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COMMENTARY

Healthcare Leadership in Resource-Limited Settings: Reimagining Public Hospital Governance in Somalia

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Abstract: Somalia's healthcare system remains among the world's most challenged, shaped by fragmentation, chronic resource scarcity, and a longstanding urban bias that leaves rural and peri-urban communities underserved. Service quality in public hospitals is frequently constrained by weak governance arrangements and leadership approaches that emphasize command and control over learning, adaptation, and accountability. Existing literature on Somali public hospitals has emphasized resource shortages and infrastructure deficits while examining how governance and leadership shape service quality and equity, suggesting a strategic entry point for reform. A reimagined governance model is needed that shifts from top-down bureaucracy to relational and adaptive leadership suited to a fragile context, embeds clinical governance, strengthens federal and state coordination, and institutionalizes mentored leadership development to cultivate hospitals capable of delivering equitable, safe, and high-quality healthcare. The novel contribution of this paper is the integration of relational leadership, adaptive leadership, clinical governance, and federal coordination into a single, context-sensitive governance framework, accompanied by a clear distinction between short-term feasible priorities and long-term institutional reforms. This commentary aims to reframe public hospital governance in Somalia by advocating for a shift from top-down control to relational, adaptive leadership supported by stronger clinical governance and improved federal and state coordination as a pathway to more equitable and higher-quality care.

Keywords: public hospital governance, relational leadership, adaptive leadership, clinical governance, federal-state coordination, Somalia

Introduction

Somalia's health landscape has been profoundly shaped by decades of conflict and institutional disruption, contributing to a mixed system in which the public sector provides only an estimated 20% of services, while a largely unregulated private sector fills much of the gap.[1,2] Despite the gradual re-establishment of public hospitals over the last decade, the quality of performance and patient experience remain suboptimal.[3] Recent assessments in Mogadishu have described chronic shortages of essential equipment, prolonged waiting times, and low staff job satisfaction, all of which undermine trust in public facilities.[3,4] Underlying these operational shortcomings is a persistent leadership and governance gap, with hospital management frequently characterized as authoritarian and bureaucratic and with limited flexibility to respond to volatility, shifting resources, and complex patient needs.[4]

Building on this picture, a clear research gap has emerged in the Somali health systems literature.[3,4] Most published assessments have concentrated on tangible inputs such as workforce shortfalls, equipment gaps, and financing constraints, while the role of leadership and governance as a determinant of service quality has been comparatively underexplored.[1,2] Yet evidence from broader low-income and post-conflict settings consistently identifies leadership and governance as a foundational health system building block, on a par with workforce and financing in shaping outcomes.[5,6] Leadership and management are also recognized as cross-cutting leverage points whose strengthening can improve the performance of every other health system component, suggesting that governance reform is a high-yield,

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lower-cost entry point for resource-constrained systems such as Somalia's.[7] Focusing the next phase of reform on governance and leadership is therefore not a substitute for continued investment in inputs, but a precondition for ensuring that those inputs translate into reliable, equitable, and high-quality care.[5,7]

Against this background, this commentary aims to reframe public hospital governance in Somalia by arguing for a shift from top-down control toward relational, adaptive leadership supported by stronger clinical governance and improved coordination between the Federal Government of Somalia and its Federal Member States, as a pathway to more equitable and higher-quality care.[1,8]

The Current Leadership Paradigm

Leadership in Somali public hospitals has long centered on hierarchical chain-of-command structures and centralized decision-making.[4] While such hierarchy can in principle provide clarity and accountability, in practice it tends to cultivate a compliance-oriented culture in which local managers defer even routine decisions to higher authorities.[4,9] That dynamic can slow operational responses, create ambiguity during emergencies, and weaken frontline problem-solving, as observed during crises such as the coronavirus disease 2019 (COVID-19) pandemic.[8,9] Compounding these constraints, the limited strength of regulatory institutions has resulted in inconsistent policy implementation and uneven oversight of clinical standards across facilities and regions.[8] The result is a governance environment in which rules may exist on paper, but the everyday mechanisms that translate standards into supervision, feedback, and improvement remain fragile.[4,8]

Reimagining Governance: From Authoritarian to Relational

Improving performance under these conditions requires a leadership model that matches the realities of fragility, constrained resources, and complex community expectations.[9,10] A shift toward relational leadership is therefore essential, emphasizing trust, communication, shared purpose, and collective decision-making rather than rigid hierarchy.[9] Evidence from sub-Saharan Africa indicates that effective leaders in low-income settings commonly articulate a value-based vision, demonstrate self-awareness, and maintain meaningful relationships with staff and community stakeholders.[10] These relational capabilities are not soft add-ons; in fragile health systems, they often determine whether teams coordinate, remain motivated, and persist through prolonged disruptions.[9,10]

Adaptive leadership complements this relational orientation by supporting both stability and learning, which is particularly relevant in Somalia.[11] Rather than rejecting structure entirely, adaptive leadership encourages a balanced posture that combines directive action when immediate order is required with participatory methods that build ownership of long-term quality improvement.[11] When healthcare workers feel heard and empowered, adherence to protocols becomes more internally motivated, strengthening professional conviction and improving consistency in care processes.[12] Over time, such leadership can transform hospital culture from rule-following to problem-solving, where teams identify bottlenecks, test practical solutions, and sustain improvements even where resources are limited.[11,12]

Strengthening Clinical Governance and Federalism

Relational and adaptive leadership must be reinforced by structural change, and embedding clinical governance in hospitals can strengthen accountability for safety, quality, and risk management.[13] Approaches adapted from resource-limited settings, such as senior clinical oversight models in which specialist review is integrated into admission or case-decision pathways, have been associated with fewer errors and more efficient resource allocation.[13] In Somalia, even incremental steps toward structured morbidity and mortality (M&M) reviews, standardized clinical audits, and routine supervision aligned with clear standards could yield measurable improvements in patient outcomes and staff confidence.[13,14]

Beyond the hospital, Somalia's federal arrangement creates both challenges and opportunities, and the country's New Federalism provides a pathway to decentralize decision-making and tailor services to local realities, even as fragmentation and regional disparities continue to hinder standardization and continuity of care.[8] A reimagined governance framework would promote coordinated federal and state collaboration through a national health council that aligns standards, financing priorities, and accountability mechanisms across the Federal Government and Federal Member States.[1,8] Decentralization should be matched with practical authority at hospital and district level, enabling managers to make timely financial and administrative decisions that respond to local needs while still adhering to nationally agreed standards.[1,8]

Decentralization is not, however, an unqualified good and may itself generate risks that policy design must anticipate.[15,16] Comparative evidence shows that, when devolution proceeds without adequate fiscal transfers, technical assistance, and minimum-standard regulation, it can widen inter-regional inequities, fragment service delivery, and concentrate scarce specialist capacity in better-resourced states.[15,16] Because state capacities differ markedly across Federal Member States, an explicit equity-oriented design is therefore warranted in Somalia, including pooled financing arrangements, transparent resource-allocation formulas weighted to need, and federal stewardship of clinical standards even where service delivery is decentralized.[8,15]

Investment in Capacity and Evidence-Based Practice

Structural reform must be accompanied by sustained investment in human capacity, since leadership is learned and strengthened over time and cannot be assumed.[17,18] Somalia has limited institutionalized leadership training, leaving many managers to develop their skills primarily through experience, often without structured mentoring or formal support.[17] Strengthening governance therefore requires deliberate investment in leadership development that is practical, mentored, and linked to performance improvement.[7,18] One feasible approach is mentored training through structured fellowships or leadership programs that combine classroom learning with supervised field attachments, equipping clinicians and nurses with operational management skills that can be applied directly in hospital practice.[18]

Equally important is the normalization of data-driven decision-making.[14] Hospitals need functional health information systems (HIS) and routine feedback loops that allow teams to monitor service quality, identify gaps, and track whether changes are effective.[6,14] Evidence from nearby settings suggests that managers working within organizations with structured feedback systems are substantially more likely to practice good governance, underscoring the value of simple but consistent performance review routines.[14] In Somalia, building these routines can begin with feasible indicators such as waiting times, stock-out frequency for essential supplies, infection-prevention adherence, referral completion, and patient-complaint resolution, with findings reviewed in regular management and clinical governance meetings.[3,14]

Capacity investment must also explicitly address gender equality as a core health system priority.[5] Women provide a substantial share of frontline care in Somalia through community-based and facility-based roles, yet formal leadership opportunities remain constrained by social and structural factors that can limit professional autonomy and advancement.[10,19] Expanding pathways for women's leadership in hospital governance is not only an equity imperative but also a strategy for strengthening representation, responsiveness, and empathetic leadership within facilities.[5,10] Institutional policies that support women's advancement, mentorship opportunities, and transparent promotion criteria can help dismantle persistent glass ceilings and improve the inclusiveness of governance structures.[5,10]

Implementation Barriers and Contextual Considerations

Translating this governance framework into practice will require explicit attention to implementation barriers that are particularly salient in Somalia.[4,8] Political instability and intermittent insecurity continue to disrupt service delivery, displace health workers, and constrain federal-state policy continuity, complicating the long-term institutionalization of leadership reforms.[8] Resource constraints compound this picture, with persistent under-financing, donor dependency, and shortages of trained mid-level managers limiting the bandwidth available for clinical audit, mentorship, and information-system investment.[1,4] Cultural and social considerations are equally important, including the influence of clan structures and traditional authority on hospital decision-making, gendered norms that shape access to leadership roles, and community expectations regarding hierarchy that may slow the adoption of more relational, participatory management styles.[1,19] Recognizing these barriers does not invalidate the proposed framework; rather, it underscores the need for context-sensitive sequencing, realistic timelines, and continuous engagement with clinical staff, hospital boards, religious leaders, and women's professional networks to build legitimacy for governance reform in Somali public hospitals.[7,8]

Short-Term Priorities and Long-Term Institutional Reforms

Acknowledging these barriers, a practical reform agenda must distinguish what is feasible in the near term from what requires sustained institutional investment.[6,7] In the short term, hospitals can introduce structured M&M reviews, basic clinical audit cycles, standard operating procedures (SOPs) for high-volume conditions, and routine monthly

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performance dashboards using a small set of feasible indicators such as waiting time, stock-out frequency, infection-prevention adherence, and patient complaints, supported by mentored coaching of department heads.[13,14] These steps are technically modest, low-cost, and can be initiated with existing staff while signaling a cultural shift from compliance to learning.[7,13]

Over the longer term, governance transformation requires institutional reforms that lie beyond the boundaries of any single hospital.[5,6] These include the establishment of an independent national clinical-standards and licensure body with statutory authority across the Federal Government and Federal Member States, the codification of an intergovernmental health council that aligns financing and accountability mechanisms, the creation of accredited national leadership and management fellowships embedded in Somali universities and teaching hospitals, and the progressive integration of interoperable health information systems with closed-loop feedback to facility managers.[5,8,18] Sequencing matters, since short-term gains can build the political constituency, managerial confidence, and data infrastructure that make the longer-term reforms politically and technically feasible.[7,15]

Conclusion

Public hospital governance in Somalia is at a critical juncture where infrastructure expansion and additional financing alone cannot deliver the equitable, safe, and high-quality care that the population needs. A fundamental shift in leadership philosophy is required, moving away from authoritarian, urban-centric bureaucracy toward adaptive, relational, and evidence-informed governance that strengthens accountability, motivates frontline staff, and improves patient outcomes. Embedding clinical governance, harmonizing federal and state coordination, institutionalizing mentored leadership development, and advancing women's leadership emerge as practical cornerstones of resilient public hospitals that serve all Somali communities equitably and safely. Therefore, a sequenced action agenda is warranted. In the near term, every public referral hospital should establish a functioning clinical-governance committee, run monthly morbidity and mortality reviews, and report a small core set of quality and equity indicators to its board of directors. Federal and state authorities should jointly designate an intergovernmental health council to harmonize standards and resource allocation, while ministries of Health and partner universities should commission accredited leadership and management fellowships, with explicit places reserved for female clinicians and managers. Donors and policymakers should make sustained investments in clinical governance infrastructure, mentored leadership training, and interoperable information systems an explicit condition of health system support. Future efforts should focus on testing these governance reforms in real Somali settings, evaluating their impact on patient safety, equity, and workforce retention, and refining the framework as more evidence accumulates. Sustained commitment to governance reform offers a credible pathway toward a Somali health system in which leadership matches the demands of a fragile, federalizing context and public hospitals reliably deliver dignified, high-quality care to every community.

Data Sharing Statement

No new data were generated for this commentary; all sources cited are publicly available through the digital object identifiers and institutional links provided in the reference list.

Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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