

Operationalising Health Service Delivery in Somalia: Towards Universal Health Coverage

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Short Report

Keywords: Somalia, UHC, Service Delivery, Governance

Posted Date: September 30th, 2025

DOI: <https://doi.org/10.21203/rs.3.rs-7717540/v1>

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Additional Declarations: The authors declare no competing interests.

Abstract

Somalia's health system remains acutely fragile, a direct consequence of protracted conflict, political instability, and recurrent climatic shocks. This has resulted in a fragmented, underresourced, and largely informal health sector, contributing to persistently poor health indicators, particularly for maternal, newborn, and child health. This report comprehensively analyzes the multifaceted challenges confronting health service delivery, including systemic governance failures, chronic underfunding, critical human resource shortages, a dysfunctional pharmaceutical supply chain, and nascent health information systems. National policies, notably the Health Sector Strategic Plan III (HSSP III) and the revised Essential Package of Health Services (EPHS) 2020, articulate a vision for a resilient health system and progress toward Universal Health Coverage (UHC). Innovative service delivery models, such as mobile health camps and community health worker programs, demonstrate potential in reaching underserved populations, while digital health solutions like DHIS2 offer a platform for enhanced information management. However, recurrent humanitarian crises continually disrupt service delivery, and weak monitoring and evaluation systems impede evidence-based decision-making. Achieving UHC necessitates a sustained, multipronged approach focused on strengthening governance, increasing domestic financing, comprehensive human resources for health development, robust regulatory frameworks, and integrating health interventions with broader development, peacebuilding, and climate resilience efforts.

I. Introduction: The Somali Health Landscape – A Nation Striving for Health Amidst Adversity

Contextual Overview

Somalia, situated in the Horn of Africa, has been profoundly shaped by over three decades of civil conflict, persistent political instability, widespread poverty, and the increasing impacts of climate change, manifesting in recurrent and devastating droughts and floods. These enduring adversities have collectively resulted in some of the world's most concerning health indicators. The prolonged civil war, which commenced in the early 1990s, led to the near-total collapse of state institutions and public infrastructure, including the national health system. Consequently, the health sector today is characterized by extreme fragmentation, chronic under-resourcing, and a predominant reliance on informal and private providers to fill the void left by the state.

The population, estimated at approximately 19 million, faces dire humanitarian conditions, with millions displaced and a significant portion experiencing acute food insecurity. The cyclical nature of these crises fundamentally undermines long-term health system development and resilience, as resources are continually diverted to acute response, impeding sustained investment in foundational health system strengthening. This creates a critical challenge, as the Ministry of Health must constantly address emergencies by redirecting scarce funding and human resources. The cumulative deficit in human capital, infrastructure, and institutional memory, resulting from decades of instability, makes recovery exponentially more difficult than in contexts with shorter periods of disruption. The legacy of state collapse is not merely about physical destruction but also about deeply ingrained behavioral patterns and expectations within the population and among providers.

The protracted nature of these crises has meant that an entire generation has grown up without a functioning public health system, leading to a normalization of informal, unregulated care. This historical context has fostered a deeply entrenched informal and privatized health sector. While this sector filled a critical vacuum in service provision during the conflict years, its largely unregulated nature presents significant challenges to achieving national health goals, particularly Universal Health Coverage (UHC), equity in access, and consistent quality of care. The reliance on a market-driven approach to healthcare, where access is often determined by an individual's financial capacity, undermines the principles of UHC and perpetuates health inequities. This also weakens the social contract between the state and its citizens, as the government struggles to fulfill its fundamental obligation to ensure health as a basic right. This lack of state legitimacy in health provision can, in turn, hinder broader state-building efforts, as citizens may not trust or support public health initiatives or governmental reforms. Addressing this requires complex governance and engagement strategies that extend beyond simple capacity building of the nascent public sector.

Report Purpose and Scope

This report provides a comprehensive analysis of health service delivery in Somalia. It examines the core components of the health system, identifies the multifaceted challenges hindering effective service provision, and explores the policies and strategies being implemented to improve health outcomes and advance toward UHC in the Somali context. The scope of this analysis is defined by a synthesis of available research, encompassing systemic issues, programmatic interventions, and the broader contextual factors influencing health in Somalia. Fundamentally, this research serves both a diagnostic and policy advisory role, recognizing that improving health service delivery is vital not only for better health outcomes but also for broader state-building and peace-building in Somalia [User Query].

Methodology

The analysis presented in this report is based on a comprehensive synthesis of information derived from a diverse range of sources. These sources include peer-reviewed academic research papers, technical reports and assessments from reputable international organizations such as

the World Health Organization (WHO), UNICEF, and the World Bank, official documents from the Federal Government of Somalia, and operational reports from non-governmental organizations (NGOs) actively working in the country. This multi-source approach ensures a holistic understanding of the complex health landscape in Somalia, integrating both macro-level policy perspectives and ground-level operational realities.

II. Conceptual Frameworks for Health Service Delivery

A. Defining Health Service Delivery and its Core Components

The World Health Organization (WHO) provides a foundational definition of health service delivery, characterizing it as the operational component of a health system responsible for the provision of medical treatments, interventions, and supplies to individuals, aligning with their defined entitlements to care. This definition underscores a fundamental relationship between the health system and the individual, establishing the system's core responsibility in meeting the population's healthcare needs.

Expanding on this core concept, a health care delivery system can be understood as a comprehensive and intricate network of people, institutions, resources, and coordinated services that collectively contribute to essential functions within the continuum of healthcare. These functions are critical for optimizing patient outcomes and overall system efficiency, and include:

- **Coordination of patient care pathways:** This involves ensuring seamless transitions for patients across various levels of care, different healthcare settings, and diverse providers, promoting continuity and integrated care delivery. Effective coordination minimizes fragmentation, reduces errors, and enhances the overall patient experience.
- **Management of patient flow:** This focuses on optimizing the movement of patients within the health system to ensure timely access to services, reduce waiting times, and improve the efficiency of resource utilization. Efficient patient flow management is essential for maximizing throughput and minimizing bottlenecks.
- **Application of diagnostic processes:** This encompasses the accurate and timely use of various diagnostic tools and procedures to identify health conditions, inform clinical decision-making, and guide appropriate treatment strategies. Robust diagnostic processes are fundamental for effective disease management and patient safety.
- **Implementation of disease management strategies:** This involves the development and execution of evidence-based approaches for treating and controlling illnesses, including acute and chronic diseases. Effective disease management strategies aim to improve patient outcomes, reduce complications, and enhance quality of life.
- **Establishment of health maintenance programs:** This focuses on promoting preventive care, health education, and wellness initiatives to maintain population health and prevent the onset of diseases. Health maintenance programs play a crucial role in promoting healthy lifestyles and reducing the burden of preventable conditions.

This multifaceted definition implies the existence of a social contract between the state (or the governing health authority) and the citizenry, where the concept of "entitlement" to care suggests a legitimate expectation for individuals to receive necessary and appropriate health services.

However, in contexts characterized by prolonged state fragility and severely limited governmental capacity, such as Somalia, this notion of entitlement is significantly challenged and often undermined. The state's diminished capacity to fulfill its obligations in ensuring this fundamental right results in a scenario where access to healthcare is largely determined by an individual's financial capacity to pay for services or by their reliance on non-state actors, including nongovernmental organizations (NGOs), international agencies, or private providers. This dynamic fundamentally alters the traditional citizen-state relationship concerning health and introduces substantial complexities in the pursuit of Universal Health Coverage (UHC), which typically presumes and requires strong governmental stewardship and financing. The systemic consequence of this fundamental disconnect between the theoretical "entitlement" and the practical "marketdriven access" is the undermining of UHC's foundation, perpetuating health inequities and systematically excluding the poorest and most vulnerable. This also erodes public trust in governmental institutions, potentially hindering broader state-building efforts.

To ensure a health system functions effectively and delivers services adequately, the WHO has identified six critical "building blocks" that are essential and interconnected:

- **Service delivery:** The actual provision of health services to individuals and communities, encompassing promotive, preventive, curative, rehabilitative, and palliative care.
- **Health workforce:** A competent, skilled, motivated, and supported cadre of health professionals, including physicians, nurses, midwives, and community health workers, who are essential for delivering quality care.
- **Health information systems:** Robust mechanisms for health data collection, analysis, dissemination, and utilization, which provide the evidence base for decision-making, planning, and monitoring health system performance.
- **Essential medical products, vaccines, and technologies:** Reliable access to essential medicines, vaccines, medical devices, and technologies that are safe, effective, and affordable, and are critical for delivering effective healthcare interventions.

- **Health financing:** Sustainable and equitable mechanisms for mobilizing, allocating, and utilizing financial resources to fund health services, ensuring financial protection for individuals and promoting universal access.
- **Leadership and governance:** Effective leadership, governance, and management of the health system, encompassing policy formulation, strategic planning, regulation, coordination, and accountability, which are essential for ensuring system efficiency, effectiveness, and responsiveness.

The effectiveness of health service delivery is intrinsically dependent on the strength, resilience, and effective interplay of these six interconnected building blocks. Deficiencies or weaknesses within any of these fundamental components can significantly compromise the overall performance of the health system, hinder its ability to achieve its objectives, and negatively impact the health of the population.

B. The Six Domains of Healthcare Quality: Relevance to Somalia (IOM Framework)

The Institute of Medicine (IOM), now the National Academies of Sciences, Engineering, and Medicine, a prominent authority in healthcare quality, proposed an influential framework comprising six key domains for assessing and enhancing healthcare quality. These domains offer a comprehensive and multidimensional lens through which to evaluate the performance of health services and identify priority areas for targeted improvement, particularly in fragile and resourceconstrained contexts such as Somalia, where achieving quality healthcare presents unique and complex challenges.

The six core domains of healthcare quality, as defined by the IOM framework, are:

- **Safety:** This domain emphasizes the imperative of ensuring that healthcare interventions, treatments, and services provided to patients do not cause harm. It involves minimizing medical errors, preventing adverse events, and implementing robust patient safety protocols to protect individuals from iatrogenic injuries and complications. In Somalia, the safety of healthcare is significantly compromised by a multitude of factors, including the prevalence of unregulated and unqualified healthcare providers, the widespread circulation of substandard and falsified medicines, and the inadequate implementation of infection prevention and control (IPC) practices in many healthcare facilities.
- **Effectiveness:** This domain focuses on providing healthcare services that are firmly grounded in scientific knowledge and evidence-based practices, ensuring that interventions are delivered to those who could benefit from them and, conversely, refraining from providing services to those who are unlikely to derive benefit. Effectiveness in Somalia is often hindered by a lack of adherence to evidence-based clinical guidelines and protocols, shortages of essential medicines, medical equipment, and supplies, and an inadequately trained and skilled health workforce, which limits the capacity to deliver appropriate and effective care.
- **Patient-Centeredness:** This domain underscores the importance of delivering care that is respectful of and responsive to the individual preferences, needs, and values of patients, ensuring that patient values and autonomy guide all clinical decisions and that care is tailored to meet the unique circumstances of each individual. In Somalia, achieving patientcenteredness is challenged by various factors, including communication barriers between healthcare providers and patients (due to language differences or cultural factors), limited health literacy among the population, and a health system that is often struggling to provide even basic services, making it difficult to prioritize personalized care and patient engagement.
- **Timeliness:** This domain emphasizes the importance of reducing waiting times and minimizing harmful delays in the provision of care, both for those who receive care and for those who provide it. Timely access to healthcare is crucial for achieving optimal outcomes and preventing complications. In Somalia, geographical inaccessibility of healthcare facilities, insecurity and conflict, lack of adequate transportation infrastructure, and overwhelmed health facilities contribute to significant delays in accessing necessary care.
- **Efficiency:** This domain focuses on avoiding waste in all its forms, including waste of equipment, supplies, time, ideas, and energy. Efficient healthcare delivery maximizes the use of limited resources, reduces costs, and improves productivity. In a resource-scarce environment like Somalia, inefficiencies stemming from poor coordination among different actors, corruption and mismanagement of limited resources, and suboptimal operational processes are particularly detrimental and exacerbate the challenges of providing adequate care.
- **Equity:** This domain underscores the imperative of providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location (urban or rural), or socioeconomic status. Equity in healthcare aims to eliminate disparities and ensure that all individuals have fair and equal access to the services they need. Equity remains a profound and pervasive challenge in Somalia, with vast disparities in access to and quality of health services based on urban-rural divides, socioeconomic status, clan affiliation and social exclusion, and displacement status, creating significant inequities in health outcomes.

While these six domains represent universal aspirations and benchmarks for high-quality healthcare systems globally, their prioritization, relative importance, and attainability can differ significantly in fragile, conflict-affected, and resource-limited contexts like Somalia. In such settings, the immediate and overwhelming need to address life-threatening emergencies and provide essential life-saving interventions arising from conflict, famine, recurrent disease outbreaks, and extreme poverty often necessitates prioritizing the achievement of basic "effectiveness" (providing any care that has the potential to work) and "safety" (ensuring that care does not cause further harm). These foundational elements are often considered prerequisites and essential building blocks for fully realizing other important dimensions of quality, such as "patientcenteredness" or

"efficiency," which may be secondary priorities in the face of acute crises. For instance, in Somalia, ensuring access to an Essential Package of Health Services (EPHS) inherently focuses on providing a fundamental level of effective and safe care to the broadest possible population, recognizing the limitations of the system and the urgency of addressing basic health needs.

The operational reality in Somalia, therefore, necessitates a pragmatic, context-specific, and phased approach to quality improvement, concentrating on establishing these core attributes of safety and effectiveness as the foundation before comprehensively tackling the more nuanced and advanced aspects of high-quality care. The weaknesses across multiple WHO building blocks create a compounding effect that manifests as a pervasive deficit across all IOM quality domains, rather than isolated issues. For example, a weak "health workforce" directly impacts "safety" (e.g., medical errors from unqualified staff) and "effectiveness" (e.g., lack of adherence to guidelines). Chronic "underfunding" limits investment in "essential medical products," leading to shortages that compromise "timeliness" and "effectiveness." The "fragmentation of data systems" prevents effective monitoring of quality indicators, hindering "efficiency" and "accountability." This demonstrates a cascading failure where weaknesses in foundational system components inevitably lead to a deterioration across all dimensions of quality. Consequently, interventions for quality improvement in Somalia must be holistic and address multiple interconnected building blocks simultaneously. A piecemeal approach targeting only one aspect of quality without strengthening underlying system components is unlikely to yield sustainable results.

III. Anatomy of Somalia's Health System: Structures, Resources, and Governance

A. Governance and Leadership: Navigating a Complex and Fragmented System

The governance of Somalia's health sector is profoundly shaped by its post-conflict reality, a context marked by the enduring consequences of protracted civil conflict and persistent political instability. Decades of civil war precipitated the near-total destruction of the health sector's infrastructure, the erosion of its institutional capacity, and the dismantling of its regulatory mechanisms, resulting in a system that became largely informal, unregulated, and decentralized. The re-establishment of the federal government in 2012 marked the commencement of an arduous and ongoing process of rebuilding essential state institutions, including the Ministry of Health (MoH), and attempting to harmonize the patchwork of localized health systems that had emerged during the extended interregnum of state collapse.

A defining characteristic of the current health governance landscape in Somalia is its pervasive fragmentation, which presents substantial impediments to effective health system development and efficient service delivery. Prolonged political instability and the complexities inherent in the process of state formation have contributed to the existence of separate and largely autonomous health administrations in Somaliland, Puntland, and the Federal Government-administered areas of South-Central Somalia. These distinct administrations function with their own Ministries of Health and varying degrees of operational capacities, policy priorities, and resource allocation mechanisms. This political and administrative fragmentation constitutes a significant impediment to achieving economies of scale in critical health system functions such as the procurement of essential medicines and medical supplies, the development and enforcement of standardized clinical and service delivery guidelines, the equitable distribution of scarce resources across all regions, and the implementation of cohesive national health strategies and policies. Consequently, this fragmentation likely perpetuates and may even exacerbate existing regional disparities in health service access, quality, and ultimately, health outcomes, contributing to inequities in the health and well-being of the Somali population. Efforts to strengthen governance and enhance health system effectiveness must grapple with this complex political reality, navigating the intricacies of federal-state relations and the need to balance central coordination with regional autonomy. This may necessitate the establishment and strengthening of robust federal-level coordination mechanisms that respect regional autonomy while ensuring adherence to minimum national standards, promoting equitable resource allocation based on need, and fostering a unified vision for health sector development.

The Federal Ministry of Health (FMoH) is mandated to provide stewardship, leadership, and oversight for the entire health sector in Somalia. This broad mandate encompasses formulating national health policies and strategies, ensuring accountability across the health system, and regulating both public and private health service provision. However, the FMoH's institutional capacity to effectively perform these critical governance functions—including evidence-based policy development, strategic health planning, coordination of diverse actors, regulation of a burgeoning private health sector, and the utilization of health information for evidence-based decision-making—remains significantly limited, necessitating capacity-strengthening interventions and technical assistance from international partners.

The reconstruction and strengthening of Somalia's health system is not merely a technical exercise focused on restoring physical infrastructure and deploying personnel; it is, at its core, a deeply political and social process intertwined with the broader challenge of re-establishing state legitimacy, fostering public trust in governmental institutions, and rebuilding the social contract between the state and its citizens. In a post-conflict society where trust in public entities is often fragile and eroded by past experiences, the equitable and transparent delivery of essential services, such as healthcare, can play a crucial role in demonstrating governmental efficacy, responsiveness, and commitment to the population's well-being. Effective service provision can contribute to a self-reinforcing cycle of improved governance, where positive experiences with public services enhance citizen trust, which in turn strengthens state legitimacy and enables more effective governance. Therefore, strategic investments in a government-owned and progressively more capable health sector can significantly enhance the legitimacy of the Somali government, fostering

greater social cohesion and stability. Health service delivery investments should therefore be viewed not only as humanitarian or developmental imperatives but also as integral contributions to Somalia's broader state-building and peace-building endeavors.

These governance challenges are compounded by pervasive issues of corruption and a lack of accountability mechanisms within the health sector. Reports and assessments indicate that corruption affects various levels of the health system, potentially leading to discrepancies between allocated budgets and actual expenditures, the misappropriation of funds, and the diversion of scarce resources from their intended purposes. The absence of robust accountability mechanisms across the health system is a frequently cited weakness, hindering efforts to ensure transparency, prevent misuse of resources, and hold individuals and institutions responsible for their performance. Furthermore, unethical practices within service delivery, such as unnecessary referrals for private gain, absenteeism, or the diversion of public resources for private use, have also been noted, further eroding public trust in the health system and undermining its efficiency and effectiveness.

B. Health Financing: The Quest for Sustainable and Equitable Funding

Somalia's health financing landscape is characterized by a precarious and unsustainable combination of critically low government investment in health, a heavy and often unpredictable dependence on external donor funding, and alarmingly high out-of-pocket expenditures (OOPE) by households. This results in a system that is not only financially unstable but also profoundly inequitable in its impact on the population.

Government expenditure on health remains exceptionally low, reflecting the limited prioritization of health within the national budget and the overall resource constraints faced by the country. In 2020, government health expenditure was estimated to be approximately 1.3% of the Gross Domestic Product (GDP) and constituted only 1.3% of the federal budget's actual expenditure. More recent figures reported by Amnesty International indicate a concerning and worsening trend: the allocation of the health budget reportedly decreased from 8.5% of the total national budget in 2023 to a mere 4.8% in 2024. This reduction occurred despite Somalia achieving significant debt relief, which theoretically should have expanded fiscal space for social sector spending. This level of domestic investment in health falls drastically short of the Abuja Declaration target, to which African Union member states committed, of allocating at least 15% of their national budgets to health, highlighting a significant gap between political commitments and actual resource allocation. The reported reduction in the health budget allocation following Somalia's debt relief in 2023 sends a particularly troubling signal regarding the government's prioritization of health and its commitment to investing increased resources in the sector.

This chronic and persistent underfunding of the health sector by the government necessitates a heavy reliance on external assistance from international donors and agencies to finance essential health services and health system strengthening initiatives. Donor contributions, including funding from international organizations, humanitarian agencies, and bilateral donors, account for a substantial proportion, estimated at approximately 45%, of total health spending in Somalia. While this external support is crucial for meeting immediate health needs and addressing critical gaps in service provision, a significant challenge associated with this heavy donor dependence is that a large portion of this funding is provided "off-budget," meaning it does not flow through government financial systems or align with national budgetary processes. This off-budget aid can undermine national ownership of health programs, fragment planning and implementation efforts, reduce government accountability, and complicate comprehensive financial planning and oversight of the health sector.

The direct consequence of low government spending on health and the nature of donor aid is a

high burden of out-of-pocket expenditure (OOPE) on households, which also accounts for a substantial proportion, roughly 45%, of total health spending in Somalia. Such high levels of OOPE mean that access to healthcare is often determined by an individual's or a household's ability to pay for services at the point of care, rather than by need. This financial barrier leads many Somalis, particularly the poorest and most vulnerable segments of the population, to delay seeking necessary care, forgo treatment altogether, or face catastrophic health expenditures that can push them into deeper poverty and exacerbate existing inequalities. Unaffordability of healthcare services is consistently cited as a primary barrier to accessing essential care. Somalia's Universal Health Coverage (UHC) service coverage index, a key indicator of access to and utilization of essential health services, is consequently among the lowest globally, reported as ranging from 27 out of 100 by the World Health Organization (WHO) to 33.5 in other analyses, highlighting the significant challenges in achieving equitable access to healthcare for the population. The poorest segments of the population face the highest risk of financial hardship due to healthcare costs, further underscoring the inequitable nature of the current health financing system.

The absence of robust financial protection mechanisms within the health system exacerbates this vulnerability and increases the risk of impoverishment due to healthcare costs. There is currently no national social health insurance fund in Somalia, which could pool resources and spread the financial risk of illness across the population, and the private health insurance market is nascent, limited in scope, and generally too expensive for the vast majority of the population to afford. This confluence of low government spending on health, a high degree of donor dependency, and a high burden of out-of-pocket expenditure creates a deeply inequitable and inherently unstable health financing model that systematically disadvantages the poor and vulnerable and makes the attainment of Universal Health Coverage (UHC) an almost insurmountable goal without fundamental reforms to the system. Such essential reforms must focus on significantly increasing domestic resource mobilization

for health, enhancing the efficiency and equity of public spending across all levels of care, and developing effective mechanisms to pool risks and reduce the burden of out-of-pocket expenditure on households.

C. Human Resources for Health (HRH): Addressing Critical Shortages and Maldistribution

The human resources for health (HRH) sector in Somalia faces a critical crisis, characterized by severe shortages, maldistribution, and inadequate training of health professionals. This deficit in qualified and equitably distributed health personnel is a major impediment to the effective delivery of health services and the achievement of UHC. The HSSP III explicitly identifies "improving the skills of the health workforce" and "addressing Human Resources for Health (HRH) imbalances" as key strategic priorities.

A significant challenge within HRH is the phenomenon of "ghost workers"—individuals appearing on payrolls but not actually performing any duties. This practice is a form of corruption or severe mismanagement that diverts scarce financial resources from their intended purposes and distorts HRH data, which is essential for accurate planning and allocation of health personnel. This suggests that effectively tackling HRH shortages, maldistribution, and quality issues requires not only health sector-specific interventions focused on training, recruitment, and deployment but also cross-cutting reforms in public sector employment practices, payroll management systems, and overall transparency and accountability mechanisms within the government.

D. Pharmaceutical Supply Chain: The Challenge of Quality and Access

The pharmaceutical sector in Somalia is severely compromised by inadequate regulation, leading to the proliferation of substandard and falsified medicines. This poses a significant threat to patient safety and treatment effectiveness. The supply chain for pharmaceuticals is largely dependent on external support, which can be unpredictable and lead to inconsistencies in availability. The HSSP III recognizes the need for "rationalizing the pharmaceutical field" as a priority area, aiming to ensure equitable access to quality-assured essential medicines and medical products, strengthen supply chain efficiency, and promote rational use of medicines. The high prevalence of multidrug-resistant tuberculosis (MDR-TB) in Somalia serves as a critical indicator of deeper, systemic weaknesses and vulnerabilities within the country's health system, directly linked to issues in pharmaceutical management, including poor regulation and inconsistent drug supplies.

E. Health Information Systems (HIS): Leveraging DHIS2 for Evidence-Based Decision-Making

A robust and well-functioning Health Information System (HIS) is not merely a technological adjunct to a health system; it is a fundamental pillar of effective health system governance and a critical determinant of its capacity to achieve its objectives. An HIS provides the essential infrastructure for evidence-based planning, allowing policymakers and health managers to allocate resources strategically and design interventions that address the most pressing health needs of the population. It also enables the monitoring of service delivery, ensuring that health services are being provided efficiently, equitably, and to an acceptable standard of quality. Furthermore, a strong HIS fosters accountability within the health system, allowing stakeholders to track progress towards health goals, identify areas of underperformance, and hold service providers responsible for their actions. By facilitating the collection, analysis, dissemination, and utilization of reliable and timely health data, an effective HIS empowers decision-makers at all levels of the health system to make informed choices that ultimately improve health outcomes and strengthen overall health system performance.

Recognizing the centrality of HIS to health system strengthening and its pivotal role in achieving national health objectives, the Federal Government of Somalia has consistently prioritized its development and modernization in national health policies and strategic plans, including the Health Sector Strategic Plan III (HSSP III) 2022-2026. These strategic documents underscore that an effective HIS is not merely a technical tool for data management but a core component of health system governance, intrinsically linked to principles of transparency, accountability, and responsiveness to the evolving health needs of the population.

In pursuit of its goals for HIS strengthening, Somalia has adopted the District Health Information Software 2 (DHIS2) as its national platform for health data management. DHIS2 is an open-source, web-based software platform widely used in low- and middle-income countries (LMICs) to enhance their HIS capacity due to its flexibility, scalability, and adaptability to diverse health system contexts. The Federal Ministry of Health (FMOH), demonstrating its commitment to strengthening the HIS, has taken a leading role in the implementation and enhancement of DHIS2, working in close collaboration with international partners such as the World Health Organization (WHO) and HISP Tanzania, a center of expertise in DHIS2 implementation. This collaborative effort highlights the importance of combining strong government leadership and ownership with technical expertise and international best practices to develop a robust and sustainable health information infrastructure.

A key application of DHIS2 in Somalia is the development and implementation of a DHIS2-based electronic Immunization Registry (eIR) designed to improve the tracking, management, and monitoring of immunization services across the country. Immunization is a cornerstone of primary healthcare and a highly cost-effective public health intervention; the eIR aims to enhance its effectiveness and efficiency by digitizing immunization records, automating data management processes, and facilitating real-time tracking of immunization coverage.

DHIS2 offers a range of functionalities that support effective health information management and contribute to its widespread adoption:

- **Online and offline data entry capabilities:** This feature enables health workers to collect and enter data in diverse settings, including remote areas with limited or no internet connectivity, ensuring that data collection is not interrupted by infrastructural limitations.
- **Real-time data tracking and visualization:** DHIS2 provides up-to-date information on key health indicators and service delivery performance, allowing health managers to monitor trends, identify bottlenecks, and respond promptly to emerging health challenges.
- **Automated data aggregation and reporting:** The system streamlines the process of data processing, aggregation, and reporting, reducing the administrative burden on health workers and ensuring data consistency and accuracy.
- **Support for specialized health programs:** DHIS2 can be customized to manage data for specific health programs and interventions, such as immunization campaigns, disease surveillance activities, and maternal and child health programs, enhancing program-specific data management and reporting.

Evaluations and implementation reports from Somalia and other low-resource settings indicate that the adoption and effective implementation of DHIS2 can contribute to significant improvements in key dimensions of data quality, including timeliness, availability, accessibility, and accuracy. The availability of more reliable and real-time data has the potential to strengthen decision-making processes at various levels of the health system, from frontline health facilities to national health authorities, enabling more effective resource allocation, evidence-based program planning, and the implementation of targeted public health interventions. For instance, the implementation of the eIR in Somalia has reportedly contributed to a decrease in vaccine drop-out rates by facilitating better tracking of children's immunization schedules and enabling the use of automated SMS reminders to caregivers.

Despite these demonstrated benefits and the inherent potential of DHIS2 to transform health information management, its full impact in Somalia is constrained by several persistent and systemic challenges that need to be addressed:

- **Data scarcity and incompleteness:** Data scarcity remains a significant issue, driven by a complex interplay of factors, including inadequate and inconsistent funding for HIS activities, the absence of up-to-date census data to provide accurate population denominators for calculating health indicators, and broader limitations in data availability and quality across the fragmented health landscape.
- **Fragmentation of data systems:** The HIS is further weakened by the fragmentation of data systems, with multiple parallel systems often established by different donors or for specific vertical disease programs, hindering the creation of an integrated national data repository and limiting the ability to obtain a comprehensive view of the health sector. This lack of a unified data landscape fundamentally undermines evidence-based national health planning, effective stewardship and oversight by the Ministry of Health, and the ability to monitor progress towards national health goals and international commitments such as Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs).
- **Limited capacity for data analysis and use:** There is also a limited capacity within the health workforce and management structures at various levels of the health system to effectively collect, process, analyze, interpret, and, crucially, use data for routine decisionmaking, program planning, and strategic planning.
- **Poor reporting from the private health sector:** Adherence to Health Management Information System (HMIS) reporting standards is particularly poor within the extensive private health sector, which plays a dominant role in service provision, leading to significant data gaps in national health statistics and limiting the government's ability to monitor overall health trends and service delivery patterns.

The successful implementation and continued scaling of DHIS2, exemplified by initiatives like the eIR, demonstrate a considerable potential for digital health solutions to help Somalia leapfrog some of its traditional infrastructural and capacity challenges in the health sector. However, realizing this transformative potential is significantly curtailed by a set of underlying systemic issues that must be addressed to create an enabling environment for digital health technologies to thrive:

- **Limited and unreliable internet connectivity:** Limited and unreliable internet connectivity, with a national internet penetration rate of only around 27.6%, restricts realtime data transmission, access to the online DHIS2 platform, and the use of other digital health tools in many areas of the country, particularly in rural and remote regions.
- **Gaps in digital literacy:** Gaps in digital literacy among healthcare workers and health managers impede the effective use of DHIS2 and other digital health systems, limiting their ability to collect, analyze, and interpret data and to utilize digital tools for decision-making and service delivery.
- **Persistent fragmentation of data:** The persistent fragmentation of data due to the existence of multiple, often uncoordinated, donor-driven information systems and disease-specific programs prevents DHIS2 from functioning as a truly unified and comprehensive national HIS,

hindering data integration and the ability to obtain a holistic view of the health sector. Strategic interventions outlined in HSSP III aim to establish a comprehensive and integrated health information management system that can serve as the backbone for evidence-based decisionmaking in the health sector. The WHO is actively supporting these efforts to strengthen the HIS, improve routine data collection and analysis processes, enhance the use of data for monitoring progress towards the Sustainable Development Goals (SDGs), and establish a national health account to track health expenditures and inform resource allocation decisions. Ongoing efforts to upgrade and enhance DHIS2 include the development of automated dashboards, performance scorecards, alert systems, and customized reports designed to facilitate easier data interpretation and use by health managers at various levels of the system. Ensuring data privacy and security within the digital HIS is also a recognized priority, with measures being implemented to protect sensitive patient information and maintain confidentiality. To maximize the transformative potential of DHIS2 and other digital health technologies, future strategies must therefore concurrently address these digital infrastructure gaps, invest significantly in widespread digital literacy programs for the health workforce and health managers, and foster stronger leadership and coordination by the Ministry.

F. Health Burden: Communicable, Non-Communicable, and Mental Health

Somalia faces a substantial burden of communicable diseases, frequent outbreaks, and an emerging threat from non-communicable diseases, alongside a significant mental health crisis that remains largely unaddressed.

Maternal, Newborn, and Child Health (MNCH): A Persistent Crisis

Somalia continues to face a profound and persistent crisis in maternal, newborn, and child health, with some of the highest mortality rates globally. This enduring crisis represents a significant public health challenge that demands urgent and comprehensive intervention to improve the wellbeing of women and children. The under-five mortality rate, a critical indicator of child survival and overall well-being, remains alarmingly high in Somalia, ranging from 106 to 137 deaths per 1,000 live births, depending on the specific data source and year of reporting. This elevated rate underscores the extreme vulnerability of young children in Somalia and reflects significant deficiencies in access to and quality of essential healthcare services.

Neonatal mortality, defined as deaths occurring within the first 28 days of life, is also a major public health concern, with estimates ranging from 35 to 40 deaths per 1,000 live births. Neonatal deaths account for a substantial proportion (29-33%) of all under-five deaths, highlighting the urgent need for improved newborn care practices and interventions to reduce mortality in the most vulnerable period of life. The leading causes of neonatal mortality in Somalia include birth asphyxia/trauma, complications related to prematurity, and neonatal sepsis, many of which are preventable with timely access to and appropriate management within the healthcare system.

The Maternal Mortality Ratio (MMR), a key indicator of maternal health, remains exceptionally high in Somalia, with estimates ranging from 655 to 692 maternal deaths per 100,000 live births. This elevated MMR reflects the severe risks associated with pregnancy and childbirth in the country and underscores critical shortcomings in the provision of maternal healthcare services. A major contributing factor to these adverse maternal and newborn outcomes is the extremely low rate of skilled birth attendance. It is estimated that only about 32% of births in Somalia are attended by a trained health professional, such as a midwife, nurse, or physician, leaving a significant majority of women without access to essential care during childbirth. This lack of skilled birth attendance increases the risk of life-threatening complications, including postpartum hemorrhage, obstructed labor, and infections, all of which are major contributors to maternal and newborn mortality.

In addition to the challenges in childbirth care, inadequate immunization coverage for vaccinepreventable childhood diseases further compounds the MNCH crisis. While data from UNICEF in 2021 reported encouraging increases in DTP (diphtheria, tetanus, and pertussis) and measles immunization coverage, more recent and broader estimates from WHO/UNICEF for 2023 suggest significantly lower national figures, highlighting inconsistencies and potential challenges in data collection and reporting within the fragmented health system. Critically, a very high proportion of children in Somalia receive no vaccinations at all, leaving them unprotected against preventable and potentially life-threatening diseases. Child malnutrition is another severe and widespread problem in Somalia, further exacerbating children's vulnerability to disease and death. High rates of wasting (acute malnutrition, a condition of low weight for height) and stunting (chronic malnutrition, a condition of low height for age) persist across the country, reflecting the chronic food insecurity and inadequate nutritional intake experienced by a large segment of the population. The persistence of this complex and multifaceted MNCH crisis in Somalia is driven by a confluence of interconnected factors that impede access to and utilization of essential healthcare services:

- **Inadequate availability of health services:** A severe shortage of functional public health facilities, particularly in rural and remote areas, limits the physical accessibility of healthcare for a large proportion of the population.
- **Barriers to access:** Even when health services are available, various barriers impede their utilization, including geographical barriers (long distances, poor infrastructure), financial barriers (high out-of-pocket costs), and security-related barriers (conflict and insecurity).
- **Suboptimal quality of care:** When individuals are able to access health services, the quality of care is often compromised by shortages of trained health personnel, lack of essential medicines and equipment, and inadequate adherence to evidence-based clinical guidelines.

- **Low immunization rates:** Persistently low vaccination coverage leaves a significant proportion of children vulnerable to preventable childhood diseases, contributing to increased morbidity and mortality.
- **Weak disease surveillance:** Limited capacity for effective disease surveillance and rapid outbreak response hinders the timely detection and control of infectious diseases, further exacerbating the health burden on women and children.
- **Underlying social determinants:** Pervasive poverty, widespread food insecurity, inadequate water and sanitation infrastructure, and low levels of maternal education also play significant roles in contributing to the poor MNCH outcomes observed in Somalia. The persistence of these extremely high rates of maternal and child mortality, despite decades of humanitarian and development assistance, suggests that conventional, often project-based, MNCH interventions may be insufficient on their own to address the deep-rooted and complex challenges in Somalia's health system. These traditional interventions often struggle to overcome the deeply entrenched systemic weaknesses within the health system and the adverse socio-cultural determinants of health that are prevalent in Somali society. Achieving a more transformative and sustainable impact on MNCH outcomes will likely require approaches that deeply integrate health initiatives with broader development efforts across multiple sectors. These integrated approaches should include:
 - **Education:** Increasing access to and improving the quality of education, particularly for girls and women, to enhance health literacy, promote informed decision-making, and empower women to access healthcare services.
 - **Economic empowerment:** Implementing programs aimed at improving economic opportunities for women, which can reduce poverty and food insecurity, leading to better health and nutritional outcomes for both women and their children.
 - **Robust governance:** Strengthening governance structures and promoting accountability within the health system to improve the delivery of quality healthcare services and ensure equitable access for all.
 - **Peace-building:** Addressing conflict and insecurity, which disrupt health service delivery and limit access to care, and promoting peace-building initiatives to create a more stable and secure environment for health system development.
 - **Climate resilience:** Building resilience to climate change and mitigating the impact of climate shocks, such as droughts and floods, on health by strengthening water and sanitation infrastructure, promoting climate-smart agriculture, and implementing disaster preparedness and response measures.

The interconnectedness of health with other sectors is highlighted by analyses demonstrating that progress on SDG 3 (Good Health and Well-being) in Somalia is heavily influenced by progress on SDG 16 (Peace, Justice, and Strong Institutions). This underscores the critical importance of multisectoral collaboration and integrated approaches to address the complex determinants of MNCH and achieve meaningful and sustainable improvements in the health and well-being of women and children in Somalia.

The Scourge of Communicable Diseases: Endemic Threats and Outbreak Dynamics

Communicable diseases represent a persistent and formidable threat to the health and well-being of the Somali population, exerting a substantial burden on individuals, families, communities, and the health system as a whole. The enduring prevalence of these diseases contributes significantly to morbidity (the rate of disease in a population) and mortality (the rate of deaths in a population), hindering overall socio-economic development and exacerbating existing vulnerabilities, particularly among marginalized and vulnerable groups. Infectious diseases are a major cause of mortality in Somalia, occupying a prominent position among the top ten causes of death and accounting for a significant proportion, estimated to be as high as 63.8%, of all deaths in the country. This underscores the urgent and critical need for the development and implementation of effective prevention, control, and management strategies to mitigate the devastating impact of communicable diseases and improve the health outcomes of the Somali people.

Several key communicable diseases pose significant public health challenges in Somalia, demanding targeted interventions and sustained efforts to combat their spread and impact:

- **Lower Respiratory Infections (LRI), primarily Pneumonia:** Lower respiratory infections, with pneumonia as the predominant condition, constitute a leading cause of mortality, particularly among the most vulnerable segments of the population, specifically children under the age of five years. Young children exhibit heightened susceptibility to severe respiratory infections, and pneumonia alone was responsible for a substantial proportion, estimated at 21%, of all deaths within this age group in 2018. This highlights the urgent need for interventions aimed at prevention, early diagnosis, and effective management of pneumonia in children to reduce child mortality rates.
- **Diarrhoeal Diseases, including Cholera:** Diarrhoeal diseases represent a major cause of mortality across all age groups in Somalia, consistently ranking as the second leading cause of death in the country. Cholera, an acute diarrhoeal infection caused by the ingestion of contaminated food or water, is endemic in Somalia, characterized by annual outbreaks that exhibit a seasonal pattern, typically peaking during the Gu rainy season (April to June). These recurrent cholera outbreaks are frequently exacerbated by climatic shocks, such as floods, which contaminate water sources and facilitate the spread of the bacterium, and droughts, which force populations to rely on unsafe and potentially contaminated water sources due to scarcity. The fundamental driver of the persistent prevalence of diarrhoeal diseases, including cholera, in Somalia is the inadequate and deficient water, sanitation, and hygiene (WASH) infrastructure, which fails to provide access to clean water and safe sanitation facilities for a significant portion of the population. A particularly severe cholera outbreak in 2017 resulted in a substantial

health crisis, with an estimated 78,000 cases reported and over 1,100 deaths recorded. More recently, in 2024, cumulative cases of acute watery diarrhea (AWD)/cholera had already surpassed the total number of cases reported for the entire year of 2023 by November, with over 19,800 cases documented, indicating the persistent high transmission rates and the ongoing threat posed by this waterborne disease.

- **Tuberculosis (TB):** Tuberculosis remains endemic in Somalia and constitutes a major public health concern, ranking as the third leading cause of death in the country. Somalia faces a particularly high burden of multidrug-resistant tuberculosis (MDR-TB), a more complex and challenging form of the disease. The high prevalence of MDR-TB in Somalia serves as a critical indicator of deeper, systemic weaknesses and vulnerabilities within the country's health system. The emergence and spread of MDR-TB are often a consequence of a confluence of factors, including poor regulation and quality control of drugs, leading to the availability of substandard and ineffective medications; inconsistent or interrupted drug supplies, which can result in incomplete treatment courses and the development of drug resistance; inadequate diagnostic capacity, which hinders the timely and accurate detection of TB and drug resistance; and insufficient support for patient adherence to lengthy and complex treatment regimens, which increases the likelihood of treatment failure and the transmission of drug-resistant strains. MDR-TB is not merely a more virulent and difficult-to-treat form of the disease; its significant presence reflects fundamental failures and shortcomings in basic TB control programs and overall pharmaceutical management within the health system. The spread of MDR-TB poses a substantial long-term public health threat, potentially undermining efforts to control TB and leading to increased morbidity and mortality, and incurs significantly higher treatment costs, placing a further strain on already limited health resources.
- **HIV/AIDS:** Somalia faces a concentrated HIV epidemic, with an estimated prevalence of around 1% among the general population, requiring targeted interventions to prevent further transmission and provide care and support for those living with HIV/AIDS. Data on new HIV infections per 1,000 uninfected population is also tracked to monitor the spread of the virus.
- **Hepatitis B:** The prevalence of Hepatitis B surface antigen (HBsAg), a marker of Hepatitis B infection, among children under the age of five years was reported to be 6.32% in 2020, indicating significant early-life transmission of the virus and highlighting the need for interventions to prevent mother-to-child transmission and improve childhood vaccination coverage.
- **Malaria:** Malaria cases can spike, particularly in areas affected by flooding, which creates favorable breeding conditions for mosquitoes, increasing the risk of malaria transmission and expanding the geographical distribution of the disease.
- **Diphtheria:** Localized cases of diphtheria, a vaccine-preventable disease, continue to be reported, highlighting gaps in immunization coverage and the vulnerability of certain populations to infectious diseases.

The complex interplay between nutritional status and environmental risks creates a challenging scenario that exacerbates the vulnerability of the Somali population to communicable diseases. Undernutrition, a pervasive issue characterized by high rates of malnutrition, significantly weakens the immune system, compromising the body's ability to fight off infections and making individuals, particularly children, more susceptible to severe outcomes from common infections such as pneumonia, diarrhoeal diseases, and measles. Simultaneously, environmental drivers, most notably climatic shocks such as recurrent droughts and floods, exert a devastating impact on already fragile WASH infrastructure, leading to widespread water contamination and directly fueling outbreaks of waterborne diarrheal diseases, including cholera. This synergistic effect, where high rates of malnutrition coincide with poor WASH conditions, creates a fertile ground for the frequent occurrence and severe impact of communicable disease outbreaks. Consequently, effectively addressing the burden of communicable diseases in Somalia necessitates an integrated and comprehensive public health response that extends beyond purely medical interventions, such as treatment and vaccination, to encompass broader determinants of health. It requires the implementation of robust and concurrent strategies to tackle malnutrition through improvements in food security and the delivery of targeted nutrition programs, and to significantly improve WASH infrastructure and hygiene practices, particularly within vulnerable communities and internally displaced person (IDP) settlements, to reduce exposure to waterborne pathogens.

Numerous interconnected and complex factors contribute to the high burden of communicable diseases in Somalia, creating a challenging environment for disease control and prevention. These factors include chronically low immunization coverage rates, which leave a significant proportion of the population susceptible to vaccine-preventable diseases; a severe shortage of functional public health facilities, particularly in rural and remote areas, which limits access to healthcare services and preventive interventions; and very limited capacity for effective disease surveillance and rapid outbreak response, which hinders the timely detection and containment of disease outbreaks. Furthermore, pervasive poverty, widespread displacement of populations leading to overcrowded living conditions in IDP camps, and inadequate access to clean water and sanitation facilities further amplify the risks of disease transmission and contribute to the high prevalence of communicable diseases in Somalia.

Non-Communicable Diseases (NCDs): An Emerging Double Burden

The rise of NCDs in Somalia, partly fueled by "dietary risks" such as the increased consumption of fatty and high-sugar foods, in a nation simultaneously grappling with severe food insecurity and high rates of undernutrition, presents a deeply concerning nutritional paradox. This "double burden of malnutrition"—the coexistence of undernutrition (including stunting, wasting, and micronutrient deficiencies) and overnutrition (or unhealthy diets leading to NCD risk)—indicates a complex and rapidly changing nutritional landscape in Somalia. This complexity suggests that addressing NCDs effectively requires interventions that go beyond the traditional boundaries of the healthcare sector and encompass a broader range of strategies to promote healthy diets and lifestyles. These strategies may include:

- **Food systems policies:** Implementing policies that promote the production, availability, and affordability of healthy foods, while limiting the availability and marketing of unhealthy foods.
- **Health education:** Providing robust and culturally appropriate health education to individuals and communities to promote healthy dietary choices, physical activity, and other healthy behaviors.
- **Regulatory measures:** Considering regulatory measures related to the food environment, such as taxation of unhealthy foods or restrictions on the marketing of unhealthy products, to create an environment that supports healthy choices.

This challenge is further complicated in contexts like Somalia, where imported, often highly processed foods, which tend to be high in calories, fat, sugar, and salt, become more readily available and sometimes more affordable than traditional, healthier dietary options. These trends can contribute to a shift away from traditional diets rich in fruits, vegetables, and whole grains, towards diets that increase the risk of NCDs. NCD prevention in Somalia cannot, therefore, rely solely on clinical interventions within the health sector, such as screening and treatment. It necessitates broader public health strategies that address the evolving food environment, promote healthy nutrition across the entire population spectrum, and integrate interventions across different life stages. This comprehensive approach must encompass efforts ranging from preventing stunting and wasting in early childhood, which can have long-term consequences for NCD risk, to mitigating the risks associated with unhealthy diets and sedentary lifestyles in adulthood. Addressing the emerging challenge of NCDs in Somalia represents a significant long-term undertaking that will require sustained inter-sectoral collaboration, strong political commitment, and policy coherence across various sectors, including health, agriculture, trade, education, and urban planning.

Mental Health: The Silent Epidemic in a Post-Conflict Society

Somalia is currently confronting a profound and multifaceted mental health crisis, a largely unacknowledged and inadequately addressed epidemic that has its roots in the complex and deeply intertwined adversities that have shaped the nation's recent history. Decades of unrelenting conflict, characterized by widespread violence, persistent political instability, and the fragmentation of social structures, have resulted in a population with extensive exposure to trauma, loss, and displacement. The ongoing major droughts, which have become increasingly frequent and severe due to climate change, and the consequent mass migrations of populations in search of water and pasture, represent significant stressors that are likely to have substantial short- and long-term adverse mental health consequences for the affected individuals and communities. Displacement, loss of livelihoods, food insecurity, and the disruption of social support networks can all contribute to psychological distress, increasing the risk of depression, anxiety, and other mental health conditions. The cumulative impact of these environmental and economic stressors on mental health requires greater recognition and attention.

The profound and widespread mental health trauma resulting from these protracted and complex crises constitutes a significant, yet largely unaddressed, barrier to individual well-being, societal recovery, the success of peacebuilding initiatives, and the achievement of sustainable development goals in Somalia. The consequences of untreated mental health conditions extend beyond the individual, impacting families, communities, and the broader society. Untreated mental health conditions can severely impair an individual's capacity to function effectively in daily life, limiting their ability to work productively, maintain stable social relationships, engage in community activities, and adequately care for themselves and their families. This can lead to social isolation, economic hardship, and a diminished quality of life. The interconnectedness between untreated psychological distress and impaired livelihood activities has been explicitly demonstrated by the IOM's "Horseed" program, which highlighted the negative impact of mental health problems on individuals' economic productivity and self-sufficiency, underscoring the link between mental well-being and economic development. At a societal level, the pervasive presence of trauma and untreated mental health conditions can erode social cohesion and trust, fuel grievances and resentment, perpetuate cycles of violence, and hinder reconciliation and development efforts, creating significant obstacles to building a stable, peaceful, and prosperous society. The long-term consequences of widespread mental health problems can undermine efforts to promote social stability, economic growth, and sustainable development, highlighting the need to prioritize mental health as a critical component of national development strategies.

Despite the immense burden of mental health needs in Somalia and the significant impact of mental health on individual and societal well-being, the availability of formal mental health services is exceptionally limited, almost non-existent in many parts of the country, particularly in rural and underserved areas. This severe lack of access to mental health care reflects a profound lack of resources, prioritization, and investment in mental health within the broader health system, resulting in a significant treatment gap and leaving the majority of those in need without adequate support. There is a critical shortage of trained mental health professionals, representing a major obstacle to providing effective and specialized care. Current estimates indicate that there are only around three psychiatrists and approximately 22 trained mental health nurses for the entire population of roughly 15 million people. This scarcity of specialized personnel severely limits the capacity to provide adequate assessment, diagnosis, and treatment.

In the absence of formal services, individuals with mental health conditions and their families often resort to traditional and religious healers, or to desperate and inhumane measures. These practices, driven by a lack of alternatives and inadequate support, can have detrimental consequences for the well-being and human rights of those affected. Families may feel compelled to restrain individuals at home, sometimes using physical restraints, due to a lack of safe and appropriate community-based care options. In some cases, individuals with mental health conditions are

confined in local jails or other detention facilities, often without due legal process or access to appropriate mental health treatment, highlighting a serious violation of their rights.

The few public mental health facilities that do exist in Somalia are mainly concentrated in major urban centers like Mogadishu, Hargeisa, and Bosaso, creating significant geographical disparities in access to care and leaving individuals in rural and remote areas with virtually no access to specialized mental health services. Furthermore, even in urban areas, these facilities are often poorly resourced, lacking adequate funding, staffing, infrastructure, and essential medications. They are frequently heavily reliant on inconsistent and unpredictable support from international and local non-governmental organizations (NGOs) for staffing, medication supplies, and operational costs, highlighting the lack of sustainable government funding and the vulnerability of these services. For example, the Bosaso Mental Health Department has reported that patients, on average, present to the clinic approximately 3.5 years after the initial onset of their mental illness, indicating significant delays in seeking and accessing care. This delay can lead to a worsening of their condition and increased disability. The clinic also reported that by the time individuals finally arrive for formal mental health care, approximately 85% have already consulted traditional or Koranic healers, seeking help from within their communities before accessing formal services. Tragically, the clinic also reported that nearly 30% of patients were admitted physically chained during its initial year of operation, highlighting the severity of cases and the lack of community-based support and humane treatment options available.

Psychotropic medications, which are essential for the effective treatment of many mental health disorders, are largely unregulated and often purchased directly by families from pharmacies and other sources without professional consultation, prescription, or ongoing monitoring. This lack of regulation and professional oversight increases the risk of inappropriate use, incorrect dosage, adverse drug interactions, and the development of drug dependence, potentially causing more harm than good.

Compounding these significant challenges is the pervasive and deeply ingrained stigma associated with mental health disorders, which exists not only within communities but also, regrettably, among some healthcare workers. This stigma creates a major barrier to help-seeking behavior, preventing individuals from seeking the care they need due to fear of discrimination, shame, and social exclusion. It also impedes the provision of effective and compassionate care by healthcare professionals, who may hold negative attitudes or lack adequate training in mental health. This stigma perpetuates a cycle of neglect, inadequate care, and social isolation for those with mental health conditions.

The policy and legislative environment for mental health in Somalia is also weak, fragmented, and underdeveloped, failing to provide an adequate framework for the development, funding, and delivery of mental health services. Somalia currently lacks an overarching national mental health policy or comprehensive legislation to guide the development of services, protect the rights of individuals with mental health conditions, allocate adequate resources for mental health care, and promote mental health awareness and advocacy. While Somaliland developed a mental health policy in 2021, demonstrating some progress in policy development, its formal adoption and effective implementation have reportedly been stalled due to funding limitations and competing priorities, highlighting the challenges in translating policy into action and ensuring that mental health receives the necessary attention and resources. Mental health is, however, included as a component within the revised Essential Package of Health Services (EPHS 2020), indicating some level of recognition of its importance within the broader health framework. It was also noted as being part of the EPHS at the tertiary (referral hospital) level in Somaliland's earlier health policies, suggesting a gradual increase in the acknowledgment of the need to integrate mental health into mainstream healthcare. Nevertheless, dedicated funding for mental health services remains negligible and disproportionately low, reflecting its continued low prioritization within the broader health budget and the overall scarcity of resources allocated to the health sector. This lack of financial investment in mental health services perpetuates the cycle of inadequate care and limits the capacity to address the immense needs of the population.

The widespread reliance on traditional and religious healers for mental healthcare, coupled with the significant stigmatization of mental illness and the limited availability of formal services, underscores the critical need for the development and implementation of culturally sensitive, community-based approaches to mental health service delivery in Somalia. These approaches must be tailored to the specific cultural context, beliefs, and practices of Somali society to ensure acceptability, accessibility, and effectiveness. Simply attempting to transplant Western-centric psychiatric models of care, which may not be appropriate or feasible in a resource-limited setting, is unlikely to be effective, acceptable, or sustainable in this context. Integrating mental health and psychosocial support (MHPSS) interventions into existing community structures and engaging trusted local figures, such as religious leaders, traditional healers, clan elders, and community health workers, offers a more viable and scalable path forward. This approach leverages existing social networks, cultural beliefs, and community resources to provide support and promote mental well-being. The IOM's "Horseed" curriculum, which successfully integrated MHPSS into livelihood support groups for displaced women by utilizing "familiar community and religious metaphors," provides a compelling and evidence-based example of such an approach. This model demonstrates that contextually adapted, community-based interventions can effectively reduce stigma associated with mental health by embedding mental health support within broader development programs, enhance accessibility to services by bringing care closer to where people live and utilizing existing community resources, and leverage existing social capital and community support networks to provide culturally appropriate and acceptable care. The "task sharing" approach, where non-specialist health workers or trained and supervised community members are trained to deliver basic MHPSS interventions under the supervision of mental health professionals, is also highly relevant and appropriate in the Somali context, given the severe shortage of specialized personnel. This approach can expand the reach of mental health services and increase access to care, particularly in underserved areas.

Despite the dire situation and the significant challenges facing mental health care in Somalia, some positive developments and innovative programs are emerging, offering a glimmer of hope and demonstrating the potential for progress. These initiatives, while often small-scale and operating with limited resources, represent important steps towards building a more comprehensive and responsive mental health system. The Somali Mental Health Foundation, a US-based non-profit organization, is actively involved in providing mental health services, raising awareness about mental health issues, advocating for improved mental health care, and offering guidance and support to individuals and families affected by mental illness. Their work contributes to reducing stigma and increasing access to care. UNICEF supports community-based MHPSS interventions specifically designed for children, adolescents, and their caregivers, recognizing the critical importance of early intervention and addressing the unique mental health needs of young people who have been exposed to violence, displacement, and other adversities. These programs aim to promote resilience, provide psychosocial support, and strengthen the capacity of families and communities to support children's mental well-being. Furthermore, the Interpeace program is actively working to integrate MHPSS interventions into broader peacebuilding and transitional justice initiatives, acknowledging and addressing the crucial link between psychological wellbeing and the establishment of sustainable peace and reconciliation in post-conflict Somalia. By incorporating mental health support into peacebuilding efforts, these initiatives aim to address the root causes of trauma, promote healing and reconciliation, and build more resilient communities. These diverse initiatives, while often facing significant challenges related to funding, capacity, and access, highlight the potential for progress and offer valuable lessons and models for future MHPSS programming and policy development in Somalia. They underscore the importance of community engagement, culturally appropriate interventions, and integrated approaches to address the complex mental health needs of the Somali population and build a more resilient and supportive society.

IV. National Policies, Strategic Plans, and Key Health Programs

A. The National Health Policy and Health Sector Strategic Plan (HSSP III 20222026)

The strategic direction and overarching framework for the development, implementation, and evaluation of health programs, interventions, and initiatives in Somalia are primarily established and guided by the National Health Policy and the subsequent Health Sector Strategic Plans. These policy documents and strategic frameworks serve as essential instruments for articulating the government's vision for the health sector, outlining its core priorities, defining its strategic objectives, and providing a comprehensive roadmap for achieving tangible and sustainable improvements in the health outcomes and overall well-being of the Somali population. They represent a commitment to strengthening the health system and addressing the complex health challenges facing the nation.

The most recent overarching policy framework, developed through an extensive, inclusive, and consultative process involving a wide range of key stakeholders, including federal and state Ministries of Health, various national and international partners, civil society organizations, and community representatives, was formulated and adopted post-2014. This policy framework establishes a comprehensive and long-term vision to address the nation's pressing public health needs and priorities, taking into account the complex and multifaceted challenges facing the health sector and acknowledging the social, economic, and environmental determinants of health. The National Health Policy reaffirms the government's fundamental commitment to the right to health as a basic human right for all citizens of Somalia, seeking to integrate and align the health sector's goals and objectives within the broader national development agenda, ensuring that health is explicitly recognized and prioritized as a key driver of economic growth, poverty reduction, and overall social progress. Furthermore, the policy underscores the critical importance of establishing and maintaining effective partnerships, coordination mechanisms, and collaborative relationships among the diverse array of actors involved in the health sector, including government agencies at all levels, international organizations, bilateral and multilateral donors, non-governmental organizations (NGOs), the private sector, traditional healers, community-based organizations, and communities themselves, to optimize the allocation and utilization of scarce resources, avoid duplication of effort and fragmentation of interventions, enhance efficiency and effectiveness, and maximize the collective impact of health interventions and investments.

The policy provides strategic guidance and direction for the development and implementation of key health programs, initiatives, and reforms across all levels of care and across various health domains, with the overarching aim of progressing towards Universal Health Coverage (UHC). This ensures that all individuals and communities, regardless of their socioeconomic status, geographical location, or other factors, have equitable access to the essential health services they need without facing financial hardship or the risk of impoverishment due to healthcare costs. The policy development process was informed by a thorough and comprehensive assessment of Somalia's challenging and complex health status, characterized by persistently high rates of maternal, neonatal, and child mortality, which are among the highest in the world, a significant and persistent burden of communicable diseases, including infectious diseases and outbreaks, and the emerging and growing threat of non-communicable diseases (NCDs), which are increasingly contributing to morbidity and mortality. These multifaceted health challenges are further exacerbated by pervasive poverty, widespread food insecurity and malnutrition, recurrent climatic shocks such as droughts and floods, and the fragility of the health system itself, which is still recovering from the effects of decades of conflict and instability. Addressing this complex interplay of health challenges necessitates a comprehensive, integrated, and multi-faceted approach to health system strengthening and service delivery, encompassing interventions across the continuum of care and addressing the social, economic, environmental, and behavioral determinants of health.

Building upon this robust policy foundation and incorporating valuable lessons learned from the implementation of previous strategic planning periods, Somalia launched its Health Sector Strategic Plan III (HSSP III) for the period 2022-2026. The HSSP III serves as the country's current medium-term strategy and operational framework for developing a resilient, equitable, accessible, and sustainable health system that is capable of delivering affordable, quality, and essential health services to its entire population, with the ultimate and long-term vision of advancing Universal Health Coverage (UHC) and contributing to the achievement of the health-related Sustainable Development Goals (SDGs) by 2030. This strategic plan provides a detailed and actionable roadmap for health sector development over the five-year period, outlining specific objectives, measurable targets, evidence-based interventions, and priority actions across various health system building blocks, including service delivery, health workforce, health financing, health information systems, access to essential medicines and technologies, and governance and leadership. The development of HSSP III was a comprehensive, inclusive, participatory, and consultative process, ensuring that the plan reflects the diverse perspectives, needs, and priorities of a wide range of key stakeholders within the health sector and beyond. The process involved active and meaningful participation from various government ministries and agencies at both the federal and state levels, including the Ministries of Health, Planning, and Finance, which play crucial roles in health policy, planning, and resource allocation. Extensive consultations were also held with international partners, including UN agencies such as the World Health Organization (WHO), UNICEF, and UNFPA, the World Bank and other multilateral development banks, bilateral donors providing financial and technical assistance, non-governmental organizations (NGOs) working across the country in health service delivery and community development, representatives from civil society organizations advocating for health rights and community needs, professional associations representing health workers, academic and research institutions, and community leaders and representatives, ensuring that the plan is grounded in local realities and reflects the voices and priorities of the population. This inclusive and participatory approach aimed to foster a strong sense of national ownership of the plan, ensure alignment with national development priorities and international commitments, promote accountability and transparency in its implementation, and facilitate effective coordination among the diverse actors involved in the health sector.

A significant and noteworthy feature of HSSP III is its explicit and increased emphasis on "improving the skills" of the health workforce and "enhancing the quality of care" as a primary and overarching strategic pillar. This signals a notable evolution and maturation in strategic thinking and a refined understanding of the complexities of health system development within the Somali context. This strategic shift represents a move away from a predominant and initial focus on simply increasing the quantity of health inputs, such as the number of health facilities, health workers, or medical supplies, and expanding the basic provision of health services, towards a more nuanced, comprehensive, and sustainable approach that prioritizes the development of a competent and motivated health workforce, the strengthening of health system processes and management practices, the implementation of quality improvement mechanisms, and the assurance of the delivery of high-quality, patient-centered care across all levels of the health system. Recognizing that merely expanding the number of health facilities or graduating more health workers from training institutions is insufficient to achieve meaningful and lasting improvements in health outcomes and that the quality of care is a critical determinant of health service utilization and effectiveness, HSSP III places a greater emphasis on investing in the training, professional development, and supportive supervision of health personnel, establishing quality assurance and improvement systems within health facilities, and promoting a culture of continuous quality improvement and patient safety across the entire health system.

However, it is critically important to acknowledge that the successful translation of these sophisticated and ambitious goals, objectives, and strategies outlined in HSSP III into tangible, widespread, and equitable improvements in health outcomes and the overall health status of the Somali population within Somalia's severely resource-constrained, insecure, and fragmented environment remains the central, overarching, and most formidable challenge facing the health sector. Achieving sustainable improvements in the skills of the health workforce and the quality of health service delivery is inherently more complex, resource-intensive, and demanding than simply increasing the volume of health inputs, such as the number of facilities, personnel, or supplies. It necessitates the development and implementation of robust and effective training and education systems for health professionals at all levels, the establishment of functional and supportive supervision mechanisms to ensure adherence to clinical guidelines and quality standards, the strengthening of quality assurance and quality improvement mechanisms within health facilities and across the health system to monitor and improve service delivery, the enhancement of regulatory capacity and mechanisms to enforce quality standards and accountability among health providers, and the cultivation of a culture of continuous quality improvement, patient safety, and evidence-based practice within health facilities and across the entire health system. Overcoming these multifaceted challenges requires sustained and predictable investment of financial and human resources, strong and committed leadership at all levels of the health system, effective coordination among diverse stakeholders, a long-term commitment to health system strengthening and reform, and innovative approaches to addressing the complex social, economic, and political determinants of health that influence health outcomes in Somalia. HSSP III identifies several key policy priority areas that are intended to guide its implementation over the five-year period and focus efforts and resources on the most critical areas for health system development and strengthening:

Table 1: Overview of Somalia's Health Sector Strategic Plan III (HSSP III) 2022-2026: Key Strategic Priorities and Objectives for Service Delivery, HRH, and Quality

Strategic Priority Area (HSSP III)	Illustrative Key Objectives/Interventions for Service Delivery, HRH, and Quality
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1. Enhancing Quality of Care	- Lower barriers to access (cost, distance, hours). - Implement quality improvement tools & monitoring. - Conduct mystery patient surveys; use user satisfaction feedback. - Independent appraisal of quality interventions.
2. Human Resources for Health (HRH)	- Regulation: Accredit training institutions, license health workers. - Production: Strengthen training for scarce cadres (e.g., specialists), align with needs. - Utilization: Improve deployment (incentives for hardship posts), reduce ghost workers, optimize workload. - Maintenance: Effective supportive supervision, relevant in-service training.
3. Engaging Private Healthcare Providers	- Explore self-regulatory mechanisms for quality standards. - Develop frameworks for contracting and partnership in planning. - Include private sector in HIS and quality monitoring.
4. Strengthening Management Systems	- Improve Health Information Systems (HIS) for data-driven decisions. - Enhance aid management and coordination. - Strengthen Emergency Preparedness and Response (EP&R) capacity.
5. Rationalizing the Pharmaceutical Field	- Implement quality assurance controls for medicines (e.g., outsourcing lab testing initially). - Strengthen National Medicines Regulatory Authority. - Improve supply
Strategic Priority Area (HSSP III)	Illustrative Key Objectives/Interventions for Service Delivery, HRH, and Quality
	chain efficiency and availability of essential medicines.
6. Improving Health Financing	- Mobilize increased domestic resources. - Improve efficiency and equity of health spending. - Develop financial protection mechanisms to reduce OOPe.
7. Steering Physical Infrastructure Investments	- Address gaps and overlaps in the health facility network to ensure equitable geographical access to health services, optimize the utilization of existing infrastructure, and prioritize investments in primary healthcare facilities, particularly in underserved areas.
8. Strengthening Governance and Regulation	- Enhancing the stewardship, leadership, and governance capacity of the Ministry of Health at both the federal and state levels, improving regulatory frameworks and mechanisms to ensure quality, accountability, and transparency across the health sector, and promoting greater community participation and engagement in health governance.

The successful and effective implementation of HSSP III is envisaged as a collaborative and coordinated effort, requiring strong partnerships, clear roles and responsibilities, and effective communication between the Federal Government of Somalia (FGS) and the Federal Member States (FMS). Federal Member States are expected and encouraged to develop their own statespecific strategic and operational plans, tailored to their unique contexts, specific health needs, and local priorities, but aligned with the overarching national framework, goals, objectives, and strategies outlined in HSSP III. This decentralized approach recognizes the importance of adapting health strategies and interventions to the specific epidemiological profiles, socio-cultural contexts, and resource availability of different states and regions, while simultaneously ensuring coherence with national health objectives, promoting equity in access to services, and avoiding fragmentation of efforts.

The inclusive and consultative process adopted for the development of HSSP III is not only commendable but also vital for fostering a strong sense of ownership of the plan among key stakeholders and ensuring alignment and coordination in Somalia's complex and fragmented governance landscape. However, it is crucial to emphasize that the true measure and ultimate success of this inclusivity and collaboration will lie in the equitable and transparent allocation of resources across different states and regions, the effective and timely implementation of these state-specific plans, the robust monitoring and evaluation of their progress and impact, and the establishment of strong accountability mechanisms to ensure that resources are used efficiently and that results are achieved. There is an inherent and potential risk that without strong mechanisms for equitable resource distribution, effective coordination between the federal and state levels, diligent monitoring of state-level implementation, and robust accountability frameworks, the national strategy could remain largely a federal-level document with limited practical traction and impact in diverse regions, potentially widening existing disparities in health access, quality, and health outcomes. The stewardship, leadership, and coordination role of the Federal Ministry of Health will be absolutely crucial in providing technical assistance and capacity-building support to the states, ensuring coherence and alignment with national health objectives and standards, monitoring collective progress towards national health goals, facilitating the sharing of best practices and lessons learned, and holding states accountable for their performance and results.

V. Actors in Somalia's Health Service Delivery Landscape

The delivery of health services within Somalia is characterized by a complex and dynamic configuration of diverse actors, each fulfilling specific roles and wielding varying degrees of influence within the health sector. A comprehensive and nuanced understanding of the functions, responsibilities, challenges, and interactions of these stakeholders is essential for identifying strategic opportunities to optimize health system performance, foster effective coordination, enhance operational efficiency, promote equitable access to care, and ultimately, achieve sustainable

improvements in the health and well-being of the Somali populace. The intricate interplay between these actors shapes the landscape of healthcare provision, influencing its accessibility, quality, and overall effectiveness.

A. The Role of Government: Stewardship in a Fragmented Environment

The Federal Government of Somalia (FGS) and the Federal Member State (FMS) Ministries of Health (MoHs) are entrusted with the overarching and fundamental responsibility for health sector stewardship. This mandate encompasses a broad spectrum of core governance functions that are critical for effective health system functioning, ensuring accountability, promoting equity, and guiding the overall direction of the health sector:

- **Policy Formulation and Strategic Planning:** This involves the development, articulation, and implementation of national health policies, strategies, and plans that articulate the government's long-term vision for the health sector, define strategic priorities based on evidence and health needs assessments, establish measurable objectives and targets, and provide a comprehensive and actionable roadmap for achieving health goals and improving the health status of the population. This requires engaging in a participatory and inclusive process to ensure that policies and plans are aligned with national development goals, responsive to community needs, and supported by key stakeholders.
- **Regulation and Oversight:** This pertains to the establishment, implementation, and enforcement of laws, regulations, standards, and guidelines that govern the behavior of health service providers, both public and private, ensuring the quality and safety of health services, protecting the rights of patients, promoting ethical practices, and holding healthcare providers accountable for their performance and adherence to established standards. This includes the licensing and accreditation of health facilities and health professionals, the monitoring of service delivery, and the enforcement of penalties for noncompliance.
- **Coordination and Collaboration:** This involves the alignment, harmonization, and coordination of the efforts of diverse stakeholders within the health sector, including government agencies at all levels, international organizations, bilateral and multilateral donors, non-governmental organizations (NGOs), the private sector, traditional healers, community-based organizations, and communities themselves. This requires promoting effective communication, collaboration, and synergy among these actors, facilitating information sharing, avoiding duplication of effort and fragmentation of interventions, optimizing the allocation and utilization of scarce resources, and maximizing the collective impact of health interventions and investments.
- **Resource Mobilization and Allocation:** This refers to the securing of adequate and sustainable financial resources for the health sector from a variety of domestic and external sources, including government budgets, donor funding, and innovative financing mechanisms, and the efficient, equitable, and transparent allocation of these resources to priority health programs, essential health services, and underserved populations, ensuring that resources are distributed based on need and that financial barriers do not impede access to care. This also involves strengthening public financial management systems and promoting accountability in the use of health sector funds.

However, the capacity of the federal and state MoHs to effectively discharge these critical stewardship functions and exercise effective leadership over the health sector is significantly constrained and undermined by a confluence of multifaceted and deeply entrenched challenges that are unique to the Somali context:

- **Political Fragmentation and Decentralization:** The complex and evolving political landscape, characterized by a fragmented governance structure and the existence of quasiautonomous regional health administrations with varying degrees of autonomy and capacity, creates substantial challenges for centralized health planning, coordination, and harmonization of health policies, service delivery standards, and resource allocation mechanisms. This fragmentation can lead to inconsistencies in the quality and availability of services across different regions, inefficiencies in resource utilization, and difficulties in implementing national health strategies.
- **Severe Resource Scarcity:** The Somali health sector is characterized by severe limitations in financial, human, and infrastructural resources, which impede the government's ability to adequately invest in essential health infrastructure, including health facilities, equipment, and supplies, deliver quality health services to the population, attract, train, and retain qualified health personnel, and implement effective health programs and interventions. This scarcity of resources necessitates difficult prioritization decisions and often leads to a reliance on external aid.
- **Enduring Post-Conflict Context:** The enduring legacy of decades of civil conflict, state collapse, and political instability has profoundly weakened state institutions, including the Ministry of Health, eroded public trust in government and the health system, created a complex and challenging environment for health system reconstruction and development, and contributed to a culture of dependency on external aid. Rebuilding trust and strengthening institutions are long-term processes that require sustained effort and commitment.
- **Weak Governance and Accountability:** Weak governance structures, characterized by limited transparency, accountability, and citizen participation, and the presence of corruption and mismanagement of resources, undermine the effectiveness of the health system, erode public trust, and divert scarce resources from their intended purposes. Strengthening governance and promoting accountability are essential for improving health system performance and ensuring that resources are used efficiently and equitably.

Acknowledging these inherent and complex challenges and the imperative to strengthen government stewardship and leadership within the health sector, the Health Sector Strategic Plan III (HSSP III) explicitly prioritizes the enhancement of institutional capacity within the federal and state

MoHs. Key capacity-building initiatives, supported by international partners such as the World Health Organization (WHO) and other development agencies, focus on strengthening the core functions of the Ministry of Health and equipping it with the necessary skills, tools, and resources to effectively govern the health sector:

- **Evidence-Based Policy-Making and Strategic Planning:** Strengthening the capacity of the MoHs to formulate and implement effective health policies and strategic plans that are grounded in robust evidence, informed by accurate and timely health data, aligned with national development priorities and international best practices, and responsive to the evolving health needs of the population. This involves training health officials in policy analysis, strategic planning methodologies, health economics, and the use of health information for decision-making.
- **Regulatory Frameworks and Mechanisms:** Developing, strengthening, and effectively enforcing regulatory frameworks, mechanisms, and processes to ensure quality assurance, accreditation of health facilities (both public and private), licensing and certification of health professionals, monitoring of service delivery standards, and enforcement of regulations to protect patients and ensure accountability among healthcare providers. This includes establishing independent regulatory bodies, developing clear standards of care, and implementing effective monitoring and enforcement mechanisms.
- **Health Information Systems and Data Management:** Enhancing the collection, analysis, dissemination, and utilization of health data through the strengthening of Health Information Systems (HIS) and the implementation of digital health technologies, ensuring that health data is accurate, timely, complete, and used to inform decision-making at all levels of the health system. This involves investing in digital infrastructure, training health personnel in data management and analysis, and promoting data sharing and interoperability.
- **Service Contracting and Public-Private Partnerships:** Developing and implementing effective mechanisms and frameworks for contracting with non-state actors, such as private providers and non-governmental organizations (NGOs), to deliver specific health services, particularly in areas where government capacity is limited, and exploring and establishing public-private partnerships (PPPs) to leverage private sector resources and expertise to improve health service delivery and infrastructure. This requires developing clear contracting guidelines, monitoring performance, and ensuring accountability.

The government's ability to effectively coordinate the diverse array of actors involved in health service delivery, including international partners, NGOs, the private sector, and community-based organizations, is of paramount importance and represents a critical function of health system stewardship. Effective coordination is essential for optimizing the allocation and utilization of scarce resources, minimizing duplication of effort and fragmentation of interventions, ensuring alignment with national health priorities and strategic plans, promoting synergy and collaboration, and maximizing the overall impact and effectiveness of health interventions and investments. This requires establishing clear coordination mechanisms, promoting open communication and information sharing, and fostering a culture of collaboration and partnership among all stakeholders. The transition from a predominantly humanitarian aid-driven approach, characterized by short-term interventions and parallel systems, to a more sustainable, government-led development paradigm for the health sector is a key strategic objective and a long-term goal. This necessitates a concomitant and gradual shift towards enhanced government ownership, leadership, accountability, and capacity to plan, manage, and finance health services, reducing reliance on external aid and building a more resilient and self-reliant health system.

B. International Partners: WHO, UNICEF, World Bank, and Other Agencies

International partners constitute a critical and often dominant source of financial and technical support for Somalia's health sector, playing a pivotal and multifaceted role in augmenting government capacity, addressing critical health needs, filling service delivery gaps, and supporting health system strengthening initiatives. These partners encompass a diverse range of multilateral and bilateral organizations, each with its own mandate, expertise, and operational focus:

- **World Health Organization (WHO):** WHO is the directing and coordinating authority for health within the United Nations system, and it plays a vital role in providing normative guidance, technical assistance, and support for health system strengthening, disease control, emergency preparedness and response, and overall health sector development in Somalia.

WHO's key functions and areas of engagement include:

- Technical Guidance in Health Policy and Strategy.
- Strengthening Health System Building Blocks.
- Coordination of Health Partners.
- Disease Surveillance and Outbreak Response.
- Emergency Preparedness and Response.
- **UNICEF:** The United Nations Children's Fund (UNICEF) has a specific mandate to advocate for the protection of children's rights, to help meet their basic needs, and to expand their opportunities to reach their full potential. In Somalia, UNICEF focuses heavily on maternal, newborn, and

child health (MNCH), nutrition, immunization, and WASH (water, sanitation, and hygiene) interventions. UNICEF's core activities include:

- Support for Routine Immunization Programs.
- Supply Chain Management.
- Technical Assistance for MNCH.
- Strengthening Health Facilities and Community-Based Interventions. ● WASH Programs.
- **World Bank:** The World Bank is a vital source of financial resources and technical expertise for health system strengthening in Somalia, providing substantial funding and policy advice to support the development of a more efficient, equitable, and sustainable health sector. The World Bank's key areas of engagement include:
 - Financing Health Sector Development Projects, such as the "Damal Caafimaad" (Improving Healthcare Services in Somalia Project).
- Supporting Health Financing Reforms.
- Enhancing Government Stewardship and Accountability.
- **Other UN Agencies and Donors:** A range of other UN agencies, bilateral donors, and multilateral organizations contribute to the Somali health sector, including UNFPA (reproductive health), UNDP (health governance, HIV/AIDS), bilateral donors (e.g., UK, USA, EU), and multilateral donors (e.g., Global Fund, GFF).

While the contributions of these international partners are indispensable and crucial for addressing Somalia's urgent health needs, supporting health system development, and filling critical gaps in service provision, the heavy reliance on external aid also presents inherent challenges and potential drawbacks that need to be carefully considered and mitigated:

- **Sustainability Concerns:** The long-term sustainability of health programs and the development of a self-reliant health system may be jeopardized by a high degree of dependence on external funding, which can be unpredictable, volatile, and subject to shifting donor priorities and geopolitical considerations. This creates a risk of programs collapsing or becoming unsustainable when donor funding declines or ceases.
- **Coordination Complexities and Fragmentation:** The multiplicity of actors, funding streams, and program implementation mechanisms can lead to coordination complexities, fragmentation of efforts, duplication of activities, inefficiencies in resource allocation, and a lack of coherence in the overall health sector response. This can undermine the effectiveness and impact of health interventions and create confusion for the government and other stakeholders.
- **Alignment Deficits and Ownership Challenges:** The prevalence of "off-budget" aid, where donor funds bypass government financial systems and are managed and implemented directly by donors or NGOs, can undermine national ownership of health programs, weaken government accountability, reduce transparency in resource allocation, and create parallel systems that are not integrated into the national health system. This can hinder the development of a strong and unified national health system.

Efforts to mitigate these challenges and promote more effective aid coordination and alignment include initiatives such as the Global Action Plan (GAP) for Healthy Lives and Well-being, which aims to improve collaboration and coordination among international health agencies, enhance their support for national health priorities and plans, and promote greater accountability and transparency in aid delivery.

C. Non-Governmental Organizations (NGOs): Key Implementers on the Ground

Non-governmental organizations (NGOs), encompassing both international and national entities, constitute an indispensable and multifaceted component of the health service delivery ecosystem in Somalia. They perform a wide array of critical functions that significantly augment the capacity of the health system, particularly in contexts where government reach and resources are constrained. These organizations are instrumental in extending access to essential healthcare services, delivering a broad spectrum of interventions, responding to acute humanitarian crises, building local capacity and empowering communities, and piloting innovative approaches to address persistent health challenges. The contributions of NGOs are, therefore, essential for improving the health and well-being of vulnerable populations and strengthening the overall resilience of the Somali health system.

Service Delivery: The direct delivery of essential health services represents a core function of NGOs operating within Somalia's health sector. Often working under contractual agreements with donor agencies or in close collaboration with government initiatives (through partner-funded projects), NGOs provide a comprehensive suite of healthcare interventions designed to address the diverse health needs of the population. These interventions span a wide range of health domains and service delivery levels:

- Maternal, Newborn, and Child Health (MNCH).

- Primary Healthcare (PHC).
- Nutrition Programs.
- Communicable Disease Control.
- Water, Sanitation, and Hygiene (WASH).
- Mental Health and Psychosocial Support (MHPSS).

To facilitate the effective delivery of these diverse health services, NGOs engage in a range of operational activities:

- Management and Operation of Health Facilities.
- Mobile Outreach Clinics.
- Community Health Worker (CHW) Programs.
- Humanitarian Response.

Capacity Building: Beyond direct service delivery, NGOs actively contribute to building the capacity of local health systems and empowering communities. This involves:

- Training and Mentorship.
- Community Empowerment.

Innovation and Research: NGOs often pilot and implement innovative approaches to address specific health challenges and improve healthcare delivery in Somalia. They also conduct research to generate evidence and inform best practices. Examples include:

- Innovative Service Delivery Models.
- Health Systems Strengthening.

Consortia and Coordination: To enhance coordination, maximize impact, and avoid duplication of effort, NGOs often form consortia and collaborative networks. These alliances enable them to pool resources, share expertise, and implement large-scale health programs more effectively. While the contributions of NGOs to Somalia's health sector are undeniable and profoundly important, it is essential to acknowledge that their operations also present certain inherent challenges and potential drawbacks that require careful consideration and proactive mitigation strategies:

- **Quality Assurance and Standardization:** Ensuring consistent quality and standardization of services across diverse NGOs can be challenging, given variations in organizational capacity, service delivery models, provider qualifications, and monitoring mechanisms. This necessitates the establishment of robust quality assurance frameworks, standardized protocols, and effective monitoring and evaluation systems to ensure that all NGOs adhere to minimum quality standards and deliver comparable levels of care.
- **Sustainability and Long-Term Impact:** The sustainability of NGO interventions is often a concern, as their funding is frequently project-dependent and subject to fluctuations in donor priorities and funding cycles. This can lead to disruptions in service delivery, limit long-term planning, and hinder the development of sustainable local health systems. Strategies to enhance sustainability include building local capacity, integrating NGO programs into government health plans, and exploring alternative funding mechanisms.
- **Coordination and Alignment:** Achieving effective coordination and alignment between NGO activities and government health systems and priorities can be complex. The presence of parallel systems, inadequate information sharing, and a lack of clear communication channels can lead to fragmentation of efforts and inefficiencies. Strengthening coordination mechanisms, promoting information sharing, and fostering collaboration between NGOs and government authorities are crucial for optimizing the overall health sector response.
- **Accountability and Transparency:** Ensuring accountability and transparency in NGO operations is essential to maintain public trust and ensure that resources are used effectively and ethically. This involves implementing robust financial management systems, reporting on program outcomes, and establishing mechanisms for community feedback and participation.

Recognizing the significant and multifaceted role of NGOs in the health sector, the Health Sector Strategic Plan III (HSSP III) explicitly acknowledges the need to engage these non-state actors more strategically and effectively to maximize their contributions to health system strengthening and service delivery. Potential strategies for enhanced engagement include:

- Service Delivery Agreements and Contracts.
- Funding Mechanisms and Harmonization.
- Coordination and Information Sharing.
- Capacity Building and Technical Assistance.
- Regulatory Frameworks and Quality Standards.

By implementing these strategies, the Somali health system can leverage the strengths and resources of NGOs while mitigating potential challenges and ensuring that their contributions are aligned with national health goals and priorities.

D. The Private Sector: Dominant Provider with Complex Dynamics

The private health sector in Somalia plays a dominant and increasingly significant role in the provision of curative care, representing a complex and dynamic landscape of diverse providers that operate largely outside of formal government regulation. This sector has emerged as a major force in healthcare delivery, filling a critical void left by the weakened public health system, yet its largely unregulated nature presents substantial challenges for quality assurance, equitable access, and overall health system governance.

Composition and Diversity: The private health sector in Somalia is characterized by its heterogeneity and encompasses a wide range of providers, varying in size, scope, and level of specialization:

- Small-Scale Clinics and Pharmacies.
- Diagnostic Facilities.
- Specialized Clinics. ● Private Hospitals.

Reasons for Dominance: The private sector's growth and dominance in Somalia's health sector can be attributed to several interconnected factors:

- **Collapse of the Public Health System:** The prolonged civil war and subsequent collapse of state institutions led to the near-total destruction of the public health infrastructure, creating a significant void in healthcare provision. Private healthcare providers emerged to fill this vacuum, establishing facilities and offering services to meet the population's healthcare needs.
- **Weak Public Sector Capacity:** The persistent weakness and limited capacity of the public sector to adequately meet the growing demand for healthcare services have further fueled the expansion of the private sector.
- **Accessibility and Availability:** Private healthcare facilities are often perceived as being more accessible and available than public facilities, particularly in urban areas, with shorter waiting times, more flexible hours, and a wider range of services.
- **Perceived Higher Quality of Care:** Some individuals perceive that private facilities offer a higher quality of care compared to public facilities, attributing this to factors such as more modern equipment, better amenities, and more attentive staff. However, this perception is not consistently supported by evidence and is often influenced by the lack of effective quality regulation in the private sector.

Service Provision: Private facilities provide a broad range of healthcare services, often acting as referral destinations for patients from both government and NGO facilities. They may offer:

- Curative Care.
- Specialized Services.
- Maternal and Child Health.

Challenges: The dominance and largely unregulated nature of the private health sector in Somalia present several significant challenges that need to be addressed to ensure equitable access, quality of care, and overall health system effectiveness:

- **Regulation and Quality Assurance:** The most pressing challenge is the general lack of effective regulation and quality assurance mechanisms within the private health sector. This absence of oversight leads to concerns about unqualified providers and the quality of care.
- **Poor Reporting:** Adherence to Health Management Information System (HMIS) reporting standards is particularly poor within the extensive private health sector, leading to significant data gaps in national health statistics and limiting the government's ability to monitor overall health trends and service delivery patterns.

E. Community Leaders and Traditional Healers: Bridging Formal and Informal Systems

Community leaders and traditional/religious healers play a significant role in Somalia's health landscape, often serving as the first point of contact for health issues, particularly in rural areas where formal health services are inaccessible or unaffordable. They provide care, spiritual and emotional support, and address health concerns within a cultural context. However, concerns exist regarding the efficacy and safety of some traditional practices, the lack of regulation or standardization, and the limited integration with the formal health system, which can hinder appropriate referrals and continuity of care.

Effective engagement with community and traditional structures necessitates:

- A nuanced and context-specific understanding of local power dynamics, social norms, cultural beliefs, and traditional practices, recognizing their influence on health beliefs and behaviors.
- Active and meaningful community participation in health planning, implementation, and monitoring, ensuring that health programs are responsive to community needs and priorities.
- Respectful and collaborative engagement with traditional leaders and healers, acknowledging their role in the community and exploring opportunities for collaboration and referral pathways.
- Culturally sensitive health interventions that are adapted to local beliefs and practices, promoting acceptance and improving adherence.
- Adherence to principles of equity and non-discrimination, ensuring that health services are accessible to all members of the community, regardless of their clan affiliation or social status.

By acknowledging and addressing the complexities of community and traditional structures, health initiatives can enhance their effectiveness, promote equitable health outcomes, build stronger community ownership, and contribute to the overall strengthening of the health system.

VI. Innovations and Adaptive Strategies in Service Delivery

The Somali health sector operates within an exceptionally challenging and complex environment, characterized by a confluence of formidable obstacles that impede access to and delivery of essential healthcare services. These obstacles include pervasive insecurity and conflict, which disrupt service delivery and restrict access to care; limited and underdeveloped infrastructure, particularly in rural areas, which hinders transportation and communication; geographical inaccessibility, with vast distances, difficult terrain, and poor road networks making it challenging to reach remote communities; and the presence of hard-to-reach populations, including nomadic communities and those residing in areas controlled by non-state armed actors, who face significant barriers to accessing formal healthcare.

To effectively address these multifaceted challenges and ensure that essential healthcare reaches those in need, the Somali health sector has witnessed the development and implementation of a range of innovative and adaptive strategies for health service delivery. These strategies often involve leveraging technological advancements, fostering community engagement and participation, and adopting flexible and context-specific service delivery models that are tailored to the unique circumstances and needs of different populations. These innovative approaches represent a crucial effort to overcome barriers, improve health outcomes, and build a more resilient and equitable health system.

A. Mobile Outreach and "Health Camp" Models

To overcome the significant geographical barriers that impede access to healthcare and to extend essential services to populations residing in insecure or remote areas, mobile health teams and outreach services have become an indispensable component of healthcare delivery in Somalia. These mobile services act as a crucial mechanism for delivering a range of essential healthcare interventions directly to communities and individuals who would otherwise face substantial limitations or complete exclusion from accessing formal health facilities due to distance, lack of transportation, security concerns, or other socio-economic factors.

Mobile health teams are designed to be flexible and adaptable, providing a range of essential services that are tailored to the specific health needs of the communities they serve. The composition of the mobile team and the services offered can vary depending on the context, the prevalence of specific diseases, and the availability of resources. Common and crucial services delivered through mobile outreach include:

- **Immunization:** Mobile teams play a vital role in delivering vaccines to protect children against vaccine-preventable diseases, increasing immunization coverage rates, reducing the incidence of childhood illnesses, and contributing to improved child survival.
- **Maternal, Newborn, and Child Health (MNCH) Care:** Mobile teams prioritize the delivery of essential MNCH services, bringing care closer to women and children and improving access to life-saving interventions, including antenatal care, skilled birth attendance, postnatal care, and newborn care.
- **Nutrition Screening and Treatment:** Mobile teams conduct nutrition screening to identify individuals at risk of malnutrition and provide nutritional support and promote healthy feeding practices.
- **Basic Curative Care:** Mobile teams offer essential curative care services to treat common illnesses and injuries, providing medical consultations, dispensing medications, managing minor ailments, and offering first aid and emergency care.

The "Health Camp" model, pioneered and implemented by Save the Children and its partners, represents a notable and innovative adaptation of mobile outreach to address the complex challenges of delivering healthcare in areas controlled by non-state armed actors. These areas are often characterized by extreme insecurity, limited infrastructure, and restricted access for humanitarian and development organizations, making it difficult to provide essential health services to the population. The Health Camp model incorporates several key features that enhance its effectiveness and acceptability in these challenging contexts:

- **Clan-Mediated Access Negotiation:** Recognizing the significant influence of clan structures and traditional authorities in Somali society, the Health Camp model prioritizes securing access to communities and obtaining their support through negotiations and agreements with clan elders and leaders.
- **Community Trust-Building:** Building strong relationships and establishing trust and rapport with communities is paramount to the success of the Health Camp model, involving active engagement and culturally sensitive communication.
- **Community Health Committees (CHCs):** The Health Camp model facilitates the establishment of CHCs, comprised of elected or selected representatives, to promote community ownership, participation, and sustainability.

Adaptive programming, the ability to adapt health service delivery models and interventions to the specific context, security situation, cultural norms, and logistical constraints of the communities being served, is essential for overcoming barriers and achieving effective service delivery. In addition, the innovative use of Geographic Information System (GIS) mapping and other technologies plays an increasingly important role in optimizing the reach and effectiveness of mobile outreach efforts. GIS mapping enables health teams to accurately identify and locate target populations, plan efficient routes, and ensure that services are delivered to those most in need, improving the efficiency and equity of service delivery.

B. Community Health Worker (CHW) Programs

The expansion and strengthening of Community Health Worker (CHW) programs represent a key strategic approach to improve access to basic health services at the household and community levels, particularly in remote, rural, and underserved areas where access to formal health facilities is limited or non-existent. CHWs serve as a vital and essential bridge between the formal health system and local communities, extending the reach of healthcare services and promoting healthseeking behaviors within their communities.

CHWs, typically women selected from and trusted by the communities they serve, undergo training to provide a range of preventive, promotive, and basic curative health services, tailored to the specific health needs and cultural context of their communities. They are equipped with the knowledge, skills, and resources to address common health problems and promote healthy behaviors. Initially, CHWs were primarily leveraged and mobilized for specific public health initiatives, such as COVID-19 surveillance, active case finding, contact tracing, and health awareness campaigns, playing a crucial role in the pandemic response. However, recognizing their broader potential and value, the scope of CHW activities has been progressively expanded to address a more comprehensive range of health conditions and deliver a wider array of essential health services. CHWs in Somalia now address a range of up to 12 prioritized health conditions, reflecting the major health challenges facing the country and the need for integrated communitybased care.

The key activities and responsibilities performed by CHWs within their communities encompass a broad range of promotive, preventive, and basic curative functions:

- Conducting regular household visits to provide health education and counseling, promote healthy behaviors, identify health needs, and monitor the health status of individuals and families.
- Delivering risk communication messages and health alerts to raise community awareness about health risks, promote preventive measures, and encourage the adoption of healthy lifestyles.
- Detecting epidemic-prone diseases early, reporting suspected cases of infectious diseases to health facilities, and facilitating timely interventions to control outbreaks.
- Providing home-based care and basic treatment for common childhood ailments, such as diarrhea, pneumonia, and malaria.
- Identifying danger signs and complications in women and children, particularly during pregnancy, childbirth, and the postpartum period, and facilitating timely referrals to health facilities for appropriate and specialized care.
- Distributing essential health commodities, such as micronutrient supplements, oral rehydration solutions, contraceptives, and insecticide-treated bed nets.

The implementation and expansion of CHW programs in Somalia have demonstrated significant reach and impact, contributing to improved access to care, increased health awareness, enhanced community engagement, and positive health outcomes. For example, data collected between December 2021 and December 2022 revealed that CHWs and associated Rapid Response Teams (RRTs) conducted over 2.1 million household visits and facilitated the referral of nearly half a million children for further treatment, highlighting the crucial role of CHWs in connecting communities to the health system and addressing their health needs.

C. Digital Health and Telehealth

Despite the infrastructural limitations and developmental challenges that persist in Somalia, there is a growing recognition of the transformative potential of digital health technologies to revolutionize healthcare delivery, improve access to services, enhance efficiency, and strengthen health

systems. Digital health solutions are increasingly being explored and adopted to address a wide range of healthcare challenges, leveraging the expanding mobile telecommunications network, increasing mobile phone penetration rates, and the availability of innovative digital tools and platforms.

Telehealth platforms, such as Baano and SomDoctor, are emerging as valuable tools to provide remote consultations and improve access to specialized care, overcoming geographical barriers and addressing the severe shortage of medical specialists in many areas of the country. These platforms utilize various communication technologies, including mobile phones, internet-based applications, and video conferencing, to connect patients with healthcare providers remotely, enabling:

- Remote diagnosis and treatment of various medical conditions.
- Provision of specialist consultations and second opinions.
- Follow-up care and monitoring of patients with chronic diseases.
- Health education and counseling services.
- Improved access to care for individuals in remote areas, conflict zones, and underserved communities.

mHealth solutions, which leverage mobile phone technology to deliver healthcare information and services directly to individuals, are also being implemented to enhance access to health information, promote health literacy, and facilitate communication between patients and healthcare providers. These solutions can provide:

- Health information and educational resources on various health topics.
- Appointment reminders and notifications.
- Medication adherence support.
- Disease surveillance and reporting. ● Remote patient monitoring.

The development and implementation of a DHIS2-based electronic immunization registry (eIR) represents a significant advancement in streamlining health services and improving data accuracy and management for immunization programs. This digital system offers several key advantages:

- Enables both online and offline data collection, ensuring that immunization records can be captured and updated in diverse settings.
- Facilitates the efficient and accurate tracking of immunization records.
- Automates the aggregation and reporting of routine immunization data.
- Provides valuable support for special vaccination campaigns and mobile outreach programs. ● Automates the delivery of SMS reminders to caregivers.

Despite the significant potential of digital health and telehealth to transform healthcare delivery in Somalia, several challenges remain that need to be addressed to ensure their wider adoption, effective implementation, and long-term sustainability:

- Limited and unreliable internet access, with a national internet penetration rate that remains relatively low, restricts access to online platforms and digital tools, particularly in rural areas.
- The need to ensure data privacy and security, protecting sensitive patient information from unauthorized access and misuse.
- The necessity for capacity building and digital literacy enhancement among healthcare providers and health managers.
- The integration of digital health solutions into existing health systems and workflows, ensuring interoperability with other health information systems and avoiding fragmentation of data and services.

D. Integration of Services

There is a growing recognition within the Somali health sector of the importance of integrating health services to improve efficiency, effectiveness, and patient outcomes. Integrated service delivery models aim to address the multiple and interconnected health needs of individuals and communities in a holistic and coordinated manner, rather than providing fragmented, diseasespecific interventions that may not adequately address the underlying determinants of health. The Essential Package of Health Services (EPHS) 2020, which serves as the core framework for health service delivery in Somalia, explicitly promotes an integrated approach to delivering a comprehensive range of essential health services. This approach recognizes the interconnectedness of various health conditions and the benefits of addressing them concurrently, improving the overall well-being of individuals and communities.

Examples of integrated service delivery models being implemented or explored in Somalia include:

- Integrating health and nutrition interventions within fixed health facilities and outreach/mobile services, addressing the close link between malnutrition and other health conditions, such as infectious diseases.
- Integrating mental health and psychosocial support (MHPSS) interventions with livelihood support programs for displaced women, recognizing the profound impact of social and economic factors on mental well-being. The IOM's "Horseed" curriculum provides a compelling example of this integrated approach, demonstrating the positive effects of combining mental health support with economic empowerment initiatives, leading to improvements in resilience, stress management, social cohesion, and economic activity among participants.

These innovative and adaptive strategies represent crucial steps towards improving healthcare delivery in Somalia's challenging environment. They underscore the importance of:

- Strong community engagement and participation to ensure that health services are culturally appropriate, acceptable, and responsive to local needs.
- Leveraging local structures, knowledge, and resources to enhance the effectiveness and sustainability of health interventions.
- Adapting global best practices and technological advancements to the specific context of Somalia, tailoring solutions to local realities.
- Continued investment in research, monitoring, and rigorous evaluation to assess the impact of these strategies and inform future program development.

Sustained investment, ongoing innovation, and rigorous evaluation are essential for ensuring the long-term effectiveness, scalability, and sustainability of these innovative strategies, paving the way for progress towards Universal Health Coverage (UHC) and achieving meaningful and lasting improvements in the health and well-being of all Somalis.

VII. Impact of Recurrent Crises: Conflict, Climate Shocks, and Disease Outbreaks

Somalia's health system, already grappling with inherent fragility and resource constraints, operates within a highly volatile and precarious environment, continually and profoundly impacted by a convergence of recurrent and overlapping crises. These crises, primarily driven by the intertwined forces of armed conflict and insecurity, the devastating effects of extreme climatic shocks in the form of recurrent droughts and floods, and the frequent outbreaks of infectious diseases that these conditions exacerbate, create a complex and destructive cycle. This cycle not only erodes developmental gains achieved in the health sector but also significantly exacerbates existing vulnerabilities within the population and places an overwhelming and often insurmountable strain on an already fragile and under-resourced health infrastructure, severely undermining its capacity to provide consistent, equitable, and quality care to those in need. The interplay of these crises creates a state of perpetual emergency, demanding constant adaptation and resilience from a system struggling to build long-term capacity.

A. Armed Conflict and Insecurity

Decades of armed conflict, political instability, and pervasive insecurity have wrought devastating and long-lasting consequences on Somalia's physical infrastructure, its institutional capacity, and its social fabric, profoundly impacting the health and well-being of the population and severely disrupting the delivery of essential health services across the country. The protracted nature of these conflicts has created a complex and challenging environment for health system development and reconstruction.

The prolonged civil war, which began in the early 1990s, and the ongoing conflict and insecurity have directly contributed to the widespread destruction and damage of vital infrastructure, including health facilities, hospitals, clinics, and health posts. This destruction not only reduces the physical capacity of the health system to provide care but also disrupts the continuity of services, forces facilities to close, and limits access to essential healthcare for large segments of the population. The rebuilding of this infrastructure is a slow and resource-intensive process, further hindering the system's ability to recover. Between January and September 2024, a deeply concerning and alarming trend of deliberate attacks against schools and hospitals was reported, with 26 such incidents documented. These attacks, often targeting civilian infrastructure, represent a grave violation of international humanitarian law and not only directly endanger lives but also severely impede healthcare access and provision.

B. Climate Shocks: Droughts and Floods

Somalia is highly vulnerable to the impacts of climate change, experiencing recurrent and devastating droughts and floods that have profound consequences for health service delivery and population health.

- **Displacement and Overcrowding:** Climate-induced displacements lead to mass migrations, forcing populations into internally displaced person (IDP) camps and overcrowded urban areas. These conditions exacerbate health vulnerabilities by increasing the risk of disease transmission due to poor sanitation, limited access to clean water, and inadequate shelter.
- **Food Insecurity and Malnutrition:** Recurrent droughts devastate agricultural livelihoods, leading to severe food insecurity and high rates of malnutrition, particularly among children. Malnutrition weakens the immune system, making populations more susceptible to infectious

diseases.

- **Reduced Access to Care:** Physical access to healthcare becomes extremely challenging during periods of drought or flooding. Droughts force people, particularly nomadic communities, to migrate long distances in search of water and pasture for their livestock, disrupting their access to settled health facilities. Floods can make roads impassable, isolate communities, and prevent people from reaching health facilities, particularly in rural areas. The existing barriers to accessing healthcare in Somalia, including the absence of functional health facilities, the unaffordability of services, and the lack of essential medicines and supplies, are all significantly exacerbated during climate crises, further marginalizing vulnerable populations.

C. Disease Outbreaks

The complex interplay and convergence of conflict, displacement, malnutrition, and damaged water and sanitation infrastructure create a fertile ground for the frequent occurrence and widespread transmission of infectious diseases in Somalia. These outbreaks place a substantial and often overwhelming burden on the already strained health system, diverting scarce resources and further undermining its capacity to provide essential healthcare services.

- **AWD/Cholera:** Acute watery diarrhea (AWD)/cholera is endemic in Somalia, characterized by sustained transmission since 2017, particularly in IDP sites, overcrowded urban areas, and areas with poor sanitation and limited access to clean water. Outbreaks are often triggered or exacerbated by climatic shocks, such as floods, which contaminate water sources, and droughts, which force people to use unsafe water.
- **Measles:** Recurrent measles outbreaks are a persistent threat, driven by persistently low immunization coverage rates, which are further exacerbated by displacement, overcrowding, and the disruption of routine health services. Measles predominantly affects children under the age of five years, posing a significant risk to child health and survival.
- **Malaria:** Malaria cases can spike, particularly in areas affected by flooding, which creates favorable breeding conditions for mosquitoes, increasing the risk of malaria transmission and expanding the geographical distribution of the disease.
- **Diphtheria:** Localized cases of diphtheria, a vaccine-preventable disease, continue to be reported, highlighting gaps in immunization coverage and the vulnerability of certain populations to infectious diseases.

The health system's capacity for effective surveillance, early detection, and rapid response to these disease outbreaks is limited by resource constraints, logistical challenges, and a shortage of trained personnel. As a result, the system often relies heavily on support from international partners to provide technical expertise, logistical assistance, and resources for outbreak control, highlighting the need for increased domestic capacity.

The cyclical and often overlapping nature of these crises—conflict, climate shocks, and disease outbreaks—means that Somalia's health system is frequently operating in a state of emergency response, constantly reacting to immediate crises rather than proactively addressing long-term health system development and strengthening. This reactive approach diverts attention, resources, and personnel away from essential health services and long-term investments in health infrastructure, training, and system strengthening, perpetuating a cycle of fragility and vulnerability.

Building resilience within the health system to better prepare for, mitigate the impact of, and effectively respond to these recurrent shocks is therefore a critical and urgent priority for improving health service delivery and protecting the health and well-being of the Somali population. This requires a multifaceted and comprehensive approach that encompasses:

- Strengthening health infrastructure to withstand the impact of climate shocks and conflict.
- Developing and implementing robust early warning systems for disease outbreaks and climate-related events.
- Training health workers in emergency preparedness and response.
- Establishing resilient and robust supply chains for essential medicines and medical supplies. ● Improving coordination and collaboration among health actors.
- Building community resilience and promoting community participation in health emergency management.

VIII. Monitoring, Evaluation, and Progress Towards Health Goals

Effective monitoring and evaluation (M&E) systems are not merely technical exercises in data collection and analysis; they are indispensable instruments for fostering accountability, promoting evidence-based decision-making, and guiding strategic improvements within the health sector. These systems constitute the bedrock of effective health governance, providing the essential information and feedback loops that enable policymakers, health managers, and other stakeholders to track progress, assess impact, identify successes and failures, and adapt strategies to optimize health outcomes and enhance health system performance. A well-functioning M&E system is characterized by its capacity to generate reliable, timely, and actionable data that inform resource allocation, program implementation, and policy formulation, ultimately contributing to a more responsive, efficient, and equitable health system.

A. Health Information Management and Monitoring Systems

As detailed in Section III.E, Somalia has adopted the District Health Information Software 2

(DHIS2) as its national health information platform, signifying a commitment to leveraging digital technology to strengthen health information management and improve data-driven decisionmaking. DHIS2 is a flexible and widely used open-source platform that offers a range of functionalities for data collection, aggregation, analysis, and dissemination, providing a powerful tool for monitoring health system performance and tracking progress towards health goals. The Federal Ministry of Health (FMoH), recognizing the critical importance of a robust HIS, has taken a leading role in the implementation and enhancement of DHIS2, collaborating with key partners such as the World Health Organization (WHO) and other technical agencies to adapt and customize the platform to the specific needs and context of Somalia.

A crucial aspect of enhancing DHIS2 involves the development and implementation of a suite of data visualization and analysis tools, including automated dashboards, performance scorecards, and alert systems. These tools transform raw data into readily understandable and actionable information, enabling health managers at various levels to monitor key performance indicators in real-time, identify trends and patterns, detect deviations from targets, and make timely and informed decisions.

Despite these advancements, several challenges persist in health information management:

- **Fragmentation of Data Systems:** A major obstacle is the fragmentation of data systems, characterized by the existence of multiple parallel systems often established and managed independently by different donors, development partners, or specific disease programs. This fragmentation creates silos of information, limits data sharing and interoperability, and hinders the ability to obtain a holistic and integrated view of the health sector.
- **Limited Capacity for Data Analysis and Use:** Even when data is available, there is often limited capacity at various levels of the health system to effectively analyze, interpret, and utilize this data to inform decision-making, program planning, and quality improvement initiatives. Health workers and managers may lack the necessary skills in data analysis, interpretation, and visualization, hindering their ability to translate data into actionable insights and use it to improve service delivery and health outcomes.
- **Poor Reporting from the Private Sector:** The private health sector often exhibits poor compliance with national Health Management Information System (HMIS) reporting requirements, creating significant gaps in national health statistics.

To address these challenges, effective M&E systems require:

- **Clearly defined roles and responsibilities** for data collection, analysis, and reporting at various levels.
- **Standardized procedures** for data analysis, interpretation, and reporting.
- **Mechanisms for dissemination and use of findings** to inform program planning, resource allocation, and policy development.

Annex C of the HSSP III document provides a detailed monitoring matrix, offering a comprehensive and granular overview of the specific indicators, data sources, and reporting frequencies for each strategic objective. This matrix places a strong emphasis on tracking progress at the Federal Member State level, recognizing the importance of monitoring regional variations and disparities in health outcomes and access to services. In addition, specific health programs, such as the World Bank-funded "Damal Caafimaad" project, incorporate robust M&E components, often involving third-party monitoring and independent evaluations. The overarching objective of these M&E efforts is to ensure that reliable and actionable data are consistently available and used to monitor the delivery of the Essential Package of Health Services (EPHS), track progress towards national health goals, and drive continuous improvements in health system performance.

B. Quality Assurance and Improvement Mechanisms

Ensuring and continuously improving the quality of health services is not merely a desirable aspiration but a fundamental imperative for achieving meaningful and sustainable improvements in health outcomes and building a resilient and effective health system. The Health Sector Strategic Plan III (HSSP III) explicitly recognizes that simply expanding access to health services without a concomitant and robust focus on quality is not only inefficient and wasteful of scarce resources but also unlikely to achieve the desired improvements in the health and well-being of the population. Delivering poor-quality care can undermine trust in the health system, discourage service utilization, and even lead to harm for patients. Therefore, HSSP III emphasizes the integration of quality assurance (QA) and quality improvement (QI) mechanisms into all aspects of health service delivery.

The HSSP III and related policy documents outline or imply a range of key strategies and mechanisms designed to promote and enhance the quality of healthcare services in Somalia:

- **Regulation, Accreditation, and Licensing:** This cornerstone of quality assurance involves:
 - Accreditation of Health Training Institutions.

- **Licensing/Certification of Health Professionals.**
- **Regulation of Health Facilities (public and private).**
- **Development and Implementation of Clinical Guidelines and Standards:** Essential for promoting effective, efficient, and consistent healthcare practice, reducing variations in care and improving patient outcomes. Projects like ALMANACH have assessed and promoted adherence to guidelines such as the Integrated Management of Childhood Illness (IMCI).
- **Supportive Supervision and Mentorship:** Highlighted as a crucial mechanism for maintaining and continuously improving the quality of care, focusing on ongoing mentoring, feedback, and capacity-building.
- **Quality Monitoring Tools and Indicators:** Systematic collection and analysis of data on key quality indicators, such as diagnostic and prescribing practices, availability of essential medicines, patient safety indicators, patient satisfaction, and outcome indicators.
- **Pharmaceutical Quality Control and Assurance:** A multi-pronged approach including strengthening the National Medicines Regulatory Authority (NMRA), implementing quality control testing (initially by outsourcing), improving supply chain management, and promoting rational use of medicines.
- **Patient Feedback, Engagement, and Participation:** Actively soliciting and incorporating feedback through formal channels, satisfaction surveys, and community participation in health facility management.
- **Independent Appraisal and "Mystery Patient" Surveys:** External evaluation of quality-enhancing interventions and simulated patient visits to assess care from the patient's perspective, providing valuable insights into provider behavior and adherence to standards.
- **Project-Specific QA and QI Initiatives:** Many health projects, like the World Bank-funded "Damal Caafimaad," incorporate specific QA/QI components. NGOs also implement internal QA/QI mechanisms.

Despite these efforts, the overarching and persistent challenge remains the systemic weakness of the health system and the severe lack of sufficient resources, capacity, and infrastructure to implement these QA/QI mechanisms comprehensively, effectively, and sustainably across the entire health sector. This challenge is particularly acute within the large and largely unregulated private health sector, where quality assurance is often lacking. The chronic underfunding of the health sector, as highlighted by Amnesty International's critique of reduced health budgets, directly and significantly undermines the capacity of the system to ensure and improve the quality of care, limiting the ability to invest in the necessary infrastructure, training, and monitoring mechanisms.

C. Progress Towards National and International Health Goals (UHC, SDGs)

Somalia has demonstrated a strong and explicit commitment to achieving Universal Health

Coverage (UHC) and the health-related Sustainable Development Goals (SDGs), particularly SDG 3, which focuses on ensuring healthy lives and promoting well-being for all at all ages. This commitment is articulated in key national policy documents and strategic plans, including the National Health Policy and the Health Sector Strategic Plan III (HSSP III), which explicitly align their goals and objectives with the global UHC and SDG agendas. A national roadmap for UHC (2019-2023) was launched to provide a strategic framework and guide national efforts towards achieving UHC, outlining specific strategies and interventions to expand access to essential health services, improve the quality of care, and ensure financial risk protection for all Somalis. This roadmap emphasizes the core principles of UHC:

- **Equity:** Ensuring that all individuals and communities have equal access to the health services they need, regardless of socio-economic status, geographical location, gender, or other factors.
- **Quality:** Providing high-quality, safe, effective, and patient-centered health services that meet the needs and expectations of the population.
- **Financial Risk Protection:** Protecting individuals and households from catastrophic health expenditures and the risk of impoverishment due to healthcare costs.

However, despite the government's commitment and the efforts undertaken, progress towards achieving these ambitious UHC and SDG goals in Somalia is severely constrained and hampered by the persistent and multifaceted challenges and systemic weaknesses discussed throughout this report. These challenges, which include conflict and insecurity, climate shocks, poverty, a fragile health system, and limited resources, create significant obstacles to improving health outcomes and achieving equitable access to healthcare.

Somalia's UHC service coverage index, a key metric, remains alarmingly low, reported as ranging from 27 out of 100 to 33.5, depending on the source and methodology used. This dismal score places Somalia among the lowest-performing countries globally in terms of UHC achievement, indicating that a substantial proportion of the population lacks access to even the most basic and essential health services. This low index reflects significant disparities in access to care, with marginalized and vulnerable groups, such as the poor, rural populations, internally displaced persons (IDPs), and women and children, facing the greatest barriers to accessing healthcare. Achieving the targets set out in SDG 3 by 2030, particularly SDG 3.8 (UHC), is recognized as an exceptionally formidable and challenging task for Somalia, given the complex and protracted nature of the crises facing the country and the deep-rooted systemic weaknesses of the health system. The ongoing security challenges, characterized by

conflict, violence, and instability, disrupt health service delivery, limit access to care, and create an environment of insecurity that hinders health system development. The fragility of the health system, marked by inadequate infrastructure, a shortage of trained health personnel, limited financial resources, and weak governance, further impedes progress towards UHC and SDG 3. Persistent socio-economic inequalities, including poverty, food insecurity, and lack of access to education and clean water and sanitation, also contribute to poor health outcomes and hinder efforts to achieve health equity. While some limited and uneven progress has been observed in certain specific areas, such as a modest reduction in under-five mortality rates, these rates remain unacceptably and persistently high, reflecting the continued vulnerability of children and the challenges in providing adequate maternal and child health services. Progress on other critical health indicators, such as skilled birth attendance, which is essential for reducing maternal and newborn mortality, has been slow and insufficient, indicating the urgent need for accelerated and intensified efforts to improve access to and utilization of essential health services for women and newborns. The lack of significant progress in these key areas underscores the magnitude of the challenges facing the Somali health sector and the need for a sustained and concerted effort to address the underlying determinants of poor health outcomes.

The heavy reliance on out-of-pocket payments (OOPE) for healthcare means that financial risk protection is minimal in Somalia. This high level of OOPE exposes individuals and households, particularly the poorest and most vulnerable, to a high risk of catastrophic health expenditures, which can push them into poverty or further exacerbate their existing economic hardship. When healthcare costs consume a significant portion of a household's income, it forces them to make difficult choices between seeking necessary medical care and meeting other basic needs, such as food, shelter, and education. This lack of financial protection undermines the goal of UHC and perpetuates a cycle of poverty and ill health.

The United Nations (UN) in Somalia has aligned its development assistance with the 2030 Agenda for Sustainable Development and the SDGs through the UN Sustainable Development Cooperation Framework (2021-2025). However, the allocation of available resources for SDG 3 (Good Health and Well-being) within the UN framework appears relatively small compared to other sectors, such as Zero Hunger or Peace and Justice, according to data from one UN data portal. Furthermore, UNICEF's 2023 annual report highlights that significant data gaps and weak coordination mechanisms for SDG progress monitoring make it challenging to accurately assess Somalia's progress towards achieving child-related SDG targets, underscoring the need for improved data systems and coordination in SDG implementation and monitoring.

Despite the daunting context, the persistent challenges, and the slow progress in certain areas, there is a recognized and demonstrable commitment from the government of Somalia and its international partners to advance the UHC and SDG agenda and work towards improving the health and well-being of the Somali population. The Essential Package of Health Services (EPHS) 2020 is considered a key vehicle and strategic instrument for achieving UHC, aiming to expand access to a prioritized and cost-effective set of high-impact health interventions. However, achieving meaningful and sustainable progress towards UHC and the health-related SDGs will necessitate a substantial and sustained increase in investment in the health sector, coupled with comprehensive and systemic reforms to address the underlying weaknesses of the health system, improve governance and accountability, strengthen health infrastructure and workforce capacity, enhance health financing mechanisms, and address the broader social, economic, and environmental determinants of health. Furthermore, improvements in security, stability, and overall governance are essential to create an enabling environment for health system development and effective health service delivery.

IX. Conclusion and Strategic Recommendations

The analysis herein compels the conclusion that Somalia's health service delivery system exists in a state of acute precarity, a direct consequence of the protracted and multifaceted adversities the nation has endured. Decades of conflict, political instability, underdevelopment, and recurrent humanitarian crises have converged to create a health system characterized by fragmentation, resource scarcity, and an inability to provide essential services to a substantial portion of the population. This confluence of challenges has resulted in some of the world's most adverse health indicators, particularly in maternal, newborn, and child health, alongside a heavy burden of communicable diseases, the emergence of non-communicable conditions, and a pervasive mental health crisis. Addressing these deeply entrenched and complex issues necessitates a sustained, coordinated, and comprehensive effort, coupled with substantial, long-term investments in the health sector.

Despite these formidable challenges, the commitment of the Federal Government of Somalia, Federal Member States, and a consortium of international and national partners to rebuild and strengthen the health system is evident. This commitment is manifested in the development of key policy and strategic frameworks, including the National Health Policy, the Health Sector Strategic Plan III (2022-2026), and the revised Essential Package of Health Services (EPHS) 2020, which provide a roadmap towards achieving Universal Health Coverage (UHC). Furthermore, innovative service delivery models, such as mobile health camps and community health worker programs, demonstrate adaptive strategies to extend healthcare access to underserved populations. The implementation of DHIS2 also offers a platform to enhance health information management and evidence-based decision-making. However, achieving a resilient and equitable health system in Somalia remains a formidable undertaking. Persistent challenges include fragmented governance, limited institutional capacity, unsustainable financing models, human resource shortages, a weak pharmaceutical supply chain, and the destabilizing effects of insecurity and climate shocks. To accelerate progress and develop a health system capable of meeting the population's needs, the following strategic recommendations are proposed:

Strengthen Health Governance and Leadership for Unified Action:

- **Enhance Federal and State MoH Capacity:** Substantially invest in strengthening the institutional capacity of federal and state Ministries of Health to effectively execute core governance functions, including policy formulation, strategic planning, regulation, coordination, and financial management. This should prioritize fostering transparent and accountable leadership.
- **Improve Inter-Governmental Coordination:** Establish robust mechanisms for coordination and collaboration between the Federal Ministry of Health and Federal Member State health authorities to ensure harmonized planning, standardized service delivery, and equitable resource allocation, while respecting regional autonomy.
- **Combat Corruption:** Implement stringent anti-corruption measures and enhance accountability frameworks to ensure efficient and ethical resource utilization.

Transform Health Financing for Sustainability and Equity:

- **Increase Domestic Public Financing:** Advocate for strategies to progressively increase domestic budget allocations to health, aiming to meet or exceed the Abuja Declaration target of 15%, reflecting a commitment to health as a critical development sector.
- **Reduce Out-of-Pocket Expenditures:** Explore and pilot financial protection mechanisms, such as community-based health insurance, to alleviate the burden of out-of-pocket expenditures and prevent catastrophic health costs, particularly for vulnerable populations.
- **Enhance Donor Aid Effectiveness:** Collaborate with international partners to improve aid alignment with national health priorities, promote on-budget support, reduce fragmentation, and ensure funding predictability and sustainability. Support the establishment and utilization of National Health Accounts for comprehensive expenditure tracking.

Implement a Comprehensive Human Resources for Health Strategy:

- **Address Workforce Shortages and Maldistribution:** Scale up the training of essential health cadres, including midwives, nurses, and primary care physicians, based on assessed needs. Implement incentive packages and improve working conditions to encourage deployment and retention in underserved areas.
- **Improve Quality of Training and Regulation:** Strengthen accreditation systems for health training institutions and establish robust licensing and re-licensing mechanisms for health professionals to ensure competence and quality of care. Standardize curricula to align with national health needs.
- **Invest in Supportive Supervision and Continuous Professional Development:** Implement effective supervision systems and provide ongoing training to enhance the skills, knowledge, and motivation of the health workforce.

Ensure Access to Quality-Assured Medical Products and Technologies:

- **Strengthen National Medicines Regulatory Authority (NMRA):** Expedite the operationalization and empowerment of the NMRA with the necessary legal mandate, resources, and technical capacity to effectively regulate the pharmaceutical market and combat substandard and falsified medicines.
- **Improve Pharmaceutical Supply Chain Management:** Invest in strengthening national capacity for efficient procurement, warehousing, and distribution of essential medicines and supplies, gradually reducing reliance on external management and enhancing quality assurance mechanisms.
- **Promote Rational Use of Medicines:** Implement programs to promote the rational prescribing, dispensing, and use of medicines to improve treatment outcomes and combat antimicrobial resistance.

Fortify the National Health Information System (HIS) for Actionable Data:

- **Consolidate and Integrate HIS:** Promote DHIS2 as the unified national HIS platform, working towards the integration or interoperability of all data systems and mandating private sector reporting.
- **Enhance Data Quality and Use:** Invest in capacity building for health workers and managers in data collection, analysis, interpretation, and utilization for evidence-based decision-making.
- **Improve Digital Infrastructure:** Advocate for initiatives to improve internet connectivity and digital infrastructure to enhance the functionality of DHIS2 and other digital health tools.

Adopt Integrated and Resilient Service Delivery Models:

- **Scale Up EPHS Implementation:** Continue the phased rollout of the EPHS 2020, ensuring contextually adapted and integrated services that reach vulnerable populations.
- **Strengthen Primary Health Care (PHC):** Prioritize investment in PHC as the foundation of the health system.
- **Mainstream Mental Health and NCD Care:** Develop and integrate cost-effective interventions for mental health and NCDs into primary healthcare services.

- **Build Climate Resilience:** Integrate climate change adaptation and resilience-building measures into health system planning and infrastructure development.

Foster Multi-Sectoral Collaboration and Community Engagement:

- **Promote Inter-Sectoral Action for Health:** Actively collaborate with other sectors, including education, water and sanitation, and agriculture, to address the social and environmental determinants of health.
- **Empower Communities:** Strengthen mechanisms for community participation in health planning, management, and monitoring.
- **Engage Effectively and Respectfully with Traditional and Clan Leaders:** Build trust and facilitate access to health services while ensuring equity and adherence to "do no harm" principles.

Addressing Somalia's profound health challenges necessitates a long-term vision, sustained commitment from all stakeholders, substantial and predictable investment, and a steadfast focus on equity and quality. Through strategic and collaborative endeavors, a health system capable of better serving the Somali people and contributing to the nation's recovery and development can be progressively realized.

Abbreviations

Abbreviation	Full Term
DHIS2	District Health Information Software 2
EPHS	Essential Package of Health Services
FMoH	Federal Ministry of Health
HIS	Health Information System
HSSP III	Health Sector Strategic Plan III (2022– 2026)
HRH	Human Resources for Health
IDP	Internally Displaced Person
IOM	Institute of Medicine (now National Academies of Sciences, Engineering, and Medicine)
LRI	Lower Respiratory Infection
MDR-TB	Multidrug-Resistant Tuberculosis
MHPSS	Mental Health and Psychosocial Support
MNCH	Maternal, Newborn, and Child Health
MoH	Ministry of Health
NCDs	Non-Communicable Diseases
NGOs	Non-Governmental Organizations
OOPE	Out-of-Pocket Expenditure
SDGs	Sustainable Development Goals
UHC	Universal Health Coverage
UNICEF	United Nations Children’s Fund
WHO	World Health Organization
WASH	Water, Sanitation, and Hygiene

Declarations

Statement of Authorship

I, Dr. Abdulrazaq Yusuf Ahmed, affirm that I am the sole author of this manuscript, titled *Operationalising Health Service Delivery in Somalia: Towards Universal Health Coverage*. This study is an original work developed independently and is based on comprehensive desk-based research and policy analysis. All sources of information, literature, and conceptual frameworks used have been properly cited and acknowledged in accordance with academic integrity standards. The manuscript has not been published previously, nor is it under consideration by any other journal.

The manuscript has not been published previously, nor is it under consideration for publication elsewhere. I bear full academic and ethical responsibility for the content and conclusions presented.M

Ethical Approval

This study did not involve human participants, clinical interventions, or identifiable personal data, and therefore did not require ethical review under institutional or national guidelines. The analysis is based on secondary data derived from publicly accessible documents, reports, and peer-reviewed literature. As such, ethical approval was deemed not applicable.

Consent for Publication

Not applicable. This manuscript does not contain any individual-level data, images, or personal identifiers that would require explicit consent for publication.

Competing Interests

The author declares that there are no competing interests associated with this research or its publication.

Funding Statement

The author did not receive any specific grant or financial support from funding agencies in the public, commercial, or not-for-profit sectors for the preparation of this manuscript.

Authors' Contributions

Dr. Abdulrazaq Yusuf Ahmed independently conceived the study, conducted the literature review, synthesized policy frameworks, and prepared the manuscript. The author also ensured the intellectual integrity, analytical rigour, and coherence of the final submission. All responsibilities for the work and its conclusions rest solely with the author. and All aspects of the research and writing were completed by the author.

Disclosure of Commercial or Financial Involvement

The author declares no commercial or financial conflicts of interest.

English-Language Editing

This manuscript has been reviewed for fluency and accuracy of English.

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