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Training reproductive health professionals in a post-conflict environment: exploring medical, nursing, and midwifery education in Mogadishu, Somalia

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Abstract: *Following two decades of civil war, Somalia recently entered the post-conflict rebuilding phase that has resulted in the rapid proliferation of higher education institutions. Given the high maternal mortality ratio, the federal government has identified the reproductive health education of health service professionals as a priority. Yet little is known about the coverage of contraception, abortion, pregnancy, childbirth, and sexual and gender-based violence (SGBV) in medicine, nursing, or midwifery. In 2016, we conducted a multi-methods study to understand the reproductive health education and training landscape and identify avenues by which development of the next generation of health service professionals could be improved. Our study comprised two components: interviews with 20 key informants and 7 focus group discussions (FGDs) with 48 physicians, nurses, midwives, and medical students. Using the transcripts, memos, and field notes, we employed a multi-phased approach to analyse our data for content and themes. Our findings show that reproductive health education for medical and nursing students is inconsistent and significant content gaps, particularly in abortion and SGBV, exist. Students have few clinical training opportunities and the overarching challenges plaguing higher education in Somalia also impact health professions programmes in Mogadishu. There is currently a window of opportunity to develop creative strategies to improve the breadth and depth of evidence-based education and training, and multi-stakeholder engagement and the promotion of South–South exchanges appear warranted. DOI: 10.1080/09688080.2017.1405676*

Keywords: reproductive health, abortion, contraception, pregnancy, delivery, sexual and gender-based violence, Somalia, post-conflict, fragile state

Introduction

Somalia recently emerged from a two-decade-long civil war during which period already fragile systems effectively collapsed.^{1,2} Prior to the beginning of the civil war in 1991, Somalia's health system was widely recognised as weak and the government directed the majority of foreign aid toward military spending.¹ The collapse of this government in 1991 resulted in chaos, civil conflict, the destruction of local infrastructure, and a lack of regulation.³ During the civil war years, public sector institutions, including formal educational institutions and hospitals, were sparse and this

confluence of dynamics left 80% of the population without access to basic health care.^{4,5}

Somalia's reproductive health indicators reflect these dynamics. At over 1000 deaths per 100,000 live births, Somalia has the third highest maternal mortality ratio in the world as well as one of the highest infant mortality rates at just under 100 deaths per 1000 live births.^{6,7} With a total fertility rate of nearly six children per woman and a contraceptive prevalence rate of only 1%,⁸ Somalia's reproductive health indicators evince the lack of available pregnancy, childbirth, and family planning services. Indeed, abortion is only legally

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permissible in Somalia to save the life of the woman.⁹ Post-partum haemorrhage and unsafe abortion are major contributors to reproductive health-related deaths in Somalia.¹⁰ Recent qualitative research with both key stakeholders and women in Somalia has showcased these pronounced reproductive health needs.^{11,12}

The reproductive health challenges facing Somalia are exacerbated by a dearth of health service professionals; obstetrician/gynaecologists (Ob/Gyns), nurses, and midwives are few and far between.^{8,13} The lack of functioning formal educational institutions during the civil war from 1991 to 2012 meant that the training of a generation of health-care workers did not occur. Out-dated medical procedures, practices based on tradition rather than evidence, and an absence of best practice protocols further aggravated the decay of the health system during the conflict period.⁸ For those trained prior to the start of the 1991 civil war, continuing education and training stagnated and licencing exams and oversight boards lapsed as the central government crumbled.

Since its installation in 2012, the new federal government in Somalia has prioritised developing the health workforce and replacing the ageing cohort that will soon be leaving the profession. The overarching plan involves a number of strategies including educating and employing more young people in health care.² Minting more midwives is especially prioritised as they require less time to train and are generally preferred by women.² Consequently, over the last 10 years, the formal education sector has changed drastically; in 2013, 22 universities were operational in Mogadishu, of which nearly half housed public health or medical sciences faculties, and accounted for about 20% of the 25,000 higher education students in Somalia's capital.¹⁴ The number of functioning post-secondary institutions nearly doubled by 2016¹³ and the private sector has been a major driver of this proliferation.^{14,15}

After the installation of the first federal government in over 20 years and the emergence of a relatively stable security situation, a window of opportunity arose to explore the current state of reproductive health education and training. In an effort to inform reproductive health policies and programming in Somalia, we conducted a multi-methods study to understand the reproductive health education and training landscape and identify avenues by which development of the next generation of health service professionals could be improved.

Methods

In April–June 2016, our research team conducted a multi-methods study dedicated to reproductive health education in Somalia. Our overarching project included a review of existing curricular materials, key informant interviews with stakeholders in the health and education sectors, and focus group discussions (FGDs) with health professionals in medicine, nursing, and midwifery and medical students in Mogadishu, Somalia. Although reproductive health encompasses a range of topics and issues, in this study we focused on contraception, abortion, pregnancy and delivery, and sexual and gender-based violence (SGBV). In this paper, we focus specifically on the results from the key informant interviews and the FGDs.

Data collection: key informant interviews

We conducted 20 key informant interviews with leaders and decision-makers in a range of positions, including representatives from the Ministries of Health and Education, Deans and professors of medicine, nursing, and midwifery at public and private universities and institutions, representatives from local and international non-governmental organisations (NGOs), hospital staff and administrators, and practising health-care professionals. To obtain a range of perspectives, we purposively contacted individuals in specific organisations and institutions, using publicly available information, the personal networks of the study team, and early participant referrals.

AY, a Somali-Canadian completing his master's degree in the Interdisciplinary Health Sciences program at the University of Ottawa, interviewed all key informants in English and/or Somali, after receiving training from AMF, a medical anthropologist and medical doctor with extensive experience conducting reproductive health research in conflict-affected settings. Using an interview guide developed specifically for this study, our domains of inquiry included participants' demographic characteristics, knowledge and experiences related to reproductive health services and higher education, insights into curricular development and the incorporation of reproductive health topics into training programmes, perspectives on the challenges facing health professions education, and ideas for improving and expanding reproductive health education in Somalia. Our interviews averaged 50 minutes and took place at the key

informant's place of business or in offices provided by local partners. With the consent of participants, we audio-recorded all interviews, which we later transcribed and translated (as necessary) into English. Immediately after each interview AY formally memoed, a reflexive process that also served as a critical analytic step.

Data collection: focus group discussions

We conducted seven FGDs with health service professionals and medical students. In order to create a degree of homogeneity, we organised two FGDs each with physicians, nurses, and medical students and one FGD with midwives. Given prevailing social norms and our topic of inquiry, we gender-grouped all of the FGDs; because midwifery is a woman-dominated field we conducted only one FGD. Representatives of our local university partners, the University of Mogadishu and Al-Imra International University, helped recruit participants from several hospitals, clinics, and universities in the city. Recruitment took place through announcements, word-of-mouth, and personal networks.

Each group comprised 5 to 10 participants. We held all of our FGDs in a private meeting space provided by our local university partners. AY facilitated all discussions with men and MH, a Somali national with a medical and research background, co-facilitated and took notes throughout. After receiving training from AY, MH led the discussions with women and AY served as co-facilitator. We used a discussion guide created specifically for this study and led all discussions in Somali.

The discussions began with participants introducing themselves and providing basic demographic information. We then explored participants' knowledge of, attitudes toward, and experiences with reproductive health care and service provision in Somalia. Our next domain of inquiry centred on participants' knowledge about and opinions of reproductive health curricula and curricular materials. We then explored the participants' knowledge of and opinions about contraception, abortion, pregnancy and delivery care, and SGBV. We concluded with a discussion on priority areas and avenues for improving and expanding reproductive health education and service delivery in Mogadishu. We obtained verbal consent from all participants prior to the start of the FGDs and audio-recorded the discussions. Each discussion lasted an average of 90 minutes. To thank participants for contributing to the

study and to cover costs associated with travel, we gave participants USD10. Immediately after each discussion, AY and MH debriefed on the process, content, verbal and non-verbal dynamics, and facilitation. In addition, AY formally memoed after each FGD in order to reflect further on the overarching dynamics and begin the analytic process. We later transcribed and translated into English all discussions.

Data analysis

Our analytic plan centred on content and themes. We used ATLAS.ti qualitative data management software to organise our data, comprising English-language transcripts, memos, and field notes. Content and thematic analysis is an iterative, ongoing process that begins with data collection. Based on our study questions and the interview and discussion guides, we developed *a priori* (pre-determined) codes and categories and as we familiarised ourselves with the data we created additional codes to capture emergent ideas; this process thus involved both deductive and inductive techniques.^{16,17} For the FGDs, we used a modified constant comparative analytic approach to explore similarities and differences between the groups based on field, gender, and professional/student status. Initially, we analysed the two components of the project separately. In the final phase of the analytic plan, we combined the findings from the key informant interviews and the FGDs, paying particular attention to discordance. Regular study team meetings throughout the process guided our overall interpretation.

Ethical considerations

The Social Sciences and Humanities Research Ethics Board at the University of Ottawa approved the project. In addition, researchers in medicine at the University of Somalia reviewed our study protocol and all instruments and determined that our approach met local research standards. In the "Results" section, we present key themes that emerged during our discussions and include illustrative quotes to support our interpretation. We have masked or redacted all personally identifying information and use pseudonyms throughout.

Results

Participant characteristics

We interviewed 20 key informants, 11 men and 9 Women. Our key informants worked for a range

of institutions and organisations, including government agencies, universities, hospitals/clinics, and NGOs. On average, our key informants had worked in the field of reproductive health for 15 years. With respect to our FGDs, 48 people participated, 18 men and 30 women. Our health service professional participants ranged in age from 22 to 34; on average, they had worked in their respective fields for 8 years. Our 14 medical student participants attended 3 different medical schools in Somalia. We provide more information about the characteristics of our FGD participants in Table 1.

Coverage of reproductive health is inconsistent and significant content gaps exist in medicine and nursing

“Each university creates its own curriculum ... [Universities] try to follow the international standards but there are no curricula that the Ministry brings out.” (Ali, male lecturer in medicine)

Both key informants and FGD participants repeatedly emphasised that the coverage of reproductive health varies tremendously in different medical and nursing programmes. A number of key informants noted that the absence of national curricular guidelines contributed to this dynamic. As one male informant, Abdirahman, noted, “I teach

[medicine] at multiple universities, but it is not the same. Each university places its credit hours [differently] per topic.” As a consequence, reproductive health coverage is influenced by the priorities of leaders and decision-makers at individual programmes as well as by their donors and the medical and nursing curricula in other countries; many individual schools are funded by or directly tied to programs in Turkey, the Arab world (the Gulf states in particular), and East Africa.

Despite the variability between institutions, some reproductive health topics are consistently prioritised over others. Students in all medical and nursing programmes receive didactic information about pregnancy and childbirth. A male Dean of Medicine at a private university in Mogadishu explained, “[Perinatal education is] very important ... from how to deliver, [manage] the pregnancy, after the delivery, everything’s important.” Key informants and FGD participants described this component of reproductive health as routinely incorporated into both maternal health and family health courses. Birth spacing and contraception are also included in most medical and nursing curricula. However, in both medicine and nursing, there appears to be a focus on “traditional” rather than “modern” methods. Fatima, a nurse who

Table 1. Composition of our seven FGDs with 48 participants

FGD	Type	Sex	Number of Participants	Description
1	Nurses	F	8	Female nurses working in Mogadishu between the ages of 22 and 34
2	Nurses	M	8	Male nurses working in Mogadishu between the ages of 22 and 34
3	Physicians	M	5	Male medical doctors working in Mogadishu between the ages of 24 and 34
4	Physicians	F	5	Female medical doctors working in Mogadishu between the ages of 24 and 34
5	Medical students	F	9	Female medical students attending 3 different universities in Mogadishu between the ages of 18 and 34
6	Medical students	M	5	Male medical students attending 3 different universities in Mogadishu between the ages of 18 and 34
7	Midwives	F	8	Female midwives working in Mogadishu with some formal education between the ages of 18 and 34

participated in an FGD, explained, “We learned about contraception, but we believe the traditional methods are the best.” Our discussions with both key informants and health professionals in the FGDs suggest that misinformation about modern contraceptive methods abounds and is reinforced by didactic instruction in medical and nursing programmes. As another nurse in our FGDs explained, “If I use an injection [Depo-Provera] I might pick up a disease. Now there’s a ring, [what] if I lose it? ... The effects are too adverse.” Aisha, a female medical student, echoed this sentiment, “We have been using them [traditional methods] for a very long time. Why should we use these things [modern contraceptives] when they bring side effects? And what if we can’t have kids anymore? Who’s going to fix that?”

In contrast with pregnancy and contraception, induced abortion care and SGBV receive scant didactic coverage. Medical students and recent medical school graduates reported receiving some exposure to post-abortion care and miscarriage management and generally felt that responding to pregnancy loss was an essential part of maternal health. However, both induced abortion and SGBV issues appear to be conceptualised as familial and social issues, not medical issues. In response to questions about the coverage of SGBV, one key informant expressed sentiments that were widely held by others, “We have procedures in place to deal with issues within the family; you go to the elders, so it’s not very important in medical education.”

Finally, although didactic coverage varies by topic and institution, participants in both study components reported that medical and nursing students receive very little practical training in reproductive health. Key informants identified the lack of clinical training opportunities, in general, as the biggest challenge facing medical and nursing programmes in Mogadishu. Fathiya, a government worker, stated “They don’t have [clinical training] ... because you need hospitals that are equipped and you need them to take part and to have good doctors in place to be able to teach [students].”

Enhancing pregnancy and childbirth education and training are priorities in medicine and nursing

“Pregnancy and child birth are very important areas; it’s saving the life of two people!” (Fathiya, female government worker)

Key informants repeatedly and consistently identified comprehensive perinatal care as a top priority for both medicine and nursing. Our interviewees and FGD participants recognised the high maternal mortality ratio and infant mortality rate as critical for the country and asserted that all health professionals – not just women – should be comprehensively trained. Asli was met with agreement by other participants in the midwifery FGD when she said, “Men should learn [childbirth care] too; it’s important for everyone to be able to save a life.” Participants in both components of the project emphasised the need for didactic instruction, clinical training, and public awareness-raising campaigns about the importance of institutional deliveries as ways of addressing a significant public health problem in Somalia.

In contrast, most key informants expressed minimal interest in prioritising comprehensive contraceptive coverage in medicine and nursing education and training. Participants in both study components indicated that a lack of overall demand, concerns about side effects, and mistrust of the Global North’s motives in promoting family planning shaped their reservations. A female physician in one of the FGDs commented on contraception, “That’s a Western thing that, you know, they [Somali women] reject, so it’s unimportant.” Key informants and FGD participants often referenced socio-cultural norms and dominant local interpretations of Sunni Islam. When nursing professionals in the FGDs discussed the challenges in improving contraceptive education among health service professionals, one female participant expressed the view of the group, “Somalis are ready to have children, we are not at a stage where we need to stop pregnancies yet.”

Similarly, when discussing the role of comprehensive abortion care in medicine and nursing education participants frequently referenced their perceptions of the socio-cultural and religious permissibility of induced abortion. Participants generally believed that an abortion was justified to save the life of the woman but otherwise ended a life and interfered with God’s will. As Saida, a midwife, explained, “God entrusted us with this knowledge; we must use it to please him [by saving lives] and not disobey him [by inducing abortions].” However, key informants and some FGD participants acknowledged that abortions occur and thus health professionals should receive didactic education on the topic. The female director of an NGO in Mogadishu, Zaynab,

commented, “Abortion as knowledge is fine to learn about. But if people learn about [doing it], they will perform abortions on anyone, and that’s not good for our society.”

The conceptualisation of SGBV as a social rather than a medical issue meant that participants in both components of the project did not feel that training in screening, documenting, managing, or treating SGBV cases was a priority. Key informants were especially emphatic that SGBV should be addressed through familial and community processes. As expressed by a representative of an international NGO, “We have procedures in place to deal with issues within the family – you go to the elders, so it’s not very important in medical education.” Medical students echoed this opinion; as expressed by one female FGD participant, “It’s not important for us to learn if we aren’t going to use it. [There’s] things that are more important for us to deal with.”

Midwifery programmes consistently include a range of reproductive health issues

“We receive midwives year round and we train them on how to do deliveries until they are comfortable [doing them] alone.” (Faisa, midwifery instructor at a teaching hospital)

Key informants and FGD participants repeatedly sang the praises of the midwifery programmes in Somalia, describing these programmes as the “gold standard” for reproductive health education and training. Key informants explained that, unlike medicine and nursing, the Somali government plays a significant role in midwifery education and influences the curriculum, which is standardised. The expansion of midwifery programmes in the post-conflict period resulted from a government initiative to build local capacity and strengthen perinatal services.

Drawing from international guidelines, both key informants and midwives in our FGD reported that programmes in Mogadishu include a range of reproductive health issues and prioritise clinical training opportunities. Somali midwifery programmes focus on training a cadre of women to perform safe deliveries in the community and to recognise when to refer a pregnancy or labouring woman to a hospital for an institutional delivery. Placements in maternity hospitals and with NGOs help ensure that midwives develop appropriate clinical skills.

Midwifery students are also introduced to a range of contraceptive technologies, particularly for use in the post-partum period. As Asli explained, “We are taught about the different modalities [of contraception] and their efficacy as well as how to recommend it to women.” The programmes also routinely incorporate information about abortion and SGBV. According to Asli, “We don’t really learn about how to perform abortions, but to recognize when to refer people, and [it’s the] same for sexual and gender-based violence.” Thus midwifery programmes appear to incorporate a wider range of reproductive health issues into routine education and training than medical or nursing programmes. However, abortion and SGBV care focuses more on referrals and, given that physicians and nurses are receiving minimal training in these areas, these referrals may not be sufficiently addressing needs.

Broader challenges facing higher education influence reproductive health coverage

“Our biggest problem is the lack of the government.” (Muna, nursing FGD participant)

According to our key informants, higher education in Somalia faces a number of challenges. The proliferation of privately run higher education institutions is rapidly expanding post-secondary opportunities. However, the lack of government oversight has resulted in a lack of unified standards and private institutions. Abukar, a lecturer, explained, “There are too many universities and they all are competing for students, so their standards aren’t kept.” Key informants also reported that due to the fear of losing students to their competitors, universities often have to streamline programmes and get students out quickly; this has implications for how robust the curricula are.

Participants in the medicine and nursing FGDs also repeatedly expressed concern about the quality of health professions training. Lack of clinical placement opportunities, lack of consistency in the curricula, and the absence of national standards plague medicine and nursing programmes in general, not just in the area of reproductive health. Consequently, both key informants and FGD participants expressed the need for the Somali federal government to assert control over all health professions, not just midwifery, and facilitate the development of national standards and curricular priorities.

Discussion

Over the last decade, the higher education sector in Somalia has grown significantly; most of this growth has been concentrated in the capital of Mogadishu.^{14,15} These institutions, the majority of which are private, have become a symbol of progress in the post-conflict era of enhanced stability and security. In 2013, more than 50,000 students across Somalia attended over 40 institutes of higher learning, a number that continues to increase with each passing year.¹⁴ Yet the proliferation of private institutions has resulted in fierce competition for limited resources and qualified personnel; only 11% of lecturers hold a PhD or its equivalent and 50% hold a master's degree.¹⁴ The majority of these institutions lack libraries, information technology facilities, and science laboratories, dynamics which compromise the quality of education and the ability of students in a variety of fields to train to competence.^{1,14}

Our findings suggest that these overarching dynamics are influencing the comprehensiveness and quality of reproductive health training in medicine and nursing. Although reproductive health has been identified as a priority area by the Somali federal government² our results indicate that health service professionals lack comprehensive reproductive health information and training and there is tremendous inconsistency in what is offered. Midwifery stands out as an exception; this field has a unified curriculum that is informed by the global educational standards of the International Confederation of Midwives.¹⁸ Midwifery programmes have benefited from logistical support from the United Nations Population Fund (UNFPA) and oversight by the Somali government and have been recognised for the quality and comprehensiveness of training and education. Although there is still some room for improvement, the trajectory of midwifery in Somalia may offer lessons for those engaged in ongoing efforts to improve education and training, in general and in reproductive health, in both medicine and nursing.

With a lack of standardisation in reproductive health curricula in medicine and nursing, decisions regarding what to include appear to become discretionary. As a result, our findings suggest that content and coverage appears heavily influenced by socio-cultural and religious beliefs about what is permissible, acceptable, and constitutes a health issue. Theological positioning within Sunni Islam

generally deems the use of non-permanent methods of contraception in the marital relationship and induced abortion prior to ensoulment religiously permissible.^{19–21} However, participants in this study did not routinely engage with these dominant interpretations, a finding that is consistent with previous research in Somalia.¹¹ Promoting the exchange of ideas and information between representatives of programmes in Mogadishu and representatives of programmes in other Sunni Muslim majority countries that have incorporated a more comprehensive range of reproductive health issues could prove valuable.

Our results suggest that identifying creative strategies to increase clinical training opportunities in comprehensive reproductive health issues for medical and nursing students is warranted. In the absence of overarching changes in the higher education system resulting in increased government oversight, these efforts will likely take place through the NGO and private sectors. Supporting efforts by international NGOs to offer high quality, evidence-based training and clinical placement opportunities could fill a significant gap. Working with the government to develop minimum standards for reproductive health content could help ensure some degree of uniformity. Tapping into the vast Somali diaspora of health professionals might also be a mechanism for increasing culturally resonate training capacity. Finally, facilitating efforts to create voluntary quality assurance boards or accreditation standards²² could support the eventual development of national standards.

Limitations

Our study has a number of limitations. Although we are confident that the themes we identified have import beyond the immediate study population and reflect broader social norms, the qualitative nature of this study by definition means that our findings are not generalisable. That we did not include nursing or midwifery students in this study is a gap that should be addressed by future research efforts. Furthermore, for a number of pragmatic reasons, including the security situation at the time of data collection, we limited our project to Mogadishu. Although the majority of universities and students are located in the capital, future projects would benefit from including universities from other parts of the country. Positionality is important in qualitative research and we understand that the researchers influenced both the

key informant interviews and the FGDs. We took multiple measures, including memoing debriefing, and holding regular team meetings, to understand these influences and increase the credibility and trustworthiness of the study.

Conclusion

Creating a comprehensively trained health workforce and incorporating a range of reproductive health issues into health professions programmes are significant priorities in Somalia. However, reproductive health education continues to be fragmented. Midwifery education provides a model for what can be achieved with multi-sectoral collaboration. The post-conflict rebuilding climate and the stated commitment of the federal government to reducing maternal death and disability offer a window of opportunity to develop creative strategies to improve the breadth and depth of evidence-based education and training.

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Disclosure statement

The authors declare that they have no conflicts of interest, financial or otherwise.

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Résumé

Après deux décennies de guerre civile, la Somalie est récemment entrée dans la phase de reconstruction postérieure au conflit qui a abouti à une prolifération rapide d'institutions d'enseignement supérieur. Compte tenu du taux élevé de mortalité maternelle, le Gouvernement fédéral a estimé que la formation à la santé génésique des professionnels de santé était une priorité. Pourtant, on sait peu de chose sur la couverture de la contraception, l'avortement, la grossesse, l'accouchement et la violence sexuelle et sexiste en médecine, soins infirmiers ou obstétrique. En 2016, nous avons réalisé une étude à plusieurs méthodes pour comprendre la situation de la formation et de l'enseignement en matière de santé génésique ainsi que pour identifier des moyens d'améliorer le développement de la prochaine génération de professionnels des services de santé. Notre étude comprenait deux volets : des entretiens avec 20 informateurs clés et sept discussions de groupes d'intérêt avec 48 médecins, infirmières, sages-femmes et étudiants en médecine. À l'aide de transcriptions, de mémorandums et de notes d'observation sur le terrain, nous avons appliqué une approche à plusieurs phases pour analyser le contenu et les thèmes de nos données. Nos conclusions montrent que l'enseignement de la santé génésique suivi par les étudiants en médecine et en soins infirmiers n'est pas cohérent et qu'il comporte des lacunes importantes de contenu, en particulier sur l'avortement et la violence sexuelle et sexiste. Les étudiants ont peu d'occasions de formation clinique et les obstacles globaux dont souffre l'enseignement supérieur en Somalie touchent également les programmes des professions de santé à Mogadiscio. Il existe actuellement une possibilité de définir des stratégies créatives pour améliorer

Resumen

Tras dos décadas de guerra civil, Somalia recientemente inició la fase de reconstrucción postconflicto, cuyo resultado ha sido la rápida proliferación de instituciones de educación superior. Ante la alta tasa de mortalidad materna, el gobierno federal ha identificado como prioridad la educación sobre salud reproductiva para profesionales de salud. Sin embargo, en medicina, enfermería o partería no se sabe mucho acerca de la cobertura de anticoncepción, aborto, embarazo, parto, violencia sexual y violencia de género. En el año 2016, realizamos un estudio de múltiples métodos para entender el panorama de educación y formación en salud reproductiva e identificar las vías por las cuales se podría mejorar el desarrollo de la próxima generación de profesionales de salud. Nuestro estudio consistió en dos componentes: entrevistas con 20 informantes clave y siete discusiones en grupos focales (DGF) con 48 médicos, enfermeras, parteras y estudiantes de medicina. Utilizando transcripciones, memorándums y notas de campo, aplicamos una estrategia multifásica para analizar nuestros datos con relación al contenido y temáticas. Nuestros hallazgos muestran que la educación sobre salud reproductiva para estudiantes de medicina y enfermería es incongruente y que existen brechas significativas de contenido, en particular sobre aborto, violencia sexual y violencia de género. Los estudiantes tienen pocas oportunidades de recibir capacitación clínica y los retos generales que acosan la educación superior en Somalia también afectan los programas de profesiones sanitarias en Mogadishu. Actualmente hay una ventana de oportunidad para formular estrategias creativas para mejorar el

l'ampleur et la profondeur de l'enseignement et de la formation à base factuelle, et la participation pluripartite de même que la promotion d'échanges Sud-Sud semblent justifiées.

alcance y la profundidad de la educación y formación basadas en evidencias, y la participación de múltiples actores y promoción de intercambios Sur-Sur parecen ser necesarias.