ASSOCIATION OF MEDCIAL COUNCILS OF AFRICA PROTOCOLS

PROTOCOL ON INFORMATION EXCHANGE 2025

PREAMBLE

WHEREAS practitioners have the liberty to migrate across jurisdictions to ply their trade, migration creates regulatory challenges, particularly in confirming the status of the practitioner concerned and whether he or she is a fit and proper person to be registered;

RECOGNISING the need to regulate the movement of practitioners to protect the public from those who may be fugitives of justice in their jurisdictions due to adverse ethical, professional, or disciplinary findings against them;

ACKNOWLEDGING that the timely exchange of regulatory information is essential to ensuring transparency, upholding professional standards, and maintaining public confidence in healthcare systems across Member States;

FURTHER RECOGNISING the importance of digital innovation and interoperable systems to enable real-time, secure, and reliable communication of practitioner status between regulatory authorities;

NOW THEREFORE, the Member States of the Association of Medical Councils of Africa (AMCOA), being parties to this Protocol, hereby agree to adopt the following principles and obligations concerning information exchange and the issuance of Certificate of Status:

ARTICLE 1: OBJECTIVES

1.1. This Protocol establishes a framework for the mutual exchange of regulatory information among AMCOA Member States concerning registered practitioners.

1.2. It aims to enhance public protection, ensure regulatory transparency, and prevent the unlawful cross-border movement of practitioners facing professional, ethical, or legal sanctions.

1.3. It further seeks to promote the harmonisation of standards governing the issuance and recognition of Certificates of Status (COS) across Member States.

ARTICLE 2: INFORMATION EXCHANGE

2.1. The signatories to this Protocol hereby agree to exchange information on practitioners within their registers with other Member States in relation to:

a) Disciplinary actions (concluded or pending);
b) Conditions of impairment;
c) Revocations, suspensions, or practice limitations;
d) Any other matter deemed necessary to protect public safety.

2.2. Information may be exchanged either:

a) Proactively (at the initiative of a regulatory body); or
b) Upon request by a regulatory authority of another Member State.

2.3. Member States shall work towards developing or adopting secure digital platforms, including real-time

data-sharing infrastructure, to facilitate confidential, traceable, and prompt information exchange.

ARTICLE 3: AREAS OF DISCLOSURE

3.1. A signatory to this Protocol who has taken disciplinary action shall, proactively or upon request, provide such information to the other Member States.

ARTICLE 4: CERTIFICATE OF STATUS (COS)

4.1. The Certificate of Status shall be issued by the regulatory authority of a Member State and shall include:

a) Verified practitioner identification details and current registration/licensure status.
b) A declaration confirming whether the practitioner is a fit and proper person to practise.
c) Any endorsement reflecting disciplinary action or conditions of impairment.

4.2. In cases involving impairment or disciplinary matters, the Certificate of Status shall provide a clear, concise summary of the concern, including any imposed conditions or monitoring arrangements, subject to legal allowances for confidentiality.

4.3. Subject to local laws, a receiving Member State shall not register/License a practitioner from another jurisdiction unless:

a) A valid Certificate of Status, issued within the past 180 days, is provided by the originating regulatory authority;
b) The Certificate of Status confirms that the practitioner's registration is current and either free from material concerns or discloses such concerns for proper evaluation and acceptance under the host country's framework.

ARTICLE 5: CONFIDENTIALITY AND DATA PROTECTION

5.1. All signatories commit to protecting the confidentiality of practitioner data, especially in cases involving mental health, impairment, or sensitive disciplinary matters.

5.2. Disclosed information shall be:

a) Shared only with authorised regulatory officers;
b) Used exclusively for regulatory, licensing, or disciplinary purposes;
c) Protected under applicable national data protection laws and ethical principles.

ARTICLE 6: ENABLING FRAMEWORK

6.1. Each Member State shall take appropriate steps to align or develop national legislation, regulations, or policy frameworks to support the implementation of this Protocol.

6.2. This includes enabling:

a) Legal recognition of foreign Certificate of Status under defined standards;
b) Authorisation for inter-regulatory information exchange.

ARTICLE 7: AMENDMENT AND REVIEW

7.1. This Protocol may be amended by consensus of Member States, subject to:

- Written proposals submitted to the Secretariat;
- Technical review by the relevant AMCOA committee;
- Formal adoption by a two-thirds majority of Member States.

DECLARATION

IN WITNESS WHEREOF, the undersigned, being duly authorized representatives of their respective Member States and Regulatory Authorities, have adopted this Protocol on behalf of their countries.

Adopted at **SPEKE RESORT, MUNYONYO, REPUBLIC OF UGANDA**, this **31ST DAY OF JULY, 2025**:

1. **Eswatini** Medical and Dental Council
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PROTOCOL ON TASK SHIFTING 2025

PREAMBLE

WHEREAS Member States within the Association of Medical Councils of Africa (AMCOA) apply varied approaches to task shifting in medical practice, differing in structure, scope, and legal context;

RECOGNISING the need to promote access to essential health services in the face of growing disease burden, human resource shortages, and healthcare delivery challenges across the continent;

FURTHER RECOGNISING the importance of harmonising procedures and standards on task shifting to ensure patient safety, accountability, and quality of care across AMCOA Member States;

NOW THEREFORE, the Member States of the AMCOA being parties to this Protocol, hereby agree as follows:

ARTICLE 1: DEFINITIONS

1.1. For the purposes of this Protocol:

a) Task Shifting refers to the rational redistribution of specific healthcare tasks from highly trained professionals to health workers with less training, where appropriate, to maximise efficiency and resource use.

b) Scope of Practice means the range of healthcare services a professional is authorised to provide, with or without supervision, as defined by national or regional regulation.

ARTICLE 2: IMPLEMENTATION OF TASK SHIFTING

1.1. Member States agree to implement task shifting within an evidence-informed, structured framework that ensures:

a) Identification of tasks to be shifted and to whom;

b) Assessment of training needs and capacity;

c) Structured consultation with stakeholders;

d) Defined roles, responsibilities, and regulatory oversight.

1.2. The rationale for task shifting shall be grounded in:

a) Shortage and uneven distribution of trained health personnel;

b) Increased burden of disease and service demand;

c) Pressure to deliver primary and preventive services at scale.

ARTICLE 3: SCOPE OF PRACTICE AND REGULATION

3.1. The scope of practice for cadres involved in task shifting shall be clearly defined prior to training or deployment.

3.2. Member States shall ensure the existence of an enabling legal framework for task shifting, including

clearly assigned regulatory responsibility, defined liabilities, supervision and licensing requirements, CPD obligations, and mechanisms for monitoring and evaluation.

ARTICLE 4: LEGAL AND ETHICAL SAFEGUARDS

4.1. Member States agree to guarantee patient safety and uphold ethical standards by defining competencies and the scope of practice, ensuring referral pathways, and enacting appropriate statute to regulate task shifting and its legal implications.

ARTICLE 5: LICENSING AND REGISTRATION

5.1. Member States shall ensure that cadres assuming shifted tasks are duly licensed by:

a) Verifying the assigned tasks, corresponding training, and scope of practice;
b) Accrediting appropriate training programs with defined supervisory structures, including ongoing support supervision mechanisms;
c) Establishing Continuing Professional Development (CPD) requirements; and
d) Facilitating collaboration and mutual recognition among regulatory authorities.

ARTICLE 6: QUALITY ASSURANCE

6.1. Task shifting shall be implemented in a manner that safeguards the quality of care, without substituting the recruitment of qualified health personnel or involving interns and other trainees still under supervision.

ARTICLE 7: STANDARDISATION

7.1. For consistency across Member States, task shifting procedures shall be standardised at national, regional, and continental levels in the following domains:

a) Roles and competencies;
b) Training and assessment;
c) Certification;
d) Supervision and referral guidelines.

ARTICLE 8: ENABLING FRAMEWORK

1.1. All signatory Member States commit to reviewing or enacting legislation and policy frameworks to enable the full implementation of this Protocol.

DECLARATION

IN WITNESS WHEREOF, the undersigned, being duly authorised representatives of their respective Member States and Regulatory Authorities, have signed this Protocol on behalf of their countries.
Signed at **SPEKE RESORT, MUNYONYO, REPUBLIC OF UGANDA,** THIS **31ST** DAY OF **JULY, 2025**.

DECLARATION

IN WITNESS WHEREOF, the undersigned, being duly authorized representatives of their respective Member States and Regulatory Authorities, have adopted this Protocol on behalf of their countries.

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PROTOCOL ON LICENSURE FOR MEDICAL AND DENTAL PRACTICE 2025

PREAMBLE

WHEREAS Member States within the Association of Medical Councils of Africa (AMCOA) apply varied approaches to licensure for medical and dental practice, differing in structure, scope, and regulatory procedures;

RECOGNISING the need to promote access to competent and ethical medical and dental practitioners across the continent, while ensuring patient safety, professional accountability, and quality of care;

FURTHER RECOGNISING the importance of harmonising licensure procedures and frameworks to facilitate safe cross-border practice, uphold public confidence, and support workforce mobility;

NOW THEREFORE, the Member States of AMCOA, being parties to this Protocol, hereby agree as follows:

ARTICLE 1: DEFINITIONS

1.1. For purposes of this Protocol:

a) Licensure refers to the formal authorisation granted by a regulatory authority for a practitioner to engage in medical or dental practice within a jurisdiction.
b) Foreign Qualified Practitioner refers to any practitioner whose qualifications were obtained outside the jurisdiction of the licensing Member State.
c) Impairment refers to a mental, physical, or substance-related condition that affects or has the potential to affect a practitioner's ability to practise safely, competently, and ethically.
d) Scope of Practice means the range of services that a practitioner is legally permitted to perform, as determined by training, experience, competence, and regulation.
e) Fitness to Practise (FTP) refers to a practitioner's suitability to hold a licence, including competence, conduct, and health.

ARTICLE 2: LICENSURE REQUIREMENTS AND REGISTERS

1.1. Member States agree to implement licensure based on transparent, verifiable standards that include:

a) Evidence of valid qualifications, subject to source verification or recognised international verification systems;
b) Valid licence and certificate of good standing from the originating jurisdiction;
c) Demonstrated compliance with Continuing Professional Development (CPD) requirements;
d) Payment of prescribed licensing fees.

1.2. Member States shall maintain up-to-date national practitioner registers, including but not limited to:

a) Medical and dental students;
b) Interns/provisional registrants;

c) Foreign/temporary practitioners;
d) Permanently licensed practitioners;
e) Specialists and sub-specialists.

1.3. Member States shall work towards the reciprocal recognition of licences, where appropriate, through standardised criteria and inter-country agreements.

ARTICLE 3: REGULATION OF HEALTH FACILITIES

3.1. Member States shall support the categorisation, registration, and licensure of health facilities, including oversight of standards where medical or dental services are delivered.

ARTICLE 4: CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

4.1. Member States shall develop and enforce CPD policies to ensure that practitioners engage in lifelong learning, with programmes that:

a) Align with a practitioner's individual scope of practice;
b) Are delivered through flexible and context-relevant platforms;
c) Are linked to licensure and renewal cycles;
d) Are accredited and monitored for quality assurance.

4.2. Member States shall ensure standardisation of CPD across AMCOA Member States through:
a) Recognition of accredited CPD activities and providers;
b) Alignment of CPD credit systems and terminology;
c) Shared CPD calendars and platforms, including AMCOA's central portal.

4.3. Mechanisms shall be established for monitoring and evaluating CPD programmes, with shared accountability between regulators and providers.

ARTICLE 5: FITNESS TO PRACTISE (FTP)

5.1. Member States shall develop policy frameworks and procedures for managing FTP issues that:
a) Prioritise corrective rather than punitive approaches;
b) Establish independent panels to handle FTP matters;
c) Ensure timely notification and communication to all stakeholders;
d) Provide for licensing pathways for practitioners with managed FTP concerns.

5.2. Where applicable, FTP policy shall also address:
a) Safe and supportive practice environments;
b) Working hours, workload management, and wellness support;
c) Mental and physical health screening, disclosure, and support systems.

5.3. Member States shall collaborate with professional associations and support networks to enhance awareness and establish structured interventions for practitioners facing FTP challenges.

ARTICLE 6: STANDARDISATION AND REGIONAL COORDINATION

6.1. Member States shall pursue harmonisation in the following areas:

a) Legal frameworks for reciprocal licensing and recognition;
b) Standardisation of medical and dental education and training;
c) Common examination procedures and internship requirements;
d) Joint inspection and evaluation of training institutions;
e) Integration of foreign-trained practitioners into regulated systems.

ARTICLE 7: ENABLING FRAMEWORK

7.1. All signatory Member States commit to reviewing or enacting legislation and regulatory policies to facilitate the implementation of this Protocol.

DECLARATION

IN WITNESS WHEREOF, the undersigned, being duly authorized representatives of their respective Member States and Regulatory Authorities, have adopted this Protocol on behalf of their countries.

Adopted at **SPEKE RESORT, MUNYONYO, REPUBLIC OF UGANDA**, this **31ST DAY OF JULY, 2025**:

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PROTOCOL ON REGULATION, REGISTRATION, STANDARDS, AND TRAINING FOR HEALTH SYSTEM STRENGTHENING 2025

PREAMBLE

WHEREAS Member States of the Association of Medical Councils of Africa (AMCOA) recognise the critical role of effective regulation in advancing national and continental health objectives;

ACKNOWLEDGING the ongoing challenges facing regulatory bodies, including outdated legal frameworks, limited institutional capacity, and weak monitoring systems, which undermine efforts to improve health workforce quality and access;

RECOGNISING the need to align regulatory functions with modern public health priorities, including universal health coverage, health equity, and the integration of emerging health technologies;

NOW THEREFORE, the Member States of AMCOA, being parties to this Protocol, agree as follows:

ARTICLE 1: DEFINITIONS

1.1. For purposes of this Protocol:

a) Regulatory Authority refers to a statutory body mandated to oversee the registration, licensure, and regulation of medical and dental professionals and training institutions within a Member State.

b) Health Systems Strengthening means the process of improving the performance of the six health system building blocks—service delivery, health workforce, information, products, financing, and governance.

c) Health Outcomes refer to the measurable impact of healthcare services or interventions on population health status.

ARTICLE 2: REGULATION AND LEGAL REFORM

2.1. Member States shall review and amend national laws to address systemic weaknesses, align with emerging health priorities, and empower regulatory bodies to operate more effectively.

2.2. Member States shall:

a) Strengthen internal governance through well-defined organograms and job descriptions;

b) Enhance secretariat capacity for data management, inspections, and stakeholder engagement;

c) Develop clear administrative directives to cover areas not fully addressed in current legislation.

ARTICLE 3: TRAINING AND ACCREDITATION

3.1. Regulatory authorities shall urgently review and standardise guidelines for the accreditation of medical and dental schools, with a focus on:

a) Community-responsive medical education;

b) Infrastructure, faculty, and curriculum standards;

c) Integration of public health priorities into training programmes.

3.2. Member States shall support periodic inspection of training institutions to ensure continued compliance and alignment with national and regional health goals.

ARTICLE 4: STANDARDS OF PRACTICE AND MONITORING

4.1. Regulatory bodies shall develop and enforce professional practice standards, including:

a) Minimum clinical competencies;
b) Ethical and professional conduct;
c) Health facility standards (where relevant to practice environments).

4.2. Member States shall support:

a) Development of national standards aligned with continental benchmarks;
b) Monitoring and evaluation systems to track compliance with these standards;
c) Periodic review and publication of performance reports.

ARTICLE 5: ENABLING FRAMEWORK

5.1. All signatory Member States commit to formulating and implementing legal, policy, and institutional measures to operationalise the principles enshrined in this Protocol.

DECLARATION

IN WITNESS WHEREOF, the undersigned, being duly authorized representatives of their respective Member States and Regulatory Authorities, have adopted this Protocol on behalf of their countries.

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PROTOCOL ON CONTINUING PROFESSIONAL DEVELOPMENT (CPD) 2025

PREAMBLE

WHEREAS the Association of Medical Councils of Africa (AMCOA) has adopted varying models of Continuing Professional Development (CPD) within its Member States;

RECOGNISING that ongoing advancements in medical and dental knowledge, technologies, and methodologies require practitioners to continuously update their competencies;

FURTHER RECOGNISING the need for harmonised CPD standards and mutual recognition frameworks across Member States to ensure regional alignment, improved patient care, and practitioner mobility;

NOW THEREFORE, the Member States of AMCOA being parties to this Protocol, hereby agree as follows:

ARTICLE 1: DEFINITIONS

1.1. For purposes of this Protocol:

a) Continuing Professional Development (CPD) refers to the maintenance and acquisition of current knowledge, measurable professional skills, and acceptable ethical attitudes by medical and dental practitioners for the benefit of patients and the public.

b) Accredited CPD Provider is an individual or institution recognised by a regulatory authority or approved accreditation agency to deliver CPD programmes.

c) CPD Credit refer to a unit of measurement allocated to CPD activities based on time, learning outcomes, or relevance to practice.

ARTICLE 2: PHILOSOPHY AND EXPECTED OUTCOMES

2.1. CPD shall be treated as lifelong learning grounded in adult learning principles and tailored to the practitioner's scope of practice.

2.2. The core outcome of CPD is enhanced practitioner competence and better management of patients across diverse healthcare contexts.

ARTICLE 3: CPD PRINCIPLES AND MODALITIES

3.1. All practitioners shall engage in CPD immediately after internship.

3.2. CPD activities shall:

a) Be contextualised to local and regional disease profiles and health priorities;

b) Take the form of on-the-job learning, self-directed study, formal training, or blended modalities;

c) Be accessible through a variety of delivery platforms, including in-person and digital formats.

3.3. CPD programmes shall be accredited by the respective Councils/Boards or by agencies recognised

by them.

3.4. CPD shall be linked to renewal of registration and licensure.

ARTICLE 4: ACCREDITATION, STANDARDISATION, AND MUTUAL RECOGNITION

4.1. Councils/Boards shall set clear guidelines for:

a) Accrediting CPD providers and activities;
b) Assigning credit values;
c) Periodic review of accredited content for relevance and impact.

4.2. Member States shall work towards standardising:

a) CPD credit systems and reporting formats;
b) Terminologies, certification processes, and performance indicators.

4.3. AMCOA shall develop a regional directory of accredited CPD providers and foster mutual recognition of certified CPD programmes.

ARTICLE 5: MONITORING, EVALUATION, AND COMPLIANCE

5.1. Regulatory authorities shall establish systems for:

a) Annual returns by practitioners and providers as proof of compliance;
b) Performance assessment based on defined indices;
c) Integration of CPD data into registration/licensure systems.

5.2. Non-compliance shall attract remedial or corrective measures, including but not limited to:

a) Supervised practice;
b) Assessment and re-training;
c) Conditional registration.

ARTICLE 6: GOVERNANCE AND OVERSIGHT STRUCTURES

6.1. Each Member State shall designate a CPD Committee within its regulatory authority to:

a) Provide strategic oversight;
b) Coordinate accreditation;
c) Maintain national CPD records.

6.2. AMCOA shall convene periodic technical exchanges and develop regional policy guidance to support implementation.

ARTICLE 7: ACCESS AND EQUITY

7.1. Member States shall promote inclusive access to CPD, ensuring:

a) Availability across rural and urban settings;

b) Equitable pricing models;

c) Gender and specialty-sensitive programme designs.

7.2. Digital transformation shall be leveraged to expand reach and engagement.

ARTICLE 8: ENABLING FRAMEWORK

8.1. All Member States shall align or enact relevant legal and policy frameworks to facilitate implementation of this Protocol.

DECLARATION

IN WITNESS WHEREOF, the undersigned, being duly authorized representatives of their respective Member States and Regulatory Authorities, have adopted this Protocol on behalf of their countries.

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PROTOCOL ON HEALTH WORKFORCE MIGRATION 2025

PREAMBLE

WHEREAS the Member States of the Association of Medical Councils of Africa (AMCOA) continue to face challenges relating to the shortage, uneven distribution, and migration of health personnel;

RECOGNISING that an accessible, available, and competent health workforce is essential for the provision of quality and equitable health services;

FURTHER RECOGNISING the need to retain health professionals within AMCOA member countries while facilitating responsible and well-managed intra-regional mobility;

NOW THEREFORE, the Member States of AMCOA being parties to this Protocol, hereby agree as follows:

ARTICLE 1: DEFINITIONS

1.1. For the purposes of this Protocol:

a) Health Workforce Migration means the movement of health professionals within or outside AMCOA member states for employment, training, or other professional purposes.

b) Emigration/Immigration Form refers to the standardized application form used to track the cross-border movement of medical and dental practitioners among AMCOA member states.

ARTICLE 2: MIGRATION MONITORING TOOLS

2.1. Member States shall develop and utilize a standardized digital Migration Tracking Form for use by health practitioners who intend to migrate or return within AMCOA member countries.

2.2. The digital form shall include fields on:

a) Name and nationality

b) Country of registration and license details

c) Reason for migration (work, training, etc.)

d) Intended destination

e) Duration of stay or return status.

ARTICLE 3: NATIONAL REGISTERS AND REPORTING

3.1. Member regulatory authorities shall:

a) Maintain updated national registers of foreign and emigrated health practitioners;

b) Annually submit migration status reports to the AMCOA Secretariat.

3.2. The reports shall include:

a) Outflows and inflows by profession

b) Returnees and reintegration efforts

c) Identified gaps and policy recommendations.

ARTICLE 4: REGIONAL MIGRATION DATABASE

1.4. The AMCOA Secretariat shall develop and manage a secure, centralized digital database on health workforce migration within the region.

1.5. The database shall:

a) Allow real-time updates from member states
b) Generate dashboards for analysis and planning
c) Flag trends and urgent mobility concerns.

ARTICLE 5: INFORMATION EXCHANGE AND COORDINATION

3.2. Member States shall ensure regular exchange of data and insights on health workforce migration through secure digital platforms.

3.3. An annual AMCOA Migration Roundtable shall be convened to:

a) Review status reports;
b) Address emerging trends and coordination gaps;
c) Recommend regionally harmonized strategies.

ARTICLE 6: ADVISORY AND POLICY ALIGNMENT

6.1. Member States shall advise their respective governments on the development of comprehensive policies to:

a) Retain health professionals through incentives, safe work environments, and fair remuneration;
b) Support reintegration of returning practitioners;
c) Align with AU, EAC, SADC, ECOWAS labour mobility agreements where applicable.

6.2. Member States shall also initiate bilateral or multilateral arrangements on ethical recruitment, capacity exchange, and regional workforce planning.

ARTICLE 7: ENABLING FRAMEWORK

4.4. All signatory Member States commit to reviewing and enacting legislation and policies that enable the full implementation of this Protocol.

DECLARATION

IN WITNESS WHEREOF, the undersigned, being duly authorized representatives of their respective Member States and Regulatory Authorities, have adopted this Protocol on behalf of their countries.

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PROTOCOL ON PROFESSIONAL CONDUCT AND ETHICS 2025

PREAMBLE

WHEREAS professional conduct and ethics are foundational to effective health regulation and to the integrity of medical and dental practice in Africa;

RECOGNISING the diversity of ethical codes and disciplinary procedures among member states of the Association of Medical Councils of Africa (AMCOA);

FURTHER RECOGNISING the need to consolidate and harmonize the 2012 Protocol on Ethical and Professional Issues in Medical and Dental Practice and the 2016 Protocol on Medical and Dental Malpractice into a single comprehensive framework;

ACKNOWLEDGING that ethical and professional conduct safeguards public trust, enhances patient safety, and upholds the dignity of the healthcare professions;

NOW THEREFORE, the Member States of AMCOA being parties to this Protocol, hereby agree as follows:

ARTICLE 1: DEFINITIONS

1.1. For the purposes of this Protocol:

a) Professional Misconduct: Any act, omission, or behaviour that contravenes ethical standards, codes of conduct, or regulatory obligations, thereby compromising the integrity, competence, or trust expected of a health professional.

b) Fitness to Practise: A practitioner's physical, mental, and professional capacity to perform their duties safely, competently, and ethically, without posing a risk to patients or the public.

c) Self-Regulation: A system wherein professional bodies or practitioners assume responsibility for setting, monitoring, and enforcing standards of ethical conduct, registration, and practice within the framework of enabling legislation.

d) Autonomy: A patient's right to make informed decisions about their own health and treatment, free from coercion.

e) Privacy: The right of individuals to keep their health information and personal details secure and undisclosed without consent.

f) Confidentiality: The ethical and legal obligation of health professionals to protect patient information acquired during care.

ARTICLE 2: PRINCIPLES OF ETHICAL AND PROFESSIONAL PRACTICE

2.1. Member states agree that all practitioners shall:

a) Adhere to principles of integrity, transparency, respect, beneficence, non-maleficence, and justice;

b) Uphold professional competence through the maintenance of knowledge, skills, and ethical attitudes;

c) Engage in ethical decision-making aligned with evidence-based practice, cultural sensitivity, and patient rights.

ARTICLE 3: DUTIES OF PRACTITIONERS

3.1. Duty to Patients

Practitioners shall:

a) Respect patients' autonomy, privacy, and confidentiality;
b) Obtain informed consent prior to any intervention;
c) Provide care in the best interest of the patient;
d) Avoid discrimination and uphold patient dignity;
e) Act promptly in emergencies and refer or escalate when a case is beyond their scope of practice.

3.2. Duty to Colleagues and Health Professionals

Practitioners shall:

a) Demonstrate mutual respect, honesty, and professional courtesy;
b) Communicate effectively and collaborate in multidisciplinary teams;
c) Share knowledge and support continuous improvement.

3.3. Duty to Society

Practitioners shall:

a) Serve with integrity and professionalism;
b) Uphold public health principles and advocate for equitable access to healthcare;
c) Contribute to health education and ethical research.

ARTICLE 4: PROFESSIONAL AND ETHICAL CONDUCT

4.1. Performance Components

Practitioners shall exhibit:

a) Knowledge;
b) Attitude; and
c) Skills.

4.2. Standard of Care

Regulatory authorities shall ensure that practitioners:

a) Deliver care based on clinical evidence and accepted standards;
b) Engage in shared decision-making;
c) Accurately document patient care and maintain records;
d) Practice within their defined scope of competence;
e) Refer or delegate appropriately and safely.

4.3. Good Standing and CPD

Practitioners must:

a) Be duly registered and licensed by their regulatory body;
b) Participate in Continuing Professional Development (CPD);
c) Ensure at least 10% of CPD points cover ethics, and CPD providers include an ethics component;
d) Understand and mitigate medico-legal risks.

4.4. Conflict of Interest and Advertising

Practitioners shall:

a) Disclose potential conflicts of interest in all professional dealings;
b) Adhere to ethical advertising standards and national regulatory guidelines.

ARTICLE 5: FITNESS TO PRACTISE (FTP)

1.2. Regulatory authorities shall:

a) Monitor, assess, and respond to FTP concerns using standardized criteria;
b) Facilitate remediation and support where appropriate;
c) Establish structures for fair inquiry into physical, mental, or professional impairments affecting FTP.

ARTICLE 6: MANAGEMENT OF MISCONDUCT

6.1. Regulatory authorities shall:

a) Enforce codes of conduct and ethical standards consistently;
b) Maintain disciplinary frameworks aligned with national laws and regional protocols;
c) Conduct timely, fair, and transparent inquiries into allegations of misconduct;
d) Educate practitioners on disciplinary procedures and reporting obligations.

ARTICLE 7: REGULATION IN EMERGENCIES AND RESOURCE-CONSTRAINED CONTEXTS

4.2. Member states shall:

a) Promote self-regulation while preserving professional standards;
b) Advise governments on ethical healthcare delivery during crises;
c) Regulate third-party providers (e.g., NGOs, faith-based institutions) to ensure quality and accountability.

ARTICLE 8: ENSURING PATIENT SAFETY

8.1. Member states shall:

a) License and verify all practicing health professionals;
b) Ensure facilities meet minimum standards in staffing, equipment, and services;
c) Empower patients with information and protect their right to choose care providers.

ARTICLE 9: ENABLING FRAMEWORK

9.1. All AMCOA member states that are signatories to this Protocol agree to align or enact legislative and policy frameworks to implement the principles set out herein.

DECLARATION

IN WITNESS WHEREOF, the undersigned, being duly authorized representatives of their respective Member States and Regulatory Authorities, have adopted this Protocol on behalf of their countries.

Adopted at **SPEKE RESORT, MUNYONYO, REPUBLIC OF UGANDA**, this **31ST DAY OF JULY, 2025**:

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PROTOCOL ON CORPORATE GOVERNANCE 2025

PREAMBLE

WHEREAS the Member States of the Association of Medical Councils of Africa (AMCOA) acknowledge that good corporate governance is fundamental to the effective functioning, accountability, and legitimacy of health regulatory authorities;

RECOGNISING the diversity in the structure, practices, and statutory mandates of Councils and Boards across AMCOA member states, and the need to harmonize core governance principles for regulatory effectiveness;

FURTHER RECOGNISING that transparency, ethical leadership, sustainability, and institutional integrity are cornerstones of public confidence in health regulation;

NOW THEREFORE, the Member States of AMCOA being parties to this Protocol, hereby agree as follows:

ARTICLE 1: DEFINITIONS

1.1. For the purposes of this Protocol:
a) Corporate Governance means the systems, principles, and processes by which an organization is directed, controlled, and held to account.
b) Board/Council means the legally established governing body of a health professions regulatory authority in any AMCOA member state.
c) Environmental, Social, and Governance (ESG) refers to the set of standards for an organization's operations that socially conscious stakeholders use to screen performance and risk.
d) IT Governance refers to the structures and processes that ensure information technology supports and enhances organizational goals, including compliance, security, and data protection.

ARTICLE 2: CORE GOVERNANCE VALUES

2.1. Member States shall ensure that regulatory authorities are guided by the following minimum values:
a) Fairness – Treat all stakeholders equitably, balancing rights and expectations.
b) Accountability – Embrace responsibility for decisions and the public interest.
c) Responsibility – Uphold integrity, ethical conduct, and fiduciary duties.
d) Transparency – Maintain openness in operations, reporting, and engagement.

ARTICLE 3: GOVERNANCE PRINCIPLES

3.1. Member States shall uphold the following principles:
a) Sustainability as a Strategic Imperative: Councils shall integrate sustainability into their policies, operations, and oversight, recognizing its moral and economic significance.
b) Social Justice and Redress: Social transformation, equity, and inclusion shall be mainstreamed in governance systems.

c) Innovation and Collaboration: Innovative governance practices and inter-agency collaboration shall be promoted as vehicles for change and improved regulatory outcomes.
d) Risk Management and Internal Controls: Boards shall institutionalize risk governance systems, internal audits, and compliance frameworks.
e) Ethical and Effective Leadership: Leadership shall demonstrate competence, integrity, vision, and commitment to public service.

ARTICLE 4: ENVIRONMENTAL, SOCIAL & GOVERNANCE (ESG) INTEGRATION

4.1. Councils shall adopt ESG frameworks including:
a) Alignment with international standards (e.g., GRI, IFRS Sustainability Disclosures, WHO Health System Building Blocks);
b) Monitoring environmental impacts of regulatory operations (e.g., digital records, green offices);
c) Promoting gender equity, community engagement, and inclusion in Council mandates;
d) Embedding governance indicators in strategic and operational plans.

ARTICLE 5: IT GOVERNANCE AND DATA PROTECTION

5.1. Regulatory Councils shall institutionalize IT governance frameworks to ensure:
a) Cybersecurity and protection of confidential health and professional data;
b) Compliance with national and regional data protection laws;
c) Digital accountability and risk controls for electronic licensing, CPD tracking, and disciplinary systems;
d) Regular audits of information systems and reporting tools.

ARTICLE 6: MONITORING AND EVALUATION

6.1. Member States shall ensure that Councils establish internal performance management systems that track governance performance against agreed benchmarks, including:
a) Board performance evaluations;
b) Annual governance reports submitted to national authorities and AMCOA;
c) Participation in peer learning reviews among AMCOA members.

ARTICLE 7: CAPACITY BUILDING AND CONTINUOUS IMPROVEMENT

7.1. Member States shall:
a) Support the development of leadership and governance skills of Council members and executives;
b) Encourage cross-learning, twinning, and mentorship among AMCOA member states;
c) Require mandatory induction, governance, and ethics training for all Board members upon appointment.

ARTICLE 8: ENABLING FRAMEWORK

8.1. All signatory Member States commit to reviewing and enacting legislative, policy, and institutional reforms that support the effective implementation of this Protocol.

DECLARATION

IN WITNESS WHEREOF, the undersigned, being duly authorized representatives of their respective Member States and Regulatory Authorities, have adopted this Protocol on behalf of their countries.

Adopted at **SPEKE RESORT, MUNYONYO, REPUBLIC OF UGANDA**, this **31ST DAY OF JULY, 2025**:

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AMCOA PROTOCOL ON DISCIPLINARY PROCEDURES 2025

PREAMBLE

WHEREAS the Member States of the Association of Medical Councils of Africa (AMCOA) acknowledge that effective, fair, and harmonized disciplinary procedures are essential for regulating medical and dental practitioners in the public interest;

RECOGNISING that a well-structured disciplinary process enhances ethical standards, public confidence, and quality of care;

FURTHER RECOGNISING the need to adopt emerging digital technologies, strengthen regional coordination, and ensure restorative mechanisms for safe practitioner reintegration;

NOW THEREFORE, the Member States of AMCOA, being parties to this Protocol, hereby agree as follows:

ARTICLE 1: DEFINITIONS

1.1 For the purposes of this Protocol:

a) **Council** means any Medical or Dental Regulatory Authority that is a member of AMCOA.

b) **Disciplinary Procedures** refer to processes undertaken by a regulatory authority to investigate and adjudicate complaints of misconduct.

c) **Professional Misconduct** means behaviour or acts that breach legal, professional, or ethical standards of medical or dental practice.

d) **Fitness to Practise** means a practitioner's ability to practise safely, competently, and ethically, considering conduct, competence, and health.

e) **Public Participation** means the involvement of lay persons in disciplinary processes to reflect societal perspectives.

f) **Self-Regulation** is a system where the profession governs its members through law-backed regulatory authorities.

g) **Restorative Justice** refers to structured mechanisms for correcting behaviour, including rehabilitation, support, or reintegration for impaired practitioners.

ARTICLE 2: RECEIPT AND PROCESSING OF COMPLAINTS

2.1 **Complaint Sources**

Member Councils may receive complaints from:

a) Patients;

b) Next of kin;

c) Third parties (with written patient consent);

d) Media or whistleblowers (as permitted by law);

e) Anonymous sources (evaluated case-by-case).

2.2 **Submission and Logging**

Complaints shall be submitted in a standard format (digital or physical) and logged in a centralized case management system.

2.3 **Preliminary Review**

a) All complaints shall be triaged based on seriousness, jurisdiction, and admissibility.

b) Non-serious complaints may be mediated or closed administratively.

c) Serious complaints proceed to formal inquiry.

ARTICLE 3: STAGES OF DISCIPLINARY INQUIRY

3.1 Member Councils shall follow a three-tiered disciplinary structure:

- **Tier I**: Administrative Review by Secretariat
- **Tier II**: Standing Conduct Committee
- **Tier III**: Independent Committee (includes public member)

3.2 **Composition & Competency**

a) Inquiry panels shall include:

- Legal expert;
- Medical/dental professional;
- Layperson (Tier III only).

b) All panelists shall receive training in disciplinary procedures.

ARTICLE 4: APPEALS

4.1 **Right of Appeal**

All decisions at each tier are subject to appeal as follows:

a) Tier I decisions → appealable to Tier II

b) Tier II decisions → appealable to Tier III or tribunal (depending on national law)

ARTICLE 5: INTERIM SUSPENSION

5.1 **Precautionary Measures**

Where public safety is at risk, a practitioner may be temporarily suspended, subject to:

- Immediate notification;
- Review within 14–30 days;
- Full rights to appeal and due process.

ARTICLE 6: OUTCOMES AND SANCTIONS

6.1 Sanctions may include:

a) Acquittal;

b) Warning, caution, or reprimand;

c) Fine;

d) Supervised or restricted practice;

e) Mandatory re-training;

f) Suspension;

g) Removal from the register;

h) Restitution or compensation (as per national law);

i) Referral for rehabilitation (in cases of substance abuse or impairment).

6.2 **Sentencing Guidelines**

Councils shall adopt Sanctioning Guidelines to ensure proportionality and consistency.

ARTICLE 7: RESTORATIVE AND REHABILITATIVE JUSTICE

7.1 Regulatory authorities shall:

a) Develop frameworks for the rehabilitation and reintegration of impaired professionals;

b) Partner with mental health and addiction experts;

c) Monitor fitness-to-practise restoration through clinical and ethical re-evaluation.

ARTICLE 8: CROSS-BORDER COORDINATION

8.1 Member Councils shall:

a) Notify other AMCOA members of practitioners removed or sanctioned, through secure channels;

b) Maintain a shared registry of disciplinary outcomes to prevent "jurisdiction-hopping";

c) Consider disciplinary history in registration decisions.

ARTICLE 9: DIGITAL DISCIPLINARY SYSTEMS

9.1 Member Councils shall adopt secure digital tools for:

a) Complaint intake;

b) Case tracking and performance monitoring;

c) Evidence submission and communication;

d) Report generation and analytics.

9.2 The AMCOA Secretariat shall support capacity building for harmonized digital systems.

ARTICLE 10: PUBLIC COMMUNICATION AND TRANSPARENCY

10.1 Each Council shall:

a) Clearly outline how decisions are communicated to complainants, practitioners, and the public;

b) Publish outcomes (where lawful) to enhance public trust;

c) Establish patient safety measures during pending investigations (e.g. restricted practice, supervision).

ARTICLE 11: ENABLING FRAMEWORK

11.1 Member States agree to:

a) Align national laws to support this Protocol;

b) Ensure sufficient resources for disciplinary infrastructure and training;

c) Update internal rules, policies, and disciplinary manuals in line with these Articles.

DECLARATION

IN WITNESS WHEREOF, the undersigned, being duly authorized representatives of their respective Member

States and Regulatory Authorities, have adopted this Protocol on behalf of their countries.

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PROTOCOL ON THE MANAGEMENT OF MEDICAL LITIGATION 2025

PREAMBLE

WHEREAS the management of medical litigation in the Member Councils and Boards of the Association of Medical Councils of Africa (AMCOA) takes various forms both in structure and content;

RECOGNISING that the burden of medical litigation is an increasing concern across the AMCOA region;

FURTHER RECOGNISING the urgent need to establish harmonised guidelines and proactive strategies among AMCOA Member States to prevent, minimise, and manage medical litigation;

NOW THEREFORE, the Parties to this Protocol do hereby adopt the principles enshrined herein as a framework for the management of medical litigation in the region.

ARTICLE 1: SHORT TITLE

This Protocol shall be cited as the AMCOA Protocol on the Management of Medical **Litigation**.

ARTICLE 2: INTERPRETATION

In this Protocol, unless the context otherwise requires:

- **"AMCOA"** means the Association of Medical Councils of Africa.
- **"Council"** means the regulatory authorities for medical and dental practice in Member States, including Councils and Boards as applicable.

ARTICLE 3: GUIDELINES ON MEDICAL LITIGATION

Member Councils agree to:

3.1. Develop and adopt guidelines for the management of medical litigation, including pre-litigation review, dispute resolution pathways, and stakeholder communication.

3.2. Develop an effective communication and public awareness strategy to educate stakeholders on rights, responsibilities, and institutional mechanisms for redress.

3.3. Establish and strengthen alternative dispute resolution (ADR) mechanisms, including mediation, conciliation, and early neutral evaluation, to reduce reliance on court processes.

ARTICLE 4: PROFESSIONAL INDEMNITY

Councils shall:

4.1. Develop and advocate for compulsory, affordable, and sustainable professional indemnity frameworks for healthcare practitioners and institutions.

4.2. Engage relevant stakeholders, including insurers, governments, and healthcare institutions, to design context-sensitive indemnity schemes that promote accountability and financial risk protection.

4.3. Encourage the progressive enactment of legal provisions mandating professional indemnity as a regulatory requirement.

ARTICLE 5: DISCIPLINARY REFERRALS ARISING FROM LITIGATION

Where a medical litigation case reveals potential professional misconduct or ethical breach:

5.1. Councils shall ensure timely referral of the matter to the appropriate disciplinary organ or committee in accordance with their national regulatory frameworks.

5.2. Disciplinary action shall be clearly separated from compensatory processes, while maintaining procedural fairness and natural justice.

ARTICLE 6: FUTURE LITIGATION LANDSCAPE AND LEGAL REFORM

Member Councils commit to:

6.1. Act strictly within their statutory mandate to protect public interest and uphold professional standards.

6.2. Proactively propose legal and policy reforms, including:

- Explicit legal provision for professional indemnity;
- Recognition of non-adversarial compensation systems (e.g., no-fault mechanisms);
- Protection for practitioners acting in good faith within defined scopes of practice.

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ARTICLE 7: ENABLING FRAMEWORK

All signatory Member States commit to:

7.1. Pursue legislative, regulatory, and policy alignment in support of this Protocol.

7.2. Strengthen institutional capacity for legal risk mitigation, claims management, and litigation data analysis.

7.3. Establish or enhance centralised databases to track trends in litigation, claims resolution, and disciplinary action.

DECLARATION

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AMCOA PROTOCOL ON INTERNSHIP TRAINING 2025

PREAMBLE

WHEREAS the Member States of the Association of Medical Councils of Africa (AMCOA) acknowledge that internship training across the region takes varied forms in terms of structure, duration, and content;

RECOGNISING that a well-structured, supervised, and competency-based internship programme provides the foundation for safe, ethical, and effective medical and dental practice;

FURTHER RECOGNISING the need to harmonize internship training standards and infrastructure across AMCOA Member States to ensure regional consistency, enhance healthcare quality, and support professional mobility;

NOW THEREFORE, the Member States of AMCOA, being parties to this Protocol, hereby agree as follows:

ARTICLE 1: DEFINITIONS

1.1 In this Protocol, unless the context otherwise requires:

a. AMCOA means the Association of Medical Councils of Africa.
b. Council means a medical or dental regulatory authority that is a member of AMCOA.
c. Internship means the mandatory, supervised practical training period undertaken by a newly qualified medical or dental graduate in order to gain clinical experience and meet the requirements for independent professional practice.
d. Internship Site means a health facility or institution accredited by a Council to host and train medical or dental interns.

ARTICLE 2: PURPOSE OF INTERNSHIP

2.1 To create a structured learning environment for interns under professional supervision.
2.2 To ensure a guided transition from academic training to independent clinical practice.
2.3 To instill professional ethics, communication skills, and good clinical judgment in interns.
2.4 To expose interns to interdisciplinary teamwork and healthcare system operations.

ARTICLE 3: EXPECTED OUTCOMES

3.1 Enable interns to provide safe, ethical, and competent care within their level of training.
3.2 Ensure acquisition of all core clinical competencies as defined by national Councils.
3.3 Foster professional values including integrity, respect, altruism, justice, and commitment to lifelong learning.
3.4 Promote awareness of professional limitations and adherence to codes of conduct.

ARTICLE 4: MANAGEMENT OF INTERNSHIP

4.1 Councils shall accredit internship training sites based on:

a. Adequate infrastructure and case load
b. Availability of qualified supervisors
c. Support systems for clinical education and evaluation.

4.2 Councils shall conduct periodic inspections of internship sites to ensure training standards are upheld.

4.3 Each Council shall establish mechanisms for intern assessment and supervision including:

a. Regular written reports by site coordinators;
b. Use of logbooks to track progress;
c. Verification of rotations and competencies by supervisors.

4.4 Member States shall establish clear documentation procedures for tracking intern performance and certification.

ARTICLE 5: INTERNSHIP DURATION AND DOMAINS

5.1 The duration of internship shall not be less than 12 months and not exceed 24 months, commencing immediately upon graduation.

5.2 Medical Internship Domains shall include but are not limited to:

a) Surgery
b) Orthopaedics and Trauma
c) Internal Medicine (including Mental Health, Oncology, and NCDs)
d) Obstetrics and Gynaecology
e) Paediatrics
f) Anaesthesia and Critical Care
g) Primary Healthcare and Hospital Management

5.3 Dental Internship Domains shall include but are not limited to:

a) Conservative Dentistry
b) Orthodontics
c) Oral and Maxillofacial Surgery
d) Prosthodontics
e) Periodontics
f) Public Health Dentistry

ARTICLE 6: MOVEMENT OF INTERNS ACROSS JURISDICTIONS

6.1 Member States shall, where feasible, provide internship opportunities for qualified graduates from other AMCOA Member States.

6.2 Such movement shall be guided by mutual recognition arrangements and compliance with national regulatory requirements.

ARTICLE 7: MONITORING, EVALUATION AND QUALITY ASSURANCE

7.1 Member Councils shall establish robust systems for monitoring the quality and consistency of internship programmes.

7.2 Data from assessments, inspections, and feedback mechanisms shall inform ongoing programme improvements.

ARTICLE 8: ENABLING FRAMEWORK

8.1 Member States shall align national laws, policies, and regulations with the principles of this Protocol.

8.2 Each Council shall:

a) Ensure adequate resources for internship programme implementation;

b)Update internal procedures and manuals to reflect harmonized standards;

c) Establish clear lines of accountability and stakeholder coordination.

DECLARATION

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AMCOA PROTOCOL ON SPECIALTY TRAINING 2025

PREAMBLE

WHEREAS the Member States of the Association of Medical Councils of Africa (AMCOA) acknowledge that specialist training is an essential pillar in building a competent and responsive healthcare workforce;

RECOGNISING the existence of varying standards of postgraduate medical and dental education across Member States, which creates disparities in healthcare quality, practitioner mobility, and mutual recognition of qualifications;

FURTHER RECOGNISING the urgent need to harmonize specialist education and training frameworks across the AMCOA region in order to enhance the quality of healthcare, strengthen health systems, and foster regional professional mobility;

NOW THEREFORE, the Member States of AMCOA, being parties to this Protocol, hereby agree as follows:

ARTICLE 1: DEFINITIONS

1.1 For the purpose of this Protocol, unless the context otherwise requires:

a) Council means any Medical or Dental Regulatory Authority that is a member of AMCOA.
b) AMCOA means the Association of Medical Councils of Africa.
c) Specialty refers to a nationally or internationally recognized area of medical or dental practice for which a structured and accredited postgraduate training programme exists.
d) Specialist Training Programme refers to a formal, structured curriculum approved by a regulatory authority, leading to specialist qualification and independent specialist practice.

ARTICLE 2: PURPOSE OF SPECIALTY TRAINING

2.1 The overall objective of specialist training in AMCOA Member States shall be to:

a) Produce competent, ethical, and reflective practitioners capable of addressing current and emerging health needs;

b) Equip specialists with the necessary knowledge, skills, and attitudes to provide patient-centered, evidence-based, and contextually relevant care;

c) Foster continuous learning and professional growth aligned with global best practices;

d) Promote intra-African collaboration and recognition of specialist qualifications.

ARTICLE 3: STRUCTURE OF TRAINING PROGRAMMES

3.1 Member States shall ensure that all specialty training programmes:

a) Have clearly defined curricula incorporating the core competencies outlined in Article 5;

b) Have an appropriate duration covering basic, intermediate, and advanced modules as per the scope of the specialty;

c) Are outcome-based and structured to support progressive acquisition of competencies;

d) Include practical and theoretical components, mentorship, and supervised clinical exposure.

3.2 The duration of specialist training shall:

a) Be sufficient to enable mastery of the full scope of the specialty;

b) Vary depending on the complexity of the specialty, but generally not be less than three (3) years post-qualification.

ARTICLE 4: TRAINING INSTITUTION REQUIREMENTS

4.1 Each Council shall develop guidelines, in collaboration with key stakeholders, governing:

a) Accreditation criteria for specialist training institutions;

b) Required teaching and learning infrastructure, including libraries, laboratories, clinical facilities, ICT tools, and supervisory personnel;

c) Quality assurance mechanisms, including site inspections and performance assessments;

d) Minimum institutional capacity, including staff-to-trainee ratios and access to diverse case exposure.

ARTICLE 5: CORE COMPETENCIES OF SPECIALIST TRAINEES

5.1 Member States shall ensure that all specialist training programmes foster the following core competencies:

a) Medical/Dental Expert

i. Demonstrate specialist-level clinical reasoning, diagnostic, procedural, and therapeutic skills;
ii. Provide safe and effective care within their defined scope;
iii. Integrate preventive, promotive, curative, rehabilitative, and palliative care into practice.

b) Communicator

i. Establish therapeutic relationships with patients and families;
ii. Communicate complex information clearly, ethically, and compassionately;
iii. Maintain accurate and timely clinical documentation.

c) Collaborator

i. Work effectively with interdisciplinary teams;
ii. Promote mutual respect and shared decision-making;
iii. Ensure continuity and coordination of care.

d) Leader and Manager

i. Contribute to effective health system performance;
ii. Manage resources responsibly and ethically;
iii. Engage in strategic planning and decision-making.

e) Health Advocate

i. Address individual and population health needs;
ii. Promote equity, access, and health system responsiveness;
iii. Engage in community-based advocacy and accountability.

f) Scholar

i. Engage in lifelong learning and reflective practice;
ii. Contribute to research and evidence-informed care;

iii. Teach and mentor future professionals.

g) Professional

i. Uphold high ethical standards, integrity, and accountability;

ii. Demonstrate cultural competence and respect for patient autonomy;

iii. Adhere to national laws, professional codes, and regulatory requirements.

ARTICLE 6: MONITORING AND EVALUATION

6.1 Each Council shall:

a) Develop monitoring and evaluation tools and checklists for specialist training programmes;

b) Conduct periodic site visits and audits of accredited institutions;

c) Assess programme outcomes, trainer and trainee satisfaction, and post-training integration;

d) Require submission of periodic institutional reports to maintain accreditation status.

ARTICLE 7: INTER-STATE MOBILITY AND MUTUAL RECOGNITION

7.1 Member States shall:

a) Work towards mutual recognition of accredited specialist qualifications;

b) Facilitate equitable access to specialist training across jurisdictions;

c) Develop joint programs, faculty exchange, and shared accreditation models where possible.

ARTICLE 8: ENABLING FRAMEWORK

8.1 All Member States agree to:

a) Align national laws, training regulations, and professional recognition policies with this Protocol;

b) Build institutional capacity and support mechanisms for continuous programme improvement;

c) Engage training institutions, professional associations, and ministries of health in harmonization efforts.

DECLARATION

IN WITNESS WHEREOF, the undersigned, being duly authorized representatives of their respective Member States and Regulatory Authorities, have adopted this Protocol on behalf of their countries.

Adopted at **SPEKE RESORT, MUNYONYO, REPUBLIC OF UGANDA**, this **31ST DAY OF JULY, 2025**:

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PROTOCOL ON UNDERGRADUATE MEDICAL EDUCATION AND TRAINING 2025

PREAMBLE

WHEREAS Member States of the Association of Medical Councils of Africa (AMCOA) recognize that undergraduate medical education and training across the continent take varying forms in structure, content, and quality;

RECOGNISING the urgent need to harmonize minimum standards in medical education to ensure competence, ethical practice, and professional mobility within and beyond the AMCOA region;

FURTHER RECOGNISING the critical role of medical education in producing a knowledgeable, skilled, and patient-centered health workforce responsive to the continent's health needs;

NOW THEREFORE, the Member States of AMCOA, being parties to this Protocol, hereby agree as follows:

ARTICLE 1: SHORT TITLE

1.1. This Protocol may be cited as the "AMCOA Protocol on Undergraduate Medical Education and Training."

ARTICLE 2: DEFINITIONS

2.1. For purposes of this Protocol, unless the context otherwise requires:

a) AMCOA means the Association of Medical Councils of Africa.

b) Council means any Medical or Dental Regulatory Authority that is a member of AMCOA.

c) Standardization means the process of establishing minimum acceptable standards agreed upon by AMCOA Member Councils.

d) Undergraduate Medical Education refers to the formal training program offered to students leading to a basic medical or dental degree enabling registration for internship.

ARTICLE 3: PURPOSE OF UNDERGRADUATE MEDICAL EDUCATION

3.1 The purpose of undergraduate medical education shall be to:

a) Develop ethical, caring, competent, and knowledgeable professionals;

b) Equip learners with lifelong learning skills and positive attitudes;

c) Prepare graduates to respond effectively to the health challenges of their communities and the broader African context.

ARTICLE 4: STRUCTURE AND PROCESS OF EDUCATION

4.1 Medical education and training programs shall incorporate:

a. Student-Centered and Integrated Learning – including community-based, problem-based, and technologically enhanced methods;

b. Appropriate Student-to-Tutor Ratios – to ensure quality engagement and supervision;

c. Course Content – structured around modular descriptors and credit-weighted systems;
d. Quality Assurance Systems – including accreditation, student indexing, progression tracking, and final licensing examinations;
e. Faculty Competence – ensuring trainers are qualified professionals and registered practitioners;
f. Language of Instruction – support for students not fluent in the language of instruction.

ARTICLE 5: ENTRY REQUIREMENTS AND PROGRAM DURATION

5.1 Entry Requirements

Each Member State shall determine minimum entry qualifications, which shall include a satisfactory background in:

a) Biology
b) Chemistry
c) Physics and/or Mathematics

5.2 Duration of Training

a) The minimum duration for undergraduate medical education shall not be less than five (5) years.

b) Graduate entry medical programs shall not be less than four (4) years.

c) Language orientation support shall be provided where applicable.

ARTICLE 6: COMPETENCIES AND EXPECTED OUTCOMES

6.1 Knowledge Areas

Graduates shall demonstrate knowledge in:

a) Basic and clinical sciences
b) Legal and regulatory frameworks
c) Medical ethics and human rights
d) Research, health systems, and public health

6.2 Attitudes and Values

Graduates shall demonstrate:

a) Compassion, empathy, and respect
b) Professionalism and patient-centeredness
c) Commitment to continuous learning

6.3 Skills

Graduates shall be competent in:

a) Patient assessment (history taking, examination, diagnosis)
b) Emergency care and clinical decision-making
c) Communication, documentation, and health promotion
d) Basic surgical and medical procedures

ARTICLE 7: MANAGEMENT OF IMPAIRED STUDENTS

7.1 Each Council shall ensure:

a) All admitted students are certified physically and mentally fit by a licensed practitioner prior to admission.

b) Where impairment arises during training, a Fitness to Practice Committee shall assess and make recommendations, including support or withdrawal if necessary.

ARTICLE 8: MONITORING AND QUALITY ASSURANCE

8.1 Member Councils shall establish:

a) Mechanisms for periodic curriculum review;

b) Guidelines for accreditation of undergraduate training institutions;

c) National licensing or exit examinations as a standard for assessing graduate competence.

ARTICLE 9: ENABLING FRAMEWORK

9.1 All signatory Member States commit to:

a) Align national laws and curricula with this Protocol;

b) Promote regulatory oversight of education and training institutions;

c) Develop institutional policies and tools to operationalize the Protocol's provisions.

DECLARATION

IN WITNESS WHEREOF, the undersigned, being duly authorized representatives of their respective Member States and Regulatory Authorities, have adopted this Protocol on behalf of their countries.

Adopted at **SPEKE RESORT, MUNYONYO, REPUBLIC OF UGANDA**, this **31ST DAY OF JULY, 2025**:

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AMCOA PROTOCOL ON UNIVERSAL HEALTH COVERAGE 2025

PREAMBLE

WHEREAS the Member States of the Association of Medical Councils of Africa (AMCOA) recognize that Universal Health Coverage (UHC) is a key pillar in achieving equitable and accessible healthcare for all;

RECOGNISING that UHC aims to ensure access to quality healthcare services without exposing users to financial hardship;

FURTHER RECOGNISING the need for harmonized strategies, professional regulation, and adequate investment to drive UHC across the AMCOA region;

NOTING FURTHER that UHC requires strong political commitment, intersectoral collaboration, and the principle of solidarity as a core value;

NOW THEREFORE, the Member States of AMCOA, being parties to this Protocol, hereby agree as follows:

ARTICLE 1: DEFINITIONS

1.1 For the purpose of this Protocol:

a) AMCOA means the Association of Medical Councils of Africa.
b) Council refers to any Medical or Dental Regulatory Authority that is a member of AMCOA.
c) Universal Health Coverage (UHC) refers to ensuring that all individuals and communities receive the health services they need without suffering financial hardship.
d) Professional Indemnity refers to insurance that protects health professionals against legal liability for malpractice.
e) Digital Health includes mobile health (mHealth), electronic health records, telemedicine, and other ICT-enabled health solutions.

ARTICLE 2: QUALITY ASSURANCE FOR UHC

2.1 Councils shall uphold the highest standards in the training of human resources for health.

2.2 Measures include:

a) Harmonized undergraduate and postgraduate curricula across AMCOA member states;
b) Joint accreditation criteria for health training institutions;
c) Quality assurance systems that promote continuous improvement.

ARTICLE 3: FINANCING STRATEGIES FOR UHC

3.1 Councils shall advocate for increased public and private investment into UHC.

3.2 Member States shall:

a) Prioritize UHC in national fiscal frameworks;
b) Support pooled funding models to minimize out-of-pocket health expenditures;
c) Explore social insurance mechanisms anchored in equity.

ARTICLE 4: HUMAN RESOURCE PLANNING

4.1 Councils shall prioritize health workforce planning as essential for UHC realization.

4.2 With support from AMCOA, Councils shall:

a) Develop unified policies for recognition of foreign-trained practitioners;

b) Adopt regional guidelines on:

i. Scope of practice;

ii. Continuous Professional Development (CPD);

iii. Health worker-patient ratios;

iv. Strategies to detect and curb fraud and corruption.

ARTICLE 5: DIGITAL HEALTH AND E-HEALTH SYSTEMS

5.1 Member States shall adopt secure digital technologies to support:

a) Electronic medical records;

b) Telemedicine;

c) Mobile health applications for remote and underserved populations.

5.2 The AMCOA Secretariat shall coordinate digital health initiatives and build capacity in member states.

ARTICLE 6: CLIMATE RESILIENCE IN HEALTH SYSTEMS

6.1 Councils shall promote health systems that are climate-resilient by:

a) Integrating environmental risk assessments into national health strategies;

b) Supporting climate adaptation plans for healthcare facilities and practitioners;

c) Promoting research on climate-related health risks in Africa.

ARTICLE 7: PATIENT SAFETY AND LITIGATION

7.1 Councils shall:

a) Enforce professional codes of conduct and ethics;

b) Promote mandatory professional indemnity insurance schemes;

c) Support Alternative Dispute Resolution (ADR) and compensatory mechanisms for victims of medical harm;

d) Share medico-legal case data and incident reporting systems across AMCOA.

ARTICLE 8: MONITORING AND EVALUATION OF UHC

8.1 Councils, in collaboration with national governments, shall adopt common performance indicators aligned

to SDG 3.8 to track UHC progress, including:

a) Coverage of essential health services;

b) Financial risk protection;

c) Workforce availability and quality metrics.

8.2 Regular peer reviews and regional scorecards shall be coordinated by AMCOA.

ARTICLE 9: ENABLING FRAMEWORK

9.1 Member States agree to:

- Align national laws and policies with this Protocol;
- Allocate adequate resources for implementation;
- Promote public participation and stakeholder engagement.

DECLARATION

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PROTOCOL ON MEDICAL CERTIFICATION OF CAUSE OF DEATH 2025

PREAMBLE

WHEREAS accurate and reliable Medical Certification of Cause of Death (MCCD) is critical for generating valid mortality statistics that inform evidence-based public health policy, planning, resource allocation, and disease surveillance in Africa;

RECOGNISING that inconsistent practices, limited training, underdeveloped systems, and poor-quality data continue to undermine mortality reporting across AMCOA member states;

FURTHER RECOGNISING that quality cause-of-death data is essential for strengthening national Civil Registration and Vital Statistics (CRVS) systems, and that failure to produce such data hampers the ability to detect and respond effectively to public health threats;

NOTING FURTHER that effective implementation of MCCD requires a robust legal, institutional, and technical framework supported by harmonized procedures, standardized tools, sustained capacity building, and alignment with World Health Organization (WHO) standards;
NOW THEREFORE, the Parties to this Protocol do hereby adopt the principles enshrined herein as a framework for strengthening and harmonizing Medical Certification of Cause of Death within AMCOA Member States.

ARTICLE 1: SHORT TITLE

1.1. This Protocol may be cited as the *AMCOA Protocol on Medical Certification of Cause of Death, 2025.*

ARTICLE 2: INTERPRETATION

2.1. For the purposes of this Protocol, unless the context otherwise requires:

a) AMCOA means the Association of Medical Councils of Africa.
b) Council refers to the Medical or Dental Regulatory Authority in any AMCOA member country.
c) MCCD means Medical Certification of Cause of Death.
d) CRVS means Civil Registration and Vital Statistics system.
e) ICD means the International Classification of Diseases, as developed and maintained by the WHO.
f) COD-Edit/ANACoD are WHO-endorsed software tools used to assess quality and usability of mortality data.

ARTICLE 3: OVERARCHING PRINCIPLES

3.1 The purpose of this Protocol is to guide member states in improving the quality, consistency, and timeliness of medically certified cause-of-death data.
3.2 It acknowledges that countries are at different stages of implementation and encourages context-specific adaptation.
3.3 The implementation of this Protocol shall be aligned with WHO frameworks and global best practices.

ARTICLE 4: KEY STRATEGIC PILLARS

4.1 Leadership, Coordination, and Governance

a) Establish or strengthen national CRVS Steering Committees and/or Mortality Technical Working Groups.
b) Define clear roles across ministries (Health, Interior, Education) and stakeholders.
c) Ensure leadership buy-in for sustained resource allocation and policy support.

4.2 Priority Setting and Planning

a) Identify country-specific priorities in MCCD training, data quality, digital infrastructure, and certification systems.
b) Develop national implementation roadmaps linked to CRVS improvement strategies.

4.3 Implementation and Capacity Building

a) Integrate MCCD into medical and dental curricula and continuing professional development (CPD) courses.
b) Promote the use of WHO-compliant MCCD forms and ICD-10/ICD-11 standards.
c) Encourage the digitization of the certification process for real-time access and auditability.
d) Promote quality assurance checks, supervision, and timely feedback mechanisms to practitioners.

4.4 Monitoring and Evaluation (M&E)

a) Establish a robust monitoring system to track quality, completeness, and timeliness of MCCD entries.
b) Use standard tools such as ANACoD and COD-Edit to assess data usability and guide interventions.
c) Conduct periodic national evaluations to assess system-level performance and impact.

ARTICLE 5: ILLUSTRATIVE M&E MATRIX FOR MCCD

illustrative matrix table for monitoring MCCD indictors

Strategic Objective	Output	Indicator	Source
To produce and disseminate reliable vital statistics including causes of death according to international standards	All Health facilities have adopted the use of the international form of the MCCD form and ICD mortality coding system	% Of deaths with a medically certified COD[1]	CRVS or HIS
	Medical certification of cause of death is part of the medical school curriculum	# Of medical schools with the new Curriculum with a course unit on medical certification of cause of death	CRVS or HIS
	The MCCD is an integral part of the CPD course	% Health professionals who completed the MCCD training course as a requirement for licensure/re-licensure	CRVS or HIS
	The quality of cause of death for ICD-coded data-measured as the percentage of records with ill-defined or unknown causes of mortality	Percent of deaths with unusable COD[3]	ANACoD tool

ARTICLE 6: IMPLEMENTATION FRAMEWORK

6.1 AMCOA members shall apply the WHO MCCD framework, adapting its stages to suit local context.
6.2 Councils shall:

a) Develop regulatory instruments to mandate MCCD compliance;
b) Engage universities, hospitals, and regional centers of excellence to strengthen training;
c) Explore partnerships with research institutions to evaluate interventions.

ARTICLE 7: COMMON CHALLENGES AND SOLUTIONS

7.1 Common constraints include:

a) Inadequate knowledge of MCCD forms;
b) Tendency to record modes of death (e.g., “cardiac arrest”) instead of underlying causes;
c) Lack of feedback and data use;
d) Fragmented or paper-based systems.

7.2 Proposed responses:

a) Build institutional capacity and designate MCCD focal persons;
b) Train and regularly retrain health workers;
c) Digitize the MCCD workflow where feasible;
d) Promote inter-agency collaboration across ministries and stakeholders.

ARTICLE 8: KEY RECOMMENDATIONS FROM AMCOA MEMBERS

The following are endorsed as complementary strategies to support effective MCCD rollout:

a) Standardize curricula across AMCOA countries;
b) Develop a Pan-African policy on digital health and MCCD digitization;
c) Promote task sharing rather than task shifting in death certification;
d) Create safe, motivating work environments for practitioners;
e) Institutionalize telemedicine regulation and support ethical AI integration;
f) Integrate MCCD into national UHC and public health emergency response frameworks.

ARTICLE 9: ENABLING FRAMEWORK

9.1 Member States shall align national laws, policies, and institutional arrangements with the principles of this Protocol.

9.2 Councils shall allocate adequate resources for implementation, including digital infrastructure, training programs, and research partnerships.

DECLARATION

IN WITNESS WHEREOF, the undersigned, being duly authorized representatives of their respective Member States and Regulatory Authorities, have adopted this Protocol on behalf of their countries.

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AMCOA PROTOCOL ON THE USE AND REGULATION OF INNOVATION AND DIGITAL TECHNOLOGY IN HEALTHCARE 2025

PREAMBLE

WHEREAS the regulation and use of technology in healthcare in AMCOA Member States varies significantly in structure, implementation, and enforcement;

RECOGNISING the exponential growth of digital health innovations such as e-health, m-health, telemedicine, artificial intelligence (AI), and electronic medical record systems;

FURTHER RECOGNISING the need to re-align health workforce regulation to embrace innovation and prepare for the future of healthcare delivery and training;

NOTING FURTHER that innovation and digital technologies must be deployed in ways that ensure patient safety, respect for privacy, ethical practice, and public trust;

NOW THEREFORE, the Parties to this Protocol do hereby adopt the principles enshrined herein as a framework for the effective use and regulation of innovation and digital technology in healthcare across AMCOA Member States.

ARTICLE 1: OBJECTIVES

1.1. This Protocol aims to:

a) Harmonise regulatory approaches to the use of digital and technological innovation in healthcare;

b) Promote ethical, safe, and equitable adoption of digital tools in health practice, training, and management;

c) Build resilient, digitally competent health systems that contribute to Universal Health Coverage (UHC) and improved outcomes;

d) Strengthen AMCOA members' oversight roles in digital transformation across education, practice, and health governance.

ARTICLE 2: DEFINITIONS

2.1. In this Protocol, unless the context otherwise requires:

a) AMCOA – Association of Medical Councils of Africa

b) Council – A national regulatory body for medical and dental practice in a Member State

c) Technology in Healthcare – Any software, hardware, digital application, platform, AI system, or tool used in delivering, documenting, training, regulating, or analysing healthcare services

d) Innovation – The application of novel ideas, methods, or technologies in healthcare to improve efficiency, outcomes, access, or safety

e) Digital Health – Includes telemedicine, m-health, e-health, electronic records, AI-assisted diagnostics, and virtual learning environments

ARTICLE 3: PRINCIPLES

3.1. AMCOA Member Councils shall be guided by the following principles:

a) Patient safety and ethical use must be central to any digital innovation.

b) Data protection and confidentiality shall be mandatory across all technologies.

c) Equitable access and inclusion should guide technology deployment.

d) Cross-border collaboration shall promote harmonisation and reduce fragmentation in regulation.

e) Evidence-based and context-sensitive approaches shall inform regulation and adoption.

ARTICLE 4: STRATEGIC COMMITMENTS

4.1. Member States commit to:

a) Develop a policy to guide the use of innovation and digital technology in healthcare delivery and training by December 2024;

b) Reform training and education towards a standardised core curriculum across AMCOA partner states;

c) Establish collaborative frameworks for wellness and equitable distribution of healthcare workers;

d) Strengthen digital infrastructure and governance systems to support sustainable and secure innovation;

e) Facilitate stakeholder engagement in the development of AI, telemedicine, and other digital tools.

ARTICLE 5: GOVERNANCE AND REGULATION

5.1. Member Councils shall:

a) Develop or revise national regulatory instruments that cover:

- Informed consent for digital platforms;
- Conflict of interest in technology-based services;
- Licensing and oversight of telemedicine and e-health platforms;
- Data privacy, cybersecurity, and ethical safeguards;
- Disposal and decommissioning of outdated health tech systems.

b) Collaborate with national ICT and health agencies to verify the safety, suitability, and ethical compliance of technologies.

ARTICLE 6: SYSTEM ACCESS, DATA PROTECTION AND INTEGRITY

6.1. All healthcare-related systems must:

a) Include audit trails, access logs, and change-tracking mechanisms;

b) Enforce role-based access control and maker-checker systems;

c) Ensure that no system allows for unauthorised alterations or breach of confidentiality.

ARTICLE 7: EDUCATION, TRAINING, AND CAPACITY BUILDING

7.1. Councils shall:

a) Ensure that all users of healthcare technology are trained prior to system use;

b) Incorporate digital ethics, cybersecurity, and innovation use in undergraduate and postgraduate

curricula;

c) Require mandatory CPD in digital health for registration and re-licensure.

ARTICLE 8: ADVOCACY AND STAKEHOLDER ENGAGEMENT

8.1. Member States shall:

a) Promote public and professional awareness on responsible digital technology use;

b) Advocate for legislative and policy reforms to support safe digital transformation;

c) Encourage ethical online conduct, especially regarding social media and patient confidentiality.

ARTICLE 9: MONITORING, EVALUATION, AND ENFORCEMENT

9.1. Each Member State shall:

a) Establish a monitoring system for technology use and digital compliance;

b) Investigate complaints related to technology-related malpractice or ethical breaches;

c) Apply sanctions and corrective actions in line with national laws and professional codes.

9.2. Suggested indicators include:

a) % of health professionals trained in digital ethics;
b) Number of facilities compliant with national tech regulations;
c) Incident reports of digital breaches or misuse;
d) Adoption rates of digital health platforms with ethical approval.

ARTICLE 10: EXPECTED OUTCOMES

10.1. By implementing this Protocol, AMCOA Member States aim to:

a) Enhance public trust in digital and tech-enabled healthcare;

b) Reduce digital malpractice and data breaches;

c) Standardise regulation of digital health across the continent;

d) Enable ethical innovation for improved health outcomes and UHC.

ARTICLE 11: ENABLING FRAMEWORK

11.1. All signatory countries agree to:

a) Review and amend legislation, regulations, and institutional policies to enable implementation;

b) Allocate resources for digital transformation and regulation;

c) Share good practices and collaborate across Member States.

DECLARATION

IN WITNESS WHEREOF, the undersigned, being duly authorized representatives of their respective Member States and Regulatory Authorities, have adopted this Protocol on behalf of their countries.

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PROTOCOL ON THE REGULATION OF ARTIFICIAL INTELLIGENCE IN HEALTHCARE 2025

PREAMBLE

WHEREAS the regulation of Artificial Intelligence (AI) in healthcare across AMCOA Member States varies in structure, content, and enforcement;

RECOGNISING the need to develop robust guidelines and procedures for the safe, ethical, and effective use of AI technologies in healthcare;

FURTHER RECOGNISING the transformative potential of AI in improving diagnostics, treatment, patient management, health records, and administrative efficiency;

ALSO RECOGNISING the urgency to standardise the governance of AI in healthcare across the AMCOA region to ensure patient safety, accountability, interoperability, and professional integrity;

NOW THEREFORE, the Parties to this Protocol do hereby adopt the principles enshrined herein as a unified framework for the regulation of Artificial Intelligence in Healthcare.

ARTICLE 1: DEFINITIONS

1.1. In this Protocol, unless the context otherwise requires:

a) Artificial Intelligence (AI): Computer systems designed to perform tasks requiring human-like intelligence, such as diagnosis, prognosis, and treatment planning.
b) Certification: The formal process through which AI systems are evaluated and approved before being deployed in healthcare settings.
c) Clinical Validation: Testing AI systems in real-world clinical settings to verify their effectiveness, reliability, and safety.
d) Data Privacy: Protection of patients' personal health information in compliance with data protection laws.
e) Data Security: Mechanisms to prevent unauthorized access, tampering, or loss of healthcare data.
f) Ethical Standards: Moral principles guiding the use of AI, including fairness, transparency, and respect for patient rights.
g) Patient Autonomy: The right of patients to make informed decisions, aided but not overridden by AI tools.
h) Risk Management: The identification, assessment, and mitigation of risks associated with AI technologies.
i) Transparency: Clear and comprehensible disclosure of how AI systems function, including decision logic and data inputs.

ARTICLE 2: TRAINING AND RESEARCH

2.1. All AMCOA Member States shall ensure that foundational and advanced training in AI is integrated into healthcare education at all levels.

2.2. Comprehensive, hands-on training shall be encouraged to enhance user competency, and continuous professional development (CPD) in AI should be made available to all practitioners.

2.3. Research on AI applications, ethics, and patient outcomes shall be promoted, including cross-border collaborative studies among AMCOA members.

ARTICLE 3: SAFETY AND EFFICACY

3.1. All AI systems must undergo rigorous pre-deployment validation and certification by recognized national or regional regulatory bodies.

3.2. Certification shall include clinical trials and simulation-based evaluations that prove safety, reliability, and clinical accuracy.

3.3. Systems shall be subject to post-deployment surveillance, including reporting and analysis of adverse events or malfunctions.

ARTICLE 4: DATA PRIVACY AND SECURITY

4.1. Member States shall ensure that all AI systems comply with national data protection laws and international privacy standards.

4.2. Encryption, anonymisation, and access control mechanisms must be built into AI systems to protect patient data during storage and transmission.

4.3. Personal identifiers shall be de-identified or pseudonymised when used in training datasets or operational models.

ARTICLE 5: ETHICAL CONSIDERATIONS

5.1. AI systems must be designed to identify and mitigate algorithmic bias and should not promote discriminatory outcomes.

5.2. Regular ethical audits shall be conducted to ensure fairness, inclusiveness, and accountability.

5.3. Systems must explain their decision-making processes in a clear, understandable way to both patients and clinicians.

5.4. AI tools shall not replace human decision-making but rather enhance informed choices, preserving patient autonomy.

ARTICLE 6: RISK MANAGEMENT

6.1. Risk assessments shall be conducted prior to the implementation of any AI system to identify and document foreseeable risks.

6.2. Member States shall mandate risk management plans, including mitigation strategies, fall-back protocols, and system override capabilities.

6.3. AI systems shall be continuously monitored, reviewed, and updated throughout their operational lifecycle.

ARTICLE 7: ENABLING FRAMEWORK

7.1. AMCOA Member States agree to enact or revise national laws and regulations to reflect the provisions of this Protocol.

7.2. Councils/Boards shall establish inter-agency collaboration mechanisms to align AI regulations with national ICT, cybersecurity, and public health authorities.

7.3. Member States shall report annually on progress in AI regulation, capacity-building, and system implementation.

DECLARATION

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14. Medical Council of **Tanzania**
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16. Health Professions Council of **Zambia**
17. Medical and Dental Practitioners Council of **Zimbabwe**