Research Square

Preprints are preliminary reports that have not undergone peer review.
They should not be considered conclusive, used to inform clinical practice,
or referenced by the media as validated information.

Rethinking health governance in fragile, multi-jurisdictional settings: a scoping review of the literature with significance for Somalia

Abdirazak Ali Mire
Somalia Institute for Health Research
Anas Ismail
Newcastle University
Mohamed Mustaf Ahmed
SIMAD University
Abdi Gele
Somalia Institute for Health Research
Hodan Duale
Somalia Institute for Health Research
Maria Paola Bertone
Mbertone@qmu.ac.uk
Queen Margaret University

Systematic Review

Keywords: Health governance, multijurisdictional, fragile and conflict-affected settings, scoping review, Somalia

Posted Date: May 22nd, 2026

DOI: https://doi.org/10.21203/rs.3.rs-9630329/v1

License: This work is licensed under a Creative Commons Attribution 4.0 International License. Read Full License

Additional Declarations: No competing interests reported.

Abstract

Background

Health governance is a core function of health systems, which ensures effective and equitable service delivery and health systems performance. However, health governance is often undermined in fragile and conflict-affected settings (FCAS) and even more so in FCAS that are characterised by multi-jurisdictional arrangements, where authority is divided, shared, or contested across multiple actors and levels of government. This review examines health governance in such contexts in order to synthesise evidence on what works and what does not work, identifying enabling and constraining factors with policy relevance for Somalia.

Methods

We conducted a narrative scoping review of literature published between 2010 and 2025 on low- and middle-income, fragile settings that operate within multi-jurisdictional governance arrangements (federal, devolved, or contested governance systems). Thirty-nine documents were included and analysed using a framework based on health governance linkages between key actors, expanded from existing governance models to reflect the complexity of fragile, multi-jurisdictional settings.

Results

Findings show that governance challenges are amplified in these contexts due to fragmented authority, overlapping mandates, weak institutional capacity, and the presence of multiple state and non-state actors. Key challenges include coordination between central and sub-national authorities and with external partners, inconsistent policy implementation, limited regulatory oversight of providers. The literature also highlights promising approaches and way forwards, such as inclusive and decentralised planning, hybrid governance arrangements combining top-down and bottom-up approaches, and network-based governance models that acknowledge the interdependence of actors. Community engagement, trust and locally legitimate governance structures also emerged as important for sustaining service delivery.

Conclusions

Overall, the evidence suggests that effective health governance in fragile, multi-jurisdictional contexts requires flexible, relational governance approaches that prioritise coordination, local decision space, and collaboration across diverse actors. These findings offer insights to inform ongoing health governance reforms in Somalia and other similarly complex settings.

Background

Health governance is widely acknowledged to be a core element of the health system and of its building blocks (1) and is critical to ensuring effective and equitable service delivery and health system performance, through leadership, coordination, accountability and responsiveness of healthcare services (2). The WHO defines health governance as ‘ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, the provision of appropriate regulations and incentives, attention to system design, and accountability (1). However, there is ample evidence that health governance is undermined in fragile and conflict-affected settings (FCAS), due to the unstable political settlements, weak overall institutional structures, and fragmentation and contestation of authority that is often a consequence of conflict, crises and fragility (2, 3). In FCAS, multiple, competing and contested authorities might emerge because of fragmented territorial control and de facto jurisdictional boundaries, which lead to different regions being governed by different rules, regulations and health policies, complicating standardization and coordination of health services and requiring informal

governance structures (4). In addition, fragmentation emerges due to the presence of an increased number of non-state actors, both domestic (for example, private sector, civil society, de facto authorities) and international (e.g., development partners, implementing agencies, humanitarian actors), that may have competing interests or overlapping mandates, in a context of low trust and legitimacy, and general lack of accountability mechanisms (2). A further layer of complexity in FCAS is added by increased devolution, which can be introduced *de jure* by new constitutions and frameworks within the emerging political settlement after a crisis or conflict, but that is often also an emerging, de facto feature deriving from the loss of control of central authorities on the periphery (5, 6).

Somalia's health system sits at the junction of these contextual features and political and health governance challenges. At the political level, the conflict, which has been ongoing for over 30 years, has resulted in an intricate political system which is largely influenced by clan-based power sharing arrangements underpinning the current federal system. The federal system was adopted in 2004 with the establishment of the Transitional Federal Government and became more established in 2012 with the ratification of the Provisional Federal Constitution and the formation of the Federal Government of Somalia (FGS). Over the last decade, six Federal Member States (FMSs) were formed – although FMSs remain de facto as they have not yet been endorsed by Parliament as required in the Provisional Federal Constitution, and some states reject the federal authority. In practice, each FMS is dominated by a main clan, and the federal government in Mogadishu exerts influence over FMS based on its relationship with the leading clan of each state, typically represented by the state's President. Moreover, some parts of the country remain under the control of Al Shabab, the Islamist political and paramilitary organisation (7). As a consequence, despite progress, many aspects of Somalia's federal model remain contested, particularly the allocation of power and resources between different levels of government, including in relation to the health system, so that the underlying political settlement remains weak (8, 9).

With regards to the health sector, the decades long conflict, as well as the governance challenges, resulted in significant disruption of essential services, including healthcare (10, 11). Health governance has been severely affected by the overall governance context, which has led to high fragmentation both between regional and sub-regional governments, but also due to the presence of large numbers of international aid and humanitarian organisations which play a critical role in providing health services (12). Health governance challenges are compounded by a large presence of private sector providers, which account for 70% of service delivery, as well as the ongoing presence of *de facto* authorities particularly in regions under Al-Shabaab control (13). Despite harmonisation efforts such as through the introduction of an Essential Package of Health Services (EPHS) (14), making coordinated national health strategies remains difficult to implement (15, 16). The main reason lies in the fragmented and contested health governance, manifested by lack of implementation at the State Ministry of Health (MoH) level of health policies and guidelines drafted by the federal MoH, leading to inconsistent policies and practices.

Against this background, this review aims to synthetise evidence on what works and what does not work for health governance, and identify enabling and hindering factors that explain the how and why, across fragile, multi-jurisdictional settings within low and middle-income countries (LMICs) in order to inform policy guidance that can be relevant to Somalia to address critical gaps in health governance. While health governance has been extensively studied, also with reference to conflict-affected settings (2, 17), there remains gaps in the conceptualisation of health governance in fragile, multi-jurisdictional settings and in our understanding of the challenges as well as lessons learned on what work to strengthen health governance arrangements (and therefore health systems performance) in such settings. In this review, we aim to address this gap and generate actionable evidence for the Somali health system.

We define multi-jurisdictional settings as geographic or political areas where administrative and legislative authority is divided, shared, or contested across multiple layers of government or competing actors. Thus defined, multi-jurisdictional settings encompass both federal or devolved systems where authority is constitutionally divided between national (central) government and sub-national governments, or where certain powers are transferred to sub-national governments (in the case of devolved systems), as well as de facto or contested settings where unrecognised groups have functional control of

a portion of territory, creating overlapping, contested and conflicting governance structures (as in the case of Syria pre-2025, ethnic areas of Myanmar, Yemen, Libya).

Methods

Study design

We conducted a narrative scoping review to identify and synthesize evidence on health governance in LMIC, that are considered fragile or affected by conflict and also have overall governance arrangements that multi-jurisdictional, either because of federal, devolved or characterised by multiple, contested overlapping (recognised or unrecognised) authority. This review used the Arksey and O'Malley scoping review framework (18) and is reported in accordance with the PRISMA-ScR guidelines (19). This approach was chosen because of the broad research questions that are qualitative and exploratory in nature. As such, a scoping review was deemed the preferred approach for document identification – although its limitations are noted in the Discussion section. Additionally, a narrative synthesis allowed to capture and synthetise the qualitative information gathered through the documents.

Document search and selection

The review team defined and adopted clear and specific criteria for the selection of relevant documents. We selected eligible countries based on geographic scope, defined to include LMICs based on the World Bank's country classification by income level for 2024-2025 (20), which are also categorized as Fragile and Conflict affected settings (FCAS) by the World Bank (21) and cross-checked using the OECD fragility framework (22). Exceptionally, we included Kenya despite not being included in the World Bank FCAS list, because of the proximity to Somalia and shared features in relation to the fragility of some counties in Kenya. The second criteria for country inclusion were the overall governance system type, where we included countries that have multiple jurisdictions, in the form of a federal or devolved governance structure (not simply decentralized, and not with reference to the health sector, but to the broader governance systems), and/or in the form of multiple, contested overlapping (recognised or unrecognised) authority. Source of information on governance structures was the CIA World Factbook (23). These criteria were deemed the most relevant to select countries that share key structural and governance contextual features that are comparable to Somalia, and therefore useful to draw lessons for the ongoing health governance reforms in that setting. Figure 1 presents the final list of countries included (see also Table 3).

We searched the following databases: PubMed, Scopus, Web of Science, Embase, and Google Scholar, focusing on the period between 2010 and 2025. To capture unpublished and programmatic evidence, we also searched for grey literature sources (including organizational repositories and reports, such as

WHO/UN and other institutional databases). Reference lists of included articles and key reviews were also screened to identify additional eligible sources (snowballing). Search terms were developed based on our research questions and the list of eligible countries as defined above, and combined concepts related to:

- fragile/conflict-affected settings (e.g., "fragile setting," "fragile and conflict-affected setting"),
- governance arrangements (e.g., "devolved," "federal," "multi-jurisdictions," "limited statehood").
- health governance and health service delivery (e.g., "health system governance," "health service delivery")
- coordination and harmonization (e.g., "coordination," "harmonization,"
- we additionally used the names of the included countries as search terms.

Annex 1 provides a detailed overview of the search strings used for each database.

All retrieved records were imported into review software by Rayyan for de-duplication and screening. Screening was conducted in three stages (title, abstract, and full-text screening). Two reviewers (AM and MMA) independently screened records using the predefined eligibility criteria, with support from MPB and AI when third opinions were needed. Inclusion

and exclusion criteria were defined as presented in Table 1. The PRISMA chart below (Figure 2) presents a summary overview of the different steps.

Table 1: Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
• Studies conducted in eligible countries as described above • · Studies examining reasons for fragmentation in governance and healthcare delivery in conflict-affected areas; Research addressing the provision of coordinated health services. • · Empirical studies employing quantitative, qualitative, or mixed methods approaches for data collection; Grey literature, including government reports, documents from international organizations, and evaluations that provide insights into health service delivery. • · Peer-reviewed journal articles, official reports, and policy documents. • · Literature published in English to ensure accessibility. • · Studies published within the last 15 years (2010-2025) to capture current and evolving trends	• · Studies not focused on health service delivery in conflict-affected areas. • · Articles or reports that do not address coordination, harmonization, or fragmentation of healthcare services. • · Research is limited to high-income countries, unless offering comparative perspectives with relevance to low- and middle-income contexts.

Data extraction and analysis

An extraction matrix was developed for analytical purposes. The extraction matrix included codes that pertained to the bibliometric features of the documents (such as authors, year of publication, type of document and type of study, country/ies of focus, health sub-sector or building block of focus), which are reviewed in the Bibliometric analysis section of the findings. The second part of the extraction matrix reflects deductive themes drawn from existing health governance frameworks and in particular the health governance triangle (24-26), with also the 'missing links' identified by Bigdeli et al (26), that closely guided our analysis. These seminal frameworks identify the key actors at the core of governance relations in the health sector and, more specifically, describe the bidirectional linkages between them. It results in a health governance triangle, comprising of the State and policy-makers (at the top), providers and citizens, with six 'principal-agent' linkages between each of these dyads.

However, as we progressed in our analysis, the triangle structure appeared insufficient to capture all the health governance actors involved in fragile, multi-jurisdictional settings. To reflect this, coding remained open and inductive themes were also added to reflect the health governance actors and relations that emerged, reflecting the multiple, fragmented state and non-state, internal and external actors that contribute to, and participate in, health governance in the settings we are interested in. As much as possible, we aimed to capture health governance relations that are both formal and informal, e.g., including formal and informal (e.g. de facto, unrecognised authorities, non-state actors, etc.) actors. As new actors and linkages emerged, we have added them to the original framework also making adjustments in the definitions of the existing linkages as needed. The result was a list of eight linkages (from the 6 original ones) between a range of different health governance actors. Table 2 describes and defines the health governance linkages we have adopted in this scoping review.

Table 2: Health governance linkages used in this review

Health governance linkage	Description of the linkage and dyad of actors involved
Devolved or federal authority	Relation between central level authorities and devolved (state, regions, etc.)
Cooperation with unrecognised / de facto authorities	Formal and informal mechanisms of coordination and collaboration between external or state authorities and de facto authorities.
Coordination with, and among, external partners	Formal or informal mechanisms and arrangements for coordination and collaboration among external stakeholder groups, designed to maximise the effectiveness and cohesiveness of action. Different internal and external stakeholders jointly planning and organising their activities to ensure they are aligned and cohesive.
Multisectoral/multiagency partnership	Collaborative relationship between two or more parties in different sectors or agencies (health, education, infrastructure, etc) for the achievement of goals (27). Joint working between different stakeholders to share ideas and resources.
Stewardship and oversight of service provision	Relation between government [central and decentralised] and health providers/implementers [including public, private, NGOs, faith-based, etc], includes strategic vision, policy, regulations, stewardship, oversight, harmonisation].
Accountability & voice	Relations between communities and health authorities at different levels of government, non-state actors/NGOs/CSOs, de facto authorities
Responsiveness	Relations between providers (formal, informal, state and non-state) and communities
Intelligence and information sharing	Relations between providers (public, private, non-state) and health authorities/funders

For each of the health governance linkages identified deductively or inductively, we extracted information on the existing governance arrangements, strengths and enablers, weaknesses or challenges, how they affected health system performance, any adaptations suggested, frameworks or models of reference.

The data and information included in the extraction matrix was then analysed and it is reported below in two sections, the first focusing on the bibliometric findings and the second section looking in turn at each of the health governance relations identified and unpacking core findings in relation to what worked and what did not, within each governance relation, and how this affected service delivery and other functions of the health system.

Findings

Bibliometric analysis

In this first section of the findings, we provide an overview of the body of literature that was selected based on the criteria above and that we have reviewed. A total of 39 documents were included in this scoping review, with direct reference to health governance in low and middle-income settings that are fragile and multi-jurisdictional, either because of federal, devolved or characterised by multiple, overlapping (recognised or unrecognised) authority. Annex 2 provides a summary overview of all studies included.

In terms of year of publication, we found no clear trend although there was a sense that literature has increased in particular since 2014, likely driven by the increasing number of publications in relation to the crises in Syria and Yemen. There were no publications found for the period 2010-2013 (Figure 3).

The majority of the documents included were peer-reviewed journal articles (n=33), although some reports (n=5) and 1 conference proceeding were included. In relation to methods, 18 documents presented qualitative case studies, while 8 were mixed method studies. Another 14 documents were based on documentary reviews for a specific country or set of countries.

Bibliometric analysis by country (Table 3) shows that some settings are better covered in the literature than others (note that the total of countries in the table below is higher than 39 as some documents refer to more than one country). In particular, the cases of Kenya, Ethiopia and Syria were particularly well covered. Extending the analysis further, we note that there are some clusters in the body of literature. One particular cluster (n=9) is around countries that are not fragile in the World Bank (Kenya) or OECD classifications (Nepal) that have been undergoing relatively recent processes of federalisation or devolution. Similarly, another cluster include countries where the OECD fragility index is comparatively low and have historically functioned with a devolved or federal governance system, such as Nigeria and Ethiopia (n=12). In contrast, another cluster of settings is characterised by a namely unitarian government but with very fragmented governance structures due to unrecognised or informal authorities. These settings include Syria (pre-2025), Libya, Yemen and Myanmar (n=15). Somalia is at the intersection between these clusters due to the ongoing federalisation process, as well as its extreme fragility and still fragmented authority in some areas, and therefore all are relevant for our scoping review. Furthermore, we note that these three clusters cover the majority of documents reviewed and, as relevant, we explore patterns within and across these clusters in the analysis below.

Table 3: Documents reviewed by country (including income, fragility and governance status)

Country	Income status	WB FCAS list	OECD Fragility Framework	Governance Structure	Num of Documents
Syria	Low income	Yes	Extreme fragility	Multi-jurisdictional	9
Ethiopia	Low income	Yes	High fragility	Federal	8
Kenya	Middle Income	No	High fragility	Devolved	6
Nigeria	Middle Income	Yes	High fragility	Federal	4
Myanmar	Middle Income	Yes	High fragility	Multi-jurisdictional	4
Nepal	Middle Income	Yes	--	Federal	3
Somalia	Low income	Yes	Extreme fragility	Federal	3
Palestine	Middle Income	Yes	High fragility	Multi-jurisdictional	3
Yemen	Low income	Yes	Extreme fragility	Multi-jurisdictional	2
Iraq	Middle Income	Yes	Extreme fragility	Multi-jurisdictional	1
Papua New Guinea	Middle Income	Yes	High fragility	Multi-jurisdictional	1
Comoros	Low income	Yes	High fragility	Federal	--
Libya	Middle Income	Yes	Extreme fragility	Multi-jurisdictional	--
Micronesia	Middle Income	Yes	--	Federal	--
Venezuela	Middle Income	Yes	High fragility	Federal	--
Total					**46**

In terms of topics analysed (Figure 4), we note that, unsurprisingly and in line with our selection criteria, the majority of documents explored health governance issues (n=23), but it is interesting to note that other elements or building blocks of the health systems were also discussed in the paper in addition to health governance, including service delivery (n=18), health financing (n=8), health workforce and health information systems (n=4 each) and medical equipment/supply chain (n=2).

Finally, we look at the body of literature reviewed in relation to the eight health governance linkages between dyads of governance actors that we have identified as guiding framework for our analysis (Figure 5). The majority of documents included (n=11) explored health governance relations between central and devolved authorities, followed by papers analysing health governance in settings with unrecognised or de facto authorities. Six papers explored donor coordination in settings that are fragile and multi-jurisdictional, while 5 papers each looked at the governance relation between health authorities (at different levels) and healthcare providers, and between multisectoral agencies. Finally, a limited number of studies described the governance relations between communities and health authorities, communities and providers, providers and health authorities in settings that are fragile and multi-jurisdictional.

Health governance linkages

In this second part of the findings, we explore each of the health governance linkages that emerged from our analysis (Table 2). For each of the dyad of health governance actors, we detail the health governance arrangements that are in place as described in the document, what worked well (and the factors that enabled or facilitated good governance in that domain), as well as what did not work (and any weakness, challenges or bottlenecks reported). If detailed in the document reviewed, we also analyse how the health governance arrangements affected the health system performance and/or health outcomes, and why. We also present any recommendations included in the articles in relation to how to improve health governance.

Devolved or federal authority

The majority of documents reviewed pertained to the relation between central level authorities and devolved (whether state, regions, etc.). This is likely due to the selection criteria which purposefully focused on devolved settings. In these settings, a shift of power and control to other levels of the government has advantages, in particular in relation to the ability of devolved settings to deliver public services better because of their proximity to demand, but also creates important challenges.

Coordination between levels was highlighted in the literature as a particularly stark challenge. For example, in Ethiopia, devolution led to decision making power shifting to regional and district (woreda) levels and required increased coordination capacity between Ministry of Health (MoH), Ministry of Finance and also between central level MoH and Regional Health Bureaus (RHB) (28). In Kenya, the rapid devolution of the health functions has been partial and has led to coordination challenges and ambiguity over responsibilities in service management and delivery, which are coupled with constraints at county level over fiscal resources and decision spaces. This mismatch between what counties should be able to do and what they can actually do because of fiscal and administrative resources was found to limit their ability to deliver services and distort accountability as citizens blamed counties while key levers remained nationally controlled (29, 30). In addition, devolution has reshaped vertical (i.e., between national and county levels of government) and horizontal (i.e., within central and within county levels) coordination mechanisms. The result has been a duplication and fragmentation of coordination structures in the health system and unclear roles between actors at different levels. This, in turn, has increased transaction costs and reduced efficiency, while siloed supply chains deepen fragmentation (31). All studies called for reforms, such as clarification of roles between actors at different levels, capacity strengthening of counties, alignment of all actors to core health policies and frameworks, enhanced donor coordination through common funding arrangements and integrated vertical disease programmes, inter-county coordination mechanisms, to be implemented to strengthen devolution to ensure that health system functions efficiently and efficiently. At sub-sector level, findings were similar. For example, another study in Kenya focused on the impact of devolution on health workforce management and similarly indicated coordination challenges (32). In this context, it found that the development of a HRH coordination framework, enacted through inter-county forums and technical working groups, was instrumental to expedite the dissemination and tailoring of national HRH

policies to the counties, support mentoring of county officers by national staff, provide collaborative platform between peers at country level to resolve HRH challenges and harmonize HR practices nationwide.

In Ethiopia, the MoH at federal level executes a stewardship function rooted in its leadership role as assigned by the constitution, while RHBs at state level are key actors in relation to service delivery, including quality of care, infrastructure planning, supplies and health workforce management. The vertical coordination between federal and state levels is ensured by working protocols to regulate their interaction, while a permanent Joint Steering Committee between the MoH and RHBs meets regularly to discuss outstanding health sector programs, evaluate shared plans, and coordinate joint programmes (33). Challenges with coordination and fragmentation were addressed with a shift to inclusive planning that blended top-down and bottom-up approaches. On the one hand, the central government established the main directions and priority areas, which are then transferred to RHBs, zones, and finally to the basic decentralized administrative units (woredas). On the other hand, each lower unit could adapt the plans based on its local realities (34). However, challenges remained. For example, in vertical sectoral meetings, the MoH took the upper hand in drawing the agenda and chairing the meetings, which negated the principle of co-equal status in federal-state relations, and most federal-state sectoral interactions were conducted informally and without written rules or protocols, except for the MoH-RHBs relationship (33).

Other studies highlighted challenges concerning the fidelity or adherence to original (national/federal) policies when they were translated into implementation at state or regional levels. In Ethiopia, a study exploring the implementation of Community Health Workers programme found that the gap between the macro (national) level policy and the implementation at the micro (woreda) level is a blind spot for the community-based health system in rural areas, that needs urgent addressing (35). In Nigeria (36), devolution of PHC governance to state level created challenges in policy implementation with the weak state governments lacking accountability and transparency and exercising significant discretion in implementation. It appeared that there was a disconnect between central and state levels in terms of priorities and implementation approach, and that state governments were more interested in executing low hanging fruits in order to access national incentives. As a result, none of the states analysed fully implemented the PHC framework and service delivery lacked the standardisation and harmonisation needed for effective health system performance. The study also noted that a factor that enabled better implementation was the presence of development partners or governors who had shown commitment towards improving health sector performance. It concluded that, while complete implementation of health policies in devolved settings may not be expected, other factors that can improve implementation fidelity included gaining political commitment of sub-national levels through consistent advocacy, policy incentives, supportive supervision and mentoring with respect to policy implementation and change management. In contrast, although tempting, top-down approaches from federal government that bypassed local governments posed the risk of resulting in over-dependence by states on the national government to implement what should otherwise be the responsibility of the lower tiers. This is also confirmed a study (6) looking at the experience of Papua New Guinea, the Philippines, Indonesia, Pakistan, Myanmar and Nepal, which found that a key element that influences health system performance under decentralisation in fragile settings is the decision space at local level to tailor policies and implementation. When planning was conducted centrally with limited local inputs, it resulted in weaker transfer and worst health system performance.

Two articles reflected on the ongoing federalisation process in Nepal and on opportunities and challenges of the process (37, 38). They stressed that the decentralisation process has been well managed through a series of committee and groups (high-level committee, Technical Working Group for functional analysis, Federalism Implementation Unit). Concerns regarding possible de-prioritisation of health sector spending were also addressed with the decision that federal government channelled health sector budget under a conditional grant which allowed for uninterrupted delivery of the priority health interventions. However, challenges remained in relation to the lack of clarity between jurisdictions in the different layers of government, in particular due to the large number of local governments (753) and the lack of a clear decision on the existence and role of provincial ministries of health and coordinating structures at district/local level. Other major challenges identified were the lack of capacity at local levels and the resistance of civil servants to change in the power structure. However, we note that none of the papers reviewed on Nepal specifically reflects on the federalisation process in relation to Nepal's history of fragility.

With specific reference to fragile settings and looking at the experience of Papua New Guinea, the Philippines, Indonesia, Pakistan, Myanmar and Nepal, Brennan & Abimbola (6) stressed that in FCAS *de jure* devolution can be coupled with *de facto* devolution, deriving from the fragility itself which leaves centralised institutions weaker, more diverse, fragmented and contested. Importantly, one of the factors that they identified that influences health system performance under decentralisation in fragile settings is the character of armed conflict. They suggested that where conflict entailed two main actors (such as in Nepal) conflict resolution could more successfully support health system performance under decentralisation. On the other hand, in settings with multiple conflict actors (such as Myanmar and the Philippines), conflict appeared more intractable and *de facto* decentralisation occurred with various centres of decentralised/multijurisdictional health governance built around geographical and historical lines, with mixed results in terms of health systems performance. They concluded that factionalism and clientelism in FCAS may hinder the capacity to govern decentralised health systems, requiring greater coordination and regulation to enhance efficiency and support democratic institutions at the local level.

Cooperation with unrecognised / de facto authorities

Cooperation with unrecognised and *de facto* authorities reflects the formal and informal mechanisms of health governance between external or state authorities and de facto authorities. We found this linkage to be relevant for the case of Northwest Syria, Yemen and Myanmar in particular, where overlapping, contested and unrecognised health authorities exist that oversee the provision of health services to specific communities. While we know this is relevant for parts of Somalia, no literature with specific reference to Somalia was identified.

Across all studies looking at this health governance linkage, the issue of legitimacy emerged as a central one, as unrecognised authorities could be seen as legitimate to different degrees by their own societies compared to by international actors (39). In Northwest Syria, it is found that the lack of formal recognition of the local health authorities proved to be a barrier to cooperation, and resulted in expanded roles of NGOs at least initially (40). However, establishing alternative governance structure in the form of technical bodies (health directorates) formally independent from ruling militias and therefore 'depoliticised', ensured cooperation and protected the health system (39-41). Despite the progress, challenges remained due to the presence of multiple health directorates that lacked coordination between them and had only limited leadership role (40), as well as because of lack of funding and technical support (41). Later on, following the military advance of Hay'at Tahrir al-Sham (HTS), support to health directorates was suspended due to their perceived closeness to military groups. Instead, another governance arrangement emerged known as the 'central bodies', such as the Syrian Board of Medical Specialties (SBOMS), Syria Immunization Group (SIG), Infection Prevention and Control (IPC body), Referral Network, and Health Information System (HIS) unit (or District Health Information Unit DHIS). However, a study found that the central bodies approach remained fragmented and verticalized (as governance bodies referred to specific services or sub-sectors of the health systems), based on organizational and individual interests and initiatives rather than strategic, long-term planning and goals (42, 43). A subsequent study in Northwest Syria on the governance of vaccination confirmed the difficulties in coordination of multiple, officially unrecognised authorities with no single body having legitimate oversight, with adverse effects on health system performance including resurgence of polio in 2013 and measles in 2017 (44). The study highlighted the potential of a hybrid governance model that combined top-down and bottom-up approaches to promote local ownership (see also "Accountability and voice").

In Yemen, where authority and legitimacy are contested and overlapping in the presence of two governments, different health systems operated in the same territory without coordination, each with its own agenda (45). This is compounded by lack of effective leadership in both ministries, although health directorates had better capacity and clearer guidelines and policies. The fragmentation leaded to suboptimal coordination with international partners and inefficient duplications.

In Myanmar, during the democratisation phase before the 2021 coup, the central government began a process of recognition and integration of the parallel ethnic health systems that had developed in the contested border areas. This so-called 'convergence' process aimed to reduce the gap between the two health systems and promote mutual understanding and trust, by ensuring alignment to central policies while recognising local planning process and the complementarity of the

health systems (46). However, challenges remained due to the differences in the views of the respective roles for central and ethnic authorities, where the latter were in favour of an approach that fully reflected a devolved political system allowing more decision-making space at decentralised level, as well as because of the difficulties in the broader peace process, now completely halted following the coup and return of active conflict (46, 47).

Coordination with, and among, external partners

Coordination with, and among, external partners reflects the formal or informal mechanisms and arrangements for coordination and collaboration among external stakeholder groups, designed to maximise the effectiveness and cohesiveness of action in support of health systems. Challenges in coordinating external partners are well known and they are compounded in settings that are devolved. Much of the literature identified in this category referred to the case of Ethiopia and highlighted mechanisms such as aligned planning (for example, the One Plan, One Budget, One Report approach), resource mapping in order to avoid duplications, and joint 'triangular' coordination mechanisms, which include government, international partners and civil society (34, 48).

With specific reference to fragile settings, the literature reviewed highlighted further challenges due to the fragmented context where multiple actors needed to be coordinated, including humanitarian and development partners and implementers. A comparative study across multiple fragile/disputed settings (Cameroon, Somalia, Sudan, Ukraine, Palestine) argued that recognised governments often have limited practical control in disputed territories, thus leaving humanitarian clusters, cross-border networks, and NGOs as key coordinators of service delivery. The authors emphasis that these coordination mechanisms could sustain basic services, but responsiveness to more complex needs and equitable coverage remained constrained in contested multi-jurisdictional contexts (49). In a similar vein, a case study on service provision in limited statehoods, with reference to Somalia, made the case that external partnership could be effective to deliver comparatively simple health services, often through parallel or vertical systems and still requiring the support from local communities and the existence of alternative forms of authority. In contrast, more complex service delivery required state capacity and legitimacy that went beyond mere donor coordination and vertical approaches (50).

In some settings, coordination needed to operate across borders, as in the case of Northwest Syria where most development partners and NGOs remained on the Turkish side of the border, relying on implementers within Syria. A study on this setting highlighted the circular flows of interactions and dynamics among actors, although with limits due to the lack of trust, security concerns, lack of transparency in reporting mechanisms, which led to lack of coordination and of standardization of monitoring and evaluation processes between funders. Against this background, creative and effective bottom-up strategies emerged that enhanced cross-border coordination of aid delivery into Syria, for example through engagement of local communities in remote monitoring, through relying on a "low-profile approach" to gain access to populations of concerns and through efforts to integrate Syrian NGOs in the international response through their inclusion in formal coordination structures (51).

Multisectoral/multiagency partnership

Multisectoral/multiagency partnership refers to the collaborative relationship between two or more parties in different sectors or agencies (health, education, infrastructure, etc) for the achievement of shared goals (27). Across the literature reviewed, experiences of health governance arrangements in relation to multisectoral partnership emerged in particular in relation to devolved contexts that are not acutely fragile (Ethiopia, Nigeria, Kenya) and only partially reflected the issue of devolution.

Overall, the studies examined stressed the importance of multisectoral partnerships for the delivery of health services. In Nigeria, intersectoral collaboration for adolescent sexual and reproductive health through a collaboration architecture between health, education and community was shown to contribute to trust-building, shared goals, and communication processes that overcame organisational silos, and it led to improved access and service responsiveness when institutional

support and funding aligned (52). Similar findings emerged from a study in Kenya on community-level multisectoral structures for nutrition that cut across health, agriculture, education, and WASH sectors (53).

In Ethiopia, a multisectoral governance structure has been established to support nutrition services, that works across 13 bodies including ministries, UN agencies, donors, and academia. While the design was positive, in practice a study found that multisectoral coordination remained largely ineffective due to fragmentation, lack of legal accountability mechanisms and the perceived biased leadership of the MoH which prioritised its own programmes and resources. Authors suggested that the establishment of an independent body in charge of multisectoral coordination for nutrition would be beneficial to address some of these challenges (54). Another study (55) reported on multisectoral governance for nutrition at State level in Amhara State and found that there the multisectoral partnership arrangements have been more successful. This is because of clear divisions of roles, accountability and monitoring as well as the leadership role played by State authorities and an NGO operating in the area. Importantly, the type of health governance arrangements in place reflected those of a network governance model through structures such as steering and technical committees that distribute roles and responsibilities and acknowledged the shared, networked structure of governance rather than imposing a top-down one. Factors identified that enabled the network governance model include the interdependency of actors that allowed for coordination and complementary of resources; informal communication to execute activities; formal agreements that increased clarity of roles and responsibilities.

Stewardship and oversight of service provision

Stewardship and oversight describe the relation between (central and decentralised) government and health providers, including public, private, NGOs, faith-based, and includes health governance elements such as strategic vision, policy, regulations, stewardship, oversight, harmonisation.

In northern Nigeria, the delivery of the PHC Under One Roof policy was strengthened at state and local government authority-level via changes that reinforced the stewardship structures, such as boards and integrated governance, improved coordination arrangements, strengthened HMIS (e.g., DHIS2 and feedback loops), and community engagement mechanisms (e.g., for budget tracking) (56). These reforms highlighted the value of integrating health governance reform with systems strengthening as the health governance reforms together contributed to improve service coverage and operational performance of service providers. However, the article also noted continuing constraints such as shortages of health staff, donor dependence, and sociocultural barriers (57).

Other articles described stewardship and oversight in relation to non-state providers, such as NGOs and the private sector. In Palestine (58), the MoH focused on providing health services within the essential package while NGOs focus on gaps and complement MoH service delivery. This complementarity worked well, although it was undermined by the political divisions and the multi-jurisdictional character of the Palestinian territory. This weakened the position of the MoH and its capacity for stewardship and oversight, also creating a sort of competition for access to external funding between MoH and NGOs. The authors suggested that a clearer division of tasks, fewer political pressures within the MoH, as well as more inclusive coordination forums could address some of these issues. Similarly, a multicounty WHO reported on the governance of private provider in fragile settings and found weak coordination and lack of regulation and enforcement capacity from the MoH as a main concern resulting in haphazard and fragmented governance (59). Although not specific to multi-jurisdictional settings, the study suggested that approaches that work best across FCAS are stewarded ones, underscored by constant dialogue and focus on alignment on the broader aims of service delivery aims (for example, through EPHS or contracting) to achieve concordance between actors and ensure provision of aligned health services.

Accountability and voice

Accountability and voice refers to the relation between communities and health authorities at different levels of government, as well as de facto authorities or external (funding or implementing) agencies that take a leadership role in the absence of local health governance structures. This relationship was particularly interesting in settings where more traditional,

hierarchical governance structures and (central) state authority were weak and had little legitimacy vis-a-vis communities. As pointed out in a study in Northwest Syria (60), in such settings, bottom-up, community-based forms of health governance that rely on local communities to express views and determine plans and policy direction emerged as more legitimate and effective by enhancing trust and cooperative behaviour that sustained health interventions and achieves their sustainability. Hybrid or mixed governance models between communities and authorities were also preferrable to top-down governance. These hybrid models allowed for shared decision-making processes and responsibilities between governmental bodies and local or community-based organisations, and aimed at balancing standardisation and adaptability to ensure that health services were effective and met local needs and expectations.

In Palestine, in the context of limited statehood, non-state actors and in particular international NGOs acted as de facto health authorities. It is argued that the NGOization created a 'new form of colonial control' that excluded local voices and communities (61).

Responsiveness of health providers

Due to selection criteria that focused on governance and health authority in multi-jurisdictional and fragile settings, limited literature was selected that looked at the responsiveness of health providers and the relation between formal, informal, state or non-state providers and communities. One relevant article however emerged which described the case of Myanmar. It found that, in the aftermath of the 2021 coup in the absence of a functioning government, non-state actors providing health services (local NGOs or CBOs) emerged as an important element of resilience of the health systems to continue service delivery addressing needs of communities. The governance relation between non-state providers and communities was informal and direct rather than mediated by the government - in fact, collaboration with government was interrupted as it is seen as threatening legitimacy and trust of communities in non-state providers (62).

Intelligence and information sharing

Intelligence and information sharing reflects the linkages between (public, private, non-state) providers and health authorities. Only one paper described this relation, in reference to the devolution process in Kenya (which is a low fragility setting). It found that devolution had both positive and negative effects on information sharing between providers and health authorities. On the one hand, devolution had weakened the national government's control on the governance of the health system, resulting in inadequate supportive supervision and training, increased tensions in management of the country's health information system database and reduced funding as counties prefer to invest in visible infrastructural projects than information systems. What worked in this context was that, with more power to lower administrative levels, the demand for health data for planning and implementation significantly increased, enhancing the culture of information use and accountability at county level (63).

Discussion

This rapid review aimed at synthetising the current evidence on health governance in settings that are relevant to the case of Somalia, in particular focusing on LMICs and fragile, conflict-affected settings that also have overall governance arrangements that multi-jurisdictional, either because of federal, devolved or characterised by multiple, contested overlapping (recognised or unrecognised) authority. We focused on gathering evidence on the different health governance arrangements that exists in these settings, by categorising them based on a series of health governance linkages that connect dyads of actors within the health systems in these settings. We also explored what works and what does not work, enablers and hindering factors, in relation to these health governance arrangements.

We found an important and expanding body of literature relevant to these research questions, even if not necessarily cohesive as few settings share the specific contextual features of Somalia. For example, a number of documents refer to settings that are devolved but not necessarily fragile as a whole, or to a lesser degree than Somalia (Kenya, Ethiopia, Nigeria, Nepal). Historical pathways also differ with countries of more established devolution process (Nigeria, Ethiopia) and others with more recent or ongoing devolution (Nepal, Kenya). However, while their experience as a newly federalised or devolved systems could be of relevance for Somalia, there remain substantial differences between their transition from centralised to federal system and Somalia's transition from separate/regionalised governance to federal. Other settings are more specifically characterised by presence of unrecognised or overlapping and contested authority rather than devolution, such as Yemen, Myanmar and Syria (for which there is an extensive literature). Despite these contextual variations, some important findings emerge from our analysis.

A central point is that health governance in fragile, multi-jurisdictional contexts is more complex than in relatively stable settings with unitary political arrangements due to the number of actors at different levels of the health systems and also because of the fragmentation and contestation that is associated with fragile, conflict-affected settings (2). Health governance challenges that are often discussed in more stable and unitary settings are also reported in this literature, and likely made starker by the specific features of the contexts we are interested in. Such challenges include coordination between governance actors, challenges in translating policies into implementation, lack of clarify of roles and responsibilities, diverging priorities, lack of capacity at decentralised levels. These challenges in turn affect the performance of the health system, leading to inefficiencies and inequalities in service provision.

Despite the challenging backdrop, our synthesis also highlights positive examples of what works for health governance in such settings and what enabling factors can be identified. At the more immediate level, findings call for better clarification of roles and tasks between actors at different levels, capacity strengthening, alignment and harmonisation of all actors and programming to core health policies and frameworks (for example, the 'One Plan, One Budget, One Report' approach), enhanced donor coordination and integration of service delivery – these recommendations are broad and similar to those made across most LMIC settings, in particular the most aid dependent (64, 65). However, the analysis also reveals that there are substantial barriers to such 'simple' solutions, due to the complexity of the health governance linkages and the political economies that they establish (in terms for example, of varying incentives, priorities and interests among actors).

At a deeper level, findings from the body of literature reviewed point to further, more radical options to review (and improve) health governance in fragile, multi-jurisdictional settings. An element that emerges across studies is the importance of decision spaces at decentralised level. This is mentioned for example with reference to Ethiopia's inclusive planning (34). Across settings, concordance or alignment in service delivery does not emerge through tight, top-down control, but rather from dialogue and stewardship often through informal governance structures. Further, decision space at local level to tailor policies and implementation consistently leads to better policy implementation, and better health system performance and health outcomes (6, 47). This is in line with other literature on decision spaces, including in FCAS and in relation to resilience (66). For example, a recent study on health workers in Palestine showed that creating or expanding coordination bodies and spaces resulted in a more effective and coordinated response to emergencies by all actors involved (67).

In addition, what appears to work across the different health governance linkages explored are not top-down, hierarchical approaches but rather models that blend top-down and bottom-up approaches. This is mentioned with reference to Syria where bottom-up or hybrid governance approaches were seen as more legitimate and effective (60), as well as at state level in Ethiopia were multisectoral partnership for nutrition worked through distributed roles and responsibilities (55). With reference to Nigeria, it emerged that top-down approaches might reduce the sustainability of implementation, while better implementation fidelity could be achieved through political commitment of sub-national levels increased by consistent advocacy, policy incentives, supportive supervision and mentoring (36). These approaches favour a more flexible, tailored, and relational model of health governance, rather than viewing one single actors (e.g. a central governmental entity) at the centre or at the top of the health governance configuration, such as in a 'governance triangle' model (24, 68). This is in line with emerging literature on network governance, for example as applied to the health sector in the context of the East of the

DR Congo (69) and to the liminal health system at the border between Myanmar and Thailand (4), that stress the emergence of informal and horizontal governance structures and networks. Factors identified that enabled network governance models include the acknowledgement of the interdependency of actors which allowed for better and clearer coordination and complementarity of resources; formal agreements that clarified roles and responsibilities, coupled with informal communication and connections.

Furthermore, the evidence reviewed stressed that, while coordination of external actors is essential for (basic) service delivery in contested multi-jurisdiction contexts (49), health systems strengthening approaches that can sustain service delivery in the longer term necessitate at the minimum the trust of local community and the support of locally legitimate authorities (whether formal or informal/de facto), and ideally some state capacity and legitimacy (50). In these settings, adaptations involve decentralized service delivery, extensive community engagement and leveraging local governance structures to navigate the complexities of different jurisdictions (3, 70). Contextual features such as the complexity of the conflict and the (in)stability of the political settlement are identified as potential barriers to the establishment of effective health governance arrangements, requiring more time and careful consideration (6)– which is a challenge all too familiar in the Somali setting.

Limitations

This scoping review of the literature has a number of limitations largely due to its exploratory nature. The body of literature that we set out to review is varied and heterogeneous in nature, making search and selection more complex and leading to possible biases. Overall, we found an important and expanding body of literature relevant to our research questions, even if the literature is not necessarily cohesive as few settings share the specific contextual features of Somalia. Furthermore, in some cases while the context is relevant, articles do not reflect on issues of governance with explicit reference to the multi-jurisdictional or fragility features of the setting. Quality of studies included was not formally assessed, but we noted it was varied. In addition, the heterogeneity of contexts included in the review makes it difficult to ensure external validity and generalisability to other settings, although we have attempted to distil what might be relevant for the specific context of Somalia. Finally, the emergent conceptualisation of health governance linkages between dyads of actors in fragile, multi-jurisdictional settings (Table 2) would need further theoretical refinement and empirical testing. However, it makes for a novel contribution and holds promise in terms of pointing to a network model of governance in fragile and multi-jurisdictional settings.

Conclusions

This review highlights that health governance in fragile, multi-jurisdictional settings is shaped by complex political and institutional dynamics, including fragmented authority, multiple state and non-state actors, and contested legitimacy. Across the literature reviewed, governance challenges commonly include weak coordination between levels of government, inconsistent policy implementation, limited regulatory capacity, and difficulties aligning external partners and service providers. These challenges can undermine coherence in health service delivery and contribute to inefficiencies and inequities in access to care.

At the same time, the evidence points to a number of governance approaches that show promise in such contexts. In particular, governance arrangements that combine national stewardship with meaningful decision space at decentralised levels appear to support more effective implementation and responsiveness to local needs. Hybrid and network-based governance models, characterised by collaboration across government, non-state actors, communities, and external partners, also emerge as particularly relevant where authority and capacity are fragmented.

For Somalia, where federalisation is ongoing and authority remains contested in some regions, these findings underline the importance of strengthening coordination mechanisms between federal and state levels while recognising the role of informal and locally legitimate actors in health governance. Building inclusive governance platforms, fostering dialogue

across actors, and supporting locally adapted implementation of national policies may help reduce fragmentation and support more coherent and resilient health system performance.

Declarations

Ethics approval and consent to participate

Not applicable

Consent for publication

Not applicable

Availability of data and materials

All data generated or analysed during this study are included in this published article and its supplementary information files.

Competing interests

The authors declare that they have no competing interests

Funding

This work received financial support from the Alliance for Health Policy and Systems Research. The Alliance is able to conduct its work thanks to the commitment and support from a variety of funders. These include our long-term support from the Swedish International Development Cooperation Agency (Sida) and the Norwegian Agency for Development Cooperation (Norad), as well as designated funding for specific projects within our current priorities. This work was funded by the Department of Health and Social Care (DHSC) using international development funding from the Government of the United Kingdom of Great Britain and Northern Ireland to support global health research. The views expressed in this publication are those of the authors and] are not necessarily those of DHSC or the Government of the United Kingdom. For the full list of Alliance donors, please visit https://ahpsr.who.int/about-us/funders.

Authors' contributions

AG and HD acquired funding for this work; AG, HD and MPB contributed to its conceptualisation; AAM, MMA, developed the methodology with support from AI, MPB; AAM, AI, MMA, MPB curated the data (screening, extraction); MPB led on data analysis with AI, AAM and MMA; AAM and MPB led on writing. All authors read and approved the final manuscript.

Acknowledgements

Authors would like to thank Drs Sam Boland and Zubin Shroff at the Alliance for HPSR for their precious support to this work at different stages.

References

1. WHO. Strengthening health systems to improve health outcomes: WHO’s framework for action. Geneva: WHO. 2007.
2. Lokot, M. et al. (2022) ‘Health system governance in settings with conflict affected populations: a systematic review’, Health Policy and Planning, 37(5), pp. 655–674. https://doi.org/10.1093/heapol/czac027.
3. Bogale, B. et al. (2024) ‘Health system strengthening in fragile and conflict affected states: A review of systematic reviews’, PLOS ONE, 19(6), p. e0305234. https://doi.org/10.1371/journal.pone.0305234

4. DiStefano, L., K. K. Than, T. Traill, S. Witter, C. Lee, A. Moodie, T. Russell, T. La, H. M. Wai, S. Vaccher, J. Tartaggia and M. P. Bertone (2026). "A liminal health system: Exploring the resilience strategies of healthcare providers and communities along the Thailand-Myanmar border." SSM - Health Systems **6**: 100209.
5. Bertone MP, Falisse J-B, Russo G, Witter S (2018) Context matters (but how and why?) A hypothesis-led literature review of performance-based financing in fragile and conflict-affected health systems. PLoS ONE 13(4): e0195301. https://doi.org/10.1371/journal.pone.0195301.
6. Brennan E, Abimbola S. The impact of decentralisation on health systems in fragile and post-conflict countries: a narrative synthesis of six case studies in the Indo-Pacific. Confl Health. 2023;17(1):31.
7. Lanfranchi, G. (2025). The moving pieces: Major changes in domestic politics and international assistance. In Shifting sands in Somalia: Scenarios for the near-term future and policy options for the EU (pp. 5–20). Clingendael Institute. [Available from: http://www.jstor.org/stable/resrep73129.6].
8. SDP (2022), Options for allocating powers in Somalia's federal system. Somali Dialogue Platform, Policy paper SDP.F20.03 [Available from: https://riftvalley.net/wp-content/uploads/2022/09/SDP%E2%80%A6Policy%E2%80%A6AllocationOfPowers%E2%80%94EN%E2%80%94A01.pdf].
9. SDP (2022), Revitalizing the negotiation of contentious political issues. Key considerations going forward. Somali Dialogue Platform, Policy paper SDP.F20.01 [Available from: https://riftvalley.net/wp-content/uploads/2022/09/SDP%E2%80%A6Policy%E2%80%A6ContentiousIssues%E2%80%94EN%E2%80%94A01.pdf].
10. Hammond, L. (2013) 'Somalia rising: things are starting to change for the world's longest failed state', Journal of Eastern African Studies, 7(1), pp. 183–193 [Available from: https://doi.org/10.1080/17531055.2012.755316].
11. Hidig, S.M., Mohamed Hanfı, R.A. and Egeh, G.A. (2024) 'The challenges facing the healthcare system in Somalia: A review and The Way Forward', Healthcare Issues, 3(1).
12. Ahmed, A.Y. et al. (2023) 'Universal Health Coverage in Somalia: Charting the Path to Equitable Healthcare Financing and Governance', Health, 15(11), pp. 1298–1317. [Available from: https://doi.org/10.4236/health.2023.1511085.].
13. Jackson, Ashley. Humanitarian Negotiations with Armed Non-State Actors: Key Lessons from Afghanistan, Sudan and Somalia. ODI, 2014. JSTOR.
14. Jama, M. et al. (2023) 'Revising the essential package of health services through stakeholder alignment, Somalia', Bulletin of the World Health Organization, 101(11), pp. 738–742. [Available from: https://doi.org/10.2471/BLT.23.289733].
15. Said AS, Kicha DI. Implementing health system and the new federalism in Somalia: challenges and opportunities. Front Public Health. 2024;12:1205327.
16. Warsame, A., Handuleh, J. and Patel, P. (2016) 'Prioritization in Somali health system strengthening: a qualitative study', International Health, 8(3), pp. 204–210. https://doi.org/10.1093/inthealth/ihv060.
17. Munzer Alkhalil, Zedoun Alzoubi, Salah Safadi et al. (2025) From Ground Realities to Policy: A Framework for Assessing Multipolar Health System Governance in Conflict-Affected and High-Risk Areas, Global Health 22, 23 (2026). https://doi.org/10.1186/s12992-025-01183-8
18. Arksey, H., & O'Malley, L. (2005). Scoping studies: towards a methodological framework. International Journal of Social Research Methodology, 8(1), 19–32. https://doi.org/10.1080/1364557032000119616.
19. Tricco, AC, Lillie, E, Zarin, W, O'Brien, KK, Colquhoun, H, Levac, D, Moher, D, Peters, MD, Horsley, T, Weeks, L, Hempel, S et al. PRISMA extension for scoping reviews (PRISMA-ScR): checklist and explanation. Ann Intern Med. 2018,169(7):467-473. doi: 10.7326/M18-0850
20. World Bank country classifications by income level for 2024-2025 [Available from: https://blogs.worldbank.org/en/opendata/world-bank-country-classifications-by-income-level-for-2024-2025].
21. Classification of Fragile and Conflict-Affected Situations [Available from: https://www.worldbank.org/en/topic/fragilityconflictviolence/brief/classification-of-fragile-and-conflict-affected-situations].

22. OECD (2025), States of Fragility 2025, OECD Publishing, Paris; [Available from: https://doi.org/10.1787/81982370-en.].
23. CIA World Factbook; [Internet]. Available from: https://www.cia.gov/the-world-factbook/countries.
24. Brinkerhoff DW, Bossert TJ. Health governance: principal-agent linkages and health system strengthening. Health Policy Plan. 2014;29(6):685-93.
25. World Bank. 2003. World Development Report 2004: Making Services Work for Poor People. World Bank. http://hdl.handle.net/10986/5986
26. Bigdeli M, Rouffy B, Lane BD, Schmets G, Soucat A. Health systems governance: the missing links. BMJ Global Health. 2020;5:e002533. https://doi.org/10.1136/bmjgh-2020-002533
27. WHO. Building a working definition of partnership. Geneva: World Health Organization; 2009.
28. Gadisa (2022) Decentralization and Health Sector Reform: Lessons from Ethiopia; https://doi.org/10.31579/2834-8745/002.
29. Ochieng (2017) Who is responsible? Local government and accountability for service delivery in Kenya's devolved health sector.
30. Rodr□□guez DC, Balaji LN, Chamdimba E, Kafumba J, Koon AD, Mazalale J, et al. Political economy analysis of subnational health management in Kenya, Malawi and Uganda. Health Policy Plan. 2023;38(5):631-47.
31. Nyawira L, Njuguna RG, Tsofa B, Musiega A, Munywoki J, Hanson K, et al. Examining the influence of health sector coordination on the efficiency of county health systems in Kenya. BMC Health Serv Res. 2023;23(1):355.
32. Thuku Mathew. Coordinating Health Workforce Management in a Devolved Context: Lessons from Kenya. 2019; doi:10.21203/RS.2.19658/V1.
33. Afesha N. Sectoral Intergovernmental Relations in Ethiopia Federation: Normative and Empirical Considerations. Mizan Law Review. 2023.
34. Bekelle 2019, Implementing effective leadership and coordination systems for better health outcomes in Ethiopia (2004-2016).
35. Gebremeskel AT, Udenigwe O, Etowa J, Yaya S. Unpacking the challenges of fragmentation in community-based maternal newborn and child health and health system in rural Ethiopia: A qualitative study. PLoS One. 2023;18(9):e0291696.
36. Eboreime EA, Abimbola S, Obi FA, Ebirim O, Olubajo O, Eyles J, et al. Evaluating the sub-national fidelity of national Initiatives in decentralized health systems: Integrated Primary Health Care Governance in Nigeria. BMC Health Serv Res. 2017;17(1):227.
37. Thapa R, Bam K, Tiwari P, Sinha TK, Dahal S. Implementing Federalism in the Health System of Nepal: Opportunities and Challenges. Int J Health Policy Manag. 2019;8(4):195-8.
38. Regmi K, Upadhyay M, Tarin E, Chand PB, Uprety SR, Lekhak SC. Need of The Ministry of Health in Federal Democratic Republic of Nepal. JNMA J Nepal Med Assoc. 2017;56(206):281-7.
39. Paterson A, Palmer J, Sondorp E. Health system governance cooperation with unrecognised health authorities: a political economy analysis in Afghanistan and Northwest Syria. Confl Health. 2025;19(1):30.
40. Al-Abdulla O, Ekzayez A, Kallström A, Valderrama C, Alaref M, Kauhanen J. Health system recovery in Northwest Syria–challenges and operationalization. Humanities and Social Sciences Communications. 2023;10(1):399.
41. Douedari Y, Howard N. Perspectives on Rebuilding Health System Governance in Opposition-Controlled Syria: A Qualitative Study. Int J Health Policy Manag. 2019;8(4):233-44.
42. Alaref M, Al-Abdulla O, Al Zoubi Z, Al Khalil M, Ekzayez A. Health system governance assessment in protracted crisis settings: Northwest Syria. Health Res Policy Syst. 2023;21(1):88.
43. Alzoubi Z, Iyad K, Othman M, Alnahhas H, Hallaj O. Reinventing state: Health Governance in Syrian Opposition-Held Areas2019.

44. Baatz RK, Ekzayez A, Najib Y, Alkhalil M, Salem M, Alshiekh MA, et al. Vaccination governance in protracted conflict settings: the case of northwest Syria. BMC Health Services Research. 2024;24(1):1056.
45. Dureab F, Hussain T, Sheikh R, Al-Dheeb N, Al-Awlaqi S, Jahn A. Forms of Health System Fragmentation During Conflict: The Case of Yemen. Front Public Health. 2021;9:659980.
46. Tang K, Zhao Y. Health system strengthening in post-conflict ethnic regions of Northeastern Myanmar: a qualitative study. Health Policy Plan. 2019;34(2):151-9.
47. Biesty CP, Brang AJ, Munslow B. Conflict affected, parallel health systems: challenges to collaboration between ethnic and government health systems in Kayin State, Myanmar. Confl Health. 2021;15(1):60.
48. Teshome SB, Hoebink P. Aid, ownership, and coordination in the health sector in Ethiopia. Development Studies Research. 2018;5(sup1):S40-S55.
49. Mariia YV, Tetiana YP. REAL-LIFE APPROACHES EMPLOYED BY RECOGNIZED GOVERNMENTS TO ENSURE HEALTH COVERAGE OF CITIZENS IN FRAGILE SETTINGS, INCLUDING THE POPULATION OF THE DISPUTED TERRITORIES, STRUGGLING FOR INDEPENDENCE. Wiad Lek. 2021;74(5):1268-73.
50. Schäferhoff M. External Actors and the Provision of Public Health Services in Somalia. Governance. 2014;27(4):675-95.
51. Duclos D, Ekzayez A, Ghaddar F, Checchi F, Blanchet K. Localisation and cross-border assistance to deliver humanitarian health services in North-West Syria: a qualitative inquiry for The Lancet-AUB Commission on Syria. Confl Health. 2019;13:20.
52. Mbachu CO, Eze, II, Onwujekwe O. Strengthening intersectoral collaboration for adolescent sexual and reproductive health: a community-embedded intervention in Ebonyi state, Nigeria. Reprod Health. 2025;22(Suppl 1):74.
53. Korir J, Gichohi-Wainaina WN, Park OH, Kwon SW, Colwell MJ, Oldewage-Theron W. Mapping the Drivers of Multisectoral Nutrition Governance and Its Link to Nutrition Outcomes in Kenya: A Qualitative Inquiry. Nutrients. 2025;17(2).
54. Ayele S, Zegeye E, Nisbett N. Multi-Sectoral Nutrition Policy and Programme Design, Coordination and Implementation in Ethiopia. 2020.
55. Amare Tadesse H. Multi-Stakeholder Partnerships (MSPs) for Health Service Delivery in Ethiopia. Developments in Administration. 2021;3(1):91-110.
56. Odutolu O, Ihebuzor N, Tilley-Gyado R, Martufi V, Ajuluchukwu M, Olubajo O, et al. Putting Institutions at the Center of Primary Health Care Reforms: Experience from Implementation in Three States in Nigeria. Health Syst Reform. 2016;2(4):290-301.
57. McKenzie A, Abdulwahab A, Sokpo E, Mecaskey JW. Creating the Foundation for Health System Resilience in Northern Nigeria. Health Syst Reform. 2016;2(4):357-66.
58. Abu El Kheir-Mataria, 2019 Enhancing Ministry of Health-NGOs Partnership in Palestine for Effective Health Services Delivery: Advancing Towards Universal Health Coverage.
59. World Health Organization (2024). Governance of the private sector in fragile, conflict-affected and vulnerable settings. World Health Organization. https://iris.who.int/handle/10665/378755. License: CC BY-NC-SA 3.0 IGO.
60. Alkhalil M, Turkmani R, Gharibah M, Patel P, Mehchy Z. Capturing sources of health system legitimacy in fragmented conflict zones under different governance models: a case study of northwest Syria. Global Health. 2024;20(1):71.
61. Arda L, Banerjee SB. Governance in Areas of Limited Statehood: The NGOization of Palestine. Business & Society. 2021;60(7):1675-707.
62. Than K, Bertone MP, La T, Witter S. Assessing the role of non-state actors in health service delivery and health system resilience in Myanmar. Int J Equity Health. 2024;23(1):221.
63. Manya A, Sahay S, Braa JA, Shisia B. Understanding the Effects of Decentralization on Health Information Systems in Developing Countries: A Case of Devolution in Kenya. 2018 IST-Africa Week Conference (IST-Africa). 2018:Page 1 of 11-Page of

64. Sharma L, Heung S, Twea P, Yoon I, Nyondo J, Laviwa D, et al. Donor coordination to support universal health coverage in Malawi. Health Policy and Planning. 2024;39(Supplement_1):i118-i24.
65. Future of GHIs (2023), The Lusaka Agenda; [Internet]. Available from: https://futureofghis.org/final-outputs/lusaka-agenda/
66. Bossert T. Analyzing the decentralization of health systems in developing countries: decision space, innovation and performance. Soc Sci Med. 1998;47(10):1513-27.
67. Ismail A, Salah M, Gilbert M, Abu Alreesh YH, Jones C. Rebuilding Gaza's health system: A qualitative study of healthcare workers' experiences and lessons learned from responding to mass casualty incidents (2018-2021). PLoS One. 2026;21(2):e0342654.
68. World Development Report 2004 : Making services work for poor people - Overview (English). World Development Report|World Development Indicators Washington, DC : World Bank Group. http://documents.worldbank.org/curated/en/527371468166770790.
69. Bwimana A. Heath Sector Network Governance and State-building in South Kivu, Democratic Republic of Congo. Health Policy Plan. 2017;32(10):1476-83.
70. Durrance-Bagale A, Marzouk M, Tung LS, Agarwal S, Aribou ZM, Ibrahim NBM, et al. Community engagement in health systems interventions and research in conflict-affected countries: a scoping review of approaches. Glob Health Action. 2022;15(1):2074131.

Figures

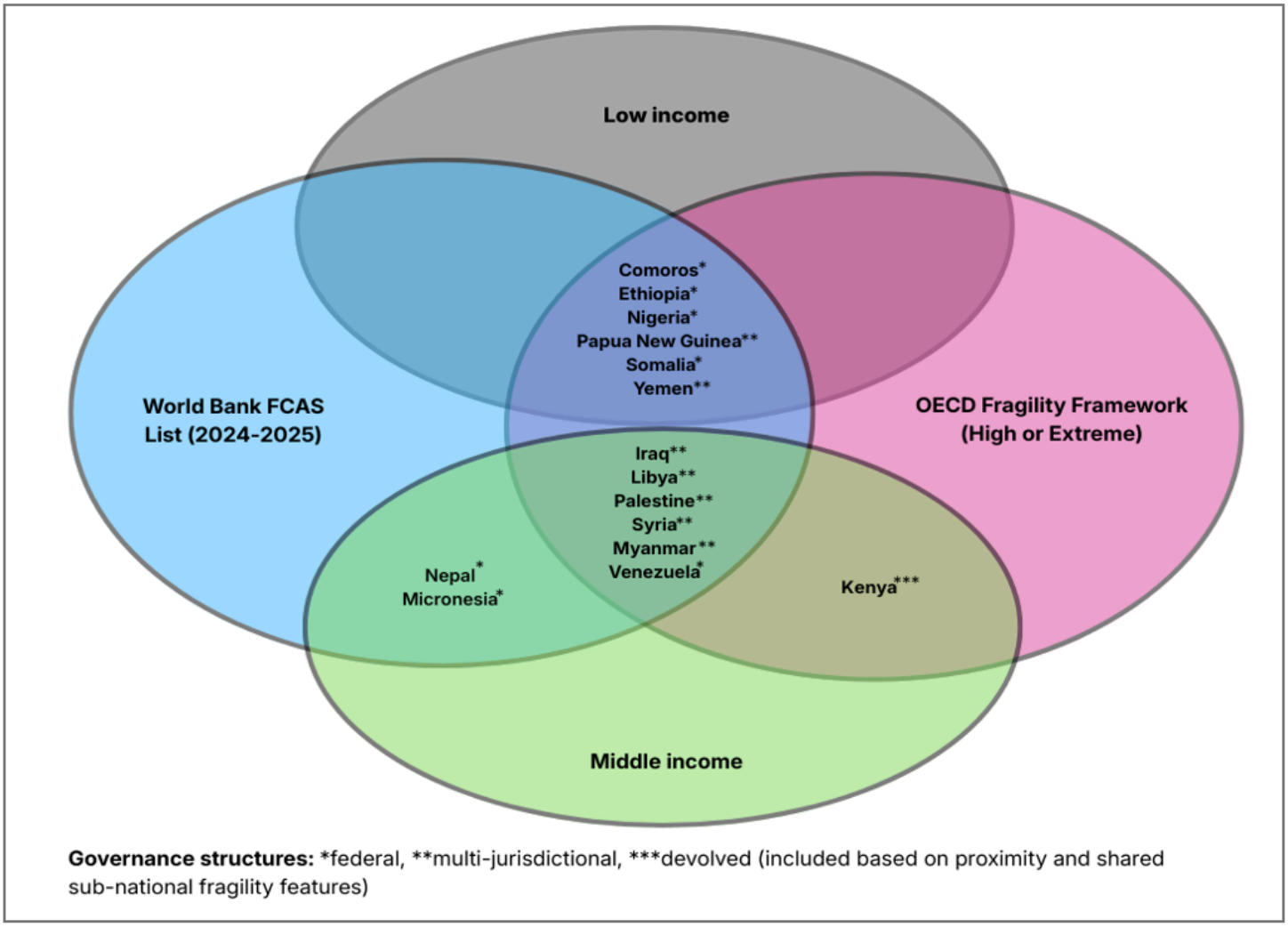


Figure 1

Venn diagram of countries eligible for inclusion in scoping review

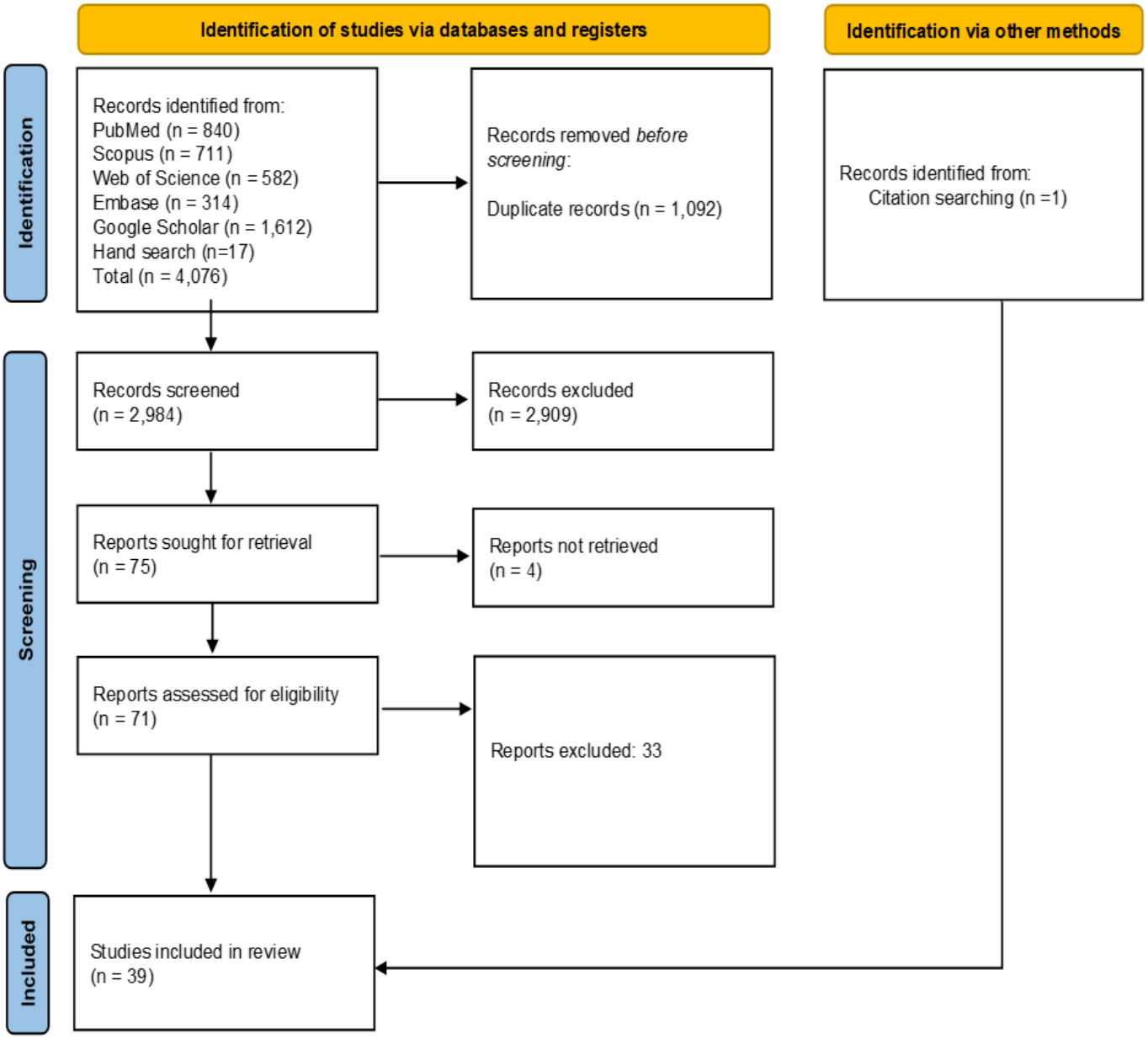


Figure 2

PRISMA follow diagram showing the review search and screening process

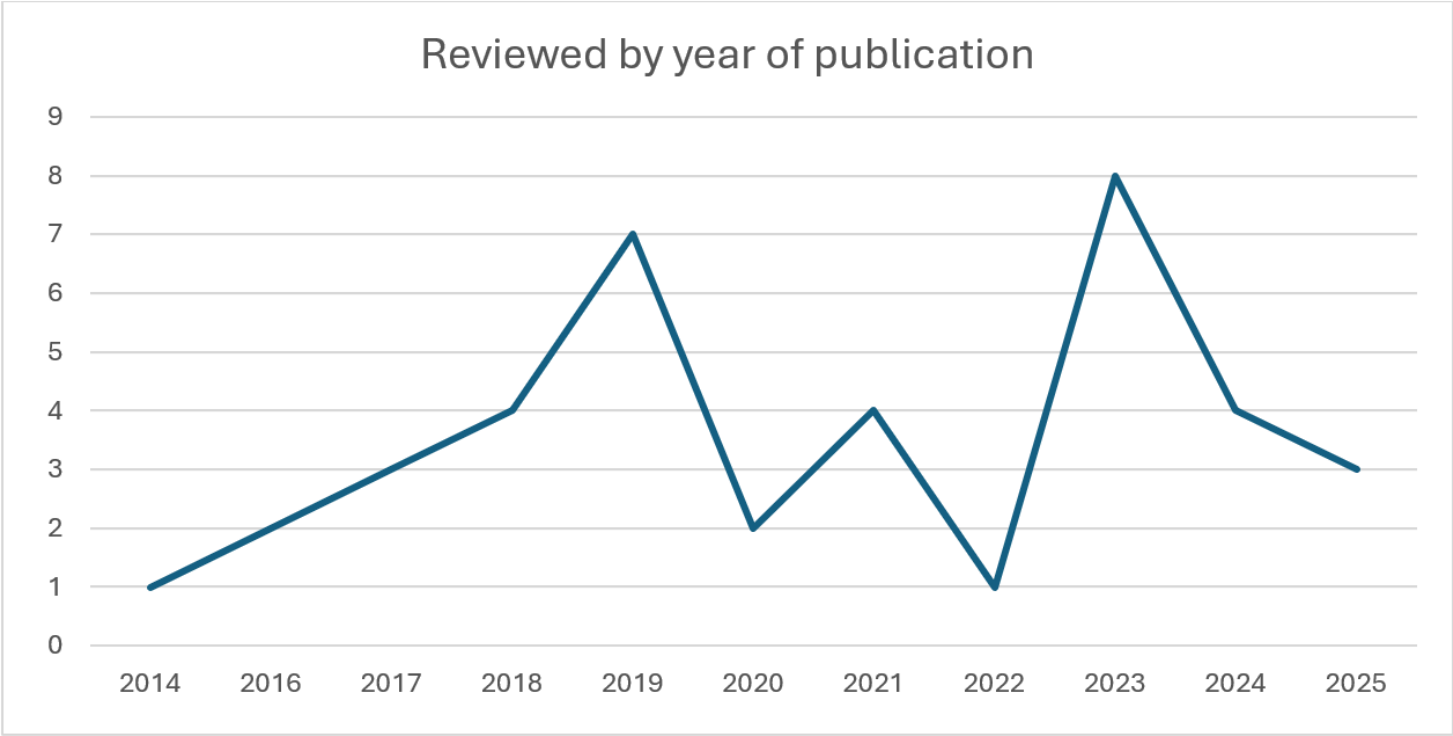


Figure 3

Documents reviewed by year of publication

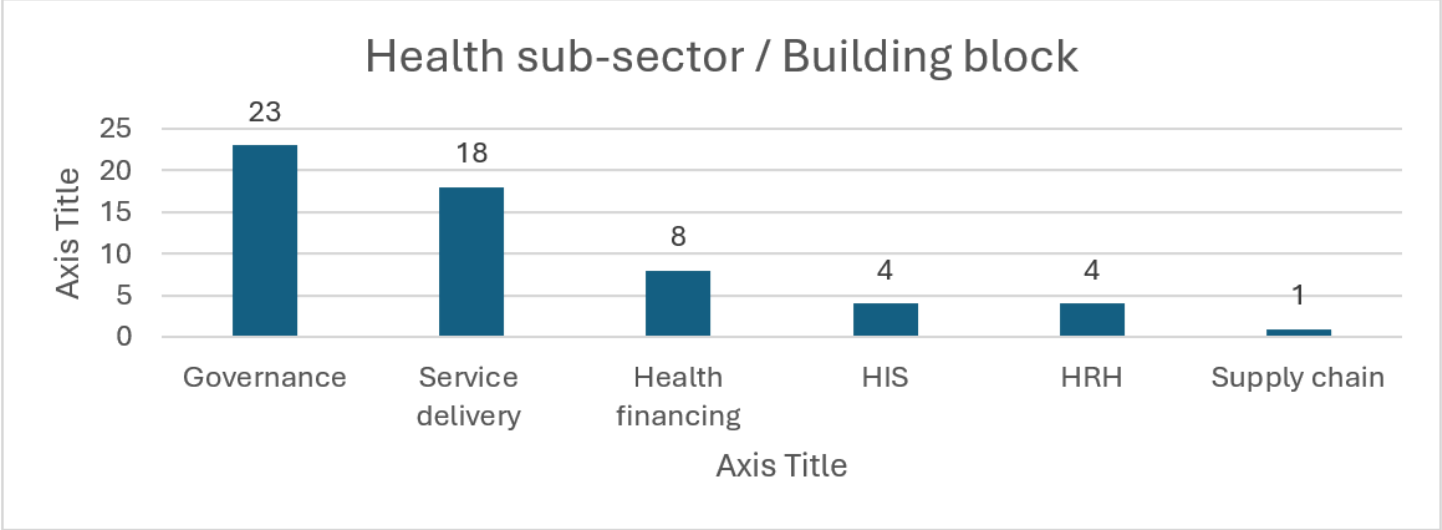


Figure 4

Documents by topic (health sub-sector / building block)

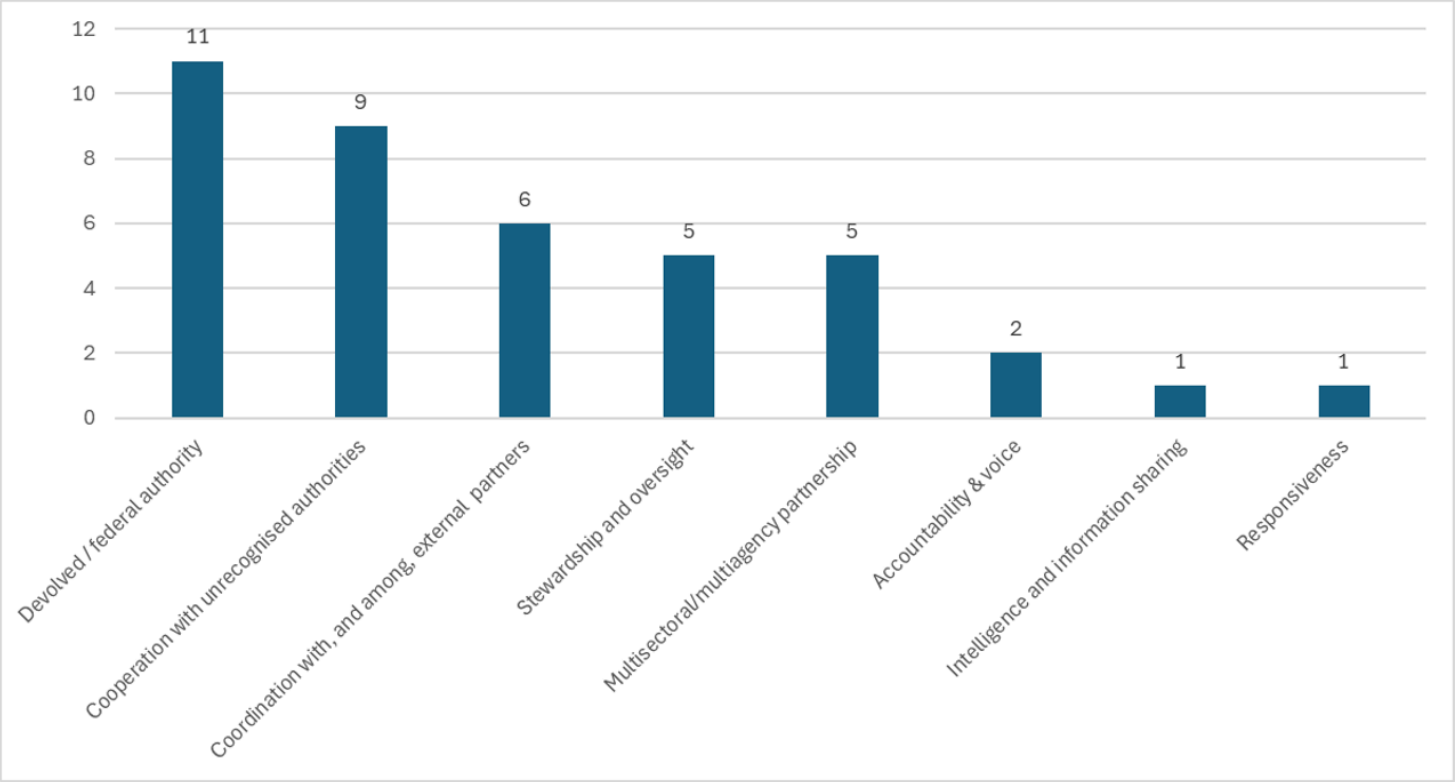


Figure 5

Documents by health governance linkage described

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- AnnexesHealthgovernanceinmultijurisdictionalFCASsettings.docx