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Strategies and Challenges of Universal Health Coverage in Somalia

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Author's contribution

The sole author designed, analysed, interpreted and prepared the manuscript.

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ABSTRACT

Aims: Universal health coverage (UHC), means making sure everyone can afford the medical attention they need. UHC rests on the foundation of people having access to primary healthcare that is both inexpensive and of high quality. Somalia's health care system is among the world's worst, and its universal health care ranking is one of the lowest. The Somali health care framework remains powerless, under-resourced, and inequitable. A few 3.2 million women and men in Somalia need emergency health services. The aim of this research is to determine strategies and challenges of universal health coverage in Somalia.
Methods: We conducted on review on published articles and grey literature carried out in Somalia. A total of 10 studies and documents met our inclusion criteria. We included studies studied universal health coverage, universal health coverage financing, health system strengthening and health system.
Conclusion: Conclusively, strategies on achieving universal health coverage were limited on advancing UHC by accelerating primary health care led recovery, promote healthier population, and address emergencies and disease outbreaks, while poor health workers, limited provision of drugs and other medical supplies, insecurity and cost of delivering were the most challenges reported in achieving universal health coverage in Somalia.

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1. INTRODUCTION

“Somalia is gravely off-road in the realization of the Millennium Development Goals [1]. With a populace of 15.44 million in 2019, Somalia may well be a youthful and fast-growing country with a three percent yearly population increase. Since the late 1980s, Somalia has experienced outfitted conflict, viciousness, and a course of action of ordinary and human-made catastrophes, which come about in a long, drawn-out, and total state collapse [2].”

According to Warsame, [2] “Earlier, of the state crumple in early 1991, Somalia had a straightforward public health structure framework sensible by African benchmarks. The health department directed the sector's governmental and authoritative structure, even though regional health care authorities had little power. In 1972, healthcare administrations were primarily centralized at that point. The “military government” and a vast portion of the national budget have been distributed to the military.”

“The Somali health care framework remains powerless, under-resourced, and inequitable. A few 3.2 million women and men in Somalia need emergency health services [3]. It has been noted that "Cholera and other widespread communicable diseases such as HIV/AIDS, tuberculosis, and cardiovascular diseases, are among the deadliest in Somalia" [4].

Seal & Bailey, [5] “Stated that Somalia is additionally one of the foremost prohibitive and unreliable situations for “development and humanitarian actors” [6]. Compassionate help has been an essential portion of Somalia's economy, and political control has been built upon it and utilized to control get to it.”

Destitute administration within the Somali health care Framework has been symptomatic of the breakdown within the country's more comprehensive administration, which has been in a state of extraordinary delicacy for more than two decades.

As a result, there was restricted stewardship capacity, responsibility, and technical capacity related to satisfactory health care framework administration, and it has been both a cause and a result of powerless joins between the administration building-block, such as human assets, health care administrations, health approach, and health expenditure [7].

“Somalia's under-five mortality rate is among the highest in the world, with one out of every seven Somali children dying before their fifth birthday. Over 300,000 children under the age of five are acutely malnourished, and fewer than half of children estimated to have been vaccinated against measles [8].”

Universal health coverage (UHC), means making sure everyone can afford the medical attention they need. UHC rests on the foundation of people having access to primary healthcare that is both inexpensive and of high quality [9]. The Somali government is committed to improving primary health care (PHC) as part of its work to reach UHC and the SDGs related to health. According to WHO [10], health facility density per 10,000 populations (2016–18) in Somalia was 1.69 (076 publics and 0.93 privates), hospital beds per 10,000 populations (2017): 8.7, and essential health workforce per 1,000 populations (2014): 0.34. Physicians per 1,000 populations (2017): 0.05. Psychiatrists per 100,000 populations (2017): 0.05; surgeons per 100,000 populations (2017): 0.1; "Marwo Caafimaad" (female health workers) trained and deployed in their own communities: 500; Total per capita health expenditure (2016-2017): US$ 15.8-19.4 Government health expenditure per capita (including ODA): US$ 9.8-12.

Somalia's health care system is among the world's worst, and its universal health care ranking is one of the lowest. Government health spending accounts for 1% of total health spending, while out-of-pocket health spending amounts to $6-7.4 billion. Development aid for health and private expenditure are two major sources of finance under the country's inadequate taxation system. Somalia's economic capability is unable to finance the nation's health care demands in an effective manner. A lack of strategic knowledge and data about the health care system and its operations is the primary obstacle that must be overcome.

Somalia needs more medical and nursing staff to meet the needs of different parts of the country. Financial needs for the health sector remain high given the exceptionally low health indicators and the high operational costs [11].

Within the country's "South and Central" range, around 60% of the populace has no health care [3]. "The 2016 Service Availability and Readiness Assessment (SARA) survey13 surveyed the healthcare foundation and its responsiveness in giving essential administrations," Warsame [2] writes. The SARA report found 1,074 healthcare offices within the nation, of which, as it were, 799 were operational and open, demonstrating intense deficiencies, including the private health sector. The total thickness score for public health care in inpatient and maternal beds was 28.3%, which shows that there are only 72% as many health care facilities as there should be. Simultaneously, the centre health workforce thickness was 18.6 percent and the benefit operation level was 6.3 percent, which collectively add up to the typical benefit accessibility rate of 17.7 percent [2].

Health care in Somalia has been plagued by underfunding, poor administration, and a lack of strategic planning and policy formulation ever since the country gained independence.

This research is important since many LDCs' development programmes prioritise improved health. Better health care helps achieve the SDGs. Universal health coverage (UHC) implies that everyone has access to necessary medical treatment and is financially protected in the event of illness or accident. The emergence of universal health care on international and national policy agendas has not been matched by more study of possible impediments, especially health funding.

Thus, this study is crucial in contributing to unfold and deeply analyse the challenges as well as opportunities in achieving UHC for Somalis. Since there are no many studies regarding UHC in Somalia, my study findings not only inform health policy makers in the country but it is also an academic contribution to the UHC literature in Somalia.

2. MATERIALS AND METHODS

2.1 Research Design

In this study we used systematic and non-systematic narrative review study.

2.2 Search Strategy

Published materials regarding universal health coverage and health systems of Somalia was searched for using data bases such as Google scholar, PubMed and academia. Grey literature from Google, as well as national and international resources such as (MoH, WHO, etc.) will be used.

We used these terms “UHC”, “Universal Health Coverage”, “Healthcare system” and “Health system” with the combinations of “OR” and “AND” to find the literature.

2.3 Selection Criteria

The selection criteria included the articles with the key words of Universal Health Coverage, Health systems, Somalia, and Health. Included the systematic reviews, review articles, reports, original articles and strategic plan documents.

2.3.1 Inclusion and exclusion criteria

Peer-reviewed articles or grey literature empirical or non-empirical, editorial will be include. From the original 30 results obtained from the selected databases, 13 were disregarded as duplicates. If none of the search terms were in the titles of the remaining documents, they were taken out of the set of results. It wasn't relevant to the review's subject matter, or it had an improper title. After reading the abstracts of the remaining 17 entries, we eliminated those that did not meet our criteria for inclusion. After a second round of manual de-duplication, ten articles were looked at in their entirety. These ten articles were used as the basis for this evaluation.

2.3.2 Data presentation and analysis

Data in this study will be presented as a form narrative, all of the relevant publications that were located were thoroughly researched, and their findings were condensed and summarised for the purpose of possible inclusion in this report.

Table 1. Eligibility criteria for the studies

Population	Concept	Context
Health policy makers, government and non-govermental organizations, healthcare providers	UHC, Health systems	Somalia

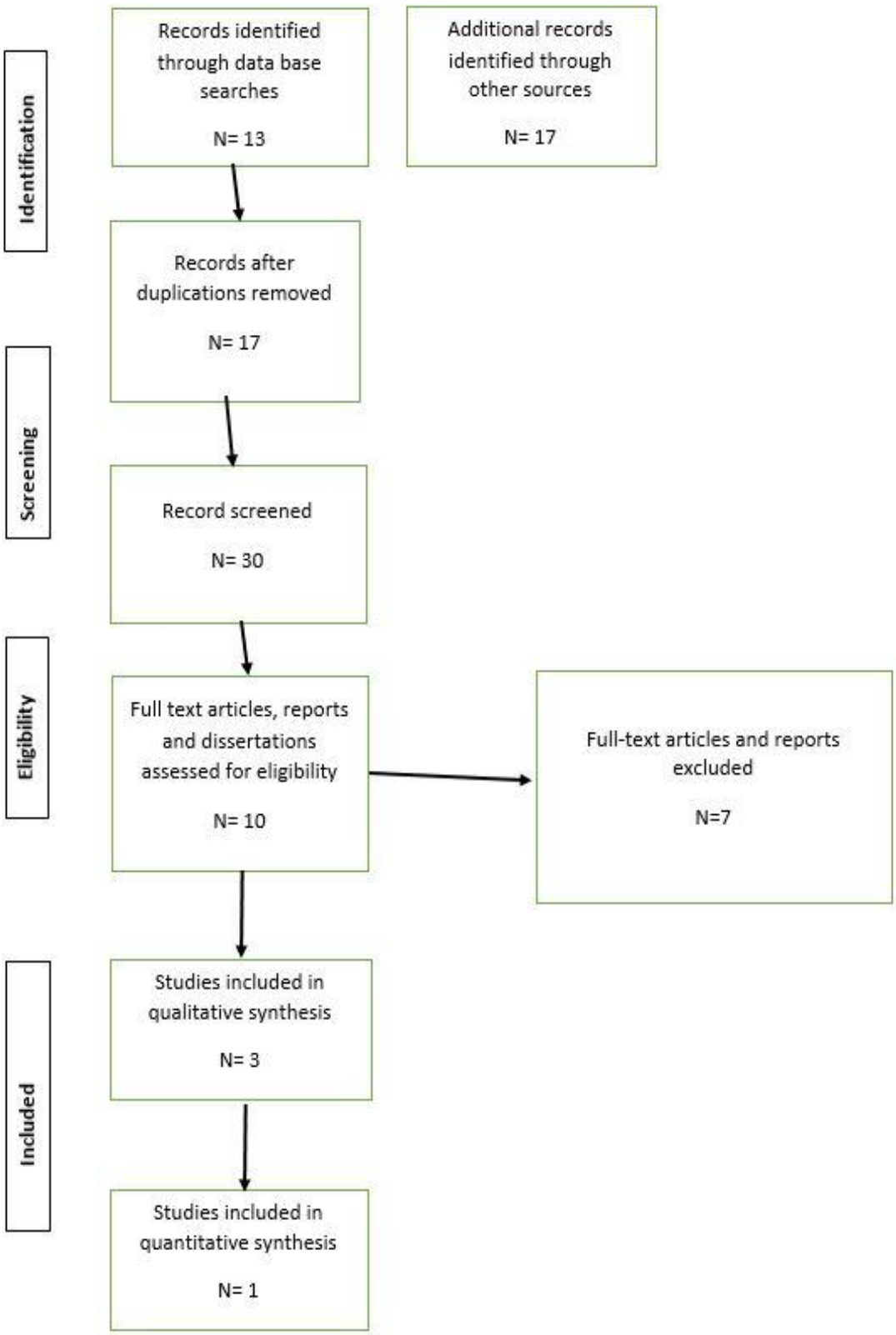

Fig. 1. Shows the selection Procedure of the reviews

Table 2. Data presentation

Journal	Title	Year	Author	Method	Sample size	Summary
The Royal Society of Tropical Medicine and Hygiene	Prioritization in Somali health system strengthening: a qualitative study	2016	Warsame A., Handuleh J., Patel P. [12]	Qualitative study	14	"Key priorities identified by participants were strengthening of local governance and management capacity; scaling-up efforts to structure a robust health financing mechanism; engagement with the burgeoning and dynamic private sector; as well as investing in the appropriate human resources for health. The study found that there was widespread agreement among participants that strengthening the health system through a coordinated system would improve long-term outcomes."
Dovepress	Beneficiaries of conflict: a qualitative study of people's trust in the private health care system in Mogadishu, Somalia.	2017	Gele, A. A., Ahmed, M. Y., Kour, P., Moallim, S. A., Salad, A. M., & Kumar, B. [13]	Qualitative study	23	"Almost all the medical doctors interviewed agreed that there is no functional government with the capability to provide public health care services to the people. Therefore, they think that government-related factors serve as barriers to an effective public health care system in the country. The factors mentioned include poverty, as well as the government's lack of competence and commitment to provide public services to its citizens."
------	Effect of United States–Somalia Partnership on Universal Healthcare Coverage for Women in Mogadishu City	2022	Mursal, A. [14]	quantitative and qualitative techniques	10 NGO 5 FGD	there is a general frustration among the top leadership of the ministries of health about the lack of funding and technical support to develop the health workforce. This frustration can be attributed to the fact that there is a shortage of both funds and technical support.
Somali Health Action	Strategies for post-conflict development of	2021	Omar, M. [15]	Review articles	---	"the post-conflict era in Somalia presents a one-of-a-kind chance for the growth and reform of the health sector. At this juncture, the health systems in Somalia are struggling under the double burden of a

Journal	Title	Year	Author	Method	Sample size	Summary
Journal	the Health Systems in Somalia: lessons from selected countries.					flawed pre-conflict health system, which was characterised by deficiencies and inequities, and the long-term impact of the conflict on the health status of the population, which has resulted in a strain on the health system. Both of these burdens have contributed to the current state of affairs.”

3. RESULTS

The online databases and search engines turned up a total of 30 entries, of which 17 were considered to have some degree of probable eligibility. Following the first screening, ten records met the criteria to be considered for inclusion in this review. The findings were arranged into categories according to each research objectives.

Warsame et al. [12] Key priorities identified by participants were strengthening of local governance and management capacity; scaling-up efforts to structure a robust health financing mechanism; engagement with the burgeoning and dynamic private sector; as well as investing in the appropriate human resources for health. The study found that there was widespread agreement among participants that strengthening the health system through a coordinated system would improve long-term outcomes.

Interviews with key informants were conducted with health and development professionals working in each of Somalia's three administrative regions, as well as with Somali officials from the Ministry of Health, global health and policy experts interested in the reconstruction of health systems in fragile states, and others. These interviews were used in the research study. In addition to this, a survey of the published and grey literature about Somalia, health systems, and fragile and conflict-affected nations was carried out with the use of PubMed and Reliefweb. A review was also conducted on the technical papers that were created for the creation of the Somali health system by foreign development partners.

Table 3. Characteristics of included studies

Author, Year	Title	UHC, Health System	Outcome	Methods used
Warsame A., Handuleh J., Patel P., (2016). [12]	Prioritization in Somali health system strengthening: a qualitative study	Health system	health system strengthening through a coordinated system would improve long-term capacity in Somalia’s health sector	Qualitative study
Gele, A. A., Ahmed, M. Y., Kour, P., Moallim, S. A., Salad, A. M., & Kumar, B. (2017). [13]	Beneficiaries of conflict: a qualitative study of people’s trust in the private health care system in Mogadishu, Somalia.	Health system	the private health care system in Mogadishu is not only unregulated but also expensive, with the cost of health care often unaffordable for the majority of the country’s citizens.	Qualitative study
Omar, M. (2021).[15]	Strategies for post-conflict development of the Health Systems in Somalia: lessons from selected countries.	Health system	The impact of conflict on the health status of population as well as health system can be catastrophic and felt for years.	Review articles
Mursal, A. (2022) [14]	Effect of United States–Somalia Partnership on Universal Healthcare Coverage for Women in Mogadishu City.	Universal health coverage	the main challenge is that resources required to implement are scarce and this ultimately impacts on long- term change and commitment to improving health services and systems strengthening	quantitative and qualitative techniques

According to Omar [15], the post-conflict era in Somalia presents a one-of-a-kind chance for the growth and reform of the health sector. At this juncture, the health systems in Somalia are struggling under the double burden of a flawed pre-conflict health system, which was characterised by deficiencies and inequities, and the long-term impact of the conflict on the health status of the population, which has resulted in a strain on the health system. Both of these burdens have contributed to the current state of affairs.

This paper presents a review and critical analysis of a paradigm for the rehabilitation of health systems in nations emerging from armed conflict. These kinds of skills and expertise may be put to use in the process of rehabilitating and developing health systems in Somalia along the lines of the health system building blocks outlined by the World Health Organization.

The effect of the conflict on the health status of the population and the health system can be catastrophic and be felt for years after the state has entered the post-conflict phase. However, the impact of the conflict presents an opportunity for reforms in the health sector in the conflict-affected state.

According to the findings of Gele et al. [13], the private health care system in Mogadishu is not only unregulated but also very costly. As a result, the majority of the country's residents are often unable to pay the expense of receiving medical treatment. There is evidence that patients are prescribed unsuitable treatments, that unnecessary laboratory tests are frequently performed, that an excessive amount of advanced diagnostic technology is utilised, and that excessive overcharging occurs; this includes the common practise of scheduling additional appointments for follow-up, which drives up the costs. The survey also concluded that there is widespread mistrust of the private health care sector and bad interactions between patients and providers.

The research conducted Between the months of August and November of 2016, a qualitative research project employing unstructured interviews was carried out in Mogadishu. Purposive sampling was used to recruit a total of 23 participants, including eight patients, five medical students, three senior officials from the Ministry of Health, three medical doctors who own private health clinics, and three senior officials from the Ministry of Health. A thematic analysis was used in order to make sense of the data.

Mursal [14] mentioned that there is a general frustration among the top leadership of the ministries of health about the lack of funding and technical support to develop the health workforce. This frustration can be attributed to the fact that there is a shortage of both funds and technical support. According to the findings of the research, the collaboration between the United States and Somalia had helped increase women's access to basic healthcare services. However, the study found that Somalians were unable to pay for secondary or specialised treatment. There is a health cluster within the government that is quite active and participates in the coordination of humanitarian efforts. However, the most significant obstacle is the scarcity of resources necessary for implementation, which, in the end, has an effect on the commitment to long-term change as well as the improvement of health services and the reinforcement of health systems.

In this study, a mixed-methods research design was applied, and both quantitative and qualitative approaches were used to obtain and analyse the data.

3.1 To Determine Strategies in Place for Universal Health Coverage in Somalia

Studies on strategies for universal health coverage were very limited.

Advance Universal Health Coverage.

Advance UHC by accelerating the PHC-led recovery with a view to supporting the goals of integrated health services:

Support implementation of the revised EPHS 2020 as a way to achieve health for all by all, especially targeting the most vulnerable and disadvantaged people.

Develop and implement a strategy for development, recruitment and retention of the health workforce for delivery of the EPHS and to tackle the acute shortage of health workers.

Promote health actions and services linking short-term relief with long-term development goals, in line with the humanitarian–

development–peace nexus, and reinforcing coherent, integrated planning and implementation to achieve collective goals in the transition to peace and health.

Implement key, evidence-based mother and child health interventions with proven effectiveness in settings with limited resources.

Optimize community health worker programmes and invest in community-based interventions for disease prevention and control, and delivery of preventive, promotive and curative health services as part of an effective and equitable approach to expand access to PHC.

Promote innovations in health services, for instance use of solar power to provide medical oxygen, to accelerate progress in health.

Addressing health emergencies and disease out-breaks, 1.6 million more people protected from health emergencies.

Promoting healthier populations, 1.6 million more people enjoying better health and well-being.

3.2 To Determine the Challenges of Universal Health Coverage in Somalia

Proper community and population platforms are missing; further there is no clear strategic direction on inter-sectoral interventions and people centred service delivery approaches.

Somalia has the lowest UHC index (22) in the world.13 Review of EPHS based on Disease Control Priorities-3 (DCP3)16 indicates that overall only 45 (20.5 percent) of the 219 globally recommended essential universal health coverage (EUHC) interventions are being implemented, while Somali EPHS (2009) has only 14 (6.4 percent) of the 219 globally recommended essential health services Somali EPHS (2009) does not have all five platforms for essential services i.e. Community level, Health centre, First-level hospital, Referral hospital and Population based.

3.3 Poor Health Work Force

With expansion of scope of EPHS aligned to EUHC, human resources for health may not have the right capacities and skills.

According to Warsame et al. (2015) It would appear that the most significant obstacle is the availability of health care providers. The quick and ongoing "brain drain" that was created by the civil war was cited as the cause of this difficulty by a significant percentage of participants. Inadequate numbers of public sector health practitioners are only one of the many obstacles standing in the way of equitable geographical distribution and high-quality medical attention. It was also stressed that many kinds of health workers, such as providers of mental health services, were in short supply. Many of the participants held the opinion that the quality of education and training played a significant role in the decline of the overall level of service offering. In addition, a considerable number of medical professionals are concentrated in major urban areas, which results in a substantial shortage in the provision of healthcare in rural areas.

3.4 Provision of Drugs and Other Medical Supplies

“The provision of safe and reliable pharmaceuticals has been a persistent challenge in the Somali health system. The sale of pharmaceuticals represents one of the largest sections of the privatized Somali health economy. One of the challenges of this largely unregulated industry is that it is difficult to assess quality and authenticity of medicines. This is due, however, to the weak capacity of health authorities and deep economic interests in the industry (Warsame et al. 2015).”

3.5 Cost of Delivering UHC

According to one estimate, the requirement for achieving Universal Health Coverage (UHC) is of US$271 per person per year (range 74–984) across country contexts.14 Somali is very far away even from reaching the lower limit of US$ 74 per capita per year, with a current per capita total health expenditure (THE) of around US$21-24 including US$8-10 as OOP expenditure and only US$13-15 through public sector which is also mainly through budgetary donor support (FMoH, 2019).

Very high poverty level in Somalia is also reflected in the estimated out-of-pocket (OOP) expenditure in Somalia, which is surprisingly very low at 38 percent17 (inability to pay). Many specialized services are not available in the country and people are dependent on financial

support from Somali diaspora or other means which lead to catastrophic health expenditure. Alternatively, most of the poor people have no option but to access services from private sector pharmacies which don't have qualified staff (FMOH, 2021).

The instability of service provision in the context of restricted government spending and unclear support from donors Since the existing system has a tax base that is practically nonexistent, it is primarily dependent on donations from outside parties, which makes the system completely susceptible. It is complete and utter dependence. This opinion was also mirrored by development partners, who identified low government expenditures and primarily earmarked donor funds as important budgetary obstacles. Development partners also acknowledged a lack of financial resources available from the government (Warsame et al. 2015).

3.6 Insecurity

According to Warsame et al. [12] the majority of interviewees identified insecurity as one of the most significant challenges facing the Somali health system, particularly in some regions of southern and central Somalia. It was said that having long-term security is a precondition for maintaining and attracting skilled health workers, and this makes perfect sense. Instability on the political front, as well as a high attrition rate within the federal Ministry of Health as a result of that instability, was cited as a significant barrier to long-term advancement.

4. DISCUSSION

When we talk about universal health coverage (UHC), we mean making sure everyone can afford the medical attention they need. Universal health care enables nations to maximise the value of their most valuable resource: their people.

The were no studies or reviews focused on the strategies of universal health coverage in Somalia, other hand the governmental and organizational documents and reports we found were not detailed are very or clearly defined the strategies.

The Universal Health Coverage (UHC) Index for Somalia is the lowest in the world, at 0.025, meaning that just 25% of the population had access to the minimum necessary health care services in 2017. Compared to the rest of Africa, this is shockingly low. The 2019 Global Health Security Index, which examines a country's ability to avoid, identify, and respond to health emergencies, ranks Somalia's health system as the world's second-weakest [9].

4.1 Poor Health Workforce

As stated Warsame et al. [12] In Somalia, there is a severe shortage of medical personnel across all specialties. The low health workforce ratios that existed before the war have worsened as a result of high levels of emigration among healthcare workers. As a result, there are now an estimated three physicians per 100,000 populations (a total of 253 physicians), 11 nurses per 100,000 populations (861 nurses), and two midwives per 100,000 populations (116 midwives) serving the entire country [16].

In addition, in order to realise the goal of universal health coverage (UHC), it is necessary to make investments in healthcare infrastructure, such as the recruitment and retention of medical personnel in Africa. According to the World Health Organization (WHO), in order to attain universal health coverage by the year 2030, more than 18 million extra health professionals would be needed; hence, there is a need to provide healthcare employees in low- and lower-middle-income nations. In order to achieve universal health coverage, it is essential to make significant strides toward improving the infrastructure of the health system. This includes things like ensuring access to basic healthcare, training and retaining healthcare workers, and developing healthcare facilities. This is especially important in regions with limited resources, such as Africa [17].

According to Bogren et al.'s [18] findings, the lack of qualified medical professionals in Nepal and Somalia was a major factor in the restricted access to high-quality medical treatment in those two countries. Because of this, the medical facilities were only open for a few hours each day, which had a detrimental effect on the delivery of healthcare services.

The healthcare providers believe that the availability of quality healthcare services could be ensured if there was an adequate payment system for their salaries, as opposed to the current situation, in which they are required to work multiple jobs in order to receive a regular salary. Because of how things are now, they

have to work more than one job to get a steady pay check.

Somalia needs more medical and nursing staff to meet the needs of different parts of the country. The identification of such needs, however, requires more precise data on population health measures. Even if help from abroad is essential, it is the local workforce that will be most instrumental in bringing about long-term change. It's crucial not to skimp on investing in better service organisation and training for medical staff [11].

It is very necessary for a nation to have a sizable workforce in the medical field in order to guarantee continued access to high-quality medical treatment. The shortage of competent healthcare personnel in Africa is a significant barrier to achieving universal health coverage and has been for some time. Africa has a big problem with not having enough doctors, nurses, and midwives. This is because not enough people have worked in the healthcare field before [19].

4.2 Provision of Drugs and Other Medical Supplies

Warsame et al. [12] pointed out that the supply of services might be unpredictable due to the unpredictability of donor money and the restrictions placed on government expenditure. ‘Because there is not much of a tax base, the existing system is primarily reliant on donations from outside parties, which makes it very susceptible to attack.

Even though medicine was provided to hospitals free of charge, the healthcare practitioners in both nations indicated that there was a restricted supply of medication owing to corruption at higher levels of hospital administration. According to the statement of one participant from Nepal, the government is responsible for providing medication, but the administration of hospitals keeps all of the money for itself. Patients have to buy the medicine from the pharmacist instead of getting it from their doctor [18].

The provision of safe and reliable pharmaceuticals has been a persistent challenge in the Somali health system. The sale of pharmaceuticals represents one of the largest sections of the privatized Somali health economy [12].

Access to necessary medications remains a challenge in many African countries, notwithstanding the little headway that has been achieved toward the realisation of UHC in those regions. Lack of knowledge, insufficient finance, and poor management at pharmaceutical businesses are the primary factors contributing to the difficulties associated with gaining access to pharmaceuticals on the African continent. Another issue is that certain health insurance providers will not pay for certain medications; as a result, those who are already in precarious financial situations are perpetually left out in the cold [17].

4.3 Cost of Delivering UHC

Regrettably, there is a significant cause for worry on the basis of financial risk protection in Somalia. Due to the ineffectiveness of the Federal Government of Somalia's revenue system, the two most major sources of finance for the health sector are private expenditure and development aid for health; nevertheless, private health insurance does not exist. It was noted that there were significant out-of-pocket expenses (OOP) [20].

Due to a shortage of cash or revenue, several different African governments were forced to increase their budgets by 15% in order to meet the objective set in Abuja in 2001 for providing healthcare services. But by 2014, only four African countries—Ethiopia, the Gambia, Malawi, and Swaziland—had reached and kept the Abuja goal [19].

One of the most significant challenges is maintaining the salary of national health workers [21]. However, incentives for health professionals that are dispersed in an appropriate manner have the potential to also have the capability of redressing the imbalance between rural and urban health employees. One review found that there was little evidence to support the occurrence of this transition in several fragile states, despite the fact that several participants mentioned the large-scale reliance on donor funding and the need to shift toward locally generated financing mechanisms. This was despite the fact that several participants mentioned the need to shift toward locally generated financing mechanisms [22]. Building up the local capacity in Somalia should be a top priority, and this calls for some foreign non-governmental organisations to shift their focus

from being service providers to being capacity builders.

Research that was carried out in the past focused on health funding, and their findings revealed that financial restrictions constitute a substantial barrier to gaining access to excellent healthcare services in LMICs. This would imply that individuals who are responsible for covering the price of their own medical care are often unable to get the treatments that they need. Therefore, in order to move toward universal health coverage, health systems and robust financial mechanisms in all nations need to be strengthened [23].

The lack of health financing in addressing availability, and subsequently acceptability, can be seen as a lack of national planning which hampers efforts at all system levels.

In spite of the insurmountable obstacles, the whole system has been quietly expanding and reviving its glorious past via the implementation of a decentralised health governance structure through the ministries of health at the federal and member state levels [2].

As stated Hammond and Lee, [24] Because the power dynamics that govern the political economy of aid have become so entrenched, especially in south central Somalia, there has been a significant loss of trust between the different stakeholders, as well as an increase in insecurity for humanitarian staff, such as health workers living in the most conflict-affected areas, which has severely limited the space for humanitarian assistance [25-38].

5. CONCLUSION

The strategies on achieving universal health coverage were limited on advancing UHC on accelerating primary health care led recovery, promote healthier population, and address emergencies and disease outbreaks. While poor health workers, limited provision of drugs and other medical supplies, insecurity and cost of delivering were the most challenges reported in achieving universal health coverage in Somalia.

6. RECOMMENDATIONS

Capacity building for health workers for peter provision of health services, establishing reliable funding for the health care financing.

Further studies should also be Conducted on Health systems and universal health coverage on Somalia, future studies should attempt to broaden the pool of informants as much as possible in order to obtain a greater scope of views.

7. STUDY LIMITATION

Mostly we relied on reports and governmental documents because of Lack of published Universal Health Coverage and health literature on Somalia.

CONSENT AND ETHICAL APPROVAL

It is not applicable.

COMPETING INTERESTS

The author declared that there is no conflict of interest. The researcher fills out research approval form to the declare that there is no conflict of interest on conducting this study.

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