

Health System Transformation in Somalia: An Analysis of Justice, Sustainability, and Resilience in a Fragile State

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Abstract

Background: Health systems in fragile and conflict-affected states (FCAS) like Somalia face uniquely compounded pressures requiring transformative approaches that prioritize equity and long-term viability. The legacy of prolonged conflict, weak governance, pervasive socio-economic disparities, and acute climate vulnerability present formidable obstacles to achieving Universal Health Coverage (UHC). This paper provides a comprehensive analysis of Somalia's evolving health system through the critical, interconnected lenses of health justice and sustainability.

Methods: A qualitative synthesis methodology was employed, involving in-depth analysis of core Somali policy documents (Health Sector Strategic Plan III 2022-2026; Somali Health and Demographic Survey 2020; Somalia Facts & Figures 2022), specialized reports addressing climate change impacts (NCEA Advice, 2021; UNDP Factsheet, 2025), and relevant peer-reviewed Health Policy and Systems Research (HPSR) literature focusing on FCAS, resilience, and equity. Thematic analysis centred on governance, financing, service delivery (Essential Package of Health Services - EPHS), human resources (HRH), health equity, and climate adaptation.

Results: Somalia's health system remains severely fragmented, characterized by a dominant, unregulated private market, under-resourced public facilities, and numerous NGOs. Public health expenditure is critically low (approximately 0.18% of GDP), leading to heavy reliance on volatile external aid and catastrophic out-of-pocket payments (>25% of households use distress financing). Profound health injustices manifest as stark disparities across geographic (nomadic 4% facility delivery vs. urban 34%), socioeconomic (poorest 20% facility delivery 5% vs. wealthiest 20% 48%), and gender (MMR 692) lines. Key indicators like skilled birth attendance (32%) and full child immunization (11%) remain alarmingly low. Extreme vulnerability to climate change exacerbates health risks and continuously undermines the system's limited adaptive capacity.

Conclusion: Meaningful health system transformation in Somalia necessitates a paradigm shift, embedding health justice and climate resilience within policy design, implementation, and evaluation. This requires integrated strategies that address structural drivers of inequity, strengthen governance for pro-poor regulation, mainstream climate adaptation, and develop sustainable financing. Politically-informed, participatory HPSR is crucial for generating actionable evidence to navigate this complexity, foster adaptive management, and support progress toward equitable and resilient health for all Somalis.

Keywords: Somalia, Health Systems Strengthening, Health Equity, Health System Resilience, Climate Change Adaptation, Fragile and Conflict-Affected States (FCAS), Health Governance, Health Financing, Universal Health Coverage (UHC)

1. Introduction

The aspiration of Universal Health Coverage (UHC) championed by the global health community is rooted in the principle that every individual should be able to access the health services they require without experiencing financial distress. However, in fragile and conflict-affected states (FCAS) such as Somalia, achieving this vision is fraught with exceptional complexity. Here, persistent conflict has left deep scars, resulting in fragmented governance, entrenched inequalities, and an acute susceptibility to external shocks—most notably, those arising from climate change. Somalia's contemporary health landscape is shaped by decades of civil unrest that have effectively dismantled the country's formal public health infrastructure. In the vacuum left by the state's retreat, a diverse yet largely unregulated private sector has emerged, supplemented by the interventions of international non-governmental organisations (NGOs), substantial contributions from the Somali diaspora, and the gradual re-emergence of public sector institutions.

These nascent government bodies strive to establish capacity and relevance amidst persistent instability and insecurity. The resultant health system is highly pluralistic and operates under extraordinary pressure. Recurrent climatic disasters—such as protracted droughts and devastating floods—further intensify these challenges by destroying livelihoods, displacing communities, and overwhelming limited coping mechanisms. This creates a self-reinforcing cycle: the inherent fragility of the Somali state, rooted in protracted conflict, renders both its population and institutions exceptionally vulnerable to environmental shocks. These shocks, in turn, deepen existing weaknesses, escalate health needs, and place ever-greater strain on a system already stretched to breaking point. Thus, the obstacles to UHC in Somalia are not solely the legacy of past conflict but the result of an ongoing interplay of multiple, mutually reinforcing stressors.

These dynamic and intersecting challenges have the effect of continuously undermining progress towards health system strengthening, threatening to reverse gains or render them transient. In this context, effective interventions must be both comprehensive and adaptive, targeting not only the enduring consequences of conflict but also the evolving impacts of climate change. Recognising the interconnectedness of these factors is paramount; strategies must be designed with an appreciation for how these forces interact and perpetuate systemic fragility. Transforming Somalia's health system, therefore, requires an unwavering focus on health justice and sustainability as foundational, interdependent pillars. Health justice within the Somali context demands a candid reckoning with the stark realities of exclusion and inequity—realities that are starkly illuminated by national datasets such as the Somali Health and Demographic Survey (SHDS) 2020.

Systemic inequities deprive large segments of the population of essential health services, resulting in persistent poor health

outcomes. This particularly affects rural and nomadic populations, who face profound geographic and economic barriers; internally displaced persons, who are deprived of consistent care; the majority living in poverty, for whom health costs are ruinous; and women and girls, who disproportionately bear the burdens of mortality and morbidity. Addressing these injustices requires not only the expansion of services but also the establishment of robust mechanisms for accountability, reforms in governance, and the rebalancing of power structures that perpetuate marginalisation. Sustainability, meanwhile, must be conceptualised as encompassing more than just financial stability. While the Somali health system's fiscal base is critically weak—evidenced by public spending at just 0.18% of GDP and a heavy, often fragmented reliance on external aid—true sustainability also requires institutional resilience and ecological soundness.

Strengthening sustainability demands the cultivation of adaptive leadership, enhanced management capacity, and resilient governance structures within both the Federal Government of Somalia (FGS) and the Federal Member States (FMS) Ministries of Health. These institutions must be equipped to navigate complex political realities and to effectively coordinate a mixed health economy. Environmental sustainability and climate resilience are equally indispensable. Somalia's ranking as the world's most climate-vulnerable country (ND-GAIN rank 181/181) translates into immediate and long-term health threats: malnutrition surges during droughts, outbreaks of vector-borne diseases follow floods, and water scarcity undermines basic hygiene. Indirectly, the destruction of livelihoods and mass displacement further erode the health system's ability to respond. A health system that fails to integrate climate adaptation into its core functions cannot hope to achieve enduring sustainability.

The stark disparities observed in Somalia highlight a vicious cycle: injustice increases vulnerability to shocks, as marginalised groups lack the resources and services needed to withstand crises. This heightened vulnerability, in turn, undermines the resilience of the health system, leaving it ill-prepared to manage surges in demand during emergencies. A system that lacks resilience is prone to breakdowns and recurrent reliance on emergency interventions, rendering it unsustainable in the long run. Conversely, a system that is not sustainable—whether financially, institutionally, or environmentally—will be unable to deliver health justice, as it will be perpetually under-resourced and unable to provide equitable services. Thus, health justice, sustainability, and resilience are not discrete objectives but are mutually reinforcing and must be pursued in tandem to achieve lasting transformation. Somalia's national policy frameworks, notably the Health Sector Strategic Plan III (HSSP III, 2022–2026) and the National Development Plan 9 (NDP-9), acknowledge these complexities and articulate a vision for strengthening the health system in pursuit of UHC. HSSP III, in particular, prioritises the delivery of the Essential Package of Health Services (EPHS 2020) and identifies critical areas for intervention across the World Health Organization's six building

blocks: governance, human resources for health, financing, health information systems, pharmaceutical management, and infrastructure development.

This paper seeks to provide a rigorous and nuanced examination of Somalia's health system, dissecting its current state, interrogating the structural barriers to health justice and sustainability, and critically appraising the scope and limitations of prevailing national strategies such as HSSP III. The analysis further explores the vital role of context-sensitive and politically astute Health Policy and Systems Research (HPSR) in informing and guiding meaningful transformation. Drawing on national surveys, strategic policy documents, environmental assessments, and the broader HPSR literature, this work aims to illuminate both the challenges and the opportunities for building a more equitable, resilient, and sustainable health system for all Somalis.

2. Materials and Methods

This research utilizes a qualitative synthesis approach, employing a comprehensive review and thematic analysis of national policy documents, large-scale survey reports, specialized assessments concerning environmental factors, and relevant peer-reviewed academic literature. The aim is to develop a sophisticated and critical evaluation of the Somali health system's evolution, with particular emphasis on the intricate relationships among systemic transformation, health justice, and sustainability within the context of a notably fragile state.

2.1. Data Source Selection and Scope

2.1.1. Documents Reviewed for this Analysis Encompass

• National Policy and Strategy

The Somalia Health Sector Strategic Plan III (HSSP III, 2022-2026) serves as the principal reference for government priorities, strategic directions across key health system domains (governance, financing, human resources for health, service delivery), and planned interventions to achieve universal health coverage. The National Development Plan 9 (NDP-9) offers additional context regarding broader developmental goals.

• National Empirical Data

Quantitative insights are primarily drawn from the Somali Health and Demographic Survey (SHDS) 2020, which provides extensive data on health status, determinants, service utilization, and equity indicators. Its granular breakdown facilitates the assessment of disparities by geographic location (urban, rural, nomadic), socioeconomic status, education level, and gender. Supplementary demographic and economic information is sourced from Somalia Facts & Figures 2022.

• Sustainability and Climate Context

To examine climate resilience and environmental challenges, specialized reports such as the NCEA Advice on Sustainable Programme Development in Somalia (2021) and the UNDP Factsheet on Building Climate Resilience in Somalia (2025) are analyzed. These sources illuminate Somalia's climate vulnerabilities, current adaptation strategies, patterns of environmental degradation, and

the intersection between environmental conditions, livelihoods, and health system requirements.

• Scholarly Literature (HPSR & FCAS Context)

Relevant scholarly works were systematically identified using databases including PubMed and Google Scholar. The literature review emphasizes health policy and systems research (HPSR) concepts—governance, financing, equity, resilience, and political economy—within the framework of fragile and conflict-affected settings (FCAS). Selected publications provide theoretical foundations, comparative analyses, and comprehensive perspectives on the dynamics influencing health system performance in fragile contexts.

2.2. Data Extraction and Synthesis

A thorough and meticulously executed thematic analysis was carried out, following the well-established principles of framework analysis. This method involved the methodical extraction and organization of data from all identified sources, with each piece of information carefully coded against a detailed analytical framework created to tackle the main goals of the study. The analytical framework included the following domains:

• Health System Components

Key dimensions included Governance and Leadership, Financing, Service Delivery (with a particular focus on the Essential Package of Health Services – EPHS), Human Resources for Health, Health Information Systems, and Medical Products and Technology. Each component was scrutinised for both policy intent and operational realities, enabling a nuanced understanding of systemic strengths and vulnerabilities.

• Cross-Cutting Themes

The analysis paid particular attention to Health Justice and Equity, examining structural and contextual barriers to access, disparities in service utilisation, and differential health outcomes across diverse population groups (urban, rural, nomadic, and marginalised communities). Sustainability was interrogated across financial, institutional, and environmental dimensions, while Resilience was evaluated with reference to the health system's absorptive, adaptive, and transformative capacities. The Political Economy domain explored the interests, incentives, and power relations shaping institutional performance and policy implementation.

• Policy-Practice Dynamics

A critical examination was undertaken to assess the alignment—and often, the divergence—between stated strategic intent as articulated in national frameworks such as HSSP III and the empirically documented realities captured in sources like the SHDS 2020 and specialised assessment reports. This included identifying implementation bottlenecks, contextual constraints, and opportunities for reform.

Quantitative evidence, predominantly drawn from the Somali Health and Demographic Survey (2020), was strategically employed to illustrate and substantiate the magnitude of specific health challenges and inequities identified through qualitative synthesis. This enabled the quantification of trends and provided

empirical grounding to the thematic findings. The synthesis process involved an iterative comparison and contrast of insights across diverse document types—juxtaposing policy aspirations set forth in strategic plans with empirical utilisation data and reported implementation challenges. Recurring themes were identified and systematically mapped, facilitating the construction of an integrated narrative that directly responds to the overarching research questions.

Particular emphasis was placed on triangulating evidence from multiple sources to enhance the credibility and validity of the findings. Where data gaps or potential sources of bias were detected—for instance, in relation to under-represented regions or vulnerable groups—these were explicitly acknowledged and considered in the interpretation of results. Finally, the discussion contextualises the synthesised findings from the Somali health system within the broader debates and theoretical frameworks of Health Policy and Systems Research (HPSR), especially as they pertain to fragile and conflict-affected settings (FCAS). This approach ensures that the analysis not only addresses the immediate realities of Somalia but also contributes to the wider discourse on health system transformation, equity, and resilience in challenging environments.

2.3. Methodological Rigor and Limitations

To ensure methodological rigor, this study employed a systematic approach to document selection, prioritizing sources of relevance and authority. A structured analytical framework was applied, and information was triangulated across multiple source types. By adhering to established qualitative synthesis methodologies and maintaining transparent reporting practices, the credibility and trustworthiness of these findings are enhanced. Nevertheless, certain limitations intrinsic to secondary data analysis persist. The reliability of survey data, such as SHDS 2020, may be affected by restricted access and security challenges in specific Somali regions, potentially resulting in underrepresentation of inaccessible or marginalized populations. Policy documents may reflect intended objectives rather than actual implementation outcomes. Additionally, given the dynamic context in Somalia, circumstances may have changed since the publication of key materials. Therefore, while this analysis synthesizes the most robust evidence currently available, it should be supplemented by ongoing contextual reassessment.

3. Results

The situational analysis of Somalia's health landscape, informed by a comprehensive review of national data and policy documents, highlights a system facing persistent challenges rooted in its post-conflict context, institutional weaknesses, pronounced social stratification, and significant environmental vulnerability. The interplay of these factors presents considerable obstacles to achieving equitable health outcomes and sustainable development within the health sector.

3.1. Health System Architecture: A Fragmented Polity with Limited Public Capacity

Prolonged periods of state instability and subsequent federal state-building initiatives have produced a health system characterized by complexity, fragmentation, and notable capacity limitations at various levels.

3.2. Governance and Stewardship Challenges

The Health Sector Strategic Plan III (HSSP III) explicitly identifies “weak management” within both the Federal Government of Somalia (FGS) and Federal Member States (FMS) Ministries of Health (MoHs) as a significant obstacle. Resource constraints, emerging institutional frameworks, political dynamics, and ongoing security concerns frequently hinder effective implementation. Essential stewardship responsibilities—such as integrated strategic planning across federal entities, comprehensive performance monitoring, regulation of a substantial private sector, establishment of quality assurance mechanisms, and equitable distribution of resources—remain insufficiently developed. Coordination, particularly of external aid which constitutes the bulk of health financing but often bypasses government systems, is a persistent challenge despite established coordination forums. The regulatory environment is embryonic; bodies like the National Medicines Regulatory Authority and National Health Professional Council have been legally established but lack the resources and enforcement capacity to meaningfully govern the vast and varied landscape of private and informal health providers and pharmaceutical importers.

This governance vacuum contributes significantly to issues of quality, cost, and equity across the sector. The persistent governance deficits extend beyond mere technical weaknesses. The presence of a “dominant, largely unregulated private market” suggests that the lack of effective regulation is not simply an oversight but may be influenced by powerful private interests. These interests, potentially through mechanisms such as elite capture, may actively resist robust regulation. Furthermore, the observation that external aid often “bypasses government systems” weakens the MoH's authority and capacity, perpetuating a cycle of aid dependency rather than fostering sustainable domestic governance. This creates parallel systems that undermine national planning and accountability. Therefore, the governance vacuum is not solely a technical problem; it is a deeply entrenched political challenge where power dynamics and vested interests actively shape the health system's architecture and limit the state's ability to steer it towards public health goals and equity.

3.3. Service Delivery - The EPHS Coverage Gap

The Essential Package of Health Services (EPHS) 2020 provides a crucial framework for prioritizing interventions based on Somalia's burden of disease, focusing heavily on maternal, newborn, and child health (MNCH), nutrition, and communicable diseases. Delivery is theoretically structured through community health workers, Primary Health Units (PHUs), Health Centres (HCs), and District/

Regional Hospitals. However, the SHDS 2020 reveals a vast gap between the EPHS framework and population coverage. Key service utilization rates are alarmingly low: only 31% of women receive skilled antenatal care (ANC); 32% of births have skilled attendance; merely 21% of deliveries occur in a health facility; and full basic vaccination coverage for children aged 12-23 months is only 11%. Public facilities are often geographically inaccessible, particularly in rural and nomadic areas, understaffed, poorly equipped, and face frequent stock-outs of essential medicines.

The extensive private sector, concentrated in towns, ranges from unregulated pharmacies to sophisticated hospitals. While offering alternatives, concerns about affordability, quality control, and geographic reach persist. The pragmatic, phased EPHS rollout proposed in HSSP III is necessary, but bridging the profound coverage gap requires immense investment, innovative delivery models, and strategies to effectively leverage or regulate the private sector towards public health goals. The existence of a comprehensive EPHS framework alongside strikingly low utilization rates highlights a significant challenge: the problem is not merely the absence of services but profound barriers to equitable access and actual utilization. Geographic inaccessibility, particularly for rural and nomadic populations, means that services are physically out of reach. Financial barriers, primarily due to high out-of-pocket (OOP) expenditures, render services unaffordable. The unregulated private sector further complicates this situation. This complex interplay suggests that achieving UHC requires moving beyond simply defining an EPHS. It necessitates comprehensive strategies that actively dismantle financial and geographic barriers and improve the quality and trustworthiness of all service providers.

3.4. Health Financing - Chronic Underfunding and High Household Burden

Somalia's health financing architecture is fundamentally inadequate and inequitable. Domestic government allocation to health is minuscule, approximately 0.18% of GDP and 1.9% of the national budget in 2020, falling drastically short of international benchmarks. This leaves the system heavily reliant on external donor funding, which, while substantial, is often fragmented, unpredictable, tied to specific projects, and channeled outside government budgets, complicating national planning and sustainability efforts. The most significant consequence of this financial structure is the massive burden placed on households through Out-of-Pocket (OOP) expenditure. Cost is cited by 65% of women as the primary barrier to accessing care. Households predominantly finance health care from meager incomes (48%) or resort to coping mechanisms like selling assets (11%) or borrowing (14%), pushing vulnerable families into deeper poverty. Formal health insurance is virtually non-existent, with less than 1% coverage.

This situation represents a systemic failure to establish a sustainable and equitable financing model. The direct consequence of chronic

underfunding and fragmented aid is the massive burden of OOP expenditure, which represents a profound financial injustice, forcing the poorest to bear the highest proportional cost. This OOP burden, in turn, pushes vulnerable families into deeper poverty, creating a feedback loop where ill-health exacerbates poverty, and poverty prevents access to care. This implies that financial reforms must strategically focus on increasing domestic fiscal space for health, pooling and aligning donor funds through government systems, and implementing robust financial protection mechanisms to drastically reduce catastrophic OOP expenditures.

3.5. Human Resources for Health (HRH) - A Complex Crisis

Somalia's health workforce is currently experiencing a complex crisis that extends beyond simple staff shortages. Despite not having the lowest personnel density in the region, substantial challenges such as workforce maldistribution, unregulated training institutions, inconsistent quality assurance, and ineffective management systems significantly undermine the health sector's ability to provide equitable and high-quality care, particularly in rural and nomadic settings.

A considerable proportion of skilled health workers are concentrated in urban areas, mainly within the private sector. Consequently, many rural and nomadic populations depend on minimally trained community health workers or informal providers lacking proper support, supervision, and resources. This uneven distribution is further exacerbated by non-governmental organisations (NGOs) that offer salaries considerably higher than those available in the public sector. These salary disparities incentivise professionals to prefer employment with NGOs or private facilities, making it increasingly challenging for government institutions to attract and retain qualified staff.

Additionally, the proliferation of private, often unaccredited, training institutions results in graduates whose competencies may not align with the Essential Package of Health Services (EPHS) or meet national and international standards. The absence of robust regulatory and accreditation mechanisms leads to inconsistencies in training, certification, and ongoing professional development, resulting in variable skill levels and diminishing public confidence in the health system.

The national Health Sector Strategic Plan (HSSP III) acknowledges these systemic shortcomings and appropriately prioritises the adoption of a comprehensive Human Resources for Health (HRH) policy, along with the establishment of regulatory councils to oversee training, accreditation, and professional standards. However, translating policy into effective practice will require sustained efforts to address deeply rooted issues. Achieving equitable workforce distribution and strong quality assurance will demand innovative public sector incentives to attract and retain staff in underserved locations, as well as stringent regulation of private providers and training institutions.

In summary, the HRH crisis in Somalia is fundamentally a matter of workforce quality and distribution, rather than just numbers. The prevailing influence of an unregulated private sector, combined with elevated NGO remuneration, generates significant market distortions that lead to the migration of human capital away from public service. This trend severely impairs the state's capacity to deliver equitable and high-quality health services, especially for those in remote or marginalised communities. Addressing these challenges necessitates a strategic, multifaceted approach including strengthened regulatory frameworks, alignment of training programmes with national health priorities, and the development of effective incentives to ensure the availability and willingness of qualified professionals across all regions.

3.6. Health Information Systems (HIS) – Data Gaps and Implications for Decision-Making

The ability to implement evidence-based policies and effective management is significantly limited by a weak, fragmented, and under-resourced Health Information System (HIS). Despite nationwide adoption of DHIS2 since 2017, its operational effectiveness remains below optimal levels. Major challenges include insufficient integration with complementary platforms such as Integrated Disease Surveillance and Response (IDSR), incomplete data reporting—particularly from private sector entities—concerns regarding data quality, and inadequate analytical capacity at sub-national levels. The absence of reliable, timely, and comprehensive health information impedes strategic planning, progress monitoring toward HSSP III objectives, measurement of equity indicators, and adaptive management.

This deficit in dependable data presents a substantial barrier for policymakers, hindering accurate assessment of health inequities, tracking of universal health coverage (UHC) advancement, and monitoring of climate-related impacts. The lack of robust evidence constrains responsive management and undermines the formulation of well-informed policy decisions. Accordingly, strengthening HIS is essential for promoting health equity—by identifying disparities—and enhancing health system resilience through informed, adaptive management. Addressing these issues transcends technical improvements; it constitutes a critical component of governance and accountability within the health sector.

3.7. The Face of Injustice: Pervasive and Intersecting Health Inequities

The systemic challenges discussed above contribute to significant health disparities among various groups within the Somali population, including differences stemming from geography, wealth, education, gender, and displacement status. The SHDS 2020 offers quantitative data that illustrates these patterns. Geographic inequities are particularly pronounced, with urban residents enjoying markedly better access to health services compared to their rural and nomadic counterparts. For example, only a small proportion of nomadic women receive skilled antenatal

care or deliver in health facilities, and vaccination coverage among nomadic children remains alarmingly low. Rural populations also face substantial barriers, although their health indicators are slightly better than those of nomadic groups, they still lag far behind urban dwellers. This disparity reflects both historical neglect and the challenge of delivering services to dispersed and highly mobile communities.

Socio-economic status exerts a powerful influence on health outcomes. Households in the lowest wealth quintile have dramatically lower rates of facility-based deliveries, skilled antenatal care, and child immunisation compared to those in the highest quintile. The poorest families are often forced to finance health care through out-of-pocket payments, resorting to asset sales or borrowing, which can entrench poverty and limit access to essential services. The cost barrier is especially acute for women, with the majority citing financial constraints as the main reason for not seeking care. Educational attainment, particularly among women, further compounds these disparities. Female literacy rates are significantly lower in poorer households, which correlates with reduced health service utilisation and poorer health outcomes for mothers and children. Gender-based inequities are also evident, with women facing additional obstacles in accessing care due to cultural norms, lower educational levels, and economic dependency.

Displacement status introduces another layer of vulnerability. Internally displaced persons (IDPs) often reside in informal settlements with minimal infrastructure, making them more susceptible to disease outbreaks, malnutrition, and limited access to health services. The convergence of these factors—geography, wealth, education, gender, and displacement—creates intersecting disadvantages that disproportionately affect certain segments of the population, reinforcing cycles of ill-health and poverty. In summary, the data from SHDS 2020 starkly reveal the depth and breadth of health inequities in Somalia. Addressing these disparities requires targeted strategies that expand access, reduce financial barriers, improve quality, and prioritise the needs of the most marginalised groups.

3.8. The Tyranny of Geography

The disparity between urban centers and the vast rural and nomadic periphery is perhaps the most glaring inequity. Nomadic populations, estimated at 26% of the total population, are virtually excluded from the formal health system. For instance, only 9% of nomadic women receive skilled antenatal care (ANC), 4% deliver in a facility, 8% of births are attended by skilled personnel, and less than 1% of children aged 12-23 months are fully vaccinated. Access to improved water (35%) and basic sanitation (1%, with 94% practicing open defecation) is abysmal for this group. Rural populations, comprising 23% of the total, fare somewhat better but still dramatically lag behind urban dwellers across all indicators. This reflects a historical and ongoing failure to prioritize and adequately resource service delivery models suited to dispersed

and mobile populations.

3.9. Poverty as a Health Barrier

Socio-economic status significantly influences access to healthcare in Somalia. As detailed in Table 1, the lowest-income 20% of households demonstrate substantially lower utilization rates than the highest-income 20%. For example, facility-based deliveries occur in only 5% of the poorest households compared to 48%

among the wealthiest, skilled antenatal care (ANC) is received by 12% versus 56%, and full childhood vaccination rates are 2% versus 20%, respectively. Female literacy further reflects this disparity, with just 6% among the poorest compared to 62% within the wealthiest group. The high cost of healthcare—predominantly out-of-pocket—serves as a significant barrier, restricting essential services for low-income populations and perpetuating the cycle of poverty and poor health outcomes.

Indicator	Urban	Rural	Nomadic	Poorest 20%	Wealthiest 20%
Facility delivery	34	25	4	5	48
Skilled birth attendance	34	25	8	8	49
Skilled antenatal care (ANC)	48	26	9	12	56
Full childhood vaccination (12–23 months)	19	15	<1	2	20

Source: Adapted from Somali Health and Demographic Survey (SHDS) 2020

Table 1: Dimensions of Health Inequity in Somalia (SHDS 2020 Data)

3.10. Gender Inequality and Health

Somali women face multiple layers of disadvantage. Low educational attainment, with 75% of women aged 15-49 having no schooling, limits access to health information and economic opportunities, correlating strongly with poorer health outcomes. Harmful traditional practices, particularly Female Genital Mutilation/Cutting (FGM/C), remain near-universal (99% prevalence, 64% Pharaonic type), contributing to significant morbidity and mortality risks. High fertility (Total Fertility Rate of 6.9), early marriage (34% of women aged 20-49 married by 18), minimal use of modern contraception (1%), and lack of access to skilled maternal care (only 32% skilled birth attendance) converge to produce one of the world’s highest Maternal Mortality Ratios (MMRs) at 692 deaths per 100,000 live births. Furthermore, women often lack autonomy in health decisions (only 20% decide mainly on their own health care).

3.11. The Vulnerability of the Displaced

While not explicitly disaggregated in SHDS 2020, the immense scale of internal displacement due to both conflict and recurrent climate shocks (e.g., over 1.3 million displaced by drought between 2021 and 2023) creates a population with acute health needs. Internally Displaced Persons (IDPs) often reside in overcrowded, underserved informal settlements, lacking basic Water, Sanitation, and Hygiene (WASH) facilities and facing heightened risks of infectious disease outbreaks, malnutrition, and psycho-social distress. These populations often fall through the cracks of both humanitarian aid and nascent public service provision.

3.12. Ecological Precarity: Climate Crisis and Health System Vulnerability

Somalia’s geographic location and socio-economic structure

render it exceptionally susceptible to the impacts of climate change, which poses a direct and growing threat to population health and the sustainability of the health system itself.

3.13. Climate Change as a Health Determinant

Somalia is experiencing the stark realities of climate change through increasingly frequent and severe extreme weather events, primarily droughts and floods. The multi-year 2021-2023 drought affected nearly half the population, causing mass displacement, widespread livestock loss, acute food insecurity, and excess mortality linked to malnutrition and related diseases. Conversely, recent El Niño-related floods have inundated communities, destroyed infrastructure (including health facilities), contaminated water sources, and heightened the risk of waterborne diseases like cholera and vector-borne diseases like malaria. These direct impacts are layered upon chronic environmental stresses, including widespread land degradation, significant deforestation (linked to charcoal production), and potential depletion of vital groundwater resources. This ecological precarity directly undermines population health through nutrition insecurity, water scarcity impacting hygiene, increased exposure to infectious diseases, and psycho-social stress related to displacement and livelihood loss.

3.14. Health System Resilience Under Strain

The existing health system possesses minimal inherent resilience to absorb, adapt to, or transform in the face of these escalating climate-related health threats. Recurrent climate shocks routinely overwhelm existing service delivery capacity, diverting resources to emergency response and disrupting essential routine services like vaccination and maternal care. Infrastructure is vulnerable to damage, and supply chains are easily disrupted.

While HSSP III acknowledges the need for Emergency Preparedness & Response (EP&R) strengthening, this largely focuses on absorptive capacity (coping with immediate impacts). Developing adaptive capacity (adjusting practices and infrastructure, e.g., climate-resilient facilities, climate-informed disease surveillance) and transformative capacity (addressing underlying drivers of vulnerability) remains a critical gap. The system's financial fragility further constrains its ability to invest in necessary adaptation measures. The NCEA (2021) assessment highlights Somalia's extremely low 'preparedness' score, largely attributed to governance weaknesses, indicating a critical need to build institutional capacity for climate-health action.

3.15. Policy Responses: The HSSP III Framework and Implementation Gaps

The Somalia Health Sector Strategic Plan III (HSSP III, 2022-2026) represents the government's most comprehensive articulation of its strategy to address these multifaceted challenges and progress towards UHC. It aims explicitly to improve equitable access to quality essential services, build institutional capacity, and enhance health system resilience.

3.16. Key Elements Include

• Service Delivery via EPHS 2020

The cornerstone is the phased implementation of the revised EPHS, prioritizing MNCH, nutrition, and communicable disease control, delivered through a strengthened Primary Health Care (PHC) platform.

• System Strengthening Across Building Blocks

HSSP III outlines actions across all WHO domains: Governance (enhancing coordination, regulation), Financing (increasing domestic resources, aligning aid), HRH (implementing policy, standardizing training), Information (strengthening DHIS2), and Medicines/Technology (establishing regulatory capacity).

• Engaging the Pluralistic System

Recognizing private sector dominance, the plan proposes dialogue, incentives, and gradual regulatory oversight.

• Resilience Focus

Explicitly prioritizing enhanced EP&R capacity and IDSR integration.

Despite this comprehensive framework, significant gaps remain between policy articulation and implementation feasibility. HSSP III lacks detailed operational plans and costing, making resource mobilization and accountability challenging. Crucially, while acknowledging challenges like insecurity and capacity gaps, the plan under-articulates concrete strategies to navigate the complex political economy that shapes health system realities—including clan politics, elite interests in the (often unregulated) private health and pharmaceutical markets, aid dependencies, and the influence of nonstate actors. Furthermore, the integration of climate change

adaptation as a core health system function, beyond generalized EP&R, is insufficiently developed.

4. Discussion

The foregoing analysis paints a picture of a Somali health system ensnared in a complex web of post-conflict fragility, deeply entrenched inequities, and intensifying climate vulnerability. This reality resonates strongly with the core themes of health policy and planning, demanding innovative and politically conscious strategies to foster meaningful change towards health justice and sustainability. Achieving progress requires moving beyond purely technical health system strengthening interventions to address the underlying structural, political, and environmental determinants of health and system performance in this unique FCAS context.

4.1. Deepening the Health Justice Agenda

The profound disparities documented by SHDS 2020 are not mere statistical variations; they represent systemic health injustices rooted in unequal power relations, resource maldistribution, and historical marginalization. While HSSP III's focus on expanding EPHS access is necessary, a genuine commitment to health justice demands more radical interventions. This includes:

• Pro-Equity Resource Allocation

Shifting from geographically blind resource allocation towards needs-based formulas that explicitly favor underserved FMS, districts, and population groups (rural, nomadic, IDP settlements).

• Tailored Service Delivery Models

Investing significantly in context-appropriate models beyond fixed facilities, such as strengthening the scope, training, supervision, and logistical support for the Female Health Worker program, implementing integrated mobile outreach services for nomadic populations, and establishing dedicated service points within IDP camps. For instance, in Yemen, a project provided essential services to 7.21 million people, including 12% who were internally displaced, by supporting 72 hospitals and 2,198 primary health facilities, demonstrating feasibility in conflict-affected contexts

• Addressing Financial Barriers

Moving beyond reliance on Out-of-Pocket (OOP) expenditure requires exploring and piloting feasible financial protection mechanisms. Given state capacity limits, options could include targeted subsidies for essential MNCH services for the poorest quintiles or expanding publicly financed free EPHS at the PHC level. Successful reforms in Cote d'Ivoire, for example, expanded insurance coverage by 89%, specifically targeting the poorest households.

• Regulating for Equity

Strategies for engaging the private sector must explicitly incorporate equity objectives. This could involve performance-based contracting conditional on serving poor populations or offering specific EPHS services at agreed prices. In Afghanistan, strengthening the Ministry of Public Health's capacity to oversee a basic package of health services, largely provided through NGO

contracts, led to a major expansion of primary health services and rapid improvements in key health indicators.

• Strengthening Accountability

Developing multi-pronged accountability mechanisms, including stronger parliamentary oversight, community scorecards linked to local governance structures, and accessible grievance redress mechanisms, is vital for fostering responsiveness and trust.

4.2. Integrating Sustainability and Climate Resilience

Achieving sustainability in Somalia necessitates a holistic focus on financial viability, institutional capacity building, and ecological resilience.

• Climate-Resilient Health Systems

It is essential to reframe climate adaptation as an integral component of public health and health system operations rather than an isolated environmental issue. This approach requires committed leadership within Ministries of Health, along with the integration of climate considerations into national health strategies, budgeting processes, and monitoring and evaluation frameworks. Concrete measures include conducting climate-informed health vulnerability assessments, investing in resilient infrastructure—such as solar-powered facilities, water harvesting systems, and robust cold chains—strengthening integrated disease surveillance for climate-sensitive illnesses, and tailoring health promotion communications accordingly.

• Several low- and middle-income countries offer relevant precedents

Indonesia’s \$4 billion investment in energy-efficient medical equipment and telemedicine aims to maintain service delivery during climate shocks; Sierra Leone is acquiring sustainable health equipment and upgrading facilities with solar technology; Nigeria is mainstreaming climate adaptation across its health sector reforms. Sustainable Financing: In addition to increasing domestic resource allocation as a long-term objective, it is important to enhance the efficiency and equity of current expenditures, advocate for more predictable and harmonized donor funding, and pursue opportunities to access global climate finance for health adaptation co-benefits—by, for instance, demonstrating the health-related impacts of climate change to entities such as the Green Climate Fund or Adaptation Fund.

• Institutional Adaptation

Strengthening institutional resilience involves reinforcing key management functions—planning, human resources for health management, and financial administration—at both federal and state levels. It also entails promoting adaptive leadership to respond effectively to uncertainty and advancing intersectoral collaboration through platforms such as One Health.

4.3. Utilising HPSR to Drive Transformational Change

Navigating this complexity demands a specific kind of research—Health Policy and Systems Research (HPSR)—that is deeply embedded, politically aware, rigorous yet flexible, and geared towards supporting iterative learning and adaptation. HPSR’s role in Somalia is crucial for:

• Unpacking the Political Economy

Conducting nuanced research into how formal and informal power structures, elite interests, clan dynamics, aid relationships, and private sector lobbying influence health policy decisions, resource flows, and implementation bottlenecks.

• Evaluating Equity Impacts

Rigorously assessing the differential impacts of various policies and interventions (e.g., EPHS rollout models, private sector contracting) on vulnerable and marginalized groups, using both quantitative (disaggregated survey data) and qualitative (community perspectives) methods.

• Co-designing and Testing Solutions

Employing implementation science and participatory action research approaches to collaboratively design, pilot, and evaluate context-specific service delivery models, governance innovations, or resilience-building strategies with local stakeholders to ensure feasibility and ownership.

• Strengthening Learning Systems

Integrating research into routine M&E cycles and policy dialogues to create feedback loops, support evidence-informed adjustments to strategies (adaptive management), and build institutional capacity for learning and problem-solving.

5. Conclusion

Somalia’s health system transformation journey is undeniably arduous, constrained by the enduring legacies of conflict, profound structural inequities, and the accelerating impacts of the climate crisis. The national ambition, articulated in HSSP III, to build a stronger, more equitable system capable of progressing towards UHC is commendable but requires translation into tangible actions that confront the deep-seated challenges head-on. This analysis underscores that technical fixes alone are insufficient; meaningful progress demands integrated strategies that prioritize health justice and embed sustainability, particularly climate resilience, at their core.

Based on this synthesis, several critical policy implications emerge. First, equity commitments must be operationalized through pro-equity resource allocation formulas that explicitly favor underserved populations (nomadic, rural, IDPs) and investment in contextualized service delivery models, such as enhanced community-based platforms and mobile outreach. Second, accountable and effective health governance must be built through focused, long-term capacity enhancement at federal and state levels, alongside a realistic, phased roadmap for private sector regulation that gradually builds state capacity for oversight. Third, climate resilience must be mainstreamed into the health system, moving beyond emergency response to include integrated planning in national strategies, climate-proofing infrastructure investments, and strengthening climate-sensitive disease surveillance. Finally, fostering a learning health system is essential.

This requires sustained investment in the national HIS (DHIS2) to improve data quality and use, and supporting embedded,

politically-informed HPSR to navigate implementation challenges and guide adaptive solutions. Achieving a just, sustainable, and resilient health system in Somalia demands a departure from 'business as usual'. It requires navigating complex political realities, making difficult choices about resource allocation, fostering genuine partnerships between government, communities, the private sector, and international actors, and committing to a long-term vision grounded in iterative learning and adaptation. While the challenges are immense, focusing strategically on health justice and climate resilience offers the most promising pathway towards securing the right to health for all Somalis. Health Policy and Systems Research (HPSR) is essential for driving health system reform in Somalia. Effective HPSR must be context-specific, responsive to political realities, methodologically sound yet flexible, and focused on continuous learning and adaptation. In Somalia's changing health sector, HPSR plays several critical roles.

- **Examining the Political Economy**

Health Policy and Systems Research (HPSR) enables a comprehensive understanding of the influence that both formal and informal power structures—such as elite interests, clan affiliations, donor relationships, and private sector involvement—exert on health policy development, resource distribution, and implementation challenges. Through systematic analysis of these multifaceted dynamics, HPSR can reveal the fundamental factors contributing to inequity and inefficiency, thereby informing the design of more equitable and effective policy interventions.

- **Evaluating Equity Impacts**

A central responsibility of Health Policy and Systems Research (HPSR) is to systematically evaluate how different policies and interventions—such as alternative models for implementing the Essential Package of Health Services (EPHS) or private sector contracting strategies—impact vulnerable and marginalised populations. This assessment involves employing both quantitative methods (such as analysing disaggregated survey and administrative data) and qualitative techniques (including participatory community consultations) to encompass a wide range of perspectives and ensure that reforms effectively promote equity.

- **Collaborative Design and Evaluation of Solutions**

Utilizing implementation science and participatory action research, Health Policy and Systems Research (HPSR) facilitates the joint development, piloting, and assessment of innovative, contextually adapted service delivery models, governance frameworks, and resilience strategies. Involving local stakeholders throughout these stages strengthens solution relevance and feasibility while promoting local ownership—an essential factor for long-term sustainability and successful scale-up.

- **Strengthening Learning Systems**

Integrating research into routine monitoring and evaluation processes, as well as policy dialogues, establishes essential feedback mechanisms that facilitate evidence-based decision-making and adaptive management. By enhancing institutional capacity to learn from and address emerging challenges, HPSR

supports the development of a resilient and responsive health system.

5.1. Conclusion and Policy Recommendations

Somalia's journey towards transforming its health system is marked by formidable obstacles, including the protracted consequences of conflict, entrenched structural inequities, and the escalating threats posed by climate change. The ambition set forth in the Health Sector Strategic Plan III (HSSP III)—to construct a robust, equitable health system advancing towards Universal Health Coverage (UHC)—is laudable. However, the translation of this vision into tangible progress demands more than technical interventions; it requires a holistic and integrated strategy that places health justice and sustainability, particularly climate resilience, at the forefront.

5.2. Based on the previous analysis, several policy considerations can be identified

I. Operationalising Equity Commitments

Equity must be embedded in resource allocation through pro-equity funding formulas that explicitly prioritise underserved populations—such as nomadic groups, rural communities, and internally displaced persons (IDPs). This should be matched by substantial investment in tailored service delivery models, including strengthened community-based platforms and mobile outreach services, to ensure accessibility and responsiveness in diverse contexts.

II. Building Accountable and Effective Governance

Effective health governance is contingent on sustained capacity enhancement at both federal and state levels. This involves not only technical training but also fostering adaptive leadership and robust regulatory frameworks. A phased, realistic approach to private sector regulation should be pursued, gradually increasing state oversight and ensuring that private sector engagement aligns with public health objectives and equity principles.

III. Mainstreaming Climate Resilience

Climate adaptation must be integrated as a core component of health system planning, moving beyond reactive emergency responses. National strategies should incorporate climate-proofing of health infrastructure, investment in sustainable technologies (such as solar energy and water harvesting), and the strengthening of surveillance systems for climate-sensitive diseases. This proactive approach will be essential for safeguarding health outcomes in the face of increasing climate variability and extremes.

IV. Fostering a Learning Health System

The establishment and continuous improvement of a national Health Information System (HIS), such as DHIS2, is critical for enhancing data quality and utilisation. Investments in embedded, politically-informed HPSR are equally vital, as they enable the health system to navigate complex implementation challenges, adapt strategies in real time, and ensure that reforms are both evidence-based and contextually appropriate.

Establishing a health system in Somalia that is just, sustainable, and resilient necessitates a departure from traditional methodologies.

This process requires careful navigation of complex political dynamics, prudent decision-making regarding resource allocation, and the development of substantive partnerships among governmental bodies, communities, private enterprises, and international stakeholders. Central to this effort is an unwavering commitment to a long-term strategy characterised by continuous learning and adaptive responses. Despite significant obstacles, prioritising health equity and climate resilience remains the most credible path to advancing the right to health for all Somali citizens. Through the adoption of these foundational principles and targeted investment in the requisite systems and capacities, Somalia can progress towards a health system that is inclusive, responsive, and capable of meeting future uncertainties.

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Reflexivity Statement

This manuscript was conceived, written, and revised by the author. The interpretations presented reflect the author's analysis of available evidence and contextual experience.

Author Contributions

Dr. Abdulrazaq Yusuf Ahmed conceptualized the manuscript, developed the framework and analysis, drafted the full text, and approved the final version for publication.

Ethical Approval

This research utilized publicly accessible documents, reports, and scholarly literature; consequently, formal institutional ethical approval was not required.

Data Availability Statement

Data sharing is not applicable to this article, as no new data were generated or analyzed. All referenced materials are either publicly available or appropriately cited.

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