REPORT ON THE 22ND ANNUAL CONFERENCE FOR THE ASSOCIATION OF MEDICAL COUNCILS OF AFRICA

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1. PREAMBLE

The members of AMCOA meet on an annual basis to discuss means of ensuring an integrated process of medical regulation, standardisation/harmonisation of education and training, the enhancement of quality healthcare, etc.

The vision of the Association of Medical Councils of Africa [AMCOA] is to be globally recognised as the leading organisation for regulatory bodies in protecting the public and guiding health professions in Africa.

The primary purpose of AMCOA is to create an environment for best practice by health professions regulatory bodies in partnership with member councils and engagement of other stakeholders through:

- harmonisation of standards for medical education, training, practice and fostering compliance thereof;
- promotion of professional and ethical practices;
- capacity building & information exchange; and
- Improved Access to Health.

2. APPROACH TO THE REPORT

This report is a summary of events over the 5-day conference, which comprised of –

(i) Pre-conference workshops and technical meetings;
(ii) Scientific conference; and
(iii) Annual General Meeting.

Under **Section A**, the report will address the pre-conference workshop and technical meetings and the overall outcomes thereof.

Under **Section B**, the report will further address the scientific conference and the key issues covered in the oral presentations made by member countries. It does not attempt to address each presentation made during the meeting but rather seeks to highlight areas, which were duly considered and placed into the final AMCOA protocol as best practices for possible application by its members.

Under **Section C**, the report will focus on the highlights of the Annual General Meeting as well as the proposed way forward for AMCOA activities.

3. INTRODUCTION

The 22nd Annual Conference of the Association of Medical Councils of Africa was proudly hosted by the Medical and Dental Council of Ghana at the Royal Senchi Hotel, Akosombo, Ghana from 23 – 27 July 2018.

The focus of this year's conference was on the "Changing Landscape in Medical Education and Training".

In line with the AMCOA mission, the conference facilitated ongoing exchange of information among regulatory authorities within the Africa and International Region. This led to the revision of current protocols on education and the development of new protocols, namely –

(i) Protocol on Undergraduate Medical Education and Training;
(ii) Protocol on specialty Training; and
(iii) Protocol on Internship Training.

The Health Regulatory Authorities of the following countries were represented –

1. Botswana
2. Ghana
3. Gambia
4. Kenya
5. Lesotho
6. Liberia
7. Malawi
8. Namibia
9. Nigeria
10. Rwanda
11. Seychelles
12. South Africa
13. Southern Sudan
14. Swaziland
15. Uganda
16. United States of America
17. Zambia
18. Zimbabwe

3. SECTION A | PRE-CONFERENCE WORKSHOPS

3.1. AMCOA CAPACITY BUILDING WORKSHOP

In line with Strategic Goal 6 of AMCOA (i.e. to create effective and efficient mechanisms for improving capacity within the regions) a capacity building workshop was held to address the following aspects –

(i) **Modernising** existing **institutions** by forming sound policies, organisational structures, and effective methods of management and revenue control;
(ii) The need for Health Professions Regulators to build their **own Strategy Toolbox;**
(iii) **The tools** that should be found in the Regulator's Strategy Toolbox;
(iv) **Understanding of the pitfalls of strategy planning and execution** as can be applicable to Health Professions regulatory environment;
(v) **Capacity** that Health Professions Regulators must work towards **building**; and
(vi) **Understanding the required fit** between Corporate Strategy and Organisational Structure.

The workshop was undertaken by the Health Professions Council of South Africa and had an attendance

of approximately 100 delegates from the various member countries present.

Presentations Annexure A

3.2. AMCOA SUB COMMITTEE MEETINGS

AMCOA Sub Committees embarked on the development of the Committee Handover Reports for the term 2015 - 2018, which focused on the following aspects –

(i) Activities, achievements, challenges and future plans in line with AMCOA's vision, mission and strategic goals;
(ii) Committees' performance reports based on deliverables;
(iii) Terms of Reference; and
(iv) All supporting policies or guidelines necessary for the functioning of the Committees.

The Committee's reports were completed and presented to the Annual General meeting where it was approved.

3.3. HEALTH WORKER MIGRATION WORKSHOP

AMCOA had, in a previous conference, adopted a Protocol on Health Worker Migration which addressed the need to increase and maintain health workforce within Africa. The Management Committee of AMCOA had in its strategic session highlighted the shortage of qualified health workers worldwide and the imbalanced geographical distribution within and between countries in Africa and resolved that a session be held at the conference which would be aimed at creating dialogue on the following issues –

(i) Co-operation on matters concerning health personnel migration and health systems strengthening;
(ii) Cognizance of the need to have data that would further inform research but most importantly elicit dialogue to inform policy intervention;
(iii) Modalities of retaining health workforce for a strengthened health system;
(iv) Need for Policies/Guidelines to track migrant health workers of all levels and for all reasons; and
(v) Possible mode of co-operation between host and recipient country.

The session was led by Dona Anyona, Regional Policy Manager – Health Systems Advocacy Project, AMREF Health Africa. During the discussions the following statistics were noted –

Reason for Migration	**Rwanda**
Application for further Studies and Employment	1
Employment (Especially from Congo and Burundi)	113
For Further Studies	1
Immigration	2
Marriage	1
Relocation	0
Total	**118**

Reason for Migration	Kenya
External Residency Rotation	2
Out-migrating / Relocating	22
Postgraduate / Further Studies	1425
Potential Employer Recruitment	147
Professional Registration Requirement	27
Total	**1623**

Reason for Migration	Uganda
Employment	3
Immigration	1
Marriage	1
Relocation	1
Study	263
To Practice	1
Visiting	2
Total	**272**

Reason for Migration	Zambia
Employment Purposes	27
Registration with another Regulatory Body	27
Further Studies	23
Total	**77**

After reviewing the progress reports as presented by the various Member Councils, it was agreed that the Registrars and CEOs of the various Member Councils should review the tracking tools, the data provided and further refine the reports.

Member Councils were urged to, within their legislative mandate in their respective countries, pursue the processes of developing legislative or other policy frameworks to facilitate monitoring and retention of health worker migration within the regions.

Presentation Annexure B & Protocol Annexure C

3.4. ROLE OF THE REGULATOR IN UNIVERSAL HEALTHCARE COVERAGE (UHC)

A short session was held to discuss the role of regulators within Africa in terms of the new era of Universal Healthcare Coverage (UCH). A presentation was made by Dr Njeri Mwaura of World Bank Group on its activities within Kenya on the implementation and development of UHC.

The session highlighted the following –

(i) Regulations/Laws and its impact on demand and supply within the health environment (i.e. (i) Demand Side - Healthcare, Financing and Communities and (ii) Supply Side - Human Resources for Health; Health Facilities, Commodities and ICT; and

(ii) The need for Universal Healthcare Coverage to be accessible, equitable, affordable and qualitative.

3.5. REGIONAL BLOCK WORKSHOPS

The regional block workshops were aimed at facilitating proactive coordination, cooperation, harmonisation of the standards of the education and collaboration among member councils to protect, promote, and maintain the health and safety of the public of the regions.

The attendees were grouped according to regional representation (i.e. SAD; EAC and ECOWAS). The agenda focussed on the following –

(i) Standardisation of Medical & Dental Curricula for Under/Post Graduates;
(ii) Inspection and Accreditation of Medical & Dental Schools and Teaching Hospitals; and
(iii) Single Exit Exam for Foreign Qualified Practitioners.

The outcomes were presented at a plenary session and the following was highlighted –

East African Community (EAC)

Attendees

1. Kenya
2. Rwanda
3. South Sudan
4. Uganda

Outcomes

(i) Core curriculum for medical and dental undergraduate training was developed in 2012;

(ii) The minimum standards for the core curriculum were jointly developed by the medical and dental councils and the Councils for Higher Education in the Region;

(iii) The EAC member states Kenya, Rwanda, Burundi, Tanzania and Uganda are implementing the Core Curriculum for Undergraduate training;

(iv) The purpose of the standardised curriculum was to assist in facilitating mutual and reciprocal recognition of the graduates in the region;

(v) There is postgraduate training in the EAC member states for MMED and collegiate platforms BUT there are no standardised guidelines within the region;

(vi) The core curriculum informed the development of the Joint inspection and accreditation tools (***guidelines and checklists***);

(vii) Joint Inspection and Accreditation Tools are in place for both Medical and Dental Schools and Teaching Hospitals;

(viii) Joint Regional Inspections of Medical/Dental Schools and Teaching Hospitals were carried out in 2013 and 2015 (***Burundi, Kenya, Rwanda, Tanzania and Uganda***);

(ix) The guidelines and the inspection checklists have been reviewed twice in 2014 and 2017. The purpose of the review was to make them user friendly, objective and with measurable expectations;

(x) Internship training centres have not been JOINTLY inspected through the EAC regional collaboration platform;

(xi) Dentistry requires a special emphasis as there are currently serious gaps in the system of accreditation of dental internship sites;

(xii) Exploit the feasibility of involving private sector to be part of the internship sites for certain specialty rotations;

(xiii) Each member state administers exam to a foreign trained medical/dental practitioner under their respective laws and regulations;

(xiv) In Kenya, Rwanda and Uganda administer the following examinations before registration and licensure to practice medicine or dentistry for graduates who have been trained outside the EAC recognised medical and dental schools:
   a. pre-registration,
   b. internship qualifying examination, and
   c. peer review (***for specialists***).

(xv) In South Sudan pre-registration examination is carried out after internship for one to qualify for full registration.

Economic Community of West African States (ECOWAS)

Attendees

1. Gambia
2. Ghana
3. Liberia
4. Nigeria

Outcomes

(i) In Country, the minimum standards for undergraduate training in medical and dental schools are the same;

(ii) In West Africa, the curricula for medical and dental undergraduate training has been harmonised under the West Africa Health Organisation (WAHO);

(iii) The implementation of the harmonised curricula is yet to be done as it is yet to be ratified by the

Ministers of Health;

(iv) Internship in the four (4) countries is similar except for the duration and available disciplines.
   a. Gambia – 4 disciplines (*medicine, paediatrics, surgery, obstetrics & gynaecology*). Each rotation is for 6 months (duration 2 years).
   b. Ghana – 4 disciplines out of 6 (psychiatry & anaesthesia); 6 months per discipline (duration 2 years).
   c. Liberia – 4 disciplines; 12 weeks per discipline (duration 1 year).
   d. Nigeria – 4 disciplines; 12 weeks per discipline (duration 1 year).

(v) Internship/Housemanship is yet to be harmonised;

(vi) Post Graduate Training in Basic Sciences is done in the various universities and recognised by the Councils;

(vii) The Post Graduate training in clinical sciences is done by the Postgraduate Colleges;

(viii) Limited exemptions and reciprocity within and across member countries;

(ix) The harmonisation of training curricula by the Postgraduate Colleges is ongoing;

(x) There is an overarching West Africa Postgraduate Medical College with tripartite Committee which meets biannually to discuss training issues with the National Colleges. There is active participation by Liberia, Gambia and Sierra Leone whom do not yet have National Colleges; and

(xi) The Medical and Dental Council of Nigeria will host the 1st Sub-Regional Meeting.

Southern African Development Community (SADC)

Attendees

1. Botswana
2. Lesotho
3. Malawi
4. Namibia
5. South Africa
6. Swaziland
7. Zambia
8. Zimbabwe

Outcomes

It was reported that –

(i) In line with the resolution taken in November 2016 at the SADC Health Ministers meeting held in Swaziland, the SADC Medical and Dental Regulatory Association (SADC MDRA) was established;

(ii) A series of meetings were held to finalise its terms of reference, strategy and operational plans;

(iii) The purpose of the SADC MDRA is to, under the umbrella of AMCOA, (a) provide a pedestal for information sharing among member regulators of the SADC Region, (b) facilitate proactive

coordination, cooperation, harmonisation of the standards of the medical and dental education and (c) collaborate among member councils to protect, promote, and maintain the health and safety of the public of the SADC region;

(iv) The Secretariat as elected was Malawi;

(v) The implementation of the strategic plan called for the establishment of various committees within the SADC MDRA namely –

a. Finance Committee (Chair Namibia)
Objective 6: Resource and Finance mobilisation.

b. Education Committee (Chair Lesotho)
Objective 3: To strengthen the standard of undergraduate, postgraduate and continuing medical education.
Objective 4: To assist member Councils to develop and establish strategies of improving standards of professionalism in accordance with their needs.

c. Communication Committee (Chair South Africa)
Objective 1: To establish close collaboration and mutual exchange of information between medical Councils of the SADC region countries.
Objective 2: To assist member Councils to adopt beneficial practices to function efficiently and effectively.
Objective 5: To establish close relationships with other international organisations committed to improving professional standards among medical practitioners.

d. Audit and Risk Committee (Chair Zimbabwe)
To have oversight functions over all committees.

(vi) The SADC MDRA Chairperson (Malawi) attended the SADC Health Ministers' meeting on 6th November 2017 to present the progress report on the execution of the SADC Health Ministers in 2016 however was not able to present; and

(vii) The SADC MDRA and its committees will now commence with the implementation of the strategy and operational plans and report back to AMCOA at its next meeting.

3.6. SIDE MEETING – REGULATORS & FEDERAL STATE MEDICAL BOARDS – SINGLE EXIT EXAM FOR FOREIGN QUALIFIED PROFESSIONALS

The Health Professions Council of South Africa held a meeting with the Federation of State Medical Boards and the National Board of Medical Examiners to discuss the proposal for the implementation of Medical Examination for South Africa (SPEXI) for foreign qualified practitioners wishing to register with the Medical and Dental Professions Board of South Africa. Phase 1 would consist of delivering a single-day, multiple-choice question (MCQ) examination administered during one test administration window in the second quarter of 2019. Should both organisations agree to a continuation of the pilot, Phase 2 will occur with a second administration of the examination during the fourth quarter of 2019. The meeting was also attended by other regulators from the EAC, SADC and ECOWAS region. Vouchers were made available to those regulators to review the proposed examination platform and provide feedback to the AMCOA Secretariat.

3.7. CROSSING INTERNATIONAL BORDERS

Presentations were made by various international stakeholders; namely –

INTERNATIONAL ASSOCIATION OF MEDICAL REGULATORY AUTHORITIES

IAMRA, represented by Dr Alison Reid, gave a presentation on its structures and the common challenges faced by regulatory authorities.

She went on to detail to regulators the importance of accreditation systems and its purpose to ensure the provision of high quality medical education, identify inadequate medical education programmes, assist education providers to improve the quality of their programmes and ultimately, protect patients.

She advised that the IAMRA statement on Accreditation highlighted the following –

(i) Worldwide, there has been a rapid expansion in the number of medical education programmes, increasing diversity in the bodies offering these programmes and innovations in the way programmes are delivered. Medical education is provided in both the government and private sectors and there is potential for the quality of the programmes to vary considerably, even within a country. The *World Directory of Medical Schools1* lists medical education programmes worldwide. Currently, there are nearly 3000 medical schools, with the number of new medical schools increasing at a rate of approximately 5-10% per year.

(ii) Internationally, there are three main models for ensuring the quality of medical graduates:
   a. accrediting medical education programmes to ensure that they and their graduates meet an appropriate standard;
   b. requiring new graduates to sit a licensing examination;
   c. a hybrid of models a and b.

(iii) Some countries already have well established accreditation and approval programmes, generally provided by the Medical Regulatory Authority, government, or by an independent body established for the purpose. Other countries utilise licensing examinations alone to determine new graduates' fitness to practise.

(iv) In the absence of an accreditation system that requires an appropriate standard of medical education, graduates may find that after four, five or six years of study, they are unable to pass the licensing examination and therefore, cannot work in their chosen profession. With or without a licensing examination, a robust medical school accreditation system is highly desirable.

(v) **The benefits of an accreditation process**

   a. Independent accreditation processes:

      i. enable the community to be satisfied that a medical education provider and its medical programme meet the approved accreditation standards, benefiting prospective students, employers of the graduates of the programme and, ultimately, healthcare consumers;

ii. enable the establishment of standards that are relevant to the local healthcare environment;
iii. assist medical education providers to ensure that their programs respond to evolving health needs and practices, and educational and scientific developments while retaining diversity and encouraging innovation;
iv. enable education providers to identify the weaknesses and strengths of their programme;
v. assist the local Medical Regulatory Authority to assess a graduate's suitability for registration/licensure;
vi. assist other Medical Regulatory Authorities to assess the quality of an applicant's basic medical education, and therefore their suitability for registration/licensure.

(vi) **Accreditation standards**

a. Accreditation should be undertaken with reference to clearly stated standards and requirements. The accrediting body should set standards, or adopt, and as necessary, adapt template standards for the delivery of medical education and training.

b. One such set of standards is produced by The World Federation for Medical Education (WFME). WFME undertakes to promote the highest scientific and ethical standards in medical education, and to encourage development of learning methods, new instructional tools, and innovative management of medical education.

c. The WFME standards, in several languages, are available at http://wfme.org/standards/bme

(vii) **Accreditation framework**

a. An accreditation body should have an appropriate governance structure to oversee its accreditation activities.

b. Ideally, an accreditation process should be underpinned by law to ensure that participation and outcomes are enforceable.

c. An accreditation body should: a. be independent, and members of the accreditation team should have no personal conflict of interest:

i. respect each education provider's autonomy to set its educational policies and processes;

ii. in making decisions, gather and analyse information from multiple sources and viewpoints, including from medical students;

iii. follow documented procedures, and implement its accreditation process in an open and objective manner;

iv. adopt mechanisms to ensure that members of assessment teams, committees and staff apply standards and procedures in a consistent and appropriate fashion;

v. review its processes and the accreditation standards on a regular basis;

vi. gather feedback on and evaluate its performance.

d. An accreditation process should:

i. focus on the achievement of objectives, maintenance of educational standards, public safety requirements, and expected outputs and outcomes rather than on detailed specification of curriculum content or educational method;

ii. incorporate a self-assessment component;

iii. monitor the implementation of recommendations and other developments in the programme;

iv. require a cycle of assessments, with a periodic full assessment of each programme;

v. provide for a range of accreditation outcomes, such as accreditation with commendation, accreditation, conditional accreditation, withdrawal of accreditation.

(viii) **Accrediting accreditation bodies**

a. The reliability and value of work undertaken by an accreditation body can be further enhanced if the body is, itself, independently accredited. This is strongly encouraged.

b. One such accreditation system is available through the World Federation for Medical Education (WFME), which in collaboration with the Foundation for Advancement of International Medical Education and Research (FAIMER®), has developed a *Programme for Recognition of Accrediting Agencies*. The objective is to create a transparent and rigorous method of ensuring that accreditation of medical schools, world-wide, is always at an internationally accepted and high standard.

EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES

ECFMG, represented by Dr William W Pinsky, President and Chief Executive Officer of the Educational Commission for Foreign Medical Graduates (ECFMG) and Chair of the Foundation for Advancement of International Medical Education and Research (FAIMER), ECFMG's non-profit foundation, gave a presentation on its structures and its functioning.

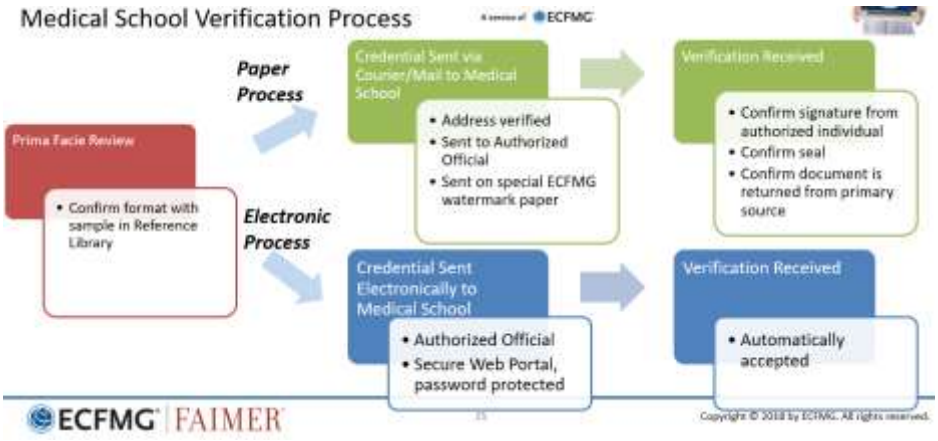
He highlighted that –

(i) ECFMG's Mission included promoting quality healthcare and medical education worldwide;

(ii) As part of this mission, ECFMG partners with the world's medical regulatory authorities to protect the public through services such as primary-source verification of physician credentials

(iii) Areas of Expertise –

a. Physician credentials
b. Primary-source verifying medical credentials
c. U.S. immigration issues impacting physicians



AMERICAN OSTEOPATHIC ASSOCIATION

AOA, represented by the CEO, Dr Adrienne White-Faines, gave a presentation on its structures and Osteopathic Medicine, the following was highlighted –

(i) Osteopathic Medicine is a Distinct branch of medical practice and practitioners are referred to as DOs.
(ii) Whole-person philosophy where all systems of the human body are interrelated and work together to heal the body in times of illness.
(iii) Was pioneered by Andrew Taylor Still, MD, DO at the end of the nineteenth century.
(iv) Dr Still developed a holistic approach to medicine. His philosophy stressed the importance of preventive medicine and used a set of manual techniques, now known as **osteopathic manipulative treatment**, to help diagnose, treat and prevent illness and injury.
(v) DOs are one of two types of fully licensed physicians in the U.S. (DOs & MDs) and practice their patient-centered philosophy of medicine in every medical specialty.
(vi) It is projected that before 2025 DOs will comprise over **20%** of the US physician population.
(vii) Today, 1 of every 4 **(25%)** of US medical students are enrolled in Colleges of Osteopathic Medicine (COM).
(viii) DOs **focus on prevention**, considering how a patient's lifestyle and environment can impact their wellbeing.

Presentations Annexure D

4. SECTION B| SCIENTIFIC CONFERENCE

4.1. WELCOME

The conference commenced with a warm welcome by the Chairperson of Medical and Dental Council of Ghana, Prof. Paul Kwame Nyame and the AMCOA President, Prof. George Magoha.

This was followed by further words of welcome by the Honourable Minister of Health, Kwaku Agyemang-Manu. The Honourable Minister of Health, in his address, advised that he had no doubt that the deliberations of the conference should consider innovative ways of galvanising support for quality healthcare provided by well trained, appropriately regulated and adequately motivated professionals.

He stated that the choice of theme for such important annual meeting could not have been more appropriate: “the changing landscape in medical education and training”. This was mainly because, the world has fast become a global village and there is no reason to deny the people of Africa global quality healthcare primarily possible through proper standard training of our professionals across the continent.

In closing, he applauded the comrades from the Southern and Eastern African Blocks for the great initiative and their leading roles in driving AMCOA to become a global force in medical regulation and urged the West African sub region under the umbrella of West African Health Association (WAHO) to take up membership in AMCOA to make it even stronger and better.

4.2. OPENING ADDRESS

The official conference opening was undertaken by HIS EXCELLENCY ALHAJI DR MAHAMUDU BAWUMIA, Vice President of the Republic of Ghana on behalf of HIS EXCELLENCY, NANA ADDO DANKWA AKUFO-ADDO, the President of the Republic of Ghana.

His Excellency, the Vice President, in his opening remarks stated that he firmly believed that a platform, such as AMCOA, serves as a critical resource and reference point for regulatory authorities in their quest to better protect the interest of the public and guide the profession.

Furthermore, His Excellency, the Vice President recognised that –

(i) there were concerns about the significant numbers of healthcare professionals who abuse substances or work under the influence of substances including chronic alcoholism or suffer from infirmities of the mind calling into question their **fitness to practice**;

(ii) the experience from the Medical and Dental Council, Ghana, shows that majority of these professionals had challenges during their undergraduate training and that early identification of impairment is associated with better outcomes;

(iii) additionally, there is an increasing number of private medical and dental and physician assistant training institutions with varied institutional values and commitments raising fears of disparate standards in training and the implications of that on our collective health and safety;

(iv) the entire continent was now witnessing the double burden of fighting both communicable and non-communicable diseases in a resource-constrained environment;

(v) the lack of adequate physical infrastructure and space has led to a situation where students who are otherwise qualified to train in medicine or dentistry cannot obtain admission here in Ghana;

(vi) it was not only appropriate but necessary to ask whether the doctor or dentist or more generally, the health professional we have, meets the exigencies of modern healthcare practice;

(vii) as a Government, we believe that the public wants medical and dental practitioners and health professionals in general who are not only clinically competent but who also behave in an ethical and professional manner; a profession that is accountable and acts responsibly towards the people who depend on it;

(viii) the questions that needed to be addressed was –

a. does the doctor we produce today meet our expectation of the doctor we want as a continent, a country, or a community?

b. does the curricula, syllabi, the mode of delivery of contents as well as the ethical guidance we use to guide the training of our doctors meet the current needs and requirements?

In closing, His Excellency, the Vice President, congratulated and highly commended AMOCA and its leadership for their responsiveness and foresight into the theme of the annual conference. He further urged all member countries to robustly deliberate on all the confounding factors, to work robustly towards yielding the rightful answers to the very weighty issues that the conference theme sought to address, specifically to gain clarity on the medical education and training that is appropriate for the needs and aspirations of today's patient.

4.3. KEYNOTE ADDRESS AND SPECIAL PRESENTATIONS

The keynote address was delivered by Prof. Harold Amonoo-Kuofi, a Professor of Clinical Anatomy and Medical Practitioner and also the immediate past Provost, College of Health and Allied Sciences of the University of Cape Coast, the Founding Dean of the University of Cape Coast School of Medical Sciences and the School of Allied Health Sciences at the University with extensive experience nationally and internationally in medical education with over 15 years in curriculum development and programme management specific to medical education and health care. His areas of expertise include academic leadership, health related strategy development, proposal development, leading steering committees, planning and development of physical infrastructure and administrative set-up of medical schools, curriculum design, problem-based learning

In his opening remarks, the Professor extended a word of thanks to the organisers for choosing such a very topical and thought-provoking theme as it was a conversation that was trending globally and not just in the countries of Africa.

Prof. Amonoo-Kuofi moved into delivering an inspirational talk wherein he highlighted the following issues –

(i) it is said that half of what a student learns in medical school is obsolete 10 years later, but you are not sure at the time which half. This cliché expresses both the uncertainty and the rapidly evolving nature of medical knowledge;

(ii) many of the universities are too conservative and averse to new ideas. Long-established medical schools, especially, are reluctant to change curricular content;

(iii) the rapidly changing needs, expectations and demands of our populations for safe, accessible and personalised care means that the doctors we are graduating nowadays must not only possess knowledge and skills, they must be MOTIVATION-READY, ENTREPRENEURSHIP-READY and INNOVATION-READY;

(iv) it was time to critically and dispassionately reflect on how we are training medical students, and to ask whether the training they receive prepares them adequately to meet the challenges, the healthcare needs and expectations of the communities they serve;

(v) before thinking about the next 20 years, regulators and educators should think about what has changed in the last 45 or so years;

(vi) Medical doctors are a product of the curriculum they are trained with. At the point of graduation their skills and competences are determined by the training they have received. However, that doctor goes into the world facing a lifetime of endless change;

(vii) the changes in the population and communities within which the doctor practices will place new and changing demands on the doctor as well as on the system;

(viii) the demands often go beyond what the traditional medical curriculum prepared the newly qualified doctor for; and

(ix) the challenges are heightened even more if the doctor travels to a different country to work.

He further added that the changes in the landscape of medical education are complex and multi-faceted; and mainly emanate from issues that are **external** to the curriculum but have a direct impact on it. These were issues that newly qualified graduate must contend with in his/her daily practice.

Most medical school curricula, however, are rather old-fashioned and inflexible. They do not address these challenges and therefore fail to train and prepare physicians for the relentlessly CHANGING HEALTHCARE MARKET.

The Professor challenged Regulators to play a leading role in the campaign for harmonisation of curricula and advocate for globalisation by collaborating with Medical Educators in Africa. He urged AMCOA to promote initiatives directed at creating opportunities for internationalisation such as:

- Organising annual international scientific conferences
- Publishing an international medical education journal
- Giving travel grants to enable faculty attend conferences and seminars

- Supporting partnerships, faculty exchange, joint projects and research collaboration.
- Sponsoring webinars in which students, teachers, researchers and other medical education stakeholders worldwide can be encouraged to interact regularly and share ideas
- Co-sponsoring consultative meetings and regional initiatives to put forward appropriate policies, strategies and guidelines for curriculum development and medical education.

Prof. Amonoo-Kuofi concluded his talk with the following thoughts and guidance namely –

(i) While many aspects of being a doctor, such as clinical encounter, communication, and clinical knowledge, are the same, much has radically changed, for example: working in teams, leadership, non-clinical roles of the physician, and uses of technology;

(ii) Medical education would therefore need to respond to this increasingly complex, diverse and uncertain landscape;

(iii) There was a legitimate and compelling demand for fundamental curricular reforms to accommodate these changes and to equip doctors to meet the expectations of the communities they serve;

(iv) The reforms cannot simply be made by adding more information to the already congested curricula;

(v) Nevertheless, changes will be required at different levels of the curriculum, namely: **content, delivery** and the **system** of education; and

(vi) The design would need to be flexible enough to allow students' choices based on their career preferences.

Keynote Annexure E

4.4. COUNTRY EXPERIENCES

The conference moved into the sharing of experiences by member countries, where the needs and expectations of the community, global challenges in various areas of medical education and training were considered, namely –

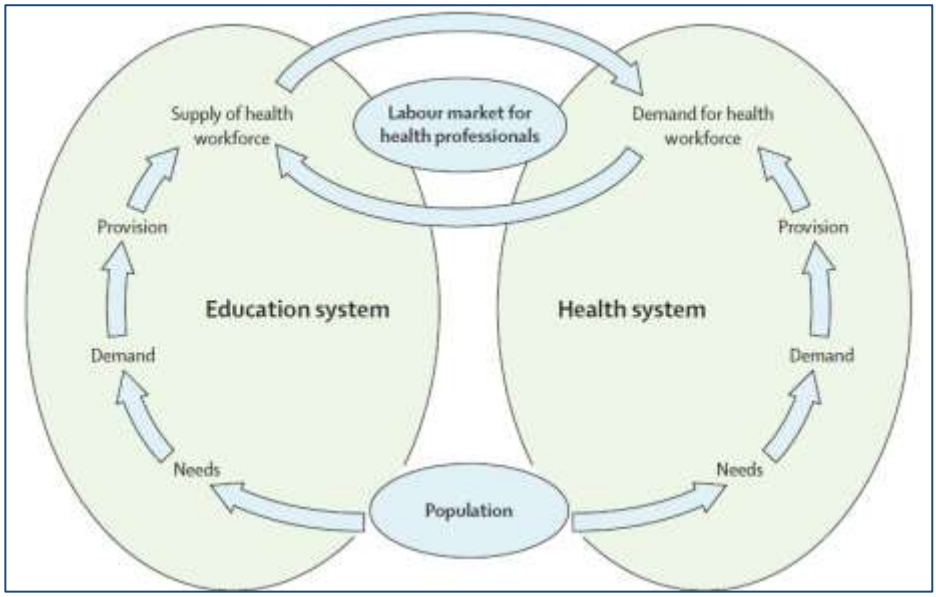
- The Doctor we want - **Uganda**
- Medical Core Curriculum & the Delivery Mode - **Zambia**
- The Impaired Student – **Nigeria**
- Internship Training – **Kenya**
- Competency Based Assessment of Candidates – **Ghana**
    - Local Graduates
    - International Graduates
- Speciality Training – **South Africa**

Presentations Annexure F

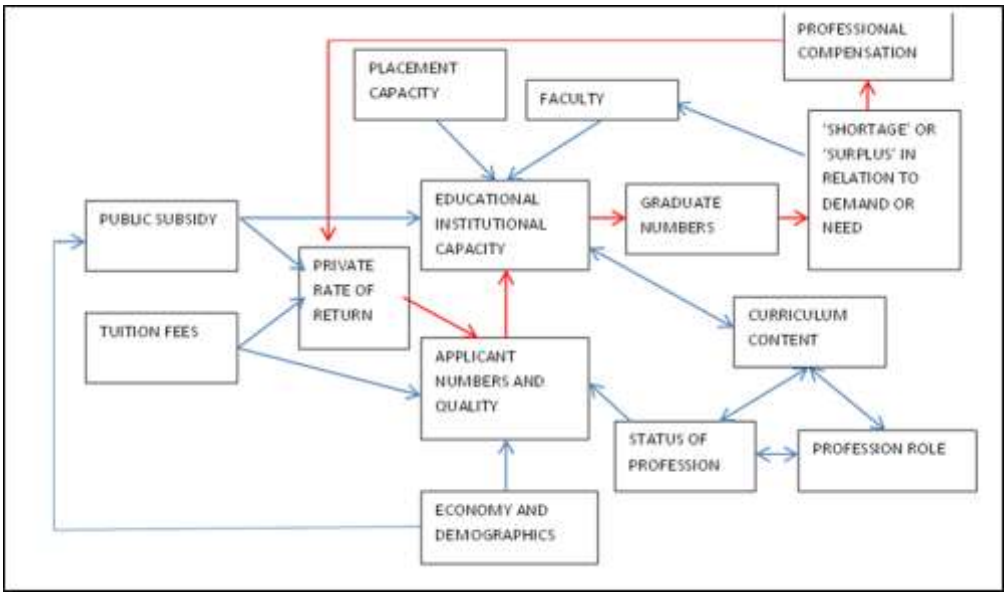
The Country experience session was followed by a presentation from Prof. Khama Rogu MD PhD, lead Health Sector Specialist with the World Bank and Head of the World Bank Group's Health in Africa Initiative and a prominent advocate and global authority on reproductive health issues, who is a visiting professor at several universities and author of over 100 papers and book chapters.

Prof. Rogu, having reviewed the various Country Experiences, highlighted the following in his presentation titled “Regulating Medical Education in the 21st Century”, namely –

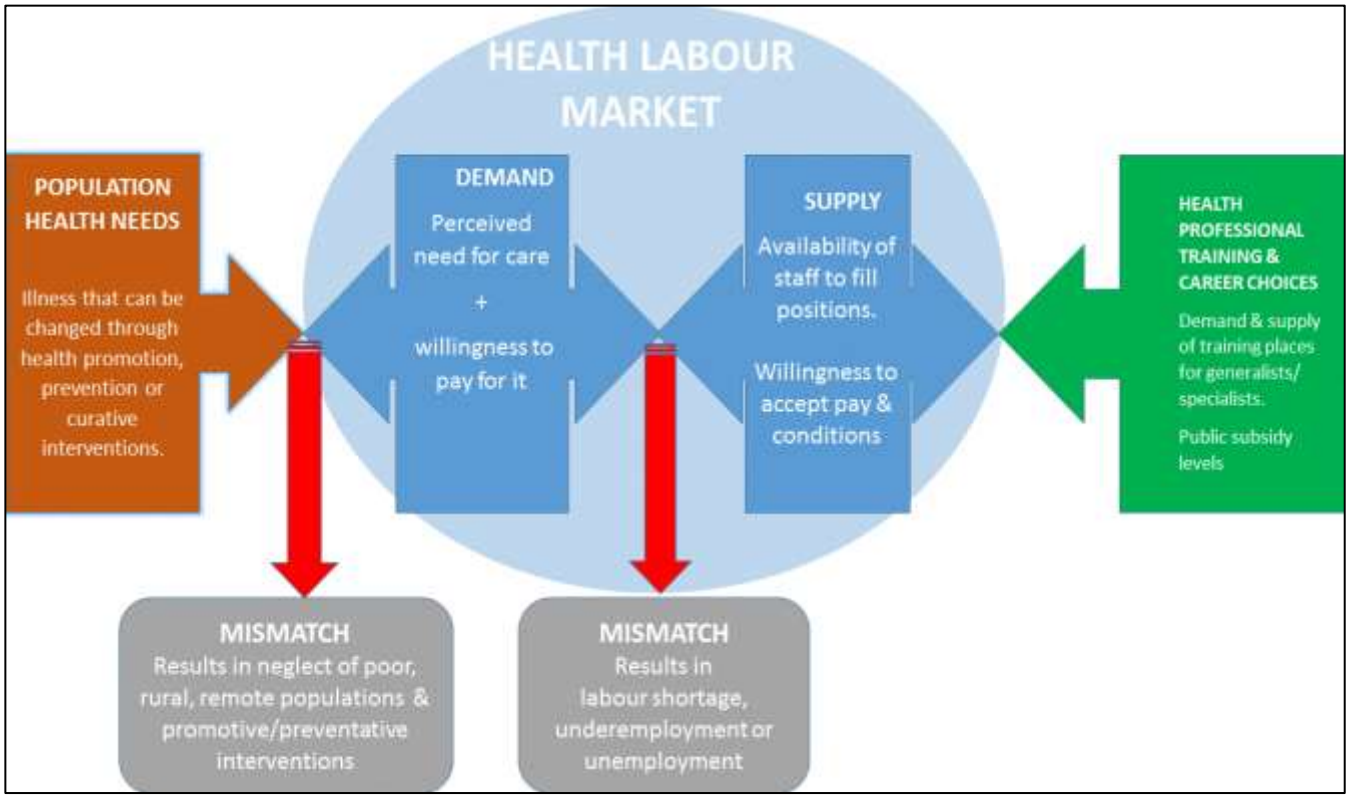
The intersection between Education Systems, Labor Markets and Health Systems



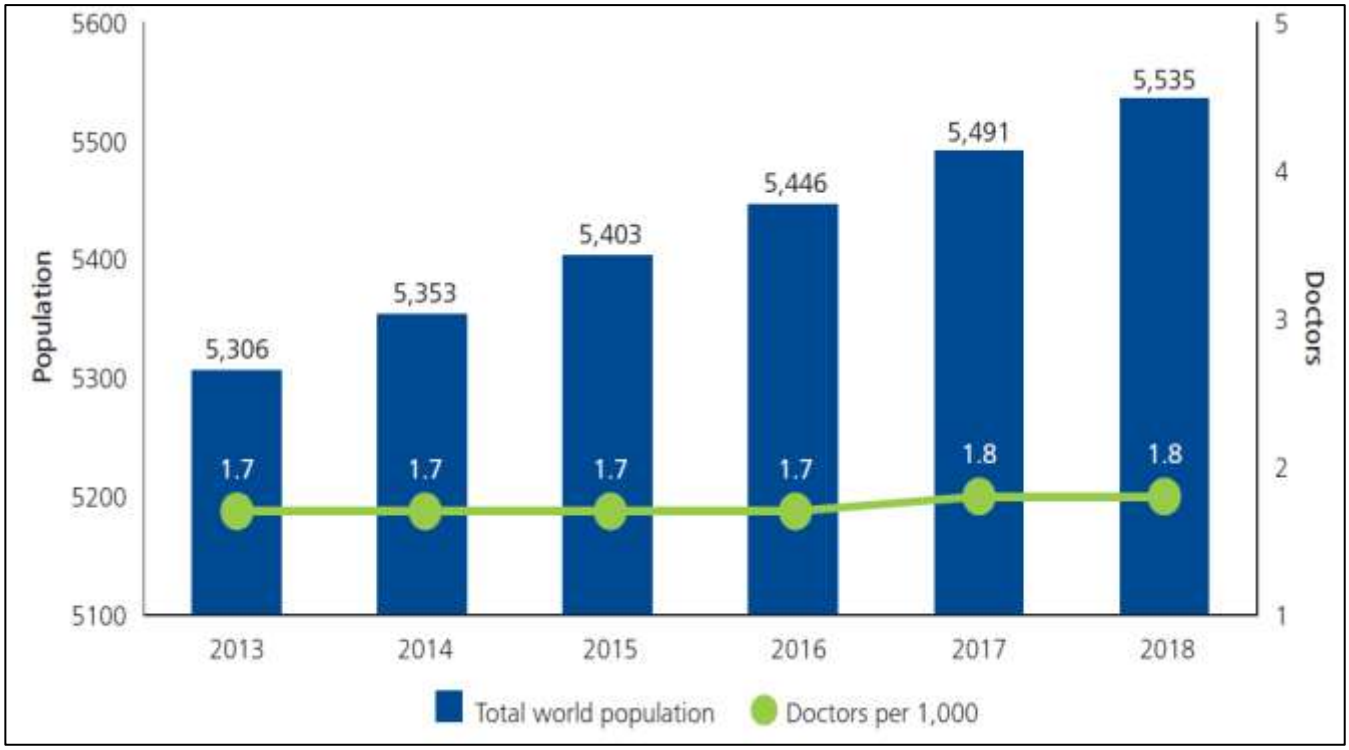
Demand and Supply elements



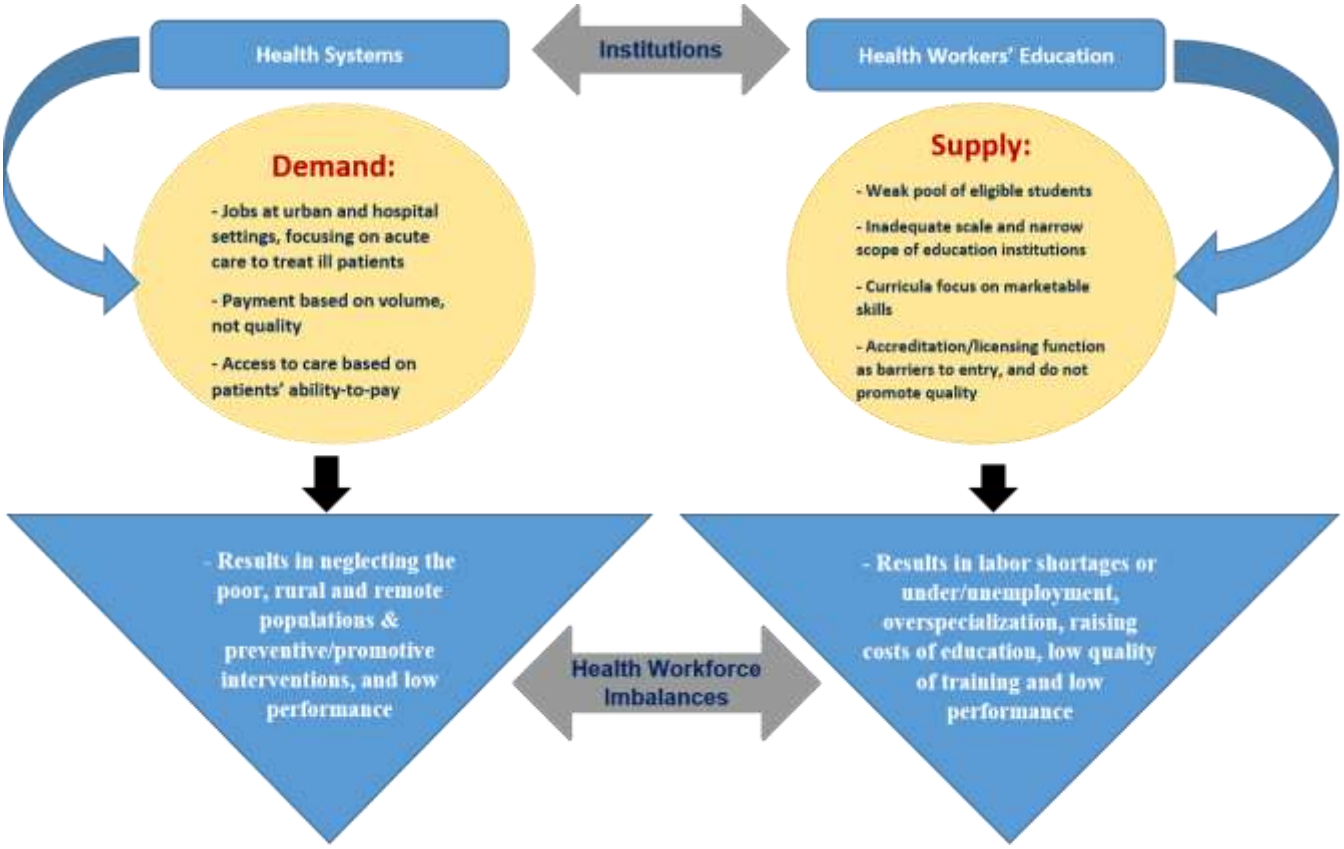
Education Systems, Labor Markets and Health Systems: labor market outcomes



How the supply does not respond to the increased demand… Doctors (per 1,000 population) as compared with the total world population (millions)



Current drivers of the demand and supply of health workers



Policy Implications

- Economic incentives are critically important in shaping demand for health professional training
- Most countries manage economic incentives poorly => workforce is overspecialised, over medicalised and hospital-centric systems
- Prioritise and weight subsidies in nursing and medical training toward generalist training
- Prioritise investment in training mid- and low-level providers => high social rate of return
- high private rates of return to specialist training implying that those benefiting will be willing to invest in their own training
- Mobilise private international investment for regulating private training providers
- Weak knowledge base => lack of data on wages and incomes of health professionals as well as education sector

4.5. GROUP SESSIONS

After the plenary sessions, delegates moved into group discussions which enabled further interactive sharing of member experiences under the three grouped content areas, namely –

Group 1 Medical and Dental Education and Training

Group 2 Internship Training

Group 3 Speciality Training

Following the group sessions, three draft protocols were formulated, namely –

i. AMCOA Protocol on Undergraduate Medical Education and Training
ii. AMCOA Protocol on Specialty Training
iii. AMCOA Protocol on Internship Training

The protocols were tabled to the Annual General Meeting, whereupon it was approved.

Protocols attached under Annexure G

5. SECTION C | ANNUAL GENERAL MEETING

Highlights from the Annual General Meeting are –

5.1. IMMEDIATE PAST PRESIDENT TERM REPORT 2015 - 2018

As outgoing President, Prof Magoha offered a word of thanks to all members for the support accorded to the Management Committee. He further appreciated the fact that AMCOA has been placed on a sound and solid footing to achieve its objects with the structures and plans that have been put in place.

He extended a special thanks to the AMCOA Secretariat, Ms Butt, and her team for their active support and dedication as well as to Dr Kgosi Letlape and Adv FP Khumalo for providing technical support and capacity building to AMCOA States, Boards & Councils throughout his term of office.

In closing, he wished members well in steering AMCOA to greater heights of prosperity in line with the newly approved strategic objectives. He challenged members to continue participating actively in AMCOA and keep the bond alive.

5.2. ELECTED LEADERSHIP FOR THE TERM 2018 - 2021

The following persons were appointed to the leadership of AMCOA for the term of office 2018 – 2021:

Office Bearers

• President	Dr TKS Letlape	South Africa
• Vice President	Prof. P Nyame	Ghana

Additional Management Committee Members

- Associate Prof. E Rudakemwa Rwanda
- Prof. A Macheka Zimbabwe
- Prof. S Banda Zambia
- Dr K Lekau Botswana

AMCOA Committees to be established by the AMCOA Management Committee.

5.3. NEW MEMBERSHIPS

The following regulatory bodies and associations were affirmed as members and associate members to AMCOA –

- Gambia Medical and Dental Council
- Rwanda Allied Health Professions Council
- ECFMG

5.4. ANNUAL CONFERENCES

The future Annual AMCOA Conference Hosts were confirmed as follows –

i.	23rd Annual Conference	2019	Zimbabwe
ii.	24th Annual Conference	2020	Nigeria

6. CONCLUSION

In closing, the newly elected President of AMCOA, Dr TKS Letlape and the Immediate Past President of AMCOA, Prof. George Magoha acknowledged the contributions of all member states and delegates who presented papers and engaged in different breakaway sessions. AMCOA Management and AMCOA Secretariat was also commended for their stewardship and minute-to-minute guidance, support and encouragement at every point of time throughout the conference.

Dr Letlape further took the opportunity to thank the sponsors, exhibitors and hotel staff for adding to the conference experience. Special thanks were extended to the Medical and Dental Council of Ghana and its Organising Team for their sterling commitment in organising a conference of such calibre as it was one for the history books of AMCOA.

In conclusion, the AMCOA President, Dr TKS Letlape reaffirmed his commitment to AMCOA and specifically the need to ensure that AMCOA proactively advocates for (i) the implementation of Health Information Systems, (ii) Improvement in human resource for health, (iii) Implementation of monitoring mechanisms to arrest the increase of counterfeit doctors and (iv) Training and Capacitation for all regulators in regulatory affairs.

∞ END OF REPORT∞