a structure in which any external shock is, by construction, a systemic shock. Second, the contraction itself: committed external financing for 2026 stood 61% below the 2025 level at data collection, with the humanitarian channel down 81% from its peak and the sector's second-largest

financier exiting entirely rather than reducing — against which government financing rose 239% in a single year, lifting its share of the total from under 1% to 6.9%: a material counter-cyclical fiscal signal, though from a very low base. Third, concentration: four financiers already supplied 59% of external funding, and the contraction concentrates the remainder further — by 2026 a single financier accounts for 40% of committed external resources and constitutes the only channel operating through government treasury systems. Fourth, an allocation profile that leaves the system least able to absorb the shock: 78% of financing purchases service delivery while the functions that would let government manage a smaller envelope — health financing capacity (1.3% of the system-strengthening envelope), workforce restructuring (1.8%), private-sector engagement (0.6%) — are financed at residual levels. The arithmetic consequence is that available 2026 financing delivers the Essential Package of Health Services at roughly one-fifth of population coverage, with 50% coverage requiring nearly three times the committed envelope.

Comparison with existing evidence

These findings give country-level precision to a shock so far characterised mainly in global and regional terms. The OECD projects health ODA declines of 29–46% between 2024 and 2026 across providers [1]; Somalia's committed single-year contraction of 61% in external health financing indicates that maximally dependent settings sit well beyond the global average, consistent with vulnerability frameworks that rank countries by dependence, fiscal capacity and donor concentration [3] — on all three of which Somalia occupies the extreme end. The findings also extend the aid-architecture literature. Donor proliferation and fragmentation are known to impose transaction costs on recipient administrations [18, 19], and Somalia's programme-level mapping — twenty financiers in reproductive, maternal, newborn and child health alone — shows those costs persisting even as the envelope collapses, echoing sector-level evidence from Sierra Leone [20] and the broader record of parallel delivery in conflict-affected states [21].

The channel analysis speaks directly to the use-of-country-systems literature, which finds that donors' willingness to use government systems correlates only weakly with measured system quality [16]. Somalia's on-budget share of external financing rose from 9% to 33% between 2022 and 2025 and reached 47% of committed 2026 resources — but the improvement is substantially compositional, produced by the withdrawal of off-budget financiers and the growth of a single financier whose operating model channels funds through government. Alignment achieved through exit and concentration is fragile alignment. Afghanistan's experience is the standing caution on both dimensions: the Sehatmandi programme demonstrated that consolidated, pooled financing can reduce fragmentation at scale, and its aftermath demonstrated how quickly gains unwind when a narrow financing base withdraws before domestic systems and revenues can carry the load [17].

The Somali transition in comparative perspective: five fragile states

Somalia is one node in a class of maximally aid-dependent health systems now undergoing donor transition, and its evidence reads differently when set against the class (Table 5). Three transition modes recur across the six settings. **Political rupture** severs financing and modality together: Afghanistan's Sehatmandi era demonstrated that pooled, government-contracted financing can run national service delivery through active conflict, and August 2021 demonstrated the converse — within months, an on-system architecture was reconstituted off-system, with World Bank resources routed through United Nations agencies outside government entirely [17, 24]. Sudan compounds the mode: aid suspension after the 2021 coup was followed by a war that has physically destroyed much of the system the aid had financed [26]. **Chronic bypass** is transition postponed indefinitely: South Sudan's Health Pooled Fund and Yemen's emergency health operations show that pooling and country-systems use are separable — both settings pool substantial financing, and both deliberately route it around national institutions, through managing contractors and UN agencies respectively [24, 25]. The Democratic Republic of the Congo exhibits the fragmentation variant: heavy but provincially uneven dependence, recurrent emergency surges financed vertically, and stewardship capacity that the financing model persistently bypasses rather than builds [16, 21]. **Measured retrenchment** — a large contraction arriving through budget decisions rather than political rupture, in a setting still able to plan — is Somalia's mode, and at present Somalia is its clearest documented case.

Table 5
Six fragile-state donor transitions compared.

Setting	Dependence profile	Transition trigger and mode	Modality response	Government measurement and stewardship instruments	Lesson carried into the Somali design
Afghanistan	Near-total external financing of service delivery	Political rupture (2021)	On-system pooled → off-system UN-managed	Lost with recognition	Pooling works in conflict; a narrow financing base and political recognition risk are the fragility
Sudan	High dependence; system destroyed by war	Coup-driven suspension (2021), then war (2023)	Development financing → residual humanitarian	Collapsed	Transition planning cannot begin after rupture
South Sudan	Extreme; government health spending minimal	Chronic bypass since independence	Pooled but off-government (managing contractor)	None government-led	Pooling without country systems builds no state capability
Yemen	Near-total for operating costs since 2015	Conflict-driven chronic bypass	IDA and pooled funds via UN agencies	Fragmented across authorities	Emergency modalities harden into architecture if unpriced
DR Congo	High and provincially uneven	Chronic fragmentation; vertical surges	Project-based; emergency verticals	Partial	Surge financing bypasses the systems it repeatedly needs
Somalia	99% external (2022–2026); US$12.50 pc	Measured retrenchment (− 61%, 2026)	Concentration toward one on-system financier	**RMET census; costed EPHS; pooled mechanism proposed**	The instrumented transition: measured, costed, and negotiable

Sources: [16, 17, 21, 24–26] *and this study. Characterisations are structural summaries; country detail is cited in text.*

The comparison yields the study's sharpest structural claim: **what distinguishes Somalia is not the depth of its dependence — South Sudan and Yemen match or exceed it — but that its transition is instrumented.** Somalia enters the contraction with a government-led financing census able to measure the shock in near-real time, a costed national service package able to price what the remaining envelope buys, and a stewardship proposal on the table before the transition is complete. None of the five comparators combined these at their transition moment. Afghanistan had the pooled instrument without the domestic revenue base or the political insurance; South Sudan and Yemen have pooling without government; Sudan lost the possibility of planning altogether; the DRC has never consolidated the baseline. The comparative reading also disciplines optimism: Afghanistan shows that instruments do not survive politics, and the concentration documented in this study — one financier at 40% — is precisely the exposure that turned Afghanistan's consolidation into its single point of failure.

What the case contributes to global health financing knowledge

Four contributions travel beyond Somalia. First, the study moves the post-2025 aid-contraction literature from projection to measurement: it provides, to our knowledge, the first government-measured, partner-validated quantification of the shock's magnitude, channels and functional incidence inside a single national health sector, and demonstrates that vulnerability-index extremes [3] translate into single-year contractions roughly twice the global projected range [1]. Second, it contributes a measurement caution with general application to alignment monitoring: under contraction, on-budget shares rise mechanically as off-budget financiers exit — Somalia's 47% is composition, not conversion — so alignment indicators must be decomposed by financier before improvement is claimed, in Somalia, in GPEDC monitoring, and anywhere transition is underway. Third, the 239% counter-cyclical movement of the federal health budget supplies rare feasibility evidence for domestic resource mobilisation at the extreme of fragility: small in dollars, the shift demonstrates that domestic fiscal response to an aid shock is politically achievable even where government financing begins below 1% of the sector. Fourth, the study demonstrates a replicable instrument: a ministry-led resource-mapping census, classified against national service and system frameworks and validated with partners, produced transition evidence of publishable quality within one budget cycle — a template any aid-dependent ministry can implement with the support the GFF already provides for resource mapping.

Government stewardship under contraction

The transition's five focal dimensions — donor withdrawal, financing, stewardship, dependence and fragility — converge on a single institutional question: what does government stewardship concretely consist of when the state finances 7% of its health sector and the other 93% is contracting? The Somali evidence suggests a four-function answer. *Visibility* is the precondition: a ministry cannot steward flows it cannot see, and the RMET census is the instrument that converted an opaque donor landscape into a measured one — the difference between experiencing a 61% contraction and being able to state it, source by source, in a validation workshop with the financiers concerned. *Allocation* is the substance:

under contraction, stewardship means choosing what the residual envelope buys — the explicit prioritisation this study's coverage arithmetic forces — rather than presiding over the sum of project closures. *Protection* is the boundary condition: as institutional financing halves, the residual claim shifts to households already at 38.8% hardship incidence, and a steward that does not monitor and mitigate that shift is managing the budget while losing the population [15, 23]. *Negotiation* is the external face: a government holding a costed requirement trajectory, a measured envelope and a proposed pooled instrument negotiates transition terms; one holding none of these receives them. On this reading, stewardship in maximal aid dependence is not a residual that grows as money becomes domestic — it is a set of capabilities that can be built while dependence persists, and the Somali case documents each being built under the least favourable conditions in the study period. That is the operational meaning of the counter-intuitive finding running through this paper: the contraction has advanced stewardship even as it has devastated financing, because it forced the state from bystander to principal in a single budget year.

Policy implications

Five implications follow. First, consolidation should be governed rather than endured: the concentration now occurring by default is the strongest case yet for the government-managed pooled financing arrangement proposed in 2026, which would convert de facto reliance on one financier's systems into a jointly governed, multi-contributor pool anchored on a single national expenditure programme [12, 22]. Second, prioritisation must become explicit: an envelope that funds one-fifth of EPHS coverage forces choices between depth and breadth of the package, and those choices should be made deliberately through the sector's coordination structures rather than emerge from uncoordinated project closures. Third, domestic revenue instruments move from aspiration to necessity — and the 239% budget increase of 2026 demonstrates that domestic fiscal movement for health is politically achievable: the Ministry's proposed health excise, national health insurance contributions and solidarity levies — projected in government analysis to yield on the order of US$100 million per year under medium scenarios — would, if enacted, roughly match the entire committed 2026 external envelope [12, 22]. Fourth, the composition of what remains should be rebalanced: protecting and expanding the residual shares now devoted to health financing capacity, workforce and information systems is the condition for the sector to manage any future envelope, large or small. Fifth, measurement should be institutionalised: this study was possible because a government-led RMET exists; conducting it annually, digitalising collection to raise direct response rates, and extending it to Federal Member State level would give Somalia — and the partners that remain — a shared, national instrument for navigating the transition [11, 12].

For other maximally aid-dependent settings, the Somali case offers a template and a warning. The template is methodological: a ministry-led financing census, classified against national service and system frameworks and validated with partners, can quantify an aid shock in near-real time and anchor the response in government-owned evidence. The warning is structural: where dependence, concentration and commodity-skewed allocation coincide, an external contraction does not shrink the

health system proportionally — it removes its financing base while leaving its stewardship functions unbuilt.

Implications for WHO, the World Bank, the GFF and development partners

The findings carry addressed implications. **For WHO**, the contraction converts financial protection from a monitoring topic into the sector's leading risk indicator: as institutional financing halves, the residual claim falls on households whose hardship incidence was 38.8% before the shock [15, 23]; WHO's country support should prioritise Somalia's first National Health Accounts, hardship monitoring on the revised SDG 3.8.2 definition, and financing-policy dialogue that treats the pooled mechanism as the vehicle for its own free-at-point-of-use primary care guidance. **For the World Bank**, anchor status carries governance duty: at 40% of committed external financing and sole occupant of the treasury channel, the Bank's choice is between de facto dominance and deliberately shared governance — the Somali evidence argues for converting its position into a multi-contributor pooled mechanism with minimum-contributor safeguards, and for extending the RCRF payroll modality it already operates to the health workforce, the single largest step available toward country-systems use. Afghanistan is the standing warning against allowing consolidation to equal concentration [17]. **For the GFF**, whose technical support made the RMET possible, the case validates resource mapping as core country capability rather than project accessory: institutionalising annual, digitalised, state-disaggregated RMETs — and adding financier-decomposed alignment metrics to country monitoring so compositional improvements are not credited as reform — would generalise the Somali template across the GFF portfolio. **For development partners collectively**, three design rules follow from the evidence: transition compacts should carry dated financing floors set against the costed requirement trajectory rather than open-ended intentions; the residual envelope's composition should protect the stewardship functions now financed at 0.6–1.8% — the capabilities that determine whether any future envelope can be managed; and exit, where it must occur, should be sequenced against the government's published requirement calendar rather than the donor's fiscal one.

Strengths and limitations

The study's principal strengths are census coverage of all identified institutional financiers, government leadership with partner validation (bilateral validations and a multi-stakeholder workshop), triangulation against implementing-partner records to eliminate double counting, and classification against national service and system frameworks rather than donor categories.

Six limitations qualify the findings. First, 2026 figures are commitments confirmed at data collection; with several donors operating July–June fiscal years and others holding unsigned budgets, the final 2026 envelope will exceed the floor reported here, although validation identified no offsetting scale-up that would alter the finding of a structural contraction. Even under a scenario in which late-year commitments recovered half of the 2025–2026 gap, the 2026 envelope would close approximately 30% below the 2025 level; the structural-break finding is therefore robust to substantial additional

commitments. Second, this paper reports the validated preliminary RMET series; residual revisions in the final report may adjust point estimates. Third, four partners — including the largest humanitarian financier — were captured indirectly through implementing partners and secondary sources, and two Gulf-state supporters provide unrecorded in-kind assistance, so total external support is conservatively estimated. Fourth, 4.5% of cumulative funding could not be attributed to specific financiers where donors co-finance single projects, and some donor budget lines mapped imperfectly onto the HSS/EPHS classification, requiring judgement in categorisation. Fifth, the analysis reports commitments and allocations rather than expenditure reaching facilities; expenditure-side follow-through is a distinct question. Sixth, results are not yet disaggregated by Federal Member State, an extension the Ministry has identified as a priority for the next RMET cycle; and as a single-country study, generalisation rests on structural similarity — dependence, concentration and fragility — rather than statistical inference.

Future research

Four extensions follow. State-level disaggregation of the RMET would reveal the subnational incidence of the contraction. Expenditure tracking from commitment to facility would close the gap this study's commitment-side data leave open. Prospective monitoring of service outputs and financial hardship through the transition would convert the coverage arithmetic reported here into observed consequences — the evaluation baseline for any mitigation the sector mounts. And replication of the census methodology in the comparator settings of Table 5, where feasible, would allow the transition-mode typology proposed here to be tested rather than illustrated.

Conclusion

Somalia entered 2026 with a health sector financed almost entirely by external partners, and exits the year's commitment cycle with a 61% smaller committed external envelope, a collapsed humanitarian channel, and two-fifths of remaining resources supplied by a single financier. The contraction is structural, not cyclical: the sector's second pillar has exited rather than reduced, and no offsetting scale-up is in view. What remains finances the essential package for roughly one person in five. The response cannot be to wait for the previous architecture to return. It is to govern the consolidation already underway — through a pooled financing mechanism under government stewardship, explicit prioritisation of the essential package, enactment of domestic revenue instruments, protection of the system functions that make a smaller envelope manageable, and an institutionalised annual resource mapping exercise as the sector's shared instrument of navigation. For the growing set of countries confronting the post-2025 aid landscape, Somalia's evidence defines both the scale of the challenge and a government-led way of measuring — and therefore managing — it.

Declarations

Contributors. KMM conceived and designed the study, led the RMET exercise, conducted the analysis, and wrote and revised the manuscript. KMM is the guarantor and accepts full responsibility for the work, had access to the data, and controlled the decision to publish.

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Competing interests. The author serves as Health Financing Specialist at the Ministry of Health and Human Services, Federal Government of Somalia, where he leads the Health Economics and Financing Office responsible for the RMET exercise analysed in this study, and is Chief Executive Officer of the Institute of Public Finance, Somalia. No other competing interests are declared.

Ethics approval. Not required. The study analyses aggregate institutional financial and administrative data; no human participants or individual-level data were involved. The Ministry of Health and Human Services approved use of the RMET data for publication.

Data availability. The consolidated RMET summary tables underlying the analysis are available in the supplementary materials and from the Ministry of Health and Human Services on reasonable request, subject to institutional permissions.

Patient and public involvement. Patients and the public were not involved in this research.

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Figures

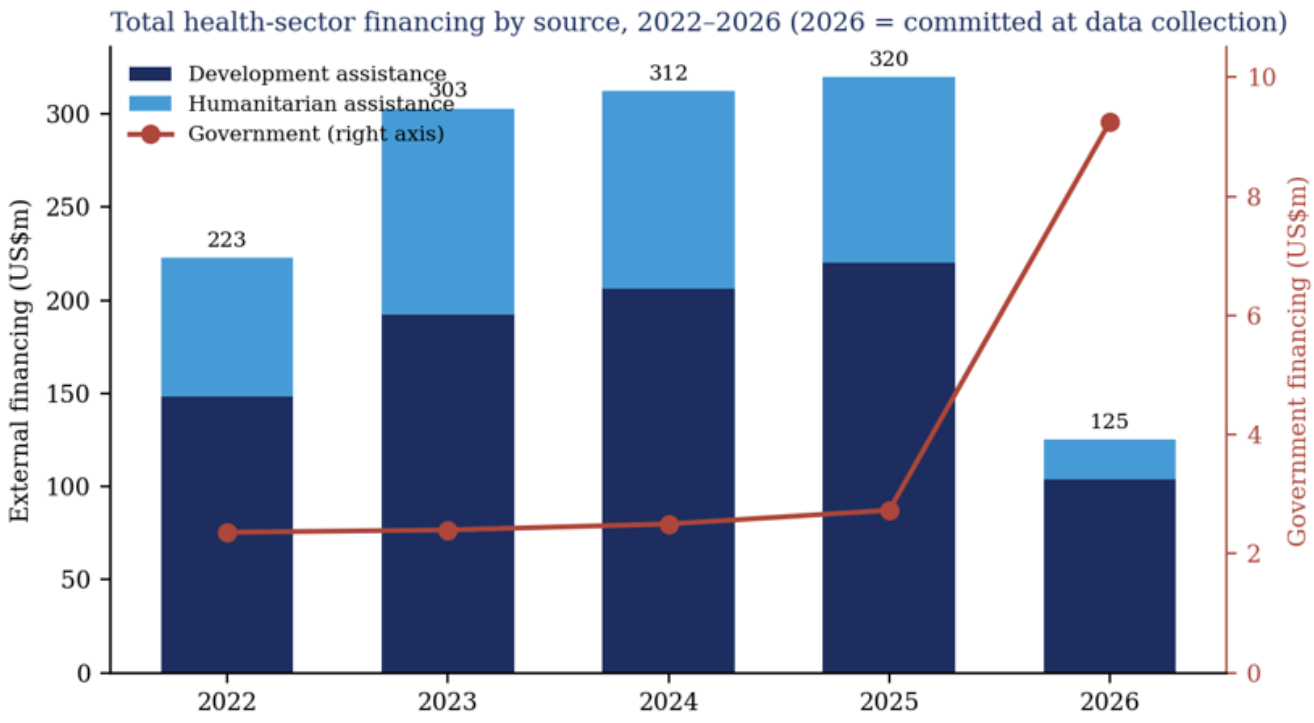


Figure 1

Total health-sector financing by source, 2022–2026. *External financing (stacked bars, left axis) and government financing (line, right axis), US$ millions. 2026 = committed at data collection.*

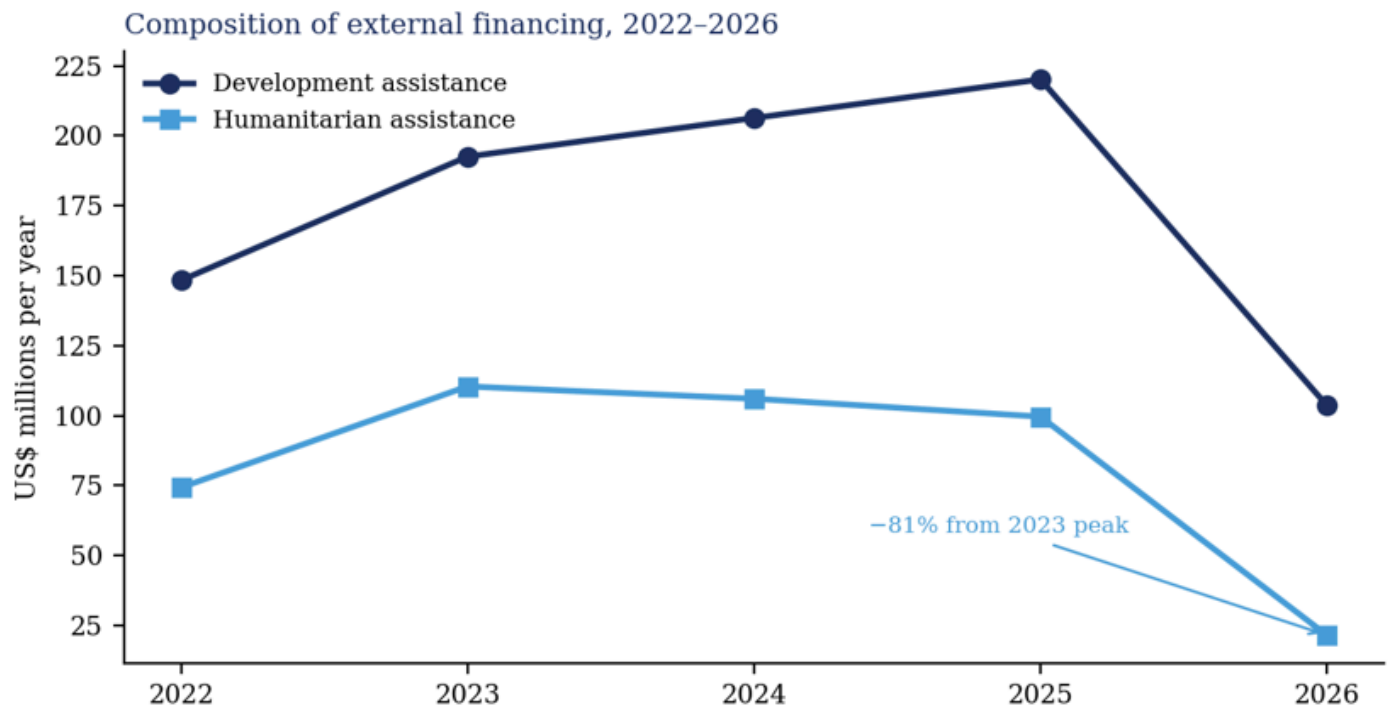


Figure 2

Composition of external financing, 2022–2026. *Development assistance and humanitarian assistance, US$ millions per year.*

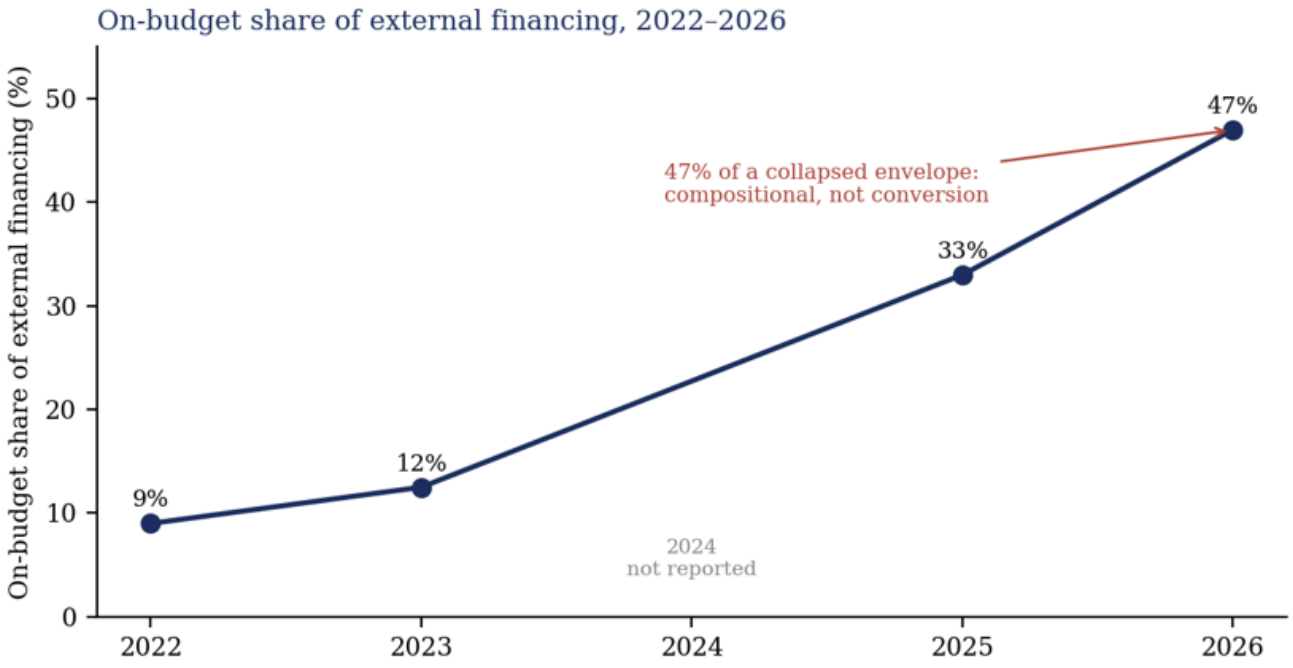


Figure 3

On-budget share of external financing, 2022–2026. *Reported years shown; 2024 not reported in the validated preliminary series. On-budget = reflected in government budget documentation.*

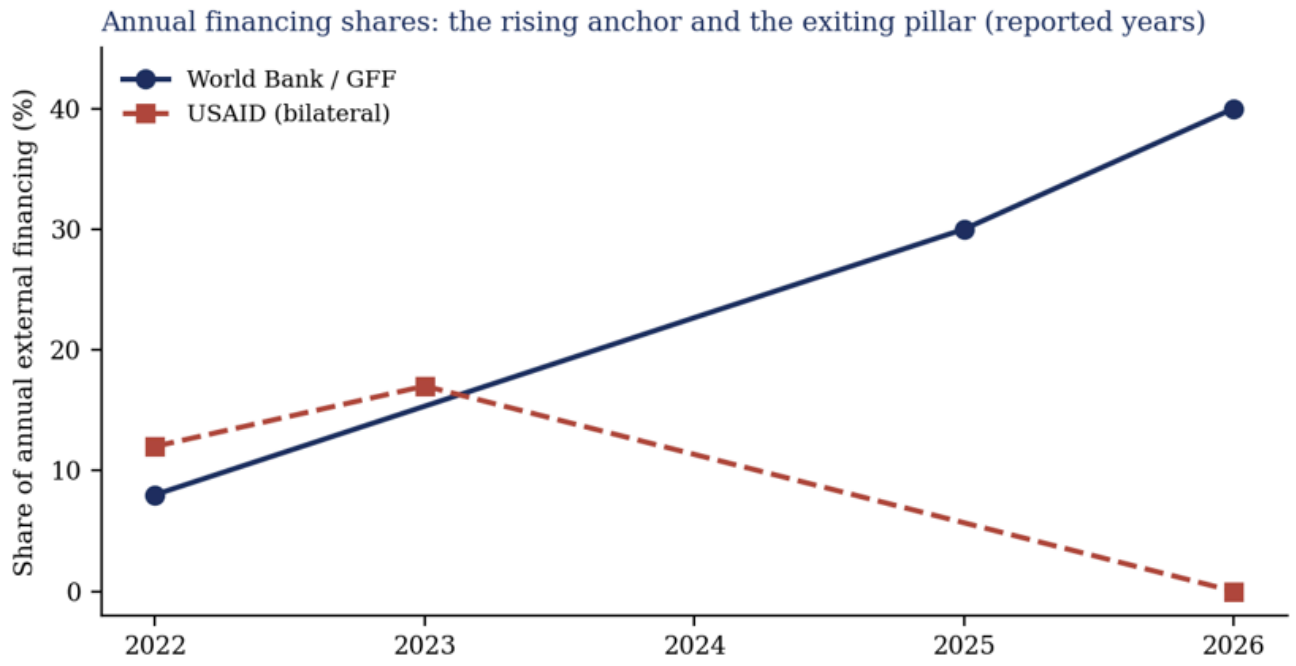


Figure 4

Annual external financing shares of the rising anchor financier and the exiting pillar (reported years). *World Bank/GFF share rises from 8% to 40%; USAID share falls from a 17% peak to 0%.*

Supplementary Files

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- Supplementarymaterial.docx