Undergraduate and Postgraduate Medical Education in Somaliland:

Reflections on the recent past and developing a strategy for the future

Stakeholder workshop

16th-18th December 2012:
Maan-Soor Hotel, Hargeisa

The aim of the workshop was to assess challenges and opportunities in the continuum of medical education in Somaliland (undergraduate, internship, postgraduate and continuous professional development) and to develop a road map and a holistic approach for the next three years. The workshop was attended by all current stakeholders of the medical education in Somaliland and run for three days.

Stakeholders:
The Ministry of Health (MoH)
Hargeisa Group Hospital (HGH)
Boorama General Hospital (BGH)
National Health Professions Council (NHPC)
University of Hargeisa (UoH)
University of Amoud (UoA)
Somaliland Medical Association (SMA)
Tropical Health Educational Trust (THET)
King's Centre for Global Health (HCGH)
Nooleynta Naruurada Mustaqbalka (NNM)
Somdev

Agenda
Day 1 08:30-15:00

- Medical education in Somaliland: presentations from stakeholders

Day 2 08:30-15:00

- Workshop: undergraduate education
- Workshop: Internship programme

Day 3 08:30-15:00

- Workshop: postgraduate education
- Final session: Debrief and steps forward

Delegates

Mr Abdi Ahmed Nour	Director General of Ministry of Health
Dr Ahmed Suleiman Shine	Human Resource Development Department
Dr Lula J Hussein	National Health Professions Council
Dr Mohamed Ahmed	Amoud University
Dr Ahmed Ibrahim Bede	Somaliland Medical Association
Dr Mahdi Haji Ali Mohamed	University of Hargiesa
Dr Ahmed Omar Askar	Hargeisa Group Hospital
Dr Said Walhad	Amoud University
Hamse Mohamoud	Hargeisa Group Hospital
Dr Espen Heen	NNM
Dr Adam Ibrahim Liban	Amoud University
Dr Abdirashid Omar Ibrahim	Amoud University
Dr Ismail Mohil Aye	Boroma Hospital
Adnan Sayid Abdo	Hargeisa Group Hospital
Dr Mumin Farah Ismail	Amoud University
Dr Yassin Arab Abdi	Man-Haal Hospital
Edna Adan Ismail	Edna Adan University Hospital
Dr Paula Kitto	Edna Adan University Hospital
Dr Abdirahim Abdilahi Dualeh	Ministry of Health
Dr Mohamed Daud Qauden	Amoud University
Fouzia Mohamed Ismail	Somaliland Nursing and Midwifery Association
Jamad Ali Egaal	Somaliland Nursing and Midwifery Association
Dr AbdirashidDahir Aye	Amoud University
Dr Tim Fader	SomDev
Dr David Fox	SomDev
Dr Gudon Adam Abdi	Hargeisa Group Hospital
Wario Galma	THET
Emelien Nkusi	THET
Hussein Said Ahmed	THET
Mohamud A Yonis	THET
Mr Andy Leather	King's Centre for Global Health
Dr Susie Whitwell	King's Centre for Global Health
Prof John Rees	King's Centre for Global Health
Molly Fyfe	King's Centre for Global Health
Hannah Franklin	King's Centre for Global Health

Apologies

Dr Hussein Mohamud Mohamed	Minister of Health
Dr Hassan Ismail Yusuf	University of Hargeisa

Day 1: Medical education in Somaliland: presentations from stakeholders

Agenda

08.30 - 09.00	Registration and Holy Koran Recitation
09.00 - 09.05	Chairman's introduction
09:05 – 09:30	Minister of Health official welcome
09.30 - 09:35	Wario Galma THET's CR official welcome and opening of the meeting
09.35 – 10.00	presentation: Ministry of Health Human Resources Development Department
10:00 - 10:30	presentation: King's THET Somaliland Partnership
10:30 - 10:50	*Coffee Break*
10.50 - 11:20	presentation: University of Hargeisa
11:20 - 11:40	presentation: University of Amoud
11.40 - 12.10	*Break for prayers*
12.10 - 12:30	presentation: NNM
12.30 – 12:50	presentation: Somdev
12:50 – 13:10	presentation: NHPC
13.10 - 14:00	*Lunch*
14:00 - 15:00	Summary of discussion points raised in presentations and preparation for workshops

1) **Chairman's Introduction-Dr. Shine, Dr Whitwell, Wario Galma**
   - Dr. Shiine welcomed everyone and introduced the different stakeholders.
   - Gathered to discuss health workforce development – review achievements, share good practice and common challenges and think about a future roadmap for medical education in Somaliland.
   - Introduce Dr Susie Whitwell as the new KTSP lead

2) Wario Galma Welcomed everyone:
   - THET and Kings want to have these open discussions from all stakeholders and is look forward to the outcome of these meetings.
   - The MoH is making a significant progress, but cannot do this alone
   - There needs to be a holistic strategy
   - As THET, we are going through a process of change and will consider the outcome of this meeting and your input as we move forward.
   - The need for more qualified and well trained doctors is apparent if you travel to the different regions of the country and I have witnessed this from my short travels to some of these regions.

3) **Director General of the Minister of Health**
   - The minister of health sends his warm greetings and on behalf of the Ministry, I will like to welcome all the stakeholders.
   - As a ministry of health the IP program is very important and is a key priority for the health training of the country.
   - MoH is committed in facilitating and coordinating all activities/projects and programs conducted by stakeholders for the improvement of

country's health care and we will seek a breakthrough for the current existing challenges.

4) Ministry of Health Human Resources Development Department- Dr Shine Presentation

- It is crucial to produce quality doctors and the issue of supervisors must be discussed.
- As it is very important to the quality of health care provision, the continuation of the intern has to be revived.
- Opportunity to discuss undergraduate studies; internship program, CPD and post graduate studies
- Ministry recognizes two medical faculties- Amoud University (AU) and University of Hargiesa (UoH)
- Need to coordinate intakes for each university and project the numbers of health professionals needed in Somaliland, as well as the number that the health system can accommodate
- Need to discuss teaching facilities beyond Hargeisa Group Hospital (HGH) and Boroma Hospital (BH)
- Need to discuss educational supervisors
- MoH wants to commit to stability of the internship program, but needs additional support up to 2015
- Discuss future development of Postgraduate education- will it happen in other countries or do we need capacity to train in Somaliland?

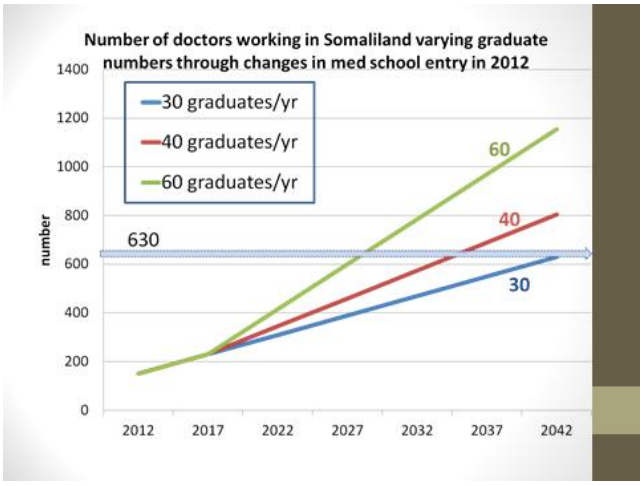
5) King's THET Somaliland Partnership (KTSP) - Dr. Andy Leather
Presentation: Medical Education and Training in Somaliland

- Need to address the continuum of medical education: undergraduate, internship, formal postgraduate and continuous CPD
- Original aims of the internship – do these need to change?
    - Equip graduates with the knowledge, skills and attitudes and experience to serve as registered doctors in Somaliland.
    - Lay foundations for the continuous medical education which would be open to all to all qualified medical professionals
    - Improve the provision of medical services provided in public hospitals in Somaliland
- 2007- internship started with defined rotations and clinical supervision
- 2009- dramatic increase of qualifying doctors coming into the internship and therefore expansion of the programme
    - First combined cohort from UoH and AU – 24 interns
    - need to rethink leadership and governance
    - need for admin support – intern coordinator hired
    - idea to send interns into rural regions
    - financial limitation caused internship to shorten from 24 months to 15 months
- To prepare for interns in the regions, met with hospital directors and evaluated hospitals
- Combined internship cohorts promoted collaboration between the universities
- Community acceptance of new interns grew – positive example from Erigavo
- Monitoring and Evaluation- logbooks, Audit, assessment forms attempted, but not completed. Survey of interns self-perceptions of competency

- SMA took part of this monitoring and went to the regions.
- Original logbooks covered 78 procedures. Four categories: observed, assisted, assisted unsupervised. Didn't assess quality of procedures
- No data on quality of supervision during the internship

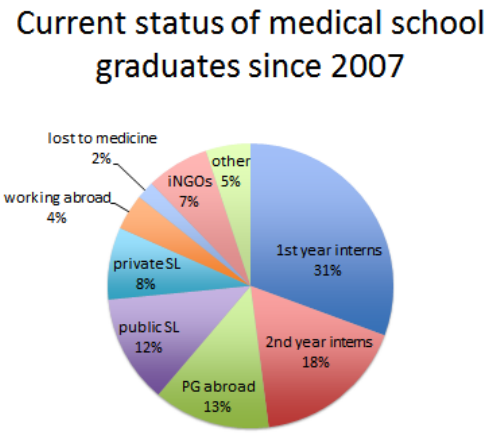
Question: What is the appropriate numbers of doctors for Somaliland?

- According to SAMSS survey (see appendix), about 30% of trained doctors leave practice
- If aim for SSA average of 18/100,000, will need 630 doctors in Somaliland
- At 30 graduates per year, will reach 630 in 2042. If 60 graduates per year, will reach 630 in 2027



- Based on current intakes in UoH and Amoud are looking to graduate 60 per year
- Can current system accommodate 60 students per year:
    - Enough faculties?
    - Facilities for clinical training for undergraduates (about 10 patient/beds needed per student)
    - Placements and supervision of interns- need to bring in new sites
    - Costs of the internships (salaries and supervision)
    - Opportunities for Postgraduate training- something for post interns to progress into
- In Boroma, currently, 330 patient/ beds (capacity for 30 students). Currently have the clinical facilities to meet student needs, but not when move to 60 students/year year. Other medical schools also using BH and HGH for training?
- Private sector training as a possibility. Interns are already seeking out supervision and training in private hospitals, although not officially allowed
- **What is our role as international trainers?**
    - as trainers
    - for distance training and mentoring through Medicine Africa (MA)
    - teaching trips
    - Faculty development and leadership training to increase capacity of young graduates
- Costs of the internship raising as intern numbers increase
    - 5 interns salary (2007) (430x5x12 - $25,800
    - 30 interns salary (450x30x12) - $162,000 (5% of health budget)
    - 60 interns salary- (450x60x12)- $324,000 (10.12% of health budget)
    - Above figures don't include other financial costs for the internship programme, other health professionals salaries or postgraduate training

- Sustainability
    - Financial
    - Faculty
    - Beds
    - Dedicated Clinical supervisors
- Postgraduate training



    - Family medicine postgraduate training in Boroma – the importance of generalists in remote referral hospitals
    - Those returning from postgraduate training abroad can start programmes in Somaliland – realistically 2015 onwards
- Opportunities
    - Cap number of medical students and interns (at MoH capacity)
    - Strengthen faculties
    - Improve supervision
    - Innovative use of private sector for undergraduate and internship training
    - Support generalist postgraduate training, and specialist training
    - Support accreditation of institutions

Discussion points rose from floor:

- MoH support is needed to provide ***10 patients per student*** for adequate training.
- Need to know the numbers of doctors currently practising in Somaliland, including immigrating professionals and diaspora
- Include graduates from other medical schools e.g Golis?
- 60-80% of all health services are private and most training institutions are private. Need to consider the role of the private sector in training healthcare workers given the increasing numbers of graduates and need for sub-specialty experience.
- MoH needs to consider criteria for training institutions, including those in the private sector.
- It will be hard for MoH to cap enrolment if not financially supporting the medical schools. Need to find a way to match enrolment to institutional training capacity.
- How do we ensure a continuum between schools (theory) and practical experience?
- Look into regional development, as some of the graduates are already receiving specialization trainings in Kenya, Ethiopia and Uganda.
- The associated cost of clinical teachings to Hospitals has to be considered as these facilities are over burdened with such costs.

6) University of Hargeisa- Dr. Mahdi

Presentation

- Apologies on part of Dean, Dr. Hassan
- Hargeisa- 260 students, 60 graduates, 27 lectures
- Local lecturers not always experts/ specialists. Need quality instructors for quality students. Getting qualified lectures is a challenge
- CPD can help current lectures to update their skills and knowledge.
- Overcrowding of facilities as students increase.
- Competencies for clinical education. Balance between what is feasible to train students to do (institutional capacity), and needs of the country.
- NNM supported workshop (with THET) to review training of students
- Started a clinical coordination unit at HGH with NNM support, which vital for the coordination and monitoring of clinical teachings.
- Some of the challenges from the internship program were lack of proper coordination office.
- Other incoming Dr into the country must be accounted for such as diasporas.
- We need teaching and curriculum development.

7) University of Amoud- Dr. Walhad

Presentation

- Six schools in Amoud University – medicine, nursing, dentistry, pharmacy, lab technology and now public health
- Educational strategy based on being responsive to population health needs, including community based education
- Internship strengthened referral systems and improved working between different health professionals. Internship also sold 'future doctors' to the community and got both universities collaborating
- Challenges for AU
    - Limited human resources that need developing
    - School development
        - Curriculum
        - Teaching techniques
        - Training supervisors
        - Bed side teaching
    - Limited facilities
    - Financial constraints
- Opportunities
    - Regulation
    - Improve services through internship programme
    - Set a trend in medical education
- Now thinking how to manage the number of health professionals when previously Somaliland was training none should be seen as a positive

8) NNM- Dr Espen Heen

Presentation

- NNM is a small organization, looking for role within wider context
- Aims to develop new generation of health workers.
- Working with nursing student, medical students, junior doctors but looking to expand to academic staff support. Also providing administration support and training for HGH
- Finds hands on clinical supervision the major gap in medical education.

- Ward management limits potential for clinical teaching
- Want agreement on who will teach the students/interns
- Developed a clinical log book working from THET competencies for interns for 4th, 5th, 6th year medical students but not enough clinical supervisors to observe/ check off log books

9) Somdev- Dr Tim Fader

Presentation

- The role of family medicine in Somaliland
- Primary care should be the foundation of the health system – it's cost effective and evidenced
- Basic Primary Health Services (BPHS). District hospital links community and hospital care. District hospitals serve a defined catchment.
- Generalist versus specialists. Family medicine able to cover about 90% of cases that present to the district hospital. Can coordinate referrals between regional hospitals and community health centres. Family medicine trained to promote population health
- Somdev running a 3 year family residency programme in Boroma with a broad rather than deep curriculum, giving doctors the key skills they need to perform remotely
- Opportunities
    - integrate medical education
    - integrate public and private
    - faculty development
    - research

10) National Health Professionals Council- Dr Lula Hussien

Presentation

- Has central role in the future of healthcare in Somaliland
- Legal act amended, has been passed by 2 houses of parliament, awaiting signature of president *(As of now it has been signed by the president)*
- Aims to raise the quality of the health care system, set standards, ensure professional competency, accredit and regulate institutions. Address malpractice and negligence
- Phased actions:
    - Accredit institutions
    - Register/ license foreign professionals
    - Registering and licensing pre-war professionals
    - Public education and awareness
- Need guidelines from MoH and MoE
- Working to align standards between different regions in Somaliland.
- All stakeholders should advocate for accreditation and regulation, not just the MOH

11) Summary of discussion points raised

- Questions to be addressed in workshops over the following days:
    - How many health professionals do we need?
    - How do we regulate medical school enrolment?
    - The internship is very important for the quality of doctors
    - Aims of the internship needs reviewing?

- How to Monitor and Evaluate the internship programme, including a review of the internship committee and coordinator role
- How do we ensure quality supervision? Who should supervise students and interns?
- How many clinical services/ facilities are needed for training? How / where will it be provided?
- Hospital support, especially clinical supervisory financial support
- Link between schools and hospitals
- Link between public and private
- How to transfer from training to practicing
- Role of the international community
- How to integrate medical education
- What role can SMA play, especially in the mentoring and CPD for junior doctors
- How do we develop faculty, including returning postgraduate students

Day 2: Undergraduate and Internship programme workshops

Agenda

8.45 – 9.00	Introduction
9.10- 10.00	Workshop 1: Undergraduate medical education
10.00- 10.40	Workshop 1 feedback
10.40- 10.55	*Coffee break*
10.55 – 11.00	Presentation from interns
11.00- 11.50	Workshop 2: Internship Programme
11.50 – 12.15	*Prayers*
12.15 – 13.00	Workshop 2 feedback
13.00 – 13.45	*Lunch*
13.45 – 15.00	Structured discussion around action points proposed

Presentation from Interns:

- Impact on national health
  - Adds fresh blood to healthworkforce
  - Improve access to services
  - Better trained doctors
- Impact on individual
  - Knowledge and skills
  - Build confidence in ability to serve community
  - Time recognize extent of responsibility, develop professional identity
  - Communicate with and interact with the community
  - Explore speciality areas for postgraduate study
- Impact on medical students
  - Interns available to the medical students. Medical student present HX and EX to the interns, Interns more available than supervisors
  - Medical students comfortable talking to interns, describe needs and weak points
- Challenges:
  - Commitment of supervisors
  - Lack of M and E of interns

- Pressure from family for interns to earn more money
- Lack of financial support

Discussion points raised:

- Now interns at HGH (unpaid)
- Excellence in internship can lead to selection of postgraduate
- Need to include interns in the internship committee.

Workshop sessions on each of the three themes of discussion (undergraduate medical education, the internship programme and postgraduate medical education/continued professional development) were used to answer questions frequently raised the previous day. Delegates were divided into facilitated groups, given a question to discuss and asked to develop some action points to take forward. One member of the group then presented back to the delegates before a wider discussion on the action points took place.

Workshop Presentations, Session 1: Undergraduate medical education

Q. What faculty development do we need? How do we deliver?

1. Dedicated senior member of faculty to lead medical education.
2. Undergraduate coordination committee, to connect between schools, hospitals and other stakeholders
3. Mapping the possibilities of teaching (including resources), where students are being taught, hence where the teachers are. Would aid collaboration between different institutions
4. Human resources development. Long and short term. Training for new faculty. Refresher for old.
5. A standardized National curriculum, including periodic review
6. Upgrade facilities within the faculty to strengthen their capacity.

Q. Do we need to cap the number of medical students in Somaliland and if so, how?

- Should we cap? Yes consensus
- How do we cap?
- Need harmonization of policy for medical school admissions i.e. national exam where top students can enter medical schools.
- Who do we cap? Amoud and Hargeisa but what about other medical schools? What is the ideal number? Needs more analysis.
- Numbers of supervisors just as important –need to consider number of patient/beds and number of quality supervisors.
- Issue of is there enough quality within the public sector, or do we need to tap into the private sector?
- If not, how do we support the public hospitals?

Q. What quality assurance should be set up in undergraduate medical education?

- Need to be sure curriculum is clear, objectives set for each attachment or teaching session.
- Strong coordination between the universities and teaching hospitals to facilitate professionalism and ethics?
- Ensure student: teacher ratios for quality teaching/supervision and to avoid overwhelming patients with huge groups
- Clear job descriptions for supervisors, interns and medical students
- Uniform/ dress to identify student by cadres

- Set standards
- Education for lectures and supervisors
- Provide skills lab for communication and skills. Teach communication and skills before students go to the ward.
- Routine Audit in which supervisors check records
- Student feedback/ evaluations

Q. Does the current curriculum meet the needs of Somaliland?

- Curriculum: content, instruction and assessment
- How do you know if your curriculum is working?
- Standard competencies needed, including standard competency assessment
- Regular curriculum review needed to examine gaps in theory and practical delivery
- Student evaluation/ feedback essential
- How will curriculum review be undertaken, by who, and how often?

Discussion on Undergraduate education action points:

- Admissions should consider more than academic achievement, such as character, motivation.
- English skills should be assessed in selection process
- Should universities have the ultimate decisions on admissions? Universities set their own admission criteria, but agree to numbers advised by the MoH so deans can defend these to the university
- 30-40 admissions per year suggested during group discussion – how will this be reached?
- How to coordinate resources around the country? Can do an environmental assessment to check what is available and pool resources:
    - skills lab in Boroma is being used by doctors and nurses effectively
    - University of Hargeisa is using Edna Adan skills lab during exams
- Does it make sense to have different oversight between undergraduate training and internship training? They use the same resources, supervisors and occur in the same location. Bringing the two together could ensure continuity and would enable same key supervisors for interns and students.
- Need to have more rigorous selection of supervisors in order to have quality supervision. Should people apply for the job, to ensure they are interested, then the ministry can train them?
- Limited number of qualified people to supervise clinical teachings. It would be more efficient to bring undergraduate, internship, and postgraduate under the same system, creating a hierarchy for learning where the more senior individuals supervise the junior. Need to pool limited human resources
- Quality assurance system needed to achieve this, built in from the start. Could be done collaboratively between the universities.

Workshop Presentation, Session 2: Internship Programme

Q. How do we ensure quality in clinical supervision?

- Supervision is mentoring, rather than just administration
- Action points:
    - Selection criteria for supervisors. Need to be joint appointments between the universities and hospitals.

    - A supervisor/ student of 1:6 (including interns or final year medical students). For example, at HGH right now with 16 MS and 21 interns would mean 2 full time supervisors on each ward.
    - Have senior and junior supervisors (e.g post interns) working as a team. Then if the senior is not there, a post intern doc can be there. Junior doctors could then be eligible for masters programs to bring them into the medical faculty.
    - All supervisors accountable (for clinical care)to what is going on in the ward.
    - Need incentives to keep people in these positions to keep them full time.
    - Need job descriptions for supervisors to communicate what is expected. Need to be jointly written by universities and hospitals
    - Monitoring and evaluation of teaching. Students need opportunity to give feedback.

Q. What is the role of stakeholders in the internship program?

- Stakeholders are: MoH (including HRD, medical directors of hospitals, interns and clinical supervisors), NHPC, SMA, universities, INGOs
- All stakeholders represented on an internship committee. Need to reorganize the internship committee.
- Components of the internship committee:
    - Leadership and governance
    - Coordination and management
    - Management at facility level (eg: HGH)
    - Supervision
    - Program feedback
- Action point: reorganize/re-commission internship committee to take on these roles.

Q. What monitoring and evaluation process need to be in place for the internship?

- End of internship examination exam not felt to be appropriate
- Need to know what evaluating, need expectation in order to assess whether they are achieved
- Build on what is already there, like the log book. But needs to change to include aspects of quality (not just record events). Need to be able to ensure that what is in the log books is accurate.
- Year 1:
    - 3 month reports that include attendance commitment
    - responsibility for collection and analysis is the responsibility of the internship coordinator and committee
    - internship coordinator to visit sites 2x per year
    - Does level on internship coordinator need to be different – senior individual more suitable?
- Year 2:
    - Log books in year 2, but include more self evaluation and reflection.
    - Some assessment in year to coming from the hospital direct.
    - Internship committee should visit all internship sites at least twice a year.
    - Overlap between interns in regional placements, a handover, to ensure continuity
- Final evaluation of whether internship is satisfactorily completed. Review all evidence from two years. May need longer than two years until competent enough to be signed off.
- Does this evaluate clinical competence? Do we need board exams?

- Self-reflection is a more constructive way of evaluating internship. Interns identify their own strengths/weaknesses
- Log books not currently being used appropriately: things being signed off that have not been done yet.

Q. Are the original aims of the internship fit for purpose?

Aims:

- Equip graduates with the knowledge, skills and attitudes and experience to serve as registered doctors in Somaliland.
- Lay foundations for the continuous medical education which would be open to all to all qualified medical professionals
- Improve the provision of medical services provided in public hospitals in SL

Presentation:

- Add an aim: including structured support, including supervision and financial
- Need to move focus from 'registered' to competent
- Current aims focus on national level – little relevance to the individual intern
- Need to specify each aim into measureable objectives – for both intern and supervisor
- Use competency as criteria for progression (may need more than one year)
- Health care delivery needs to be expanded beyond hospital care: eg: community or clinic.

Discussion on the Internship programme presentations and action points:

- Doctors in the first year of the internship can expect to receive clinical supervision.
- The group discussed what is meant by supervision and clarified that clinical supervision meant the day to day observing, training and mentoring by a senior doctor as opposed to the supervision by an employer which does not have a training aspect.
- Year two, when the interns work in the districts did not have clinical supervision although it was noted their employment was supervised by organisations such as the regional health board.
- Clinical supervision in the regions was not thought to be currently possible but should be revisited in the future
- Interns should remain in a specific training centre (where clinical supervision and training is possible) in year 1 until they are deemed competent to go into the districts – this could take over a year
- 2nd year of internship could be called 'national service' as it represents a period of service provision rather than training given the lack of clinical supervision in the regions.
- Although the second year represents service delivery rather than training, we recognised the need to provide support, given their junior status
- Mentoring rather than supervision? Mentors need to be different from supervisors who have an evaluation/ assessment role
- Interns should experience both Hargiesa and Boroma during internship, even if the internship is the responsibility of their faculty. Important for students from different universities to know each other and work together.
- Need careful selection of who to send where; send most capable interns to most challenging placements

Day 3: Postgraduate Medical Education and Continued Professional Development and final debrief

Agenda

8.45 – 9.00	Introduction
9.10- 10.00	Workshop 3: postgraduate medical education
10.00- 10.40	Workshop 3 feedback
10.40- 10.55	*Coffee break*
10.55 – 11.50	Debrief and steps forward
11.50- 12.00	Closing remarks

Workshop Presentations, Session 3: Postgraduate medical education and CPD

Q. How should postgraduate medical education be lead, governed and managed in Somaliland?

- Goal:
    - The right number of postgraduate (specialists and generalists) doctors to deliver comprehensive health services in all regions
    - Training programmes accredited by SSA Colleges and here in SL
- What happens in other countries in the region? Uganda, Kenya and Ethiopia?
- Need to understand how this is done and learn from their model
- Also need to look at Somaliland's current postgraduates overseas training experience
- Who should lead?
    - Higher education board
    - MoH
    - Major teaching hospitals
    - Universities (medical faculty)
    - Ministry of Finance
    - NHPC
    - SMA
    - International supporting partners
- Above should form steering committee with 3 roles:
    1. Internship management
    2. Take charge of PG training in interim period (e.g. selection/sponsorship of overseas training)
    3. Start to lead on formal postgraduate medical education in SL

Q. How to coordinate Postgraduate Medical Education abroad in this interim period before local training is established?

1. Link to specific training institutions in region eg Kenya
2. Prioritise specialties – 3 individuals in Surgery, O&G, Paeds and Internal medicine in first year (2 individuals then needed to set up programme)
3. Training for 3-4 years then commit doctors to work for university/hospital/MOH on return for a similar time. May require local guarantor, accreditation only on return, contract.
4. On return set up Somaliland postgraduate medical training in 2nd year
5. Training in teaching, education and management

6. Subsequently train 2 more individuals every other year in initial 4 specialties before building up to include further specialties eg mental health
7. Those self funded have no restrictions
8. Approx costs year1 = $180,000
   Year 2 = $360,000
   Year 3 = $540,000
   Year 4 = $720,000
9. Selection by a committee (including university and MOH) based on merit and suitability (transparent) – subgroup of internship committee?

Q. What are the priorities for postgraduate medical education in Somaliland?

1. Assess needs in Somaliland – data, specialist vs. generalist
2. Incentivise working in regions – bonding doctors for period of time, financial incentives
3. Cap NGO salaries to promote working in public sector
4. Scholarships and national service
5. National level negotiations of international PG training

Discussion on the postgraduate medical education and CPD action points:

- Needs to include continuing professional development as well as long term training.
- Those self-funded candidates will need incentives to return – can't enforce this
- Are we expecting current overseas trainees to return? Where will they go if so? Private sector? Need to be creative and look for opportunities
- Do we need specialists in regions? If family medicine model works well, generalists can work in referral hospitals and refer to specialists
- Generalists need to care for acute and chronic problems and do public health for their region – something missing in current internship
- Invest in district hospital for continuity rather than individual interns coming and going
- In-country training is a big jump – realistically looking at 2015 for this

Closing remarks

Wario:

- Chance to look at medical education more holistically
- Quality is the key
- THET committed to this and enthusiastic about working with King's and all stakeholders to make steps forward the next 3 years

Edna:

- Thanks to Andy for coming to Somaliland 12 years ago and helping make medical education pipe dream a reality
- We have a foundation to build on and what we have been discussing the past 3 days is doable
- Need to move forward from original public/private criteria – all facilities belong to Somaliland and all provide teaching for future generations
- Deep appreciate for THET and their hard work

Andy:

- Thanks to Susie and Wario for facilitating
- Exciting phase we are about to enter

Recommendations:

1. The revitalization of the internship program with clear mandate and strategy has been agreed by the majority of the attendees and supported by the Ministry.
2. The group were clear on the need to ensure quality day-to-day clinical supervision and were aware it is unrealistic to expect that level of supervision from consultants. This lead to discussion around using the emerging cohort of post intern doctors who have considerable skills and clinical experience but who have not yet moved on to postgraduate training. Discussion between the universities, hospitals and THET has been around supporting these post interns to take on a supervision role, namely the creation of a new middle grade of 10 post-intern doctors who could provide supervision to current interns and medical students.

   ACTION: THET to liaise with MoH and the universities about taking this forward.

3. The group agreed to re-launch the internship committee with wider remit to include all post graduate training for doctors:
   - include universities, NGOs, hospital, MoH and interns in committee
   - rotating chair
   - quarterly meetings – suggest the first taking place March 2013
   - This body can take forward discussions raised in this stakeholder meeting including the range of training opportunities for doctors

   ACTION: THET to facilitate the re-launching of the new postgraduate committee

4. The group were clear about the need to cap numbers of student entering medical school. The suggestion of 50 admissions raised and supported by both deans.

   ACTION: This to be taken forward to the postgraduate committee

Appendix

The Sub Saharan African Medical Schools Study - http://www.samss.org/