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Universal Health Coverage in Somalia: Charting the Path to Equitable Healthcare Financing and Governance

Abdirazak Yusuf Ahmed[1*], Fawziya Abikar Nor[2], Mustafa Yusuf Ahmed[3], Marian Muse Osman[4]

[1]Dmertini Public Health, Health System Adviser at Ministry of Mogadishu Somalia, Mogadishu, Somalia
[2]The Federal Ministry of Health, Mogadishu, Somalia
[3]Dean Faculty of Medicine and Health Science at Darulhikmah University, Mogadishu, Somalia
[4]Research Department, National Institute of Health, Mogadishu, Somalia
Email: *drjalaal@hotmail.com, fawziya.nur@gmail.com, Dr.mustapha1993@gmail.com, Mariammo1994@gmail.com

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Abstract

Somalia is a country facing numerous challenges in achieving universal health coverage (UHC) and ensuring adequate healthcare financing, This article explores the complexities and obstacles that Somalia must overcome in its pursuit of UHC, the paper begins by providing an overview of the current healthcare landscape in Somalia, highlighting the lack of infrastructure, political instability, and limited financial resources that hinder the establishment of a comprehensive and equitable healthcare system. It then examines the role of international aid and non-governmental organizations (NGOs) in filling the healthcare gap, while emphasizing the need for a more sustainable, domestically financed solution. Drawing on a range of data sources and case studies, the article proposes a multi-faceted approach to strengthen healthcare governance, improve resource allocation, and foster local capacity building, the study delves into the unique obstacles that Somalia faces, including a lack of infrastructure, political instability, and limited financial resources, which hinder the establishment of a comprehensive and equitable healthcare system. The paper also examines the role of international aid and non-governmental organizations (NGOs) in filling the healthcare gap, while highlighting the need for a more sustainable, domestically financed solution. The findings underscore the importance of political commitment, international cooperation, and innovative financing mechanisms in advancing towards UHC in Somalia, providing valuable insights for other low resource, conflict affected settings.

Keywords

Universal Health Coverage, Health Governance, Health Finance, Equitable

Health Access

1. Introduction

The World Health Organization (WHO) defines UHC as ensuring all people have access to needed health services of sufficient quality without suffering financial hardship [1]. UHC is a key component of the Sustainable Development Goals (SDGs) and a priority for many countries, including Somalia. However, achieving UHC in Somalia faces many challenges, such as political instability, poverty, insecurity, weak health system, low health spending, and high burden of disease [2]. This article will discuss the current state of UHC in Somalia, with a focus on healthcare financing and governance, two essential elements for delivering quality healthcare to all citizens.

Healthcare financing refers to how health services are funded, managed, and allocated. It involves raising revenue, pooling resources, purchasing services, and providing financial protection [3]. In Somalia, healthcare financing is largely dependent on external sources and out-of-pocket payments by households. According to the Health Sector Resource Mapping and Expenditure Tracking Report [4], donors and development partners fund Somalia's public health sector. This assistance is mostly managed and distributed according to donor priorities and does not necessarily match the needs of the Somali health authorities. According to the federal Ministry of Planning and International Development (MOPIED) and the World Bank (2019), in 2017, 2018 and 2019 the public health sector received external aid respectively totaling $109.3 million, $108.6 million and $137 million. Meanwhile, Somali government spending on health amounted to less than five percent of the total health sector expenditure [5], leaving many people vulnerable to catastrophic health expenditures and impoverishment.

Healthcare governance refers to how health policies are formulated, implemented, monitored, and evaluated. It involves setting standards, ensuring quality, regulating providers, engaging communities, and promoting accountability [6]. In Somalia, healthcare governance is challenged by the complex political context and the fragmented health system [7]. The country is re-establishing health governance structures, rebuilding health institutions, re-engaging with development partners, and adopting a decentralized health governance system through ministries of health at the federal and member state levels [8]. However, there are still gaps in policy coherence, regulation enforcement, quality assurance, stakeholder participation, and data availability.

The study aims to explore the status of universal health coverage in Somalia as well as financial and governance associated factors to current situation through comparative study and reports review.

2. Literature Review

Despite the global commitment to UHC, approximately half of the world's pop-

ulation still lacks full coverage of essential health services. Financial barriers are among the most significant obstacles to achieving UHC. This research will contribute to the understanding of how healthcare financing can be structured to reduce these barriers and promote UHC, thereby contributing to the achievement of the SDGs [9].

Universal health coverage (UHC) is a central component of development goals worldwide, emphasizing equitable access to affordable and quality healthcare services for all. In Somalia, a country grappling with numerous challenges such as conflict, poverty, and weak governance, achieving UHC is a significant and complex undertaking [10]. In this article, we will examine the existing state of healthcare financing and governance in Somalia, while also exploring potential strategies to advance the nation towards the goal of universal health coverage.

Somalia, a country located in the Horn of Africa, has been plagued by conflict, political instability, and poverty for decades. These factors have significantly impacted the country's healthcare system, and universal health coverage (UHC) remains a significant challenge [7]. It is not a surprise that the country currently has some of the lowest health and well-being indicators globally. Extended periods of conflict and insecurity exacerbated by recurrent extreme droughts and floods and subsequent food insecurity have devastated the health status of the population and severely damaged its fragile health system. Droughts result in displacements, which leads to unprecedented levels of malnutrition, health emergencies and epidemics. A large proportion of the population is prone to a wide range of natural and human-induced disasters due to Somalia's geography and setting [11].

The Somali healthcare system is financed through a combination of public and private sources. The public sector is the largest provider of healthcare services, but it is underfunded and inefficient. The private sector is growing, but it is often unaffordable for the majority of the population [12].

In this article, we will explore the state of UHC in Somalia, with a specific emphasis on healthcare financing and governance. We will discuss the challenges the country faces in achieving UHC, examine the existing healthcare financing mechanisms, and highlight the importance of effective governance in ensuring access to quality healthcare for all citizens.

3. Material and Methods of the Study

The study intends to investigate the current situation of health service delivery in Somalia in terms of challenges to universal health coverage specifically governance and financing related factors.

The study is exploratory systemic review of previous studies and reports on universal health coverage in Somalia in terms UHC current situation, health financing factors and governance factors to give closer insight on the current situation and the main challenges faced.

Using the comparative element, the study will also review the situate of regional and international countries and their UHC situation.

4. Study Findings

4.1. Current Situation of Health Service Delivery in Somalia

4.1.1. Health Indicators and Somalia's Ranking in the World

The current state of healthcare in Somalia is characterized by low health indicators, weak health system, and high dependence on external funding and out of pocket payments. According to the World Health Organization (WHO) [13], the country's overall morbidity and mortality remain very high, particularly women and children. Somalia currently has the world's highest child mortality rate. One out of seven children dies before the age of five. Somali mothers suffer from the sixth highest maternal death risk in the world, with skilled health personnel attending only one in 10 births. The average Somali woman has 6.7 children, the fourth highest fertility rate in the world. Despite the immense challenges, the country's health sector is emerging from the crises and is forging a path forward. The country is re-establishing health governance structures, rebuilding health institutions, re-engaging with development partners, and adopting a decentralized health governance system through ministries of health at the federal and member state levels [14].

The country's health indicators are among the worst in the world, with high rates of maternal and child mortality, malnutrition, and infectious diseases such as tuberculosis and malaria.

Somalia faces many challenges in providing health care to its population, which is estimated at 15.4 million people. According to the World Health Organization (WHO), Somalia has one of the lowest health indicators in the world, with a life expectancy of 57 years, a maternal mortality ratio of 732 per 100,000 live births, and an under five mortality rates of 127 per 1000 live births [15]. The country also suffers from a high burden of communicable diseases, such as malaria, tuberculosis, HIV/AIDS, and cholera, as well as a growing burden of non-communicable diseases, such as diabetes, cardiovascular diseases, and mental disorders [16].

4.1.2. Health Indicators of Somalia Compared to African Countries

Somalia has one of the highest under five mortality rates in the world, with 112 deaths per 1000 live births in 2020 [17]. The 2016 Service Availability and Readiness Assessment (SARA) survey13 assessed the healthcare infrastructure and its responsiveness in providing key services. The SARA report found a total of 1,074 health facilities in the country, of which only 799 were operational and accessible, indicating an acute shortage, including private health facilities. The cumulative score of the density of public health facilities, in terms of inpatient and maternal beds, was 28.3 percent, reflecting a 72 percent deficit in the health infrastructure. At the same time, the core health workforce density was 18.6 percent, and service utilization level 6.3 percent, which collectively provide a to-

tal general service availability rate of 17.7 percent [18].

Somalia has a very low immunization coverage for children, with only 42 percentage of surviving infants receiving the third dose of DTP containing vaccine and only 8 percentage receiving the second dose of measles containing vaccine in 2020 [17]. This is far below the average of 76 percentage for DTP3 and 74 percentage for MCV2 for sub Saharan Africa and the global average of 86 percentage for both vaccines [19].

Somalia has a high prevalence of female genital mutilation (FGM) with 99 percentages of girls and women aged 15 - 49 years having undergone FGM [17]. This is much higher than the average of 21 percentage for sub-Saharan Africa and the global average of 4 percentages [20].

Somalia has a low level of skilled birth attendance with only 19 percentages of births attended by skilled health personnel in 2019 [16]. This is lower than the average of 59 percentage for sub-Saharan Africa and the global average of 81 percentages.

Somalia has a high rate of adolescent fertility rates with 98 births per 1000 women aged 15 - 19 years in 2020 [17]. This is higher than the average of 95 births per 1000 women aged 15 - 19 years for sub Saharan Africa and the global average of 41 births per 1000 women aged 15 - 19 years [21].

4.2. Health Financing

4.2.1. Health Financing and Its Impact on Somalia's Health Service Delivery

Healthcare financing in Somalia faces considerable challenges due to the absence of a functional government for several decades, leaving the system fragmented and under resourced. Currently, healthcare services are predominantly delivered through a combination of public, private, and non-Healthcare financing in Somalia faces considerable challenges due to the absence of a functional government for several decades, leaving the system fragmented and under resourced. Currently, healthcare services are predominantly delivered through a combination of public, private, and non-governmental organizations, with varying levels of quality and accessibility. The funding for healthcare primarily relies on out-of-pocket payments, external aid, and contributions from diaspora remittances.

Healthcare financing in Somalia is characterized by a mix of out of pocket payments, donor funding, and limited government spending. The high reliance on out of pocket payments has resulted in significant financial barriers to healthcare access, particularly for the poorest segments of the population.

The Somali government's expenditure on health is among the lowest globally, reflecting the country's limited fiscal capacity and competing priorities in a context of ongoing conflict and state building efforts. However, there have been recent efforts to increase domestic resource mobilization for health, including the introduction of health financing reforms such as the establishment of a health trust fund and the exploration of innovative financing mechanisms such as social health insurance.

Donor funding plays a crucial role in financing healthcare in Somalia. International donors, including bilateral and multilateral agencies, provide a significant proportion of health funding, particularly for disease specific programs and humanitarian health interventions. However, the reliance on donor funding raises concerns about the sustainability and predictability of health financing.

Somalia's healthcare financing system faces numerous challenges, including:

1) High Reliance on Out-of-Pocket Payments: The majority of healthcare expenses in Somalia are paid for out of pocket, which can be a significant financial burden for households, especially for those with low incomes. This high reliance on out-of-pocket payments has resulted in limited access to healthcare services, particularly for vulnerable populations such as women, children, and the elderly.

2) Inadequate Government Spending on Health: The Somali government's expenditure on health is among the lowest globally, reflecting the country's limited fiscal capacity and competing priorities. The low level of government spending on health has resulted in inadequate funding for essential health services, such as primary healthcare, maternal and child health, and infectious disease control.

3) Fragmented Donor Funding: Donor funding plays a significant role in financing healthcare in Somalia, but it is often fragmented and tied to specific programs or projects. This fragmentation can lead to inefficiencies and duplication of efforts, as well as a lack of coordination and sustainability in healthcare service delivery.

Current state of healthcare financing in Somali and Statistical situations of Somali health care financing: Somalia's health spending is only 1.3 percent of total government spending, which is below the 15 percent Abuja Declaration target set by African Union countries [22].

Somalia's health financing system relies heavily on out of pocket payments by households and donor funding, which account for about 45 percentage each of the total health expenditure [23].

Somalia's health sector receives both humanitarian and development aid, but most of the donor funding is off budget, meaning that it is not channeled through the government's financial management system [23].

The World Bank has approved a project called Damal Caafimaad, which is financed by a US$ 75 million International Development Assistance (IDA) grant and an additional US$ 25 million grant from the Global Financing Facility for Women, Children and Adolescents (GFF) [13].

This project aims to improve health service coverage and quality in some of Somalia's most disadvantaged areas, benefiting around 10 percent of the population. The Global Action Plan for Healthy Lives and Wellbeing for All (GAP) is a joint initiative of 12 agencies, including WHO, UNICEF, and World Bank, to

support countries in achieving their health priorities. Somalia is one of the countries where progress under the GAP is most advanced and where its added value has been most clearly demonstrated [24].

The GAP has helped Somalia to develop Universal Health Coverage (UHC) Roadmap, launched in September 2019, which identifies primary health care as the main approach to improving health outcomes in the country.

4.2.2. How Does Somalia's Health Spending Compare to Other Countries in Africa?

Somalia's health spending is very low compared to other countries in Africa.

Here are some comparisons based on the data from the World Bank [15] and the World Health Organization:

Somalia's current health expenditure as a percentage of GDP was 3.4 percent in 2020, which is lower than the average of 5.1 percentage for sub-Saharan Africa and 9.8 percent for the world [25].

Somalia's current health expenditure per capita in current US dollars was $ 16.6 in 2020, which is much lower than the average of $ 94.7 for sub-Saharan Africa and $ 1273.6 for the world [15].

Somalia's out of pocket expenditure as a percentage of current health expenditure was 44.9 percent in 2019, which is higher than the average of 35.7 percent for sub Saharan Africa and 18.6 percent for the world. This means that households in Somalia bear a large share of the health care costs themselves, which can lead to financial hardship and impoverishment.

Somalia's domestic general government health expenditure as a percentage of current health expenditure was 10.3 percent in 2019, which is much lower than the average of 38.8 percent for sub-Saharan Africa and 60.3 percent for the world. This means that the government in Somalia contributes very little to the financing of health services, leaving a large gap to be filled by external donors and households.

Somalia's external health expenditure as a percentage of current health expenditure was 44.8 percent in 2019, which is higher than the average of 25.5 percent for sub-Saharan Africa and 1.1 percent for the world. This means that Somalia depends heavily on foreign aid to fund its health sector, which can pose challenges for sustainability and alignment with national priorities.

Somalia's health spending is far below the levels needed to ensure universal health coverage and quality health care for its population governmental organizations, with varying levels of quality and accessibility. The funding for healthcare primarily relies on out-of-pocket payments, external aid, and contributions from diaspora remittances.

Healthcare financing in Somalia is characterized by a mix of out-of-pocket payments, donor funding, and limited government spending. The high reliance on out-of-pocket payments has resulted in significant financial barriers to healthcare access, particularly for the poorest segments of the population.

The Somali government's expenditure on health is among the lowest globally,

reflecting the country's limited fiscal capacity and competing priorities in a context of ongoing conflict and state building efforts. However, there have been recent efforts to increase domestic resource mobilization for health, including the introduction of health financing reforms such as the establishment of a health trust fund and the exploration of innovative financing mechanisms such as social health insurance.

Donor funding plays a crucial role in financing healthcare in Somalia. International donors, including bilateral and multilateral agencies, provide a significant proportion of health funding, particularly for disease specific programs and humanitarian health interventions. However, the reliance on donor funding raises concerns about the sustainability and predictability of health financing.

4.3. Healthcare Governance

4.3.1. Healthcare Governance in Somalia

The governance of the healthcare system in Somalia is complex, reflecting the country's federal structure and the role of various actors in health service delivery. The Federal Ministry of Health has the mandate to set national health policies and strategies, but the implementation of health programs is largely decentralized to the Federal Member States.

The current situation of health governance and leadership and health systems of Somalia is as follows:

Health governance and leadership: Somalia has a federal system of government, with a Federal Government of Somalia (FGS) and five Federal Member States (FMS), each with its own Ministry of Health. The FGS is responsible for setting national health policies, standards, and regulations, while the FMS are responsible for planning, implementing, and monitoring health services at the state and district levels.

However, the health governance and leadership in Somalia faces many challenges, such as weak institutional capacity, lack of coordination and alignment among stakeholders, limited financial and human resources, and insecurity and instability. Efforts are underway to set up a coordination mechanism for all health partners to strengthen primary health care and fill gaps in services at the district level, building consensus around a priority package of essential services and critical health system reforms and mapping the availability of services and health workers.

Health systems: Somalia's health system is characterized by low coverage, poor quality, and high inequity of health services. Three decades of civil war and instability, coupled with natural disasters such as drought and floods, have weakened Somalia's health system and contributed to it having some of the lowest health indicators in the world. Of the country's 15 million people, 26% - 70% live in poverty, depending on the region, and an estimated 2.6 million people have been internally displaced [26]. The public sector provides only about 20 percent of health services, mainly in urban areas, while the private sector provides about

80 percent, mostly in the form of unregulated pharmacies and clinics. The health workforce is severely inadequate, with only 0.4 doctors, nurses, and midwives per 10,000 population, compared to the WHO minimum threshold of 23 per 10,000 population[2]. The health information system is weak and fragmented, with limited data quality and use for decision making [27].

The essential medicine and supply chain management is also inefficient and ineffective, with frequent stock outs, high prices, poor quality, and irrational use of medicines and other health commodities [19].

1) Weak Institutional Capacity: The healthcare system in Somalia is characterized by weak institutional capacity at both the federal and state levels. This includes limited human resources, inadequate infrastructure, and weak coordination mechanisms, which hinder the effective implementation of health policies and programs.

2) Complex Federal Structure: Somalia's federal structure presents challenges for healthcare governance, as health service delivery is decentralized to the Federal Member States. This can lead to disparities in healthcare access and quality, as well as challenges in coordinating and monitoring health programs across the country.

3) Limited Community Engagement: There is limited community engagement in healthcare governance in Somalia. This can result in a lack of understanding and support for health policies and programs, as well as limited accountability mechanisms for healthcare providers.

The current status of the health workforce in Somalia is a crucial factor that affects the quality and coverage of health services and the achievement of universal health coverage. Based on the web search results, some of the main features of the health workforce in Somalia are:

The health workforce is insufficient and inadequately trained to meet the health needs of the population. According to a baseline study and human capital development strategy [28], there are only 0.4 physicians and 1.1 nurses and midwives per 10,000 population in Somalia, which is far below the WHO recommended minimum of 2.3 health workers per 10,000 population. Moreover, the health workforce lacks standardized qualifications, competencies, and skills to provide quality care.

The health workforce is unevenly distributed across regions and urban rural areas. According to the same study [28] most of the health workers are concentrated in urban areas, especially in Mogadishu, while rural and remote areas face severe shortages. There are also imbalances among different cadres of health workers, with a predominance of low skilled workers such as community health workers and traditional birth attendants.

The health workforce is poorly regulated and supervised by the authorities. According to the UHC Partnership [29] the health workforce in Somalia lacks effective regulation and supervision mechanisms, such as accreditation, licensing, and performance management. This results in low accountability and quali-

ty standards among health workers and health facilities.

The health workforce is under resourced and demotivated by the working conditions. According to the World Bank [30], the health workforce in Somalia faces multiple challenges, such as inadequate remuneration, lack of career development opportunities, recognition, and safety. These challenges affect the retention and motivation of health workers, especially in conflict affected and hard to reach areas.

4.3.2. How Does Somalia's Health Workforce Compare to Other Countries in Africa?

Somalia's health workforce is one of the lowest in Africa and in the world, according to the latest WHO data. The density of health workers per 10,000 population in Somalia is only 5.3, which is far below the WHO recommended minimum of 23 [31]. This means that there are not enough health workers to provide essential health services to the population, especially in rural and remote areas.

In comparison, the average density of health workers per 10,000 population in Africa is 14.7, which is also below the WHO recommended minimum, but still much higher than Somalia's [32]. Some of the countries in Africa that have higher densities of health workers than Somalia are South Africa (76.1), Algeria (64.4), Tunisia (58.4), Egypt (45.8), and Kenya (13.8) [33].

The low density of health workers in Somalia is a result of many factors, such as inadequate investment in health education and training, poor working conditions and incentives, lack of regulation and supervision, and political instability and conflict [34]. These factors affect the availability, accessibility, quality, and motivation of health workers in Somalia.

5. Conclusions

The journey towards UHC in Somalia is undoubtedly challenging, but not insurmountable. By addressing the challenges in healthcare financing and governance, Somalia can make significant strides towards ensuring that all citizens have access to quality healthcare services. Strengthening existing healthcare financing mechanisms, promoting effective governance, and fostering collaboration among stakeholders are crucial steps in this endeavor. With sustained efforts, Somalia can move closer to achieving UHC, providing a healthier and more prosperous future for its people.

Success of Universal Health coverage in Somalia requires a comprehensive approach that addresses healthcare financing challenges, strengthens governance mechanisms, and focuses on healthcare delivery systems. By investing in infrastructure, human resources, and health information systems, Somalia can move closer to the vision of providing equitable access to quality healthcare for all its citizens. Collaboration among stakeholders, community engagement, and learning from international experiences will be key in navigating the path towards UHC and improving the overall health and well-being of the popula-

tion.

Universal Health Coverage requires a comprehensive approach, encompassing healthcare financing, governance, and healthcare infrastructure. Somalia faces unique challenges in achieving UHC due to its complex socio-political context. However, with concerted efforts from the government, international partners, and the private sector, progress can be made towards realizing the vision of equitable and accessible healthcare for all Somalis. By embracing innovative financing mechanisms, enhancing governance frameworks, and building a sustainable healthcare infrastructure, Somalia can chart a path towards UHC, ultimately improving the health and well-being of its people.

Achieving UHC in Somalia requires concerted efforts to address the challenges in healthcare financing and governance. This includes increasing domestic resource mobilization for health, improving the efficiency and equity of health spending, strengthening the stewardship role of the government in health service delivery, and enhancing the coordination and regulation of non-state actors.

While the road to UHC in Somalia is long and fraught with challenges, the country's commitment to improving its healthcare system, as evidenced by recent health reforms and initiatives, provides a solid foundation for progress. With continued efforts from the government, support from international partners, and the resilience of the Somali people, the goal of UHC can be achieved.

6. Recommendations

Evidence based solutions and recommendations to enhance healthcare financing mechanisms, ensuring sustainable universal health coverage and improve healthcare governance and management in Somalia that contributing to SDG progress in Somalia.

Universal Health Coverage requires a comprehensive approach, encompassing healthcare financing, governance, and healthcare infrastructure. Somalia faces unique challenges in achieving UHC due to its complex socio-political context. However, with concerted efforts from the government, international partners, and the private sector, progress can be made towards realizing the vision of equitable and accessible healthcare for all Somalis. By embracing innovative financing mechanisms, enhancing governance frameworks, and building a sustainable healthcare infrastructure, Somalia can chart a path towards UHC, ultimately improving the health and wellbeing of its people.

Achieving universal health coverage (UHC) in Somalia is a complex task due to the country's unique challenges, including ongoing conflict, political instability, and a lack of infrastructure and resources. However, with concerted efforts and strategic planning, it is possible to make significant progress. Here are some more detailed strategies and practices that could be used to improve healthcare financing and governance in Somalia:

1) Improving Governance

Governance is the process of how health policies are formulated, implemented, monitored, and evaluated. It involves setting standards, ensuring quality, regulating providers, engaging communities, and promoting accountability. Governance plays a crucial role in improving access to healthcare services in Somalia, as it can help address the challenges and gaps in the health system and ensure that all people receive the health services, they need without suffering financial hardship.

Good governance is crucial for the effective delivery of health services. This involves ensuring transparency, accountability, and participation in decision making processes. Strengthening regulatory frameworks and ensuring that health policies are effectively implemented is also important. This could involve the establishment of health governance bodies at the national and local levels, the development of clear and transparent processes for decision making and accountability, and the implementation of mechanisms for public participation in health policy and planning. Healthcare governance refers to how health policies are formulated, implemented, monitored, and evaluated. It involves setting standards, ensuring quality, regulating providers, engaging communities, and promoting accountability, In Somalia, weak governance systems present formidable barriers to attaining UHC objectives, as corruption, limited coordination, and lack of transparency hinder progress.

Here are some aspects of governance.

a) Strengthening Health Systems:

Building a robust health system is the backbone of achieving UHC. This involves improving the quality and accessibility of services, ensuring that health facilities are adequately equipped and staffed, and building the capacity of healthcare providers. Training programs for healthcare workers can be implemented to improve the quality of care, and infrastructure development projects can be undertaken to increase the number of health facilities and ensure they are equipped with the necessary supplies. Additionally, efforts should be made to ensure that health services are distributed equitably, so that all individuals, regardless of their location or socioeconomic status, have access to care.

b) Strengthening Healthcare Delivery Systems:

Achieving UHC requires not only adequate healthcare financing but also a well-functioning healthcare delivery system. Somalia needs to focus on strengthening primary healthcare services, which serve as the first point of contact for individuals. This includes expanding the coverage and quality of primary healthcare facilities, ensuring the availability of essential medicines, and promoting preventive and promotive healthcare services.

c) Addressing Health Inequalities:

Somalia is characterized by significant health inequalities, with disparities in access to healthcare based on factors such as geographic location, socioeconomic status, and gender. To achieve UHC, it is essential to address these inequalities

and ensure that vulnerable and marginalized populations have equitable access to healthcare services. This can be achieved through targeted interventions, such as mobile health clinics to reach remote areas or implementing strategies to improve health literacy and empower disadvantaged communities.

Expanding access to primary healthcare services is crucial for achieving UHC. This involves investing in community health centers, mobile clinics, and other primary healthcare facilities that can provide basic healthcare services to the population. These facilities should be adequately staffed and equipped to provide preventive, curative, and rehabilitative care

Expanding the coverage and quality of essential health services, especially for women, children, adolescents, and vulnerable groups. This requires improving the availability, accessibility, affordability, acceptability, and adequacy of health facilities, equipment, supplies, medicines, and human resources. It also requires strengthening community engagement and empowerment, as well as addressing social determinants of health such as education, water, sanitation, hygiene, food security, and gender equality.

Strengthening the health workforce by increasing the number, quality, and distribution of health workers, especially in rural and remote areas. Somalia faces a severe shortage of qualified health workers, especially doctors, nurses, midwives, and pharmacists[1]. Strengthening the health workforce would require investing in pre-service and in-service training, developing and implementing a national human resource for health policy and plan, improving the regulation and supervision of health workers, and enhancing their motivation and retention through adequate remuneration and incentives.

Improving essential medicine and supply chain management by ensuring the availability, affordability, quality, and rational use of medicines and other health commodities. Somalia suffers from frequent stock outs, high prices, poor quality, and irrational use of medicines and other health commodities[1]. Improving essential medicine and supply chain management would involve strengthening the procurement, storage, distribution, and monitoring systems, establishing and enforcing quality standards and regulations, promoting the use of generic medicines and essential medicine lists, and enhancing the capacity and coordination of stakeholders.

2) Increasing Health Financing

Healthcare financing can be made more equitable in Somalia by implementing strategies that aim to increase public spending on health, reduce out of pocket payments by households, and expand financial protection and access to essential health services for all people, especially the poor and vulnerable. Adequate funding is crucial for the delivery of health services. This can be achieved through a variety of mechanisms, including domestic resource mobilization, external funding, and innovative financing mechanisms.

Suggested strategies for Healthcare Financing enhancement of Somalia

a) Enhancing domestic resource mobilization by improving the taxation sys-

tem and allocating more funds to the health sector.

b) Increasing public spending on health can help reduce reliance on external sources and out of pocket payments, and improve equity, efficiency, and accountability in health financing.

c) Aligning health financing mechanisms with the national health policy and strategic plans, and coordinating among different levels of government and stakeholders, this requires harmonizing and aligning health financing mechanisms with the national health priorities and plans and ensuring effective coordination and collaboration among all actors in the health sector.

d) Implementing health financing reforms that aim to increase efficiency, equity, and accountability in the allocation and utilization of resources.

e) A systematic review[3] suggests that some of the potential reforms include performance based financing, social health insurance, and community based health financing. These approaches can help incentivize quality and results, pool risks and resources, and empower communities and providers in health financing decisions.

f) Exploring innovative financing approaches that can complement existing mechanisms and mobilize additional resources for health.

For example, the government could increase its investment in health, implement taxes on harmful products like tobacco and alcohol to generate revenue for health services, or establish a health fund that pools resources from various sources. It's also important to ensure that funds are allocated efficiently and equitably, and that there are mechanisms in place to monitor and evaluate the use of funds.

Suggestion and Practical ideas ways that Somalia and Somali Government easily adopt and work to improve its revenue collection capacity to support healthcare financing:

a) Strengthening tax administration by professionalizing the revenue agency, implementing technology solutions, expanding the tax base, and enforcing compliance. This could include value added tax, corporate and income taxes.

b) Establishing a functional customs and trade system. As an imports reliant country, customs duties offer significant potential revenues if ports and borders are well regulated.

c) Introducing compulsory health insurance gradually starting with formal sector workers in major cities. Payroll tax deductions and employer contributions could generate a pool of funds.

e) Inducing experiments and innovative techniques with alternative models like taxing mobile money transactions which have widespread use. This spreads the burden across a large, growing economic sector.

e) Curbing corruption and redirect revenues to priority needs like healthcare. Improving transparency and accountability in collection and spending is imperative.

f) Pursing public private partnerships for infrastructure projects that generate

fees or taxes over the long term. Reconstruction provides revenue opportunities.

g) Building capacity of local districts to collect property, land, and other asset taxes tailored to different regions. Strengthen financial management at sub national levels.

h) Negating with international partners and multilateral lenders for debt relief or concessionary loans to invest in revenue generating reforms.

i) Producing regular economic data to inform realistic revenue projections and support foreign investment for growth.

3) Promoting Public Private Partnerships (PPPs):

PPPs can play a crucial role in improving health services by leveraging the resources and expertise of the private sector. This can involve partnerships with private healthcare providers, pharmaceutical companies, and other stakeholders. For example, the government could partner with private companies to provide certain health services, or to develop and distribute essential medicines and vaccines. These partnerships should be governed by clear and transparent agreements that ensure the public interest is protected.

4) Implementing Health Insurance Schemes:

Health insurance can play a crucial role in achieving UHC by providing financial protection and ensuring access to needed health services. This can involve community-based health insurance schemes, social health insurance, or private health insurance. For example, the government could establish a national health insurance scheme that provides coverage for a basic package of health services, and subsidize premiums for low income individuals and families.

Here are some micro insurance models suggesting being implemented in Somalia:

a) Community based health insurance, this involves small, local risk pools where community members pay modest premiums and are covered for basic primary care services. Examples exist in other African countries.

b) Agricultural/livestock insurance: Somalia has a largely pastoral economy. Insurers could provide payouts in the event of drought, disease or death of animals, an important livelihood asset. Parameters can be indexed to weather satellite data.

c) Mobile phone linked insurance: Partner with telecom firms utilized by most Somalis. Premiums are paid via airtime purchase and payouts delivered to mobile wallets. Simple plans could cover things like emergency transport.

d) Mutual health organizations: Community managed, non-profit groups where members pool small dues and receive healthcare in return. Models have operated successfully in other fragile states.

e) Starting on a modest scale and leveraging ubiquitous mobile technologies, creative micro insurance solutions could gradually expand financial protection for primary healthcare needs.

f) Recommended and practical ways micro insurance solutions in Somalia could potentially be scaled up to provide broader financial protection:

i) Link community-based insurance pools together through common networks/platforms to achieve larger risk pools and negotiate better provider rates.

j) Gradually mandate participation in basic insurance plans tied to national ID systems as coverage expands and ability to pay develops.

k) Introduce risk equalization mechanisms where healthier pools subsidize sicker ones to account for variable risks across regions.

l) Develop bundled product offerings covering multiple insurable risks (health, life, livestock etc.) relevant to different livelihoods.

m) Leverage partnerships between insurers, NGOs, mobile operators and farmers/livestock associations to efficiently enroll large numbers.

n) Transition successful mutual models into regulated commercial insurers as markets mature, with community participation in governance.

o) Introduce copayment tiers allowing people to select plan based on means and gradually get more comprehensive protection.

p) Incentivize preventative healthcare seeking behavior through discounted premiums or limited cost sharing for priority services.

q) Link registration in insurance plans to broader public services like food/seed subsidies or community development programs.

r) Pool revenues into common government managed funds that can subsidy private insurers covering high risk, low income populations.

s) Gradual, inclusive approaches could extend basic risk pooling to a majority over time, important for UHC.

5) Community Engagement:

Community engagement is the process of involving and empowering people and communities in the planning, implementation, monitoring, and evaluation of health policies and services. Community engagement plays a vital role in healthcare governance, as it can help improve the quality, equity, and accountability of health service delivery. Engaging communities in health decision making and service delivery can help to ensure that services are responsive to local needs and priorities. This can involve community health workers, community-based organizations, and other forms of community participation. For example, community health workers could be trained to provide basic health services and health education in their communities, and community-based organizations could be involved in health planning and decision-making processes.

6) Leveraging Digital Health Technologies:

Digital health technologies can play a crucial role in improving health services, particularly in settings with limited resources. This can involve telemedicine, electronic health records, mobile health applications, and other forms of digital health.

7) Foster Collaboration and Coordination:

Effective collaboration and coordination among healthcare stakeholders, including government agencies, NGOs, and private healthcare providers, is essential for achieving universal health coverage and improving healthcare gover-

nance. Somalia can establish a national health council or forum to facilitate collaboration and coordination among stakeholder.

Sustained multi sectoral efforts are crucial to help Somalia progress toward universal coverage over the coming decades. Improved stability, economic growth, and innovative public private partnerships could accelerate progress if governance and institution building efforts bear fruit. Effective alignment and harmonization of financial, procurement, and reporting requirements of donors and agencies should be Established and implemented:

The following steps are necessary to ensure the implementation of harmonized financial and Procurement procedures of all Donors and International Partners:

a) Convene donors and agencies to agree on a common financial management and reporting template, definitions, and timelines. This streamlines workload.

b) Establish joint auditing arrangements where a single auditor reviews all partners' programs to assess compliance and impact rather than separate audits.

c) Adopt shared procurement policies, regulations and processes for medical supplies, equipment, staffing, and infrastructure contracts across partners.

d) Utilize common procurement platforms for jointly tendering and coordinating large contracts to benefit from economies of scale.

e) Explore using a single financial management system with one bank account to pool and allocate all health development funds.

f) Agree core set of harmonized indicators to assess outcomes and evaluate performance of whole sector strategy rather than duplicative metrics.

g) Consider piloting use of country financial management/procurement systems by donors where capacity exists to strengthen national ownership.

h) Negotiate simplified due diligence and risk assessment requirements recognizing Somalia's challenges and joint commitment to rebuild systems.

i) Conduct regular joint field monitoring visits using shared tools and checklists to minimize disruptions to service providers.

j) Coordinated process streamlining within an agreed framework can maximize efficiencies with minimized burden on implementing stakeholders.

k) Achieving universal health coverage (UHC) in Somalia requires concerted efforts and strategic planning to address the challenges posed by ongoing conflict, political instability, and limited resources.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

References

[1] Universal Health Coverage Partnership Somalia. WHO/OMS Extranet Systems https://extranet.who.int/uhcpartnership/country-profile/somalia

[2] Somalia, UN Renew Promise to Deliver Health for All, Using Universal Health

Coverage, Urge Partners to Do the Same.
https://www.unicef.org/somalia/press-releases/somalia-un-renew-promise-deliver-health-all-using-universal-health-coverage-urge

[3] WHO Supports Launch of Universal Health Coverage Roadmap in Somalia.
https://www.emro.who.int/somalia/news/who-supports-launch-of-universal-health-coverage-roadmap-in-somalia.html

[4] Universal Health Coverage Day: Translating the Dream of 'Health for All" into a reality.
https://reliefweb.int/report/somalia/universal-health-coverage-day-translating-dream-health-all-reality

[5] WHO: World Health Organization (2018) SDG Monitoring Health for SDGs 2018, Aid Flows in Somalia 2018.
https://cdn.who.int/media/docs/default-source/gho-documents/world-health-statistic-reports/2023/world-health-statistics-2023_20230519_.pdf

[6] Ifeagwu, S.C., Yang, J.C., Parkes-Ratanshi, R. and Brayne, C. (2021) Health Financing for Universal Health Coverage in Sub-Saharan Africa: A Systematic Review. *Global Health Research and Policy*, **6**, Article No. 8.
https://ghrp.biomedcentral.com/articles/10.1186/s41256-021-00190-7

[7] Warsame, A.A. (2020) Somalia's Healthcare System: A Baseline Study & Human Capital Development Strategy. The Heritage Institute for Policy Studies and City University of Mogadishu.
http://www.heritageinstitute.org/wp-content/uploads/2020/05/Somalia-Healthcare-System-A-Baseline-Study-and-Human-Capital-Development-Strategy.pdf

[8] Growth and Economic Transformation Strategy (Gets) for Somalia: Social Sector Education and Health for Women and Youth Empowerment.
https://nec.gov.so/wp-content/uploads/2023/04/GROWTH-AND-ECONOMIC-TRANSFORMATION-STRATEGY-GETS-FOR-SOMALIA-SOCIAL-SECTOR-EDUCATION-AND-HEALTH-FOR-WOMEN-AND-YOUTH-EMPOWERMENT.pdf

[9] World Health Organization (2022) Country Cooperation Strategy for WHO and Somalia 2021-2025. Regional Office for the Eastern Mediterranean.
https://applications.emro.who.int/docs/9789290211280-eng.pdf

[10] Somalia: Building a Stronger Primary Health Care System.
https://www.who.int/news-room/feature-stories/detail/somalia-building-a-stronger-primary-health-care-system

[11] World Population Review.
http://worldpopulationreview.com/countries/somalia-population/

[12] Somali Community Health Strategy.
https://somalimedicalarchives.org/media/attachments/2021/09/18/somali-community-health-strategy_-final.pdf

[13] UNICEF Somalia. Community Engagement.
https://www.unicef.org/somalia/topics/community-engagement

[14] WHO Somalia Country Cooperation Strategy 2019-23.
https://www.who.int/publications-detail-redirect/WHO-CCU-17.01-Somalia

[15] Somalia (SOM)—Demographics, Health & Infant Mortality—UNICEF DATA.
https://data.unicef.org/country/som/

[16] Somalia—World Health Organization (WHO).
https://www.who.int/countries/som/

[17] World Health Organization (2022) Universal Health Coverage. https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)

[18] The Service Availability and Readiness Assessment (SARA). WHO Report 2016. https://www.who.int/data/data-collection-tools/service-availability-and-readiness-assessment-(sara)

[19] Investment Case for the Somali Health Sector 2022-2027. https://www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF-Annual-Report-2019-2020.pdf

[20] Ahmed, Z., Ataullahjan, A., *et al.* (2020) Understanding the Factors Affecting the Humanitarian Health and Nutrition Response for Women and Children in Somalia Since 2000: A Case Study. *Conflict and Health*, **14**, Article No. 35. https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-019-0241-x

[21] UNFPA Somalia. https://somalia.unfpa.org/sites/default/files/pub-pdf/FINAL%20SHDS%20Report%202020_V7_0.pdf

[22] The Somaliland Health and Demographic Survey 2020. https://somalia.unfpa.org/sites/default/files/pub-pdf/slhds2020_report_2020.pdf

[23] Somali Community Health Strategy' National Institute of Health—Somalia. https://nih.gov.so/case-studies/somali-community-health-strategy/

[24] Somalia—Health Indicators—Humanitarian Data Exchange. https://data.humdata.org/dataset/who-data-for-somalia

[25] World Bank FULL REPORT: Somalia Economic Update: Investing in Health to Anchor Growth 2022. https://www.worldbank.org/en/country/somalia/publication/somalia-economic-update-investing-in-health-to-anchor-growth

[26] World Bank Group (2017) Somali Poverty Profile: Findings from Wave 1 of the Somali High Frequency Survey. World Bank Group, Washington DC.

[27] Somalia Economic Update: Investing in Health to Anchor Growth. https://www.worldbank.org/en/country/somalia/publication/somalia-economic-update-investing-in-health-to-anchor-growth

[28] 5 Ways to Strengthen Our Health Systems for the Future. https://www.weforum.org/agenda/2022/01/5-ways-to-strengthen-our-health-systems-for-the-future-healthcare/

[29] Askar A. (2017) Bridging Gaps in Health Information Systems: A Case Study from Somaliland. http://www.emro.who.int/emhj-volume-23-2017/volume-23-issue-11/bridging-gaps-in-health-information-systems-a-case-study-from-somaliland.html

[30] World Economic Forum (2013) How to Build a Better Health System: 8 Expert Essays. https://www.weforum.org/agenda/2020/10/how-to-build-a-better-health-system/

[31] Somalia's Women and Children Are among the 1.84 Million to Benefit from Improved Healthcare Services. https://www.worldbank.org/en/news/press-release/2021/07/19/somalia-s-women-and-children-are-among-the-1-84-million-to-benefit-from-improved-healthcare-services

[32] WHO Global Health Workforce Statistics Database. https://www.who.int/data/gho/data/themes/topics/health-workforce

[33] Health Systems Strengthening—World Health Organization (WHO). https://www.who.int/data/gho/data/themes/topics/health-systems-strengthening

[34] The Somali Human Resources for Health Development Policy 2016-2021 https://www.somalimedicalarchives.org/archive/publications/418-the-somali-human-resources-for-health-development-policy-2016-2021