Mental Health is Universal Health Coverage: Somalia's Hardest Test and Its Biggest Opportunity

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Universal Health Coverage (UHC) is often described with three tidy promises: access, quality, and financial protection. In practice, those promises collide with messy realitiesespecially in fragile contexts. Nowhere is that collision more visible than at the intersection of mental health and UHC in Somalia.

Mental health is not a "nice to have" service you add once everything else is perfect. In many countries, it is the litmus test of whether UHC is real. Why? Because mental health care depends on the things health systems most struggle to do well: sustained financing, trusted primary care, a protected workforce, reliable medicines, respectful services, and community legitimacy. When those foundations are weak, mental health falls off the map firstyet the costs (social, economic, and human) show up everywhere.

The reality check: Somalia's UHC gap is also a mental health gap

Somalia's broader UHC constraints are severe. Recent health system analysis highlights that less than 30% of the population has access to essential health services, service delivery is fragmented and urban centered, and the health information system (HIS) is close to absent in many placesmaking evidence based planning and accountability extremely difficult.

On financing, the problem is not just "too little money," but how families pay. A major share of health spending comes directly from households via out of pocket (OOP) payments, exposing people to catastrophic costsexactly what UHC is meant to prevent.

And the macro picture is unstable: the national health budget share reportedly declined sharply from 8.5% of total government expenditure in 2023 to 4.8% in 2024, making long term reforms harder to sustain.

Now place mental health inside that system.

A Somalia focused mental health situation analysis reports that approximately one in three Somalis has experienced a mental health condition, while service capacity remains extremely

limitedillustrated starkly by 0.5 psychiatric beds per 100,000 people (far below regional and global comparisons).

Even more worrying is the access gap: empirical findings describe an 80–90% treatment gap, with average delays of around 3.5 years before people seek assistance, and heavy reliance on non formal careone cohort reporting 85% sought support from traditional or Koranic healers at least once.

That's not a minor service deficiency. That's a system level signal: mental health need is widespread, but the delivery and financing architecture is not yet built to meet it.

Why mental health is the "stress test" of UHC

If UHC were a bridge, mental health is the weight you roll across it to see if it collapses. Four reasons:

1) Mental health needs continuity, not one off encounters

Many mental health conditions improve best through ongoing care (follow up, adherence support, brief psychological interventions, relapse prevention). Fragmented care modelscommon in fragile settingsturn this into a revolving door.

2) Mental health depends on trust

Stigma and fear can block demand even when services exist. A Mogadishu focused study on utilization describes deep rooted cultural beliefs where mental illness may be perceived as "shame" (ceeb) or spiritual afflictiondriving concealment, mistrust of formal services, and preference for traditional healers.

3) Mental health is where financing design either worksor fails

Financial protection is not just "having insurance." It's knowing what is covered, having predictable pathways, and being able to use care without financial shock. Research among government and private employees in Mogadishu identifies an "insurance paradox": individuals may have insurance, yet remain unclear whether their plan covers mental health, and this ambiguity becomes a barrier to service use.

4) Mental health sits upstream of everything else

Untreated depression, anxiety, trauma, and substance use disorders can worsen maternal health outcomes, adherence to TB/HIV care, NCD control, school participation, employment stability,

and community safety. In other words: mental health is a multiplier for harm when neglected, and for progress when supported.

Somalia's specific challenges at the mental health–UHC intersection

A. Fragmented delivery + urban concentration = predictable inequity

Somalia's system is described as pluralistic and fragmented, with service delivery largely undertaken by private sector providers, NGOs, and humanitarian actors often operating in parallel resulting in duplication and gaps.

Mental health services mirror that pattern: limited specialized care and heavy urban concentration leave rural, nomadic, and displaced communities underserved.

B. Severe workforce constraints especially specialized capacity

UHC analysis notes a workforce density around 0.11 clinicians per 1,000, far below commonly cited thresholds, constraining service delivery and making equitable coverage difficult.

Mental health capacity is even thinner: the situation analysis emphasizes extremely limited specialist availability and that most outpatient mental health care is delivered by general clinicians with brief training.

C. Stigma isn't a side issue it's a system barrier

When people fear being labeled, avoided, or disrespected, they delay care. The Mogadishu utilization study describes stigma and cultural interpretations as major independent deterrents, shaping help seeking regardless of perceived financial capacity.

D. "Paying out of pocket" makes mental health a luxury by default

High OOP spending is repeatedly identified as a fundamental barrier to access and financial protection.

For mental health, this often means: families either do nothing, seek informal care, or pay privately in crisis when costs (and harm) are highest.

E. Youth substance use is rising and it is tied to trauma, unemployment, and access gaps

A mixed methods study of youth in Mogadishu (ages 12–25) links narcotics use drivers to peer pressure, unemployment, easy availability, and coping with stress/trauma; it also highlights that homeless youth are exceptionally vulnerable.

This is not separate from UHCit's part of the same mental health ecosystem. If UHC ignores prevention, addiction services, and youth friendly care, costs migrate to policing, prisons, and emergency rooms.

F. Weak information systems make mental health "invisible"

Without functional HIS and consistent reporting, mental health outcomes and service coverage don't show up in dashboardsso they don't show up in budgets. Somalia's near absence of robust HIS and reliable data infrastructure is explicitly flagged as a barrier to evidence based planning and monitoring.

The hopeful part: Somalia already has seeds of a workable pathway

Hope isn't a motivational poster; it's a plan with early traction.

The mental health analysis points to momentum from the rollout of mhGAP (training frontline workers to recognize and manage common mental disorders) and emerging rights based reforms, emphasizing that integrating mental health into primary care is gaining traction and early outcomes are promising.

Separately, the Mogadishu utilization work notes that mental health services are integrated into the Essential Package of Health Services (EPHS)which is crucial because EPHS is the practical "delivery spine" for UHC in constrained systems.

So the strategic question becomes:

> How do we turn these piecesEPHS, mhGAP, emerging insurance, private sector presenceinto one coherent, financed, trusted mental health pathway under UHC?

A practical roadmap: making mental health a "first class citizen" of UHC in Somalia

Below is a scientifically grounded, Somalia fit set of actionsorganized like a health system, not a wish list.

1) Define the mental health "minimum guarantee" inside EPHS

Start with a clear, limited, high impact benefit set delivered at primary care level:

1. Identification and basic management of depression, anxiety, trauma related distress, psychosis, and epilepsy (as relevant in mhGAP)

2. Brief psychological interventions (problem solving counseling, basic CBT informed techniques)

3. Essential psychotropic medicines list + reliable supply chain

4. Clear referral pathways for acute cases and continuing care

Why this matters: clarity is how systems become fundable and measurable.

2) Make financing real: pooled funding + explicit coverage rules

UHC analysis underscores that the heavy OOP burden and weak pooled mechanisms are central obstacles.

For mental health, financing must do three things:

❖ Reduce OOP at point of care (through subsidies, contracting, or insurance coverage)
❖ Pay for continuity (follow ups, counseling sessionsnot only one time visits)

❖ Protect the poorest and displaced (targeted exemptions or vouchers, aligned with EPHS)

A crucial insight from the Mogadishu insurance/utilization work: coverage ambiguity suppresses use even among insured groups. So policy should require explicit mental health benefit design and plain language communication to members.

3) Use task sharing as the engine (because specialists are too few)

Somalia cannot wait for a psychiatrist per district future before scaling care. The path is task sharing:

❖ Train general practitioners, nurses, and midwives in mhGAP competencies
❖ Train community health workers to detect distress early, support adherence, and reduce drop out
❖ Create supervision ladders (specialist → general clinician → CHW)

This approach is directly aligned with mhGAP's design and the call to integrate mental health into primary health care.

4) Build stigma reduction into the service modelnot as a side campaign

❖ Since stigma is a major determinant of low utilization, it must be tackled where people meet the system:
  ○ Private consultation spaces and confidentiality protocols
  ○ Respectful language and anti discrimination training for staff
  ○ Community dialogues with religious and traditional leaders (as allies, not competitors)
  ○ School based mental health literacy

The utilization study's finding that stigma and cultural perceptions deter help seeking suggests demand will remain suppressed unless services are culturally safe and trusted.

5) Integrate youth substance use prevention and treatment into UHC planning

The narcotics study is blunt: drug availability, unemployment, peer influence, and stress/trauma are drivers; multisectoral action and youth friendly rehabilitation are urgent.

A UHC aligned response includes:

- ❖ Youth friendly counseling services at PHC level
- ❖ Referral links to non stigmatizing rehab and psychosocial services
- ❖ Pharmacy regulation enforcement (to reduce non medical access to controlled medicines)
- ❖ Employment/skills pathways (because prevention is also socioeconomic)

6) Make mental health visible in HIS: measure what you claim to value

If Somalia's HIS is weak and fragmented, mental health will remain undercounted and underfunded.

Minimum indicators (simple, feasible) could include:

- ❖ PHC mental health screenings conducted

- ❖ Diagnoses by category (mhGAP aligned)

- ❖ Follow up rates at 1 month and 3 months

- ❖ Medicine stock out days for essential psychotropics

- ❖ Referrals completed

Perfection is not required. Consistency is.

7) Regulate and contract the private sector toward public goals

Somalia's health delivery reality includes strong private presence. The question is not "public vs private," but "aligned vs parallel." UHC analysis emphasizes fragmentation and the need for integration and stronger regulatory oversight.

Contracting arrangements can tie payments to:

- ❖ EPHS service provision (including mental health components)
- ❖ Fee caps and transparency
- ❖ Quality standards and reporting into HIS
- ❖ Referral collaboration

Scientifically grounded advice: what different actors can do now

For policymakers and health leaders

- ❖ mental health as EPHS core, not a vertical project.
- ❖ Protect financing for primary care + mental health integration, even during fiscal shocks (because discontinuity creates long term costs).
- ❖ Require explicit mental health benefits in insurance schemes; ambiguity is policy failure in slow motion
- ❖ Scale mhGAP with supervision, not one off trainingsskills decay without mentorship.

For clinicians and facility managers

- ❖ Implement stepped care: start with brief interventions and follow up, escalate to referral when needed.
- ❖ Use measurement based care (simple symptom scales; track change over time).
- ❖ Create confidential pathways to reduce stigma related drop off, acknowledging that fear of shame (ceeb) can block care.

For employers, insurers, and large institutions

- Publish a one page "What is covered" mental health summary (benefits, limits, referral steps).

- Train HR focal points to guide staff confidentially to care.

- Contract provider networks that can deliver follow up care, not just one visit.

This directly addresses the utilization "insurance paradox" where coverage ambiguity undermines access.

For communities, educators, and faith leaders

➢ Promote the idea that mental distress is treatable and compatible with faith and tradition.
➢ Normalize early support: people delay for years; shortening that delay changes outcomes.
➢ Build youth protective factors: belonging, mentorship, safe recreation, and pathways into skills and workbecause substance use is often a coping strategy for stress and trauma.

For individuals and families (practical, evidence based steps)

- Notice patterns, not labels: persistent sleep disruption, irritability, withdrawal, hopelessness, or loss of function are signals to seek support.

- Start where access exists: primary care clinicians trained in mhGAP can provide meaningful first line help.

- Prefer early care over crisis care: earlier support usually means shorter, cheaper, more effective care.

- If cost is the barrier, ask specifically about fees, follow up options, and any coverageuncertainty is common and solvable through clear information pathways.

The big idea: mental health isn't a sectorit's infrastructure

Somalia's UHC journey has to navigate federal complexity, insecurity, climate shocks, private sector dominance, donor fragmentation, and constrained fiscal space.

That's a tall order.

But mental health offers a strange and powerful advantage: if you build a system that can deliver trusted, continuous, affordable mental health care, you have almost automatically built a system

capable of delivering other chronic care priorities tooNCDs, maternal follow up, TB adherence, rehab, disability services. Mental health is the "canary in the coal mine," but it's also the blueprint for modern primary care.

Somalia's story, therefore, does not have to be "burden without capacity." The pieces already exist: EPHS as the delivery spine, mhGAP as the workforce multiplier, emerging insurance as a financing entry point, and growing national will to reduce fragmentation and strengthen stewardship.

The hopeful future is not abstract. It looks like:

- a mother in an IDP settlement receiving respectful counseling at a PHC visit,

- a young man getting early help for trauma before it becomes addiction,

- a teacher recognizing distress and connecting a student to care,

- an insured employee actually knowing their mental health benefit and using it without fear.

That is what UHC means when it stops being a slogan and starts being a system.

And yesSomalia can build that system. The universe is weird, but health reform is weirder: sometimes the hardest service to deliver becomes the one that finally forces everything else to work.

Mental Health as the Litmus Test for Universal Health Coverage in Somalia

Universal Health Coverage (UHC) is typically defined by three core principles: access, quality, and financial protection. In practice, these principles often clash with complex realities, particularly in fragile contexts like Somalia. Nowhere is this tension more acute than at the intersection of mental health and UHC.

Mental health services are not an optional addition once a health system is fully mature; they represent the true test of UHC's efficacy. This is because effective mental health care requires what health systems frequently struggle to sustain: reliable financing, robust primary care integration, a protected workforce, dependable medicine supply, respectful service delivery, and

community trust. When these foundations are weak, mental health care is the first to fail, yet the resulting social, economic, and human costs become pervasive.Contextual Challenges: Somalia's Mental Health and UHC Gap

The broader constraints on Somalia's UHC are severe. Recent health system analysis indicates that less than 30% of the population has access to essential health services, delivery is fragmented and concentrated in urban centers, and the Health Information System (HIS) is often non existent, complicating evidence based planning and accountability.

On financing, the issue is not solely insufficient funding but the detrimental payment mechanisms. A significant portion of health expenditure comes directly from households through out of pocket (OOP) payments, exposing families to catastrophic costsprecisely what UHC is designed to prevent. This precarious macro picture is compounded by reports of a sharp decline in the national health budget's share of total government expenditure, from 8.5% in 2023 to 4.8% in 2024, which threatens long term reform sustainability.

Within this environment, the mental health landscape is particularly dire. A Somalia focused mental health situation analysis estimates that approximately one in three Somalis has experienced a mental health condition, while service capacity remains profoundly limited.

This is starkly evidenced by the availability of only 0.5 psychiatric beds per 100,000 people, significantly below regional and global benchmarks. The access gap is even more concerning: empirical findings describe an 80–90% treatment gap, with average delays of approximately 3.5 years before individuals seek formal assistance. Consequently, there is a heavy reliance on non formal care, with one cohort reporting that 85% sought support from traditional or Koranic healers at least once.

This signifies a systemic failure, where widespread mental health needs cannot be met by the current delivery and financing architecture.Why Mental Health is the Litmus Test of UHC

If UHC represents the health system's operational capacity, mental health is the critical load test. This is due to four key factors:

1. Demand for Continuity, Not Single Encounters:

Effective treatment for many mental health conditions relies on sustained, ongoing care, including follow up, adherence support, brief psychological interventions, and relapse

prevention. Fragmented, single encounter care modelsprevalent in fragile settingscreate a perpetual cycle of relapse and readmission.

2. Dependence on Trust and Safety:

Stigma and fear are formidable barriers that suppress demand even when services are physically available. A Mogadishu focused utilization study highlights deep rooted cultural beliefs where mental illness is perceived as "shame" (*ceeb*) or spiritual affliction. This drives concealment, mistrust of formal services, and a pronounced preference for traditional healers.

3. Sensitivity to Financing Design:

Financial protection extends beyond the presence of insurance. It requires clear benefit packages, predictable pathways to care, and the ability to utilize services without incurring financial shock. Research among government and private employees in Mogadishu identified an "insurance paradox": many insured individuals remain uncertain if their plan covers mental health, and this ambiguity itself acts as a barrier to service use.

4. Upstream Impact on Overall Health:

Untreated conditions such as depression, anxiety, trauma, and substance use disorders invariably worsen other public health outcomes, including maternal health, adherence to TB/HIV care, NCD control, school participation, employment stability, and community safety. Mental health acts as a crucial multiplier: neglecting it exacerbates harm, while supporting it accelerates progress across the entire health system.Somalia's Specific Challenges at the Mental Health–UHC Nexus

A. Fragmentation and Urban Concentration:

Somalia's health system is pluralistic and fragmented, with service delivery heavily reliant on the private sector, NGOs, and humanitarian actors often operating in parallel, leading to duplication and service gaps. Mental health services mirror this pattern, with limited specialized care and heavy urban concentration leaving rural, nomadic, and displaced communities critically underserved, resulting in predictable inequity.

B. Severe Workforce Constraints:

UHC analysis notes a workforce density of around 0.11 clinicians per 1,000 population, significantly below common benchmarks. This severely constrains service delivery and makes equitable coverage difficult. Mental health capacity is even scarcer: the situation analysis emphasizes extremely limited specialist availability, with most outpatient mental health care being delivered by general clinicians with minimal training.

C. Stigma as a Systemic Barrier:

Fear of being labeled, avoided, or disrespected leads to care delay. The Mogadishu utilization study describes stigma and cultural interpretations as major independent deterrents, profoundly shaping help seeking regardless of perceived financial capacity.

D. Out of Pocket Payment (OOP) Makes Mental Health a Luxury

High OOP spending is consistently identified as a fundamental barrier to access and financial protection. For mental health, this often means families either forgo care, seek informal support, or pay privately during a crisiswhen costs and potential harm are at their highest.

E. Rising Youth Substance Use:

A mixed methods study of youth (ages 12–25) in Mogadishu links narcotics use to drivers such as peer pressure, unemployment, easy availability, and coping with stress and trauma, with homeless youth being exceptionally vulnerable. This issue is inseparable from UHC; if the system neglects prevention, addiction services, and youth friendly care, costs inevitably migrate to law enforcement, correctional facilities, and emergency rooms.

F. Weak Information Systems Render Mental Health Invisible:

Without functional HIS and consistent reporting, mental health outcomes and service coverage remain off the monitoring dashboardsand thus outside budget priorities. Somalia's near absence of robust HIS and reliable data infrastructure is explicitly flagged as a primary barrier to evidence based planning and monitoring.Emerging Pathways: Seeds of a Workable Strategy

Hope is grounded in existing momentum. The mental health analysis points to traction from the rollout of the Mental Health Gap Action Programme (mhGAP), which trains frontline workers in recognizing and managing common mental disorders.

Early outcomes of integrating mental health into primary care are promising. Crucially, the Mogadishu utilization work notes that mental health services are integrated into the Essential Package of Health Services (EPHS), which serves as the practical "delivery spine" for UHC in resource constrained settings.

The strategic question is how to synthesize these elementsEPHS, mhGAP, nascent insurance schemes, and the private sector presenceinto one coherent, financed, and trusted mental health pathway under UHC.A Practical Roadmap: Establishing Mental Health as a Core UHC Component

The following set of scientifically grounded, Somalia fit actions are organized around strengthening the health system:

1. Define a Mental Health Minimum Guarantee within EPHS
A clear, limited, high impact benefit set should be guaranteed at the primary care level:
- Identification and basic management of depression, anxiety, trauma related distress, psychosis, and epilepsy (aligned with mhGAP).
- Brief psychological interventions (e.g., problem solving counseling, basic CBT informed techniques).
- An essential psychotropic medicines list supported by a reliable supply chain.
- Clear referral pathways for acute cases and continuing specialized care.

Rationale: **Clarity is essential for system fundability and measurability.**

2. Secure Financing: Pooled Mechanisms and Explicit Coverage
UHC analysis confirms that a heavy OOP burden and weak pooled mechanisms are central obstacles. Mental health financing must:
- Reduce OOP payments at the point of care through subsidies, contracting, or insurance coverage.
- Compensate for continuity of care (follow ups, counseling sessions), not just one time visits.
- Protect the poorest and displaced populations via targeted exemptions or vouchers, aligned with EPHS.

Crucial Insight: Coverage ambiguity, as identified in the Mogadishu insurance/utilization work, suppresses use even among insured groups. Policy must therefore mandate explicit mental health benefit design and transparent, plain language communication to members.

3. Implement Task Sharing as the Workforce Strategy

Somalia cannot delay scaling care until a sufficient psychiatrist workforce is available. The path is task sharing:

- Train general practitioners, nurses, and midwives in mhGAP competencies.
- Train community health workers (CHWs) to detect early distress, support adherence, and reduce drop out rates.
- Establish clear supervision ladders (specialist → general clinician → CHW).

Rationale: This approach aligns directly with mhGAP's design and the imperative to integrate mental health into primary health care.

4. Embed Stigma Reduction into the Service Model

Since stigma is a major determinant of low utilization, it must be proactively addressed at the service delivery point:

- Ensure private consultation spaces and strict confidentiality protocols.
- Provide anti discrimination training for staff, emphasizing respectful language.
- Engage religious and traditional leaders in community dialogues as allies.
- Introduce school based mental health literacy programs.

Rationale: The finding that stigma and cultural perceptions deter help seeking demonstrates that demand will remain suppressed unless services are culturally safe and trusted.

5. Integrate Youth Substance Use Prevention and Treatment into UHC:

The narcotics study is unequivocal: drug availability, unemployment, peer influence, and stress/trauma are key drivers. A UHC aligned response includes:

- Youth friendly counseling services at the Primary Health Care (PHC) level.
- Referral links to non stigmatizing rehabilitation and psychosocial services.
- Rigorous enforcement of pharmacy regulation to curb non medical access to controlled medicines.
- Investment in employment and skills pathways, recognizing that prevention has a socioeconomic dimension.

6. Enhance Visibility in HIS: Measure Valued Outcomes:

If Somalia's HIS is weak, mental health will remain undercounted and underfunded. Simple, feasible minimum indicators should be implemented:

- Number of PHC mental health screenings conducted.
- Diagnoses by category (mhGAP aligned).
- Follow up rates at 1 and 3 months.
- Medicine stock out days for essential psychotropics.
- Referrals completed.

Rationale: **Consistency in data collection is more vital than initial perfection.**

7. Regulate the Private Sector to Achieve Public Goals

Given the strong private sector presence, the goal is alignment, not separation. UHC analysis stresses the need for integration and stronger regulatory oversight. Contracting arrangements should tie payments to:

- Provision of the EPHS mental health components.
- Fee caps and price transparency.
- Adherence to quality standards and reporting into the HIS.
- Collaborative referral systems.

Scientifically Grounded Advice for Key Actors

For Policymakers and Health Leaders

- **Prioritize:** Treat mental health as a core EPHS component, not a vertical project.
- **Protect Funding:** Safeguard financing for primary care and mental health integration, even during fiscal shocks, to prevent costly long term discontinuity.
- **Ensure Clarity:** Mandate explicit mental health benefits in insurance schemes; ambiguity is policy failure in slow motion.
- **Invest in Quality:** Scale mhGAP with sustained supervision, as skills erode without mentorship.

For Clinicians and Facility Managers

- **Implement Stepped Care:** Begin with brief interventions and follow up, escalating to referral when necessary.
- **Use Measurement:** Apply measurement based care (e.g., simple symptom scales) to track patient change over time.
- **Cultivate Trust:** Create confidential pathways to reduce stigma related drop off, acknowledging that the fear of shame (*ceeb*) can block care.

For Employers, Insurers, and Large Institutions
- **Communicate Clearly:** Publish a concise "What is Covered" mental health summary detailing benefits, limits, and referral steps.
- **Facilitate Access:** Train HR focal points to confidentially guide staff to care.
- **Contract for Continuity:** Contract provider networks capable of delivering follow up care, not just acute visits.

For Communities, Educators, and Faith Leaders
- **Promote Acceptance:** Normalize the idea that mental distress is treatable and compatible with faith and tradition.
- **Encourage Early Support:** Normalize seeking help early; shortening the average delay of years fundamentally improves outcomes.
- **Build Protective Factors:** Invest in youth protective factors: belonging, mentorship, safe recreation, and pathways into skills and work, recognizing that substance use is often a coping strategy for trauma and stress.

For Individuals and Families (Practical Steps)
- **Focus on Patterns:** Observe persistent sleep disruption, irritability, withdrawal, hopelessness, or loss of function as signals to seek support.
- **Start with PHC:** Begin with primary care clinicians trained in mhGAP, who can provide meaningful first line help.
- **Prioritize Early Care:** Choose early support over crisis intervention; it is typically shorter, cheaper, and more effective.
- **Demand Transparency:** If cost is a barrier, ask specifically about fees, follow up options, and coverage; this uncertainty is common and can be resolved through clear information.

Conclusion: Mental Health as Systemic Infrastructure

Somalia's UHC journey is challenged by federal complexity, insecurity, climate shocks, private sector dominance, donor fragmentation, and constrained fiscal space. However, mental health offers a unique advantage: a system capable of delivering trusted, continuous, and affordable mental health care is almost automatically a system capable of delivering other chronic care priorities (NCDs, maternal follow up, TB adherence, rehabilitation, disability services). Mental health is the "canary in the coal mine," but it is also the ultimate blueprint for modern primary care.
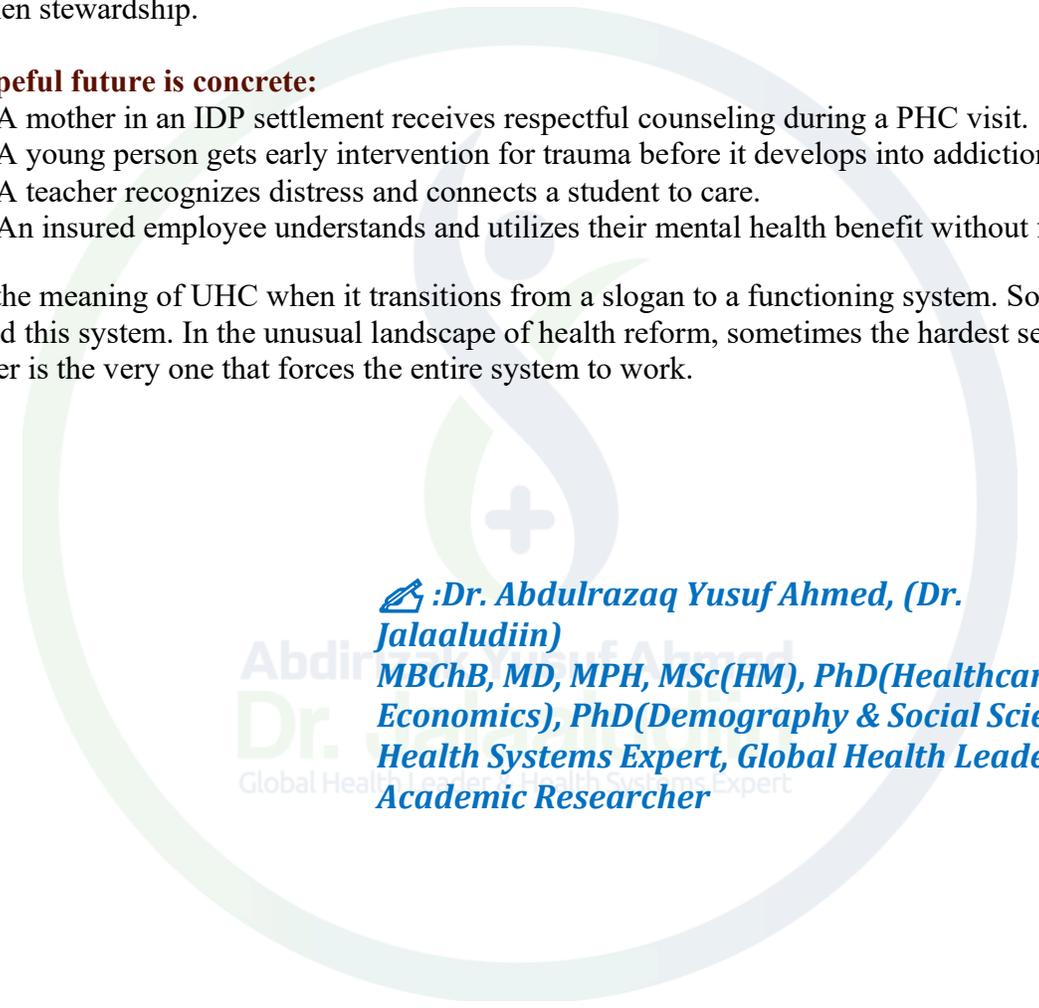
Somalia's trajectory is not limited to "burden without capacity." The essential elements are already present: EPHS as the delivery spine, mhGAP as the workforce multiplier, nascent insurance as a financing entry point, and a growing national will to reduce fragmentation and strengthen stewardship.

The hopeful future is concrete:

- A mother in an IDP settlement receives respectful counseling during a PHC visit.
- A young person gets early intervention for trauma before it develops into addiction.
- A teacher recognizes distress and connects a student to care.
- An insured employee understands and utilizes their mental health benefit without fear.

This is the meaning of UHC when it transitions from a slogan to a functioning system. Somalia can build this system. In the unusual landscape of health reform, sometimes the hardest service to deliver is the very one that forces the entire system to work.

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