

# From aid dependence to domestic resource mobilization: a policy analysis of financing universal health coverage in Somalia

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## Research Article

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## Abstract

## Background

Somalia's health system is among the most externally financed in the world. Abrupt cuts in development assistance since 2025, led by the United States, have exposed the fragility of this arrangement and made domestic resource mobilization urgent. We appraise the options open to a fragile, federal, Muslim-majority and diaspora-dependent country and examine how globalization-related processes enable or constrain each.

## Methods

We conducted a desk-based policy analysis structured by the World Health Organization's health financing functions and the fiscal-space-for-health framework. Peer-reviewed studies, official documents, agency reports and, where no other evidence existed, preprints were used to appraise six channels against five criteria: general taxation, social health insurance, zakat and Islamic finance, earmarked levies and health taxes, diaspora financing, and efficiency gains through strategic purchasing, with illustrative experience from Ghana, Rwanda, the Philippines, Afghanistan and Indonesia.

## Results

Domestic revenue is about 2.5% of gross domestic product, against an estimated 14% or more needed for universal coverage of public education and health services, so no single channel can replace aid. Efficiency gains and better alignment of external funds with national systems are the most immediately feasible. Health taxes (khat, tobacco, sugar-sweetened beverages) are feasible in the short to medium term, though khat revenue depends on cross-border supply. Broad-based taxation is the most durable but slowest channel. Zakat and diaspora financing are significant but constrained: zakat is religiously earmarked, and remittances are private transfers reaching about 15% of households and exposed to taxation and banking restrictions abroad. Social health insurance is a long-horizon pooling anchor, constrained by contribution collection from an informal economy. Every channel is shaped by decisions, flows or institutions outside Somalia.

## Conclusions

A sequenced portfolio is required: efficiency and alignment first, health and broad-based taxes in the medium term, and insurance and institutionalized Islamic finance as long-term investments. External financing remains indispensable during a managed transition, but its role should shift from substituting for the state to catalysing domestic capacity. How donors, financial institutions and remittance-source countries act will shape whether this transition protects progress towards universal health coverage in Somalia and other fragile states.

## Background

Somalia's health system is among the most externally financed in the world. More than 90% of the budget of the Essential Package of Health Services (EPHS) for 2021–2026 comes from international sources and less than 10% from the government [1], while households pay about 45% of health expenditure out of pocket, compared with a global average of 18.6% [2]. Health expenditure was estimated at about US\$6 per capita in 2019, against US\$81 in sub-Saharan Africa, and insurance – largely private plans bought for international companies and non-governmental organizations (NGOs) – accounted for about 1% of total health expenditure [3]. The consequences are visible in financial protection and in coverage: an estimated 24% of households incur catastrophic health spending (expenditure above 10% of income), compared with 11.7% globally and 16.5% in Africa [2], and the universal health coverage (UHC) service coverage index, measured on a scale of 0 to 100, rose only from 22 in 2019 to 27 in 2024 [4].

In effect, this arrangement persisted because each party could tolerate it. Donors financed services and, through NGOs and United Nations agencies, delivered them; scarce domestic revenue was committed chiefly to security and core state functions; and households met the remainder. Much external funding bypassed the treasury: donor financing accounted for about half of per capita health expenditure in 2019, much of it off-treasury, which ‘limited the Government’s involvement in many aspects of health sector programming’ [3].

That arrangement was disrupted from 2025. On 20 January 2025, Executive Order 14169 paused new obligations and disbursements of United States development assistance [5], and on 1 July 2025 the Secretary of State announced the end of the United States Agency for International Development (USAID), with remaining aid to be distributed through the State Department [6]. The United States had provided about 40% (around US\$950 million) of official development assistance to Somalia [7]. Médecins Sans Frontières (MSF) reported that ‘the suspension of USAID funding has led to the closure of at least 37 health and nutrition sites in both rural and urban areas around Baidoa’, and that its teams at Bay Regional Hospital treated 11 894 malnourished children in January–June 2025, 76% more than in the same period of 2024 [8]. CARE reported in August 2025 that funding cuts had forced it to close over 150 health facilities that year and warned that, without additional funding, at least 1.5 million people across 32 priority districts would lose access to health care [9]; by June 2026 it reported that around 500 primary health care facilities nationwide had been forced to close [10]. Multilateral financing was also affected: the Global Fund confirmed that it was cutting US\$1.43 billion from funding already allocated for its 2024–2026 cycle, about 11% of the cycle’s total and as much as 16% in some places [11]. A resource-mapping preprint that has not been peer reviewed reports that external health financing in Somalia rose from US\$223 million in 2022 to US\$320 million in 2025, but that only US\$125 million is committed for 2026, a contraction of 61% in a single year [12].

These events illustrate how the volume, timing and conditions of health financing in a low-income country can be determined by decisions taken in donor capitals and global funds, which makes aid an unstable foundation for UHC. Diversifying away from aid is, however, itself a globalized undertaking. Customs revenue depends on trade flows and on harmonization with regional tariff regimes; taxes on khat, tobacco and sugar-sweetened beverages (SSBs) engage cross-border supply chains and the commercial determinants of health; remittances travel through international money-transfer corridors and are now subject to a new tax in the United States; Islamic finance draws on transnational norms and institutions and on policy learning from other Muslim-majority countries; and the fiscal space created by debt relief was conferred through the Heavily Indebted Poor Countries (HIPC) Initiative and programmes of the International Monetary Fund (IMF) and the World Bank. An appraisal that ignored these links would misjudge both the feasibility and the risks of each option.

This paper therefore appraises the full range of domestic resource mobilization (DRM) channels available to a fragile, federal, Muslim-majority and diaspora-dependent economy. It asks three questions: which channels are feasible for Somalia and over what time horizon; how globalization-related processes enable or constrain each; and in what sequence, and with what safeguards, the channels could be combined to protect progress towards UHC while reducing dependence on external financing. Somalia is an instructive case because it combines extreme aid dependence, fiscal fragility, federalism, a Muslim-majority society and a large diaspora, and because it has experienced a sharp contraction in external health financing. The findings are relevant to other fragile and conflict-affected states facing similar shocks.

## Methods

### 2.1 Study Design

This study employs a qualitative, desk-based policy analysis combining a purposively structured document review with comparative case illustration. Given the fragmented empirical landscape characteristic of fragile and conflict-affected situations (FCAS), this design synthesizes normative policy architectures, macro-fiscal reporting, and empirical case literature to evaluate institutional viability. The study does not constitute a systematic or scoping review, nor did it involve primary empirical data collection, micro-econometric revenue modeling, or formal actuarial costing.

### 2.2 Analytical Framework

The analytical architecture is structured around the World Health Organization's (WHO) three core health financing functions: **revenue raising**, **risk pooling**, and **strategic purchasing** [13]. This structural approach departs from the premise that achieving universal health coverage (UHC) requires not merely expanding fiscal envelopes, but institutionalizing redistributive risk protection and optimizing expenditure efficiency.

To evaluate potential revenue pathways, domestic instruments were situated within the World Bank and WHO **fiscal-space-for-health** conceptual framework [14]. This model maps potential fiscal expansions across five standard dimensions:

1. **Conducive macroeconomic conditions;**
2. Sectoral reprioritization within the general government budget;
3. Health-sector-specific resource mobilization (e.g., dedicated levies, social health insurance contributions);
4. Earmarked external development assistance and grants; and
5. Efficiency gains captured from existing health expenditures.

This study systematically appraises six distinct financing channels. These comprise four orthodox domestic channels derived from the standard framework—general government tax revenues, social health insurance, earmarked consumption levies, and administrative/operational efficiency gains—alongside two non-traditional channels critical to the political economy of Somalia: **Islamic social and commercial finance** (*zakat*, *waqf*, and *sukuk*) and **diaspora-mobilized capital** (remittance leveraging and diaspora bonds).

To contextualize the scale of Somalia's macro-fiscal constraints, empirical findings were evaluated against two established normative global benchmarks:

- **The High-Level Taskforce on Innovative International Financing for Health Systems Benchmark:** Public health expenditure reaching at least 5% of gross domestic product (GDP), underpinned by a normative minimum floor of **US\$86 per capita** (adjusted for purchasing power parity and inflation) necessary to deliver an essential package of primary health interventions in low-income settings [15].
- **The 2001 Abuja Declaration Benchmark:** The commitment by African Union member states to allocate a minimum of **15% of total government expenditure** to the health sector [16], an aspirational target that remains largely unrealized across peer low-income states [17].

These benchmarks serve as comparative diagnostic instruments to measure structural financing deficits rather than prescriptive, short-term fiscal targets for post-heavily indebted poor countries (HIPC) recovery.

## 2.3 Evidence Retrieval and Data Management

Evidence retrieval was conducted purposively to synthesize multi-sectoral literature across health systems, public financial management, and macroeconomics. Eligible sources included:

- Peer-reviewed empirical and theoretical studies of health financing architectures in Somalia and relevant low- and middle-income country (LMIC) comparators;
- Primary legislative acts, national strategic development frameworks, and health policy documents from the Federal Government of Somalia (FGS) and Federal Member States (FMS);
- Macro-fiscal databases, Article IV consultation reports, Country Economic Memoranda, and project appraisal documents published by multilateral financial institutions (e.g., International Monetary Fund, World Bank Group, African Development Bank);
- Technical operational assessments from international non-governmental organizations, bilateral partners, and specialized policy research institutes; and
- Non-peer-reviewed academic preprints, restricted strictly to emerging thematic areas lacking formal peer-reviewed precedent and explicitly noted as unvetted manuscripts in the analytical text.

The literature corpus incorporates policy documents, legislative outputs, and macroeconomic indicators available up to **October 5, 2026**. Data extraction prioritized primary sources to preserve metric fidelity. Where discrepancies in macroeconomic or fiscal estimates emerged between institutional databases (e.g., Central Bank of Somalia balance-of-payments statistics versus IMF Article IV aggregates), reporting transparently reflects the identified variance, privileging primary validated state repositories where applicable. Monetary metrics are reported in their nominal denominations and vintage years as cited in source documentation (predominantly United States Dollars [USD]) without retrospective deflator adjustments.

## 2.4 Multi-Criteria Channel Appraisal

Each of the six candidate financing channels was assessed through a uniform analytical matrix covering four functional dimensions:

1. Operational mechanism and designated functional role across revenue generation, risk pooling, or purchasing;
2. Empirical baseline within Somalia's prevailing fiscal, regulatory, and institutional environment;
3. International policy transferability drawn from relevant LMIC settings; and
4. A multi-criteria feasibility appraisal evaluated against five operational parameters:
  - **Fiscal Yield and Maturation Horizon:** Estimated revenue potential and time lag to operationalization;
  - **Administrative and Legal Feasibility:** Requirements regarding statutory codification, institutional compliance, revenue collection overhead, and enforcement capacity;
  - **Risk Pooling and Equity:** Capacity of the mechanism to cross-subsidize low-income, rural, and vulnerable groups while preventing catastrophic out-of-pocket (OOP) payments;
  - **Political Economy and Governance Vulnerabilities:** Exposure to intergovernmental frictions (FGS–FMS fiscal federalism arrangements), elite capture, rent-seeking, and broader public institutional trust; and
  - **Exogenous Vulnerability:** Sensitivity to global economic volatility, shifts in external geopolitical priorities, regulatory compliance regimes (e.g., Anti-Money Laundering/Countering the Financing of Terrorism [AML/CFT] restrictions), and international capital fluctuations.

The qualitative ratings and thematic categorizations represent analytical syntheses deduced from empirical evidence and institutional constraints; they do not represent quantified metrics from a structured Delphi or consensus-scoring protocol.

## 2.5 Selection of International Comparators

Comparator cases were selected through instrumental purposeful sampling, prioritizing country contexts that offer operational lessons on specific financing instruments rather than systemic macroeconomic parity:

| Jurisdiction                   | Focal Financing Mechanism                                      | Institutional Relevance to Somalia                                                                                                                                             |
|--------------------------------|----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Ghana</b>                   | National Health Insurance Levy (NHIL)                          | Operational performance of earmarked value-added/consumption levies within a national social health insurance framework.                                                       |
| <b>Rwanda</b>                  | Community-Based Health Insurance ( <i>Mutuelles de Santé</i> ) | Institutional mechanisms for broad-scale enrollment, community-level pooling, and multi-tier equity cross-subsidization.                                                       |
| <b>Philippines</b>             | Sin Tax Reform Law (Republic Act 10351/11346)                  | Legislative earmarking of excise taxes on tobacco and alcohol to expand universal health coverage entitlements.                                                                |
| <b>Afghanistan</b>             | System-Wide NGO Service Contracting                            | Performance-based contracting of non-state providers for the delivery of essential primary health packages within fragile, insecure operating environments.                    |
| <b>Indonesia</b>               | Integrated Islamic Social Finance ( <i>Zakat, Waqf</i> )       | Regulatory and institutional integration of sovereign <i>sukuk</i> and faith-based wealth distribution instruments into primary care infrastructure and health equity schemes. |
| <b>India, Israel, Ethiopia</b> | Sovereign Diaspora Bonds                                       | Comparative experiences, structural barriers, investor-confidence determinants, and institutional prerequisites for mobilizing diaspora savings into public infrastructure.    |

Cross-jurisdictional insights were treated as analytically indicative rather than directly transposable, accounting for Somalia's nascent public financial management structures, asymmetric federal dynamics, and unique security-governance nexus.

## 2.6 Declarations and Author Contribution

The author is the sole designer, researcher, and writer of this manuscript. Generative artificial intelligence technologies were utilized exclusively as secondary linguistic aids for syntax standardization, academic formatting, and terminology consistency. The author verified all primary citations, confirmed underlying data points, finalized the critical policy synthesis, and retains direct responsibility for the academic integrity and conclusions of this study.

## Results

### Somalia's health financing landscape

Three structural features define the landscape (Table 1). First, revenue is scarce. Somalia's tax-to-GDP ratio was 2.6% in 2022, the lowest of 36 African countries and far below the African average of 16.0% [18], and domestic revenue was about 2.5% of GDP [19]. Taxes on international trade have represented over 60% of tax revenue since 2017, and almost 70% of government domestic revenue consists of import tariffs collected at a few ports and airports [20], so the revenue base is itself exposed to conditions in global trade. The World Bank projects that on current trends domestic revenue will reach about 4.5% of GDP by 2030; it estimates that, beyond 2030, providing 50% coverage of public education and health services would require about 9% of GDP, and that universal coverage of those services would require domestic revenue of 14% of GDP or higher [19]. Second, external financing is fragmented and largely off-budget, which limits government stewardship [3]. Third, pooling is minimal: with insurance at about 1% of expenditure and out-of-pocket payment dominant, there is almost no risk sharing [2, 3].

Table 1  
Selected health financing and fiscal indicators for Somalia

| Indicator                                    | Value                                                    | Source  |
|----------------------------------------------|----------------------------------------------------------|---------|
| Health expenditure per capita                | US\$6 in 2019 (sub-Saharan Africa: US\$81)               | [3]     |
| International share of EPHS budget           | More than 90% (government: less than 10%)                | [1]     |
| Out-of-pocket share of health expenditure    | 44.9% (2019–2022 data; global average 18.6%)             | [2]     |
| Households with catastrophic health spending | 24% (2023–2024 survey; global 11.7%; Africa 16.5%)       | [2]     |
| UHC service coverage index (scale 0–100)     | 27 in 2024 (22 in 2019)                                  | [4]     |
| Tax-to-GDP ratio                             | 2.6% in 2022 (Africa average 16.0%)                      | [18]    |
| Domestic revenue-to-GDP ratio                | About 2.5% (projected 4.5% by 2030)                      | [19]    |
| Share of trade taxes in tax revenue          | Over 60% since 2017                                      | [20]    |
| Government health budget share               | 8.5% in 2023; 5% in 2024 (reported)                      | [2]     |
| External debt as share of GDP                | 64% in 2018; under 6% by end-2023                        | [21]    |
| Annual remittances                           | US\$1.3 billion (IMF estimate); US\$1.73 billion in 2023 | [7, 22] |
| Households receiving remittances             | About 15%                                                | [22]    |

Values are as reported in the cited sources; they are not adjusted for inflation or harmonized across sources, and reference years differ. The out-of-pocket share is reported as 29% for 2019 in another source [4]. EPHS, Essential Package of Health Services; GDP, gross domestic product; IMF, International Monetary Fund; UHC, universal health coverage.

Macro-fiscal conditions have improved but remain fragile. Somalia reached the HIPC Completion Point on 13 December 2023, which cut external debt from about 64% of GDP in 2018 to under 6% by the end of 2023 and produced total debt-service savings of US\$4.5 billion [21]; on the same date the IMF Executive Board considered a new 36-month Extended Credit Facility arrangement of SDR 75 million (special drawing rights; about US\$100 million) [23]. The federal government recorded a small fiscal surplus in 2024, when growth was about 4.0% [24]. Growth slowed to about 3% in 2025 and is projected at 2.8% in 2026 and 3.1% in 2027, with declining aid cited as a constraint [25]. Fiscal space does not translate automatically into health prioritization: the government's health budget share reportedly fell from 8.5% of government spending in 2023 to 5% in 2024 [2].

Somalia's health policy architecture provides a platform onto which sustainable financing can be built. It comprises the Somali Roadmap towards UHC 2019–23 [26], the revised EPHS of 2020 [27], the Health Sector Strategic Plan III (HSSP III) 2022–2026, endorsed on 22 December 2021 [28], and the Investment Case for the Somali Health Sector 2022–2027 under the Global Financing Facility (GFF) [29]. The principal external vehicle is the World Bank-supported Damal Caafimaad ('Improving Healthcare Services in Somalia') project, approved on 28 June 2021 with US\$75.0 million from the International Development Association (IDA) and US\$25.0 million from the GFF [3, 30]. Including US\$4.25 million from the Green Climate Fund approved in April 2024, its financing totalled US\$104.25 million by August 2025, when a further US\$5.0 million GFF grant was proposed [30]. The project contracts NGOs to deliver the EPHS [3].

## Appraisal of six domestic resource mobilization channels

### Channel 1: General taxation and fiscal-space expansion

Broad-based taxation is the most durable route to fiscal space and underpins the state–citizen social contract. Somalia has made real gains: domestic revenue has grown rapidly from a low base since 2012, an automated customs system has been introduced at the Mogadishu port and airport, and the 2019 Revenue Act provides the legal base for the Directorate of Revenue, although little progress has been made in implementing it [20]. The World Bank's priorities include rolling out the harmonized

income-tax framework, reforming indirect taxation, adapting tax legislation and customs to East African Community (EAC) protocols and standards, and sustaining political dialogue on implementing the harmonized tax framework across the federation [19]; earlier analyses likewise called for reform of the federal tax system [31].

*Globalization pathways.* The revenue base is trade-dependent, and its reform is tied to regional harmonization. *Applicability.* High strategic value but slow yield: on current trends domestic revenue would rise from about 2.5% to 4.5% of GDP by 2030, well short of what UHC requires [19]. *Constraints.* A large informal economy; contested tax authority, including territory and revenue controlled or extorted by Al-Shabaab, whose annual revenue has been estimated at about US\$100 million, set against federal government revenue of roughly US\$250 million [32, 33]; and elite bargains in which limited enforcement of tax laws is exchanged for political stability and support [34]. Health's claim on incremental revenue will need active advocacy given the competing pull of security spending.

## Channel 2: Social health insurance

Social health insurance (SHI) could formalize risk pooling and create an institutional purchaser. The national institution responsible for this function is the Social Health Insurance Authority (SHIA), the legal name established by Prime Minister's Decree Lr206, which supersedes the designations used in earlier documents; the statement quoted below uses the name National Health Insurance Agency. SHIA remains nascent. In December 2025 the Ministry's Head of Health Governance said that the Ministry 'recently launched the National Health Insurance Agency, even though it has not been passed and made legal', and the accompanying United Nations storyline described efforts 'to revive the National Health Insurance Authority to provide free healthcare to citizens, although this will not materialise in the short term' [35].

International experience counsels realism about SHI in largely informal economies. Ghana's National Health Insurance Scheme is financed mainly by the National Health Insurance Levy, a 2.5% value-added-tax-based levy that provided about 69% of scheme revenue in 2014 [36, 37]. At the end of 2019 active members represented only 41% of the population (12.29 million people) after some fifteen years of operation, and the scheme began running financing deficits in 2009 [36]. The capping of the levy under Act 947 in 2017 and the announcement of its uncapping in March 2025 illustrate the political vulnerability of earmarked pools [36, 38]. Rwanda's community-based health insurance reached an estimated coverage of 93.1% in 2022, while out-of-pocket expenditure fell from 26.6% in 2000 to 10.4% in 2020 [39]; Africa CDC likewise reports enrolment above 90% [40]. This performance rested on strong local administration, community health workers, premiums stratified by household socioeconomic category (Ubudehe) and continuing subsidy [41], and the scheme has consistently faced financial deficits [42].

*Globalization pathways.* Global advocacy for UHC has made SHI a prominent policy template. A national purchaser could in principle become the on-budget vehicle through which external funds are pooled rather than channelled through parallel projects, whereas donor-financed premium subsidies would reproduce aid dependence in a new form. *Applicability.* A plausible long-horizon anchor for pooling, but collecting contributions from an informal, low-income population is the binding constraint; SHI should be built incrementally on a tax-financed base and not presented as a near-term solution. *Constraints.* Administrative capacity, adverse selection and the risk of a two-tier system that favours formal-sector urban workers.

## Channel 3: Zakat and Islamic finance instruments

In a Muslim-majority society, zakat (obligatory almsgiving), waqf (endowment), sukuk (Sharia-compliant bonds) and takaful (mutual insurance) are culturally legitimate and potentially large sources of finance. Indonesia offers instructive models. The national zakat agency, BAZNAS, has developed free hospitals for the poor by integrating zakat and cash waqf [43], and Cash Waqf Linked Sukuk has been proposed as an alternative financing instrument for specialized health services within Indonesia's insurance system, grounded in the objectives of Islamic law (*maqasid al-shari'ah*) of protecting life (*hifz al-nafs*) and wealth (*hifz al-mal*) [44].

*Globalization pathways.* Islamic finance operates through transnational norms, scholarly authorities and capital markets. Indonesia's experience illustrates South–South policy learning on which Somalia can draw, whereas issuing sukuk would

depend on institutional and credit standing that Somalia is still building. *Applicability.* High cultural resonance and an existing culture of giving; institutionalized zakat and waqf could fund defined services (for example maternal care or care for the poor) and health infrastructure. *Constraints.* Zakat is religiously earmarked for defined categories of beneficiaries and cannot simply be redirected to a general health budget; collection is fragmented; and trust in state-linked collectors appears limited. Al-Shabaab collects zakat coercively, through a 2.5% levy maintained by systematic intimidation [32], so any state zakat institution would operate in a contested space of legitimacy [33]. Islamic finance is therefore a complement to, not a substitute for, public financing.

## Channel 4: Earmarked levies and health taxes

Taxes on tobacco, khat and SSBs, and levies on telecommunications turnover, can raise revenue while discouraging harmful consumption, a 'double dividend'. Somalia already collects meaningful khat revenue. Administrative data cited in a simulation preprint that has not been peer reviewed indicate about US\$17.15 million from khat in fiscal year 2024, compared with about US\$3.18 million from tobacco, and a 2023 government survey reportedly found support for health taxes among about 77% of respondents [45]. Taxes on khat brought through Mogadishu airport raised US\$16.6 million in 2019, about 15% of customs and import duties and 5% of federal revenue [46]. In Somaliland, a khat levy finances a recently established mental-health programme; its revenue was reported to have risen from about US\$800 000 in 2021 to about US\$2 million annually [47].

The Philippines' 2012 Sin Tax Reform (Republic Act 10351) is the canonical success: it earmarked about 85% of incremental tobacco and 100% of incremental alcohol excise revenue for health [48]. Sin-tax revenue rose from 56.32 billion Philippine pesos (PHP) at the end of 2012 to PHP 103.38 billion at the end of 2013, and the Department of Health budget increased 'from PHP 53.23 billion (USD 1.25 billion) to PHP 83.72 billion (USD 1.89 billion) in 2014 (a year-on-year increase of 57.3%)' [49]. Earmarked mechanisms, which include telecommunications levies such as Gabon's 10% levy on mobile phone companies' turnover to finance coverage for the poor, are however unlikely to close the gap on their own: an Oxford Policy Management analysis for selected African countries pointed to combined additional funding of less than 1% of GDP, 'much less than required for UHC' [37].

*Globalization pathways.* Khat, tobacco and SSBs are traded across borders, so revenue depends on cross-border supply and border controls, and taxing tobacco and SSBs would engage transnational supply chains and the commercial determinants of health; opposition from importers and distributors should be anticipated. *Applicability.* Among the most feasible near-term channels, because collection can build on existing customs points, and even 'soft' earmarking can build public support by linking a harmful product to a valued service. *Constraints.* Khat revenue depends on cross-border supply and is politically sensitive, implicating traders, consumers and security actors; earmarks can distort budgeting and be captured or capped, as Ghana shows; levies on mobile-money transactions could penalize financial inclusion; and the combined yield of earmarked mechanisms is limited.

## Channel 5 Diaspora Financing and Remittance Dynamics

Diaspora financing constitutes a cornerstone of Somalia's macroeconomic architecture, functioning as both a critical liquidity buffer and a primary social safety net. Historically estimated by the International Monetary Fund (IMF) and the World Bank at approximately US\$1.3 billion annually [22], formal remittance inflows have expanded steadily, reaching US\$1.73 billion in 2023 [7] and sustaining volumes between US\$1.75 billion and US\$1.85 billion in subsequent reporting. Macroeconomic estimates consistently illustrate the scale of these flows: initially measured at approximately 20% of GDP in 2017 [22], remittances have fluctuated between 23% and 30% of national output in recent years, with civil society assessments suggesting an economic footprint spanning 25% to 40% of overall economic activity [50].

Notably, these private transfers surpass the cumulative value of official development assistance (ODA) and emergency humanitarian aid, serving as a primary mechanism through which households underwrite essential recurrent expenditures, including health services, food security, and education [50].

Despite their vital compensatory function during shocks, remittance flows exhibit severe distributional asymmetries. Empirical survey data from the World Bank indicate that diaspora receipts are concentrated among approximately 15% of Somali households, primarily those situated in urban corridors [22]. This spatial and socio-economic concentration limits the utility of remittances as a shared redistributive resource, entrenching horizontal inequalities between recipient households and marginalized rural or displaced populations without transnational networks.

Recognizing these structural imbalances and the need to transition from consumptive transfers to productive capital formation, the Federal Government of Somalia formally approved the National Diaspora Policy in April 2023 [51]. Developed by the Ministry of Foreign Affairs and International Cooperation in partnership with the International Organization for Migration, this framework institutionalizes diaspora engagement by seeking to reduce remittance transaction overheads, harness diaspora technical expertise, and de-risk direct investment into national development priorities and public infrastructure.

Beyond household transfers, diaspora bonds and matching-fund or diaspora-financed health-facility schemes are options. Comparative evidence counsels caution. Israel had raised more than US\$46 billion through diaspora bonds by mid-2021 [52], and India raised US\$1.6 billion in 1991, US\$4.2 billion in 1998 and US\$5.5 billion in 2000, more than US\$11 billion in total [53]. Ethiopia's issues in 2008 and 2011 failed to generate sufficient interest because of perceived default risk and concerns about the use of proceeds [52], compounded by low investor trust and a failure to register the bond with the United States Securities and Exchange Commission [54].

A new external risk has also emerged. The One Big Beautiful Bill Act, signed on 4 July 2025 [55], imposes a 1% tax on remittance transfers funded with cash, money orders, cashier's checks or similar physical instruments, effective 1 January 2026 [56]; the House version had proposed 3.5% [55]. The effect on Somalia depends on the share of transfers from the United States that are funded in cash, which the sources we reviewed do not document. The tax nevertheless adds to costs that are already high, since sending money from the United Kingdom to Somalia costs more than twice the 3% target of the Sustainable Development Goals [22], and to banking restrictions on money transfer operators, which Oxfam identifies as a threat to remittance flows [50].

*Globalization pathways.* Diaspora financing is the most directly transnational channel: it depends on the migration histories, payment systems and regulatory regimes of the countries where Somalis live, over which Somalia has little control. *Applicability.* Diaspora goodwill is real and could be channelled to specific, visible and well-governed health projects (equipment, facilities, a diaspora-backed health fund). *Constraints.* Remittances are private household money that cannot be commandeered; bonds require credible institutions, legal frameworks and a level of trust that Somalia is still building; and high transfer costs erode flows [22].

## Channel 6: Efficiency gains and strategic purchasing

The largest near-term 'resource' may be existing money spent better. Several international analyses have identified improving health-sector efficiency as 'a more promising avenue to free adequate resources' than earmarked revenue mechanisms, although the 'how' of improving sector-wide efficiency has received less attention [37]. For Somalia, this means reducing the fragmentation of donor funding, moving money on-budget, strengthening public financial management (PFM), and shifting from input-based, project-driven aid to strategic purchasing of a defined benefit package. Damal Caafimaad already contracts NGOs to deliver the EPHS [3], and a September 2026 review meeting was told that the next project will be 'a long-term one with different phases' [57]; it is therefore a natural vehicle for a purchasing transition.

Afghanistan's Sehatmandi programme, which contracts NGOs nationally under performance-based payment financed through the Afghanistan Reconstruction Trust Fund, shows both the potential and the fragility of this model in a conflict-affected setting [58, 59]. The number of functioning health facilities rose from 496 in 2002 to more than 2800 by 2018 under its predecessor [58], but when World Bank funding to the health sector was paused, the health system was exposed 'to a massive risk of losing the gains made over the last 2 decades' [60].

*Globalization pathways.* Afghanistan shows that purchasing financed from a pooled external fund can be interrupted by decisions of global institutions; a purchasing transition in Somalia should therefore be coupled with a growing domestic revenue

base. *Applicability*. High and immediate: efficiency and alignment bridge the period needed to build domestic revenue. *Constraints*. Nascent government contract-management capacity; donor reluctance to cede control; and the risk that ‘transition’ becomes a euphemism for abrupt withdrawal.

## Summary of the appraisal and cross-cutting conditions

Table 2 summarizes the appraisal. Four cross-cutting conditions determine whether any channel succeeds. *Sequencing*: efficiency and alignment can proceed first because they need no new legislation; health taxes and broad-based taxation follow; SHI and institutionalized Islamic finance are long-horizon investments. *Institutional capacity*: every channel is bottlenecked by administrative and stewardship capacity, so investment in revenue administration, PFM and purchasing institutions is a precondition and not an afterthought. *Federal–state fiscal relations*: fragmentation across levels of government hinders centralized tax systems [34], and unresolved revenue sharing means that national schemes must be negotiated with federal member states, while revenue experiments elsewhere in Somalia, such as Somaliland’s khat levy [47], offer opportunities for learning. *Trust*: limited public trust in state institutions and coercive taxation by Al-Shabaab [33] mean that visibly linking revenue to valued services, and demonstrating clean governance, is essential to the social contract on which DRM ultimately rests.

Table 2  
Appraisal of six domestic resource mobilization channels for health in Somalia

| Channel                             | Principal globalization-related pathway                                                                      | Applicability and horizon                                                | Principal constraints                                                                                                            |
|-------------------------------------|--------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|
| General taxation                    | Trade-dependent revenue base; harmonization with East African Community standards                            | High strategic value; slow yield (medium to long term)                   | Informal economy; contested tax authority; elite bargains; federal–state revenue sharing; competition from security spending     |
| Social health insurance             | Global UHC policy templates; potential on-budget vehicle for pooling external funds                          | Long-horizon anchor for pooling; build on a tax-financed base            | Collecting contributions from an informal economy; administrative capacity; adverse selection; risk of a two-tier system         |
| Zakat and Islamic finance           | Transnational Islamic finance norms and capital markets; South–South learning (Indonesia)                    | Complement for defined services and infrastructure (medium to long term) | Religious earmarking of zakat; fragmented collection; limited trust in state collectors; coercive zakat collection by Al-Shabaab |
| Earmarked levies and health taxes   | Cross-border khat trade; transnational tobacco and beverage supply chains; commercial determinants of health | Most feasible near-term channel (short to medium term)                   | Dependence on cross-border supply; political sensitivity; capture or capping of earmarks; limited combined yield                 |
| Diaspora financing                  | Remittance corridors; taxation and banking restrictions in sending countries; diaspora-bond markets          | Targeted projects (medium term); bonds only in the long term             | Private household money; high transfer costs; need for credible institutions and trust                                           |
| Efficiency and strategic purchasing | Pooled external funds and conditions (World Bank; GFF); alignment of aid with national systems               | High and immediate (short term)                                          | Contract-management capacity; donor reluctance to cede control; ‘transition’ as a euphemism for withdrawal                       |

Judgements are the authors’ qualitative appraisal against the five criteria described in Methods. GFF, Global Financing Facility; UHC, universal health coverage.

## Discussion

### Principal findings

No single domestic channel can finance UHC in Somalia. Even the World Bank’s projection that domestic revenue will reach about 4.5% of GDP by 2030 falls far short of the 14% or more that universal coverage of public education and health services

would require [19], and total domestic revenue would still be below the 5% of GDP that McIntyre and colleagues propose as a benchmark for government health spending alone [15]. As an illustration, if the national budget were financed entirely from domestic revenue, meeting the Abuja target of 15% of the budget [16] would amount to only about 0.4% of GDP at current revenue levels and about 0.7% at the projected 2030 level (authors' calculation from [19]). External financing will therefore remain necessary during any transition. The question is not whether to replace aid but how to use a period of declining aid to build institutions and revenue that reduce vulnerability to external decisions.

The channels differ in what they can deliver and when. Efficiency gains and the alignment of external funds with national systems are available immediately and need no new legislation. Health taxes can yield in the short to medium term. Broad-based taxation is slower but is the most durable. Zakat, diaspora financing and SHI are better treated as complements or long-horizon investments, each limited by the nature of the underlying resource: religiously earmarked, privately owned, or dependent on contributions from an informal economy.

## **Globalization and the financing of universal health coverage in a fragile state**

Exposure to external decisions is the common thread. The 2025–2026 aid shock reached Somalia through a bilateral policy decision in the largest donor [5, 7], through reductions in multilateral pooled funds [11] and, for diaspora flows, through a new tax in the United States [56]. The domestic channels are not insulated either: customs revenue depends on trade and khat revenue on cross-border supply [20, 46]. Reducing dependence on aid is therefore less a matter of replacing external with domestic finance than of changing the form of exposure and strengthening the state's ability to absorb shocks.

Global arrangements have also created opportunities that Somalia can use. Debt relief under the HIPC Initiative reduced external debt from about 64% of GDP to under 6% [21], but the fall in the health budget share in 2024 [2] shows that fiscal space does not by itself secure health priority. The Damal Caafimaad project illustrates how global financing mechanisms, including IDA, the GFF and, since 2024, the Green Climate Fund [30], can be aligned with a national investment case [29]. Islamic finance and diaspora engagement offer South–South and transnational sources of learning and finance that are less dependent on traditional donors.

The findings carry implications for global actors. First, donors and multilateral funds that reduce support should do so in ways that do not strand national systems: Afghanistan's experience shows how quickly gains are put at risk when pooled external financing is interrupted [60]. Predictable multi-year commitments, on-budget channels and co-financing arrangements that build national purchasing capacity would reduce that risk. Second, remittance policy in sending countries is health financing policy by another name: taxes, banking restrictions and high transfer costs reduce the resources that households use to pay for care [22, 50]. Third, taxing health-harming commodities requires attention to the commercial determinants of health and to regional cooperation on cross-border trade in khat.

## **A sequenced roadmap**

Table 3 sets out a sequenced roadmap derived from the appraisal. It rests on the principle that measures requiring no new legislation come first, and that instruments depending on trust and administrative capacity come later. Several thresholds would change these recommendations. If domestic revenue accelerates materially beyond the projected 4.5% of GDP by 2030, SHI and larger public financing could be brought forward. If aid stabilizes or partially returns, the transition can be paced more gradually. If federal–state fiscal arrangements remain unresolved, national schemes should give way to pilots in individual federal member states. If khat supply or politics disrupt that revenue stream, health taxes should pivot to tobacco and SSBs. If remittance flows fall materially because of taxation or banking restrictions in sending countries, the diaspora channel should be deprioritized and other measures to protect households financially strengthened.

Table 3  
Sequenced roadmap for domestic resource mobilization for health in Somalia

| Horizon                   | Priority actions                                                                                                                                                                                                                                                                                                                                                                                                                     | Channels engaged                                                                                     |
|---------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| Short term<br>(0–2 years) | Protect the service platform by consolidating remaining donor funds on-budget through Damal Caafimaad, strengthening strategic purchasing and PFM, and negotiating an orderly donor transition. Introduce or raise health taxes on tobacco and SSBs, and formalize khat taxation with a soft earmark for the EPHS. Establish legal and governance foundations: revenue administration, a health financing unit and purchasing rules. | Efficiency and strategic purchasing; earmarked levies and health taxes                               |
| Medium term (2–5 years)   | Broaden the tax base and raise the tax-to-GDP ratio. Institutionalize zakat and waqf for defined health purposes with transparent governance. Pilot a diaspora health fund or matching scheme tied to visible facility-level investments. Expand contracting nationally. Advocate a protected and rising health share of the growing budget.                                                                                         | General taxation; zakat and Islamic finance; diaspora financing; efficiency and strategic purchasing |
| Long term (5–10+ years)   | Build SHI incrementally on a tax-financed base, beginning with the formal sector and the subsidized poor, and progressively pool fragmented funds towards a single national purchaser. Consider sukuk for health infrastructure once institutions and credit standing allow.                                                                                                                                                         | Social health insurance; zakat and Islamic finance                                                   |

Time horizons are indicative. EPHS, Essential Package of Health Services; GDP, gross domestic product; PFM, public financial management; SHI, social health insurance; SSBs, sugar-sweetened beverages.

## Strengths and limitations

The analysis integrates six channels within a single framework, makes the role of globalization-related processes explicit for each, and sets out thresholds that would change its recommendations. Figures, dates and quotations were checked against original documents wherever these could be accessed, and discrepancies between sources are reported.

This is a policy analysis and not primary empirical research. Somali health financing data are incomplete, sometimes inconsistent across sources and often dated: for example, the out-of-pocket share of health expenditure is reported as 29% for 2019 in one source [4] and as 44.9% in another [2], and key per capita figures derive from 2019. Estimates should therefore be read as orders of magnitude. Some of the evidence, including recent analyses of aid contraction and of health taxes in Somalia, comes from preprints that have not been peer reviewed [12, 45]. The legal and institutional status of SHIA is evolving. Sources were identified purposively rather than systematically, so relevant evidence may have been missed; the appraisals are qualitative judgements that were not validated through stakeholder consultation or a formal consensus process; and we did not model revenue potential or cost the proposed measures. Comparative lessons from Ghana, Rwanda, the Philippines, Afghanistan and Indonesia are indicative and not directly transferable. The analysis is conducted at the level of financing systems and does not disaggregate by sex or gender; gendered effects of out-of-pocket payments and of health taxes warrant separate study, in line with the Sex and Gender Equity in Research (SAGER) guidelines that the journal encourages. Finally, one author holds a leadership role in the institution responsible for SHI, which is discussed as one of six channels (see Declarations). We have sought to mitigate this interest by appraising all six channels against the same criteria and by treating SHI as a long-horizon option and not as a flagship.

## Conclusions

The 2025–2026 aid shock has turned a chronic vulnerability into an acute crisis and, potentially, into an impetus for reforms that gradual approaches have struggled to deliver. No single domestic channel can finance UHC in Somalia. The realistic path is a diversified and sequenced portfolio: efficiency gains and better alignment of external funds first; health taxes and broad-based taxation over the medium term; and SHI and institutionalized Islamic finance as long-horizon investments, with diaspora financing channelled to specific, well-governed projects. External financing will remain indispensable during a managed transition, but its role should shift from substituting for the state to catalysing domestic capacity. Because every channel is shaped by decisions, flows or institutions beyond Somalia's borders, the outcome will depend not only on domestic reform but also on how donors, international financial institutions and remittance-source countries act. Somalia's experience offers a

transferable template for other fragile and conflict-affected states facing the same collision of shrinking aid and rising UHC ambition.

## Abbreviations

### **DRM**

Domestic resource mobilization

### **EAC**

East African Community

### **EPHS**

Essential Package of Health Services

### **GDP**

Gross domestic product

### **GFF**

Global Financing Facility

### **HIPC**

Heavily Indebted Poor Countries

### **HSSP III**

Health Sector Strategic Plan III

### **IDA**

International Development Association

### **IMF**

International Monetary Fund

### **MSF**

Médecins Sans Frontières

### **NGO**

Non-governmental organization

### **PFM**

Public financial management

### **SAGER**

Sex and Gender Equity in Research

### **SDR**

Special drawing rights

### **SHI**

Social health insurance

### **SHIA**

Social Health Insurance Authority

### **SSB**

Sugar-sweetened beverage

### **UHC**

Universal health coverage

### **USAID**

United States Agency for International Development

### **WHO**

World Health Organization

## Declarations

## Ethics approval and consent to participate

Not applicable. This study is a policy analysis of published and publicly available documents; it involved no human participants and no identifiable personal data.

## Consent for publication

Not applicable.

## Availability of data and materials

No primary data were generated. All sources analysed are publicly available and are listed in the reference list.

## Competing interests

Abdulrazaq Yusuf Ahmed (AYA) is connected to RIYAADA as an academic and health economist. This research adds to existing knowledge, and AYA reports no conflicts of interest. The co-authors AHM & MHM also confirm they have no competing interests.

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## Authors' contributions

IAYA conceived the study, designed the analytical framework, led the analysis and drafted the manuscript. AHM and MHM contributed to the identification and verification of sources and to critical revision of the manuscript. All authors read and approved the final manuscript.

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## References

1. Mohamud KM. Equity in health funding: an analysis of the essential package of health services (EPHS) in Somalia (2021–2026). *Discov Health Syst.* 2025;4:132. 10.1007/s44250-025-00302-x.
2. Mohamud KM, Warei SY, Abubakr AHA. Burden or benefit? Unveiling the impact of out-of-pocket health expenditures in Somalia's healthcare system. *Health Econ Rev.* 2026;16:5. 10.1186/s13561-025-00703-x.
3. World Bank. Improving healthcare services in Somalia project ('Damal Caafimaad'): project appraisal document. Report No. PAD3930. Washington, DC: World Bank. 2021. <https://documents1.worldbank.org/curated/en/671481625191487648/pdf/Somalia-Improving-Healthcare-Services-in-Somalia-Damal-Caafimaad-Project.pdf>. Accessed 5 Oct 2026.
4. Abdullahi YB, Ahmed NI, Bashir SG, Abdi YH, Abdi MS. Achieving universal health coverage in Somalia: a five-year retrospective on progress, emerging opportunities, and new challenges. *Discov Public Health.* 2025;22:895. 10.1186/s12982-025-01300-3.
5. Executive Office of the President. Reevaluating and realigning United States foreign aid. Executive Order 14169 of January 20, 2025. *Fed Regist.* 2025;90:8619. <https://www.federalregister.gov/documents/2025/01/30/2025-02091/reevaluating-and-realigning-united-states-foreign-aid>. Accessed 5 Oct 2026.

6. Anadolu Agency. US ends USAID, aid to be distributed via State Department: Marco Rubio. 1 July 2025.  
<https://www.aa.com.tr/en/americas/us-ends-usaid-aid-to-be-distributed-via-state-department-marco-rubio/3618849>.  
Accessed 5 Oct 2026.
7. Wrathall H, Lowy Institute. July. Taxing the world's most generous givers. The Interpreter,. 14 2025.  
<https://www.lowyinstitute.org/the-interpreter/taxing-world-s-most-generous-givers>. Accessed 5 Oct 2026.
8. Doctors Without Borders/Médecins Sans Frontières. Deadly delays: how funding gaps are undermining health care in Somalia. 11. August 2025. <https://www.doctorswithoutborders.org/latest/deadly-delays-how-funding-gaps-are-undermining-health-care-somalia>. Accessed 5 Oct 2026.
9. Dubow U. August. The human cost of funding cuts: lives and futures at risk in Somalia. CARE. 7 2025.  
<https://www.care.org/news-and-stories/somalia-funding-cuts-lives-futures-at-risk/>. Accessed 5 Oct 2026.
10. CARE. Somalia health centers close due to aid cuts as famine looms. Press release. 11 June 2026.  
<https://www.care.org/media-and-press/somalia-health-centers-close-due-to-aid-cuts-as-famine-looms/>. Accessed 5 Oct 2026.
11. Green A. July. Global Fund plans to cut \$1.4 billion from grants it has already awarded. Devex. 10 2025.  
<https://www.devex.com/news/global-fund-plans-to-cut-1-4-billion-from-grants-it-has-already-awarded-110481>. Accessed 5 Oct 2026.
12. Mohamud KM. The 2026 aid cliff: resource mapping evidence on donor withdrawal and health financing sustainability in Somalia. Res Square. 2026. 10.21203/rs.3.rs-10619602/v1. . Preprint (not peer reviewed).
13. World Health Organization. The world health report 2010. Health systems financing: the path to universal coverage. Geneva: World Health Organization; 2010.
14. Tandon A, Cashin C. Assessing public expenditure on health from a fiscal space perspective. HNP Discussion Paper. Washington, DC: World Bank; 2010.  
<https://documents1.worldbank.org/curated/en/333671468330890417/pdf/560530WP0Box341penditureFiscalSpace.pdf>.  
Accessed 5 Oct 2026.
15. McIntyre D, Meheus F, Røttingen J-A. What level of domestic government health expenditure should we aspire to for universal health coverage? Health Econ Policy Law. 2017;12:125–37. 10.1017/S1744133116000414.
16. Organization of African Unity. Abuja Declaration on HIV/AIDS, tuberculosis and other related infectious diseases. OAU/SPS/ABUJA/3. Abuja: Organization of African Unity; 2001.
17. World Health Organization. The Abuja Declaration: ten years on. Geneva: World Health Organization; 2011.
18. Commission OECD AU, African Tax Administration Forum. Revenue statistics in Africa 2024: tax levels and tax structures, 1990–2022. Paris: OECD Publishing; 2024. 10.1787/78e9af3a-en. [https://www.oecd.org/en/publications/revenue-statistics-in-africa-2024\\_78e9af3a-en/full-report/tax-levels-and-tax-structures-1990-2022\\_7ac89763.html](https://www.oecd.org/en/publications/revenue-statistics-in-africa-2024_78e9af3a-en/full-report/tax-levels-and-tax-structures-1990-2022_7ac89763.html). Accessed 5 Oct 2026.
19. World Bank. Toward building Somalia's social contract: state affordability, revenue mobilization, and service delivery in a nascent federal state. Washington, DC: World Bank. 2024.  
<https://documents1.worldbank.org/curated/en/099111424062026744/pdf/P1719741f0d3390fc1bb9515d17a216325d.pdf>.  
Accessed 5 Oct 2026.
20. National Economic Council, Federal Government of Somalia. Assessment of Somalia: domestic revenue mobilization and institutional development. Final report. Mogadishu. 2022. <https://nec.gov.so/wp-content/uploads/2023/04/Assessment-Somalia-domestic-revenue-mobilization-and-institutional-development-.pdf>. Accessed 5 Oct 2026.
21. World Bank. IMF and World Bank announce US\$4.5 billion in debt relief for Somalia. Press release. 13. December 2023.  
<https://www.worldbank.org/en/news/press-release/2023/12/13/imf-and-world-bank-announce-us-4-5-billion-in-debt-relief-for-somalia-afe-1223>. Accessed 5 Oct 2026.
22. World Bank. Somali poverty and vulnerability assessment: findings from wave 2 of the Somali High Frequency Survey. Summary of Chap. 6: remittances. Washington, DC: World Bank. 2020.  
<https://documents1.worldbank.org/curated/en/597711594118138283/pdf/Summary-of-Chapter-6-Remittances.pdf>.  
Accessed 5 Oct 2026.

23. International Monetary Fund. IMF Executive Board concludes the sixth review of the Extended Credit Facility for Somalia. Press release No. 23/437. 13. December 2023. <https://www.imf.org/en/News/Articles/2023/12/13/pr23437-imf-concludes-the-sixth-review-of-the-extended-credit-facility-for-somalia>. Accessed 5 Oct 2026.
24. World Bank. Somalia's economic prospects are positive, but foreign aid cuts are downsizing growth. Press release. 30. June 2025. <https://www.worldbank.org/en/news/press-release/2025/06/30/somalia-afe-economic-prospects-are-positive-but-foreign-aid-cuts-are-downsizing-growth>. Accessed 5 Oct 2026.
25. World Bank. Somalia's growth continues, but shocks and aid cuts intensify risks to jobs and livelihoods. Press release. 13. May 2026. <https://www.worldbank.org/en/news/press-release/2026/05/13/somalia-growth-continues-but-shocks-and-aid-cuts-intensify-risks-to-jobs-and-livelihoods>. Accessed 5 Oct 2026.
26. Ministry of Health, Federal Republic of Somalia, and State Ministries of Health. Somali roadmap towards universal health coverage (2019–23). Mogadishu. 2018. <https://moh.gov.so/so/wp-content/uploads/2023/05/Universal-Health-Coverage-Roadmap.pdf>. Accessed 5 Oct 2026.
27. Ministry of Health, Federal Government of Somalia. Essential package of health services (EPHS) Somalia. 2020. Mogadishu; 20 January 2020. <https://moh.gov.so/so/wp-content/uploads/2023/05/Essential-Packages-of-Health-Services-2020.pdf>. Accessed 5 Oct 2026.
28. Federal Ministry of Health and Human Services, Federal Government of Somalia. Somalia health sector strategic plan 2022–2026 (HSSP III). Mogadishu. 2021. <https://moh.gov.so/so/wp-content/uploads/2022/11/Health-Sector-Strategy-Plan-III.pdf>. Accessed 5 Oct 2026.
29. Ministry of Health, Federal Republic of Somalia. Investment case for the Somali health sector 2022–2027. Global Financing Facility. 2022. <https://www.globalfinancingfacility.org/resource/investment-case-somali-health-sector-2022-2027>. Accessed 5 Oct 2026.
30. World Bank. Project paper on a proposed additional grant from the Global Financing Facility and restructuring: improving healthcare services in Somalia project (P172031). Report No. PPIAF000198. Washington, DC: World Bank. 2025. <https://documents1.worldbank.org/curated/en/099093025011013862/pdf/P172031-3cf6f8d0-ac72-49e5-be0b-dfc6b0851aa8.pdf>. Accessed 5 Oct 2026.
31. Mohamud AA, Nor Isak N. Reforming the tax system of the Federal Government of Somalia. *J Tax Adm.* 2019;5:125–37.
32. Williams W. Oct. Reclaiming Al Shabaab's revenue. Africa Center for Strategic Studies. 27 March 2023. <https://africacenter.org/spotlight/reclaiming-al-shabaabs-revenue/>. Accessed 5 Oct 2026.
33. European Union Agency for Asylum. Somalia: country focus. Country of origin information report. May 2025. [https://coi.euaa.europa.eu/administration/easo/PLib/2025\\_05\\_EUAA\\_COI\\_Report\\_Somalia\\_Country\\_Focus.pdf](https://coi.euaa.europa.eu/administration/easo/PLib/2025_05_EUAA_COI_Report_Somalia_Country_Focus.pdf). Accessed 5 Oct 2026.
34. n den Boogaard V, Nor Isak N. The political economy of taxation in Somalia: historical legacies, informal institutions, and political settlements. ICTD Working Paper 216. Brighton: Institute of Development Studies; 2025. 10.19088/ICTD.2024.118
35. United Nations Transition Mission in Somalia. Somalia / Universal Health Coverage Day. UNifeed, United Nations., 14 December 2025 (video soundbite: Abdullahi Nour Omar, Head of Health Governance, Federal Ministry of Health). <https://media.un.org/unifeed/en/asset/d351/d3515452>. Accessed 5 Oct 2026.
36. Adin-Darko DA. Earmarking in Ghana: impacts on the financial sustainability of the National Health Insurance Scheme. Joint Learning Network for Universal Health Coverage; 2021. <https://jointlearningnetwork.org/earmarking-in-ghana-impacts-on-the-financial-sustainability-of-national-health-insurance/>. Accessed 5 Oct 2026.
37. Oxford Policy Management. Financing for universal health coverage in low- and middle-income countries: a brief overview. HEART technical note. <https://archive.ids.ac.uk/heart/wp-content/uploads/2018/01/Technical-note-Financing-for-UHC-in-low-and-middle-income-countries.pdf>. Accessed 5 Oct 2026.
38. Alliance for Reproductive Health Rights. Reversing the cap: how the 2025 uncapping could reinforce Ghana's health financing framework. 30. June 2025. <https://arhr.org.gh/reversing-the-cap-how-the-2025-uncapping-could-reinforce-ghanas-health-financing-framework/>. Accessed 5 Oct 2026.

39. African Health Observatory Platform (AHOP). New AHOP policy brief on community-based health insurance for achieving universal health coverage in Rwanda. 24. October 2025. <https://ahop.aho.afro.who.int/2025/10/24/new-policy-brief-on-community-based-health-insurance-for-achieving-universal-health-coverage-in-rwanda/>. Accessed 5 Oct 2026.
40. Africa CDC. Oct. Rwanda's health financing model offers a test ground for Africa. 11 December 2024. <https://africacdc.org/news-item/rwandas-health-financing-model-offers-a-test-ground-for-africa/>. Accessed 5 Oct 2026.
41. Chemouni B. The political path to universal health coverage: power, ideas and community-based health insurance in Rwanda. *World Dev.* 2018;106:87–98. 10.1016/j.worlddev.2018.01.023.
42. Nyandekwe M, Kakoma JB. Long-term financial sustainability of Rwanda's universal health coverage model: challenges and solutions (2011–2021) and Vision 2050. *Glob Health Econ Sustain.* 2025. 10.36922/ghes.5842.
43. Zaenal MH, Astuti AD, Sadariyah AS. Integrating zakat and waqf project: a case study of free hospital development of the National Zakat Board (BAZNAS) Indonesia [Internet]. Jakarta: Pusat Kajian Strategis Badan Amil Zakat Nasional (Puskas BAZNAS); 2017 Dec 22 [cited 2026 Oct 5]. (Puskas Working Paper Series). Available from: <https://www.iconzbaznas.com/publications/index.php/pwps/article/view/81>
44. Qamariya A, Muhaimin A. Waqf sukuk as an alternative financing instrument for specialized health services: within the Islamic health insurance system. *Zawa.* 2025;5(2). 10.31958/zawa.v5i2.16064.
45. Mohamud KM. Health taxes and domestic revenue mobilization in fragile states: simulation evidence for khat, tobacco, and sugar-sweetened beverages in Somalia. *Res Square.* 2026. 10.21203/rs.3.rs-8971071/v1. . Preprint (not peer reviewed).
46. Global Initiative Against Transnational Organized Crime. Somalia's khat ban has led to the emergence of a contraband industry. *ESA Observatory Risk Bulletin* 9. June–July 2020. <https://riskbulletins.globalinitiative.net/esa-obs-009/02-somalias-khat-ban-has-led-to-the-emergence-of-a-contraband-industry.html>. Accessed 5 Oct 2026.
47. Butini C. Oct. In Somaliland, a sin tax for mental health relief. *Devex.* 28 January 2025. <https://www.devex.com/news/in-somaliland-a-sin-tax-for-mental-health-relief-109096>. Accessed 5 Oct 2026.
48. Ulep VG, Pargas I, Alcantara A. Health earmarking in the Philippines. *Joint Learning Network for Universal Health Coverage*; 2019. <https://jointlearningnetwork.org/health-earmarking-in-the-philippines/>. Accessed 5 Oct 2026.
49. Health Promotion Fund Resource Hub. Philippines: what is the impact of a dedicated fund? Modified 7 August 2023. <https://hpfhub.info/using-health-promotion-funding/what-is-the-impact-of-a-dedicated-fund/philippines/>. Accessed 5 Oct 2026.
50. Oxfam America. Remittances to Somalia. <https://www.oxfamamerica.org/explore/issues/economic-well-being/remittances-to-somalia/>. Accessed 5 Oct 2026.
51. International Organization for Migration. Harnessing the power of Somalis abroad: what the National Diaspora Policy means for development [Internet]. Mogadishu: IOM Somalia. 2026 Apr 30 [cited 2026 Oct 5]. Available from: <https://somalia.iom.int/blogs/harnessing-power-somalis-abroad-what-national-diaspora-policy-means-development>
52. Gevorkyan AV. June. Can diaspora bonds supercharge development investment? *Migration Policy Institute.* 24 2021. <https://www.migrationpolicy.org/article/diaspora-bonds-supercharge-development-investment>. Accessed 5 Oct 2026.
53. Ketkar SL, Ratha D. Development finance via diaspora bonds: track record and potential. *Policy Research Working Paper* 4311. Washington, DC: World Bank; 2007. <https://documents1.worldbank.org/curated/en/867801468165874505/pdf/wps4311.pdf>. Accessed 5 Oct 2026.
54. Schneidman W, Tadesse A, Lissanu A. May. Diaspora bonds: an innovative source of financing? *Brookings Institution.* 27 2022. <https://www.brookings.edu/articles/diaspora-bonds-an-innovative-source-of-financing/>. Accessed 5 Oct 2026.
55. Mintz. July. The One Big Beautiful Bill Act signed into law: tax implications at a glance. 9 2025. <https://www.mintz.com/insights-center/viewpoints/2906/2025-07-09-one-big-beautiful-bill-act-signed-law-tax-implications>. Accessed 5 Oct 2026.
56. Internal Revenue Service. Treasury, IRS issue proposed regulations on the new remittance transfer tax established under the One, Big, Beautiful Bill. News release IR-2026-48. 10 April 2026. <https://www.irs.gov/newsroom/treasury-irs-issue-proposed-regulations-on-the-new-remittance-transfer-tax-established-under-the-one-big-beautiful-bill>. Accessed 5 Oct 2026.

57. Dawan Africa. Somalia reviews Damal Caafimaad health project, eyes next phase. 2026.  
https://www.dawan.africa/news/somalia-reviews-damal-caafimaad-health-project-eyes-next-phase. Accessed 5 Oct 2026.

58. World Bank. Delivering strong and sustained health gains in Afghanistan: the Sehatmandi project. Results brief. 23. October 2020. https://www.worldbank.org/en/results/2020/10/23/delivering-strong-and-sustained-health-gains-in-afghanistan-the-sehatmandi-project. Accessed 5 Oct 2026.

59. Andersen CT, Ahmadzai H, Rasekh AW, Akala FA, Haque T, Johnson R, et al. Improving health service delivery in conflict-affected settings: lessons from a nationwide strategic purchasing mechanism in Afghanistan. J Glob Health. 2021;11:04049. 10.7189/jogh.11.04049.

60. Safi N, Anwari P, Sidhu L, Ibrahim AG, Rasekh A, Naseri S, et al. The need to sustain funding for Afghanistan health system to prevent excess morbidity and mortality. East Mediterr Health J. 2023;29:119–25.

Figures

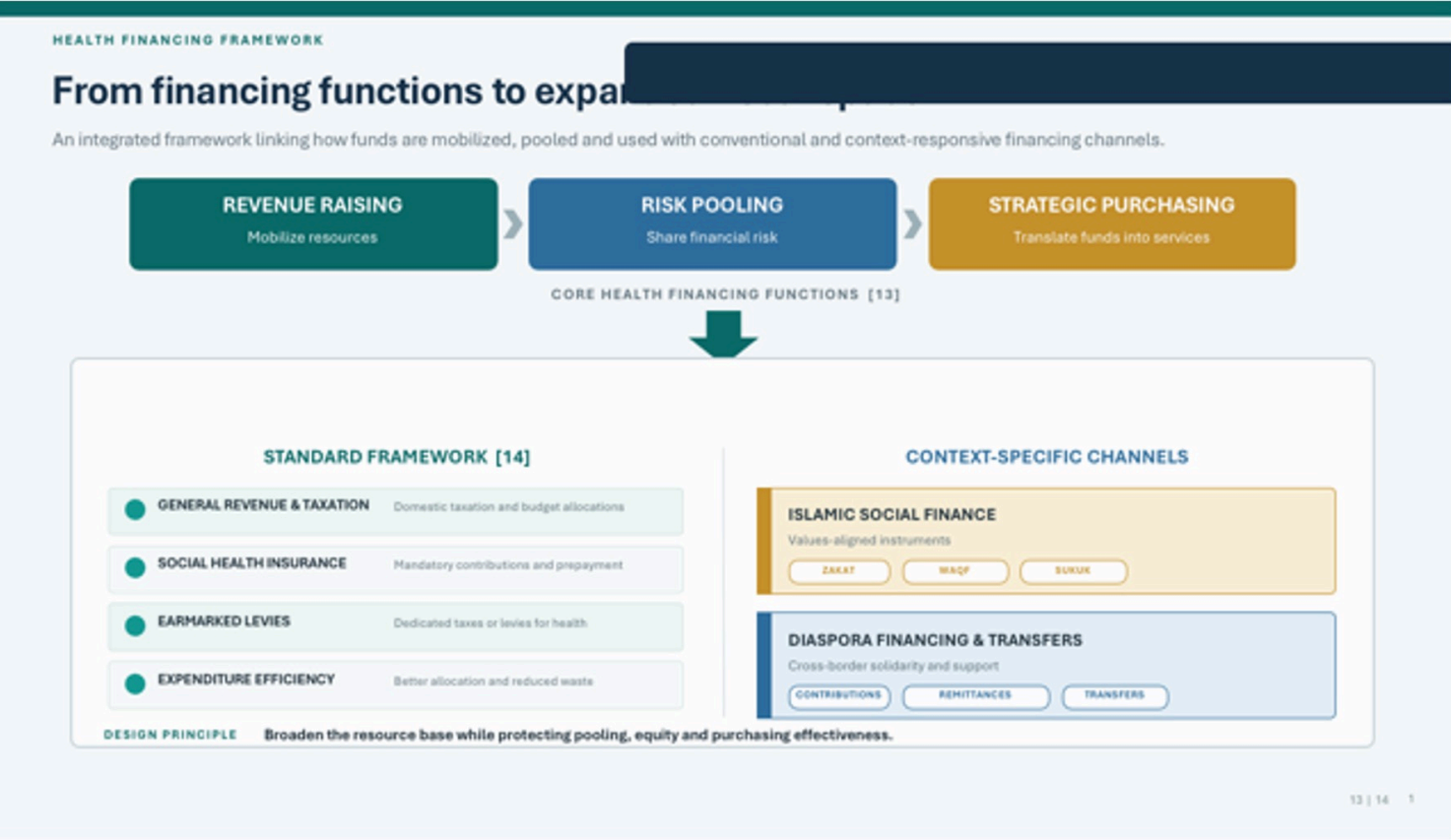


Figure 1

Unnumbered image in the Methods section.

Supplementary Files

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