PROJECT GOALS AND IMPLEMENTATION REALITIES

Lessons from the Damal Caafimaad Project in Hirshabelle, Somalia

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INTRODUCTION

Health-system strengthening in fragile and conflict-affected settings requires more than financial investment and alignment with national priorities. It depends on effective coordination, local ownership and the ability to adapt programmes to complex political, social and operational realities.

Damal Caafimaad, a World Bank-funded project, sought to expand essential health services and strengthen health-system stewardship across Somalia. This viewpoint reflects on implementation in Hirshabelle State and examines how governance, coordination, local ownership and contextual factors shaped programme implementation and continuity of services.

OBJECTIVE

To examine how governance, coordination, local ownership and contextual factors influenced the implementation of Damal Caafimaad and the continuity of essential health services in Hirshabelle.

METHODOLOGY

The analysis draws on field experience while serving as Subnational Health Cluster Coordinator for Hirshabelle.

Evidence sources

- Direct observations during project implementation and coordination
- Health facility visits
- Engagement with federal and state health authorities, implementing partners and communities
- Review of available project documentation

Analytical themes

Coordination, ownership, service integration, community engagement, accountability, institutional capacity and sustainability.

PRACTICAL IMPLICATIONS

Strengthen local ownership: engage subnational authorities throughout planning and implementation.

Integrate service delivery: reduce geographic and programmatic silos to improve continuity.

Make community engagement meaningful: involve communities in decisions and feedback.

Plan for sustainability: invest in institutional capacity and realistic transition planning.

Adapt to context: account for conflict, displacement, flooding and access constraints.

RESULTS AND DISCUSSIONS

1. Governance and coordination

Limited engagement of subnational authorities and fragmented coordination among stakeholders affected local ownership and contributed to operational challenges, including disruption of essential health services in some areas.

2. Service integration and continuity

Service delivery was often fragmented, with partners working in geographic and programmatic silos, limiting integration and continuity.

3. Community engagement and accountability

Community engagement provided opportunities to identify local concerns, but limited involvement in decision-making and weak feedback mechanisms constrained accountability and trust.

4. Contextual and access constraints

Conflict, displacement, recurrent flooding and access constraints further affected implementation.

5. Institutional capacity and sustainability

Insufficient attention to institutional capacity and transition planning created challenges for sustaining gains beyond donor support.

CONCLUSIONS

The Hirshabelle experience demonstrates that sustainable health-system strengthening requires programmes to move beyond technical design and financial investment towards genuine local ownership and adaptive cooperation.

Meaningful engagement of subnational authorities, inclusive decision-making, integrated service delivery, community participation and investment in institutions are essential in fragile settings.

Development partners should work with local health systems and adapt implementation to context to strengthen resilience and continuity of essential services.

KEYWORDS	HEALTH-SYSTEM STRENGTHENING	LOCAL OWNERSHIP	COMMUNITY ENGAGEMENT	SERVICE CONTINUITY