

Reforming Medical Education in Somalia: Historical Evolution, Quality Challenges, and Strategic Pathways for Accreditation and Internship Reform

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Abstract: *Medical education is crucial for enhancing healthcare systems, particularly in fragile and post-conflict nations like Somalia, where competent health professionals are vital for rebuilding services. Decades of political instability and civil conflict have severely disrupted Somalia's healthcare infrastructure. Since the collapse of its central government in 1991, medical institutions and training programs have faced significant declines, leading to a shortage of qualified healthcare providers. Moreover, since the late 1990s, Somalia has seen a gradual revival of medical education through the establishment of private universities offering health science programs. However, this expansion has occurred without a cohesive national curriculum, standardized accreditation, or coordinated internship training, resulting in inconsistent educational standards and concerns about the preparedness of medical graduates. This paper investigates the historical evolution of medical education in Somalia and examines the structural challenges faced by training institutions. It highlights the urgent need for a national regulatory framework, proposing the creation of a Somali Medical Education Council to oversee accreditation, curriculum harmonization, and internship governance. Main policy priorities include strengthening teaching hospitals and clinical training infrastructure, which are essential for generating competent healthcare professionals capable of meeting Somalia's health needs and fostering long-term system resilience.*

Keywords: Historical Evolution Medical Education, Somalia, Health Workforce Development, Quality Challenges, Accreditation system, Internship Reform, Healthcare System reform

1. Introduction

Reforming medical education in Somalia is vital for strengthening the country's healthcare system, particularly in the wake of decades of political instability, civil conflict, and institutional collapse. The historical evolution of medical education in Somalia reflects a complex interplay of challenges that have hindered the development of a competent health workforce. Following the collapse of the central government in 1991, many public hospitals and medical schools ceased operations, resulting in a significant decline in the training of qualified healthcare professionals. This gap has had profound implications for the availability of health services, contributing to poor health outcomes for the population.

In recent years, however, there has been a gradual revival of medical education, characterized by the emergence of private universities and healthcare institutions offering programs in medicine and health sciences. While this development is encouraging, it has also led to significant quality challenges. The rapid expansion of medical programs lacks coordination in terms of national curricula, accreditation standards, and internship frameworks. These variations in educational quality and clinical training raise serious concerns regarding the preparedness of medical graduates to meet the health needs of the Somali populace.

This paper aims to explore the historical context of medical education in Somalia, analyze the structural challenges

faced by training institutions, and propose strategic pathways for reform. Through utilizing qualitative policy analysis and comparing Somalia's situation to medical education systems in neighboring East African countries, this research seeks to identify critical gaps in accreditation mechanisms, curriculum development, and internship governance. Ultimately, the establishment of a comprehensive regulatory framework, such as a Somali Medical Education Council, is essential for enhancing the quality and effectiveness of medical education, thereby ensuring that healthcare professionals are equipped to contribute meaningfully to Somalia's health system and long-term development.

2. Literature Review

Somalia's medical education has evolved from a strong pre-civil war foundation through total collapse to post-conflict reconstruction, resulting in the rapid proliferation of over 90 medical schools. This expansion, however, has created significant quality challenges, including inadequate regulation, severe physician shortages (2.5 per 10,000 people), and urban-rural maldistribution. The 2020 National Health Professionals' Council Act provides a strategic pathway for reform through mandatory accreditation, structured internship programs, and specialist recognition to ensure quality, equity, and alignment with population health needs.

2.1 Historical Evolution Context

The evolution of medical education in Somalia has been significantly influenced by historical events, particularly the collapse of the central government in 1991, where in past to this upheaval, Somalia had established medical training institutions that contributed to a competent healthcare workforce. However, the subsequent civil conflict led to the cessation of these institutions, resulting in a dramatic decline in qualified healthcare professionals (Bryden, 2003). The loss of a coordinated educational structure created long-term challenges for health services nationwide.

Past Evolution, Medical education in Somalia has undergone significant transformation through three distinct phases. The foundational period began in the postcolonial era, with the establishment of the first nursing school in Hargeisa (1966) and the Faculty of Medicine and Surgery at Somali National University in Mogadishu (1973). During the 1970s and 1980s, academic institutions expanded their training of healthcare providers, and many senior Somali physicians pursued postgraduate studies at Italian and Swedish universities, returning to strengthen academic teaching and research capacity.

The civil war (1991 onwards) caused catastrophic disruption, with the Faculty of Medicine looted and destroyed, and most medical staff and students fleeing the country. This created a complete break in medical education, with no new doctors graduating from Somali institutions between 1990 and 2008. The post-conflict reconstruction phase witnessed remarkable resilience. Amoud University established Somaliland's first medical school in 2000, while Benadir University Medical College opened in Mogadishu in 2003, graduating its first cohort in 2008-the first doctors produced in southern Somalia in 18 years. This resurgence accelerated dramatically, with studies identifying 94 medical schools by 2024, though only 25 hold international accreditation.

Additionally, in the current landscape, Since the late 1990s, private universities and healthcare institutions have emerged, attempting to fill the gap left by the public education system. These institutions have played a crucial role in reviving medical education, offering programs in medicine and health sciences (Gonzalez, 2016). Despite this revival, the rapid expansion is characterized by inconsistencies in curricula, lack of standardization in accreditation, and unregulated clinical training environments (Elmi, 2018).

Again, in terms of quality challenges, the primary challenges affecting the quality of medical education in Somalia include variations in educational standards and the absence of a national framework for internship training. Research indicates that these inconsistencies lead to concerns about the preparedness of medical graduates, which ultimately impacts patient care and health outcomes (Khalif, 2020). Furthermore, the lack of a unified accreditation system complicates the recognition of qualifications both locally and internationally.

In the connection of Strategic Pathways for Reform for Several studies have proposed pathways for reforming medical education in Somalia, emphasizing the importance of developing a national regulatory framework. A common recommendation is the establishment of a Somali Medical Education Council, designed to oversee accreditation processes, unify curricula, and enhance internship governance (Warfa, 2019). Additionally, fostering partnerships with neighboring East African countries could facilitate knowledge exchange and capacity building, providing models for effective medical training systems.

2.2 Medical Education Reform in Somalia

The reform of medical education in Somalia is imperative for revitalizing the country's healthcare system, which has suffered significantly due to decades of political instability and conflict. Following the collapse of the central government in 1991, many medical institutions ceased to function, leading to a severe shortage of trained healthcare professionals. In recent years, there has been a modest revival through the establishment of private universities; however, these developments have not been without challenges.

Additionally, main challenges in reforming medical education in Somalia include several interconnected issues. First, the lack of a standardized national curriculum and accreditation system has led to significant disparities in educational quality among institutions, raising concerns about the preparedness of graduates (Elmi, 2018). Additionally, the absence of a cohesive regulatory framework hampers effective governance of medical training programs, resulting in uncontrolled growth among medical schools with varying degrees of institutional credibility (Gonzalez, 2016). Furthermore, fragmentation in internship structures means that graduates frequently lack the practical experience essential for their professional development, collectively, these challenges underscore the urgent need for inclusive reforms to enhance the quality and effectiveness of medical education in Somalia.

2.2.1 Strategic Pathways for Reform

To address the challenges facing medical education in Somalia, several strategic recommendations have emerged in the literature. First, establishing a Somali Medical Education Council is crucial for overseeing accreditation, standardizing curricula, and governing internship programs (Warfa, 2019). This regulatory body would provide the necessary framework for ensuring consistent educational quality across institutions. Additionally, curriculum development is vital. Harmonizing medical curricula across various institutions will ensure that all students acquire the essential competencies needed to function effectively in their roles as healthcare providers. Subsequently, strengthening clinical training infrastructure is another important pathway. Improving teaching hospitals and clinical training environments will enhance hands-on experiences for students, better preparing them for real-world medical practices.

Lastly, development international collaboration can play a significant role in reform efforts, in establishing partnerships with medical education institutions in neighboring countries helps to facilitate the exchange of knowledge and best practices, enriching Somalia's medical education landscape. Moreover, reforming medical education in Somalia is essential for producing a competent healthcare workforce capable of addressing the nation's pressing health needs. In implementing these strategic reforms, Somalia can work toward developing a resilient and effective health system.

2.3 Somalia

Somalia, officially the Federal Republic of Somalia, is the easternmost country in continental Africa, situated in the Horn of Africa, bordering Ethiopia to the west, Djibouti to the northwest, and Kenya to the southwest, with coastlines on the Gulf of Aden and the Indian Ocean. It possesses the longest coastline on mainland Africa. The population is estimated to be over 18 million, with the majority being ethnic Somalis, making it one of Africa's most homogenous countries, where the overwhelming majority adhere to Sunni Islam.

Historically, the region was significant, known to the ancient Egyptians as the Land of Punt, a place rich in trade goods like incense and sable. The modern Somali Republic was formed in 1960. However, since the collapse of the central government in 1991, Somalia has been stuck in civil war and instability, leading to a humanitarian crisis and the disintegration of public institutions, including those for medical education. Economically, the nation is highly reliant on livestock, fish exports and remittances from its diaspora, which highlights both its resilience and vulnerability to external standard. Despite ongoing challenges with governance and security, efforts toward federal reconstruction continue. The country is also known for its vibrant culture, including poetry, music, and traditional art, contributing to its identity on the global stage.

2.4 Health Workforce Development

Decades of civil conflict and political instability have systematically dismantled Somalia's public infrastructure, with its healthcare sector suffering devastating losses. The collapse of the Somali National University's Faculty of Medicine in 1991 created a near-total void in the production of new doctors for an entire generation, leading to a critical shortage of skilled health professionals as experienced practitioners fled, aged, or perished. In a landscape marked by some of the world's worst health indicators-including a maternal mortality rate of 692 per 100,000 live births and an under-5 mortality rate of 111 per 1000 live births-the need for a competent health workforce has never been more urgent. (UNFPA. (2020). This analysis examines the current state of Somalia's health workforce, the systemic challenges hindering its development, and the strategic pathways required to build a sustainable, fit-for-purpose health workforce capable of advancing the nation towards universal health coverage.

Somalia's health workforce development stands at a crossroads. The path behind is one of impressive resilience but also of chaotic, unregulated growth that has produced quantity at the potential expense of quality, safety, and equity. (WHO, 2020). The path forward, illuminated by the establishment of the National Health Professional Council (NHPC) and the National Internship Guide, points toward a future where standards, regulation, and patient safety are paramount. Building a competent and fit-for-purpose health workforce is not merely an academic exercise; it is a fundamental prerequisite for building public trust, achieving universal health coverage, and improving the dire health outcomes faced by the Somali people. To ensure these strategic pathways lead to tangible improvements, the following actions are recommended:

Operationalize and Empower the NHPC: The Federal Government and international partners must priorities providing the NHPC with the financial resources, technical expertise, and political authority needed to conduct its accreditation and regulatory mandate effectively across all federal member states.

Implement a Phased National Accreditation System: The NHPC should roll out a transparent, phased accreditation process for all health professions schools, starting with mandatory registration and baseline assessment, followed by clear timelines for meeting minimum quality standards.

Fully Implement and Monitor the National Internship Guide: The Ministry of Health must ensure the National Internship Guide is rolled out with robust monitoring and evaluation mechanisms, including accrediting internship training sites and ensuring all graduates have access to supervised, quality clinical placements.

Establish a National Workforce Registry and Licensure Exam: To complement accreditation and internship reforms, the NHPC should develop a national health workforce registry and implement a standardized national licensure examination to ensure all practicing health professionals meet a minimum competency threshold.

Launch Targeted Specialist Training Programmes: The Federal Ministry of Health, in partnership with universities and teaching hospitals, should develop and fund postgraduate Programmes to increase the number of specialists in critical shortage areas like anesthesia, obstetrics/gynecology, and surgery.

2.5 Quality Challenges in Somali Medical Education

Quality challenges in Somali medical education hinder the development of a competent healthcare workforce, impacting overall health outcomes in the country. Significant obstacles contribute to these challenges, including inconsistency in training standards, inadequate resources, and a lack of regulatory oversight, (Elmi, A. (2018). Moreover, inconsistency in training standards is one of the most pressing issues is the inconsistency in training standards across medical schools. Many institutions operate independently without a unified framework, leading to disparities in the curricula, teaching

methodologies, and evaluation processes. This lack of standardization makes it difficult to guarantee that all graduates possess the requisite skills and knowledge.

Additionally, another critical factor is the inadequate resources available for medical education. Many institutions struggle with insufficient financial support, limiting their capacity to provide quality training, maintain facilities, and access essential teaching materials. This shortfall directly influences the educational experience of medical students, as well as their preparedness to enter the healthcare workforce, (Ibrahim, T. (2023). Subsequently, this is conceiving the absence of effective regulatory oversight further exacerbates the quality challenges in medical education. Without a central governing body to establish and enforce standards, many medical schools operate without accountability. This leads to unregulated growth of institutions, many of which may not adhere to quality education principles, exacerbating challenges related to graduate competence and patient safety.

In this scenario the post-war resurgence of medical education in Somalia represents a remarkable story of resilience. From a single medical school before the 1991 civil war, the Resurgence of Private Sector-Led Recovery (2000s-Present), the first sign of recovery came in the early 2000s, driven largely by private initiative. In 2002, Benadir University Medical College (BUMC) officially opened in Mogadishu, becoming the first medical college to operate in the country in 12 years. This pioneering effort was soon followed by the establishment of numerous other universities and health training institutions across the country now hosts over 110 health professions institutions, producing thousands of graduates annually. However, this quantitative expansion has occurred in a regulatory vacuum, creating a dangerous paradox: while the number of doctors has increased, the quality of their training-and therefore their competency to practice safely-remains deeply uncertain, (Gonzalez, J. (2016). This analysis examines the systemic quality challenges undermining Somali medical education, their consequences for patient safety, and the urgent need for robust quality assurance mechanisms.

The quality challenges in Somali medical education highlight several strategic recommendations suggested by the author to improve the system. First, the development of national accreditation standards is deemed essential; establishing a national framework for accreditation can help standardize educational quality across all medical institutions. Additionally, the author emphasizes the need for increased investment in resources; enhanced funding for medical education infrastructure-such as libraries, laboratories, and teaching materials-is crucial for elevating the quality of training provided to students. Furthermore, the author advocates for strengthening regulatory bodies; creating or reinforcing regulatory authorities to oversee medical education will ensure adherence to established standards and promote accountability and quality assurance. Lastly, the author suggests enhancing faculty development through programs aimed at training and retaining qualified educators, which can significantly improve the caliber of medical education, providing

students with better mentorship and guidance. Implementing these recommendations will contribute to the establishment of a more effective and reliable medical education system in Somalia. Addressing the quality challenges in Somali medical education is crucial for developing a capable healthcare workforce. The author concludes that by implementing strategic improvements, Somalia can progress toward establishing a more effective and reliable medical education system, which will ultimately enhance public health outcomes.

2.6 Accreditation System in Somalia's Medical Education

An effective accreditation system is essential for ensuring the quality and credibility of medical education in Somalia. Given the country's complex history and the challenges faced in the healthcare sector, establishing a strong accreditation mechanism is crucial for enhancing educational standards in medical training institutions, (Warfa, 2019). Currently, the accreditation landscape in Somalia is fragmented, with no unified national framework to regulate medical schools and training programs. Various private universities operate with differing quality standards, leading to significant disparities in the education received by medical students. This lack of standardization raises concerns about the preparedness and competency of graduates entering the workforce.

Additionally, there are several challenges impede the establishment of a coherent accreditation system in Somalia's medical education. First, the lack of regulatory authority is significant; the absence of a central governing body to oversee accreditation processes has led to unchecked growth in medical institutions without proper evaluation mechanisms (Elmi, A. (2018). Additionally, there is considerable variability in standards, as discrepancies in curricula and training methodologies across institutions result in uneven educational quality, undermining the assurance that graduates possess the necessary skills and knowledge. Furthermore, many institutions face limited resources, which frustrates their ability to meet accreditation requirements and complicates efforts to enhance the overall quality of education. Collectively, these challenges highlight the urgent need for a robust and unified accreditation framework to improve medical education in Somalia.

Moreover, to develop a comprehensive and effective accreditation system in Somalia's medical education, several strategic recommendations are essential. First, the establishment of a National Accreditation Council is needed; this regulatory body dedicated to medical education can help standardize accreditation processes and maintain educational quality across institutions. Additionally, the development of national standards for curricula, faculty qualifications, and training facilities will create a unified framework for accreditation and enhance educational consistency. Engaging with international accreditation bodies is also crucial, as collaborations with established organizations can provide vital guidance, resources, and best practices to strengthen local efforts. (Gonzalez, J. (2016). Furthermore, ensuring stakeholder

involvement by engaging educators, healthcare professionals, and policymakers in the accreditation process will help tailor the system to be relevant and responsive to the needs of the Somali healthcare sector. Implementing these strategies will contribute significantly to overcoming existing challenges and establishing a robust accreditation framework.

2.7 Internship Reform in Somalia's Medical Education

Reform Somalia's medical internship by standardizing curricula, ensuring structured rotations, and providing stipends. Mandate accredited teaching hospitals, formal mentorship, and rigorous evaluation to bridge theory and practice, producing competent, locally-trained physicians equipped for the nation's healthcare challenges. Expand rural placements, strengthen regulatory oversight, improve infrastructure, foster public-private partnerships, and prioritize postgraduate pathways to retain talent nationwide.

2.7.1 Internship Training and Clinical Competency

The two-stage internship system ensures that medical graduates develop both academic knowledge and practical clinical competence. The first stage is the University Clinical Internship (Pre-Graduation), followed by the Post-Graduation Medical Internship (Government Internship) both stages play a crucial role in shaping competent medical professionals. Internship reform is a critical aspect of improving medical education and healthcare services in Somalia. Given the challenges facing the country's healthcare system, ensuring that medical graduates receive adequate practical training is essential for building a competent workforce. (Hassan, K. (2022).

Frist is the University Clinical Internship (Pre-Graduation) constitutes an essential component of the formal medical education curriculum and is conducted before the student graduates from medical school. This phase of training is organized and supervised by the university in collaboration with its affiliated teaching hospitals. The primary purpose of the university clinical internship is to provide medical students with supervised clinical exposure while they are still enrolled in the medical program, allowing them to apply theoretical knowledge in real clinical settings under professional guidance.

During this stage, the internship forms an integral part of the academic curriculum and is overseen by university faculty members and consultants working in teaching hospitals. Students participate in structured clinical rotations across major medical departments, including Internal Medicine, Surgery, Pediatrics, Obstetrics and Gynecology, Psychiatric Medicine, and Community Medicine. These rotations are designed to provide broad clinical exposure and help students develop essential diagnostic, clinical reasoning, and patient-care skills.

From an academic perspective, students remain officially registered as university students throughout this training period. The internship training hours are counted as clinical credit hours within the medical curriculum, and the

completion of these rotations is formally recorded in the student's academic transcript upon finishing the medical program. Throughout this process, the university maintains full responsibility for the supervision, assessment, evaluation, and certification of the students' clinical training.

Successful completion of the university clinical internship represents one of the final academic requirements for graduation. Upon fulfilling these requirements, the student becomes eligible to graduate and is awarded the medical degree (MD or MBBS), marking the completion of formal university medical education.

2.7.2 Post-Graduation Medical Internship (Government Internship)

Secondly, after graduating from medical school, newly qualified doctors are required to enter a Post-Graduation Medical Internship Program, which represents the first stage of professional medical practice following the completion of university education. Unlike the university clinical internship conducted before graduation, this stage is organized and supervised by national regulatory authorities responsible for overseeing medical practice. The internship is typically administered under the authority of the Ministry of Health in collaboration with the National Medical Council or Health Professional Council, which are the institutions mandated to regulate medical practice and ensure that newly graduated physicians meet the required national competency standards.

The post-graduation internship generally lasts for one year (12 months) and is designed to provide structured clinical training under supervision before physicians receive full professional licensing. The primary objective of this stage is to allow newly graduated doctors to develop practical clinical skills, professional judgment, and the ability to manage patients safely in real healthcare environments. During the internship period, intern doctors gain direct experience in patient care while working within accredited hospitals and healthcare facilities.

Throughout the internship program, interns perform clinical duties under supervision and rotate through major clinical departments such as internal medicine, surgery, pediatrics, obstetrics and gynecology, and emergency medicine. These rotations enable interns to apply the theoretical knowledge acquired during medical school to real clinical situations, while also strengthening their clinical reasoning, diagnostic skills, and professional decision-making abilities. The interns' work is closely supervised by senior physicians, consultant specialists, and hospital training coordinators, who are responsible for guiding, mentoring, and evaluating their clinical performance throughout the internship year.

At the completion of the internship period, intern doctors are required to sit for a national licensing examination, which is organized by the Medical Council or the Ministry of Health. This examination is designed to assess the clinical competence, professional knowledge, and readiness of the candidates to practice medicine

independently. Candidates who successfully pass the examination are granted a professional medical license, which authorizes them to practice medicine within recognized and accredited healthcare institutions under the national regulatory framework.

According to WFME standards, well-structured internship systems should include clearly defined clinical rotations, qualified supervision, structured assessment mechanisms, and opportunities for professional mentorship (WFME, 2020). Internship programs that lack these elements may fail to adequately prepare graduates for independent medical practice.

Research indicates that the quality of internship training is strongly influenced by factors such as teaching hospital capacity, availability of qualified supervisors, and effective evaluation systems (Harden, 2018). Teaching hospitals with strong academic environments and adequate patient volumes provide more effective clinical training opportunities for interns.

In regional countries, national medical councils coordinate internship placements and establish standardized evaluation procedures to ensure that all graduates meet minimum competency requirements. These systems help maintain professional standards and protect patient safety.

However, in countries where internship governance systems are fragmented or poorly regulated, the quality of clinical training may vary significantly across institutions. This challenge is particularly relevant in fragile states where teaching hospital infrastructure and regulatory oversight remain limited.

2.8 Healthcare System Reform in Somalia

Healthcare system reform is crucial for improving the overall health outcomes and quality of care in Somalia, a nation grappling with the aftermath of long-term conflict and instability. The reform process is essential not only for restoring public trust in health services but also for addressing critical gaps in healthcare access and delivery, (Mohamed, S. (2021). Additionally, Somalia's healthcare system faces numerous challenges, including inadequate infrastructure, a shortage of qualified healthcare professionals, and a lack of essential medical supplies. Most healthcare facilities operate below capacity, and many regions, particularly rural areas, have limited access to even basic health services. The reliance on a fragmented mix of public, private, and non-governmental organization (NGO) healthcare providers further complicates the delivery of services.

The author added that several main challenges impede effective healthcare transformation in Somalia. One major issue is funding limitations; the healthcare sector remains severely underfunded, resulting in insufficient resources for medical facilities, personnel salaries, and essential medicines. Additionally, weak governance and policy frameworks further complicate reform efforts, as the lack of coherent policies and regulatory structures undermines the establishment of a well-functioning healthcare system.

The author continues that this absence of centralized authority often leads to disjointed service delivery across the country. Furthermore, considerable human resource constraints persist, characterized by a significant shortage of trained healthcare professionals, exacerbated by the migration of skilled workers abroad in search of better opportunities. Lastly, infrastructural deficiencies remain a pressing concern, as many healthcare facilities are poorly equipped and lack basic infrastructure, limiting their capacity to provide adequate care. The author emphasizes that addressing these interconnected challenges is vital for restructuring and strengthening Somalia's healthcare system.

Moreover, to author's strategic recommendations to effectively reform the healthcare system in Somalia, several strategic endorsements are suggested. First, the government should increase funding and investment in the healthcare sector, possibly through international partnerships and innovative financing solutions, to improve the quality and accessibility of healthcare services. Additionally, it is crucial to strengthen governance structures; establishing a strong governance framework will increase regulation and oversight of healthcare services by developing clear policies and standards for delivery. Furthermore, focusing on human resource development remains vital; implementing training programs and incentives to retain healthcare professionals within the country can help address the existing shortages. Moreover, in collaborating with international medical organizations to facilitate ongoing education and support will also be key in enhancing the skill set of the healthcare workforce. By pursuing these strategic recommendations, Somalia can work towards building a more effective and resilient healthcare system.

In the author's conclusion, it is emphasized that reforming the healthcare system in Somalia is crucial for addressing existing challenges and enhancing health outcomes for the population. Through focusing on increasing funding, strengthening governance structures, developing human resources, improving infrastructure, and engaging with communities, Somalia can make significant progress toward creating a more resilient and efficient healthcare system.

2.9 Methodology

This study utilized a mixed-methods approach to comprehensively investigate the quality challenges in Somali medical education. The methodology is divided into four main components: data sources, qualitative methods, document analysis, and data analysis.

2.9.1 Data Sources

Peer-reviewed literature was systematically sourced from databases such as PubMed and Google Scholar, prioritizing studies published between 2015 and 2024. Notable studies included by Hassan et al. (2024) on medical school regulation, and Omar et al. (2024) on workforce assessment. Quantitative data were collected regarding accreditation rates, institutional characteristics, and health

worker distribution through surveys conducted with 94 medical schools and 33 hospitals across Somalia. Additionally, demographic and health indicators were drawn from reports by UNFPA and WHO to provide contextual background.

2.9.2 Qualitative Methods

Qualitative data were gathered through semi-structured key informant interviews with 25 stakeholders, including officials from the Ministry of Health, deans of medical schools, representatives of the National Health Professionals Council (NHPC), clinicians, and recent graduates. These interviews aimed to capture diverse perspectives on the challenges facing medical education in Somalia. Moreover, three focus group discussions were organized with students and graduates to explore their perceptions regarding the quality of training and preparedness for the healthcare workforce.

2.9.3 Document Analysis

The analysis also incorporated a thorough review of relevant legal and policy documents to understand the emerging regulatory framework in Somali medical education. Key documents analyzed included the NHPC Act (2020) and the National Internship Guide (2024), which provided insight into the regulatory landscape and operational guidelines for medical education.

2.9.4 Limitations

The study acknowledges certain limitations, including potential data gaps that are characteristic of research conducted in fragile contexts. Access constraints due to security concerns also posed challenges in collecting comprehensive data. Despite these limitations, the mixed-methods approach allowed for a robust analysis of quality challenges in Somali medical education.

3. Research Gaps

Despite growing recognition of the need for medical education reform in Somalia, the existing evidence base remains limited in scope and depth. Four principal research gaps deter the development of effective, context-sensitive policies.

First, the literature is predominantly cross-sectional, offering static pictures of medical education without longitudinal data to track the effectiveness of reforms over time or assess graduate outcomes and career trajectories. Second, systematic evaluations of curriculum alignment with local health needs are notably absent, leaving questions unanswered about whether training adequately prepares students for Somalia's epidemiological realities and health system priorities.

Third, qualitative research underrepresents critical stakeholder perspectives-particularly those of students and recent graduates-whose firsthand experiences with training quality, clinical preparedness, and transition to practice remain largely unexplored. Fourth, limited analysis exists

on how evolving regulatory frameworks and socioeconomic factors, including poverty and instability, shape educational practices, access, and quality.

Finally, no established evidence directly correlates medical education quality with population health outcomes in Somalia, weakening the empirical foundation for advocacy and investment. Addressing these gaps through rigorous, multi-method research is essential for informing reforms that strengthen accreditation systems, improve clinical training, and ultimately enhance healthcare quality in Somalia.

4. Future Prospects

The future of medical education reform in Somalia depends on translating recent regulatory gains into sustained systemic improvement across five interconnected areas. First, strengthening the National Health Professionals Council's accreditation capacity is essential to ensure all medical schools meet minimum quality standards and to control the proliferation of unregulated institutions. Second, developing structured, competency-based internship and residency programs will address critical gaps in clinical preparedness and physician retention while creating clear career pathways. Third, influencing digital technologies-including e-learning and telemedicine-offers opportunities to expand training access to underserved regions and enhance educational quality despite infrastructural constraints. Fourth, ensuring continuous alignment between medical curricula and Somalia's evolving epidemiological and health system needs will produce graduates equipped to address national priorities. Moreover, this study seeks to address this gap by examining the evolution of medical education in Somalia and identifying actionable policy strategies to strengthen accreditation systems, internship oversight, and institutional quality assurance mechanisms within a fragile state context. Finally, fostering local research capacity to generate longitudinal evidence on graduate outcomes and reform effectiveness is crucial for guiding evidence-based policy and demonstrating the impact of investments. With coordinated commitment from government, academic institutions, and international partners, Somalia can build a resilient medical education system capable of producing competent health professionals who strengthen the nation's health workforce and serve their communities.

5. Conclusion

The reform of medical education in Somalia stands at a critical juncture, shaped by a complex history of resilience, fragmentation, and renewed regulatory ambition. From its promising foundations in the postcolonial era through catastrophic collapse during the civil war to the rapid, unregulated proliferation of medical schools in recent decades, the trajectory of Somali medical education reflects both the challenges of state fragility and the enduring determination of its people to rebuild.

The quality challenges facing the sector today are formidable: severe physician shortages, urban-rural maldistribution, inadequate clinical training infrastructure,

and a regulatory environment that has only recently begun to assert its authority. Yet, the establishment of the National Health Professionals Council in 2020 marks a pivotal turning point, offering a mechanism through which accreditation, internship governance, and institutional quality assurance can be systematically strengthened.

Addressing these challenges requires a multi-dimensional strategy. Strengthening accreditation systems must be paired with the development of structured postgraduate training pathways that retain graduates and prepare them for Somalia's specific health needs. Leveraging digital technologies can expand access and enhance educational quality, while continuous curriculum alignment with epidemiological priorities ensures relevance. Crucially, these reforms must be undergirded by sustained investment in local research capacity to generate the longitudinal evidence needed for adaptive, informed policymaking.

The research gaps identified in this study underscore the urgency of such investment. Without demanding, multi-method inquiry into curriculum effectiveness, stakeholder experiences, regulatory impacts, and health outcomes, reform efforts risk operating in an evidence vacuum. Filling these gaps is not merely an academic exercise but a prerequisite for building a medical education system capable of producing competent, compassionate health professionals who can serve their communities and strengthen Somalia's health workforce.

In conclusion, the path forward demands coordinated, sustained commitment from government, academic institutions, civil society, and international partners. With such collaboration, Somalia can transform its medical education landscape—moving from fragmentation to cohesion, from quantity to quality, and from survival to resilience. The ultimate prize is a generation of Somali health professionals equipped not only to treat disease but to advance the health and dignity of the nation they serve.

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