ORIGINAL RESEARCH ARTICLE

Access to health care services in Somalia: Evidence from a qualitative study

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Abstract

Access to healthcare in fragile and conflict-affected contexts remains a critical public health challenge. This study aimed to explore how Somalia citizens experience and perceive access to health services in Mogadishu, focusing on barriers, trust dynamics, service utilization patterns, and evolving health expectations. A qualitative, case-based design was employed, and 54 in-depth interviews were conducted using a semi-structured guide developed through literature review. Thematic analysis revealed five major themes: low utilization of preventive care, financial and logistical access barriers, systemic fragility (including overcrowding, insecurity, and infrastructure deficits), demand for specialized services, and the centrality of trust in shaping health-seeking behavior. While the Somalia Mogadishu Recep Tayyip Erdoğan Training and Research Hospital was widely praised for its cleanliness, professionalism, and reliability, most participants reported relying on reactive care and avoiding check-ups due to costs, lack of awareness, and institutional shortcomings. Despite these challenges, participants expressed increasing aspirations for dignified, specialized services, indicating a shifting perception of health rights. The findings suggest that sustainable improvements in Somalia's health system will require a combination of health diplomacy, community engagement, digital innovation, and investment in inclusive infrastructure and governance. *(Afr J Reprod Health 2025; 29 [10]: 143-154).*

Keywords: Healthcare Access; Somalia; Qualitative Research; Health Diplomacy; Preventive Care

Résumé

L'accès aux soins de santé dans des contextes fragiles et touchés par des conflits demeure un défi majeur de santé publique. Cette étude visait à explorer comment les citoyens somaliens perçoivent et vivent l'accès aux services de santé à Mogadiscio, en se concentrant sur les obstacles, la dynamique de confiance, les modes d'utilisation des services et l'évolution des attentes en matière de santé. Une approche qualitative basée sur des études de cas a été utilisée, comprenant 54 entretiens approfondis. L'analyse thématique a révélé cinq thèmes principaux : faible recours aux soins préventifs, obstacles financiers et logistiques, fragilité systémique, demande de services spécialisés et centralité de la confiance dans les comportements de recours aux soins. Bien que l'hôpital d'Enseignement et de Recherche Recep Tayyip Erdoğan de Mogadiscio ait été largement salué, la plupart des participants ont déclaré éviter les contrôles préventifs pour des raisons de coût, de manque de sensibilisation et de dysfonctionnements institutionnels. Malgré ces défis, les participants expriment des aspirations croissantes pour des services spécialisés et dignes, indiquant un changement de perception des droits en santé *(Afr J Reprod Health 2025; 29 [10]: 143-154).*

Mots-clés: Accès aux soins de santé; Somalie; Recherche qualitative; Diplomatie sanitaire; Soins préventifs

Introduction

Access to healthcare services is crucial for promoting health, preventing diseases and premature death, reducing disability and achieving health equity.[1] Access to comprehensive, quality healthcare services is a key indicator of a health system's performance and policy effectiveness.[2,3]

Access can be defined as the use of healthcare services, conditional on the need for care[4]. This complex concept also encompasses the broader interaction between the patient and the healthcare system. Specifically, five dimensions of access have been identified: availability (the adequacy of resources such as physicians, dentists and other providers), accessibility (the spatial relationship between service location and patient residence), accommodation (how healthcare services are organized to receive patients), affordability (the cost of services relative to patients' ability to pay or insurance coverage) and acceptability (the alignment between patients'

preferences and the personal and professional characteristics of providers).[5-7] Facilitating access to healthcare services is essential for addressing health inequalities.

Many healthcare systems around the world prioritize reducing barriers to access; however, a variety of structural and financial hurdles continue to hinder this goal. For instance, high healthcare costs, inadequate transportation and difficulties securing timely appointments often prevent patients from forming consistent relationships with providers and managing their health effectively.[8,9]

In Sub-Saharan Africa, countries face severe shortages of healthcare resources and expertise to address both communicable and non-communicable diseases. Weak financing systems and underdeveloped legislation are compounded by bureaucratic inefficiencies in health governance.[10,11] In response, the Somalia government launched the Health Sector Strategic Plan (2022–2026**)** to improve access to affordable, equitable and high-quality healthcare services, aiming ultimately for Universal Health Coverage.[12-15.]

Somalia's health system remains fragile, characterized by unstable infrastructure, limited funding and a scarcity of trained medical personnel. Access to care is particularly problematic in rural and conflict-affected regions due to geographic isolation, insecurity and widespread poverty**.** In addition, endemic infectious diseases such as malaria, cholera and measles present major threats, exacerbated by weak surveillance systems and population displacement.[12,16,17]

The largely privatized healthcare sector is concentrated in urban areas, leaving rural communities without affordable services**.** The fragmented health governance system weakens national capacity to regulate private providers and hinders effective collaboration with NGOs.[18] Cultural barriers and inadequate maternal and child health services contribute to poor reproductive health indicators and low rates of family planning.[17,18] These challenges are further exacerbated by a lack of reliable health data.[18]

To address these issues, telemedicine and mobile health initiatives have been introduced, enabling remote consultations and improving access in hard-to-reach areas**.** International partnerships especially with organizations such as WHO, UNICEF and MSF have strengthened healthcare delivery, while community-based programs are beginning to provide grassroots-level services.[16,18]

Somalia is now implementing targeted health initiatives focused on education, disease prevention and maternal and child health. Continued investments in infrastructure, training and surveillance capacity are vital for empowering communities and strengthening the health system. Effective coordination between the government, civil society and international partners will be essential to overcome Somalia's complex healthcare challenges.[16]

Although notable progress has been made in Somalia's healthcare system over the past six years, access and equity issues persist.[19] Against this background, the present study aims to evaluate Somalias' access to health services and their lived experiences with care, including which hospitals they attend and how satisfied they are with those services. To our knowledge, this is the first comprehensive qualitative study addressing access to healthcare among Somalia citizens.

Methods

This study employed a qualitative, case-based design to explore individuals' lived experiences and perceptions regarding access to healthcare services in Mogadishu, Somalia. A purposive convenience sampling strategy was utilized to recruit participants, all of whom were adult family members or close contacts of midwifery students enrolled at the Somalia Mogadishu Recep Tayyip Erdoğan Faculty of Health Sciences.

Data were collected between April and June 2024 through in-depth, semi-structured face-to-face interviews. A total of 20 midwifery students (Somalia nationals who did not serve as participants) were trained in qualitative research methods prior to data collection. The training covered interviewing techniques, ethical research conduct, neutrality, active listening and note-taking or recording practices.

These trained students recruited 54 adult participants (n=54) from their family or social networks. Interviews were conducted in private and comfortable settings, typically in participants'

homes and held in the Somalia language. Each interview lasted between 25 and 45 minutes.

The interview guide consisted of 24 open-ended questions, developed by the research team based on an extensive literature review. The questions focused on participants' experiences with healthcare access, perceived barriers, hospital preferences, satisfaction and suggestions for improvement. The guide was pilot-tested with three individuals to ensure clarity, cultural relevance and feasibility.

Informed verbal consent was obtained from all participants before interviews commenced. Interviews were either audio-recorded (with permission) or documented through detailed handwritten notes. All responses were transcribed verbatim in Somalia and subsequently translated into English or Turkish by bilingual members of the research team.

Information regarding the ideal sample size in qualitative research is closely related to the quality of the data.[17] A commonly agreed-upon principle concerning ideal sample size is the concept of data saturation defined as the point at which data collection yields repetitive information. Once data saturation is reached, additional data tend to be redundant.[20] It is suggested that data collection should be discontinued when repetition first appears in the data cycle.[21] In this study, interviews were conducted until data saturation was achieved and no new information emerged. Accordingly, in-depth interviews were carried out with a total of 54 participants.

Data analysis followed Braun and Clarke's[22] six-phase thematic analysis framework. First, transcripts were read multiple times for familiarization. Then, initial codes were manually generated by two independent researchers. These codes were compared, discussed and consolidated into broader themes and subthemes representing recurring patterns. Any discrepancies in coding were resolved through consensus.

To ensure the trustworthiness of the analysis, multiple strategies were used:

- Triangulation, through the involvement of three researchers in the coding and analysis process
- Memoing, to track analytical decisions,
- An audit trail, maintained throughout the project to ensure transparency and reproducibility

The study received ethical approval from the institutional ethics committee (dated March 24, 2024; approval number: 944) and complied with the principles of the Declaration of Helsinki. Anonymity and confidentiality were strictly maintained. No identifying information was recorded or disclosed at any point during or after the research.

Results

Following thematic analysis of the 54 interviews, five primary themes emerged that characterize the participants' experiences with healthcare services in Mogadishu. Each theme includes representative codes and quotations that reflect the perspectives of participants.

The majority of the 54 individuals who participated in the study were female. Specifically, 92.6% of the participants were women, while 7.4% were men. A significant proportion of the participants were under the age of 40 (87.1%) and the rate of those who were married was notably high (81.5%). Regarding educational background, the highest proportion of participants were university graduates (27.8%). The remaining participants had completed primary school (22.2%), high school (20.4%), middle school (20.4%), or held a master's degree (5.6%), while a small minority were illiterate (3.7%). Most of the participants were housewives (64.8%); however, individuals from various occupational groups such as healthcare workers (9.3%), laborers (13.0%) and students (7.4%) were also included (Table 1).

Figure 1 illustrates the five main themes that emerged from the thematic analysis of participants' experiences with healthcare in Mogadishu, Somalia. At the center lies "Healthcare Access and Trust Dynamics," reflecting the complex interplay between individual perceptions and systemic realities. Themes such as *Preventive Care Usage*, *Access Barriers*, *Use of Preventive Care*, *Expectations of Specialized Care* and *Systemic Challenges* represent the multifaceted factors that shape healthcare access and utilization.

The diagram emphasizes that trust in the healthcare system is not isolated but is influenced by a combination of personal, institutional and contextual factors.

Table 1: Demographic characteristics of the participants (n=54)

Characteristics	f	%
Gender		
Female	50	92,6
Male	4	7,4
Age		
<40 years	47	87,1
>40 year	7	12,9
Education		
Master's degree	3	5,6
University	15	27,8
High school	11	20,4
Middle school	11	20,4
Elementary school	12	22,2
Not literate	2	3,7
Occupation		
Housewife	35	64,8
Health	5	9,3
Professional	2	3,7
Unemployed	7	13,0
Worker	1	1,9
Instructor	4	7,4
Student		
Marital Status		
Married	44	81,5
Single	10	18,5
Total	**54**	**100,0**

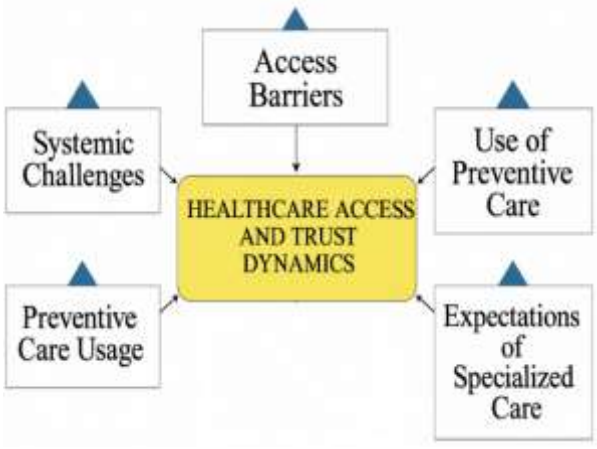

Figure 1: Thematic overview of the findings

Findings related to the theme of preventive care usage willingness

Figure 2 illustrates the primary factors that influenced participants' willingness to engage in preventive care services. Despite the generally low uptake of preventive practices, several aspects of healthcare delivery were found to positively shape participants' decisions to seek care before illness onset. These factors include cleanliness, professionalism of staff, respectful communication, modern equipment and effective medications.

Figure 2: Preventive care usage willingess code sub-code sections model

Cleanliness

Participants consistently emphasized that hygienic environments increased their confidence in the health facility and made them more comfortable returning:

"I felt comfortable going back because the rooms were always clean." (Participant 11)

"If the clinic looks dirty, we don't trust the care inside." (Participant 20)

Professionalism of staff

Competent and courteous behavior from healthcare workers encouraged patients to trust their providers and return for future visits:

"They explained everything clearly and treated me with dignity." (Participant 30)
"The midwife was very professional. I felt I was in good hands." (Participant 17)

Respectful communication

The tone, attitude and patience shown by healthcare staff were crucial in shaping the patient experience, especially among women and elderly patients:

"The nurses were kind and never shouted. That's why I returned for vaccination." (Participant 18)

"I liked that they didn't rush me or interrupt when I talked." (Participant 44)

Modern equipment

Advanced tools and up-to-date medical devices made facilities seem more capable and reliable, encouraging trust in diagnostics and early detection:

"I saw they had machines we never had before. It made me feel they could find what's wrong." (Participant43)

"When I saw the ultrasound machine, I decided to bring my sister too." (Participant 6)

Effective medications

When treatment outcomes were successful, participants were more likely to revisit the facility even for preventive purposes:

"After taking their medicine, I got better quickly. Now I trust them more." (Participant 6)
"They gave me the right antibiotics. That's why I tell others to go there early." (Participant 35)

These insights demonstrate that beyond awareness and affordability, the quality of the healthcare environment and interactions strongly affect preventive care usage, even in low-resource settings like Somalia. (Figure 3)

Findings related to the theme of access barriers

This diagram summarizes the main access-related obstacles reported by participants when seeking healthcare in Mogadishu. Three prominent subthemes emerged: high cost of care, transportation difficulties and limited hospital availability. These barriers frequently led to delays or complete avoidance of care-seeking behavior.

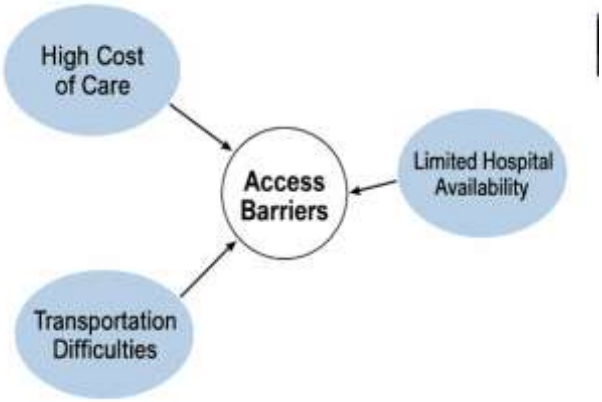

Figure 3: Access Barriers code sub-code sections model

High cost of care

Financial constraints were the most frequently cited reason for avoiding or postponing medical visits. Many participants explained that even one-time hospital visits represented a major burden on their family budgets:

"We must choose between food and medicine. Sometimes, we skip treatment to save money." (Participant 15)
"One visit costs more than what I earn in a week. How can I go regularly?" (Participant 28)

"Even the 'free' hospitals are not really free. You end up paying for drugs or transport." (Participant 40)

Transportation difficulties

Reaching hospitals posed significant logistical challenges, especially for those without private vehicles. Participants from peri-urban areas were particularly affected by a lack of reliable and safe transport options:

"If no one can drive us, we stay home. Public transport is not safe, especially for women." (Participant 32)

"I once walked for two hours because I didn't have money for a taxi." (Participant 9)

"Transport cost adds to the stress. Sometimes it's more than the medicine itself." (Participant 44)

Limited hospital availability

The lack of nearby or functioning hospitals further restricted access, particularly for preventive or non-emergency services:

"There are not enough hospitals around. The ones that exist are always full." (Participant 6)

"We have only one option and if they turn us away, there's nowhere else to go." (Participant 13)

"They say they're open, but often there are no doctors or nurses available." (Participant 36)

These access barriers contributed to patterns of delayed care, reliance on home remedies and general frustration with the healthcare system. They also underscored inequalities in access between different neighborhoods and income groups.

Findings related to the theme of use of preventive care

Figure 4 illustrates the underlying reasons behind the limited use of preventive care among participants. Three major subthemes were identified: Lack of Awareness, Reactive Behavior and Cost-Related Avoidance.

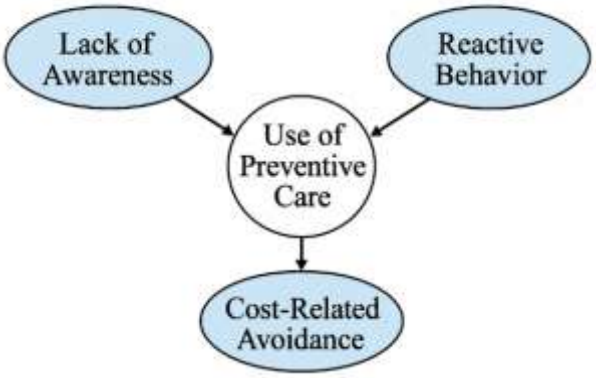

Figure 4: Use of preventive care code sub-code sections model

Lack of awareness

Many participants demonstrated a limited understanding of the purpose and benefits of preventive care. They often equated hospital visits solely with treatment rather than prevention.

"We don't go to the hospital unless we are in pain. I didn't know you could go just to check your health." (Participant 19)

"No one has ever explained to me why I should get tested if I'm not sick." (Participant 8)

"Where I live, people think check-ups are only for the rich." (Participant 35)

Reactive behavior

Healthcare-seeking behavior was largely reactive rather than proactive. Participants typically sought medical attention only after symptoms had become severe.

"I wait until the problem gets worse. Otherwise, I ignore it." (Participant 14)

"I don't go for small things. We only go to hospitals when we really need it." (Participant 24)

"Preventive care doesn't cross our minds. We're used to treating illness, not preventing it." (Participant 40)

Cost-Related avoidance

Even when participants were aware of preventive care options, financial constraints often deterred them from utilizing such services. Preventive visits were viewed as non-essential expenses.

"If I'm not sick, I won't spend money on a doctor. That money is for food or rent." (Participant 12)

"Routine check-ups are expensive. I'd rather wait and save that money." (Participant 33)

"We don't prioritize health unless there's a crisis. That's how it is when money is tight."(Participant 4)

These factors reflect a broader pattern of health system underutilization and reveal opportunities for targeted education and economic interventions to promote preventive care behaviors.

Findings related to the theme of expectations of specialized care

Figure 5 summarizes participants' expectations for advanced healthcare services that extend beyond basic care. While most participants had access to primary and secondary care, many expressed a desire for specialized services such as cancer treatment, organ transplantation, in vitro fertilization and cosmetic care.

Figure 5: Expectations of specialized care code sub-code sections model

Cancer treatment

Cancer care was repeatedly mentioned as a critical missing component of the local health system. Participants emphasized the emotional and financial burden of traveling abroad for oncological care. 54321`

"My mother died because we couldn't afford cancer treatment outside Somalia." (Participant 5)

"People here have no hope if they're diagnosed with cancer. There's nowhere to go. (Participant 26)

"We need a proper oncology unit with chemotherapy and real doctors." (Participant 39)

Organ transplantation

Organ failure was described as a "death sentence" due to the complete lack of local transplant services.

"If someone needs a kidney here, the family starts preparing for a funeral." (Participant 9)

"Transplantation is impossible. Even referrals to other countries are too expensive." (Participant 30)

"We need international support to start transplant centers. People are dying waiting." (Participant 44)

In vitro fertilization and aesthetic services

Though less frequent, some participants—particularly younger women—expressed hopes for fertility support and cosmetic procedures, associating them with modern and dignified care.

"In other countries, women get help to have children. Here, we are just told to pray." (Participant 17)

"Plastic surgery may sound unnecessary, but it matters for self-esteem and dignity. Even things like hair transplants can make people feel more confident." (Participant 41)

These findings reflect a growing consciousness around health equity and a demand for long-term, high-level investments in specialized care services within Somalia.

Findings related to the theme of systemic challenges

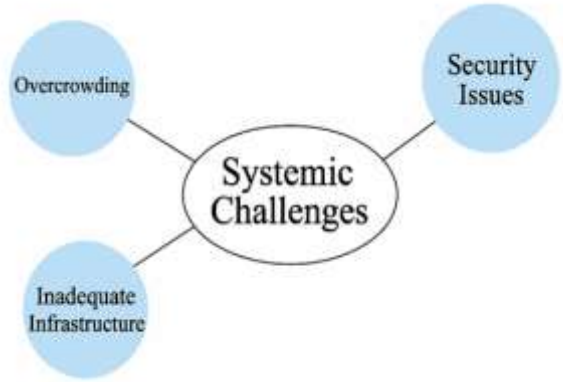

Figure 6: Systemic Challenges code sub-code sections model

Figure 6 highlights systemic-level problems that participants identified as negatively affecting the functionality and reliability of healthcare services in Mogadishu. Four major subthemes were

identified: Overcrowding, Security Issues and Inadequate Infrastructure (noted in two categories: structural and resource-based).

Overcrowding

Many participants reported feeling overwhelmed and frustrated by long queues, delayed care and a general lack of available medical staff.

"You wait for hours and sometimes go home without being treated." (Participant 2)

"Even if you arrive early in the morning, there are already too many patients ahead of you." (Participant 21)

"They told me to come back the next day because they had no time to see me." *(Participant 38)*

Security issues

Concerns about personal safety within and around hospital settings deterred some individuals from seeking care, particularly women.

"There is no proper security at the hospital gates. Anyone can enter and it's scary." (Participant 18)

"When it gets dark, we leave quickly. The surroundings aren't safe." (Participant 43)

"I avoid going alone, especially in the evenings. It's not safe." (Participant 35)

Inadequate infrastructure (structural and material)

Participants consistently highlighted poor physical conditions of buildings, lack of equipment and insufficient hygiene facilities as major limitations.

"Some rooms have broken windows or no electricity." (Participant 5)

"There was no water in the toilet." (Participant 27)

"They had no gloves, no proper examination beds." (Participant 46)

"We waited outside under the sun for hours because there was no waiting area." (Participant 34)

This cluster of issues paints a picture of a fragile health system strained by overuse, under-resourcing and operational insecurity. These structural weaknesses, unless addressed through coordinated investment and governance reform, are likely to remain persistent obstacles to equitable care access.

Discussion

This qualitative study provides a nuanced understanding of healthcare access and patient experiences in Mogadishu, Somalia. The findings suggest that although participants have access to healthcare facilities, their engagement with preventive services remains low. A significant proportion of participants reported that they do not visit hospitals for general check-ups or routine health screenings unless they are ill. This aligns with previous studies indicating that preventive care is underutilized in many low-resource settings due to limited awareness, financial constraints and cultural perceptions surrounding health and illness.[1,3]

The predominance of female participants and their high engagement with gynecology services likely reflects gender-specific health needs. Previous research has highlighted that Somalia women often face multiple barriers in accessing preventive healthcare, including inadequate knowledge of health services, cultural norms that discourage proactive care-seeking and logistical challenges.[12,18] Our findings are consistent with these insights and underscore the need for targeted health education and outreach, particularly around preventive care and women's health.

The study provides a rich examination of how Somali individuals access healthcare within a fragile healthcare system. Thematic analysis reveals that numerous systemic, social and informational barriers exist within healthcare facilities, yet they hinder meaningful and equitable healthcare access. These findings contribute to the

broader literature on healthcare utilization in resource-limited settings and highlight the importance of trust, affordability and healthcare system responsiveness.

Preventive care and trust as a conditional gateway

One of the most salient themes was the limited uptake of preventive services. Although some facilities were perceived positively particularly due to cleanliness, respectful staff and advanced equipment participants generally lacked awareness about the value of early detection and preventive visits. This aligns with Levesque *et al.'s*[23] framework on "approachability," where limited health literacy and cultural norms reduce the likelihood of proactive care-seeking.

Notably, participants described factors such as respectful communication, cleanliness and successful treatment outcomes as reasons to return for future care, indicating that interpersonal trust and facility quality can serve as critical leverage points for expanding preventive care in fragile settings like Somalia.

Financial, geographic and systemic constraints

The study revealed multi-dimensional access barriers consistent with the Penchansky and Thomas model of access (1981),[24] particularly in the domains of affordability, accessibility and availability. Out-of-pocket expenses including transport and medication were the primary deterrents for many participants, even in the presence of free public healthcare options. This reinforces WHO findings that Somalia ranks among the countries with the highest out-of-pocket health expenditure relative to income.[25]Transportation difficulties, particularly for women and peri-urban residents, reflect spatial inequalities and reinforce gender-based vulnerability, consistent with findings in other conflict-affected and post-conflict states.[26,27] Given Somalia's weak public transport infrastructure and persistent insecurity, investment in mobile clinics, community health workers and telehealth services could substantially reduce spatial disparities and improve continuity of care.

Shifting health expectations and the role of health diplomacy

Beyond basic services, participants voiced expectations for specialized care particularly in oncology, reproductive health, organ transplantation and even aesthetic procedures. These aspirations point to an evolving public consciousness shaped by exposure to international standards via diaspora, social media and health diplomacy. This aligns with Giddens' (1991)[28] concept of *reflexive modernity*, where global health norms become internalized in local communities, even amid scarcity.

Participants repeatedly cited the Somalia Mogadishu Recep Tayyip Erdoğan Training and Research Hospital as a trustworthy, clean and well-equipped facility, reinforcing the perception that health diplomacy initiatives can influence both service uptake and institutional trust. As TIKA[29] and Wilson & Redd[30] argue, such partnerships not only fill infrastructure gaps but also help shift societal expectations regarding health equity and dignity in care.

Systemic fragility and structural inequities

Despite localized examples of excellence, the broader health system in Somalia remains constrained by overcrowded facilities, staff shortages, fragile infrastructure and insecure environments. These findings align with national assessments,[16,31] which highlight ongoing governance and financing deficiencies.

Moreover, the intersection of security concerns and gendered vulnerabilities such as women avoiding facilities after dark or due to lack of safety underscores the need for gender-sensitive facility design, strengthened institutional governance and public investment in physical infrastructure and security.

Implications for policy and practice

Taken together, the findings illustrate that trust, cost and institutional quality are pivotal to healthcare access in Somalia. Future policy efforts must combine:

- Health literacy campaigns targeting preventive care uptake;

- Investment in maternal and reproductive services, particularly for low-income women;
- Digital health solutions such as mHealth and telerehabilitation, especially in remote and insecure areas;
- Sustained international cooperation that reinforces state-led health capacity rather than substitutes it.

The presence of an internationally supported institution like the Somalia Mogadishu Recep Tayyip Erdoğan Hospital illustrates how health diplomacy, if well-integrated with national priorities, can catalyze trust and set benchmarks for service quality across the system.

Conclusion

This qualitative study provides an in-depth exploration of how individuals living in Mogadishu perceive and navigate healthcare access within a structurally fragile health system. While participants acknowledged the presence of high-quality, trusted institutions particularly the Somalia Mogadishu Recep Tayyip Erdoğan Training and Research Hospital the broader landscape remains constrained by pervasive barriers including financial hardship, infrastructural inadequacies, limited availability of specialized services and low uptake of preventive care.

Healthcare-seeking behavior among participants was predominantly reactive, driven by acute illness rather than preventive motivations. Yet, interpersonal and environmental factors such as respectful communication, cleanliness and effective treatment emerged as powerful facilitators of trust and continued engagement with care services. Conversely, structural obstacles such as high out-of-pocket expenditures, overcrowding, security concerns and insufficient human resources acted as deterrents to regular healthcare utilization, especially among vulnerable populations.

Importantly, the findings reveal a shift in public expectations toward more comprehensive and dignified care, including demand for oncology, reproductive services, organ transplantation and aesthetic procedures. This evolving health consciousness, influenced by digital connectivity and diaspora exposure, signals a readiness for expanded services and more equitable health system reform.

Despite the formidable challenges Somalia's healthcare system faces including chronic underfunding, governance limitations and workforce shortages opportunities for systemic transformation are evident. Strategic health diplomacy, exemplified by Turkiye's long-term investment in infrastructure and training, has not only expanded access but also elevated public trust and expectations. However, sustainable improvement will require a parallel investment in national system strengthening, capacity building and community engagement.

Looking ahead, leveraging technological innovations such as digital health platforms, telemedicine and mobile health units could offer scalable solutions to bridge existing access gaps. Strengthening system resilience will depend on the development of inclusive, equity-focused policies, ongoing professional education and multisectoral coordination. Future research should deepen understanding of regional and gender-based inequities, assess the impact of international aid models and integrate diverse stakeholder perspectives to inform contextually grounded, evidence-based health reforms in Somalia.

Limitations

This study has several limitations that should be considered when interpreting its findings. First, data were collected through in-depth interviews conducted by midwifery students with their own family members. While this approach facilitated trust and openness, it may have introduced selection bias and limited the diversity of participant perspectives. Consequently, the findings may not be fully generalizable to the broader Somalia population.

Second, the sample was geographically confined to residents of Mogadishu. As a result, the study could not capture potential regional disparities in healthcare access, infrastructure quality, or service experiences that may exist across other parts of Somalia, particularly in rural or conflict-affected regions.

Third, although qualitative thematic analysis provided rich insights into individual experiences, the study did not include triangulation

with other data sources such as healthcare provider interviews, facility-level data, or medical records which could have enhanced the depth and credibility of the findings. The absence of multiple stakeholder perspectives also limits the ability to fully contextualize user experiences within the operational realities of the Somalia health system. Future research would benefit from incorporating broader participant demographics, regional comparisons and multi-source data triangulation to strengthen the transferability and rigor of the findings.

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Conflict of interest

No conflict of interest was declared by the authors.

Ethics approval

The study received ethical approval from the institutional ethics committee (dated March 24, 2024; approval number: 944) and complied with the principles of the Declaration of Helsinki.

Consent to participate

Informed verbal consent was obtained from all individual participants included in the study.

Authors contribution

Author Contributions: Idea/concept, writing the article, critical review, references and fundings: PGK, FKY, DK, YMJ; Design, data collection and/or processing, literature review, analysis and/or interpretation, materials: PGK, FKY, DK, YMJ; Control/supervision: PGK, FKY.

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