

DIETITIANS' VIEWS AND PERCEPTIONS OF THE IMPLEMENTATION  
OF THE CONTINUING PROFESSIONAL DEVELOPMENT SYSTEM  
FOR DIETITIANS IN SOUTH AFRICA

**Claire Juliet Martin**

Thesis presented in partial fulfillment of the requirements for the degree of  
Master of Nutrition at the University of Stellenbosch.



Project Study Leaders:

Professor Demetre Labadarios  
Mrs Debbie Marais  
Dr Edelweiss Wentzel-Viljoen

Confidentiality:

Grade A

December 2007

## DECLARATION

I, Claire Juliet Martin, declare that this thesis is my own original work and that all sources have been accurately reported and acknowledged, and that this document has not previously in its entirety or in part been submitted at any university in order to obtain an academic qualification.



Signature

Date: 15<sup>th</sup> October 2007

Kopiereg © 2007 Universiteit van Stellenbosch  
Alle regte voorbehou

Copyright © 2007 Stellenbosch University  
All rights reserved

## ABSTRACT

**INTRODUCTION:** The study's objective was to evaluate the South African Continuing Professional Development (CPD) system for dietitians, by determining their perceptions of the systems' implementation and participation in CPD activities within the system, that was in place from 1 September 2001 until 1 April 2006.

**METHODS:** The study was designed as an observational descriptive study. Three data gathering techniques were used, incorporating both quantitative and qualitative methods:-

- i) A national survey of dietitians was conducted using a self-administered questionnaire. The 40 item questionnaire comprised 3 sections, i.e. socio-demographics, the CPD system, and CPD activities. Content and face validity was conducted followed by pilot testing, prior to distribution via post and e-mail, to 1589 dietitians.
- ii) After the survey, 3 focus group discussions (FGD) were held with 19 Pretoria-based dietitians, to discuss issues that emerged from the questionnaire responses.
- iii) In-depth interviews were conducted with 6 CPD personnel representing the Health Professions Council of South Africa (HPCSA), CPD Committee and the Association for Dietetics in South Africa (ADSA) providing insights from an administrative and managerial perspective.

**RESULTS:** A response rate of 20% was achieved for the national survey. More respondents found the ADSA and CPD office helpful, friendly, easy to contact and their CPD queries efficiently handled. However respondents and FGD participants stated that the HPCSA was difficult to contact and CPD queries were unresolved. Respondents called for simplified rules and guidelines to improve understanding of the system since they felt that CPD information/correspondence was lengthy and difficult to understand. The majority of respondents (54.5%; n=156) and most FGD participants did not find the CPD administration fee reasonable. Affordability of CPD activities was also a concern with 55.2% (n=164) stating that activities were expensive. A few FGD dietitians and 29.65% (n=88) of respondents did agree that there were both expensive and affordable activities to choose from. Statistically significant differences were found between the amounts of money spent on CPD

across the various practice areas, qualifications and between provinces. Dietitians' current CPD practices were mainly attendance at lectures and seminars, followed by conferences and then journal articles. If given a preference, however, respondents ranked conferences as their top preference followed by lectures. Journal clubs were rated third, ahead of journal reading. Barriers to CPD participation included cost, limited activities close by, obtaining leave from work, family obligations and internet access. Variety and usefulness of topics for presentations and articles were also criticised, as was the technical nature of questions. In the new system, the reduced annual CPD points requirement was appreciated, however 51.7% (n= 161) preferred not to keep their own CPD records.

**CONCLUSION:** The study provided some insights into dietitians' perceptions of the CPD system. Strengths of the current system were stated as improved knowledge, improved patient care and networking with colleagues. Issues identified for improvement include simpler CPD correspondence and reasonable fees. Additionally, ways should be sought to minimise barriers to participating in CPD. Addressing these issues will contribute to the provision of quality CPD within a system that is acceptable to its participants.

## OPSOMMING

**INLEIDING:** Die doel van hierdie studie was om die implementering van die Suid-Afrikaanse Voortgesette Professionele Ontwikkelingstelsel (VPO) vir dieetkundiges te evalueer. Hierdie evaluering is op die opinies van dieetkundiges en ander rolspelers aangaande die implementering van die stelsel gebaseer, asook die vlak van deelname aan die VPO aktiwiteite binne die ou sisteem wat in plek was vanaf 1 September 2001 tot 1 April 2006.

**METODE:** Die studie is as 'n waarnemende-beskrywende studie ontwerp. Drie tegnieke, insluitende kwantitatiewe en kwalitatiewe metodes, is gebruik om inligting te versamel.

i) 'n Nasionale opname onder dieetkundiges is deur middel van 'n vraelys gedoen. Hierdie vraelys het uit veertig items in drie afdelings naamlik sosio-demografiese, die VPO stelsel as sodanig en VPO aktiwiteite, bestaan. Die vraelys se inhoud- en gesigsgeldigheid is getoets voordat dit na 1589 dieetkundiges per gewone en e-pos versprei is.

ii) Na die opname is fokusgroep-besprekings (FGB) met 'n verdere 19 dieetkundiges van Pretoria gehou om sekere aangeleenthede, verkry uit die resultate van die vraelys, te bespreek.

iii) Ses VPO personeellede is uitgesonder vir in-diepte besprekings om menings vanuit 'n administratiewe- en bestuursoogpunt te kry. Hierdie personeellede het die Raad vir Gesondheidsberoep van Suid-Afrika, die VPO komitee en die Vereniging vir Dieetkunde in Suid-Afrika verteenwoordig.

**RESULTATE:** Twintig persent van die dieetkundiges het op die vraelyste gereageer. Die meeste het gerapporteer dat die Vereniging vir Dieetkunde in Suid-Afrika en die VPO maklik bereikbaar, vriendelik en hulpvaardig is, en dat hulle VPO navrae effektief hanteer word. Van die deelnemers het egter die VPO inligting en korrespondensie langdradig en ingewikkeld gevind, en het eenvoudiger reëls en riglyne versoek. Sommige het oor onbeantwoorde navrae gekla. Die meeste vraelys-deelnemers (54.5% ; n=156), en die meeste van die fokusgroep-deelnemers het gevoel dat die VPO administrasiefooi te hoog was. Die koste van VPO aktiwiteite was ook 'n kwelpunt vir 55.2% (n=164) van die deelnemers. 'n Paar van die

fokusgroep-deelnemers en ongeveer 29.65% (n=88) van die vraelys-deelnemers het gevoel dat daar beide bekostigbare en duur aktiwiteite was om van te kies. Statisties beduidende verskille is tussen die hoeveelheid geld wat op die VPO in die verskillende praktykareas, kwalifikasies en provinsies bestee is, gevind. Die VPO-aktiwiteit waaraan die dieetkundiges voorkeur gegee het was die bywoning van lesings en seminare, gevolg deur konferensies en die lees van joernaal-artikels met 'n vraeboog. Die vernaamste voorkeur is egter vir konferensies gevolg deur lesings. Joernaalklubs is derde gelys, gevolg deur die lees van joernaalartikels. Die grootste struikelblokke tot VPO-deelname sluit kostes sowel as beperkte aktiwiteite in die nabyheid, verkryging van verlof, gesinsverantwoordelikhede en internettoegang in. Die verskeidenheid en bruikbaarheid van die onderwerpe vir lesings en artikels, asook die tegniese inhoud van die vrae is gekritiseer. Die vermindering van die vereiste jaarlikse VPO punte in die nuwe stelsel is waardeer, hoewel ongeveer 51.7% (n=161) verkies het om nie hul eie VPO rekords te hou nie.

**GEVOLGTREKKING:** Die studie het verskeie sienings van die persepsies van die dieetkundiges aangaande die VPO stelsel onthul. Die voordele van die stelsel sluit beter kennis, pasiëntversorging en skakeling met kollegas in. Knelpunte wat aandag moet geniet, is die graad van kompleksiteit van die korrespondensie, asook die kostes. Addisionele metodes om struikelblokke ten opsigte van VPO deelname te verwyder, moet gevind word. Die aanspreek van hierdie knelpunte sal bydra tot voortgesette Professionele ontwikkelingstelsel wat vir alle deelnemers aanvaarbaar is.

## **ACKNOWLEDGEMENTS**

The author is grateful to the CPD Committee for their financial assistance without which, the study would not have been possible. Thanks also to all the dietitians who spared the time to complete the questionnaire and/or participate in the focus groups. The author would also like to express sincere appreciation to Professor D Labadarios, Mrs D Marais, Dr E. Wentzel-Viljoen and Prof DG Nel for their expertise and support. A sincere and heartfelt appreciation to my family for their patience, support and encouragement. Mum, Dad, Justine and Ingrid who helped in so many ways, and who at various stages in the course of the last few years, made time available for me to study for exams and complete this project. Grateful thanks to my husband Merven for all the support, suggestions and invaluable IT help. Most importantly, thanks to Joshua and Cairenn for your understanding and love.

**DEDICATION**

In memory of my Dad, Bonaventure Frederick Martin



<b>TABLE OF CONTENTS</b>	<b>PAGE</b>
<b>DECLARATION</b>	ii
<b>ABSTRACT</b>	iii
<b>OPSOMMING</b>	v
<b>ACKNOWLEDGEMENTS</b>	vii
<b>DEDICATION</b>	viii
<b>DEFINITION OF ABBREVIATIONS</b>	xiii
<b>DEFINITION OF CONCEPTS</b>	xiii
<b>LIST OF FIGURES AND TABLES</b>	xv
<b>LIST OF APPENDICES</b>	xvii
<b>CHAPTER 1: INTRODUCTION AND STATEMENT OF PROBLEM</b>	<b>1</b>
1.1 REVIEW OF RELATED LITERATURE	2
1.1.1 Introduction	2
1.1.2 CPD and Changes in Practice	2
1.1.3 Criticisms of CPD	4
1.1.4 Benefits of CPD	6
1.1.5 The South African CPD System for Dietitians	7
1.1.5.1 Institutionalisation	7
1.1.5.2 Administration and management	9
1.1.5.3 Recent changes in the CPD system	10
1.1.5.4 Revised CPD system for dietitians	13
1.1.6 The Status of CPD for Dietitians in Other Countries	15
1.1.7 The Value of Evaluating the South African CPD System	16
1.2 STATEMENT OF PROBLEM	17
1.3 SIGNIFICANCE OF THIS STUDY	17
<b>CHAPTER 2: METHODOLOGY</b>	<b>19</b>

2.1 OBJECTIVES	20
2.1.1 Research Aim	20
2.1.2 Specific Objectives	20
2.2 STUDY DESIGN, ETHICS AND CONFIDENTIALITY	20
2.2.1 Study Design	20
2.2.2 Ethics Approval	20
2.2.3 Informed Consent and Confidentiality	21
2.3 RESEARCH METHODS:	21
2.4 THE QUANTITATIVE METHODOLOGICAL ASPECTS OF THE STUDY	22
2.4.1 Design and Development of the Quantitative Research Instrument (Questionnaire)	22
2.4.1.1 Conceptual framework	24
2.4.1.2 Formulating the questions	27
2.4.1.3 The final questionnaire	27
2.4.2 Questionnaire Evaluation	28
2.4.2.1 Content validity	28
2.4.2.2 Face validity	29
2.4.2.3 Pilot testing	30
2.4.3 Study Population for the Survey	31
2.4.3.1 Sampling for the survey	31
2.4.3.2 Exclusion criteria	32
2.4.3.3 Sampling bias	32
2.4.4 Data Collection	32
2.4.4.1 Questionnaire distribution via e-mail	32
2.4.4.2 Questionnaire distribution via postal services	33
2.4.5 Data Analysis	35

2.4.5.1 Confidential management of the questionnaire	35
2.4.5.2 Statistical analysis of the questionnaire	35
2.4.5.3 Internal consistency (reliability)	36
<b>2.5 THE QUALITATIVE METHODOLOGICAL ASPECTS OF THE STUDY</b>	<b>36</b>
2.5.1 Focus Group Discussions (FGD) for Dietitians	38
2.5.1.1 Formulating a questioning route for the FGD	38
2.5.1.2 Sampling for the FGD	41
2.5.1.3 Sampling bias	41
2.5.1.4 Data collection and facilitation of the discussion groups	42
2.5.1.5 Steps taken to improve data quality at the FGD	44
2.5.1.6 Data management and analysis of focus group transcripts	45
2.6.1 In-depth Interviews with Key CPD Personnel	46
2.6.1.1 In-depth interviews: structure, questions and format	46
2.6.1.2 Sampling for the in-depth interviews	47
2.6.1.3 In-depth interviews: data collection	48
2.6.1.4 Steps taken to improve the quality of in-depth interview data	48
2.6.1.5 Management and analysis of in-depth interview data	48
<b>CHAPTER 3: RESULTS</b>	<b>49</b>
<b>3.1 QUANTITATIVE RESULTS: SURVEY FINDINGS</b>	<b>50</b>
3.1.1 Response to the Questionnaire	50
3.1.2 Description of Survey Respondents	50
3.1.3 CPD System and CPD Activities	52
3.1.3.1 Dietitians' understanding of the CPD system	53
3.1.3.2 Correspondence, communication and coverage	53
3.1.3.3 Rules, regulations, procedures	57
3.1.3.4 Point status and record keeping of CPD activities	60
3.1.3.5 Affordability of CPD	62
3.1.3.6 Participation of dietitians in CPD activities	65

3.1.3.7 Barriers to participation in CPD activities	67
3.1.3.8 General operation of the CPD system	70
3.2 QUALITATIVE RESULTS: FGD FINDINGS	74
3.2.1 Profile of FGD Participants and Group Dynamics	74
3.2.2 FGD Participant Responses	75
3.3 QUALITATIVE RESULTS: IN-DEPTH INTERVIEW FINDINGS	80
3.3.1 Interviewee Information	80
3.3.2 In-depth Interview Findings	80
3.4 TRIANGULATION OF DATA	84
<b>CHAPTER 4: DISCUSSION</b>	<b>87</b>
4.1 DISCUSSION	88
<b>CHAPTER 5: CONCLUSION AND RECOMMENDATIONS</b>	<b>100</b>
5.1 CONCLUSION	101
5.2 RECOMMENDATIONS	101
<b>REFERENCES</b>	<b>106</b>
<b>APPENDICES</b>	<b>112</b>

## DEFINITION OF ABBREVIATIONS

<b>ADSA:</b>	Association for Dietetics in South Africa
<b>CPD:</b>	Continuing Professional Development
<b>HPCSA:</b>	Health Professions Council of South Africa
<b>HPC:</b>	Health Professions Council
<b>CEU:</b>	Continuing Education Unit
<b>FGD:</b>	Focus group discussions
<b>SAJCN:</b>	South African Journal of Clinical Nutrition

## DEFINITION OF CONCEPTS

<b>Accreditor:</b>	An institution or group that reviews applications by non-accredited service providers to offer CPD activities according to criteria set by the HPCSA. <sup>1</sup>
<b>CPD:</b>	Refers to education, skills development and training taken beyond the basic requirement to enter into the dietetics profession. <sup>2</sup>
<b>CPD activities:</b>	Opportunities to learn new skills or knowledge on an individual or group level. <sup>2</sup>
<b>CPD office:</b>	The CPD office held a registry of point status for dietitians and was responsible for the administration and coordination of points for dietitians. Additionally, accreditation of CPD activities was done through this office. <sup>2</sup>
<b>CPD system:</b>	The operations, actions and activities, including rules and regulations that constitute the system managing CPD for

dietitians. It refers also to the collection of people, procedures, organizations, committees, and events operating together to provide support and opportunities for continuing education for dietitians.<sup>2,3</sup>

**CPD system personnel, managers and staff:**

Includes personnel involved in, and responsible for overseeing, administering, decision-making, supporting and representing the CPD system in terms of the activities, rules, regulation, meetings and committees in the day to day running of the South African CPD system for dietitians.<sup>5</sup>

**Dietitians:**

Also referred to as participants or respondents in this study. Refers to all dietitians currently registered with the Health Professions Council of South Africa (HPCSA), listed in the CPD database, and required to participate in compulsory CPD.

**Implementation Evaluation:**

Yields information about the quality of an operation or system and is often termed process evaluation. It assesses services, administration and management to produce valid findings about the effectiveness of a system, highlighting problems and to recommend improvements.<sup>3, 5</sup> In this study; it is evaluated through the perceptions of the participants as well as other role players.

**Service providers:**

Accredited groups, institutions or associations that offer activities for CPD.<sup>1</sup>

## LIST OF FIGURES AND TABLES

### FIGURES

- Figure 1.1:** Factors that could impact on the CPD learning process
- Figure 1.2:** Diagrammatical representation of all personnel, committees and organizations involved in the South African CPD system for dietitians (2002 – 2006)
- Figure 1.3:** Historical development of the South African CPD system for dietitians highlighting key changes
- Figure 2.1:** Flow diagram outlining the methodological approach to the quantitative aspects of the study
- Figure 2.2:** Flow diagram summarising the national distribution of the questionnaire
- Figure 2.3:** Flow diagram outlining the methodological approach to the qualitative aspects of the study
- Figure 2.4:** Development process for the focus group questioning route
- Figure 2.5:** Summary of the qualitative analysis process for FGD data
- Figure 3.1:** Provincial representation of respondents (n=316)
- Figure 3.2:** Respondents' (n=316) views on CPD correspondence from the Professional Board for Dietetics (HPCSA) and the CPD office
- Figure 3.3:** Respondents' (n=293) views on the efficient handling of queries and provision of feedback by the various offices
- Figure 3.4:** Respondents' (n=312) views (%) on the attainability of ethics points
- Figure 3.5:** Respondents' (n=311) views (%) on maintaining personal CPD records
- Figure 3.6:** Respondents' (n=312) reported expenditure (%) on CPD activities for the year 2004
- Figure 3.7:** Approach to triangulation of study data

**TABLES:**

<b>Table 1.1:</b>	Benefits that CPD can offer the dietetic practitioner
<b>Table 2.1:</b>	Definitions of investigative concepts
<b>Table 2.2:</b>	Conceptual Framework: Components of the CPD system to be evaluated
<b>Table 2.3:</b>	Questionnaire items addressing the concepts in the conceptual framework
<b>Table 2.4:</b>	Responses from dietitians who participated in the pilot study
<b>Table 2.5:</b>	Structured interview schedule
<b>Table 2.6:</b>	Procedure used to conduct each focus group discussion
<b>Table 3.1:</b>	Demographic characteristics of respondents
<b>Table 3.2:</b>	Dietitians' responses (%) on the quality of service provided by the HPCSA, ADSA and the CPD office.
<b>Table 3.3:</b>	Dietitians' (n=314) feelings (%) about the reduction in the number of annual points
<b>Table 3.4:</b>	Dietitians' (n=287) views (%) on the CPD administration fee
<b>Table 3.5:</b>	The usual CPD activities of the survey respondents (n=315)
<b>Table 3.6:</b>	Preferred CPD activities of the survey respondents (n=312)
<b>Table 3.7:</b>	Dietitians' (n=312) views on point accumulation
<b>Table 3.8</b>	Factors acting as barriers to dietitians (n=313) participating in CPD
<b>Table 3.9:</b>	Strengths of the current CPD system as reported by dietitians (n=245)
<b>Table 3.10:</b>	Respondents' (n=252) reported weaknesses of the system and suggestions for improvement.
<b>Table 3.11</b>	Profile of the FGD participants in three focus groups
<b>Table 4.1</b>	Demographic characteristics (%) of respondents compared to the national HPCSA register of dietetic practitioners (n=1652)
<b>Table 4.2:</b>	Usual versus preferred CPD among dietitians and nurses



## **LIST OF APPENDICES**

- Appendix 1:** Board notice 122 of 2001. HPCSA - Rules relating to continuing professional development in dietetics
- Appendix 2:** Guidelines for compulsory continuing professional development for dietitians (2003)
- Appendix 3:** Continuing professional development guidelines for health professionals (November 2006)
- Appendix 4:** Survey questionnaire
- Appendix 5:** Pilot study: Comments on the questionnaire
- Appendix 6:** Consent form accompanying the survey questionnaire
- Appendix 7:** Covering letter to the survey questionnaire
- Appendix 8:** Internal reliability (demonstrated by Chronbach's Alpha) of items from the questionnaire
- Appendix 9:** Consent form for focus groups participants
- Appendix 10:** In-depth interviews - structure and questions
- Appendix 11:** Statistical analysis of selected variables - observed frequencies
- Appendix 12:** Personal CPD activity evaluation form

**CHAPTER 1: INTRODUCTION AND STATEMENT OF PROBLEM**

## **1.1 REVIEW OF RELATED LITERATURE**

### **1.1.1 Introduction**

With the practice of dietetics comes a lifelong commitment to learning.<sup>6</sup> One of the main reasons for this is that we live in the age of information where scientific research emerges at a rate faster than can be incorporated into undergraduate curriculums.<sup>7</sup> So, with a half life of just 3 years, nutrition information is quickly rendered obsolete.<sup>8</sup> Furthermore, changes in health care have prompted a shift from the traditional therapeutic location to encompass new practice opportunities. This means that it is now no longer sufficient to merely keep abreast of changes in medical research, but also trends in information technology, biotechnology, marketing and business.<sup>9,10</sup> Therefore, for dietitians, a continuous pursuit of knowledge is fundamental to improve their professional abilities and achieve their goal of optimal nutritional care of the patient and the public.<sup>11</sup>

Continuing education, referred to hereon as Continuing Professional Development (CPD), is recognised as a means to access current scientific information and keep abreast of the educational, political and social changes that affect the health care environment.<sup>12</sup> CPD furthers the education continuum after university, by helping dietitians grow within their own practice area, sharpen their skills, improve and prove their competency.<sup>6,7,10</sup> In the United States (US), CPD is found to be vital now more than ever, as the American Health Council expects accountability and responsibility from its members, and an informed public demand competent practitioners.<sup>10, 13</sup>

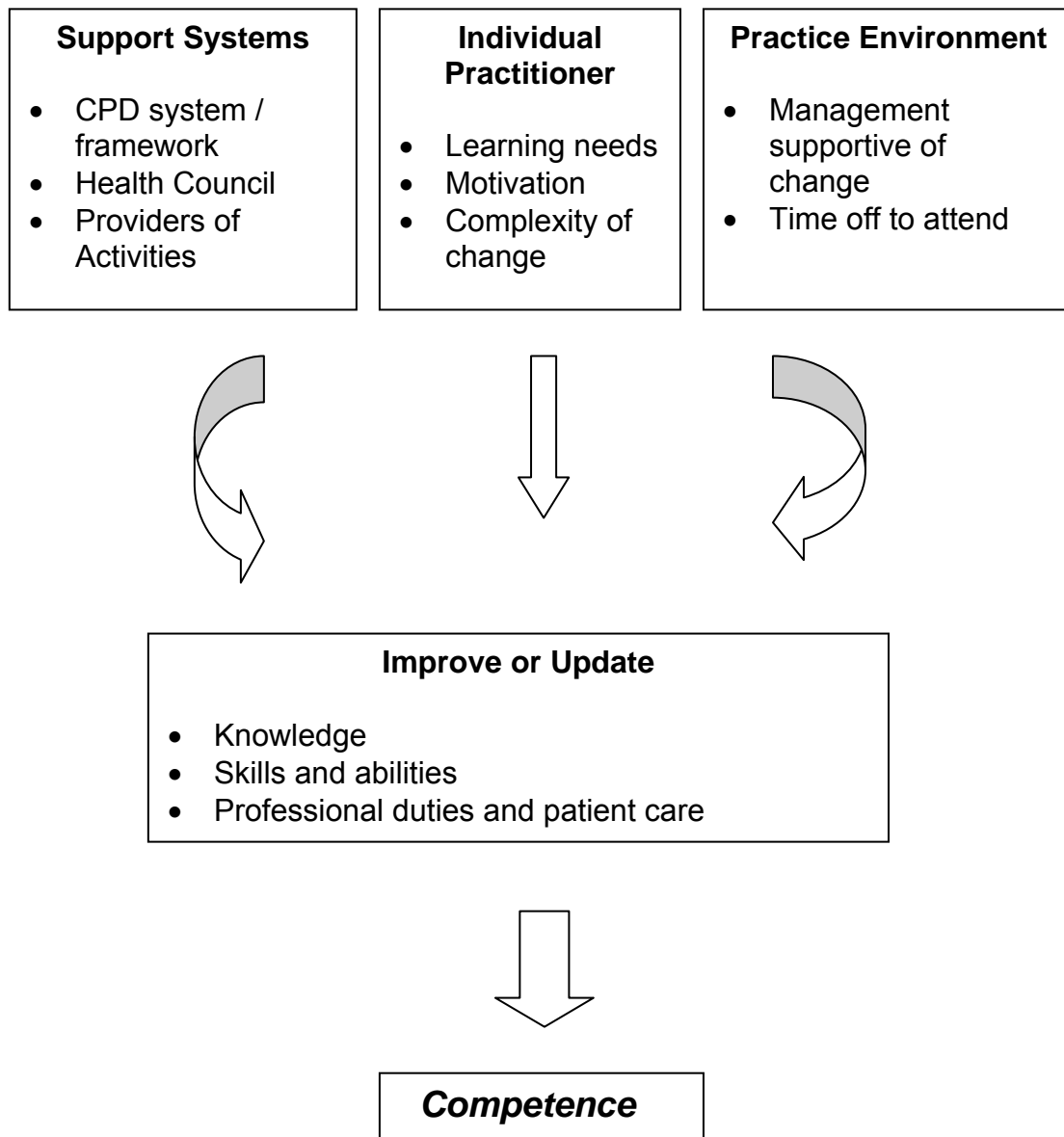
### **1.1.2. CPD and Changes in Practice**

Competence depends on updated knowledge and skills in one's field of practice. CPD is a longstanding strategy adopted by many professions to keep updated and thereby achieve competence.<sup>10</sup> There is still controversy in the literature though, about the amount of learning achieved through CPD. It is said that one cannot assume that mere attendance at a CPD activity results in a transfer of knowledge and in turn, changes in practice.<sup>8,12</sup> Nevertheless, it remains as a measure of practitioner competence.<sup>14</sup>

A 1991 meta-analysis on nursing practice benefits stated that 75% of those participating in CPD will provide better patient care when returning to their work environments.<sup>14</sup> On the

other hand, Moran quoted several studies which found no significant improvement in the quality of patient care after doctors participated in activities like conferences, reading journals and attending ward rounds.<sup>15</sup> However studies in the mid 90's, reviewing the impact of continuing medical education showed evidence that interactive continuing education directly involving participants in the activity can impact on professional practice, whereas didactic sessions do not.<sup>16</sup> The inconsistent impact of continuing education does not necessarily mean that the concept of CPD itself is flawed but rather that a number of variables can affect CPD. Take the type of activity for example: if large presentations are ineffective then providers of activities need to come up with or identify activities that take into account principles of adult learning and include more participative methods like small group discussions.<sup>15</sup>

In addition to the type of CPD activity, several other factors could potentially influence the extent to which CPD translates into changes in practice (Figure 1.1). These include factors affecting each individual, the work environment and the support systems in place.<sup>8,10,14,15</sup>



**Figure 1.1: Factors that could impact on the CPD learning process**<sup>6, 7, 14</sup>

### 1.1.3 Criticisms of CPD

The longstanding controversy disputing the effectiveness of CPD continues to surface from time to time. Most recently, some of the old criticisms and new challenges associated with CPD were highlighted in several journal articles and letters to the editor, for example, a recent study involving physicians demonstrated that while CPD does improve knowledge, it is associated with small if any improvements in patient care.<sup>17</sup> Furthermore, immediately following a lecture, a practitioner may recall its contents; however, it was questioned whether this recall is as vivid several months later, or if this knowledge filters down to the patient at all. Nonetheless, didactic lecture session activities continue, because of the need to accumulate points.<sup>18, 19</sup>

The awarding and accumulation of points itself is a debatable issue. Allen states that it does not acknowledge the complexities of learning which varies widely between individuals, nor does it consider learning that occurs continually in the practice environment; and is associated with problem solving. Additionally, points seem to be unequally awarded. A case in point would be conferences where many credits are awarded for attendance but the lectures will impact little on the practice environment. Comparatively, writing a paper that involves a vast amount of research and hours of study is awarded fewer points.<sup>19</sup>

It has even been suggested that CPD does not work as it is “driven by politicians and academics” who are under the false belief that it is effective.<sup>18, 20</sup> One health practitioner stated that since its start-up in Australia over 10 years ago, CPD has done little except to “introduce another layer of bureaucracy”.<sup>20</sup> It is recommended that the current models of CPD be dropped altogether, and efforts to improve its quality only be pursued once quality CPD is properly defined.<sup>18, 20</sup>

Another contentious issue surrounding CPD is that of cost. It has been stated that authorities put CPD in place but fail to sufficiently fund CPD. As a result, numerous pharmaceutical companies carry this cost by sponsoring meetings and employing specialists or experts to deliver lectures.<sup>20</sup> In the US this has resulted in a multi-billion dollar CPD industry. The concern raised is that it is conveniently ignored that these lectures result in little change in practice, or that the lecture gatherings are ideal platforms to promote new and expensive company products or, even the fact that the subject matter presented is often limited to the company interests.<sup>20, 21</sup>

One of the strategies used in several countries to improve the effectiveness of CPD is a personal development plan to minimize undirected learning in individuals.<sup>22</sup> However, this strategy has also been brought into question since self-directed learning that is guided by personal assessments and individual portfolios may in effect impede effective CPD if the individual practitioner inaccurately assesses their learning needs. Well-designed studies investigating various approaches to CPD are needed, and, since the effectiveness of different methods may change in various settings, this will need to be given consideration as well.<sup>23</sup>

The shortcomings of CPD have been recognised by many professional associations and strategies are continuously underway to improve the effectiveness of CPD. In the United Kingdom (UK), competency standards have now been set for specific medical specialities and defined by their medical council, so that doctors can measure their competence against these prescribed standards. Doctors are also encouraged to participate in multidisciplinary learning, i.e. to learn together with other professionals. Although it is still uncertain about how these moves positively affect patient care, it may still prove to be better than traditional lectures.<sup>21</sup> In the US, several professional medical societies and organizations are also directing efforts to improve CPD specifically with regard to practice, and hope to bring “credibility back to CPD.”<sup>17</sup> Most agree though, that the best solution to ensure competent health professionals, is to foster the desire to pursue life-learning at an undergraduate level.<sup>22</sup>

#### **1.1.4. Benefits of CPD**

The main objective of CPD is indeed to take new knowledge and skills to one’s practice setting, and therefore usually dominates the debate on the impact of CPD. However, Nolan states that it is over simplistic to view CPD as effective only to the extent in which changes in practice occur. In fact, it has the potential to impact more than simply learning something new. If positively viewed by its participants and optimally managed, CPD can encompass a wide range of learning experiences, contribute to professional growth and provide safe, quality care to the public while being personally rewarding.<sup>14</sup> In fact, a host of advantages could be gained by the professional development process (Table 1.1).<sup>8,10,14</sup>

**Table 1.1: Benefits that CPD can offer the dietetic practitioner** <sup>14</sup>

<b>AREA</b>	<b>BENEFITS</b>
<b><i>Personal</i></b>	<ul style="list-style-type: none"> <li>• Fosters a sense of lifelong learning</li> <li>• Improves assertiveness and autonomy</li> <li>• Can improve promotional prospects</li> <li>• Increases motivation</li> <li>• Better career planning</li> <li>• Provides a sense of personal satisfaction and begins a process of personal growth</li> </ul>
<b><i>Professional</i></b>	<ul style="list-style-type: none"> <li>• Promotes the exchange of ideas between dietitians</li> <li>• Increases awareness of professional issues</li> <li>• Changing trends in dietetic practice</li> </ul>
<b><i>Public</i></b>	<ul style="list-style-type: none"> <li>• Awareness of ethical issues protects the national health and welfare of the public</li> <li>• Enhances the image of the profession</li> </ul>
<b><i>Health Council/ Regulatory Body</i></b>	<ul style="list-style-type: none"> <li>• Provides proof of competence</li> <li>• Ensures public safety</li> <li>• Accountability</li> </ul>

### **1.1.5 The South African CPD System for Dietitians**

#### **1.1.5.1 Institutionalisation**

While the responsibility of CPD lies with the individual dietitian, like with most learning, it is a supportive process. A system has to be in place to assess, measure and document dietitians' skills.<sup>10</sup> Over the past 2 decades, dietetic associations in several countries, including South Africa have realized the importance of CPD to the profession and the need for a planned CPD system to be in place, if dietetics is to 'develop as a profession and continue to meet the needs of society.'<sup>14</sup>



The South African (SA) CPD system for dietitians was initiated and developed by a few dietitians in consultation with various stakeholders through the Association for Dietetics in South Africa (ADSA). It was introduced in 1995 as a voluntary system. The stated goals of the system at that stage were documented as follows <sup>2</sup>:-

- Maintain competence levels
- Provide safe public service
- Planned professional growth
- Use of scientifically sound information

Besides assisting members to meet their continuing education needs, it was envisioned that through the CPD process, the values of ADSA would be upheld to establish the image of dietitians as credible, responsible and accountable for high standards of practice at all times.<sup>2</sup>

On the 1<sup>st</sup> of September 2001, the system of CPD was made compulsory for dietitians and all health professionals in South Africa in accordance with a legislation - Section 26 of the Health Professions Act, 1974 (Act No 56 of 1974) as well as the 'HPCSA rules relating to continuing professional development in dietetics' according to the act of 1974 of the Health Professions Council of South Africa (HPCSA) (Appendix 1).

In the first compulsory cycle which ended on 31<sup>st</sup> of December 2002, 1323 dietitians participated. At the time, it was noted as encouraging that 58% of all dietitians not only met, but exceeded the mandatory 50 points.<sup>24</sup> In 2003, 57% accrued more than 50 points with some decline in this percentage to 54% in 2004. Interestingly, the highest number of points accrued during 2004 by a dietitian was 207. In that same year, 21% accrued less than and equal to 25 points.<sup>25</sup>

To accumulate their 50 points in the old system implemented until April 2006, South African dietitians had a wide variety of CPD activities available to them. These were grouped into three broad categories, i.e.

- *Category 1*: organizational activities e.g. lectures and seminars
- *Category 2*: small group activities e.g. journal clubs

*Category 3:* individual activities e.g. answering questions based on scientific articles.<sup>25, 26</sup>

In 2002, 135 CPD activities for dietitians were accredited for category 1, 57 for category 2 and 623 for category 3 CPD activities. By 2003, there were almost equal amounts of each category to choose from. The last three CPD cycles (2002, 2003, and 2004) have found the number of points from category 1 and 3 increasing, while points from category 2 reduced.<sup>25, 26</sup>

### **1.1.5.2. Administration and management**

The CPD system has always been under the auspices of the Professional Board for Dietetics within the HPCSA. ADSA was appointed by the Professional Board for Dietetics as the only “accreditor” of activities for dietitians. A CPD officer was appointed with the responsibility of accrediting activities (Accreditor) and managing points for individual dietitians (Administrator).<sup>11</sup> A CPD Accreditation committee was convened including the CPD officer, the ADSA CPD portfolio holder, Administrators from the HPCSA and members of the Professional Board for Dietetics that was responsible for the accreditation of CPD activities (Accreditor). The functions and roles were outlined in guidelines that were sent to all dietetic practitioners (Appendix 2). In summary, the CPD office was run by the CPD Officer who was responsible for:-

- The accreditation of CPD activities
- Maintaining a database for dietitians participating in CPD
- Financial management of the office
- Provision of written updates of points and information for national distribution
- Handling of all CPD related queries and
- Reporting to and communication with the CPD accreditation committee for Dietitians, the Professional Board for dietetics and the HPCSA-CPD Manager.<sup>11</sup>

Fair and responsible operation of the CPD system was the duty of the Professional board for Dietetics. All information regarding the point status of registered dietitians including those requesting deferment was reviewed by the Professional Board for dietetics. The CPD Committee for Dietitians functioned for, and reported to the Professional Board for dietetics on all matters relating to the suitable development of the CPD system.<sup>11</sup>

The individual dietitian was kept informed of updates and changes within the CPD system, their point status and payment status by the CPD office while ADSA forwarded information about activities via post and e-mail to practitioners. The responsibility of the individual dietitian was to ensure that their contact details were always updated, ensure payment of administration fees and application for points within the time frames.<sup>11</sup>

Figure 1.2 shows the various representatives, committees and personnel involved in the CPD system in relation to each other.<sup>11</sup> This was the system operating until 31 March 2006.

### **1.1.5.3 Recent changes in the CPD system**

Since its inception, the South African CPD system for dietitians has evolved substantially. Most of the changes to the system were made to improve user-friendliness and cost effectiveness.<sup>11</sup> The latest amendments however appear to have come about more in an effort to streamline the system across all Professional Boards (Figure 1.3).

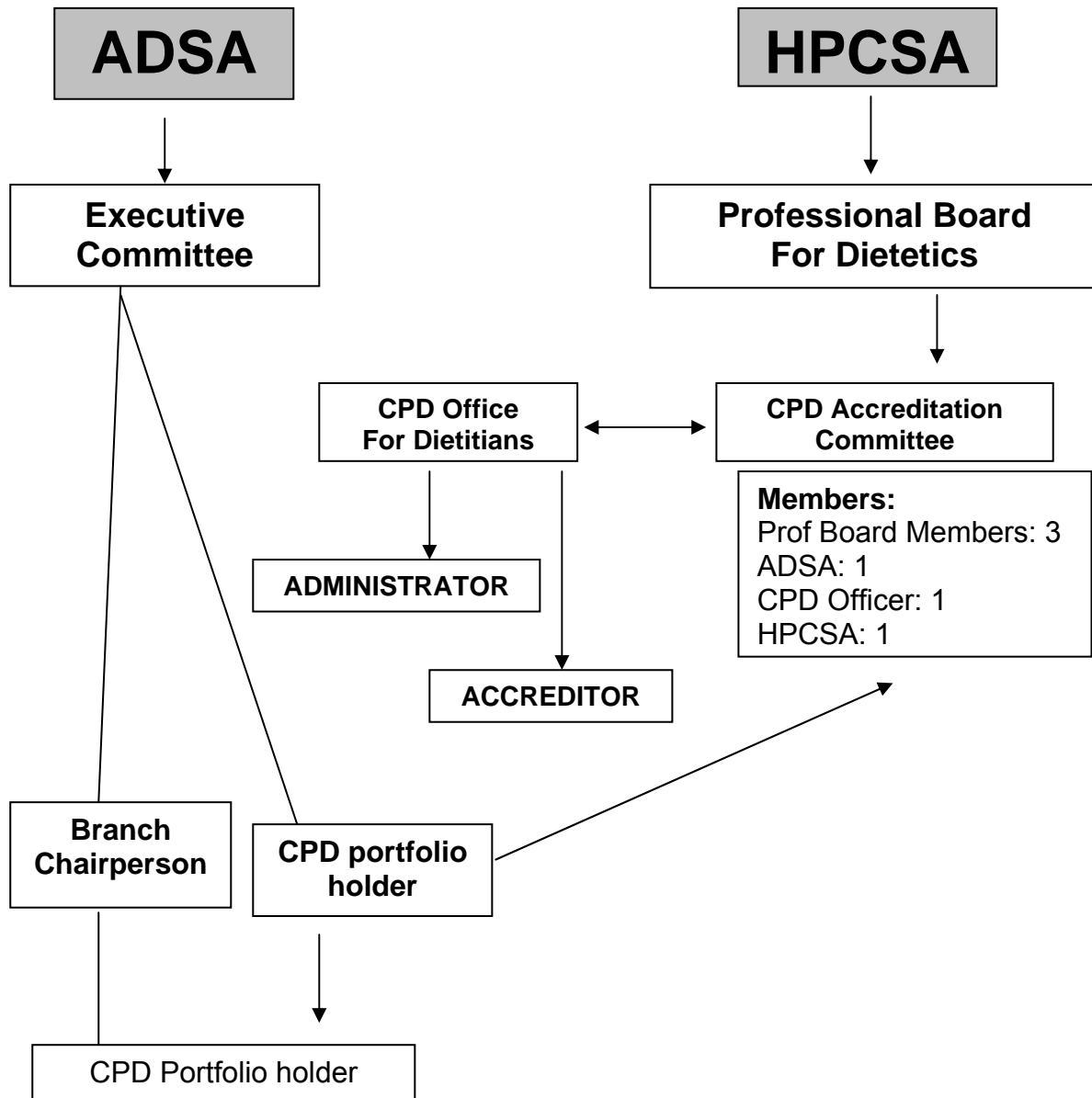
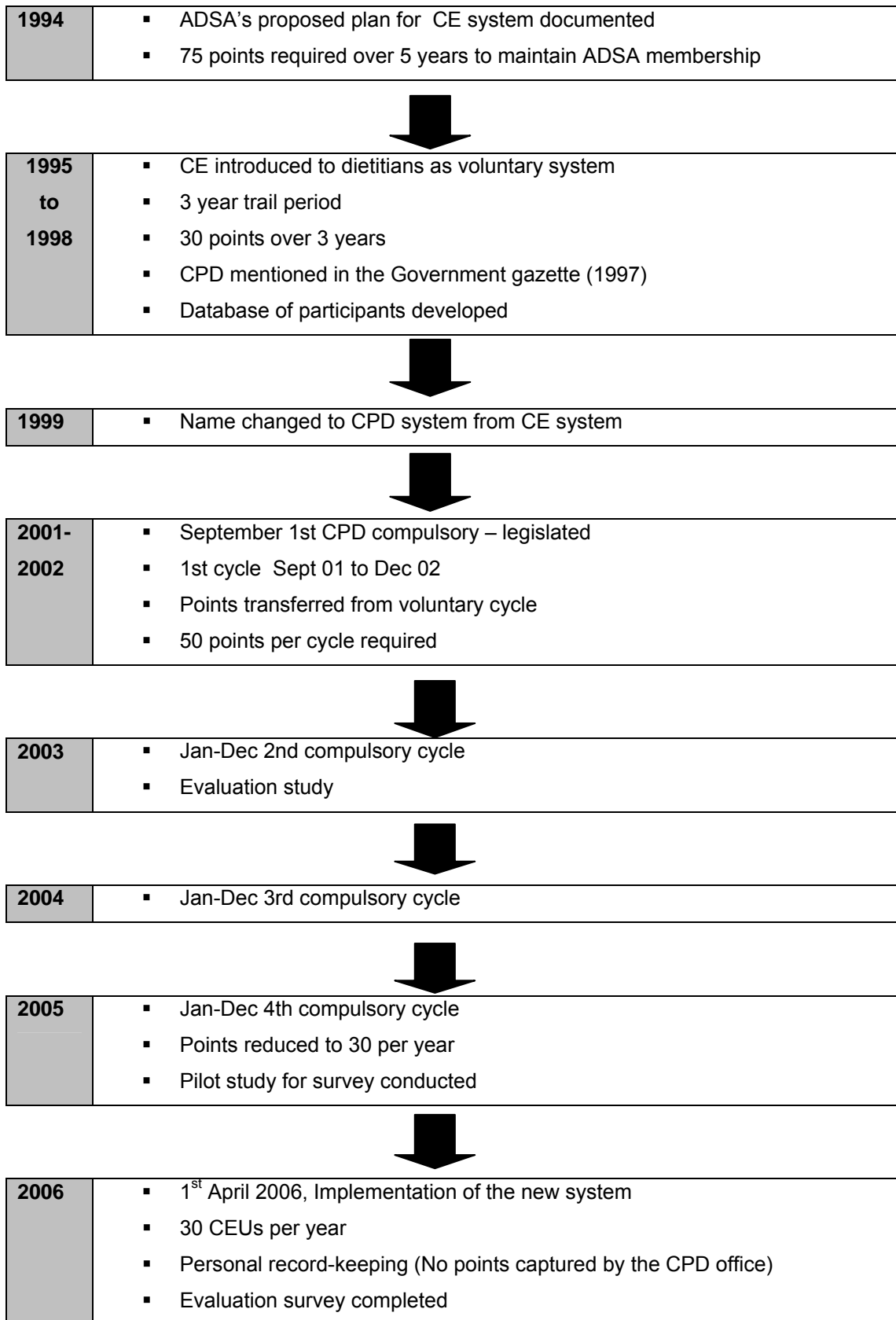


Figure 1.2: Diagrammatical representation of all personnel, committees and organizations involved in the South African CPD system for dietitians (2002-2006)<sup>11</sup>



**Figure 1.3: Historical development of the South African CPD System for dietitians highlighting key changes** <sup>1,2,26</sup>

Some difficulties in the CPD system as a whole were experienced at Council level and more specifically for the medical and dental practitioners. As a result, in March 2003 a consultant was contracted to evaluate the system and the following solutions were proposed<sup>28</sup>:-

- ▶ Providers submit their activities to the accreditors for accreditation and are obliged to provide Certificates of Attendance to all attending practitioners at all activities and then submit attendance data with points to accreditors within a month of the activity
- ▶ The accreditors are required to electronically submit these points to the HPCSA after verification for correctness
- ▶ The old Period Based System (PBS) will be replaced by a Continuing Points System (CPS), which means that all points accrued will be to the credit of the practitioner for two (2) years from date of the activity attended and will then lapse
- ▶ Practitioners will be able to check the status of their CPD points at any time electronically on the HPCSA website
- ▶ All Professional Boards will be using the same CPD system, using external accreditors. A HPCSA CPD committee with representation from all the Professional Boards was convened in 2005 to address these recommendations and plan the way forward for CPD in SA.<sup>28</sup>

#### **1.1.5.4 Revised CPD system for dietitians**

In April 2006, a new CPD system making each dietitian responsible for keeping their own records of CPD with proof of participation was implemented.<sup>25</sup> This system was still in a phase of transition for the rest of 2006 but was fully implemented on 1 January 2007.

Some of the key changes include:-

- Each dietitian will keep a personal record of their points or Continuing Education Units (CEUs) as it is now termed and will no longer be administered by the CPD office
- 30 (CEUs) are required per year and are valid for 2 years
- Activities are unrestricted by rules requiring “not more than 80% per category” or “accumulation of 2 compulsory ethics points”

- CEUs will be awarded from a developmental perspective. More CEUs will be awarded for participation in active learning sessions with measurable outcomes. For example, answering questions from an article will receive more points than being present at a lecture.<sup>27</sup>
- A check of compliance will be done through random audits by the HPCSA CPD office<sup>29</sup>

In January 2007 compulsory CPD under the new system began for all professional boards. The new system had been piloted over a six month trial period and involved the Professional Boards for Medical technology and Optometry and Dispensing opticians. During data collection, CPD was compulsory for the Professional Boards of Dietetics; Medical and Dental and Radiography and Clinical technology. It was still operating on a voluntary system for the Professional Boards of:

- Dental therapy and Oral hygiene
- Environmental health
- Emergency care
- Occupational therapy and Medical Orthotics/prosthetics
- Physiotherapy, Podiatry and Biokinetics
- Psychology
- Speech language and hearing<sup>29,30</sup>

The Professional Board of Psychology will be organising its own CPD process; however, all other Boards will follow a set of guidelines that have been standardised for all professions from January 2007.<sup>30</sup> (Appendix 3)

The HPCSA directed efforts into familiarising practitioners with the new CPD system by means of a CPD launch Road Show during October 2006 presented at venues around the country. The HPCSA reported a good turnout and support at the presentations.<sup>30</sup>

### 1.1.6 The Status of CPD for Dietitians in Other Countries

Throughout the world, dietetic associations are at varying stages with regards to addressing the issue of continued education. For example, in Greece, each dietitian is required to keep a personal record of CPD, however it is not obligatory and no limits are placed on the number of points collected.<sup>31</sup> In Ireland, the professional body encourages all dietitians to participate in CPD and keep a record of activities, and although not compulsory at this stage, this was expected to change at the end of 2006.<sup>32</sup>

CPD is compulsory in several countries. In New Zealand, CPD became a legal requirement in 2004 for dietitians to maintain registration.<sup>33</sup> The Health Professions Council (HPC) for UK health professionals have informed their registrants that as of July 2006, all health professionals are required to keep a record of their CPD activities. Prior to 2005, participation in CPD was not linked to registration with the HPC. A further stipulation is that a variety of learning activities must be used and it is up to the individual to ensure that CPD “contributes to the quality of their practice” and is of benefit to their patients. The British Dietetic Association has promoted CPD by offering higher diplomas and a degree in “advanced dietetic practice” and has even opened up a Centre for Education and Development for training dietitians in a variety of subjects. The first audit for UK dietitians is planned for May 2010.<sup>34</sup>

A system of personal record keeping is used by several countries. The UK HPC states that keeping a portfolio encourages a ‘structured approach’ to CPD.<sup>34</sup> Dietitians in the US also keep CPD records using the Personal Development Portfolio; as do those in Australia.<sup>35, 36</sup> The reasoning behind an individually planned programme is that it helps one move beyond simple information transfer and encourages reflection on goals and determining a personal learning style so that activities are planned accordingly. Thereafter one should evaluate what has been learnt and implement this into practice. Essentially, CPD must be the implementation of one’s learning plan that is detailed in the portfolio. To maintain registration, all US dietitians must accumulate a total of 75 CPEU over 5 years. For dietitians in Australia, a minimum of 30 CPD hours per annum ensures member status with the Accredited Practising Dietitians (APD). While in New Zealand, 15 annual credits are compulsory for maintaining registration.<sup>33, 35, 36</sup>



To strive towards the ideal support system for CPD in the profession, a formal evaluation is essential to identify successful characteristics of the system and highlight the pitfalls.<sup>10</sup> In fact it is stated that any system, if it is to be well managed should be repeatedly examined for improvement.<sup>24</sup>

### **1.1.7 The Value of Evaluating the South African CPD System**

Evaluation itself is a complex study. Drawing on theory from social science, there are various types available for use. These include needs assessment, implementation evaluation and outcome evaluation. For the purpose of this study, the implementation evaluation was since it deals with activities and operations of the system and is designed to address questions dealing with how well the system is running on a day-to-day basis.<sup>3</sup>

Most of the research evaluating CPD has originated in the USA, since it has a longer history of CPD than most other countries.<sup>14</sup> Amongst the documented studies, there is little on the daily operations of the CPD system. Rather, most research has focussed on professionals' perceptions, attitudes and knowledge about CPD and its activities. Nevertheless, valuable insight can be gained from these studies. Firstly, it seems consistent from the findings, that the value CPD can offer the participant is highly appreciated.<sup>37</sup> Other aspects that have also been investigated include the perceived impact of continuing education on practice, educational needs of dietitians and even reasons for non-participation in CPD.<sup>38,39</sup>

With regard to the latter, a state survey of American dietitians identified barriers to participation which included inconvenient locations or job demands.<sup>38</sup> To some extent, advances in technology have made more educational activities available to those with issues of cost and disadvantaged geographic location.<sup>37</sup> For many dietitians though, seminars, workshops and lectures are still most widely available and so most often attended.<sup>8, 37</sup> A state-wide survey conducted on nurses in Nevada highlighted the need to offer a wide variety of educational approaches to satisfy the learning needs and preferences of CPD participants. Their preference stated attendance of a congress in person as most frequently used and preferred while the internet and CD-ROM were among the least used.<sup>39</sup>

Charles and colleagues feel that such information is invaluable to providers of activities to plan events that offer a variety of learning opportunities and methods.<sup>39</sup> In fact in South Africa as well, the HPCSA is expecting that the providers of events/activities will use a “broad base” of activities that is more likely to meet the aims of CPD which is the health care of the public.<sup>27</sup>

However for managers and administrators within the CPD system, only an implementation or process evaluation can produce findings about the effectiveness of the system in any or all or aspects of operation. Such data provides invaluable feedback to management that will allow the system to be fine tuned for high performance.<sup>3, 5</sup>

## **1.2 STATEMENT OF PROBLEM**

Since the commencement of the compulsory CPD for dietitians in South Africa, no evaluation has been undertaken to determine how effectively the implementation of the system was perceived to be in terms of its daily operations and the CPD activities available to dietitians.

## **1.3 SIGNIFICANCE OF THIS STUDY**

As early on as 1994, ADSA proposed that “the whole process of continuing education be regularly evaluated” with regards to time periods, collection of points and administration. Additionally, a survey was suggested to obtain input from dietitians on resources available to them and limitations experienced. To date, no formal evaluation has been conducted.<sup>40</sup>

The time is right if not overdue for an evaluation of the CPD system for dietitians. It will be essential to provide insight into unforeseen problem areas, set a yardstick for future evaluation and support decision making as the HPCSA institutes future changes.

This study proposes looking back from where we have come by evaluating the system for successes and pitfalls through the perceptions of its participants. The results may even highlight other social and political factors that affect CPD in South Africa.<sup>12</sup>

At the International conference on Dietetics held in 2004 in Chicago, the challenges the then current system faces were listed as ensuring dietitians read CPD documentation and

understand the system, issues around ethics and finding out about dietitians' perceptions of the CPD system.<sup>26</sup> Findings from this study may provide solutions to these concerns. Additionally, obtaining dietitians' views and suggestions are important for their sense of involvement in having contributed to the systems' moulding and refining.<sup>14</sup>

Certainly no evaluation is complete without recommendations. It is envisaged that the recommendations emerging from this investigation may in some way support CPD for dietitians like that of the Welsh Nursing Board, which is "Responsive to local needs" and is a "progressive system recognised both within and outside the profession."<sup>14</sup>

## **CHAPTER 2: METHODOLOGY**

## **2.1 OBJECTIVES**

### **2.1.1 Research Aim**

The primary aim of this study was to conduct an implementation evaluation of the old South African CPD system for dietitians by determining the perceptions of dietitians as well as the views of key CPD personnel involved in the management and administration of the system that was in place from 1 September 2001 until 1 April 2006.

### **2.1.2 Specific Objectives**

The objectives were defined with reference to the CPD system that was in place from 1 September 2001 until 1 April 2006.

1. To establish dietitians' perceptions of how well the CPD system is running in its day-to-day operation.
2. To determine dietitians' perceptions about CPD activities as well as the barriers to successful CPD.
3. To obtain the views and perspectives from key CPD personnel responsible for the management and administration of the system.

## **2.2 STUDY DESIGN, ETHICS AND CONFIDENTIALITY**

### **2.2.1 Study Design**

This research project was designed as an observational descriptive study employing qualitative and quantitative research methods.

### **2.2.2 Ethics Approval**

A research proposal was submitted for approval to the Committee for Human Research, Faculty of Health Sciences, Stellenbosch University. The study was approved under project number N05/05/080.

### **2.2.3 Informed Consent and Confidentiality**

All participants were informed of the nature of the study and participation was entirely voluntary. None of the participants received any incentive to participate. The confidentiality of all participants was assured as all personal information was omitted from the data prior to analysis.

## **2.3 RESEARCH METHODS**

### ***Quantitative***

The main objective was to determine the perceptions of all dietetic practitioners using the SA CPD system with regard to its implementation. For this purpose a self-administered postal questionnaire was deemed the most appropriate data collection instrument for the reason that it is a cost-effective approach to studying a large geographical area and obtaining data from many participants, and therefore appropriate for the national survey of dietitians.<sup>5</sup> It is well documented that questionnaires are an acceptable means to obtain information about respondent characteristics as well as their beliefs, views and perceptions. Additionally respondents can maintain their anonymity in a postal survey.<sup>5, 41</sup>

As with most research methods though, there are usually limitations as well. One of the main disadvantages associated with self-administered questionnaires is a poor response rate, often 30% or lower. Secondly, if answers are missing or illegible, they are impossible to trace. Additionally one makes the assumption that the answers received are an accurate, honest response of the participant. Finally, if the instrument has predominantly closed-ended questions, it restricts the answers.<sup>5, 41</sup> In view of these limitations and bearing in mind that evaluations are fairly complex in nature, it was decided to incorporate qualitative methods into this study to expand the data received from the questionnaire and to bring to the fore views and perceptions that might be restricted in a structured questionnaire.<sup>42</sup>

### ***Qualitative***

It was therefore planned to have the questionnaire results from this study supported by focus group discussions (FGD) and in-depth interviews. While the questionnaire was conducted on a national level the FGD were to be conducted with a few dietitians on a

regional level. Key personnel (representatives from stakeholders) would be investigated using in-depth interviews.

Using this combined qualitative and quantitative approach, it was anticipated that these methods would add value to the research by providing a more direct reflection of dietitians feelings and describe the CPD situation “with more realism” than could be extracted from quantitative data only. As this formal investigation was the first of its nature for CPD and dietitians, and given that qualitative research is more exploratory, it was felt that new issues and ideas for further avenues of study may be generated. During the analysis phase, a combination of data gathering methods or multiple indicators offers an opportunity for triangulation, where several data sources are used to ‘elaborate and illuminate’ the research, strengthening its usefulness and ‘generalizability’ as well as improving the confidence of the investigative measures.<sup>14,43</sup>

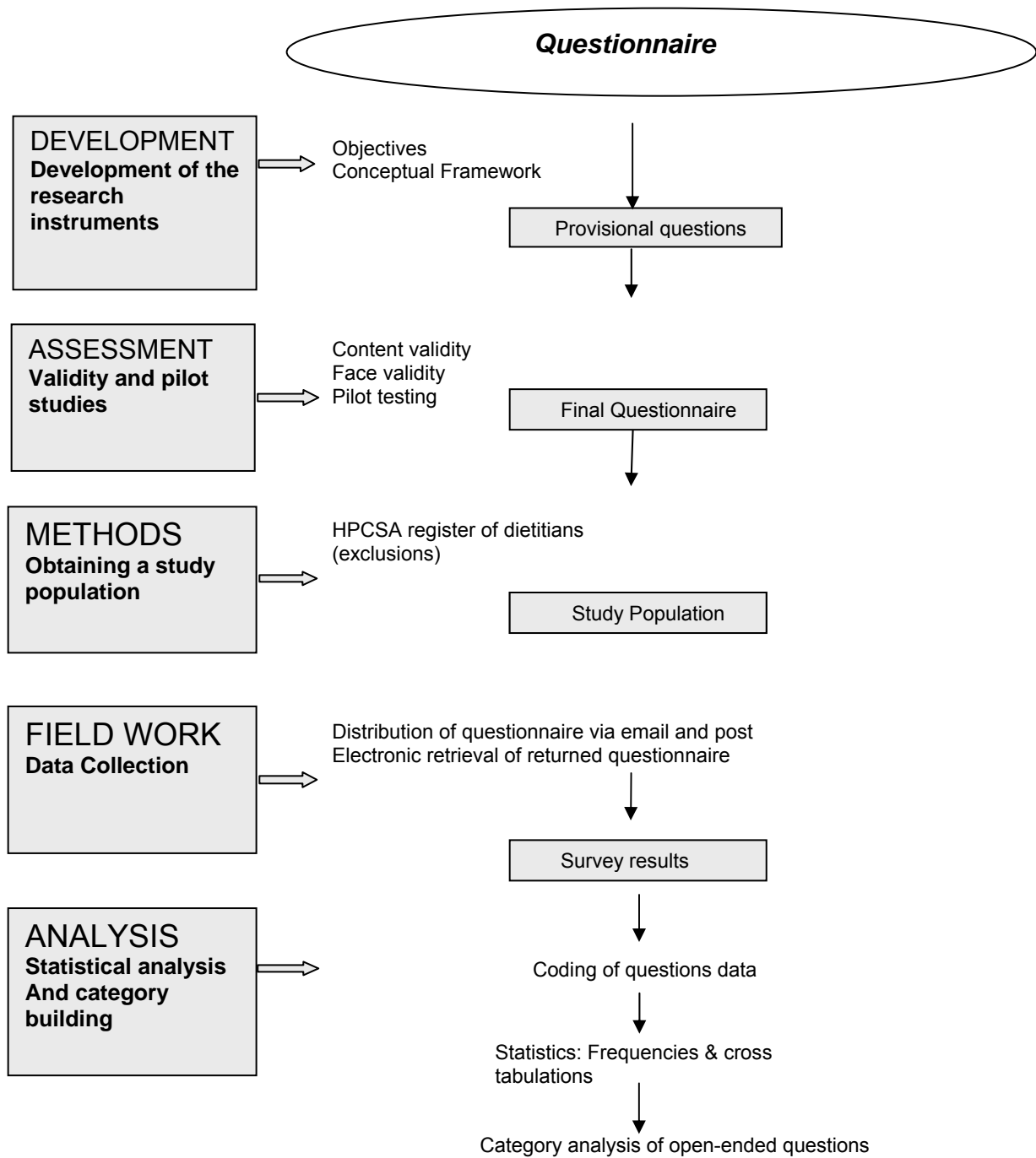
The planned sequence of data gathering was to conduct the quantitative national survey first, followed thereafter by the qualitative focus group discussions and the in-depth interviews of CPD personnel.

## **2.4 THE QUANTITATIVE METHODOLOGICAL ASPECTS OF THE STUDY**

### **2.4.1 Design and Development of the Quantitative Research Instrument (Questionnaire)**

The national survey of dietitians required the development of a suitable survey instrument or questionnaire. This was a systematic process that involved a series of steps over several months before it was finalized and appropriate for use (Figure 2.1)<sup>44</sup>.

## Quantitative Method



**Figure 2.1** Flow diagram outlining the methodological approach to the quantitative aspects of the study <sup>44</sup>



### **2.4.1.1 Conceptual framework**

At the outset, it was necessary to establish a conceptual framework that would define the nature of the information to be collected and guide the design of individual items in the questionnaire. The conceptual framework helped identify and define factors important to the topic, while maintaining a link with the research question.<sup>5</sup>

For this study this entailed identifying pertinent aspects of the CPD system that were relevant to a process evaluation; that is the issues, concerns and components that affect the daily operation of the CPD system for dietitians.

A good starting point was a framework recommended by Katzenellenbogen for conducting evaluation research of health systems. This author provided a broad list of concepts such as affordability, accessibility, coverage and a few others that could easily apply to an implementation evaluation. Issues of relevance were also identified from CPD research in the US, allowing a comparison to be drawn at a later stage.<sup>5, 38, 39</sup> A definition of each general concept before adaptation to the CPD system allowed for standardised interpretation (Table 2.1)

**Table 2.1: Definitions of investigative concepts<sup>5</sup>**

<b><i>INVESTIGATIVE CONCEPT</i></b>	<b><i>DEFINITIONS</i></b>
<b>Affordability</b>	<b>The extent to which related costs match the services offered.</b>
<b>Coverage</b>	<b>Successful contact with the target population.</b>
<b>Adherence</b>	<b>How well existing rules, regulations and procedures are followed.</b>
<b>Communication</b>	<b>The quality of interaction between all participants and role players.</b>
<b>Record Keeping</b>	<b>Maintenance of an updated record-keeping system.</b>
<b>Acceptability</b>	<b>The extent to which the participant expectations match a process or provision of services.</b>
<b>Accessibility</b>	<b>Geographical and logistical access to services</b>
<b>Availability</b>	<b>The degree to which the supply of services meets the needs</b>
<b>Attainability</b>	<b>The extent to which requirements can be achieved or met.</b>
<b>Effectiveness</b>	<b>General satisfaction with how well a service or process works?</b>

For this particular study, these concepts were expanded on and adapted to the daily operation of the South African CPD system. The tabulated framework outlined investigative concepts appropriate to an implementation evaluation and a detailed list of concepts formed a conceptual framework from which individual questionnaire items arose (Table 2.2).

**Table 2.2: Conceptual framework: Components of the CPD system to be evaluated**

<i>Concepts of evaluation</i>	<i>Specific matters investigated</i>	<i>The objective being addressed</i>
<b>Day to day operation (as part of implementation)</b>		
<b>Affordability</b>	CPD administration fees versus services rendered	1, 3
<b>Coverage</b>	All dietitians receiving correspondence	1, 3
<b>Adherence</b>	Following of rules, regulations, time frames and procedures by dietitians.	1, 3
<b>Communication</b>	Quality of communication between all participants and personnel Is correspondence about the CPD system received, sufficient and understood?	1, 3
<b>Record Keeping</b>	CPD database/ office providing information about dietitians' point performance and other general information. Personal records kept by dietitians	1, 3
<b>Acceptability</b>	Services provided by ADSA, CPD office, HPCSA.	1
<b>CPD Activities</b>		
<b>Affordability</b>	Cost of participation in CPD activities.	2, 3
<b>Accessibility</b>	Includes geographical location, time, travel, transport, notification of events. Access to different types of CPD like the internet, conferences, workshops.	2, 3
<b>Types of activities</b>	CPD educational method used and those preferred	2
<b>Availability</b>	Sufficient activities in all practice areas	2, 3
<b>Attainability</b>	How achievable are the mandatory 50 points, 2 ethics points and no more than 80% of points in any one category?	2
<b>General satisfaction with quality of service</b>	Additional comments about general satisfaction with which the system is running.	2, 3

*Objectives:-*

- 1 - *Dietitians' perceptions of the implementation of the CPD system*
- 2 - *Dietitians' perceptions about various aspects of CPD activities*
- 3 - *Perceptions of CPD activities and the running of the CPD system from a managerial and administrative point of view*

### 2.4.1.2 Formulating the questions

A list of provisional questions was formed and phrased using the conceptual framework and related literature, but adapted to the South African scenario. Additionally, telephonic discussions with the CPD officer and the ADSA-CPD executive member raised issues that could be addressed in the questionnaire. Since the system was expected to undergo changes it was also necessary to include some issues that would link to, and be of relevance to the new CPD system, ensuring usefulness of the results. Particular attention was also given to the questioning sequence to ensure a logical flow of the questionnaire as well as a carefully planned layout that was easily readable, with clear, concise and simple instructions. Questionnaire items included closed-ended questions with a choice of predetermined responses, as well as open-ended questions so that the responses were not entirely limiting. During the planning phase, a statistician was consulted to review the questionnaire items.

### 2.4.1.3 The final questionnaire

Following all adjustments, the final instrument consisted of a 40 item self-administered questionnaire with 6 open-ended and 34 closed-ended questions (Appendix 4). The questionnaire included three sections:-

Section 1:- included seven demographic questions on age, gender, education, practice areas and professional membership, employment and geographical location.

Section 2:- included 13 questions on the administrative aspects of the CPD system.

Section 3:- included 20 questions about participation in CPD activities.

Table 2.3 shows the questionnaire items as they intended to evaluate aspects of the CPD system defined in the conceptual framework.

**Table 2.3: Questionnaire items addressing the concepts in the conceptual framework**

<b>ASPECTS OF EVALUATION</b>	<b>QUESTIONNAIRE ITEMS</b>
<b>Day to day operation (as part of implementation)</b>	
<b>Affordability</b>	Question 20
<b>Coverage</b>	Question 15
<b>Adherence</b>	Questions 17, 18, 19
<b>Communication</b>	Questions 8, 9, 10,11, 15, 16
<b>Record Keeping</b>	Questions 21,22, 28, 33, 34
<b>Acceptability</b>	Questions 12,13,14
<b>CPD Activities</b>	
<b>Affordability</b>	Questions 35, 36, 37
<b>Accessibility</b>	Questions 27
<b>Participation in activities</b>	Questions 23,24, 25
<b>Attainability</b>	Questions 26, 29, 30, 31, 32
<b>General comments and satisfaction with quality of service</b>	Questions 38,39,40

## 2.4.2 Questionnaire Evaluation

“Data is only as good as the measurement instruments.”<sup>44</sup> The process undertaken to improve the quality of the data collected is termed questionnaire evaluation/assessment. It includes piloting, pre-testing and assessment of validity, and it is an integral aspect of any questionnaire design process.<sup>44</sup> Therefore, the questionnaire was assessed for content and face validity.

### 2.4.2.1 Content validity

Content validity addresses whether the concepts that are under investigation are indeed addressed in the measure.<sup>5</sup> In order to improve and evaluate the content validity of the questionnaire, it was submitted to a panel of six dietetic experts. These persons were highly recognised and respected within the profession, with expertise in research and/or

questionnaire development and validation, or who had experience in CPD management and administration.

Each dietitian was telephonically contacted, and was e-mailed the questionnaire together with the conceptual framework and a protocol synopsis. The latter two were included to determine whether the questionnaire items appropriately addressed the components of the CPD system.

Over a period of four weeks, their comments and recommendations were returned telephonically and/or via e-mail. The questionnaire was generally very well received with several positive comments on the choice of topic along with a few suggestions including alterations to some questions to avoid ambiguity in phrasing, to include more category responses to certain items, and to provide clarity on some questions for example, instead of asking “practice area”, rather indicate “major practice areas.” It was suggested that age categories be removed to enable mean calculations. There were also suggestions for questions to be included out of interest, but due to their non-relevance to the research objectives, they were not. These dietitians were excluded from the sample in the main study.

#### **2.4.2.2. Face validity**

Face validity relates to whether at face value, a question makes sense.<sup>5</sup> To ensure face validity, a different group of dietitians from those used in content validity evaluation were conveniently selected. They were registered dietitians practicing in one of each of the major practice fields, i.e. private practice, therapeutic nutrition, community nutrition, food and pharmaceutical industry, academia and food service management. They represented both managerial level and junior positions in their work environments and were from three provinces. They were likely to represent the majority of practicing dietitians. These six dietitians were telephonically contacted and invited to review the questionnaire with the intent to assess wording, sentence construction, understanding of the instructions, and clarity of questions.<sup>38</sup> They were also excluded from the main study sample.

Comments were received over a period of three weeks via telephone and e-mail. Again, the dietitians all welcomed the study stating that it was ‘long overdue.’ In general they found the questionnaire easy to understand. However, some of their comments were

aimed at improving its quality, rewording of some instructions, layout changes, listing certain category options alphabetically and explaining abbreviations. Questions requiring seemingly similar responses were also queried. Adjustments were made accordingly.

### **2.4.2.3 Pilot testing**

It is essential to the development of a questionnaire that it is given a “test-run” before being administered to the study population to provide a preview of the type of responses. Pilot testing is usually conducted on five to 20 people representative of the study population. It determines whether all questions were understood or unambiguous and that logistics around data collection proceeds as smoothly as theoretically planned. Any adjustments made from the results of a pilot study helps improve the overall quality of the questionnaire.<sup>5, 44</sup>

Hence, in September 2005, ten dietitians, typical of the study population were conveniently selected to participate in the pilot study. These were not the same dietitians used in the validation phase, but were from a variety of practice fields, provinces and various positions within their companies. They were excluded from the main study.

Pilot study participants were contacted telephonically and via e-mail explaining the pilot study. After agreeing to participate, the questionnaire was sent to them together with a covering letter introducing the study, a consent form with study information as well as a pilot study comment sheet designed to obtain comments on the receipt and sending of the questionnaire, aspects of completion, time taken to complete it and general understanding (Appendix 5). The completed questionnaires and comment sheets were returned over a period of four weeks after persistent telephonic follow-up. The responses are summarised in Table 2.4.

**Table 2.4: Responses from dietitians who participated in the pilot study**

<b>RESPONSES</b>		
<b>Documents</b>	<b>Feedback</b>	<b>Adjustments made</b>
<b>Covering letter and Consent form</b>	Clear, concise and simple to understand. However, some dietitians stated that CPD correspondence is usually too complicated to understand.	The wording was altered where necessary including the title to ensure that it is in 'simple' terminology
<b>Questionnaire</b>	All instructions for completion and the questions themselves were clear and unambiguous. It was quick to complete; most said 10 minutes, maximum 15. Add more categories where applicable	Based on the way the questions were answered, only minor changes to the wording of the open-ended questions were made. Also 1-2 additional category options were added to some answer blocks.
<b>Receiving questionnaire via e-mail</b>	No problems experienced with receiving the documents via e-mail.	
<b>Returning the completed questionnaire</b>	Four returned them without difficulty. Others experienced some technical problems and posted/telephoned their responses instead. The difficulty lay in working on the questionnaire as an opened e-mail message.	Instructions were therefore included in the covering letter on how to save the questionnaire message, complete it and then re-attach to send back. There was also an option to request a printed copy that could be returned via post or fax.
<b>Response</b>	The majority of dietitians required repeated telephonic follow-up to return the questionnaire.	A reminder message would be vital in the main study.

### 2.4.3. Study Population for the Survey

Following the development of the survey instrument, it was necessary to define the study population of intended survey participants. For this national survey, the study population included all dietitians listed at the HPCSA as registered dietetic practitioners, and, who by law are required to participate in compulsory CPD.

#### 2.4.3.1 Sampling for the survey

At the time of the study (October 2005), a complete and updated list of all dietetic practitioners registered with HPCSA was obtained from the database of the CPD office. One thousand six hundred and twenty-eight dietitians' names, along with registration numbers, e-mail addresses and postal details were documented on the list. All were



eligible with the exception of the dietitians involved in the study validation, piloting as well as the study leaders. Additionally, one registrant lacking all contact details was omitted. This left a total of 1608 dietitians as the potential sample for receipt of the questionnaire. The actual number of dietitians who received the questionnaire via post and e-mail was determined later during distribution of the questionnaire. It was decided against sub-sampling this population since a poor postal response rate was anticipated.<sup>5</sup>

#### **2.4.3.2 Exclusion criteria**

All dietitians registered with the HPCSA were invited to participate in this survey. Those that were not listed as registered with the HPCSA for any reason, or who had been granted deferment, and therefore did not have to participate in CPD were excluded from the study. Study leaders and those involved in the development of the questionnaire were also excluded.

#### **2.4.3.3 Sampling bias**

The CPD database list was the sampling frame used to obtain the national sample of dietitians. If the database was incomplete or inaccurate, bias could occur.<sup>5</sup> To minimise this sampling bias, the investigator regularly updated the database with change of addresses and new additions as they were received from the CPD Officer throughout the period of data collection.

#### **2.4.4. Data Collection**

Data collection for the survey began with the distribution of the self-administered questionnaire during October and November 2005.

##### **2.4.4.1 Questionnaire distribution via e-mail**

A flow diagram of the questionnaire distribution is presented in Figure 2.2. For reasons of cost, convenience, and time constraints, distribution of the questionnaire electronically was the preferred method. Determined from the study population, 1608 were eligible participants in the survey. Of these, 1190 had supplied the CPD office, with an e-mail address and so they were mailed the questionnaire electronically.

The final 40 item, 10 page questionnaire (Appendix 4) was e-mailed as an attachment; with a consent form (Appendix 6) and a covering letter (Appendix 7). The latter merely introduced and explained the purpose of the study and invited participation. The consent form provided more detail about the project and emphasized that participation was voluntary; and declared that returning a completed questionnaire amounted to agreement to participate.

Of the 1190 e-mailed messages, 158 messages were returned as failed and/or undelivered. These 158 dietitians then received the questionnaire via post. It was therefore assumed that 1032 dietitians would have received the questionnaire via e-mail.

The e-mails were sent from a 'Yahoo' account since it allowed the most amount of space (1gigabyte) to receive all the completed questionnaires. However, participants were also given the option of returning it via email, post or fax. Although a three week allowance period was given for return of the completed questionnaires, all returned e-mails were accepted regardless of the cut-off date. All returned questionnaires were downloaded to a separate word document file daily at the beginning of the survey for about two weeks, and thereafter the e-mail account was checked at the end of the day every two to three days.

#### **2.4.4.2 Questionnaire distribution via postal services**

The outstanding numbers of dietitians without a listed e-mail address (418) were posted the questionnaire via the SA national postal service. Additionally, the 158 failed e-mailed questionnaires were sent out via post as well. From the total posted questionnaires (576), 19 were returned due to incorrect or invalid postal address. It was therefore assumed that 557 dietitians received the questionnaire via post. In total therefore, it was presumed that 1589 dietitians received the questionnaire either by post or e-mail and hence constituted the study sample.

Each posted envelope contained the same three documents that went out via e-mail but with the inclusion of a stamped addressed envelope to return the completed questionnaire.

To improve the response rate, during November 2006, 1589 reminder notices were sent out via e-mail and postcards to all those with either functioning e-mail or postal addresses respectfully.

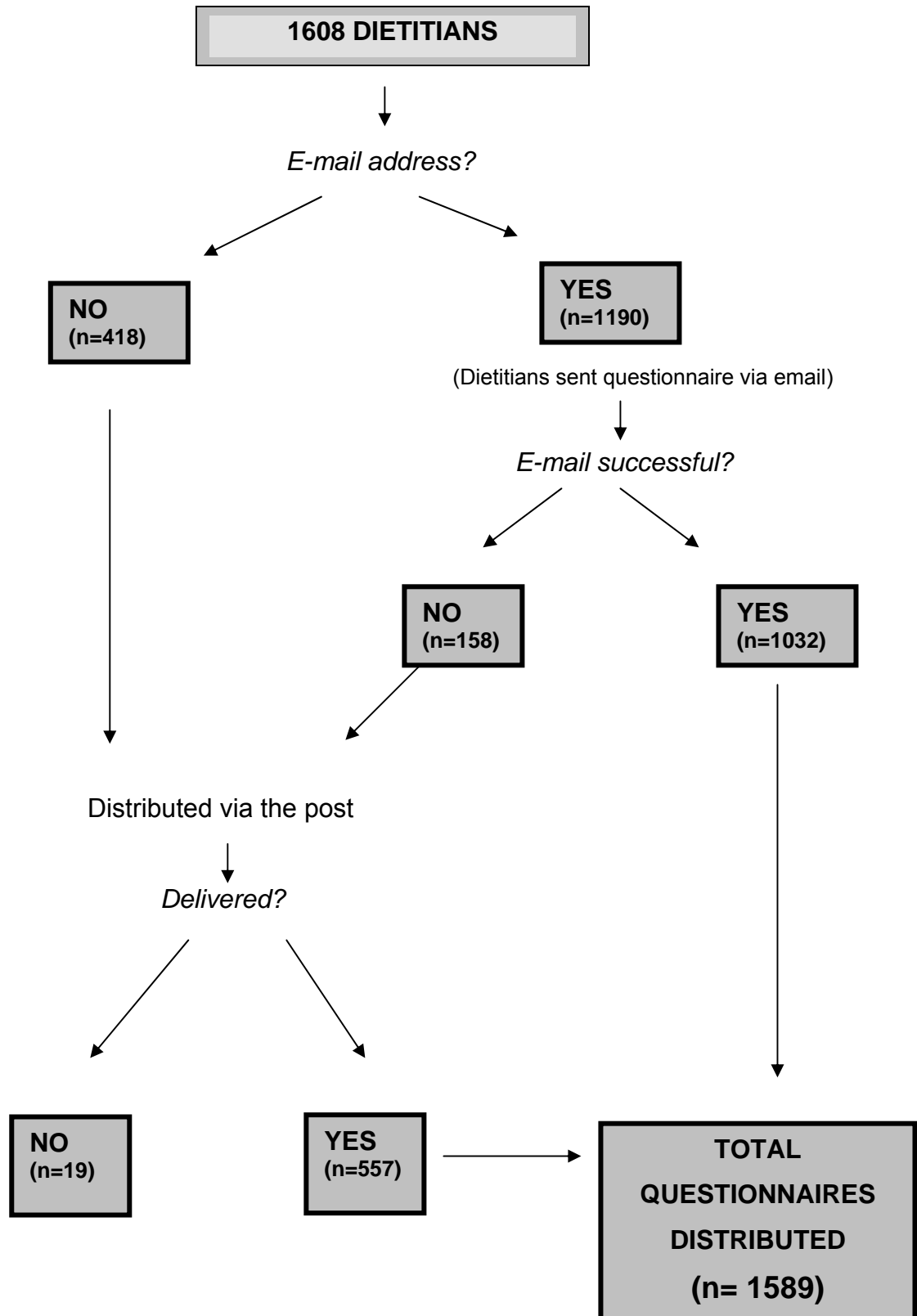


Figure 2.2: Flow diagram summarising the national distribution of the questionnaire

Nine dietitians, who had received the e-mail, requested printed copies as well, via SMS (2), phone (3), and e-mail (4).

## **2.4.5. Data Analysis**

### **2.4.5.1 Confidential management of the questionnaire**

The electronic responses were received in two formats, i.e. as an attachment, and some as rich text format as part of an e-mail. In the latter case the responses were copied off the e-mail and pasted into Microsoft Word® and saved as a document. In both instances the e-mail address from which they were received was not associated with the response, hence maintaining the anonymity of the participant.

Each questionnaire was assigned a number so that it could be referred to again. The closed-ended questions were coded and the open-ended ones were categorized into groups with similar responses, before coding.

Items on the survey instrument were divided into three parts, i.e. demographics, daily CPD system operation and CPD activities. For the purpose of reporting, it was decided to analyse and discuss questions by concepts rather than discuss each item as it appears on the questionnaire. The intent thereof was to improve readability and understanding in terms of the conceptual framework. Furthermore it would be easier to triangulate and discuss survey results with the qualitative data.

### **2.4.5.2 Statistical analysis of the questionnaire**

All data were captured onto a Microsoft Excel® spreadsheet after consultation with the Statistician. Statistical analysis included descriptive statistics and determination of frequencies. Associations between specific demographic data and ordinal variables were determined using the ANOVA/ F-test. Depending on the number of treatments/categories compared, the Kruskal-Wallis or Mann-Whitney was used to confirm the ANOVA. A value of  $p < 0.05$  was considered statistically significant. Chi-square analysis was used for cross

tabulations of selected nominal variables and demographic data. If  $p \leq 0.05$ , differences were considered significant.

The software package StatSoft Inc. (2004) STATISTICA® version 7 [www.statsoft.com](http://www.statsoft.com) was used for all analysis

#### **2.4.5.3 Internal consistency (reliability)**

Chronbach's alpha was used to calculate reliability or internal consistency of the questionnaire.<sup>46</sup>

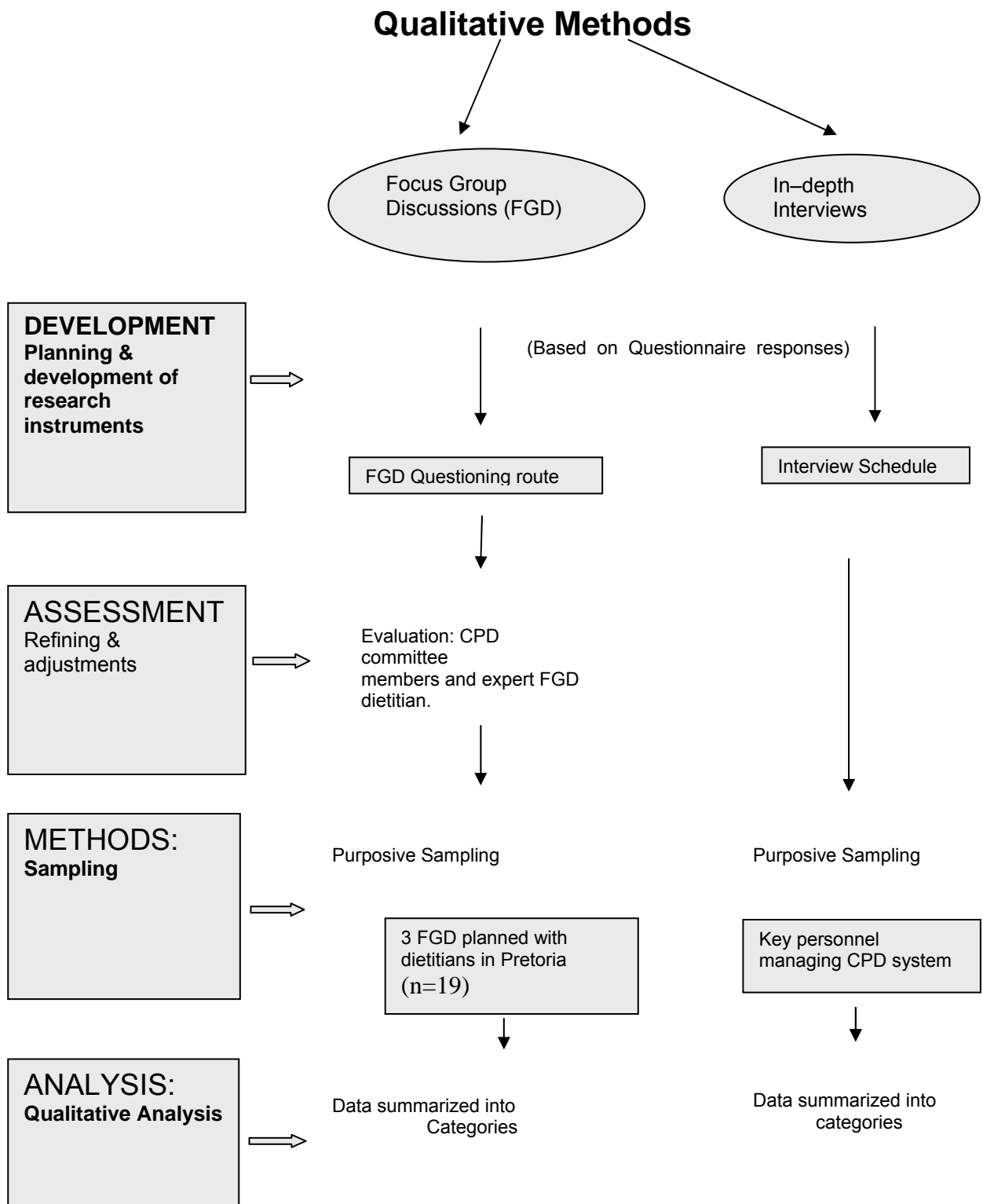
In consultation with the Statistician, the questions appropriate for reliability testing were determined. These were questions 12 through to 16. Internal consistency could not be tested on the other questions as some items were measured on different scales; i.e. variables that were nominal and others that were open-ended were inappropriate for determining Chronbach alpha values.

The alpha values for questions 12, 13, 14 fell between 0.97 and 0.98, (0 to 1 is the range), demonstrating excellent reliability. The values for questions 15 and 16 were 0.65 and 0.69 respectively, demonstrating acceptable reliability<sup>37, 46</sup> (Appendix 8).

Analysis of the questionnaire concluded the methodological aspects of the quantitative measure used in the study. The next phase of this research involved the qualitative data collection.

### **2.5 THE QUALITATIVE METHODOLOGICAL ASPECTS OF THE STUDY**

Two qualitative research methods were employed in this study namely FGD and in-depth interviews (Figure 2.3). Both were conducted after the national survey, with the FGD having been performed first.



**Figure 2.3: Flow diagram outlining the methodological approach to the qualitative aspects of the study <sup>44</sup>**

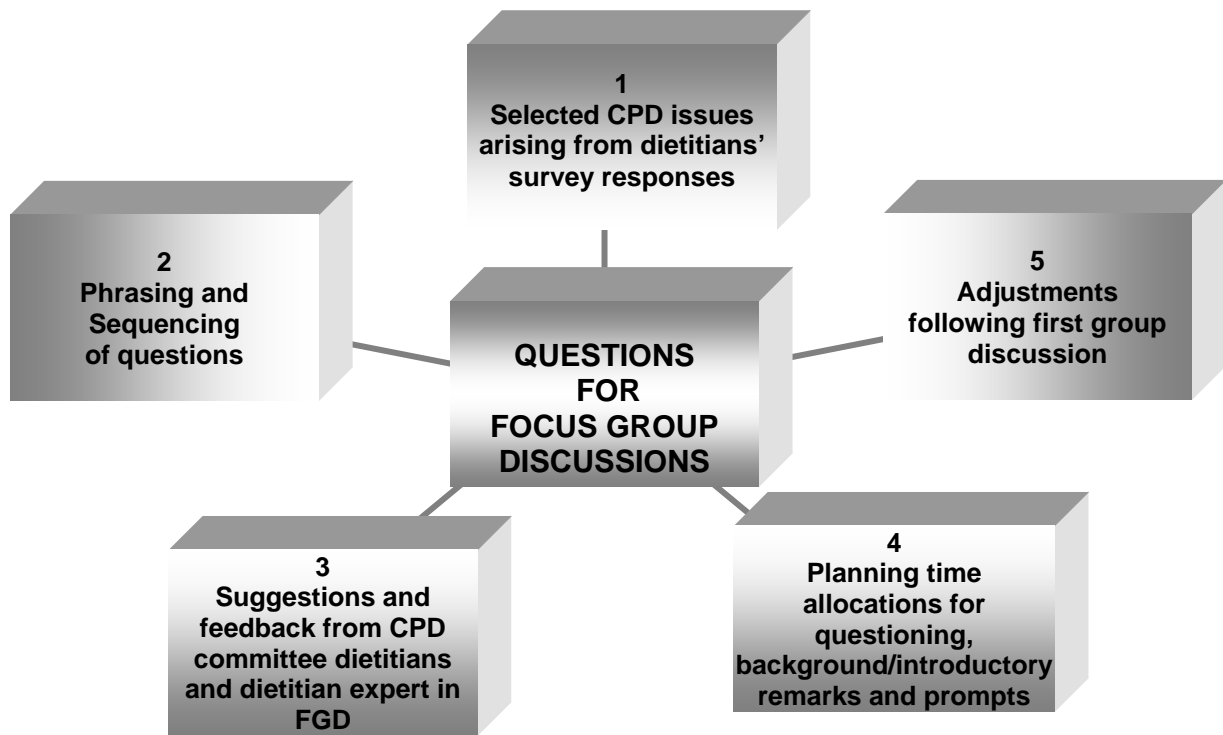
### **2.5.1 Focus Group Discussions (FGD) for Dietitians**

FGD were one of the qualitative methods employed in the study. It was planned that after national participation in the survey, a few dietitians at regional level would gather in groups to further discuss the CPD system around pertinent issues that emerged from the questionnaire. The aim of including the qualitative FGD was to further discuss the CPD system outside the restrictions of a structured questionnaire. At this point it was assumed that nationally, all dietitians had received the survey questionnaire.

Focus groups are widely used in decision making, programme and project evaluation, needs assessment and policy making. It is meant to be a focused discussion amongst a group with the intent to understand their feelings about a service, an issue or even a product. FGD are also quick to conduct. It is stated that a discussion would unfold from the participants perspective, as opposed to those of the investigator's in a questionnaire with rigid pre-selected responses. The disadvantages of FGD is that there might be a degree of group influence on individual thoughts, and the data is time consuming to analyze<sup>5, 41, 47</sup>

#### **2.5.1.1 Formulating a questioning route for the FGD**

Formulating a questioning route is the most important consideration in planning the discussion as it dictates the flow of each session, the usefulness of data gathered, and later facilitates analysis. Krueger and Casey suggested a systematic process to develop a questioning route, which was adapted for the study<sup>47</sup> (Figure 2.4).



**Figure 2.4: Development process for the focus group questioning route** <sup>47</sup>

As the questionnaires were returned by the survey participants and analysed by the investigator, it became apparent that a few common concerns repeatedly surfaced in the open-ended questions. These concerns included the cost of CPD activities, activity topics and queries about the new system. The fact that these perceptions were extracted from most, but not all the questionnaires, should be viewed as a limitation to this methodological phase.

These concerns that were already identified from the questionnaires formed the basis of the questioning route as key issues that were to be further discussed in the FGD. It was then a matter of sequencing and phrasing these concerns into clearly understandable and conversational questions.

The literature suggests that questions should flow naturally; therefore, one should begin with opening questions to introduce the topic and to get participants thinking about the topic and help them feel comfortable. Key questions follow, and these are the most important questions asked. It is recommended that two to five key questions be used. The conversation is then brought to a close with ending questions which summarise and allow room for any additional comments/discussions.<sup>47</sup>



Prior to finalizing the questions that were drawn up for the FGD, they were sent to a dietitian with experience in planning and conducting FGD, and two CPD accreditation committee members for comment. Once comments were attended to, the questioning route for the FGD was finalised (Table 2.4).

**Table 2.5 Structured interview schedule**

<b>OPENING</b>		
Think back to your experiences when dealing with the CPD system and participation in CPD activities.		
<b>KEY QUESTIONS</b>		
<b>Issue No</b>	<b>Key Issues</b>	<b>Questions and prompts</b>
1.	Cost of activities	How do you feel about the cost of CPD activities? What aspect of the CPD activity is expensive? What suggestions do you have to get around this? To what extent do journal and internet articles reduce the cost of CPD activities?
2	Activity topics	How do you think we can encourage the type of topics that are practical or relevant to your field?
3.	The new system	Are you aware that the system is undergoing changes? Do you think the new system will address any of the problems you experienced with the old system?
4.	Most important	All things considered, what do you think is the most important issue that needs to be addressed?
<b>ENDING QUESTIONS</b>		
<p>I. We want you to help evaluate the way the CPD system is run, and how and where improvements can be made. So in this regard, is there anything that we missed? Or you would like to add something that you didn't get a chance to say?</p> <p>II. If you could give any advice to those that are administering or managing the system, what would it be?</p>		

### **2.5.1.2 Sampling for the FGD**

Initially a total of three focus groups were planned for this study as a minimum, because, according to Krueger and Casey, the “rule of thumb” is to plan three to four<sup>47</sup>. Once these have been completed, one needs to determine if a point of saturation is reached. If this is so, enough discussions have been conducted; otherwise it is necessary to continue until no new information emerges. Deciding how many groups to run should also be in line with the resources available and the purpose of the study. The recommended size for each focus group discussion is six to eight, although as few as four or as many as 12 is also acceptable.<sup>5,47</sup> If the recommended group size were expected and 6 dietitians were to participate in a minimum of three groups, the expected sample size for this part of the research would have been 18. The actual numbers of participants per group were determined at each group session and discussed later.

Dietitians that were accessible to the investigator’s locale were targeted for logistical and financial reasons. Therefore all FGD were only conducted in Pretoria. Two large academic hospitals and dietitians from a food company agreed to participation in the FGD, and so formed the sample for the FGD. Information gathered at these groups determined the number of groups to organise. I.e. conducting the FGD until the point of saturation.

### **2.5.1.3 Sampling bias**

In qualitative research, convenient sampling is preferred since statistical issues of sample size are not as important. Rather, emphasis is placed on choosing individuals that would be a good source of information.<sup>5</sup>

Due to time restrictions and reluctance amongst dietitians to meet, it was difficult to bring a variety of dietetic specialities together. However the arrangement to meet dietitians who worked together rather than bring together dietitians from various fields turned out to be very favourable since by its very definition, FGD participants are typically a homogenous group of people, with similar characteristics but with different views and opinions. It is further stated that FGD run in participants’ own environment, among people they know well, allows for a spontaneous and comfortable discussion.<sup>47</sup>

All participants being from the same city may have led to information bias since dietitians from other areas in SA may have had different issues to discuss. Although this was a consideration, it was decided that the amount of bias contributed by this was considered to be minimal as FGD were not the chief data collection tool, its purpose was merely to shed more light on common issues already raised in the questionnaire; which was completed by a national sample of dietitians.

#### **2.5.1.4 Data collection and facilitation of the discussion groups**

The dietitians at the two academic hospitals and the food industry dietitians arranged to hold the groups at their departments and a mutually agreed venue. A date and time was scheduled and a reminder phone call was made a day before. Prior to attending, preparation for each discussion was made. This included working through a checklist of documents and equipment necessary for each group to run smoothly, by ensuring that all necessary items were at hand.

All groups were facilitated by the investigator and ran from December 2005 to January 2006. The investigator was self taught using a United Nations manual on FGD and a user-friendly guide on all aspects of planning, conducting and analysing focus groups.<sup>47,48</sup> A step-by-step procedure guide was drawn up to assist the investigator in following a sequence at each FGD in order to fulfil the role of facilitator efficiently and responsibly (Table 2.5).

**Table 2.6 Procedure used to conduct each focus group discussion**

<b><i>PROCEDURE FOR CONDUCTING FOCUS GROUPS</i></b>
<ul style="list-style-type: none"> <li>• Hand out questionnaires to fill for those that did not complete it</li> <li>• Welcome and thank you for allowing this discussion</li> <li>• Introduce self and Explain study and purpose of focus group Emphasize the opportunity to air personal views about the CPD system</li> <li>• Explain informed consent form, agree to participate</li> <li>• Read through main headings of consent form</li> <li>• Can recording equipment be used?</li> <li>• Explain and provide assurance of anonymity</li> <li>• Allow questions</li> <li>• Circulate form and obtain signatures</li> </ul> <p style="text-align: center;"><b>ASK FOCUS GROUP QUESTIONS</b></p> <ul style="list-style-type: none"> <li>• Thank participants</li> </ul> <p><b>DETAILS OF EACH FOCUS GROUP</b></p> <p>Date, time .....</p> <p>Venue.....</p> <p>Participants field of practice.....</p> <p>Number of participants.....</p> <p>Length of discussion.....</p> <p>Recording Equipment used.....</p>

In the period prior to the FGD and waiting for the arrival of all participants, questionnaires were given to those who had not completed it and still wanted to. Consent forms agreeing to participate were completed and signed (Appendix 9). After the necessary introductory remarks and permission to use recording equipment were granted, the questions were posed in sequence as planned. To maximise participation and sharing of information, the conversations were kept light and free flowing. Participants were asked to explain or rephrase where necessary. At the end of a question and at the very end of the FGD, probing questions were always included such as “is there anything else anyone would like to add.” Each discussion group lasted between 45 minutes to an hour.

Focus groups are usually recorded on tape with an assistant present to take written notes.<sup>47</sup> In this case, limited resources did not allow for an additional person, so two recording methods were used. All focus groups were recorded on a Dictaphone and video camera. It allowed complete attention to be given to the participants without distraction. Recording also ensured complete written transcripts and noting of non-verbal messages.

#### **2.5.1.5 Steps taken to improve data quality at the FGD**

Throughout qualitative data gathering, a number of influences could affect the quality of data collected, introducing bias and hence influencing the results and significance of the study findings. Several areas were identified as possible areas of bias and the necessary precautionary measures were taken.

Firstly, all focus groups were facilitated by one person i.e. the investigator, eliminating inter-observer variation. Secondly, the fact that the investigator was from a similar background as the participants in the focus groups, with reference to age, sex, education and profession promoted a free discussion. Thirdly, the investigator was very familiar with the topic which is highly recommended, since the literature states that 80% of information lies in the transcript while 20% is a sense or feeling which can only be achieved if actually present and not from another person reporting this.<sup>47,48</sup> Fourthly, in preparation for this role, the investigator was self-trained and acquainted with all aspects of facilitating FGD i.e. facilitating the discussion flow, probing, responses to participants, non-verbal cues or dealing with participants with a range of characteristics i.e. shy or talkative.<sup>47,48</sup> During the FGD, all questions posed to the participants were pre-set questions to avoid errors related to rewording, rephrasing and misinterpretation of questions. All answers and discussions

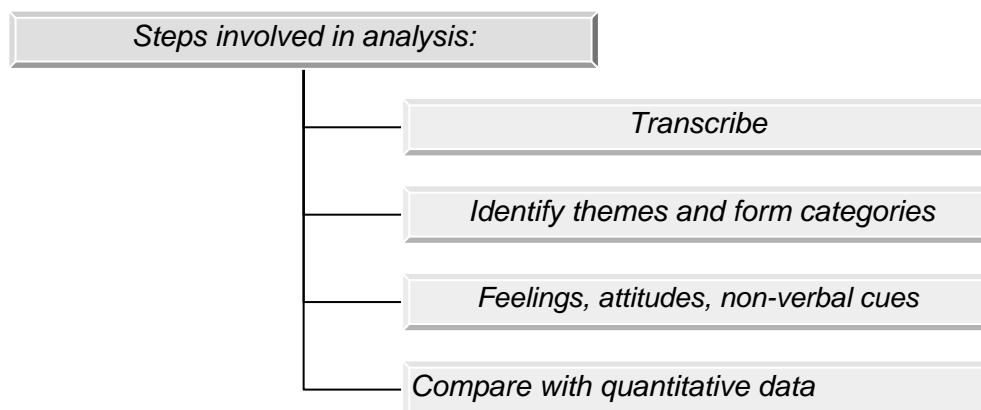
that followed were recorded which eliminated errors that occur in written records and so provide a complete and accurate transcript for analysis.

### 2.5.1.6 Data management and analysis of the focus group transcripts

All tapes (video and audio) recordings of the focus groups discussions were fully transcribed into written text. They were then assessed for non-verbal messages and other aspects that conveyed the groups' attitude and feelings. The transcribed notes were read, reviewed and sorted, eliminating any comments that were completely irrelevant to the topic. The process of transcribing was a good exercise in familiarising one with the information and proved helpful in formulating themes. Additionally, the attitude of the group and strong opinions helped decide themes and categories.<sup>41, 48</sup>

Although there is a variety of software available to analyze qualitative data, building categories and identifying themes, was done manually. Computer based analysis is typically advantageous for large amounts of data and if complex multileveled analysis is required. Both of these were unnecessary in this study.

A process of 'thematic' and category analysis was used to group responses into common themes or categories for purposes of summarization (Figure 2.5), i.e. data was reorganised from responses to questions into categories. Time spent and emphasis on specific topics, also gave the data depth, as did notations on the attitudes and feelings of the group. Although frequencies are useful, it is misleading in small numbers. In qualitative reporting, words such as 'few,' 'many' 'some' and 'all' are used as frequency indicators.<sup>48,49</sup>



**Figure 2.5: Summary of the qualitative analysis process for FGD data**<sup>41, 47, 48</sup>

The FGD data making process was conducted by the investigator without assessment by an independent reviewer, hence introducing the bias and subjectivity of the investigator.<sup>5</sup> As such; this should be viewed as a limitation in data analysis.

### **2.6.1 In-depth Interviews with Key CPD Personnel**

After both the questionnaire and FGD were used to investigate dietitians' perceptions of the CPD system, the third data collection method and second qualitative research method employed were in-depth interviews with the CPD system personnel.

Evaluation research states that when evaluating a service, as many viewpoints as possible should be sought.<sup>5</sup> In this study, it was therefore deemed necessary to obtain input from key personnel involved in the CPD system. These were people that held key administrative positions in the system. Since they had a thorough working knowledge of the system, it was felt that they could provide valuable information regarding the rules, policies, changes and direction of the CPD system in SA. For this purpose, individual in-depth interviews were deemed the most appropriate research method for this part of the study.

Described as a "conversation with a purpose", in-depth interviews help reveal the views and perspectives of the interviewee.<sup>41</sup> It is a method that allows fairly detailed information to be collected from a person and even allows for follow-up if further information or clarity is required.<sup>5, 41</sup> It was particularly beneficial in this study since each interviewee had a different role in the system and could provide valuable opinions and responses to issues that were raised in the FGD and questionnaires. It was planned therefore, that the interviews would be conducted after the other two methods were completed so that findings from the survey and FGD could be incorporated into the development of interview questions.

#### **2.6.1.1 In-depth interviews: structure, questions and format**

Each interviewee held a different position within the CPD system structure. In order to obtain useful information based on the expertise of each interviewee, it was necessary that each interview route was guided by a set of questions, yet allowed for spontaneity and free discussion based on their particular involvement in the system.<sup>41</sup> Each interview would

need to be planned such that each person could report on the policy, changes and future of CPD in SA from their perspective and experience.

The interview schedule was semi-structured, with discussion points extracted from the questionnaire and FGD. The types of questions in the interview schedule were mainly open-ended. The first few questions were introductory including clarification of the interviewee's role within the system (old and new). These were then followed by questions on specific issues (Appendix 10). While these issues were based on the same items covered in the survey questionnaire and FGD points, the questions were designed to be answered from an administrative perspective.

### **2.6.1.2 Sampling for the in-depth interviews**

Purposive sampling was used to obtain a study population for the in-depth interviews.<sup>5</sup> The interviewees were deliberately chosen to ensure that key personnel involved in the CPD system were represented. From their managerial and administrative roles in the CPD system, it was hoped that they would provide insight into the implementation of the CPD system from a view other than the participating dietitian.

This careful selection of interviewees is referred to in the social sciences as 'elite interviewing.' These experts, influential or well-known individuals usually hold administrative and management positions and are intimately familiar with financial management, organizational and other day-to-day aspects of a system. In their roles they could provide a good overall impression of the organization under study and its key relations with other associations.<sup>41</sup>

In the dietetic community, the individuals chosen were well-known by name and were well-informed due to involvement in the daily operation of the CPD system. They held key positions and were selected to provide valuable insight into the rules and regulations that govern the CPD system and its changes.

A sample of six key role-players was identified as knowledgeable in the system based on their current or previous involvement and/or position. These individuals represented the CPD office, ADSA (Executive CPD portfolio-holder), the HPCSA and Professional Board for Dietetics.



### **2.6.1.3 In-depth interviews: data collection**

The interviews formed the final data collection of the study. The first interview was conducted while awaiting questionnaire responses in November 2005 at the offices of the HPCSA. All the subsequent interviews were conducted telephonically due to geographic inaccessibility, during the period June and July 2006. Preceding each interview each participant was telephonically contacted to explain the purpose of the study with a verbal invitation to participate. A convenient date and time was scheduled and a consent form sent to each participant via e-mail.

The interviewees were aware of the study hence minimal explanations were required, except to emphasize the importance of presenting their perspective. A comfortable opening question discussed their role in the system. All questions that followed were asked using the preplanned interview schedule but not limited to it (Appendix 10). Each interview lasted between 35 minutes to an hour.

### **2.6.1.4 Steps taken to improve the quality of in-depth interview data**

It is stated that for a successful interview, the interviewer should be knowledgeable on the topic and be adequately prepared to allow the discussion to continue freely, and this was aimed for by the investigator by researching and following interview skills:-

- framing the question (non-threatening and open-ended)
- good listening skills
- probing if points require elaboration
- exploring specific issues but with respect to how participants respond to questions.<sup>5</sup>

### **2.6.1.5 Management and analysis of in-depth interview data**

The one in-person interview was audio recorded while the telephonic interviews were written in short and immediately transcribed to a full length document. The transcribed data was then managed as qualitative data and summarized into categories in a process described for the FGD. (Figure 2.5)<sup>41, 47, 48</sup>

## **CHAPTER 3: RESULTS**

For the purposes of clarity and as a reminder, data collection yielded findings from the national survey of dietitians (questionnaire), FGD with local dietitians and in-depth interviews of key personnel within the CPD system. The results are presented in this sequential order. Statistical details of inferential data analysis are given when any reported differences were statistically significant.

### **3.1 QUANTITATIVE RESULTS: SURVEY FINDINGS**

#### **3.1.1 Response to the Questionnaire**

A total of 1589 questionnaires were distributed, 1032 by e-mail and 557 by post. Of these, a total of 318 were returned giving a response rate of 20%. One was returned with missing pages and was excluded. Three hundred and seventeen useable questionnaires were available for analysis. Respondents returned the questionnaires in the following ways:-

- returned by e-mail : 142
- returned via post : 156
- returned via fax: 13
- returned at the focus group : 7

Response rate = 20 %

#### **3.1.2 Description of Survey Respondents**

The majority of the respondents (98%; n=309) were female (Table 3.1). Ages ranged from 23 to 66 years with a mean age of 32.8 years [(Standard Deviation (SD) 8.36]. Most of the respondents (60.8%; n=192) had a bachelor's degree, while 39.2% (n=124) of dietitians had gone on to earn higher qualifications. Almost three quarters (73%; n=230) of the respondents were employed on a full time basis while a small group (7%; n=22) were still completing their community service. Respondents who marked work status as 'other' were, for example, those employed on a contractual basis. Excluding the unemployed (n=10) and community service dietitians (n=22), the respondents represented all practice areas. The therapeutic/hospital environment was the main practice area (31.5%; n=91) which was closely followed by private practicing dietitians (25.3%; n=73). A total of seven

dietitians maintained registration with the HPCSA although they were no longer practicing in the field of dietetics. The vast majority of dietitians (79.5%; n=252) maintained membership with their professional association, ADSA.

**Table 3.1: Demographic characteristics of respondents**

Demographic variable	n (%)
<b>Gender (n=316)</b>	
<i>Female</i>	<b>309 (97.8)</b>
<i>Male</i>	<b>7 (2.2)</b>
<b>Highest qualification (n=316)</b>	
<i>Bachelors / Bachelors &amp; postgraduate diploma</i>	<b>192 (60.8)</b>
<i>Honours</i>	<b>88 (27.8)</b>
<i>Masters</i>	<b>29 (9.2)</b>
<i>Doctorate</i>	<b>7 (2.2)</b>
<b>Work status (n=316)</b>	
<i>Employed, full time</i>	<b>230 (72.8)</b>
<i>Employed, part-time</i>	<b>44 (13.9)</b>
<i>In community service</i>	<b>22 (7.0)</b>
<i>Unemployed</i>	<b>10 (3.2)</b>
<i>Other</i>	<b>10 (3.2)</b>
<b>Major practice area (n=289)</b>	
<i>Therapeutic/hospital</i>	<b>91 (31.5)</b>
<i>Private practice</i>	<b>73 (25.3)</b>
<i>Community Nutrition</i>	<b>20 (6.9)</b>
<i>Education/academia</i>	<b>19 (6.6)</b>
<i>Pharmaceutical industry</i>	<b>16 (5.5)</b>
<i>Foodservice Management</i>	<b>15 (5.2)</b>
<i>Nutritional consultant</i>	<b>14 (4.8)</b>
<i>Food Industry</i>	<b>14 (4.8)</b>
<i>Research</i>	<b>14 (4.8)</b>
<i>Registered but not practicing</i>	<b>7 (2.4)</b>
<i>Nutrition Information</i>	<b>6 (2.1)</b>
<b>Professional Association Membership (n=316)</b>	
<i>ADSA Member</i>	<b>248 (78.2)</b>
<i>Non-member</i>	<b>68 (21.5)</b>

Provincial representation at the time of the study (Figure 3.1) indicated that more than a third resided in the Gauteng area while the least number of questionnaires were received from dietitians in the Northern Cape. Eight percent of dietitians were practicing outside South Africa; mainly in the United Kingdom, but also in the United States and Saudi Arabia.

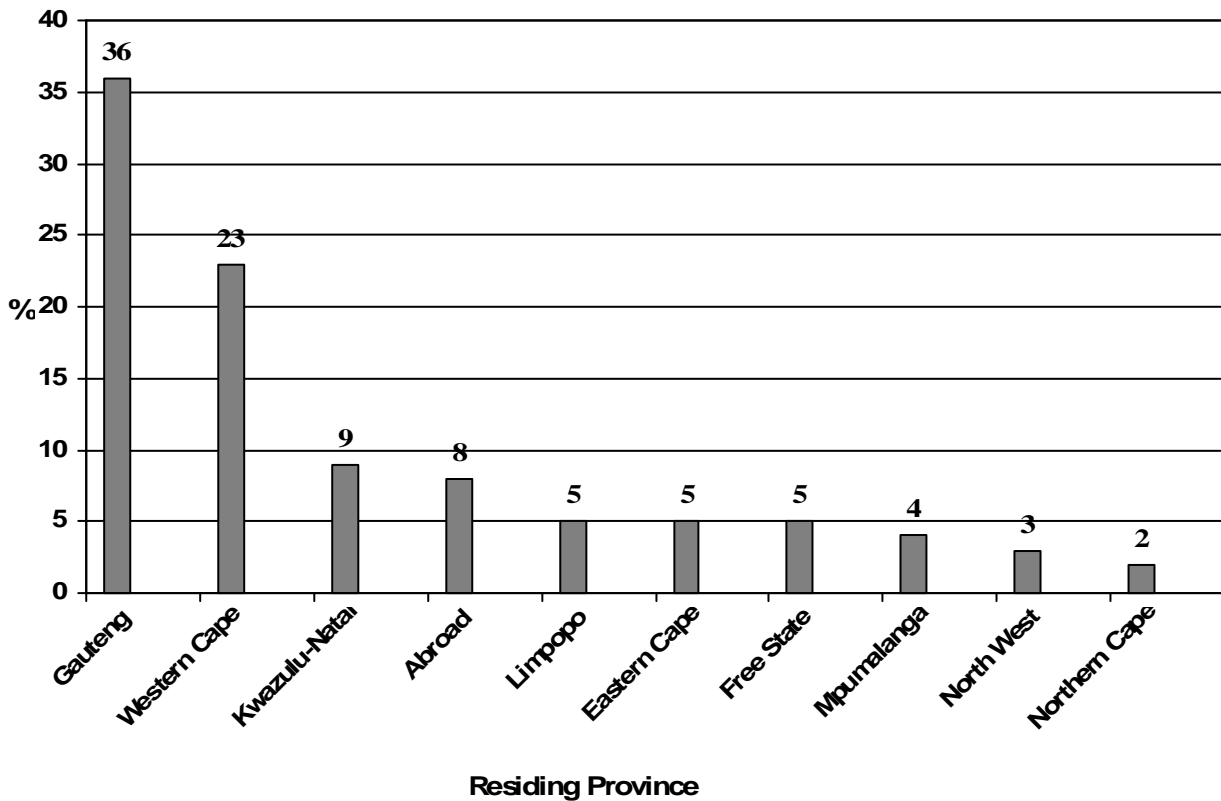


Figure 3.1: Provincial representation of respondents (n = 316)

### 3.1.3 CPD System and CPD Activities

Items on the survey instrument were divided into three parts i.e. demographics, daily CPD system operation and CPD activities. For the purpose of reporting, it was decided to present respondents' responses in concepts, rather than per item as it appears on the questionnaire. The intent thereof was to improve readability and understanding in terms of the conceptual framework. Furthermore, this approach would also facilitate the triangulation and discussion of survey results in relation to the qualitative data obtained.

### 3.1.3.1 Dietitians' understanding of the CPD system

**Questions 8, 9:**

*Do you understand the way the system is run as a whole? (Q8)*

*If not, what is it that you do not understand? (Q9)*

An overwhelming 87% (n=275) of respondents reported that they understood the CPD system, while 13% (n=41) of respondents indicated that they did not. Of the 41 dietitians who did not understand, 27 stated that all aspects of point accumulation and management were difficult to comprehend. This included point feedback, application, monitoring, and reconciliation of points. Seven participants reported not understanding the structure of the system or the key personnel and role players, while the remaining seven respondents stated that they had a poor understanding about administration costs and aspects of the new system. Of the 41 respondents who indicated that they did not understand the system, seven were in their community service year.

### 3.1.3.2 Correspondence, communication and coverage

**Questions 10 – 16:**

*If you had a CPD query, who would you contact first? (Q10)*

*How do you communicate with the CPD office, ADSA and HPCSA? (Q11)*

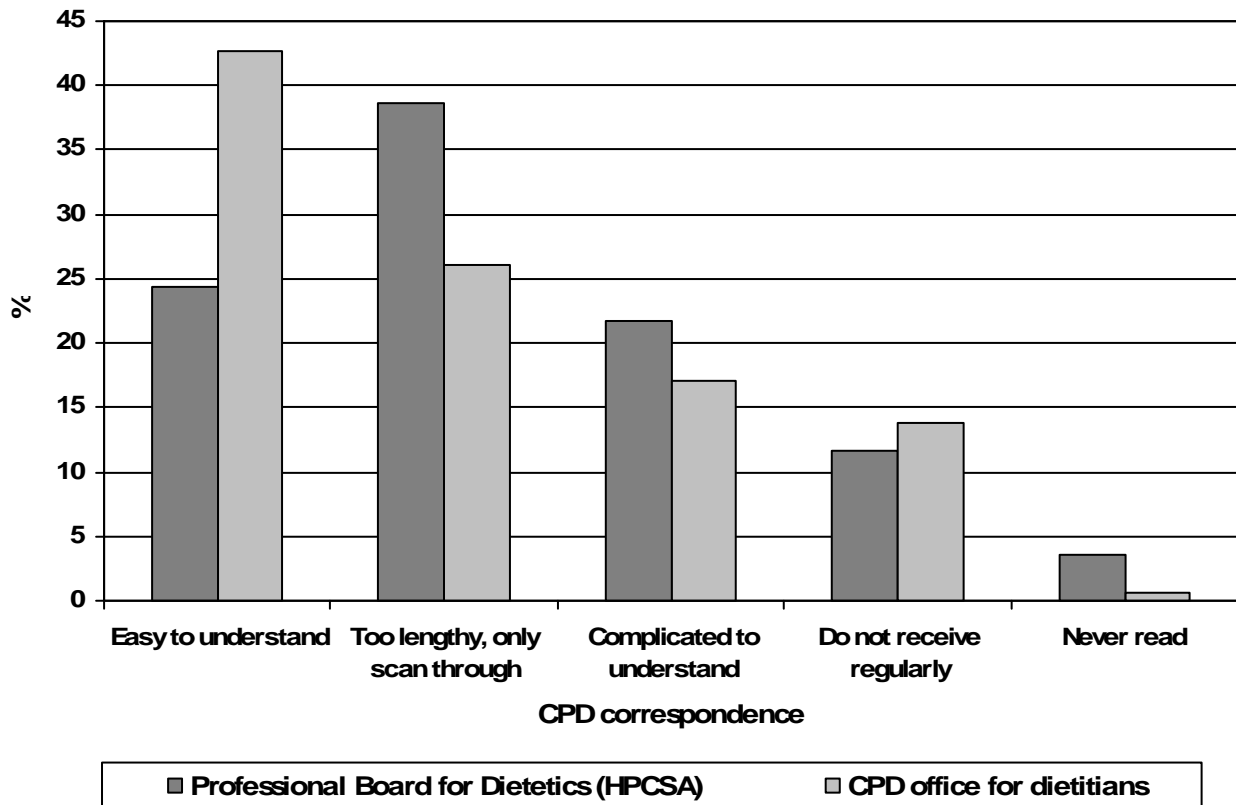
*Rate the quality of service communicating with the above offices (Q12, 13, 14)*

*How well letters and updates about CPD rules, regulations and changes are understood (Q15)*

*Give an opinion about the amount of CPD correspondence received? (Q16)*

#### **Correspondence**

With regard to written documentation supplied by the CPD office and CPD information published, 42.6% (n=133) of respondents found the correspondence from the CPD office easy to understand, while only 24.2% (n=77) found correspondence from the Professional Board for Dietetics easy to understand (Figure 3.2). Seventeen percent (n=53) of respondents also stated that information from the CPD office was complicated to understand compared to 21.8% (n=69) of respondents who felt this way about information from the HPCSA. More respondents (38.6%; n=122) also felt that HPCSA correspondence was too lengthy to read and hence only scanned through the received information, while 26% (n=81) felt this way about communication from the CPD office. A small percent (0.6%; n=2) and 3.5% (n=11) admitted never reading the documentation from either the CPD office or the HPCSA respectively. Approximately one eighth of respondents (13.8%; n=43) stated that they did not receive correspondence on a regular basis from either the CPD office or the HPCSA (11.7%; n=37).



**Figure 3.2: Respondents' (n=316) views on CPD correspondence from the Professional Board for Dietetics (HPCSA) and the CPD office**

In terms of the quantity of correspondence provided for by each supplier of CPD information, only 46.8% (n= 147) and 51.3% (n= 161) were satisfied that the amount of information as supplied by the HPCSA and the CPD office respectively was sufficient. Of the total respondents, 63.4% (n= 177) stated that the information supplied by ADSA was sufficient while 66.5% (n=139) found information supplied by the SAJCN to be satisfactory.

### **Communication**

When asked who would usually be the first point of contact with a query, the common response (61.2%; n=194) was the CPD office. ADSA was contacted by some (13.9%; n= 44), while a few (2.5%; n=8) would reportedly contact the HPSCA. Only 1.3% (n= 4) said that they would normally ask a colleague first. Of interest is that 7.3% (n=23) of all the respondents, including those in community service were completely unsure who to

contact. Several respondents (13.9%; n= 44) had not found the necessity to contact any of these offices yet, mentioning that they had the information at hand if required.

Communication modes were also rated as an indication of the adequacy of facilities at the ADSA, CPD and HPCSA offices. For respondents who had dealt with these offices, the majority reported that communication was either via e-mail or phone. From the 176 who had found the need to contact the HPCSA, 70.5% (n=124) did so telephonically, whereas of the 243 dietitians who had contacted the CPD office, most had communicated via e-mail (58%; n=32). Two hundred dietitians reported contacting ADSA about CPD matters and they also had a preference for e-mail (51.5%; n=103). The latter two offices were contacted to a lesser extent via telephone, and minimally via post or fax.

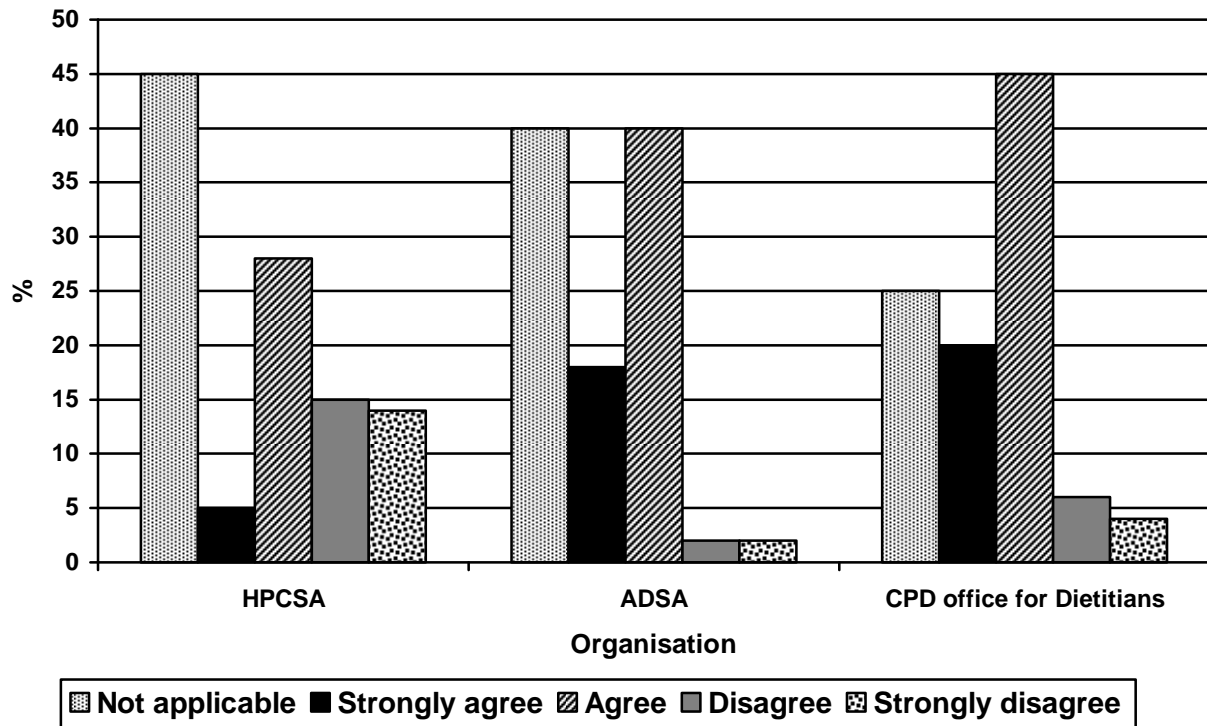
Dietitians were further asked to rate the quality of service they received upon contact with each office in terms of helpfulness, friendliness, easily contactable and whether the query was efficiently handled. If the respondents did not have any contact with one or other office, they entered responses as not applicable, and hence classified as non-users and did not rate the service. Due to the small number of respondents rating the service, the responses 'strongly agree' and 'agree' were combined, as was 'strongly disagree' and 'disagree' (Table 3.2). At all offices, more respondents were in agreement that they were received in a friendly and helpful manner. The exception was on the point of ease of contact, HPCSA was the only office where more respondents felt they were not as easy to reach (60.7%; n=101).



**Table 3.2: Dietitians' responses (%) on the quality of service provided by the HPCSA, ADSA and the CPD office**

Quality of service	HPCSA (n= 286)		ADSA (n= 294)		CPD office (n=296)	
	Respondents rating service (n= 167)		Respondents rating service (n= 187)		Respondents rating service (n= 222)	
	<i>Agree</i>	<i>Disagree</i>	<i>Agree</i>	<i>Disagree</i>	<i>Agree</i>	<i>Disagree</i>
<b>FRIENDLY</b>	78.4	21.6	95.2	4.8	91.4	8.6
<b>HELPFUL</b>	66.3	33.7	92.1	7.9	90.9	9.1
<b>EASY TO CONTACT</b>	39.3	60.7	78.8	21.2	71.1	28.9
<i>Did not rate service</i>	<i>n=119</i>		<i>n=107</i>		<i>n=74</i>	

A “Not applicable” response was entered by those who did not use the offices to handle a query. Fifty eight percent (n=163) respondents commented on the resolution or not of their query at the HPCSA, 61.9% (n=179) on ADSA and 79.2% (n=232) on the CPD office. With respect to all three offices, more respondents were in agreement that their problem/enquiry was efficiently handled, with appropriate feedback (Figure 3.3).



**Figure 3.3: Respondents' (n =293) views on efficient handling of queries and provision of feedback by the various offices.**

### 3.1.3.3 Rules, regulations, procedures

*Questions 17, 18, 19, 26, 29, 30, 31:*

*Indicate feelings about time frames for point requests and CPD fee payment (Q17)*

*Familiarity with forms and procedures for point application (Q18)*

*Ease of completion of the CPD 3 form (Q19)*

*Feelings about the '80%' rule (Q26)*

*How achievable is 2 ethics points per year (Q30)*

*With regard to CPD activities for ethics points, there are... (Q31)*

Rules, regulations and procedural aspects of any system, including the CPD system, are in place to guide its operation and to maintain a set of standards. In this study, the most commonly used rules were raised in the questionnaire to elicit dietitians' perceptions about them.

Rules that specified the way in which one should participate in activities and accumulate points included the "80% rule" that stipulated that no more than 80% of points that were accumulated should be restricted to one category only. A small percentage of respondents (10.6%; n=33) were reportedly unaware of this rule. Almost twice as many (23.1%; n=72) stated that it was difficult while 13.5% (n=42) found it easy to adhere to this

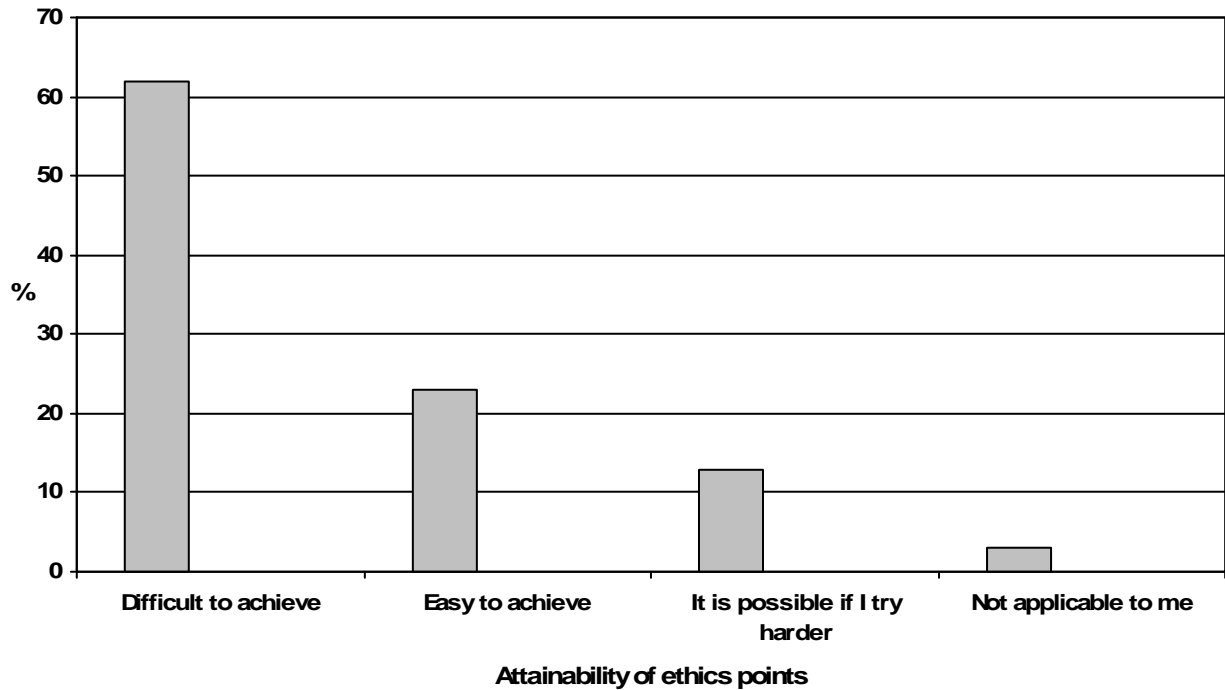
rule. The majority (52.9%; n=165) reported that they would have preferred that this be made a recommendation only.

Another rule concerned the total number of points accumulated per annum. From 2001-2005, the accumulation of 50 points per year was necessary to maintain registration. This ruling had subsequently been reduced to 30 per annum and dietitians responded with mixed feelings (Table 3.3). The overwhelming majority of responses indicated satisfaction with the reduced points required, with dietitians stating that it was more reasonable and easier to achieve.

**Table 3.3: Dietitians' (n=314) feelings (%) about the reduction in the annual points**

<b>Feelings about new 30 points ruling</b>	<b>Responses</b>
<i>Easier and reasonable to achieve</i>	68.5
<i>Still too much to achieve</i>	11
<i>Too little</i>	1.7
<i>Does not make a difference to me</i>	11.8
<i>Am unaware of this change</i>	6.9

The rules on ethics stipulated that two mandatory ethics points per year be accumulated. The majority which was almost two thirds (61.5%; n=192) found it difficult to achieve, compared with 23.1% (n=72) who did not have any difficulty obtaining these 2 points (Figure 3.4). A few (12.8%; n=40) stated that it was still possible to achieve if they tried harder. The 2.6% (n=8) who responded with 'not applicable' were in all likelihood community service dietitians to whom this rule did not apply.



**Figure 3.4 Respondents' (n=312) views (%) on the attainability of ethics points**

Following on from this, the reason most often cited by dietitians for difficulty in obtaining ethics points, were insufficient opportunities available (65%; n=197), whereas 16.2% (n=49) felt that there were sufficient opportunities. A number of respondents (18.8%; n=57) stated that the information from CPD in ethics offered nothing new.

Beside rules and regulations governing CPD activities, respondents' views on procedures involved in point application and submission were also investigated. A quarter of respondents (25.8%, n=81) were quite familiar with the procedure involved in applying for points. Most stated as never having personally applied for points (33.1%; n=104) or had the information available at hand as needed (23.6%; n=74). Less than a fifth (17.5%; n=55) were completely unsure.

The CPD 3 form was the point application document and 24.4% (n=75) found it fairly simple and easy to complete, while a combined 20.4% (n=63) found the procedure involved either too complicated or unnecessary information requested. Less than 20% (18.2%; n=56), were unsure about this form.

The CPD office also set time frames and cut-off dates for payment of fees and to apply for points. Almost half (46.6%; n=145) stated that the time frame set for payment of fees was

adequate, while 67.9% (n=212) were satisfied with the amount of time allocated to apply for points. The remainder of the respondents (44.1%; n=137) and 30.4% (n=95) either found the time too short or were unfamiliar with the time frames for applying for points and payment of fees respectively. These time frames were indicated as not applicable in a small percentage of respondents (9.3%; n= 29) and 1.6% (n=5) for points application and fee payment respectively.

### **3.1.3.4 Point status and record keeping of CPD activities**

**Questions 21, 22, 28, 33, 34:**

*Have you been keeping a record of all activities? (Q21)*

*Are you aware of an audit on activities attended? (Q22)*

*What was your point status in 2004? (Q28)*

*Would you like internet access to point status? (Q33)*

*How do you feel about keeping your own record of your point status? (Q34)*

Based on recall, the respondents reported that in 2004 6.4% (n=20) of the respondents earned less than 25 points while 23.8% (n=74) had between 25 and 49 points for the year. A large proportion (49.5%; n=154) reportedly earned more than 50 points. A fifth (20.2%; n=63) of all respondents, including those in community service, either did not know or did not participate.

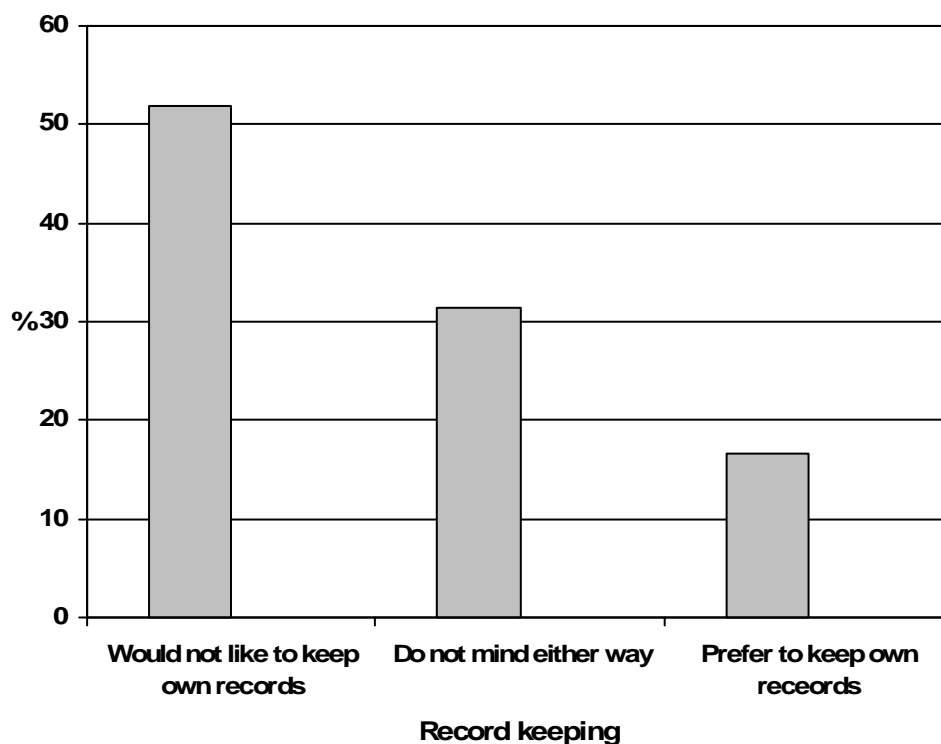
Data analysis into the relationship between selected demographic characteristics and point status, found no significant difference in respondents' reported point status by provinces, practice fields, qualification levels or even amongst ADSA membership.

Until April 2006 it was the responsibility of the CPD office to keep all records of points accumulated for each dietetic practitioner. Nevertheless approximately three quarters of respondents (74.3%; n=234) still kept a personal record. This helped individuals keep track of their status and query discrepancies, if any arose at the points reconciliation stage. Consequently, a large percentage of dietitians (79.6%; n=248) were aware of their point status for the previous year (2004).

When respondents were asked if they were aware of a possible audit, less than half of the respondents (47.5%; n=165) were aware that this could take place.

In the old CPD system, records of dietitians' points from the CPD office were sent to dietitians once annually without access to point status throughout the year. A questionnaire item enquiring whether web access to point status, which would mean continuous access to points should be encouraged, resulted in an overwhelming majority (94.2%; n=309) of respondents who responded positively.

As of April 2006, the system of record keeping changed and it is now obligatory for dietitians to keep their own records. A question to solicit their feelings about the change to personal CPD records revealed that the majority (51.7%; n=161) preferred not to do so. Only 16.7% (n=52) preferred to do so, while some did not mind either way (31.5%; n=98) (Figure 3.5).



**Figure 3.5: Respondents' (n=311) views (%) on maintaining personal CPD records**

### 3.1.3.5 Affordability of CPD

Questions 20, 35, 36, 37:

*Dietitians' perceptions about the administration fee versus services rendered (Q20)*

*Expenditure on CPD activities in 2004 (Q35)*

*Who pays for CPD activities? (Q36)*

*Dietitians' feelings about the cost of CPD activities (Q37)*

#### i) Administration fee

For the management of points and record-keeping by the CPD office, payment of an administration fee was compulsory for all dietitians.

Dietitians' perceptions regarding this issue were determined from their responses to a question investigating their feelings about the cost of the administration fee versus the services rendered by the CPD office. Similar responses to this open-ended question were grouped together under one of five differing views (Table 3.4).

Respondents were almost equally divided in their view that the fee was either reasonable (45.3%; n=130) or expensive (42.3%; n=121). To a lesser extent, some compared the fee to other professions and countries, or suggested combining the fee.

**Table 3.4: Dietitians' (n =287) views (%) on the CPD administration fee**

<b>VIEWS / PERCEPTIONS</b>	<b>EXAMPLES OF DIETITIANS' RESPONSES</b>	<b>% Responses</b>
<b>Reasonable</b>	<i>"Reasonable" "Fair" "Good" "In line with services" "Excellent" "Cost justifies services" "Happy to pay for someone to manage points"</i>	45.3
<b>Expensive</b>	<i>"Unreasonable" "Not in line with services" "Money making" "Very expensive for dismal services" "Penalised for being active"</i>	42.3
<b>Other</b>	<i>"Unaware of fees" No opinion" "Do I have a choice?" "No idea what I am paying for" "Unaware of a CPD Office"</i>	4.9
<b>Combine fees</b>	<i>"Too many fees" "Streamline costs" "Include with other fees or activity costs" "Should be carried by HPCSA"</i>	4.2
<b>In comparison</b>	<i>"Not in line with other professions" Not in line with other countries for example the UK."</i>	3.1

*ii) Costs of CPD activities*

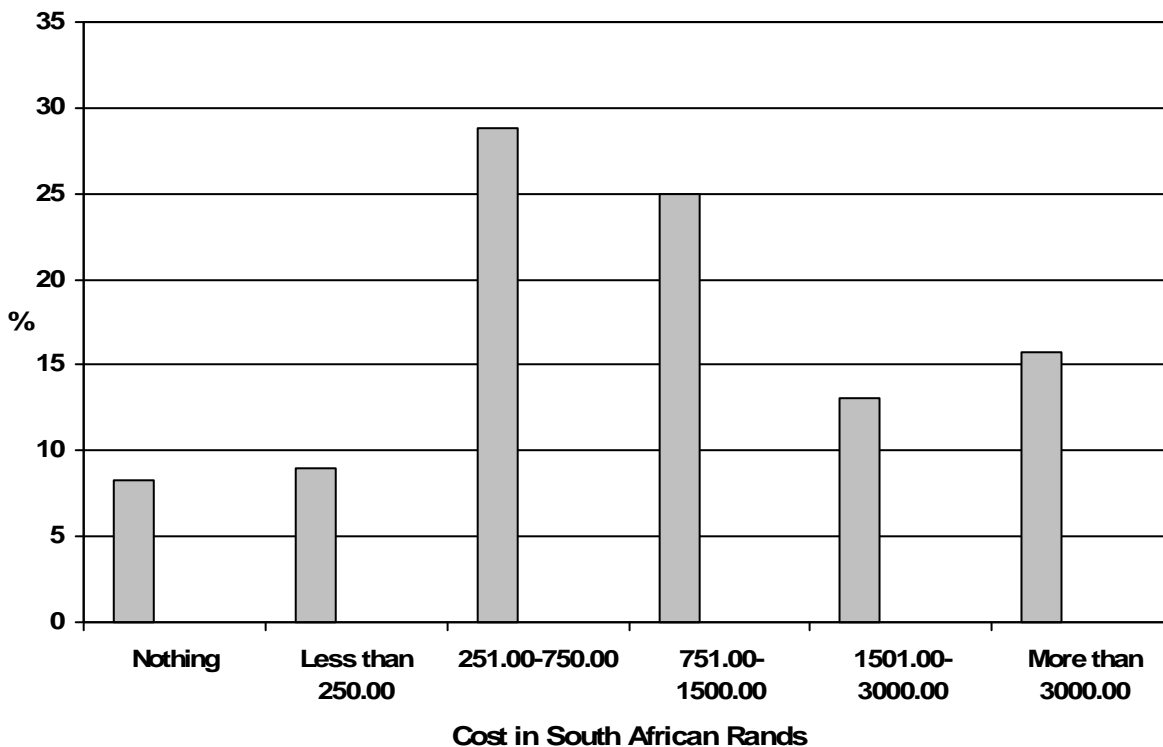
Participation in CPD activities has a cost implication. Dietitians' perceptions about this issue were raised in the questionnaire. Once again comments were classed into one of three main responses to this open-ended question:-

- Comments indicating that activities were expensive
- Comments indicating activities were reasonably priced
- Comments stating that there was a combination of both costly and reasonably priced activities available. One was free to choose from either of these.

Firstly, respondents that perceived participation in CPD activities to be costly amounted to 55.2% (n=164) of the respondents. Secondly, those respondents with views that CPD activities were reasonably priced totalled 15.2% (n=45). Finally, less than a third (29.6%; n=88) stated that a combination of activities (costly and less costly) were available to them for selection. Respondents also provided examples such as ADSA meetings, sponsored events and articles in journals that were affordable, while conferences were expensive.

Respondents were further asked to put a monetary value to their expenses for CPD activities for the year 2004 (Figure 3.6). In 2004, the majority of dietitians (28.8%, n=90) claimed to have spent between R251.00 and R750.00 on CPD activities. This was closely followed by 25% (n=78) of respondents who spent between R751.00 – R1500.00. For 8.3% (n=26) there was reputedly no cost involved, while 9.0% (n=28) spent less than R250.00. Almost equal numbers of respondents spent more than R1500.00 on CPD activities; 13.1% (n=41) between R1501.00 and R3000.00 and 15.7% (n=49) spent more than R3000.00 per year on participation in CPD.





**Figure 3.6: Respondents' (n =312) reported expenditure (%) on CPD activities for the year 2004**

The mean values of the cost categories between the demographic variables of practice area, province and qualification were compared and differences determined. Significant differences were found in the amount of money spent on CPD amongst dietitians with different qualifications (F-test,  $p=0.04$ ), between various practice areas (F-test,  $p=0.02$ ) and amidst the various provinces (F-test,  $p<0.01$ ). Dietitians with masters and doctorates spent more on CPD than those with Honours and Bachelors degrees, with the latter spending the lowest amount. Between the various practice areas, dietitians involved in research spent the most on CPD, followed by food industry/food company dietitians and then those in education. Those registered with the HPCSA and were not practicing spent the least amount of money on CPD activities. Expenditure per province also varied significantly, with those abroad spending the most in Rands, followed by Western Cape and Gauteng. Limpopo province and Northern Cape dietitians spent the least amount on CPD participation for 2004. There was no significant difference in the amount of money spent on CPD between ADSA members and non-ADSA members (F-test,  $p=0.07$ ).

Extending the investigation into the cost issue of CPD activities uncovered whether dietitians carried this financial responsibility alone or with some form of financial assistance. The preponderance of questionnaire respondents (60%; n=173) reportedly carried the cost personally. Approximately a third (32.1%; n=93) stated that CPD activities were paid for by themselves with partial financial assistance from an employer and/or sponsor. A small number (8.3%; n=24) had the all activities completely paid for by a sponsor and/or an employer.

A non-significant difference (Chi-square test,  $p=0.26$ ) was found when qualification of respondents was cross tabulated with financial responsibility for CPD. However, statistically significant differences were found amongst respondents receiving sponsorships or not, across various practice areas (Chi-square test,  $p=0.00$ ) and provinces (Chi-square test,  $p=0.005$ ) (Appendix 11). In each practice area, the majority of dietitians paid for CPD on their own with the exception of those in hospitals and academia where more dietitians received some financial help. The majority of respondents in private practice or those not practicing received the least amount of financial assistance in the form of sponsorship. Respondents who stated that they had all their CPD activities paid for were mainly from research and community nutrition areas of practice.

Per province sponsorships also varied considerably (Chi-square test,  $p=0.005$ ). For all SA provinces, more than half paid personally for CPD. SA dietitians abroad however received more financial assistance than those paying personally – a significant difference between all provinces. Respondents receiving the most partial assistance were located in Mpumalanga and the Free State, while North West respondents received the least monetary help. Respondents from the Northern Cape indicated that half paid for their own CPD activities, while the other half received total sponsorship.

### **3.1.3.6 Participation of dietitians in CPD activities**

**Questions 23, 24, 25:**

*Indicate usual CPD activities (Q23)*

*Indicate preferred CPD activities (Q24)*

*Do you use cross accreditation activities? (25)*

It was an objective of this research to ascertain dietitians' perceptions on participation in CPD activities and factors that act as deterrents (see 3.1.3.7). To this end, respondents were asked to list their three most usual methods of obtaining points. The number of times

an activity was cited was tabulated and ranked in order of the most commonly attended (ranked 1) to the least common activity (ranked 12) (Table 3.5).

Most of the respondents obtained their points predominantly through attendance at lectures and seminars, followed closely by conferences, congresses and symposiums and then answering of multiple choice questions (MCQs) to journal articles. To a lesser extent attending workshops featured next, thereafter internet articles and journal clubs.

**Table 3.5: The usual CPD activities of the survey respondents (n=315)**

<b>RANKING</b>	<b>USUAL CPD METHODS</b>	<b>NUMBER OF TIMES CITED %</b>
1	Attending lectures and seminars	22.7
2	Attending conferences, congresses and symposiums	22.2
3	Reading articles in journals and MCQs	21.4
4	Attending workshops	13.7
5	Reading internet articles and MCQs	8.2
6	Attending journal clubs or small discussion groups	6.2
7	Post graduate studies	2.4
8	Interactive TV conference	1.4
9	Other	0.7
10	Presenting a paper, lecture	0.6
11	Writing articles	0.1
12	Did not participate	0.5

In addition to the above-mentioned activities, respondents were also asked if they participated in cross-accredited CPD activities. Almost equal numbers stated that they did (18.8%; n=59) and 18.5%; n=58) did not. A smaller percentage (13.4%; n=42) did not know that this option was available to them. However, a fairly large number (49.4%; n=155) stated that they did not know what cross-accreditation meant.

To determine whether dietitians' usual CPD methods were congruent with their preference they were asked to list their top three preferred CPD methods, ranking them in order from

first through to third preference (Table 3.6). To be acquainted with the preferences of dietitians in the continuing education arena is useful to providers of activities who can provide activities with participants' preferences in mind. Findings indicated that most dietitians would like to be able to attend a conference; more than lectures and seminars. Small discussion groups and journal clubs also featured in the top three and were closely followed by journal articles and questions.

**Table 3.6 Preferred CPD activities of the survey respondents (n=312)**

<b>RANKING</b>	<b>PREFERRED CPD METHODS</b>	<b>NUMBER OF TIMES CITED (%)</b>
1	Attending conferences, congresses and symposiums	20.6
2	Attending lectures and seminars	18.4
3	Attending journal clubs or small discussion groups	16.7
4	Reading articles in journals and answering questions	16.6
5	Attending workshops	14.9
6	Reading internet articles and answering questions	8.7
7	Interactive TV conference	1.6
8	Post graduate studies	1.2
9	Presenting a paper, lecture	0.7
10	Other	0.5
11	Writing articles	0.3

### 3.1.3.7 Barriers to participation in CPD activities

**Questions 27,32:**

*List barriers to participation in CPD? (Q27)*

*How attainable are the annual point requirements? (Q32)*

In addition to establishing dietitians' usual and preferred CPD practices, it was determined whether accumulation of points occurred with ease or difficulty. Respondents could select up to three applicable options (Table 3.7). The option stating "I easily obtain points" was most often selected by respondents. This was followed closely by the fact that CPD is linked to careers. "Unable to attain the annual points" or "barely make the required points" was also frequently selected by respondents.

**Table 3.7: Dietitians' (n=312) views on point accumulation**

<b><i>RESPONSES TO POINT ACCUMULATION</i></b>	<b><i>NUMBER OF TIMES CITED (%)</i></b>
I easily obtain the points	19.9
I link the attendance of CPD activities to my own career planning	17.1
I barely make the required points	15.3
I apply for all possible points	14.5
I forget to apply for points for myself	12.1
I participate in CPD mainly for points. Once I am assured that I have all required points, I do not apply further/attend other activities.	9.0
I am unable to attain the annual points	8.1
I plan my accrument of points in advance for the year	3.1
I don't try to obtain any points at all	0.9

A probe into the factors/barriers that deterred dietitians from effectively participating in CPD was also examined. Participants could choose up to three factors that hinder participation in CPD activities (Table 3.8).

**Table 3.8: Factors acting as barriers to dietitians (n=313) participating in CPD**

<b><i>BARRIERS TO PARTICIPATION IN CPD</i></b>	<b><i>NUMBER OF TIMES CITED (%)</i></b>
Financial limitations	26.5
Distances too far to travel and few activities in my geographical area	18.6
Leave from work	14.0
Family obligations	9.4
Poor or no notification of events	8.1
Limited or no access to the internet	6.9
Topics not relevant to my field	6.2
No barriers to my participation	5.3
Uninteresting topics with little variety	2.2
Other	1.1
No transport	0.9
Disinterest in CPD activities	0.4
This is not applicable to me as I am not practicing as a dietitian	0.4

All factors featured as a limitation to participation in CPD to varying extent. However, financial limitations were most often cited as a constraint to participation (26.5%). “Distances too far to travel and few activities available to dietitians in their geographical area (18.6%),” featured predominantly, as did “obtaining leave from work (14%).” Additionally, for a female predominated profession, family obligations were also an important consideration (9.4%). To a lesser extent, factors concerning the actual activity were a limitation such as irrelevant (6.2%) or uninteresting topics (2.2%). “Other” was selected a small number of times and an example of this barrier was “living overseas and most activities not accredited by South Africa (1.1%).”

Chi-square analysis showed non-significant differences between the barriers to CPD, across various practice areas ( $p=0.54$ ), ADSA membership ( $p=0.69$ ) and qualification ( $p=0.08$ ). However, chi-square analysis of the data at provincial level indicates that the barriers experienced by respondents did vary significantly. ( $p=0.008$ ) (Appendix 11). Amongst the top rated barriers, respondents in all 9 provinces, and those abroad, consistently marked “financial limitations” as the greatest barrier. Relative unavailability of activities in area/geographical access was the most significant factor in Limpopo and

Mpumalanga, and to a lesser extent, in the Eastern Cape, Northern Cape and Free State. Getting leave from work was mainly an issue in Gauteng, Kwa-Zulu Natal, Eastern Cape and Abroad, in that order.

### 3.1.3.8 General operation of the CPD system

**Questions 38, 39, 40:**

***What is strength of the current CPD system? (Q38)***

***What is a weakness of the current system? (Q39)***

***Provide a suggestion to improve the system or should it stay the same (Q40)***

At the end of the questionnaire, dietitians were given the opportunity to respond freely to three open-ended questions on their perceptions of the strengths and weaknesses of the system and provide suggestions for improvements. Afforded this opportunity to answer freely and outside the limitations of predetermined response categories, respondents identified several of the same issues already mentioned in the questionnaire. However, more emotive language was used and personal experiences recounted. The resultant extensive data was categorized such that similar responses were grouped together (Table 3.9).

**Table 3.9: Strengths of the current CPD system as reported by dietitians (n=245)**

<b>EXAMPLES OF RESPONSES</b>
<b>STRENGTH: Benefits to dietitians and the public</b>
<i>Keeps one up to date and informed, networking, confidence in work setting, best service to clients, opportunities to learn, proactive patient care, protects public, credibility to profession, high standard of knowledge, high standard of patient care, exposed to other fields, great/excellent idea.</i>
<b>STRENGTH: Well run system</b>
<i>Organised, up to date records, excellent administration, internationally recognised, efficient, effective, easy to contact, helpful, good communication, proactive, willing to improve. Better than other countries, don't have to manage own points.</i>
<b>STRENGTH: Satisfied with activity, rules and points</b>
<i>Pleased with the type, amount, variety, flexibility and choice available. It is enjoyable. Pleased with regulations, policies, forms to complete, ethics CPD, compulsory CPD, Reasonable, low costs; Pleased with reduced points and carry over method.</i>

In summary, it was a stated strength of the CPD system that the benefits it offered extended to both the dietitian and public. The CPD system was also commended on the organised and efficient service received from the CPD office. Finally, positive feedback

was also received on the activities available, and the rules and regulations that make up the system.

Question 39 and 40 on weakness and improvements were closely linked since having stated an issue as a weakness of the system, respondents then commented that it was a point for improvement. It was decided therefore to report on the combined data from both questions from a suggestion point of view since these are the issues that respondents were dissatisfied with (weakness) and would most like changed (Table 3.10).

All areas of the CPD system came under criticism and some suggestions were provided. Yet, there were also feelings that the old system in its entirety should have remained the same.



**Table 3.10 Respondents' (n=252) reported weaknesses of the system and suggestions for improvement**

<b>EXAMPLES OF RESPONSES</b>
<p><b>System should remain the same:</b></p> <p><i>Good system. Continue administering points. System works well. No problem with it.</i></p>
<p><b>Improve all aspects of activities:</b></p> <p><i>Limited variety of topics for presentations. Make more ethics activities available. Articles are too finicky, technical and theoretical, not practical. Questions are "meant to trick you". Make more articles available in fields other than community or clinical dietetics.</i></p>
<p><b>Geographical accessibility of activities:</b></p> <p><i>Insufficient activities in outlying areas. CPD opportunities are unequally available to everyone. We are struggling to get points in our area. It seems better suited to those near dietetics learning centres. CPD favours those in the academic and environment and large academic hospitals. Decentralise activities. Too few events were available outside work hours. Make presentations available in print format for those with geographical restrictions. More on-line activities should be available for those in remote areas. There should be more articles via the post for those with limited internet access.</i></p>
<p><b>CPD related costs</b></p> <p><i>Financial burden for something that is compulsory. Streamline costs to one fee. The cost should be carried by HPCSA. It helps to attend sponsored events, but there are companies promoting their own agendas. Obtaining greater sponsorship. Making conferences accessible to everyone. Besides the activity costs, private practicing dietitians lose money by losing practice hours. The CPD system should not be seen as a business opportunity by some private companies.</i></p>
<p><b>Communication and correspondence</b></p> <p><i>Insufficient correspondence. Letters are usually too detailed. We need a summary of rules. Need letters with more concise instructions. Please simplify! I just cannot understand the system. There is not enough information for new dietitians like those in community service. Not everyone has internet access. Notices arrive too late. Update the website. Notices on websites about CPD articles and activities should be done at the beginning of the year. Need more information and communication about the new system.</i></p>
<p><b>Enforcement and policing</b></p> <p><i>Some enforcement needs to be in place for those that do not comply or provide incentive for those that do. There is no test of knowledge. Keeping records and waiting for audits feels like one is being policed. There is a constant threat of deregistration Rather than be a watchdog a more lenient approach is preferred. CPD should be a choice encouraged and not forced.</i></p>

**Administration and management**

*Disorganised and unhelpful. Usually no answer at the office. Insufficient time to appeal for points. Inaccurate points. Point updates are too late. No feedback after applying for points. -Too many rules that are limiting. Too much paper work!! (even more for cross accrediting Forms tedious and confusing. Points are unequally awarded. More regular point updates are needed. It is a bother to keep records. Have one system for all professions.*

**Points focused**

*One feels stressed to meet the points required. CPD should be learning focused, where one should be encouraged and not forced to attend for points.*

**Overseas dietitians**

*Impractical system for dietitians practicing outside South Africa. We do not receive all correspondence and journals arrive extremely late, even though fees are paid. Paper work is very time consuming and it is expensive to post back to South Africa. There should be more electronic support and options. Everything should be available online like submission of forms and more articles, otherwise the rules for overseas dietitians should be reconsidered to allow more flexibility.*

**Electronic options**

*Make everything concerning CPD available and accessible online such as appropriate forms, list of activities and websites, applying for points, contact people and user friendly information. Look into a system where dietitians can sign in at activities via an electronic card process.*

**The new CPD system**

*Too many changes to the system are confusing. Prefer one system for all professions. Keeping own points is better, but concerned that certificates that will not always arrive via post. Accredited providers may charge whatever they want. The new system is unfamiliar to community service dietitians.*

**Other**

*Dietitians with a poor attitude to CPD are a weakness to the system. Some managers do not allow time off for CPD. There should be options available for different circumstances and points should be different for each field since in some environments CPD is easier. e.g. it is more practical for those in the academic field. Keeping informed and updated should be affordable, and shouldn't take so much time and financial resources.*

Dietitians had mentioned that expanding the variety of topics at presentations would definitely be an improvement. Articles were well used and there was a call to improve the variety of on-line articles that were on offer, as well as journal articles since many respondents indicated internet access as a limitation and rely on articles received in the post. It was suggested that articles and their questions become more practically inclined. Articles were also relied upon by respondents in outlying areas who felt that there were not enough CPD opportunities geographically accessible to them. These dietitians stated that they would like to see more CPD opportunities become available in their area.

The financial costs surrounding CPD were criticised as being too high, and some respondents felt that there were too many fees for dietitians.

Criticisms surrounding the CPD office was that it was disorganised and required a lot of paperwork for application of points. Dietitians also felt a need to shift the focus from point collection to improvement of knowledge.

With regard to the new system, their feelings centred mainly on insufficient knowledge regarding it.

### 3.2 QUALITATIVE RESULTS: FGD FINDINGS

#### 3.2.1. Profile of FGD Participants and Group Dynamics

A total of 19 Dietitians participated in three focus groups in the Pretoria area (Table 3.11).

**Table 3.11: Profile of FGD participants in three focus groups**

Focus group	Numbers	Gender	Practice area represented
1	n=5	All female	Therapeutic nutrition
2	n=8	All female	Therapeutic nutrition, community nutrition, community service
3	n=6	5 female, 1 male	Private practice, food industry

All except one of the participants were female and this was a reflection of the general dietetic population in the country. It was important that practice sub-groups were represented to minimise bias. To this end, between the three groups, five practice areas were represented. The majority of participants were therapeutic dietitians, however at the hospital FGD a few of those present were busy with community service, while two were community nutrition dietitians, based at the hospital. From the third focus group (Food Company) all were from the food industry with one newly appointed dietitian who was in private practice until a few weeks prior to the focus group discussion. Additionally, all levels were represented i.e. junior, senior and managers. A total number of 19 dietitians participated in the FGD with the number of participants ranging from five to eight in each FGD.

In terms of the dynamics of the groups, it seemed that dietitians were eager to speak on this topic since at all FGD participants wanted to say more beyond the basic key questions. It is stated in the literature, and it was so in this case, that it was beneficial that the investigator was from the same background and even acquainted with several participants as this encouraged an atmosphere of free sharing. It was noted though that in the largest of the three groups, there were a few that tended to hold the floor while the quieter participants reserved their comments. The investigator had to specifically ask the quieter dietitians for their comments as well.

Only three group discussions were held since by the third focus group it became quite clear that the same issues were being raised at each focus group discussion, i.e. a point of saturation had been reached.

### **3.2.2 FGD Participant Responses**

The question and answer discussion sessions of all three FGD were summarized under issues or categories around which the dialogue centred. At the end of each discussion topic, the investigator summed up responses into a theme which emerged as the perception of dietitians about the particular issue discussed. Summing up in terms of perceptions was in line with the study objectives and to enable comparison with the results from the quantitative questionnaire.

#### **FGD issue 1: The cost of CPD activities**

It was articulated by the majority of dietitians, across all three groups, that the costs of certain CPD events were too high. In particular, the conferences, congresses and privately run CPD events were mentioned. Participants stated that the registration costs for conferences alone were very high and together with travel and accommodation, these events have been made inaccessible to many dietitians.

Participants in the therapeutic setting explained that “*fortunately we get a lot of sponsors*” with the respondents taking turns to attend CPD activities. All participants declared that they would like to attend conferences for various reasons, one being “*you get so many points at once, and you get to see a place.*” However participants added that they were aware of colleagues in other fields, for example private practicing dietitians, who found it

difficult to attend these large events as hours out of practice amounted to loss of earnings as well.

Dietitians also discussed the cost of privately organised activities. Examples given included invitations received via ADSA e-mail or via postal mail requesting *“thousands of Rands for several hours or a few days.”* While all stated that they usually *“ignore”* these, some felt strongly that these activities were *“ridiculous”* and it felt like the *“situation is being exploited”* because *“they know dietitians need to earn points.”*

The participants also put forth suggestions to reduce conference-related costs. It was proposed by a few of the dietitians that organisers arrange packages and negotiate prices for accommodation and flights. Additionally, it was proposed that organisers should rethink the venues of such events to more central locations so that there is an option to attend for the day or find alternative, cheaper accommodation nearby.

There were mixed feelings amongst the dietitians about the cost in comparison to other professions. One said that *“compared to other professions our activities are not expensive”* whilst another stated the opposite; *“we are expensive compared to other professions; “Everybody, even the doctors say they don’t pay the amounts that we do.”* However the majority of participants agreed amongst each other, that while the bigger CPD events like conferences were too pricy, small group activities organised by universities, hospitals, companies and ADSA were reasonable to attend. However, one dietitian pointed out that even with these, the problem remains for those residing away from the big cities. They mentioned being aware that there were insufficient opportunities available in rural areas. They added though that *“this is where the articles are of great benefit.”*

**Perception:**

- ❖ The costs of some CPD activities were high, but there were reasonably priced activities to choose from.

### **FGD issue 2: Journal and internet articles**

Almost all dietitians in the three groups declared that articles were used quite extensively. Some of the reasons given were:-

- *“it reduces cost”*
- *“it can be done at home”*
- *“you don’t have to pay”*
- *“you don’t leave your practice”*
- *“done in your own time”*

The topics presented in the articles received criticism on the lack of variety, quality of the research and usefulness of the information. Other statements included *“If it is too scientific then you just read for points rather than for the information and articles should be more practical. Sometimes it’s a waste,”* Another stated that *“most are interesting, it’s just when its very long research articles, it’s too much for me.”* Participants offered suggestions to improve the topic selection like offer *“more articles on ethics”* while *“an overview or meta-analysis is nice to file for reference.”*

#### **Perception:**

- ❖ Articles were well used but attention should be given to improve the variety of topics.

### **FGD issue 3: Access to point status**

Although the issue of access to point status was not raised by the investigator, it was an issue that repeatedly emerged i.e. all participating dietitians wanted access to their point status throughout the year. Several related experiences and complaints about receiving incorrect point summary information at the end of the year, with insufficient time and resources to correct any mistakes. One dietitian said *“one year there were so many mistakes on my form but there was so little time since you get the form in the post until the time you have to send it in, so if you have enough points you just leave it.”* It was also added that being unaware of ones status makes it difficult to *“guess”* more or less how many more events to attend to make up the points.

**Perception:**

- ❖ Reconciliation of points and correcting errors were a source of frustration. Regular access to point status might allow time for queries.

**FGD issue 4: The CPD administration fee**

Many participants spoke out about their dissatisfaction on this point and others in the group nodded in agreement. Besides the cost of the CPD activity, participants felt their main concern was the annual CPD administration fee. The reasons for disgruntlement were:-

- *“No other profession has an administration fee like we do.”*
- *“You don’t pay your money you don’t get your points and you’re not registered.”*
- *“Payment is twice. We pay when we attend the CPD activity and we pay again when they have to administer them.”*
- *“What’s the point of attending? It’s for knowledge. So, if I’ve accumulated the knowledge, and attended the training, it’s enough. So if points are taken away or not awarded because you don’t pay an admin fee, the whole idea is not functional anymore. It doesn’t make sense.”*
- *“It makes it seem that the CPD system is not for the knowledge benefit but for financial gain.”*

**Perception:**

- ❖ Dietitians were dissatisfied with paying an annual CPD administration fee.

**FGD issue 5: Communication and correspondence**

At one group, two participants related experiences and discussed at length the poor service they felt was received when dealing with the HPCSA and CPD office, including having to deal with answering machines to sort out problems with payments, statements and points reconciliation, since *“There are always mistakes.”* Several nodded silently in agreement or acknowledged dissatisfaction. On the other hand one dietitian felt differently stating *“I am actually glad that someone is doing it for me. I’ve got a file, but I’m a bit afraid that I am not that up to date.”*

**Perception:**

- ❖ Participants were dissatisfied with the quality of service received from the offices of the HPCSA and the CPD office.

**FGD issue 6: Changes to the CPD system**

Almost all the dietitians were aware that the points had been reduced to 30, however only three dietitians out of all participants were vaguely aware that additional changes to the CPD system were imminent. Most respondents were oblivious to the changes stating that *“we have heard nothing about it”* while at one group a few had even heard that *“it might be scrapped altogether.”* One dietitian stated *“we are the only ones continuing compared to others like physiotherapists;”* while another shrugged indifferently saying *“they’ve been changing since they started.”* They were therefore unable to provide much insight into the question on how they felt the new system would address problems of the old. One dietitian did say that the reduction in points is already an improvement but *“we have to get rid of this extra admin fee that nobody else pays.”* It was also mentioned that the managers of CPD *“don’t get feedback from people in the system to solve problems.”* One dietitian was complimentary saying that *“we are doing quite well; dietitians and the whole system.”*

**Perception:**

- ❖ Dietitians were satisfied with reduction in the points required but were unaware of any other forthcoming changes in the CPD system. Negative comments dominated the FGD as the groups may have seen this as a forum to air their frustrations. Management of points was an issue that received a few positive comments but a barrage of complaints. From the tone at the FGD it emerged that the image of the CPD administration was unfavorable.

After the key questions were asked, and before the FGD were brought to a close, all groups were posed with a final question, i.e. *“Of all issues discussed what do you feel was the main issue that needs to be addressed immediately?”* The following three issues were identified:-

- A standardized system for all professions especially with regard to the cost of an administration fee
- Access to point status



- All aspects of point management, application procedures and response to requests need attention

### 3.3 QUALITATIVE RESULTS: IN-DEPTH INTERVIEW FINDINGS

#### 3.3.1 Interviewee Information

Key personnel involved in the system provided insight into the same questions that were asked in the focus groups and questionnaire but with responses from an administrative perspective. Representatives from ADSA, the CPD office and HPCSA were interviewed. The key personnel included:-

- The CPD Officer
- CPD portfolio holder for ADSA executive
- Chairperson, Education Committee, HPCSA
- Representative on the HPCSA CPD Committee
- Chairperson, Professional Board For Dietetics
- Senior Manager CPD Registration and Records, HPCSA

#### 3.3.2 In-depth Interview Findings

Succinct points from each interview were combined and summarised.

##### **➔ *Dietitians' understanding of the CPD system***

It was the interviewees' impression that dietitians had a fairly good understanding of the system as it was, stating that *"although this may not have been the case initially, it had definitely improved towards the end of the current CPD system."* They also felt that once dietitians understood the system, they were extremely complimentary about the efficiently managed office. Two interviewees mentioned being aware of some dietitians who felt insufficiently informed about the system. One reason suggested by an interviewee was possibly because information was not communicated well, due *"to correspondence with too many guidelines."*

### → **Handling of queries**

The CPD office acknowledged a small number of complaints and queries which were most often about the completion of forms or reconciliation of points. It was stated by the CPD Officer that when such queries were followed-up it was usually found that 'DT' numbers were missing or names were omitted from the lists handed in by organisers at events. As a result, stated another interviewee, they often had to "*lead dietitians by the hand*" to assist with the paperwork.

The CPD officer also mentioned that all queries were personally handled (up to 30 e-mails per day) and stated being contactable at all times. In terms of queries by dietitians to the HPCSA, the CPD manager at the HPCSA stated that their call centre audit showed that more than 60% of calls were resolved within 24 hours, with the majority of the remaining 40% handled within 48 hours.

### → **Financial implications of CPD**

The administration fee was considered to be "*reasonable*" by all interviewees especially to have "*someone to take the admin off our hands.*" They further stated that many dietitians had also indicated this to them. It was explained by the Chairperson of the Professional Board that administrative fees were essential to cover the running costs of the CPD Office. All interviewees were unsure about the fee structure in the new system since it has not been finalised as yet. Some participants were of the opinion that there will be a fee while others felt there may not. There was agreement though, that organisers will pay and register for a lecture or CPD event. Uncertainty remained on how this payment will filter down to dietitians.

With regards to the cost of individual CPD activities, most but not all of the personnel interviewed were of the opinion that both affordable and expensive CPD activities were available to dietitians. It was stated by most interviewees that large conferences and congresses have always been a problem for dietitians without financial assistance. It was mentioned that perhaps "*we need to work out how to accommodate dietitians who want to attend, possibly by taking this up with ADSA.*"

### → **CPD and ethics**

According to the interviewees, there are currently no stipulations in place regarding ethics activities. A CPD committee member made reference to a recommendation submitted to

the Professional Board for Dietetics requesting that it be omitted. However it was stated that it is still an issue of debate with some members of the non-dietetic community at the HPCSA, proposing it be returned due to the increasing number of malpractice cases across the various professions. One interviewee mentioned that there has been a greater awareness of the importance of ethics with *“a move to incorporate the study of ethics at undergraduate level.”*

### → **Barriers to effective participation in CPD**

In the questionnaire that was sent out to dietitians, several factors were highlighted as deterrents to effective participation in CPD activities. Interviewees were asked to provide their views on some of the barriers that dietitians faced.

It was stated by the CPD personnel that initially complaints were received from dietitians in rural areas about the lack of activities. They reported that these have subsequently decreased since *“more journal and internet articles became available,”* and the introduction of cross-accreditation to *“increase dietitians’ options.”* Some interviewees recognised that restricted or no internet access still limited many free activities available to dietitians.

The CPD office acknowledged complaints regarding poor notification of events; however it was their view that dietitians have also been slow to update their contact details. It was further pointed out that as an ADSA member, a dietitian would receive more information about the CPD system and activities than a non-member since *“ADSA provides a lot of input through the journal, newsletters and e-mail.”* Hence, ADSA members *“are at a big advantage.”*

Interviewee opinion on the type of information and variety of topics at presentations and in articles were elicited. Interviewees held varying opinions. One opinion was that *“it is the responsibility of the dietitian to get something out of a presentation and show discretion in selecting topics and presenters. Dietitians should begin to practice self reflection that was mentioned in the first CPD documents over 10 years ago.”* As far as article topics were concerned, it was pointed out by the CPD officer that dietitians should be made aware that articles were limited by the fact that once the author hands his/her article to the journal, the copyright belongs to the journal, and no longer to the author. To use the article for CPD questions, permission must first be sought from the journal. Some journals were

expensive, charging per page, and others were not. While some for CPD purposes were free.

A differing opinion, from another interviewee was in agreement with dietitians who complained about the technical nature of articles. The interviewee stated that there were indeed some questions that were too academic in nature, possibly because it was mainly run by academics. It was further elucidated that *“CPD is not an exam or study, but rather the take home message is of importance.” Some hold the philosophy it is to ‘up’ the level of dietetics. It is not.”*

#### **→ Dietitians’ acceptance of the new CPD system**

It was stated by a committee member that *“change is disruptive”* and this was the reason for declining the offer to participate in the pilot of the new CPD system. Dietitians were however participating in the transitional phase of the new system while some Professional Boards were only due to begin in January 2007. It was suggested by an interviewee that dietitians should view the changes as improvements to the system, and *“one just needs to pay more attention to the information received.”* It was further added that *“unfortunately, people on the Board are usually blamed for changes but it comes from a central committee at the HPCSA with representatives from each board proportionate to their members.”* It was further elaborated that although the dietitians’ system worked well, some professions were experiencing difficulties. For example, the large numbers of medical doctors rendered their electronic system impractical, with numerous problems and errors experienced with record keeping. The need for a simple system prompted the change to personal record keeping across all Professional Boards. One member was certain that once the new CPD system has been running for one to two years, its effectiveness will be seen.

Before the close of the interview, interviewees were asked a final question i.e. *“If you could give advice to dietitians to help them adapt to the new system, what would that advice be?”* Suggestions were as follows:-

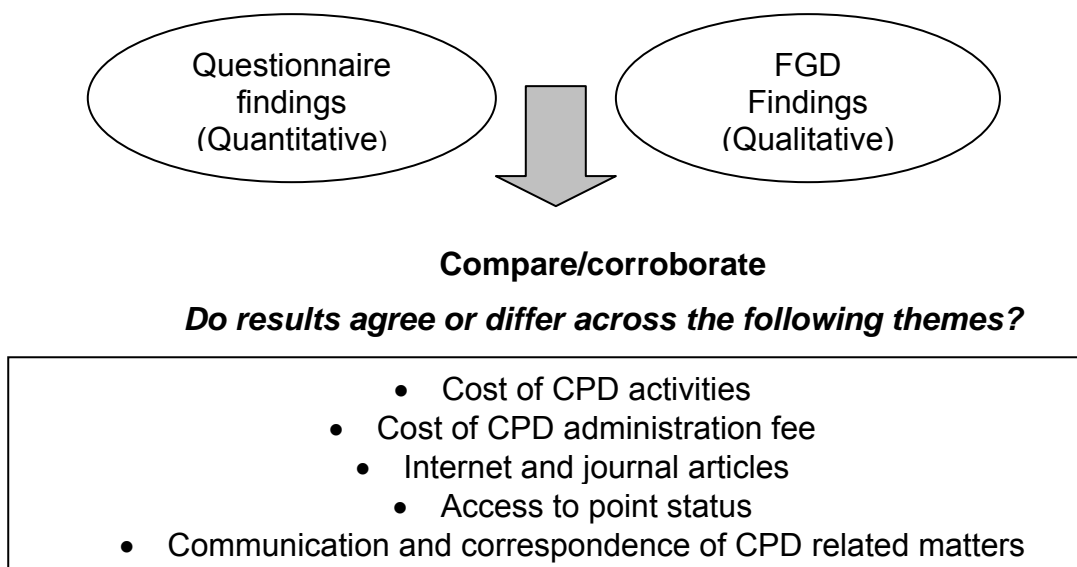
- *“Read your documents to understand the changes”*
- *“Take the responsibility to direct your career path”*
- *“Take certificates with you and keep records safe”*

- *“The system is meant to update dietitians for best practice and patient care. We should emphasize this aspect and focus less on the system.”*

### 3.4 TRIANGULATION OF DATA

Triangulation involves the comparison of data from more than one data collection technique to investigate the same variables and compare for differences and similarities to improve the confidence of the measures. It is suggested that comparing data from different measures is best done through themed responses.<sup>42, 43</sup> (Figure 3.7)

In this study, the dual indicators were data from the survey and focus groups. During the analysis of the FGD transcripts, the participant responses were divided into several core discussion issues (section 3.2.2). Comparing these dialogues with the questionnaire data allowed for identifying parallels and discrepancies in the results.



**Figure 3.7 Approach to triangulation of study data**

Costs of activities were cited as the greatest barrier to participation in CPD (ranked number 1) in the quantitative findings of the questionnaire. The issue of cost was also listed by respondents in the open-ended responses of the questionnaire as a weakness in the CPD system. These results were corroborated by the FGD findings where issues of cost also featured strongly and engaged a large portion of discussion time. Results from

the open-ended questionnaire items and FGD were in agreement that there were indeed activities that were pricy but some that were reasonable as well. Conferences received criticism from both the FGD and questionnaire for their high registration, travel and accommodation costs. Here, the FGD (as opposed to the questionnaire) expanded the issue by suggesting ideas for reducing costs. Generally conferences and large meetings received a lot of attention in the FGD since many stated that they all would like to be in a position to attend. These feelings from the FGD participants substantiated the questionnaire results where conferences also ranked the highest preferred method of CPD by respondents.

The quantitative findings from the survey revealed that articles completed for CPD purposes featured in the top five most used CPD methods. The qualitative findings from the FGD concurred; as articles also featured as an alternative to costly activities, and were widely relied on to accumulate points. Both measures were also in agreement that while the CPD article option is appreciated there is a general dissatisfaction about the topics, variety, and usefulness of the information (mentioned in FGD and open-ended questions of the questionnaire).

On the matter of the CPD administration fee, the quantitative and qualitative data differed slightly. The vast majority of FGD participants were unhappy to pay the administrative fees and fees per point, resulting in a highly emotive discussion on the unacceptable amounts that dietetic practitioners only, were required to pay. These perceptions were incongruent with the survey results where the figures show that it was a 50-50 split between those who were satisfied to pay and felt service was justified (45.3%) versus dietitians finding it expensive, not in line with other professions and were unhappy to pay this fee (45.4%).

Access to point status was a recurring suggestion that was mentioned in the open-ended items of the questionnaire and raised in the FGD as well. Results from both these measures agreed and indicated that dietitians would prefer more regular access to point status.

In terms of communicating with the CPD office and HPCSA, the questionnaire findings showed that 60.7% of respondents often experienced difficulty in contacting the HPCSA. These results were compatible with the FGD where some dietitians discussed frustration in trying to contact the HPCSA. A few FGD participants also described a similar scenario with

the CPD office. This however was incongruent with the questionnaire findings which showed that the majority of respondents (71.1%) actually found the CPD office easily contactable for queries.

In summary, the questionnaire quantified issues and the including statistical analysis allows for generalizations and conclusions to be drawn. Additionally, assessments of validity conducted during the questionnaire development phase minimize measurement bias. They are however limiting due to their pre-determined response categories.<sup>5, 42</sup> The inclusion of focus groups in this study helped compensate for this limitation by allowing other views and personal experiences to be aired. Combining both quantitative and qualitative methods is recommended as ideal and comparison between the findings of both methods gives greater depth to the results.<sup>42</sup>

**CHAPTER 4: DISCUSSION**



## 4.1 DISCUSSION

This study marked the first formal investigation of the CPD system for dietitians in South Africa. All registered dietitians in South Africa were invited to participate in the national survey with the exception of a small number involved in the developmental stages of the survey instrument. Findings from the survey and the FGD that followed indicated that whether dietitians felt that the CPD system was generally well run or flawed, almost all provided insight into aspects they were dissatisfied with or suggestions for improvements. Key areas that should receive attention were issues of cost surrounding CPD administration and activities; communication and correspondence to improve understanding of the system, access to point status and the provision of practical CPD activities.

Data gathering began at the end of 2005 and extended beyond the first quarter of 2006. During this time, a transition to a new CPD system for all health professionals was underway. Therefore, in terms of the study findings, results apply to aspects of both the old and the new CPD system. Nevertheless most of the results can be used to direct efforts to improving aspects of the new system.

Despite a reminder notice and a number of alternatives to return the questionnaire, only 318 responses were received giving a response rate of 20%. Although disappointingly low, it is widely accepted that postal surveys yield poor response rates of less than 30%.<sup>5</sup> Twenty percent is almost in line with a previous postal questionnaire to SA dietitians in an unrelated study where a response rate of 25% was obtained with two reminders and an incentive<sup>46</sup>, but it is almost half the response obtained by dietitians in the US participating in a study examining the effects of continuing education on practice, where a response rate of 40% after the first mailing and 1 follow-up postcard was received.<sup>13</sup> Possible reasons for the low response may be firstly that participation was voluntary so those unwilling to participate did not return questionnaires. Secondly dietitians who did not respond may have had little to comment on the system or were disinterested. Thirdly, unopened e-mail boxes and incorrect postal addresses meant that many may not have received the questionnaires in time. Additionally, perhaps an insufficient time period for returning the survey was a contributing factor as well as the fact that the study was conducted at the end of the year; a time when practitioners are busy, short staffed and going on leave. When a few community service dietitians contacted the investigator, it

was also discovered that they were uncertain whether the questionnaire applied to them since their participation in CPD is not compulsory. Lastly, the overlap of both old and new systems at the time of the study may have raised some confusion amongst survey participants about the purpose of the study, which in turn may have impacted on the response rate. Additionally their responses to the questionnaire items may also have been affected making it unclear as to which system was being referred to.

In terms of representivity, the December 2006 HPCSA statistics indicate that the study respondents almost identically reflect the demographics of the profession as a whole regarding gender, area of residence and ADSA membership<sup>50</sup> (Table 4.1). Per province, the percentage of dietitians who responded to the survey is in proportion to the number of dietitians practicing in that province, i.e. the majority of respondents resided in Gauteng, but there are also more dietitians in this area. It seems that the greatest disparity lies with the dietitians abroad. Furthermore, 1460 dietitians are registered as ADSA members of whom 169 were student members.<sup>51</sup> The 1291 members (78.1%) who are registered dietitians is also in line with the percentage of respondents who acknowledged ADSA membership (79.5%). The closely corresponding percentages have important implications for generalizing and drawing conclusions from the study findings.

**Table 4.1 Demographic characteristics (%) of respondents (n=316) compared to the national HPCSA register of dietetic practitioners (n=1652)**

<b>DEMOGRAPHIC CHARACTERISTICS</b>		<b>Respondents</b>	<b>National</b>
		<b>%</b>	<b>%</b>
<b>Gender:</b>	Female	97.8	96
	Male	2.2	4
<b>Province:</b>			
	Gauteng	36	35
	Western Cape	23	23
	Kwa-Zulu Natal	9	11
	Mpumalanga	4	5
	North West	3	4
	Northern Cape	2	2
	Limpopo	5	7
	Eastern Cape	5	4
	Free State	5	7
	Abroad	8	2
<b>ADSA membership</b>		79.5	78

Unlike the national survey, the FGDs were held in Pretoria only. With regards to representation, it could be viewed as a limitation to the study since dietitians in other areas may have had different issues to face in dealing with the CPD system. However, it was felt that this would not bias the study results significantly since findings from the FGDs were not the main data source. It merely helped illuminate issues already raised in the questionnaire by dietitians nationally.

In the design of the questionnaire, the use of the different questioning styles was incorporated for flexibility and to make the instrument more interesting. However it was found that use of closed-ended questions offering more than one answer option, and rank ordered responses, made processing and analysis of data lengthy and difficult in the absence of the appropriate software statistics program. The latter, (of which there were 2 items in the questionnaire) required respondents to rank a set of categories in a specific sequence. It is documented that respondents often find it tedious or complicated as they need to read the question and categories several times over. Hence, it is suggested that these be kept to a minimum.<sup>52</sup>

One of the first questions posed to dietitians in the questionnaire was regarding their understanding of the CPD system, to which the majority simply responded to with 'yes.' However, this was not in line with the open-ended questions that followed later where many dietitians frequently called for a simpler system that is more understandable. These perceptions were contradictory to the general opinion of the CPD administrative and management personnel who believed that dietitians should have had a fairly good understanding of the system since they were kept informed of all updates and changes related to CPD through the CPD office and the Professional Board for Dietetics. Generally, a smaller percentage of respondents found all CPD documentation easy to understand while more found them complicated, lengthy, and only scanned through them. Hence dietitians, including community service dietitians mentioned a need for "*more concise letters and correspondence*" to understand the system and its rules. Community service dietitians especially, requested that they would also appreciate a summary of the guidelines. From the management perspective, interview data show there is an awareness that documentation goes unread and always call on dietitians to read CPD documentation; a point that was even noted as an administrative challenge for the SA system at a recent international dietetic conference.<sup>26</sup> Perhaps the challenge may not be in getting dietitians to read the information in as much as presenting it in a simpler, more readable form.

It seems that the need for less confusing correspondence is not unique to dietitians, since it was an issue raised by optometrists, dispensing opticians and medical technologists in a 2006 report on the piloting of the new CPD system. These practitioners stated that they do not understand their CPD guidelines and would like them to be easier to read; even a short brochure on CPD was suggested.<sup>53</sup> Perhaps this might be the reasoning behind the approach of the UK HPC. Their recently released booklet is extremely simple, easily readable with succinct points stating only that all health professionals need to keep records, when the first audit will be held, who to contact and where to obtain a more detailed document.<sup>54</sup> For the SA CPD system, effective correspondence will be imperative to facilitating a smooth transition to the new system and ensuring that all dietetic practitioners understand the basic changes.

In fact an earlier CPD evaluation report submitted by Pistorius, in 2003, also states the "functionality of any system depends to a very large extent on efficient communication.

Optimal communication will not only solve many current CPD problems, but will also prevent many from occurring.”<sup>55</sup>

Besides written correspondence, communication also extends to correspondence with the relevant offices on CPD matters. The same report by Pistorius also highlighted the intense dissatisfaction expressed by medical doctors and dentists at being unable to contact the HPCSA telephonically, with complaints of being kept on hold and unanswered calls, faxes and e-mails.<sup>55</sup> In the present study, two thirds of respondents still found the offices of the HPCSA difficult to reach. In response, the HPCSA have made attempts towards improving communication with practitioners by monitoring their telephonic system with monthly audit reports and aiming for quicker response times for all CPD queries.

Ultimately though, having one's query efficiently handled is key to quality service and in this respect, the trend amongst all three offices was that the majority of respondents concurred, to varying degrees, that their problem/enquiry was efficiently handled with appropriate feedback and all three offices were perceived to be helpful and friendly. Although in the FGD, dietitians expressed dissatisfaction and frustration in following up CPD queries with the CPD office and more especially, the HPCSA.

There were many rules, regulations and procedures in place to guide the accumulation and application of points as part of the previous CPD system that are now obsolete. While it was the study's objectives to determine perceptions about participating in CPD within these rules and guidelines, it also emerged that a substantial proportion of respondents stated that they were completely unaware and unfamiliar with the time frames; forms required for points application or even the rule that guided the accrual of points e.g. the "80% rule." A small number were completely unsure who to contact with a CPD-related query while half of all respondents had no idea what cross-accreditation means. Although these rules and procedures have been in place for a few years and are communicated to dietitians through annually updated guidelines, it is disconcerting that there was unfamiliarity with many key aspects of the system. It is possible that the small number of respondents who were unfamiliar with the rules were the community service dietitians who were not provided with any CPD updates and guidelines and as such would not provide perceptions from the same stand point as other registered dietitians. However, although not compulsory, many of these new graduates are currently participating in CPD

voluntarily and have indicated the need for more information about the CPD system. This is an area that will need to be addressed as part of the new system.

When aspects of the new system were raised at the FGDs, there was a sense of both annoyance and apathy at the numerous changes. Additionally, FGD participants felt that changes were always brought about unilaterally. In the questionnaire, respondents' comments displayed feelings of anxiety towards changes. However, if the changes are viewed as improvements rather, as suggested by one of the interviewees, it may improve perceptions of the impending adjustments. In fact, it may be very well received if dietitians are aware that many adjustments concern the very rules and procedures that they were not entirely satisfied with in the previous system. A case in point would be the rule in the old system that allowed no more than 80% from any one category. Only a few questionnaire respondents admitted that they could achieve this with ease. The common preference was that this rule be a recommendation only. This rule is not part of the new CPD system.<sup>56</sup>

Another improvement involves the total number of points required annually. Before 2006, the accumulation of 50 points per year was necessary to maintain registration. Points are now termed CEUs, and only 30 per annum are required. The overwhelming majority of questionnaire respondents were pleased with the reduced points required, stating that it was more reasonable and easier to achieve. A handful though, was unaware of this change. Although the lowered requirements were well received, it was encouraging to note that half of the dietitians in the present study indicated that they had accrued more than 50 points in the previous year and stated that their points were fairly easy to obtain. Furthermore, a CPD report also indicated that a 100 community service dietitians accrued 32 points in 2004, although non-compulsory.<sup>25</sup> It can be therefore be expected that dietitians would have little problem achieving the 30 points required in the new system.

The issue of ethics surfaced repeatedly as a weakness of the system in the open-ended responses to the questionnaire. In the current study, two thirds found these points difficult to achieve stating that the main reasons were insufficient opportunities and no new information presented. In the Pistorius report, doctors also found ethics points difficult to achieve, and they suggested that ethics be handled by the HPCSA.<sup>55</sup>

The new system places no stipulations on the number of ethics CEUs to be obtained. The CPD accreditation committee for dietitians has already made recommendations to the HPCSA suggesting that ethics remain non-compulsory. As it stands, ethics is currently non-obligatory but attendance at any ethics related activity will be rewarded; receiving 3 CEUs compared with other non-measurable presentations that receive only 1 CEU per hour.<sup>25</sup> It seems though, that the topic of ethics is far from finalised, since it emerged in the in-depth interviews that the HPCSA still feel strongly that ethics be incorporated into the CPD system as part of their moral obligation to protect the public. Health care professionals should subscribe to a set of ethical principles to protect the public. In fact each professional board should set, maintain and apply ethical standards of practice.<sup>56</sup> However a disconcerting report from the HPCSA depicts sharp increases in complaints from the public against health professionals over the last few years with more than a third of all complaints involving ethical issues of substandard service or treatment and consent or confidentiality issues.<sup>29</sup>

Respondents suggest the availability of more journal and on-line ethics articles, while presentations on ethics have been criticised as offering “nothing new.” Jeffers reports that many professionals commonly view ethics as a “stagnant topic”.<sup>57</sup> However technological advancements and the changing work environment means updates in research ethics, ethical decisions and dealing with ethical conflict is vital.<sup>57, 58</sup> From this point forward in the new system, consideration will have to be given towards fostering ethical practice, professional competence and ethical decision making, since malpractice increases have still occurred despite the compulsory ethics activities that were part of the old system.

Apart from the changes to rules already discussed, probably the greatest adjustment for dietitians and all health practitioners is the move to a system of personal record keeping. Previously, recording evidence of CPD was done by the CPD office. Now the responsibility will be that of the individual. Keeping ones own record of all activities means knowing at any time how far one is towards achieving the 30 CEUs. Dietitians would find this of great value since access to points was a recurrent issue mentioned in the open-ended responses and discussed at the FGD. Dietitians complained that point status was only made available when it was too late for backtracking; and there were often problems with incorrect records. In fact dietitians were so keen to have some access to points that almost all indicated that web access to points should be available. The rest declined probably due to internet access limitations - a constraint that will not apply to personal records. With a

personal CPD folder, dietitians will always be aware of their status and can review their CPD practices as they go along. Minimal problems can be anticipated with this system since three quarters of the survey respondents kept records anyway for purposes of cross-checking with the CPD office. It is therefore a familiar concept to the majority. Of interest though, is that when respondents were specifically asked about the choice of maintaining their own records or not, only 16.7% said they would like to keep their own records, with the majority indicating that they would not like to keep their own records, while a third indicated that they wouldn't mind either way.

Concerns raised in this regard include anxieties regarding the timeous issuing and receiving of certificates. This is a valid concern since the audit report revealed that some providers did not supply attendance certificates, some were not accredited while others did not follow the guidelines for the new system.<sup>53</sup>

There will no longer be a yearly tally of points but rather a system of random auditing. This is in line with the system currently in place in the US and UK where random audits are part of their system. The first audit for dietitians in the UK is scheduled for 2010.<sup>54</sup> In SA, a voluntary audit for dietitians has already occurred. Three hundred and fifteen dietitians responded to the HPCSA's request. Their report states a compliancy rate of 92% among local dietitians who responded, and 1% of dietitians compliant abroad.<sup>30</sup>

The fact that the CPD office no longer manages and administers points has obviated the need for an administration fee. This fee was a highly contentious issue in both the FGD and in the questionnaire. Some felt the fee was justified while others felt it expensive or not in line with other professions. In response to this, the interviewees stated that it was also the only profession that had an efficient system of managed points hence necessitating an administrative fee. Of all the issues raised and discussed at the focus groups, the participants repeatedly raised this issue on their own, and felt most strongly about this; stating that paying for the activity and then again to administer them, defeats the purpose of CPD. Furthermore, they felt that attending should be for knowledge and once attended, the points should be granted and not removed for lack of payment.

Since administrative costs were a major cause for disgruntlement there were many suggestions put forward by dietitians to combine the various fees that are required of dietetic practitioners, into one fee, and to ensure that it is in line with all other health



professionals. During the course of the study, the HPCSA CPD committee finalised fees for the professional boards, by recommending maximum amounts for various activity types. Participation in most CPD activities will not require individual application for points or payment of fees since the service provider will provide the certificate and pay the annual accreditation fee. It will only be necessary for an individual application for some level 2 activities such as international conference attendance or authoring of books. General fees for dietitians are expected to be finalised in due course.

Attendance at presentations like lectures and conferences were the top two common activities amongst the respondents while journal articles with questions rated third. Interestingly, lectures and conferences still rated above the others when asked to indicate their preferences, but dietitians would like to attend more journal clubs than they currently do. Other studies have been also been done to determine usual versus preferred CPD methods amongst dietitians and other professions. Table 4.2 shows the top six usual CPD modes versus preferred CPD activities for SA and USA dietitians and nurses in the States.<sup>37, 39</sup>

**Table 4.2: Usual versus preferred CPD among dietitians and nurses**

<i>Usual CPD method</i>			<i>Preferred CPD Method</i>	
<b>Ranked Preferences</b>	<b>SA DIETITANS n= 315</b>	<b>US DIETITIANS<sup>37</sup> n= 1082</b>	<b>SA DIETITANS n= 312</b>	<b>US NURSES<sup>39</sup> n= 103</b>
<b>1</b>	Lectures and seminars	Lectures	Conferences	In-person conference
<b>2</b>	Conferences, congresses	Seminars	Lectures	Print-based self study
<b>3</b>	Articles in journals	Workshops	Journal clubs	Interactive video Conference
<b>4</b>	Workshops	Self study programs	Journal articles	Computer based internet
<b>5</b>	Internet articles	Exhibits	Workshops	Audiocassette self-study
<b>6</b>	Journal clubs and discussion groups	Professional reading	Internet articles	Computer-based CD-ROM

Like SA dietitians, the study by Keim<sup>37</sup> involving US dietitians, also stated that internet and satellite/distance learning courses were used to a lesser extent, which the authors discuss as a concern due to the importance for dietitians to be knowledgeable about technological approaches to CPD and providers to use them more often for CPD purposes.<sup>37</sup> Nevertheless advancements in technology have benefited continuing education by making a greater variety of learning approaches available. The internet articles in particular, allow for the individual to be suited in terms of time, convenience, geographic location and cost especially when compared to the conventional presentations. In all instances, presentations rated fairly high. Conferences and large gatherings have been criticised for their minimal impact on knowledge and skill, but have their own advantages like networking with colleagues, a chance to travel and see new places and allows one time away from the work place. It is predicted that conferences will always be popular but technology-aided CPD will not be far behind, especially as internet access and more computers at home and in the work place becomes available.<sup>18, 19, 39</sup>

Indeed each method carries its own amount of learning and the availability of a wide variety of activities is more likely to meet the learning styles of individuals and suit their circumstances.<sup>6</sup> Such information is important to providers of activities. Knowing the usual and preferred practices of dietitians is valuable, considering the time and monetary investment into CPD.<sup>39</sup>

For CPD to be optimally beneficial requires consideration to factors that hinder participation.<sup>14</sup> The majority of respondents cited financial limitations as their greatest limitation to participation since very few receive help sponsorship, and those that do are mainly from academic and hospital environments. Besides travel and registration costs, private practitioners also lose earnings in the hours away from work. One CPD committee member did acknowledge that the costs of conferences often made them out of reach and stated that this is an issue that would need to be addressed by the professional organization ADSA in collaboration with providers and organisers of events. Cost differences between provinces could be due to the fact that provinces like Gauteng have more activities available to them; hence dietitians from this region would spend more annually on CPD. The literature reveals similar hindrances. With US studies involving dietitians showing inconvenient times as the greatest deterrent while another showed that affordable CPD was an issue for unemployed dietitians, while a substantial number cited geographical accessibility as a problem.<sup>37, 38</sup> Affordable CPD, family obligations, less opportunities in rural areas and insufficient advertising were also a list of problems noted by practitioners who participated in the 2006 pilot project of the new SA CPD system.<sup>53</sup>

With regards to ADSA membership, the present study showed no significant difference in the cost spent on CPD activities between ADSA members versus non-members. These findings are of interest since being an ADSA member generally means paying a reduced fee at CPD activities. A likely explanation could be that ADSA members receive more notification of a wide variety of events, attend more, and so pay more. In the new system, the reduced point requirements means attendance at fewer activities and no correspondence with the CPD office and this in turn will impact on the cost as well.

Apart from cost as a barrier to participation, family obligations also featured among the top 5 barriers to participation, and deserves due consideration among providers and organisers of activities, since dietetics is a female dominated profession. For individuals with this concern and those in outlying areas, computer based options may be more

viable. Additionally, the professional journal SAJCN is provided to ADSA members with several opportunities for CPD reading activities. ADSA members are also at an advantage as they receive e-mail notification of events, and many companies use their mailing list to advertise events. This is a relevant point as dietitians also indicated in the open-ended questions that notification of events by post often arrived too late.

Respondents and FGD participants also complained about the technical nature of the articles and questions that followed. Providers should design questions on the basis of improving performance and professional abilities. In fact all activities should be translatable to professional duties, whether it is new knowledge or confirmation that the right thing is being done for patients.<sup>12</sup>

Two opposing yet interesting views of the CPD system emerged in the open-ended questions. Some respondents felt strongly that not enough is done to ensure that all dietetic practitioners are compliant, and if they are not, there is little consequence. Additionally without a test of knowledge there is potential for abuse and dishonesty. On the other hand some detest the constant threat of deregistration and prefer a system of encouraged (not forced) CPD with the emphasis on learning. The new system will be based on trust. It is hoped that practitioners will participate in CPD in the pursuit of life long learning and so meet the requirements set by the HPCSA.<sup>1</sup>

On an encouraging note, respondents were asked to state the strengths of the system, and the widely held view was that CPD keeps them informed and has provided opportunities to learn and network with colleagues. They stated also that CPD affords confidence in the work setting and a high standard of patient care. It is anticipated that dietitians would appreciate these effects to a greater extent in the new system where CPD is standardised for all professions and is similar to systems used by dietitians overseas.

As the first evaluation of the CPD system for dietitians, the findings have provided data that can be useful in the implementation of the new system as well as the planning of CPD activities. Giving due consideration to the suggestions put forward by the study participants, and promoting all changes as improvements, the new CPD system, in all likelihood, will be easily accepted.

## **CHAPTER 5: CONCLUSION AND RECOMMENDATIONS**

## 5.1 CONCLUSION

Continuing education has the potential to further one's knowledge and improve the ability to practice competently and professionally and so assure the public of quality nutritional care. This can only occur if each individual takes responsibility for her/his learning and a supportive system for optimal learning and opportunity exists. It was the purpose of this study to examine this very system through the perceptions of dietitians

Findings from this study indicate a few key issues that need to be addressed such as simple, effective communication and cost implications of CPD. Additionally, overcoming hindrances to CPD like poor notification, geographic inaccessibility, work constraints and provision of quality CPD opportunities will be valuable in the move towards a system acceptable to all participating in it.

Quality scientific information should be accessible to all dietitians, so that competent dietitians could be accessible to all those requiring nutritional care.

## 5.2 RECOMMENDATIONS

The recommendations are grouped under concepts discussed in the conceptual framework. Some recommendations include changes to the old CPD system in place until 1 April 2006. However the majority of suggestions are applicable to the current system.

### ***a) Communication and coverage***

1. Immediate priority should be given to familiarising all dietitians with amendments to the system from a view of improvement rather than change due to the negative connotations associated with change. A single mailing or a once-off notice in the journal is insufficient. The same message should be given repeatedly at meetings, on websites, and all other avenues of communication with dietitians. For example, a poster with 5 or 6 points only outlining the changes could be made available to each ADSA branch which is put up at all meetings to be viewed before the presentations and during breaks.

2. All information and CPD correspondence should be easy to understand. Professionals managing family and demanding careers need a quick reference/handy guide (with key

points only) of what to do, and who to contact. Perhaps a once-off colourful leaflet could be done and mailed to all dietitians with it also being available at all gatherings. A helpline for queries should be widely publicised and a brief mention of the amendments should be made at each ADSA meeting. Reference to the HPCSA website or the Professional Board Guidelines can be for those that are looking for more detail. An example would be a few points on a leaflet entitled “Your 3 step guide to the CPD.” Where number 1 could be “update your details” and number 2 is “keep a record,” and so forth. One can also highlight the positive changes such as “only 30 points,” and “no 80% rule.”

3. Some groups may require particular attention like the community service dietitians who feel unfamiliar with all or some aspects of the system. Websites, contact numbers and information packs should be more available to them. They currently do not receive much information, but would like to. Dietitians at their placement hospitals should encourage and guide CPD participation (even though it is not compulsory), as a means to improve their understanding. Providing more CPD options for dietitians in rural or outlying areas is also a concern that needs to be addressed by the appropriate provincial ADSA branch as they would be familiar with the area and the available experts and facilitates.

### ***b) Affordability***

Cost implications of CPD are the greatest cause for disgruntlement. This issue should receive careful consideration when deciding upon a fee. It should definitely be comparable to other professions and possibly combined with any other fee that dietitians are required to pay.

### ***c) Accessibility***

1. ADSA is frequently involved at all major events. As a service to their members they should investigate ways in which larger meetings, conferences and congresses can accommodate more dietitians e.g. Consider having more day options available or organising events near a city. Alternatively, consider making the transcripts of certain lectures or discussion groups available with multiple choice questions.

2. To assist dietitians that found obtaining leave from work a hindrance to CPD, a standard letter for employers could be drawn up by the CPD committee that briefly explains the

importance of CPD and benefits obtained by participation. Dietitians in any field could use this to present to their managers or employers.

#### ***d) Record keeping***

Dietitians should make a concerted effort to read through all CPD related documentation that is received and ensure that their contact details are continuously updated at each of the relevant offices to receive the information.

#### ***e) Planning types of activities***

1. There should be a move away from the focus on point accumulation. The emphasis should be on learning something new and impacting on patient care. All organisers should be encouraged to view activities from this perspective in their planning of CPD events; including those involved in formulating questions for articles. The challenge is not only to increase knowledge of scientific details and 'up the level' of dietetics, but for dietitians to remember what they have read and try to implement new knowledge in practice.

2. There should be a collaborative approach to CPD, encompassing all members of the CPD community including providers of activities, organisers, food companies and pharmaceutical companies that often provide events; even education departments at universities. This is to ensure that CPD is not merely a scheduling of a lecture but incorporates principles of adult learning and development that provides activities that will be of eventual benefit in the practice environment.<sup>12</sup>

3. Although the issue of ethics is still unresolved by the HPCSA, it is an important consideration. As a profession we could take the lead and make it a priority and find means to incorporate it into the CPD programme in a non-compulsory capacity e. g a cycle of lectures, discussion of case studies as well as foster ethical awareness at undergraduate level.

#### ***f) Satisfaction with the CPD system***

Continuous evaluation research of the CPD system should be promoted as a means of refining and improving the system. It should occur at regular intervals and should be



accepted as an integral part of the CPD system due to the dynamic nature of the profession and changes in the CPD environment. The results of this study can provide a standard of comparison for ongoing evaluation studies. Although this study focused on a process/ implementation evaluation of the system, other types of evaluation studies could also be conducted such an outcome evaluation which may look at, as an example, the impact of CPD on dietitians' knowledge and skills. Later research on evaluation could also focus on:-

- Including providers and accreditors
- Finding solutions for rural dietitians
- Investigating the type of learning methods that specifically aid dietitians in their practice.

In the FGD, the negative attitude of many dietitians could be viewed as a “complaints” session yet on the other hand it was also the first time that dietitians were given a forum to air their views. If, during other evaluations, they are given more opportunities, they would probably value providing suggestions to refine the system.

### **G) General recommendations**

1. CPD is crucial to dietitians and should be viewed as an integral part of practicing, and not an “add on” to the profession after graduation. Fostering a desire to become lifelong learners should be initiated at undergraduate level, with regular motivational talks on the importance of CPD in the changing work environment. Like the HPCSA CPD Road show, perhaps dietitians should also organise a Road Show. A fellow dietitian with a passion for learning and a positive attitude to CPD could speak to and motivate dietitians prior to an event that is scheduled at different branches throughout the year, as well as answer questions on the new system.

2. Finally, dietitians should be encouraged to accept more responsibility for their own learning. It is time to move away from the idea of collecting points but rather to meaningfully direct learning. The American CPD system encourages self reflection, self assessment and goal setting for more meaningful CPD. In the UK it is suggested that individuals ask themselves a set of questions, so that one seeks to extract something out of an activity, and if not, then to examine why for the next time around.<sup>9, 53</sup> Changes

associated with the new system will pose its own set of challenges. However it is suggested that the time is right to make a simple start to self reflection; especially in the light of complaints by respondents that nothing new is learnt from presentations and articles. This process might make dietetic practitioners more discerning in their choice of activities. Appendix 12 was drawn up as a suggestion of a very simple evaluation form that individuals could use. It would take a few minutes to complete after an activity, even while dietitians are still present at the venue. Hopefully, this will get dietitians to ponder a little on that educational experience.

**REFERENCES**

1. HPCSA. Continuing professional development guidelines for the health care professionals. General circular. Pretoria, November 2006.
2. Ross F, Wentzel E. Documentation for Proposed ADSA Continuing Education System-Draft 2. ADSA circular. 1995.
3. Rossi PH, Freeman HE, Lipsey MW. Evaluation, a Systematic Approach. 6<sup>th</sup> ed. Thousand Oaks: Sage publications, 1999.
4. CPD Committee. The relationship between the Professional Board for Dietetics and ADSA re CPD. South African Journal of Clinical Nutrition 2003; 16: 4.
5. Katzenellenbogen JM, Joubert G, Abdool Karim SS. Epidemiology. Cape Town: Oxford, 1997.
6. Petrillo T. Lifelong learning goals: Individual steps that propel the profession of dietetics. Journal of the American Dietetic Association 2003; 103: 298 – 300.
7. Chambers DW, Gilmore CJ, O'Sullivan Maillet J, Mitchell BE. Another look at competency-based education in dietetics. Journal of the American Dietetic Association 1996; 96: 614 - 617.
8. Competency Assurance Panel of the Commission on Dietetic Registration. The Professional Development 2001 Portfolio. Journal of the American Dietetic Association 1999; 99: 612 - 614.
9. Weddle DO, Himburg SP, Collins N, Lewis R. The professional development portfolio process: Setting goals for credentialing. Journal of the American Dietetic Association 2002; 102: 1439 - 1444.
10. Duyff RL. The value of lifelong learning: key element in professional career development. Journal of the American Dietetic Association 1999; 99: 538 - 543.

11. Professional Board for Dietetics. Guidelines for Compulsory Continuing Professional Development (CPD) for Dietitians. General Circular. Pretoria, 2004.
12. Bennett NL, Davis DA, Easterling WE, Friedman P, Green JS, Koeppen BM, Maximanian PE, Waxman HS. Continuing Medical Education: A new vision of the Professional Development of Physicians. *Academic Medicine* 2000; 75: 1167 - 1172.
13. Reddout MJ. Perceptions of clinical dietetic practice: Continuing education and standards. *Journal of the American Dietetic Association* 1991; 9: 926 - 932.
14. Nolan M, Owens RG, Nolan J. Continuing professional education: identifying the characteristics of an effective system. *Journal of Advanced Nursing* 1995; 21: 551 - 560.
15. Moran JA, Kirk P, Kopelow M. Measuring the effectiveness of a pilot continuing medical education program. *Canadian Family Physician* 1996; 42: 272 - 276.
16. Davis D, Thomson O' Brien MA, Freemantle N, Wolf FM, Mazmanian P, Taylor-Vaisey A. Impact of formal continuing medical education. *Journal of the American Medical Association* 1999; 282: 867 - 874.
17. Clancy C. Reinventing continuing medical education. *British Medical Journal* 2004; 328: 291
18. Buttery CM. Does continuing medical education work? *British Medical Journal* 2006; 333: 99
19. Allen RKA. Licensing system for doctors - accumulating points has not changed the way I learn. *British Medical Journal* 2002; 325: 393
20. Bradley PR. Licensing system for doctors, but is it necessary? *British Medical Journal*. 2002; 325: 393
21. Quam L, Smith R. What can the UK and US health systems learn from each other. *British Medical Journal* 2005; 330: 530 - 533.

22. Delva MD, Kirby JR, Knapper CK, Birtwhistle RV. Postal survey of approaches to learning among Ontario physicians: Implications for continuing medical education. *British Medical Journal* 2002; 325: 1218
23. Grol R. Improving the quality of medical care. Building bridges among professional pride, payer profit and patient satisfaction. *Journal of the American Medical Association* 2001; 286: 2578 - 2585.
24. Gericke G. A review of the CPD point status for 2002. *South African Journal of Clinical Nutrition* 2004; 17: 3
25. A review of the CPD point status of dietitians for 2002-2004. *South African Journal of Clinical Nutrition* 2006; 19: 2 – 4.
26. Marais D, Wentzel-Viljoen E. Continuing Professional Development in South Africa. Paper delivered at the International Conference in Dietetics, Chicago, May 2004.
27. E.C News. Draft of reconfigured CPD system. Newsletter for the Professional Board for Emergency Care Practitioners. Number 4, August 2005.
28. Marais D. CPD portfolio holder for ADSA executive. Western Cape: E-mail communication, September 2006.
29. Bulletin. CPD Pilot Project starts with Medical Technologists, Optometrists and Dispensing Opticians. Newsletter of the Health Professions Council of South Africa. Number 4, October 2005.
30. Modimokwane K. Health Professions Council of South Africa. Secretary to Senior Manager: CPD registration and records: E-mail communication, [kgomotsom@hpcsa.co.za](mailto:kgomotsom@hpcsa.co.za). 15 December 2006.
31. Hellenic Dietetic association. Greece: E-mail communication, [nkontou@hda.gr](mailto:nkontou@hda.gr). 28 December 2006

32. Feehan S. Manager of Nutrition and Dietetics (INDI). Ireland: E-mail communication, [sinead.feehan@amnch.ie](mailto:sinead.feehan@amnch.ie). 28 December 2006.
33. New Zealand Dietitians Association <http://www.dietitiansboard.org.nz/site/Practitioners/MaintainCompetency.aspx>. Accessed 6 December 2006
34. King. L. Professional Development Coordinator, The British Dietetic Association. Birmingham, United Kingdom: E-mail communication, [l.king@bda.uk.com](mailto:l.king@bda.uk.com) 21 September 2006.
35. Barnhill GC. Director of Recertification and Professional Assessment, Commission on Dietetic Registration. Illinois, USA: E-mail communication, [GBarnhill@etrigh.org](mailto:GBarnhill@etrigh.org). 27 September 2006.
36. Rodwell J. Administrative Assistant, Dietitians Association of Australia, Australia: E-mail communication, [jrodwell@daa.asn.au](mailto:jrodwell@daa.asn.au). 22 September 2006.
37. Keim KS, Johnson CA, Gates GE. Learning needs and continuing professional education activities of Professional Development Portfolio participants. *Journal of the American Dietetic Association* 2001; 101: 697 - 702.
38. Manning CK, Vickery, CE. Disengagement and work constraints are deterrents to participation in continuing professional education among registered dietitians. *Journal of the American Dietetic Association* 2000; 100: 1540 - 1542.
39. Charles PA, Mammary EM. New Choices for Continuing Education: A State wide Survey of the Practices and Preferences of Nurse Practitioners. *The Journal of Continuing Education in Nursing* 2002; 33: 88 - 91.
40. Ross F, Wentzel E. Documentation for proposal ADSA continuing education system. ADSA Circular. 1994.
41. Marshall C, Rossman GB. *Designing Qualitative Research*. 2<sup>nd</sup> ed. SAGE publications, Thousand Oaks. 1995.

42. Abusabha R, Woelfel ML. Qualitative versus Quantitative Methods: Two opposites that make a perfect match. *Journal of the American Dietetic Association* 2003; 103: 560 - 569.
43. Neuman WL. *Social Research Methods. Qualitative and Quantitative Approaches*. 4<sup>th</sup> ed. Boston: Allyn and Bacon, 2000.
44. Margetts BM, Nelson M. *Design Concepts in Nutritional Epidemiology*. 2<sup>nd</sup> ed. Oxford: Oxford University Press, 2001.
45. Loots A, du Toit E, Terblanche L, Theart R, Greef R, van Schalkwyk S. n' Opname van die probleme wat Arbeidsterapeute in die Wes-Kaap t.o.v. die verwerwing van Voortgesette Professionele Ontwikkeling- eenhede ondervind. Unpublished B Arbeidsterapie 1V – research project. Western Cape: Stellenbosch University. 2005.
46. Steyn NP. Development and Validation of a questionnaire to test knowledge and practices of dietitians regarding dietary supplements. MPH dissertation. Cape Town: University of Cape Town. 2003.
47. Krueger, RA, Casey MA. *Focus Groups*. 3<sup>rd</sup> ed. Thousand Oaks: Sage Publications, 2000
48. Dawson S, Manderson L, Tallo VL. *A Manual for the use of Focus Groups*. <http://www.unu.edu/unupress/food2/UNIN03E/UIN03E00.HTM>. 1993. Accessed: 5 December 2004
49. Kondraki NL, Wellman NS, Amundson DR. Content Analysis: Review of Methods and Their Applications in Nutrition Education. *Journal of Nutrition Education and Behaviour* 2002; 34: 224 - 230.
50. Daffue Y. IT Department (Statistics), HPCSA. Pretoria: E-mail communication, [YvetteD@hpcsa.co.za](mailto:YvetteD@hpcsa.co.za). 8 December 2006.
51. ADSA National Office. Johannesburg: Telephonic communication, December 2006.

52. Babbie, E. The Basics of Social Research. 3<sup>rd</sup> ed. Belmont: Thompson Wadsworth, 2005.
53. CPD Audit Report on Practitioners from the Professional Boards for Medical Technology and Optometry and Dispensing Opticians. HPCSA. Pretoria. 2006
54. Your guide to our standards for continuing professional development. Brochure. Health Professions Council. London, May 2006.
55. Pistorius G J. Report: Medical and Dental Professions Board- Continuing Professional Development. 2003.
56. Bulletin. Newsletter of the Health Professions Council of South Africa. April 2006.
57. Jeffers BR. Continuing Education in Research Ethics for the Clinical Nurse. The Journal of Continuing Education in Nursing 2002; 33: 265 - 269.
58. Andrews DH, Fostering Ethical Competency: An ongoing Staff Development Process that encourages Professional Growth and Staff Satisfaction. The Journal of Continuing Education in Nursing 2004; 35: 27 - 33.



**APPENDICES**

**APPENDIX 1****Board notice 122 of 2001  
HPCSA- Rules relating to continuing professional development in dietetics****BOARD NOTICE 122 OF 2001****HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA****RULES RELATING TO CONTINUING PROFESSIONAL DEVELOPMENT IN DIETETICS**

The Health Professions Council of South Africa has, in terms of section 26 read with section 15B of the Health Professions Act, 1974 (Act No. 56 of 1974), made the rules set out in the Schedule.

**SCHEDULE****DEFINITIONS**

1. In these rules “**the Act**” means the Health Professions Act, 1974 (Act No. 56 of 1974), and, unless inconsistent with the context-

“**board**” means the Professional Board for Dietetics established by Government Notice No. R. 75 of 16 January 1998;

“**continuing professional development**” means the continuing education and training referred to in section 26 of the Act and prescribed in terms of these rules.

**REQUIREMENTS**

2. Any dietitian whose name on 1 September 2001 appears on the register of dietitians kept in terms of section 18 of the Act, shall be required to comply with the conditions of continuing professional development laid down in these rules as a prerequisite for such dietitian to retain his or her registration in terms of the Act.
3. Any person who, after 1 September 2001, registers for the first time in terms of the Act as a dietitian in any category of independent practice or public service, shall be required to comply with the conditions of continuing professional development laid down in these rules from the following year, which shall be a prerequisite for such dietitian to retain his or her registration in terms of the Act.
4. Any person whose name had been erased from the register of dietitians shall be subject to compliance with any condition(s) which the board may specify prior to the restoration of the name of such practitioner to the relevant register.
5. For the purpose of continuing professional development, every dietitian shall, as from 1 September 2001, be required to accumulate at least 50 points within any one-year. Points accumulated in excess of 50 during any one year may be transferred to the subsequent year only. A maximum of 40 points may be transferred in any one year: Provided that, if such dietitian does not accumulate the prescribed minimum in any one-year, he or she shall be permitted to obtain the required points in the subsequent year.

6. The 50 points prescribed in rule 5 shall be accumulated by way of different educational or developmental activities accredited by the board in any of the following categories of activities:
- (1) Organisational activities;
  - (2) Small-group activities;
  - (3) Individual activities;
  - (4) Any other activity or category of activities which the board may accredit from time to time.
7. In complying with the requirements no more than 80% of points may be obtained in any one category.
8. In complying with the requirements, at least 2 points per annum shall have to be obtained by every dietitian in professional ethics.
9. Deferment of compliance with the requirements of continuing professional development may only be granted by the board on application to individual practitioners on submission of adequate reasons and subject to such requirements as the board may determine.
10. In the event of a dietitian not complying with the conditions specified in these rules within the prescribed period of time, the board may impose any one or more of the following conditions, namely-
- (a) Grant the dietitian deferment;
  - (b) Require the dietitian to follow a remedial programme of continuing education and training as specified by the board;
  - (c) Require the dietitian to write an examination as determined by the board;
  - (d) Erase the name of the dietitian from the relevant register.

---o0o---

Guidelines for compulsory continuing professional development for dietitians  
(2003)

**PROFESSIONAL BOARD FOR DIETETICS**

**GUIDELINES FOR COMPULSORY  
CONTINUING PROFESSIONAL  
DEVELOPMENT (CPD) FOR  
DIETITIANS**

**2003**



## TABLE OF CONTENTS

<b>1.</b>	<b>INTRODUCTION .....</b>	<b>118</b>
<b>2.</b>	<b>DEFINITIONS AND TERMINOLOGY .....</b>	<b>118</b>
<b>3.</b>	<b>CPD REQUIREMENTS .....</b>	<b>118</b>
<b>4.</b>	<b>ADMINISTRATION.....</b>	<b>119</b>
<b>5.</b>	<b>THE CPD COMMITTEE STRUCTURE AND TERMS OF REFERENCE.....</b>	<b>120</b>
5.1	CPD COMMITTEE STRUCTURE .....	120
5.2	TERMS OF REFERENCE.....	120
<b>6.</b>	<b>FUNCTIONING OF THE CPD OFFICE .....</b>	<b>121</b>
6.1	JOB DESCRIPTION AND RESPONSIBILITIES OF THE CPD OFFICER.....	121
6.2	ACCREDITATION OF ACTIVITIES AND MANAGEMENT OF ATTENDANCE .....	122
<b>7.</b>	<b>FINANCIAL IMPLICATIONS FOR THE INDIVIDUAL DIETITIAN .....</b>	<b>122</b>
7.1	SERVICES OFFERED FOR THE ADMINISTRATIVE FEE .....	123
7.2	LOWER PAYMENT BY ADSA MEMBERS .....	123
7.3	NON PAYMENT OF THE ADMINISTRATIVE FEE .....	124
<b>8.</b>	<b>PRINCIPLES OF POINT ALLOCATION.....</b>	<b>124</b>
<b>9.</b>	<b>POINT SYSTEM .....</b>	<b>125</b>
9.1	CATEGORY 1: ORGANISATIONAL ACTIVITIES.....	125
9.2	CATEGORY 2: SMALL GROUP ACTIVITIES.....	125
9.3	CATEGORY 3: INDIVIDUAL ACTIVITIES .....	125
9.3.1	<i>Self-study – structured assessment of activities .....</i>	<i>125</i>
9.3.2	<i>Articles published in journals for health professionals .....</i>	<i>126</i>
9.3.3	<i>Paper and poster presentations at congresses/symposiums/other scientific meetings subject to peer reviewing and managed by a scientific committee .....</i>	<i>126</i>
9.3.4	<i>Relevant additional qualifications obtained .....</i>	<i>127</i>
9.3.5	<i>Relevant non-degree, non-diploma courses.....</i>	<i>127</i>
9.3.6	<i>Examinations/Assessments.....</i>	<i>127</i>
9.3.7	<i>Teaching or training or presenting to health professionals (registered with statutory councils).....</i>	<i>128</i>
9.3.8	<i>Development of material or other related professional activities for health professionals .....</i>	<i>128</i>
9.3.9	<i>Professional involvement.....</i>	<i>128</i>
9.3.10	<i>Presentations to the lay public.....</i>	<i>129</i>
9.3.11	<i>Publications for the lay public.....</i>	<i>129</i>
9.3.12	<i>Books.....</i>	<i>129</i>
<b>10.</b>	<b>PROCEDURE FOR APPLICATION OF CPD POINTS .....</b>	<b>130</b>
10.1	CATEGORY 1: ORGANISATIONAL ACTIVITIES.....	130
10.2	CATEGORY 2: SMALL GROUP ACTIVITIES.....	130
10.3	CATEGORY 3: INDIVIDUAL ACTIVITIES .....	130
10.4	DIETITIANS RESIDING OUTSIDE THE RSA.....	130
<b>11.</b>	<b>ACTIVITIES THAT DO NOT QUALIFY FOR CPD POINTS .....</b>	<b>130</b>
<b>12.</b>	<b>DEFERMENT.....</b>	<b>131</b>
12.1	CONDITIONS FOR GRANTING DEFERMENT .....	131
12.2	RESPONSIBILITIES OF THE DIETITIAN IF DEFERMENT HAS BEEN GRANTED.....	131
12.3	PROCEDURES FOR APPLYING FOR DEFERMENT .....	132
12.4	CANCELLATION OF DEFERMENT .....	132
12.5	RETURNING TO CPD AFTER A PERIOD OF DEFERMENT .....	132
<b>13.</b>	<b>VOLUNTARY REMOVAL OF NAME FROM THE REGISTER .....</b>	<b>133</b>
<b>14.</b>	<b>RETIREMENT .....</b>	<b>134</b>
<b>15.</b>	<b>NON-COMPLIANCE WITH CPD REQUIREMENTS .....</b>	<b>134</b>
<b>16.</b>	<b>PROVIDERS OF CPD ACTIVITIES.....</b>	<b>135</b>

<b>17.</b>	<b>ACCREDITORS OF CPD ACTIVITIES.....</b>	<b>135</b>
<b>18.</b>	<b>APPROVED ACCREDITOR(S) OF CPD ACTIVITIES .....</b>	<b>136</b>
<b>19.</b>	<b>TAX.....</b>	<b>136</b>
<b>20.</b>	<b>CONTACT DETAILS OF ADSA-CPD ACCREDITOR.....</b>	<b>136</b>
<b>21.</b>	<b>INTERNET CPD INFORMATION.....</b>	<b>136</b>
	<b>ADDENDUM A.....</b>	<b>137</b>

## 1. INTRODUCTION

The Continuing Professional Development (CPD) for **all registered dietitians** became **compulsory on**

**1 September 2001** according to the resolution of the Professional Board for Dietetics in terms of Section 26 of the Health Professions Act. See Addendum A for a copy of the Act.

The CPD Committee has made some changes to the CPD guidelines, which were applicable during the first year of compulsory CPD. These changes are based on the experience gained by the ADSA-CPD Accreditor and are aimed at making the system user-friendly and cost-effective.

## 2. DEFINITIONS AND TERMINOLOGY

In these guidelines:

- “the Act” means the Health Professions Act, 1974 (Act No. 56 of 1974);
- “Professional Board” means the Professional Board for Dietetics established by Government Notice No. R75 of 16 January 1998;
- “HPCSA” means the Health Professions Council of South Africa;
- CPD means the continuing professional development referred to Section 26 of the Act and prescribed in terms of the rules;
- “practitioner” means a Dietitian registered in terms of the Act;
- “ADSA” means the Association for Dietetics in South Africa.

**Definition of CPD:** The cornerstone of any profession is the continuous pursuit of knowledge and skills. CPD is the education and training directly related to dietetics/nutrition, which is undertaken beyond the academic requirements for entry into the profession of dietetics. It encompasses one or more of the areas within the scope of dietetic practice, namely therapeutic nutrition, community nutrition and food service administration, including the management thereof. CPD is important in maintaining and enhancing the image of dietitians as professionals who are credible, responsible and accountable for maintaining high standards of professional practice. It offers members opportunities to move from their present level of practice to a higher level of practice through planned professional growth. CPD, therefore, refers to any activity where the individual has **learned** something new (i.e. updated, applicable and implementable) and/ or where a **new skill** has been acquired. This definition forms the basis on which the CPD Committee will accredit activities.

**Professional ethics (i.e. right vs wrong in a given context)** refers to any aspect relating to the care of a patient/client, practice management and/or professional conduct.

## 3. CPD REQUIREMENTS

- 3.1 Any dietitian whose name appears on the register of dietitians kept in terms of Section 18 of the Act from 1 September 2001 shall be required to comply with the conditions of CPD laid down in these guidelines as a prerequisite for such dietitian to retain his/her registration in terms of the Act.
- 3.2 Any person who, after 1 September 2001, registers for the first time in terms of the Act as a dietitian in any category of independent practice or public service, shall be required to

comply with the conditions of CPD laid down in these rules from the following year, and shall be a prerequisite for such dietitian to retain his/or her registration in terms of the Act.

- 3.3 Any person whose name had been erased from the register of dietitians shall be subject to compliance with any condition(s) that the Professional Board may specify prior to the restoration of the name of such practitioner to the relevant register.
- 3.4 For the purpose of CPD every dietitian shall, as from 1 September 2001, be required to accumulate at least **50 points** within any **one-year**. Points accumulated in excess of 50 during any one-year may be transferred to a maximum of 40 points to the subsequent year only. A maximum of 40 points may be transferred to the next year.

If a dietitian does not accumulate the prescribed minimum in any one year, he or she shall be permitted to obtain the required points in the subsequent year.

The CPD year cycle runs from 1 January to 31 December of any given year. The first compulsory cycle started on 1 September 2001 and ended at 31 December 2002, thus extending over a period of 16 months. From 2003 the cycle will run from 1 January to 31 December.

- 3.5 The 50 points prescribed in guideline 3.4 can be accumulated by way of different educational or developmental activities accredited by the Professional Board in any of the following categories of activities:
- Category 1: Organisational activities;
  - Category 2: Small-group activities;
  - Category 3: Individual activities.
- 3.6 In complying with the requirements **no more than 80%** of points may be obtained **in any one category per one-year cycle**.
- 3.7 In complying with the requirements at least **2 points in professional ethics** shall have to be obtained by every dietitian per year.
- 3.8 CPD for dietitians doing community service: dietitians are exempted from CPD while doing community service. The decision will be revised as soon as sufficient experience is accrued on the opportunities available for CPD activities during community service. No accrual of CPD points during the community service year is therefore required till further notice. The names of these dietitians will not be placed on the CPD database for the community service year.

#### **4. ADMINISTRATION**

The CPD system is administered by the Professional Board under the jurisdiction of the HPCSA. However, the responsibility to accredit and review CPD activities according to specific criteria and guidelines has been delegated to the Association for Dietetics in South Africa (ADSA) (i.e. the Accreditor). The Accreditor is also responsible for capturing of the points accrued by all registered dietitians. The Professional Board will ensure that the responsibilities delegated are carried out in a fair, equitable and responsible manner. The Professional Board therefore retains the right to review or withdraw any delegated responsibilities from the Accreditor (or any future accreditors), should the circumstances so require.



It is important to note that **prior approval of activities** for CPD purposes (Categories 1 and 2) must be obtained from the Accreditor by provider bodies. The Accreditor in consultation with the Professional Board's CPD Committee will furnish the providers of such activities with the criteria and guidelines for approval and for the allocation of points. Approved activities will be allocated a specific CPD reference number. This number should be used when advertising the activity as well as on the proof of attendance certificate and the attendance register.

Practitioners will receive yearly statements from the Accreditor regarding their CPD point status. The point status of all dietitians on the CPD database will also be sent through by the Accreditor to the HPCSA. For control purposes practitioners may be required to submit documentation to the Professional Board regarding the number of points in the respective categories of CPD activities that they have accumulated during the specific CPD year cycle.

**Practitioners should ensure that they retain copies of all documentation regarding CPD activities.**

## **5. THE CPD COMMITTEE STRUCTURE AND TERMS OF REFERENCE**

### **5.1 CPD Committee structure**

In terms of Regulation 2 of the "Regulations relating to the Functions and Functioning of Professional Boards", the Professional Board at its first meeting each year, has to appoint Committees which will function until the first meeting of the Professional Board in the following year. The composition, quorum and terms of reference of each Committee have to be determined by the Professional Board.

The CPD Committee reports to the Professional Board and is responsible for the sound development of the CPD system for dietitians according to the Terms of Reference. The CPD Committee is constituted by three members of the Professional Board, a representative of ADSA and a representative of each Accreditor.

### **5.2 Terms of Reference**

- 5.1.1 Promote an awareness of the need for CPD in collaboration with the full Professional Board.
- 5.1.2 Liaise with ADSA Executive Committee via the portfolio holder for training and career development.
- 5.1.3 Make recommendations to the Professional Board regarding revision of guidelines on point allocation if required.
- 5.1.4 Set criteria standards (including point allocation) for the accreditation of programmes and activities.

- 5.1.5 Discuss CPD point allocation for activities not listed in the guidelines, cases where the CPD officer cannot deal with the specific matter, discrepancies, queries, etc.
- 5.1.6 Deal with and finalise all activities that the Accreditor has recommended for accreditation.
- 5.1.7 Evaluate applications for new accreditor appointment(s) and make recommendations to the Professional Board.
- 5.1.8 Deal with requests for deferment and re-registration requests and make recommendations to the Professional Board.
- 5.1.9 Deal with requests for accreditation of activities where the Accreditor is involved.
- 5.1.10 Liaise with the HPCSA CPD Section.
- 5.1.11 Appoint ad hoc members to the CPD Committee as may be required.
- 5.1.12 Report to the Professional Board for Dietetics on all matters referred to above.

## **6. FUNCTIONING OF THE CPD OFFICE**

### ***6.1 Job description and responsibilities of the CPD Officer***

All secretarial and administration functions to run an efficient and effective CPD Office.

- 6.1.1 Accreditation of CPD activities
  - a. Accredite CPD activities for dietitians according to the guidelines;
  - b. Inform providers of the accreditation;
  - c. Develop and maintain a database of all activities accredited;
  - d. Updating the ADSA website on activities accredited for which the Providers gave permission for advertising.
- 6.1.2 CPD database for dietitians
  - a. Establish and maintain a database of the CPD points accrued by all dietitians;
  - b. Issue annually a CPD point status report to dietitians;
  - c. Update changes to the database (address changes, new practitioners, etc.).
- 6.1.3 Establishment of communication lines and maintenance of effective communication with
  - a. Professional Board for Dietetics;
  - b. CPD Manager and Officer of the HPCSA;
  - c. ADSA Executive committee and/or management committee;
  - d. Providers of activities;
  - e. Individual dietitians.
- 6.1.4 Prepare the agenda and keep the minutes of the CPD Committee meetings.
- 6.1.5 Financial management
  - a. Submit a budget annually;
  - b. Develop and update a fee structure;
  - c. Development and maintain a bookkeeping system;

- d. Invoice Providers of activities according to the approved fee structure;
- e. Invoice dietitians according to the approved fee structure;
- f. Receive payment from Providers;
- g. Receive payment from dietitians.

6.1.6 Development of policy and procedure documentation.

6.1.7 To evaluate applications for deferment and make recommendations to the Professional Board for Dietetics.

## **6.2 Accreditation of activities and management of attendance**

6.2.1 Evaluate proposed CPD activities with a view to their adequacy, appropriateness, professional contents and proposed points value.

6.2.2 Finalise the accreditation of all activities in collaboration with the CPD Committee.

6.2.3 Allocate the accreditation number.

6.2.4 Communicate the accreditation number and points allocated to CPD activities to the Providers.

6.2.5 Monitor the activities of Providers to ensure that the agreed upon requirements had been met.

6.2.6 Receive all attendance lists of activities accredited.

6.2.7 Maintain a record of approved activities on a database.

6.2.8 Capture all points accrued by dietitians on the database.

6.2.9 Submit the points accrued by dietitians electronically to the CPD Manager of the HPCSA.

6.2.10 Reach decisions on a consensus basis, and if not possible, the majority decision will apply.

## **7. FINANCIAL IMPLICATIONS FOR THE INDIVIDUAL DIETITIAN**

ADSA has been appointed as the Accreditor. The ADSA CPD Office is fully responsible for all administration of the CPD system for dietitians. In order to run an effective and efficient CPD office it is required of each dietitian to pay a yearly administrative fee on receipt of an invoice. The administration fee will be revised on a yearly basis.

## **7.1 Services offered for the administrative fee**

The CPD Office offers the following for the administrative fee

- 7.1.1 Accreditation of Category 3 activities (individual activities - excluding articles with questions).
- 7.1.2 Answering of questions/queries (telephonic, e-mail and mail).
- 7.1.3 Correspondence of CPD information.
- 7.1.4 Updating of the CPD database for address changes, etc.
- 7.1.5 Updating of the CPD database for points accrued by each individual dietitian.
- 7.1.6 Transferring CPD points to the Professional Board for Dietetics of the HPCSA.
- 7.1.7 Sending out annual statements to all dietitians regarding their point status.
- 7.1.8 All administration related to CPD activities.
- 7.1.9 Updating the ADSA website with information regarding accredited activities (for which the providers gave permission to advertise).

## **7.2 Lower payment by ADSA members**

The administration fee for fully paid-up members of ADSA is lower than that of non-ADSA members. There are various reasons for this of which the following are some of the reasons. Membership of ADSA is taken as on 31 March of each year for the present year (last day for payment of ADSA fees).

- ADSA National Office pays annually 15% of the full membership fee over to the ADSA CPD Office. (It is important to note that the financial management of the ADSA CPD Office is independent of the ADSA National Office);
- The ADSA CPD Office also receives other “services” from ADSA Executive and ADSA National Office that cannot be calculated in financial terms. These benefits include the following and are shared with ADSA full members: updating of the address database; sending out e-mails on behalf of the CPD Office to all ADSA full members; representing ADSA on the CPD Committee (time and expertise); assessment of articles with questions by the ADSA representative (time and expertise);
- However non-ADSA members also benefit from ADSA CPD initiatives without paying for such activities. For example ADSA acts as a joint “Provider” of activities: SA Journal of Clinical Nutrition carrying accredited articles that are accessible to all dietitians and the ADSA/VIC articles mailed to all the dietitians.

### **7.3 Non payment of the administrative fee**

Dietitians have the choice to use the services of the ADSA CPD Office to manage their CPD points. However other services for the management of CPD point are available that can be used by dietitians. *Non-payment of the administration fee by the given date on the invoice will be regarded as an indication that the dietitian prefers to not use the services of the ADSA CPD Office.*

If a dietitian prefers not to pay the administrative fee for the services rendered by the ADSA CPD Office, her/his name will be removed from the ADSA CPD data set. Once removed her/his CPD point status will not be managed (captured and updated) and transferred to the HPCSA. The name of the dietitian will also be removed from the address list and no CPD related information or invitations to CPD activities will be mailed to the dietitian. A fee could be charged to place the name of the dietitian back on the ADSA CPD data set.

## **8. PRINCIPLES OF POINT ALLOCATION**

The allocation of points is based on the following principles and is applicable to all categories, except where stated otherwise:

- 8.1 Fifty points must be accumulated per one-year cycle.
- 8.2 No more than 80 percent of the points may be accumulated in any one category over a one-year cycle.
- 8.3 A minimum of 2 points in professional ethics shall be accrued by all practitioners in each one-year cycle. Professional ethics (i.e. right vs. wrong in a given context) refers to any aspect relating to the care of a patient/client, practice management and/or professional conduct.
- 8.4 All activities to be accredited must be directly dietetics/nutrition (including management) related; beyond entry level, updated, applicable and implementable.
- 8.5 All activities are accredited for a period of one year only.
- 8.6 No extra points will be allocated for the assessment of the participants of any CPD activity.
- 8.7 For **Category 1 and Category 2** the following **additional principles** are applicable:  
The basic premise of the point allocation is that ONE-hour equals ONE point. Activities of less than 45 minutes will not be accredited. If an activity is more than one hour, 30 minutes will be rounded up to 60 minutes. Providers of activities are requested to plan activities in such a way as to enable them to apply for full hours rather than parts thereof.
- 8.8 A workshop will be accredited on the basis of one hour equals one point.
- 8.9 The maximum number of hours that will be accredited for a specific day is 8 hours; equivalent to 8 points.
- 8.10 The same activity/presentation will be accredited once only in a one-year cycle, unless it is updated for which valid proof should be provided.

- 8.11 Points can only be allocated for either the presentation or the attendance of an activity.
- 8.12 The maximum number of points that can be accrued for professional involvement is 8 points per year.
- 8.13 Any activity that is not directly related to dietetics/nutrition, but is related to the practice of dietetics/nutrition, for example computer courses, will be accredited to a maximum of 5 points per any one-year.
- 8.14 Points accumulated in excess of 50 during any one year may be transferred to the subsequent year only. A maximum of 40 points may be transferred to the next year.
- 8.15 Ethics points will not be transferred as ethics points, but as part of the total number of points.

## 9. POINT SYSTEM

### 9.1 **Category 1: Organizational activities**

#### *Attendance of accredited (formal) learning opportunities*

- 1 point per hour;
- These activities must be of a minimum duration of 1 accredited hour;
- These activities include, but are not restricted to the following: Conferences, Congresses, Lectures, Seminars, Refresher courses and Symposia;
- Activities of less than 45 minutes (i.e. single lecture) do not qualify for accreditation;
- Half points are not allocated.

#### **Note**

- Providers are requested to plan activities in such a way that will enable them to apply for full hours rather than parts thereof.

### 9.2 **Category 2: Small group activities**

#### *Participation in accredited (non-formal) learning opportunities*

- 1 point per hour (participants must be actively involved);
- These activities include, but are not restricted to the following: Professional ward rounds; Journal clubs; Small group discussions. A CPD activity, as part of a meeting, could be accredited (according to the CPD Guidelines);
- Activities of less than 45 minutes (i.e. journal club) do not qualify for accreditation;
- Half points are not allocated.

#### **Notes**

- A minimum of 3 relevant health professionals will form a quorum for these activities;
- The definition of a Professional ward round is an activity designed with the sole purpose of professional development, is beyond entry level, not part of daily patient care and can be multi-disciplinary.

### 9.3 **Category 3: Individual activities**

#### **9.3.1 Self-study – structured assessment of activities**

*Update: November 2006*

- Only self-study activities accredited for dietitians will qualify for points;
- These activities include, but are not restricted to the studying of applicable scientific journals, videos and CDRoms;
- Points will be allocated according to the achieved scores;
- The number of points for videos and CDRoms will be accredited on an individual basis.

The following number of points can be obtained for studying an accredited article and answering the preset questions pertaining to an article:

- Article of 5000 words or more in a peer-reviewed journal:
  - Score >75%: 4 points
  - Score 60 – 75%: 3 points
- Article of less than 5000 words in a peer-reviewed journal:
  - Score >75%: 3 points
  - Score 60 – 75%: 2 points
- Other accredited articles of 5000 words or more:
  - Score >75%: 3 points
  - Score 60 – 75%: 2 point
- Other accredited articles of less than 5000 words:
  - Score >75%: 2 points
  - Score 60 – 75%: 1 point

### **9.3.2 Articles published in journals for health professionals**

- Peer reviewed journals:
  - 1<sup>st</sup> author: 15 points
  - Co-author: 10 points
- Non-peer reviewed CPD journals:
  - 1<sup>st</sup> author: 8 points
  - Co-author: 4 points
- Non-peer reviewed journals:
  - 1<sup>st</sup> author: 5 points
  - Co-author: 3 points
- Editorial in a peer reviewed journal:
  - 1<sup>st</sup> author: 8 points
  - Co-author: 4 points
- Referenced Letter to the Editor in a peer reviewed journal:
  - 1<sup>st</sup> author: 4 points
  - Co-author: 2 points

#### **Note**

- Published abstracts of Congresses/symposia/other scientific meetings do not qualify for points.

### **9.3.3 Paper and poster presentations at congresses/symposiums/other scientific meetings subject to peer reviewing and managed by a scientific committee**

- Short papers (< 20 minutes), e.g. Congress papers/posters:
  - 1<sup>st</sup> author: 5 points
  - Co-author: 3 points
  - Presenter of the paper if he/she is not also the first author: 5 points

- Long papers (> 20 minutes), e.g. Invited lectures, keynote addresses: 10 points

**Note**

- Definition: Congress/symposium/other scientific meeting, subject to peer reviewing, means any relevant activity where participation is subject to approval/selection by a scientific evaluation committee/panel;
- Proof of peer reviewing and/or management by a scientific committee must be provided when requesting points.

**9.3.4 Relevant additional qualifications obtained**

- Completed Diplomas:  
Completed diplomas may be submitted to the Accreditor of CPD activities for a recommendation to and approval by the CPD Committee and, if agreed to, will be accredited for CPD purposes.
- Completed degrees:
 

Honours:	50 points
Masters:	75 points
Doctoral:	100 points

**Notes**

- A basic B-degree must be a prerequisite for the Diploma;
- Modules/courses that form part of a formal/structured framework of a post-graduate degree do qualify for accreditation, which is administered by the respective institution;
- The total number of points allocated cannot exceed the maximum nr of points irrespective of the total number of points modules per degree course;
- Any dietitian registered for post-graduate studies may apply for deferment (complete Form CPD 5-DT).

**9.3.5 Relevant non-degree, non-diploma courses**

- 1 point per hour;
- Maximum of 8 points per day;
- Maximum total points for any of these courses: 50 points.

**Note**

- Definition: Activities with duration of more than 1 day in total.

**9.3.6 Examinations/Assessments**

- These activities include, but are not restricted to the following: Moderation of postgraduate examinations; Assessment of theses or scripts.

The following number of points can be obtained:

- Moderation of postgraduate examinations (exam papers):
 

	<i>Honours</i>	<i>Masters</i>	<i>Doctoral</i>
• External examiners	1 points	2 points	3 points
- Postgraduate assessment (thesis assessment)
 

	<i>Honours</i>	<i>Masters</i>	<i>Doctoral</i>
• Promoter	5 points	15 points	20 points



- |                               |          |           |           |
|-------------------------------|----------|-----------|-----------|
| • Co-promoter                 | 3 points | 10 points | 15 points |
| • Internal/external examiners | 3 points | 10 points | 15 points |

**Note**

- Proof of appointment as promoter/examiner must be provided together with the name of the candidate, certified by the head of the relevant department.

**9.3.7 Teaching or training or presenting to health professionals (registered with statutory councils)**

- These activities include, but are not restricted to the following: lectures presented, presentations at workshops, seminars, journal clubs, other small group activities, etc;
- The presenter will be credited as follows:
- If the activity has been accredited as a lecture (Category 1 activity) for dietitians: 3 points per hour;
- If the activity has been accredited as a Category 1 (other than a lecture) or Category 2 activity (for example a small group discussion) for dietitians: 2 points per hour;
- Activities of less than 45 minutes (i.e. single lecture) do not qualify for accreditation;
- Half points are not allocated.

**Note**

- A referenced summary (maximum 2 pages) of the presentation must accompany the application.

**9.3.8 Development of material or other related professional activities for health professionals**

- These activities include, but are not restricted to the following: modules, reports, videos, training manuals, other educational material intended for use amongst health professionals;
- Can be submitted to the Accreditor of CPD activities for a recommendation to and approval by the CPD Committee and, if agreed to, will be accredited for CPD purposes.

**Note**

- A hard copy of the material must be mailed with the application.

**9.3.9 Professional involvement**

- Committee members of Professional/Scientific organisations at executive or branch level: 2 points each per year;
- Ad hoc committee member of an executive committee: 1 point per year;
- Members of Editorial boards of peer reviewed/CPD journals: 1 point per year;
- Reviewing of an article: 2 points per article reviewed;
- Reviewing of a scientific text book (pre-requisites: review must be published or formally requested) 2 points per book
- University evaluations on behalf of the Professional Board: 2 points per evaluation.

**Note**

- Professionals can be awarded points to a maximum of 8 CPD points per any one-year for this sub-category;
- Professional involvement information of ADSA, SASPEN, NSSA, SAJCN and the Professional Board for Dietetics will be submitted by the organisation on behalf of the individual.

#### **9.3.10 Presentations to the lay public**

- These activities include, but are not restricted to the following: lectures presented, modules, reports, videos, training manuals, other educational material intended for use amongst the lay public;
- Referenced presentation: 1 point per hour;
- Other activities can be submitted to the Accreditor of CPD activities for a recommendation to and approval by the CPD Committee and, if agreed to, will be accredited for CPD purposes;
- Activities of less than 45 minutes (i.e. single lecture) do not qualify for accreditation;
- Half points are not allocated.

#### **Note**

- A referenced summary (maximum 2 pages) of the presentation must accompany the application;
- Where applicable, a hard copy of the material developed must accompany the application.

#### **9.3.11 Publications for the lay public**

- Fully referenced articles can be submitted to the Accreditor of CPD activities for a recommendation to and approval by the CPD Committee and, if agreed to, will be accredited for CPD purposes with a maximum of 2 points per article.

#### **Note**

- A hard copy of the article must accompany the application.

#### **9.3.12 Books**

- Fully referenced books can be submitted to the Accreditor of CPD activities for a recommendation to and approval by the CPD Committee and, if agreed to, will be accredited for CPD purposes on an individual basis;
- The following types of books will be considered for accreditation:
  - Referenced textbooks for health professionals (registered with statutory councils)
    - 1<sup>st</sup> author: 15 points
    - Co-author: 10 points
  - Books for the lay public – points will be allocated based on the quality of the book
  - Recipe books with supporting scientific theoretical content.

#### **Note**

- A hard copy of the book must accompany the application;
- If the references are not part of the publication, a complete list must be supplied;
- An additional fee may be asked for the assessment of the book for accreditation.

## 10. PROCEDURE FOR APPLICATION OF CPD POINTS

When applying for CPD points, the **Form CPD 3-DT** must be completed and the relevant documentation as outlined in the checklist (see Form CPD 3-DT) must be attached.

### 10.1 *Category 1: Organisational activities*

- Activities must be accredited before the event;
- Complete the Form CPD 3-DT;
- Refer to the checklist for the additional information required with the application;
- Refer to the fee structure for the payment of the accreditation process.

### 10.2 *Category 2: Small group activities*

- Activities must be accredited before the event;
- Complete the Form CPD 3-DT;
- Refer to the checklist for the additional information required with the application;
- Refer to the fee structure for the payment of the accreditation of the activity.

### 10.3 *Category 3: Individual activities*

- Complete the Form CPD 3-DT;
- Refer to the checklist for the additional information required with the application;
- *Applications for accreditation must be submitted within two months of the activity;*
- Applications for accreditation for professional involvement must be submitted before the end of any one-year cycle;
- *The closing date for applications for accreditation of activities for a given one-year cycle is one month after the end of the previous one-year cycle (i.e. at the end of January for the previous year's CPD activities);*
- Refer to the fee structure for the payment of the administration fee.

### 10.4 *Dietitians residing outside the RSA*

Dietitians residing outside the RSA may apply for the accrual of points as per the application form.

- Complete Form CPD 4-DT;
- Refer to the checklist for the additional information required with the application;
- All the guidelines for Category 1, 2 and 3 activities apply.

## 11. ACTIVITIES THAT DO NOT QUALIFY FOR CPD POINTS

These activities include time spent in planning, organising or facilitating of any activity; published congress proceedings; non-referenced letters to the Editor; non-referenced publications; daily ward rounds; written assignments; compilation of student training manuals for internal use; undergraduate training or lecturing; development of modules/courses that form part of a formal/structured framework of an under- or a post-graduate degree; staff meetings; tours and/or viewing of exhibits

and food preparation demonstrations. Meetings with the sole purpose of marketing/promotion of products also do not qualify for accreditation.

## **12. DEFERMENT**

### **12.1 Conditions for granting deferment**

Dietitians may apply for deferment of CPD. The CPD Committee of the Professional Board will review such applications subjected to such requirements as the Professional Board may determine, in the case of:

- a dietitian who is not practising his/her profession;
- a dietitian who is outside South Africa for a period of time exceeding 12 months *and not employed as a dietitian*;
- a dietitian who is engaged in formal education and training for an additional qualification.

Deferment may be granted for a maximum period of three years. (Deferment will not be granted for a period less than 12 months due to the possibility of catching up with points during the subsequent year.) Any dietitian wishing to re-enter the system after deferment will be subject to the following criteria:

- If deferment was granted for more than 12 months, but for 2 years or less, the dietitian must submit proof of full employment in the profession, and will be allowed to recommence with his/her normal one year CPD cycle at the subsequent CPD year cycle;
- If deferment was granted for more than 2 years, but less than 3 years, the dietitian must submit proof of his/her employment in the interim and accordingly will/might be required to complete a period of supervised practice as determined by the Professional Board in his/her area of practice, where after his/her normal cycle will recommence at the subsequent CPD year cycle;
- If deferment was granted for longer than 12 months and the dietitian did not practice dietetics during the deferment period, he/she will/might be required to either complete a period of supervised practice or write an examination as determined by the Professional Board in all three areas of practice.

Deferment will not be granted for the following circumstances:

- Retrospectively;
- Outside SA and employed as a dietitian.

A dietitian can apply for either deferment or voluntary removal, but not for both.

### **12.2 Responsibilities of the dietitian if deferment has been granted**

It is the responsibility of the dietitian to comply with the conditions of deferment and provide proof of employment to the Professional Board once the period of deferment expires. It is the responsibility of the dietitian to inform the Professional Board if and when the conditions have changed on which basis deferment was granted.

Dietitians are reminded that deferment could have a financial implication for the practitioner.

If deferment has been granted the following will apply:

- The dietitian must still pay the annual HPCSA fee;
- The dietitian does not have to pay the ADSA CPD administration fee;
- The name of the dietitian will be removed from the ADSA CPD data base;
- No CPD points previously accrued will be kept for the dietitian;
- CPD points cannot be accrued during the period of deferment;
- The dietitian's CPD point status will not be managed (captured and updated);
- The dietitian will not receive any CPD related information or invitations to CPD activities from the ADSA CPD Office.

### **12.3 Procedures for applying for deferment**

A dietitian may apply for deferment of CPD to the CPD Committee of the Professional Board for Dietetics of the HPCSA **before the last day of March** annually in terms of Section 26 read with Section 15B of the Health Professions Act, 1974 (Act No. 56 of 1974). The latest Form CPD 5-DT (available from the CPD Officer) must be completed and mailed to The CPD Officer, PO Box 641, Bloemhof 2660 or e-mailed to the CPD Officer at [edelweis@iafrica.com](mailto:edelweis@iafrica.com).

The CPD Committee of the Professional Board will review such applications on an ad hoc basis after submission of an adequate motivation and subject to such requirements as the Professional Board may determine and make a recommendation to the Professional Board for Dietetics.

Deferment will only be considered under the following conditions:

- The application is received before the last day of March of each year; and
- There is no outstanding fees due by the dietitian; and
- There is no disciplinary investigation pending against the dietitian.

The final decision and confirmation of the deferment is the responsibility of the Professional Board. The Professional Board will inform the applicant in writing of the decision.

### **12.4 Cancellation of deferment**

It is the responsibility of the dietitian to apply for cancellation of deferment if her/his situation has changed and he/she can continue with CPD. Such an application must be addressed to the CPD Committee. The CPD Committee will review such an application and make a recommendation to the Professional Board for Dietetics.

The final decision and confirmation of the cancellation of deferment is the responsibility of the Professional Board. The Professional Board will inform the applicant in writing of the decision.

### **12.5 Returning to CPD after a period of deferment**

Once the period of deferment granted has come to an end, it is the responsibility of the dietitian to provide the CPD Committee with the following documentation:

- 12.5.1 If deferment was granted for more than 12 months, but for 2 years or less, the dietitian must submit proof of full employment in the profession, and will be allowed to recommence with his/her normal one year CPD cycle at the subsequent CPD year cycle.
- 12.5.2 If deferment was granted for more than 2 years, but less than 3 years, the dietitian must submit proof of his/her employment in the interim and accordingly will/might be required to complete a period of supervised practice as determined by the Professional Board in his/her area of practice, where after his/her normal cycle will recommence at the subsequent CPD year cycle.
- 12.5.3 If deferment was granted for longer than 12 months and the dietitian did not practice dietetics during the deferment period, he/she will/might be required to either complete a period of supervised practice or write an examination as determined by the Professional Board in all three areas of practice.
- 12.5.4 If deferment was granted because the dietitian was engaged in formal education and training for an additional qualification, CPD points will not be allocated for obtaining the additional qualification. Proof of the additional qualification must be supplied to the CPD Office.
- 12.5.5 If the dietitian cannot commence with participating in CPD activities after the deferment period has come to an end, the Professional Board must be informed immediately with a full motivation for the reasons.
- 12.5.6 All correspondence must be addressed to: The CPD Officer, PO Box 641, Bloemhof 2660.
- 12.5.7 The CPD Committee will evaluate the documentation and make a recommendation to the Professional Board for Dietetics.
- 12.5.8 The final decision and confirmation of commencement with CPD is the responsibility of the Professional Board. The Professional Board will inform the applicant in writing of the decision.
- 12.5.9 The name and details of the dietitian will be added to the CPD database.

### **13. VOLUNTARY REMOVAL OF NAME FROM THE REGISTER**

A dietitian may apply in writing to the HPCSA before the last day of March annually for voluntary removal of his/her name from the register in terms of Section 19(1)(c) of the Act. The correspondence should be addressed to: The Registrar, Professional Board for Dietetics, PO Box 205, Pretoria 0001. If a dietitian has his/her name voluntary removed from the register, the following will apply should the individual wish to reinstate his/her name on the register:

- If a person requests reinstatement after a period of 3 or more years, an examination as determined by the Professional Board must be written in all three areas of practice;
- If a person requests reinstatement after a period of 1-3 years, he/she will be required to complete a period of supervised practice as determined by the Professional Board or write an examination as determined the Professional Board in all three areas of practice;
- If a person was registered with an acceptable other Professional Board or an equivalent institution outside South Africa and complied with the CPD requirements of that institution

he/she may apply for the reinstatement of his/her name by submitting the prescribed documentation.

When the name of a dietitian has been removed from the register, the following will apply:

- The dietitian does not have to pay the annual HPCSA fee;
- The dietitian does not have to pay the ADSA CPD administration fee;
- The name of the dietitian will be removed from the ADSA CPD data base;
- No CPD points previously accrued will be kept for the dietitian;
- The dietitian's CPD point status will not be managed (captured and updated);
- The dietitian will not received any CPD related information or invitations to CPD activities from the ADSA CPD Office;
- The dietitian will not be allowed to practice as a dietitian in South Africa.

Voluntary removal can only take place under the following conditions:

- The application was received before the last day of March of each year; and
- There is no outstanding fees due by the dietitian; and
- There is no disciplinary investigation pending against the dietitian.

A dietitian can apply for either deferment or voluntary removal, but not for both.

#### **14. RETIREMENT**

CPD requirements for retired dietitians will be determined on an individual basis and within the following framework:

14.1 A dietitian who has retired but continues to practice dietetics in whatsoever capacity will be subjected to the CPD regulations pertaining to practicing dietitians in order to remain registered with the Council.

14.2 A dietitian who has retired and ceases to practice dietetics in whatsoever capacity will be exempted from the CPD requirements but can remain registered with the Council on request. The latter should be accompanied by a signed written declaration that the professional concerned will not practice dietetics in whatsoever capacity.

14.3 A retired dietitian who wishes to re-enter the practice of dietetics will be subjected to the same regulations, procedures and requirements pertaining to the reinstatement of practicing dietitians. Any such requests should be made in writing and addressed to the chairperson of the Professional Board, marked for the attention of the accreditor. The CPD committee will assess such applications on an individual basis and make a recommendation to the Professional Board.

#### **15. NON-COMPLIANCE WITH CPD REQUIREMENTS**

See Addendum A for details.

In the event of a dietitian not complying with the any one of the conditions specified in these guidelines within the prescribed period of time, the Professional Board can impose any one or more of the following conditions, namely:

- Request the dietitian to catch up the points in the next year;
- Grant the dietitian deferment;
- Require the dietitian to follow a remedial programme of continuing professional development as specified by the Professional Board;
- Require the dietitian to write an examination as determined by the Professional Board;
- Erase the name of the dietitian from the register.

The name of a dietitian will only be removed if he/she has not obtained the necessary number of points for 3 successive years. Any decisions the Professional Board may take against such professionals will be determined on an individual basis.

Removal of the name of a dietitian from the Register for Dietitians implies explicitly that the professional concerned is not allowed to practice as a dietitian in South Africa.

## **16. PROVIDERS OF CPD ACTIVITIES**

Providers include any body/academic institution such as a faculty/department at a technikon or university, a professional association, scientific society/group, e.g. the Association for Dietetics in South Africa, the South African Society for Parenteral and Enteral Nutrition, the Nutrition Society of South Africa, or any other body/institution offering educational and developmental opportunities to practitioners for CPD purposes; which could also include other related industrial or provider organisations.

Providers of CPD activities are required to submit the proposed programme of activities to the Accreditor(s) for assessment of the educational content and CPD points value thereof **prior** to the activity. Applications for approval of CPD activities must be submitted on the application form marked as Form CPD 3-DT, which will be provided by the Accreditor(s) of CPD activities on request. Only on approval of the proposed activities and on receipt of a CPD reference number from the CPD Accreditor, a provider is allowed to publicise the proposed activity(ies) as being approved for CPD purposes, as well as the accredited points value thereof.

Providers of CPD activities shall issue an attendance certificate to all dietitians who attended the activity, containing at least the name of the dietitian, the CPD reference number and the number of CPD points accrued within 3 months of the activity. For Category 2 and Category 3 activities, these certificates may be given to the individual dietitian at the end of the year. It is expected of all providers of CPD activities to assess the educational component of the CPD activity. The Professional Board reserves the right to request the submission of such assessment.

Providers will be required to pay the due accreditation fee(s). Payment(s) must be made not later than one month from the date of the issuing of the invoice. Failure of payment by a provider will lead to the cancellation of the accreditation of the activity and the dietitians, who have attended such an activity, will be informed accordingly. No CPD points can be accrued for such an activity.

## **17. ACCREDITORS OF CPD ACTIVITIES**



As referred to previously, any professional body or institution could apply to the Professional Board for recognition as an Accreditor of CPD Activities. A prospective Accreditor will be required to submit its application for approval on the relevant application form (Form CPD 2-DT), which could be obtained from the Professional Board. The applicant will be required to specify its expertise in the proposed area(s) as well as its administrative infrastructure.

## **18. APPROVED ACCREDITOR(S) OF CPD ACTIVITIES**

The Association for Dietetics in South Africa (ADSA).

## **19. TAX**

The Professional Board supports the principle that CPD activities should be tax deductible. It is recommended that individual practitioners, in submitting their tax returns, apply for deductions in terms of Section 11 of the Income Tax Act for expenditure incurred in respect of CPD activities.

## **20. CONTACT DETAILS OF ADSA-CPD ACCREDITOR**

All correspondence regarding CPD must be addressed to the Accreditor, PO Box 641, Bloemhof 2660.

E-mail address: [edelweis@iafrica.com](mailto:edelweis@iafrica.com)  
(All forms are also electronically available from the above address.)

## **21. INTERNET CPD INFORMATION**

CPD information is also available on the following websites:

[www.hpcsa.co.za](http://www.hpcsa.co.za)  
[www.dietetics.co.za](http://www.dietetics.co.za)  
[www.sun.ac.za/nicus](http://www.sun.ac.za/nicus)  
[www.sahealthinfo.org](http://www.sahealthinfo.org)

CPD points can be obtained using the Internet (free of charge) at:

[www.sun.ac.za/nicus](http://www.sun.ac.za/nicus)  
[www.nnia.co.za](http://www.nnia.co.za)  
[www.allergyadvisor.com/Educational/index.html](http://www.allergyadvisor.com/Educational/index.html)

**THE DIETITIAN AND THE PROVIDER ARE MUTUALLY RESPONSIBLE TO ENSURE THAT THE MOST UPDATED FORMS ARE BEING USED.**

January 2003

---

BOARD NOTICE  
RAADSKENNISGEWING

---

**BOARD NOTICE 122 OF 2001**

**HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA**

**RULES RELATING TO CONTINUING PROFESSIONAL DEVELOPMENT IN  
DIETETICS**

The Health Professions Council of South Africa has, in terms of section 26 read with section 15B of the Health Professions Act, 1974 (Act No. 56 of 1974), made the rules set out in the Schedule.

**SCHEDULE**

**DEFINITIONS**

1. In these rules “**the Act**” means the Health Professions Act, 1974 (Act No. 56 of 1974), and, unless inconsistent with the context-  
  
“**board**” means the Professional Board for Dietetics established by Government Notice No. R. 75 of 16 January 1998;  
  
“**continuing professional development**” means the continuing education and training referred to in section 26 of the Act and prescribed in terms of these rules.

**REQUIREMENTS**

2. Any dietitian whose name on 1 September 2001 appears on the register of dietitians kept in terms of section 18 of the Act, shall be required to comply with the conditions of continuing professional development laid down in these rules as a prerequisite for such dietitian to retain his or her registration in terms of the Act.
3. Any person who, after 1 September 2001, registers for the first time in terms of the Act as a dietitian in any category of independent practice or public service, shall be required to comply with the conditions of continuing professional development laid down in these rules from the following year, which shall be a prerequisite for such dietitian to retain his or her registration in terms of the Act.
5. Any person whose name had been erased from the register of dietitians shall be subject to compliance with any condition(s) which the board may specify prior to the restoration of the name of such practitioner to the relevant register.

5. For the purpose of continuing professional development, every dietitian shall, as from 1 September 2001, be required to accumulate at least 50 points within any one-year. Points accumulated in excess of 50 during any one year may be transferred to the subsequent year only. A maximum of 40 points may be transferred in any one year: Provided that, if such dietitian does not accumulate the prescribed minimum in any one-year, he or she shall be permitted to obtain the required points in the subsequent year.
6. The 50 points prescribed in rule 5 shall be accumulated by way of different educational or developmental activities accredited by the board in any of the following categories of activities:
- (1) Organisational activities;
  - (2) Small-group activities;
  - (3) Individual activities;
  - (5) Any other activity or category of activities which the board may accredit from time to time.
7. In complying with the requirements no more than 80% of points may be obtained in any one category.
8. In complying with the requirements, at least 2 points per annum shall have to be obtained by every dietitian in professional ethics.
9. Deferment of compliance with the requirements of continuing professional development may only be granted by the board on application to individual practitioners on submission of adequate reasons and subject to such requirements as the board may determine.
10. In the event of a dietitian not complying with the conditions specified in these rules within the prescribed period of time, the board may impose any one or more of the following conditions, namely-
- (a) Grant the dietitian deferment;
  - (b) Require the dietitian to follow a remedial programme of continuing education and training as specified by the board;
  - (c) Require the dietitian to write an examination as determined by the board;
  - (d) Erase the name of the dietitian from the relevant register.

---o0o---

**APPENDIX 3**

**Continuing professional development guidelines for health professionals  
(November 2006)**



**CONTINUING PROFESSIONAL DEVELOPMENT  
GUIDELINES FOR THE HEALTH CARE PROFESSIONALS  
NOVEMBER 2006**

## TABLE OF CONTENT

<b>GLOSSARY</b>		<b>141</b>
<b>PREAMBLE</b>		<b>143</b>
<b>1.</b>	<b>INTRODUCTION</b>	<b>144</b>
<b>2.</b>	<b>GENERAL</b>	<b>144</b>
<b>3.</b>	<b>PROCESS</b>	<b>145</b>
	<b>APPLICATION FOR ACCREDITATION AS A SERVICE PROVIDER</b>	<b>146</b>
	<b>PRESENTATION OF AN ACTIVITY BY A SERVICE PROVIDER</b>	<b>146</b>
	<b>INDIVIDUAL CPD ACTIVITY RECORD</b>	<b>147</b>
<b>4.</b>	<b>CONTINUING EDUCATION UNITS (CEUS)</b>	<b>149</b>
<b>5.</b>	<b>HIERARCHY OF LEARNING ACTIVITIES</b>	<b>149</b>
	<b>LEVEL 1</b>	<b>150</b>
	<b>LEVEL 2</b>	<b>150</b>
	<b>LEVEL 3</b>	<b>151</b>
<b>6.</b>	<b>ACTIVITIES THAT DO NOT QUALIFY FOR CEUS</b>	<b>152</b>
<b>7.</b>	<b>NON COMPLIANCE</b>	<b>152</b>
<b>8.</b>	<b>DEFERMENT</b>	<b>153</b>
<b>9.</b>	<b>PRACTITIONERS ABROAD</b>	<b>154</b>
<b>10.</b>	<b>RETIREMENT, ILLNESS AND NON-CLINICAL PRACTICE</b>	<b>154</b>
<b>11.</b>	<b>COMMUNITY SERVICE</b>	<b>155</b>
<b>12.</b>	<b>VOLUNTARY REMOVAL FROM REGISTER: DE-REGISTRATION</b>	<b>155</b>
<b>13.</b>	<b>RESTORATION AFTER ERASURE</b>	<b>155</b>

## GLOSSARY

**Accreditor/s** is a group or institution that meets the criteria set out by the HPCSA CPD Committee. The role of the Accreditor is to review applications for provision of Levels 1 and 2 CPD activities by non-accredited service providers and individuals according to the requirements for service providers and CPD activities; to monitor these activities; and to revise continuing education units (CEUs) allocated where the provider failed to comply with the rules and regulations of the CPD guidelines. Professional Boards may delegate their responsibility of accrediting service providers to Accreditors with the mutual agreement of the Accreditor. **Criteria and guidelines for Accreditors** sets out the criteria and the process to be followed for the review, approval and accreditation of Levels 1 and 2 activities offered by non-accredited Service Providers (organisation and/or individuals), as well as the procedures for record keeping.

**Attendance register** is the record of attendees at any form of learning activity in levels 1 and 2 (where relevant), reflecting the names and HPCSA registration number of those present and their signatures on completion of the activity (once off, at the end of the activity; regularly recurring, on completion of the series). This register must be held by the presenting organisation or institution for three years following the activity; the original register may be called in for validation of a compliance check.

**Compliance checks** of individual practitioners take place at least twice a year on a randomly selected sample of practitioners from every register. The CPD Section of Council conducts the checks. Practitioners submit the information requested by that Department within 21 days of receipt of notification of the compliance draw.

**Continuing Education Units** (CEUs) are the value attached to a learning activity for Continuing Professional Development.

### Continuing Professional Development

In terms of Section 26 of the Health Professions Act, 1974 (Act No. 56 of 1974) the Council may from time to time make rules which prescribe –

- (a) conditions relating to continuing education and training to be undergone by persons registered in terms of this Act in order to retain such registration;
- (b) the nature and extent of continuing education and training to be undergone by persons registered in terms of this Act; and
- (c) the criteria for recognition by the Council of continuing education and training courses and education institutions offering such courses.

**HPCSA CPD Committee** is made up of representatives from each Professional Board and works with the Professional Boards to develop policy proposals for Continuing Professional Development. The Committee is accountable to Council.

**CPD Section** of the Department: CPD, Registrations and Records at the HPCSA administers and monitors the entire CPD process.

**Criteria and guidelines for Service Providers** sets out the criteria and requirements for Accredited Service Providers as well as the learning activities and their CEUs at each level of the hierarchy together with the process to be followed to publicise, present and record the activities.

**Cross accreditation** refers to the fact that if a CPD activity was accredited by an Accreditor for a specific Board, all health care professionals may attend that activity **if there is relevance to their specific scope of practice**. They therefore do not need to also apply for the same activity to be accredited by their Board in order to attend to claim the CEUs accrued for attending that activity.

**Deferment** is formal permission from the HPCSA CPD Committee to defer a practitioner from CPD requirements for a period of time, reasonably determined by the Committee in response to an application. There are conditions for re-entry into practice and CPD.

**HPCSA Individual CPD Activity Record** is the document held by individual health practitioners as a record of every learning activity attended or completed. It should be accompanied by the Attendance Certificates for each event or series of events. For level 3 qualifications, a certified copy of the qualification is required. The record must be regularly updated and current. In the event that a practitioner's name is drawn in the compliance check, the original Individual CPD Activity Record for the previous two years, together with the original attendance certificates and certified copies of qualifications that may have been obtained during this period, must be sent to the CPD Section of Council within 21 days of receipt of notification of the draw.

**Learning activity/ies** are the three levels of activities, those with non measurable outcomes, those with measurable outcomes and those associated with formally structured learning programmes that are eligible for accreditation for CPD and from which Continuing Education Units are obtained.

**National Accreditors Forum** is the structure for the regular meeting of Accreditors at which policy and issues of common concern are discussed. Feedback is to the HPCSA CPD Committee of Council.

**Non-compliance** is the failure of an individual to obtain 30 CEUs and maintain a balance of 60 CEUs in a 24 month period. There are various penalty options; these are applied as appropriate by individual Professional Boards in collaboration with the HPCSA CPD Committee.

**Restoration after erasure** takes place according to conditions that vary, depending upon the duration of the erasure. The HPCSA CPD Committee considers the application and may consult a Professional Board if necessary; the Manager of the CPD Section attends to the technical aspects of restorations to the register once these have been approved.

**Service Provider/s** are the accredited institutions, professional associations or formally constituted professional interest groups, that present learning activities for Continuing Professional Development.

**Shelf life** refers to the time the CEUs will be valid, which is 24 months from the date that the activity took place or ended (in the event of post graduate studies), thus the CEUs have a 'shelf life' of 24 months.

## PREAMBLE

Ethical practice of the health professions requires consistent and ongoing commitment from all concerned to update and develop the knowledge, skills and ethical attitudes that underpin competent practice. This perspective protects the public interest and promotes the health of all members of the South African society.

Guided by the principle of **beneficence**, Health Care Professionals aspire to standards of excellence in health care provision and delivery. The Health Professions Act, 1974 (Act No. 56 of 1974) endorses Continuing Professional Development (CPD) as the means for maintaining and updating professional competence and for ensuring that the public interest will always be promoted and protected or ensuring the best possible service to the community. CPD should address the emerging health needs and be relevant to the health priorities of the country.

In this spirit of dedication to best practice and a desire to act and serve wisely and well, the following Guidelines for Continuing Professional Development through continuing education activities is presented for all Health Care Professionals who are registered with the Health Professions Council of South Africa. The hierarchy of activities set out herein should be viewed from a developmental perspective: learning is structured in a hierarchy from traditional learning experiences such as conference presentations and workshops through to structured courses and quality assurance audits of practices or groups of professionals in their work environments. This should encourage CPD providers to offer CPD activities that will meet the goal of continuing education: the acquisition and maintenance of new, current knowledge, relevant professional skills and ethical professional attitudes with an end benefit to the patient/client.

The system rests on a foundation of trust. The HPCSA believes that Health Care Professionals will commit themselves to meeting the requirement for continuing education in the belief that both they and their patients/clients will reap the benefits of ongoing learning, personal and professional development. The proposals for CPD are consistent with the philosophy of lifelong learning and build on adult education principles.



## 1. INTRODUCTION

The purpose of CPD is to assist practitioners to maintain and acquire new and updated levels of knowledge, skills and ethical attitudes that will be of measurable benefit in professional practice and enhance and promote professional integrity. The beneficiary will ultimately be the patient/client. All registered Health Care Professionals are required to complete a series of accredited continuing education activities each year. The activities are clustered together to represent a hierarchy of learning approaches and strategies. Health Care Professionals should select activities from the hierarchy to meet their particular needs or the demands of their practice environments. It is anticipated that the system will also address the unique South African environment by providing a range of activities that will be readily accessible to all.

The **HPCSA CPD Committee** works with Professional Boards to develop policy proposals for a uniform but flexible system of CPD that will accommodate the diversity amongst health professions; facilitate continuing assessment of all practitioners registered with the HPCSA and the Professional Boards; deal with all CPD related issues, within the existing policy parameters of Council and the Professional Boards; and report thereon to Council and the Professional Boards. All Professional Boards will approve and appoint Accreditors. Professional Boards may designate the function of approving applications for accredited Service Providers to its Accrerator/s. After the election of new board members, Professional Boards will, within the first year, review the existing Accreditors and appoint new Accreditors or re-appoint the existing Accreditors for a further period of five years.

In terms of Section 26 of the Health Professions Act, 1974 (Act No. 56 of 1974) the Council may from time to time make rules which prescribe –

- (a) conditions relating to continuing education and training to be undergone by persons registered in terms of this Act in order to retain such registration;
- (b) the nature and extent of continuing education and training to be undergone by persons registered in terms of this Act; and
- (c) the criteria for recognition by the Council of continuing education and training courses and education institutions offering such courses.

## 2. GENERAL

- The HPCSA CPD System will be administered and monitored by the **CPD Section** of the Council.
- There will be one National Accreditors' Forum with representation from each Professional Board's accreditors.

- A generic set of Guidelines for Accreditors has been developed by the HPCSA CPD Committee in consultation with Accreditors. This will enable the Accreditors to fulfil their mandate easily and speedily and will standardise the process of accreditation.
- **Existing Accreditors** who have already been approved by a Professional Board will continue to function. New Accreditors should apply to the relevant Professional Boards for registration as an Accreditor.
- **Cross-Accreditation** across professions is acceptable if the activity is approved by one accreditor. It is not necessary to have it approved by different accreditors of the other professional boards.
- The implementation of CPD will be delivered through a system of **approved Accredited Service Providers** who will present activity/activities throughout the year.
- A generic set of Guidelines for Service Providers has been developed by the HPCSA CPD Committee in consultation with Accreditors, Service Providers and Professional Boards and these will include criteria for accreditation as a Service Provider.
- **Service Providers** should apply to a Professional Board or its designated functionary to be formally accredited according to the criteria and guidelines determined by the HPCSA CPD Committee. Accredited Service Providers will be allocated a Service Provider specific identification number linked to the relevant profession.
- **Activities** or events will mainly be presented by accredited Service Providers.
- **Individual practitioners** shall attend CPD activities in order to comply with the statutory requirements as determined by the Council. They shall keep a record of their attendance at CPD activities. Health practitioners are encouraged to give feedback to Accreditors and the HPCSA CPD Committee regarding the quality of the activities presented by the Accredited Service Providers.
- **Professional Boards** will ensure that high standards are set and maintained for their Accreditors and accredited Service Providers. A Professional Board or designated functionary will be responsible for conducting quality checks on the activities the Service Providers present to their respective practitioners from time to time while the HPCSA CPD Committee shall consult with representatives from the National Accreditors Forum on matters of policy and quality assurance.

### 3. PROCESS

A departure from the old system will be the accreditation of Service Providers rather than the accreditation of every activity. This means that it will no longer be necessary to accredit every activity. Activities will be presented by accredited Service Providers who will also, under the new system no longer be required to submit any attendance data electronically to the HPCSA. Individual Health Care Professionals will retain certificates of attendance from the accredited Service Providers and keep a record of activities attended and Continuing Education Units (CEUs)

accrued. When an individual or organisation, not accredited as a Service Provider, wishes to present a single Level 1 or 2 activity he/she/it may apply to an approved Accreditor for accreditation of that activity. This new approach will have the positive effect of enhancing the efficiency of CPD delivery and administration.

#### Application for accreditation as a Service Provider

Service Providers shall submit an application for accreditation on the relevant application form. The Guidelines for Service Providers set out all of the information and documentation that should accompany the application. Applications should be accompanied by the relevant fee. The National Accreditors Forum shall together with the HPCSA CPD Committee recommend the scale of fees for the accreditation process.

The Service Provider will be allocated a board specific identification number. This number should appear on all of the accredited Service Provider's documentation. (In those instances where there is a specific need for an individual activity to be accredited an activity number will be provided by the accreditor). Activities for the purpose of training in the use of company products or technological devices should be presented by arrangement with an Accredited Service Provider. Organisations such as private hospitals, private non-profit groups, commercial enterprises or companies that support Health Care Professionals through products or services and individuals may not be Accredited Service Providers.

#### Presentation of an activity by a Service Provider

An accredited Service Provider will publicise the proposed activity/ies together with its CEUs. The activity will take place as advertised. Service Providers shall issue an activity number and keep an attendance record that reflects attendance at a full event or a complete activity. Following the CPD activity Service Providers shall issue an attendance certificate to all practitioners who attended the activity containing:

- the following numbering system to ensure standardisation: Accreditor No/Accredited Service Provider No/Year/Activity No, e.g. MP/A01/P00001/2006/00001);
- the topic of the activity;
- the level of the activity;
- the number of CEUs for that activity;
- the attendance/completion date; and
- the name and HPCSA registration number of the attendee.

**Service Providers shall provide certificates to attendees on completion of the activity or event or a series of events.** If these are not available on the day/on completion of the activity or event they should be sent to attendees within one month. (Note: in those instances where a practitioner completes a structured learning programme for degree or certification purposes, the practitioner is obviously constrained by the administrative process of the providing institution regarding the time delay between completion and formal recognition of the programme; the CPD Section will take this into consideration).

Service Providers shall keep a record of attendance at their continuing professional development activities and shall retain these **for a period of three years after the activity**. These may be required for a compliance check.

The **CPD Section of the Department: CPD, Registrations and Records at the HPCSA** will conduct compliance checks of individual Health Care Professionals at least twice a year on a randomly selected sample of practitioners. The result of this compliance check will be sent to the Professional Boards for action as set out in paragraph 7 of this document. The percentage drawn for the sample will depend on the size of the registers. Practitioners will be obliged to submit the required documents within 21 working days of the date of the audit call.

Individual Health Care Professionals shall ensure that they are in possession of the standard certificate of attendance for every activity they have attended. They shall keep these for at least two years so that their certificates will be available if required for a random compliance check.

#### Individual CPD Activity Record

In future every practitioner shall maintain an official **HPCSA Individual CPD Activity Record** which shall include the following:

- The name and registration number of the practitioner;
- The name and number of the Accredited Service Provider or individual activity accreditation number;
- The topic of the activity;
- The level of the activity;
- The number of CEUs; and
- The attendance/completion date.

This record is the only data collection required by individual practitioners. It should be duly completed so that it accurately reflects a Health Care Professional's CPD activities for the previous 24 months. This is the record that will be required for a compliance check should the practitioner be drawn in the audit sample.

When an individual is drawn in the audit, that professional may submit the data and copies of CPD certificates in one of the following three ways:

- A paper copy of the Excel spreadsheet that records his/her Individual CPD Activity Record (submitted by post to the CPD Section at HPCSA at P O Box 205, PRETORIA);
- Electronic copy of the Excel spreadsheet that records his/her Individual CPD Activity Record (submitted electronically to the CPD Section at HPCSA at [cpd@hpcsa.co.za](mailto:cpd@hpcsa.co.za));
- An Electronic copy of the Excel spreadsheet that has been captured and held by arrangement between the Health Care Professional and a relevant individual or business (submitted electronically to the CPD Section at HPCSA at [cpd@hpcsa.co.za](mailto:cpd@hpcsa.co.za)).

Health Care Professionals who are non-compliant or did not submit their portfolios will automatically be included in the following audit call.

#### 4. CONTINUING EDUCATION UNITS (CEUS)

The following principle applies: Every registered practitioner will be required to accumulate **30 CEUs** per 12 month period. Accrued CEUs for CPD activities will be valid for a period of 24 months hence the required maximum number of CEUs to cover this period will be 60. The purpose of the new approach to CPD is to **reach and MAINTAIN** a level of 60 CEUs at all times and **in any level**. The system operates on a basis of trust. Where applicable, Professional Boards will determine the CEUs required of practitioners who are on the assistant or supplementary registers. CEUs are linked to a hierarchy of learning activities based on whether the outcome is measurable or not, or is a structured learning programme.

**The CEUs will be valid (have a 'shelf life') for 24 months from the date that the activity took place or ended (in the event of post graduate studies). The implication of this decision is that practitioners should aim to accumulate a balance of 60 CEUs by the end of the second year and thereafter top up the balance as the 'sell by date' (24 month validity period) expires.**

CEUs accumulated during the 24 months prior to the implementation date of the new HPCSA CPD System may be credited with proof of certification. In addition, in order to facilitate the implementation of the new system, all practitioners will be given a starting balance of 30 CEUs (or a pro rata allocation for practitioners who are on the assistant or supplementary registers).

In those instances where practitioners are registered in two professions they are required to obtain **30 CEUs per profession per 12 month period**. Practitioners registered in more than one category **within the same Professional Board** should accrue only 30 CEUs per 12 month period. Any person who registers for the first time as a Health Care Professional after 1<sup>st</sup> January of a particular year will commence with his or her CPD programme immediately. Health administrators who are not in clinical practice are required to comply with CPD requirements, unless they are registered in the non clinical register.

#### 5. HIERARCHY OF LEARNING ACTIVITIES

Qualification and certification as a professional health care professional does not guarantee that an individual's proficiency will be maintained for the rest of his/her professional life. There are two primary reasons for this. Firstly the acquisition of new knowledge and skills for any health related field is advancing constantly and this new knowledge is not easily communicated to practitioners. Secondly the information acquired by Health Care Professionals as students becomes obsolete at some point in future. Continuing professional development therefore provides the vehicle for practitioners to acquire new knowledge and skills as well as maintain a core level of competence in their field.

There are three levels of activities, those with non measurable outcomes, those with measurable outcomes and those associated with formally structured learning programmes. **A Practitioner may obtain all of the CEUs in one level or the number of CEUs across different levels depending on personal circumstances and individual learning needs.**

## Level 1

These are activities that do not have a clearly measurable outcome and are presented on a once off non-continuous basis. CEUs are allocated according to time, 1 CEU per hour to a maximum of 8 CEUs per day.

When an event is presented by a non-accredited organisation or individual, the application for accreditation of the single event/activity is submitted to an Accreditor for approval and allocation of an activity number.

Presenters of such activities can be allocated double CEUs, eg. if attendee receives one CEU, presenters can get two CEUs excluding presenters at large group activities who would be allocated CEUs from level 2.

These activities include:

### Small groups

- (a) Breakfast meetings or presentations;
- (b) Formally arranged hospital or inter-departmental meetings or updates;
- (c) Case study discussions;
- (d) Formally organised special purpose teaching/learning ward rounds (not including the routine service ward rounds);
- (e) Formally organised special purpose lectures that are not part of a business meeting;
- (f) Mentoring and supervision activities that are specific to certain professions e.g. psychology;

### Large groups

- Conferences, symposia, refresher courses, short courses without a measurable outcome, international conferences (must be approved by a SA Accreditor (if not accredited/recognised for CEU equivalent in the country where it was held).

## Level 2

Education, Training, Research and Publications.

This includes activities that have an outcome but do not constitute a full year of earned CEUs. (Teaching to undergraduate and postgraduate students, and examining, will not be accredited if these activities fall within a registered Health Care Professional's job description). Presenters/Co-presenters can only claim once for CEUs if the same presentation is given more than once.

	<b>CEUs</b>
a Principal author of a peer reviewed publication or chapter in a book	15
b Co-author of a peer reviewed publication or chapter in a book	5
c Review of an article/chapter in a book/journal	3
d All presenters/authors of a paper/poster at a congress/refresher course	10

e	All co-presenters/co-authors of a paper/poster at a congress/refresher course	5
F	All presenters of accredited short courses	10
g	All co-presenters of accredited short courses	5
h	Interactive skills workshop with an evaluation of the outcome	10 presenter 5 participant
I	Multiple Choice Questionnaires (MCQ) in journals, including electronic journals with a pass rate of 70%;	3 per questionnaire
J	Guest/occasional lecturer at an accredited institution	3 per lecture
k	Health personnel who supervise undergraduates/interns/postgraduates in clinical/technical training in collaboration with an accredited training institution on a regular basis during the academic year (if not in the job description)	2 CEUs per student (max 16 CEUs per calendar year)
L	Part time or external examiner of Master and Doctoral thesis on completion (5 CEUs per thesis)	5 CEUs per thesis
m	Dedicated workshops, lectures, seminars on ethics (not including general presentations with a so-called component on ethics)	2 CEUs per hour
n	Single modules of Masters degrees with part-time enrolment for study for non degree purposes	5 CEUs on completion of module
o	<u>Professional Interest Groups</u> (this could include Journal Clubs if compliant with the criteria) that are formally constituted and present a regularly recurring programme that extends for one year with a minimum of 6 meetings per year. (up to 3 CEUs per attendee per meeting). These activities are ongoing or have a measurable outcome that is assessed according to criteria determined by the group, which may be inter disciplinary.	3 CEUs per attendee per meeting

### Level 3

**This comprises structured learning by which is understood a formal programme that is planned and recorded, presented by an accredited training institution, evaluated by an accredited assessor, with a measurable outcome.**

This category will earn the required CEUs for a year i.e. 30.

Activities include:

- (a) Postgraduate degrees and diplomas that are recognised as additional qualifications by the relevant Professional Board. At the end of each year of study (not exceeding the normal duration of the degree), 30 CEUs may be claimed upon submitting an academic report on progress. An additional 30 CEUs may be claimed on successful completion of the qualification;
- (b) Short courses with a minimum of 25 hours of direct contact time with additional clinical hands-on training, plus a formal assessment of the outcome;
- (c) Learning portfolios;
- (d) Practice audit.



The latter are two new proposals from the HPCSA CPD Committee and it is recommended that individual Professional Boards determine the scope and content of these activities together with the necessary protocols and accompanying documentation.

## 6. ACTIVITIES THAT DO NOT QUALIFY FOR CEUS

The following activities will not qualify for CEUs:

- time spent in planning, organising or facilitating any activity;
- published congress proceedings;
- non-referenced letters to the Editor of accredited journals;
- daily ward rounds;
- written assignments;
- compilation of student training manuals for internal use;
- staff and/or administrative meetings;
- tours and/or viewing of exhibits and technological demonstrations;
- membership of professional bodies, Professional Boards or associations;
- holding a portfolio on the professional body's executive or council structure; and
- presentations and publications to the public.

Meetings arranged by pharmaceutical companies and manufacturers or importers of products and technical devices (including assistive device technology) or their representatives purely for the purpose of **marketing and/or promoting their products** are not eligible for accreditation.

## 7. NON COMPLIANCE

The CPD Section will investigate the reasons for non compliance whereafter the names of *bona fide* non-compliant practitioners will be sent to the Professional Boards for noting. At the same time, those names will be submitted to the HPCSA CPD Committee for action in consultation with the relevant Professional Board.

The following actions may be taken:

- A letter will be sent to the non-compliant practitioner requesting a reason for the non-compliance. A practitioner will be required to furnish the CPD Section with a letter of explanation within two weeks of receipt of the letter of enquiry from the CPD Section.
- Should the explanation be acceptable, the practitioner will be given six months to comply with the CPD requirements. Evidence of such compliance must be received by the CPD Section within two weeks of the end of the six month period.
- Should the practitioner not comply with the requirement, his/her name will be forwarded without delay to the Committee of Preliminary Enquiry. The Committee of Preliminary Enquiry may decide on the basis of evidence to grant a final additional 6 month period to comply with the CPD requirements.

Should the practitioner still not comply with the CPD requirements within the second six month period, one of the following actions will be taken:

- Registration in a category that will provide for supervision as considered appropriate by the relevant Professional Board;
- A remedial programme of continuing education and training as specified by the Professional Board;
- An examination as determined by the Professional Board;
- Suspension from practice for a period of time as determined by the Professional Board; or
- Any other action as recommended by the Professional Board.

## 8. DEFERMENT

Practitioners may apply for deferment of CPD and the HPCSA CPD Committee will review such applications individually on an *ad hoc* basis. The application should be strongly motivated with appropriate evidence/documentation.

Deferment may be granted in the case of:

- a) a practitioner who is outside South Africa for a period of time exceeding 12 months **and is not practising his/her profession**;
- b) a practitioner who is outside of South Africa and practising in a country where formal continuing professional development does not take place;
- c) a practitioner who is registered for an additional qualification but is of the view that s/he will not meet the outcome within two years and thus will not be able to claim CEUs.

Deferment may be granted for a maximum period of three years. Deferment will not be granted for a period of less than 12 months (in view of the fact that a professional may collect CEUs in a following year).

Any practitioner mentioned in the above paragraphs wishing to re-enter the system after deferment will be subject to the following conditions:

- If deferment was granted for more than 12 months but less than two years, proof of full employment in the profession during that time should be submitted and the practitioner will, on review by the HPCSA CPD Committee, be allowed to recommence the CPD year immediately.
- If deferment was granted for more than two years but less than three years, the practitioner must submit proof of his/her employment during that time and the practitioner will, on the recommendation of the HPCSA CPD Committee, be required to complete a period of

supervised practice as determined by the Professional Board in his/her area of practice, and will recommence the CPD year immediately.

- If deferment was granted for longer than 12 months and the practitioner did not practice his/her profession during the deferment period, he/she will be required to complete a period of supervised practice as determined by the Professional Board in his/her area of practice.
- If deferment was granted because the practitioner was engaged in formal education and training for an additional qualification, CEUs will not be allocated for obtaining the said additional qualification. Proof of the additional qualification must be supplied to the CPD Section and the practitioner will recommence the CPD year immediately.

## 9. PRACTITIONERS ABROAD

Practitioners who are practising abroad in countries where a continuing professional development system is in place **should comply** with the requirements in that country. They should retain documentary proof of attendance at CPD activities for submission in the event of being drawn in the sample audit. For re-registration purposes documentary proof of compliance must be submitted for continuing professional development purposes in South Africa. This may be in the form of a letter from the accrediting authority in the country concerned.

When practitioners who are actively practising in South Africa attend an accredited professional or academic meeting or activity abroad it will be recognised for CPD purposes. The activity attended abroad should be accredited by an Accreditor in South Africa (if not accredited/recognised for CEU equivalent in the country where it was held). This activity should be reflected in the Individual CPD Activity Record (Form CPD1) of the practitioner.

## 10. RETIREMENT, ILLNESS AND NON-CLINICAL PRACTICE

Deferment will not be granted to practitioners who are retired or practitioners who are not practising due to ill health. Professional Boards are establishing a separate register for these categories for Health Care Professionals. Practitioners who are registered in the non-clinical practice register will be exempted from complying with Continuing Professional Development and when they apply to return to the clinical registers, the application must be submitted to the HPCSA CPD Committee who will in conjunction with the Professional Board concerned, decide on the conditions for registration, which may be any or all of the following:

- (i) passing a Professional Board examination;
- (ii) working under supervised practice; and
- (iii) collecting at least one year's total CEUs.

## 11. COMMUNITY SERVICE AND INTERNSHIP

Practitioners in internship and community service are not required to comply with CPD during the internship and Community Service years but are encouraged to attend and may accrue CEUs which will be to their credit for the full 24 months from date of accrual.

## 12. VOLUNTARY REMOVAL FROM REGISTER: DE-REGISTRATION

A practitioner must apply in writing to the HPCSA before the **last day of March** for voluntary removal of his/her name from the register in terms of Section 19(1) (c) of the Act. If a practitioner's name is voluntarily removed from the register and the practitioner was in no way practicing his/her profession, the following will apply on request for a reinstatement:

- If a person requests reinstatement following a period of one to three years, a period of supervised practice as determined by the Professional Board will be required; or alternatively a written and clinical examination in relevant areas of practice may be recommended.
- If a person requests reinstatement after a period of three years, a written and clinical examination as determined by the Professional Board will be conducted in relevant areas of practice.

If a person has been registered with an acceptable other Professional Board or an equivalent licensing institution/body outside South Africa and has complied with the CPD requirements of that institution/body he/she may apply for the reinstatement of his/her name by submitting proof of that registration and compliance with the CPD of that country/institution/body.

## 13. RESTORATION AFTER ERASURE

1. Restoration after erasure in terms of Section 19(1) (d):
  - (a) When a practitioner's name has been erased from the register for more than a year but not exceeding two years, **but the practitioner has been attending CPD activities**, the practitioner shall submit proof of CEUs that may have been collected during this period to the HPCSA CPD Committee before his/her name can be restored to the register.
  - (b) Should such an applicant then have **at least 67% of the required CEUs for that period** and s/he complies with the other requirements for restoration of his/her name to the register, the Senior Manager: CPD, Registrations and Records may approve the application. The HPCSA CPD Committee and the Professional Board should be advised of the fact that a practitioner has been restored to the register as soon thereafter as possible.

- (c) Applicants may be requested to submit to the CPD Section further proof of CEUs that they have collected within three months following restoration to ensure that they are complying with CPD and to identify whether they will have sufficient CEUs for compliance by the date of the following compliance check.
- (d) When a practitioner's name has been erased from the register for more than a year but not exceeding two years but s/he **has not collected any CEUs** the application for restoration must be submitted to the HPCSA CPD Committee for a resolution, which may be any or all of the following:
  - (i) passing a Professional Board examination;
  - (ii) working under supervised practice; and
  - (iii) collecting at least one year's total CEUs.
- (e) When a practitioner's name has been erased from the register for **three years or more** the application must be submitted to the HPCSA CPD Committee for a recommendation to the relevant Professional Board for resolution.

2. Restoration after erasure in terms of Section 42: Guilty of misconduct:

These applications do not fall within the ambit of the HPCSA CPD Committee and must be submitted to the relevant Professional Board.

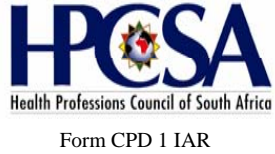
**PROPOSED INTERIM PROCEDURE FOR THE RESTORATION OF NAMES OF PRACTITIONERS TO THE RELEVANT REGISTER:**

In light of the mandate given to the HPCSA CPD Committee and in order to assist with the administration of these applications to prevent long delays in the restoration process, The Senior Manager: CPD, Registrations and Records is authorised to:

- Restore the names of practitioners to the register in terms of the existing procedure without information regarding their CPD status; and
- Process these applications until further notice as determined by the HPCSA CPD Committee of Council.

**Secretariat:**

The secretariat for CPD shall be located in the CPD, Registrations and Records Department of the HPCSA. All correspondence relating to CPD (but not applications for accreditation of activities or Service Providers) should be addressed to the CPD Officer, HPCSA, P O Box 205, Pretoria 0001 or electronically to cpd@hpcsa.co.za.



**HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA**  
**INDIVIDUAL ACTIVITY RECORD**

**Please complete and return to:** The CPD Officer, HPCSA, P O Box 205, PRETORIA, 0001 or submit the above with the supporting documentation electronically to [cpd@hpcsa.co.za](mailto:cpd@hpcsa.co.za) or fax to 012 328 9690.

This record is the only data collection required for individual practitioners. It must be duly completed and accurately reflect your CPD activities. Please attach all relevant certificates.

<b>Professional Board</b>	
<b>Registration No. with HPCSA</b>	
<b>Surname</b>	
<b>First Names</b>	
<b>ID Number</b>	
<b>Date of the Audit</b>	

Please indicate the category in which you are currently working:

Public Service  Training institution  Private Practice  Research  Education  Other.....

**Points accrued** (Please attach certificates)

Name of Provider	Description of Activity/Accreditation Number	Date		Cat 1 Lev 1	Cat 2 Lev 2	Cat 3 Lev 3	Total
		From	To				

Name of Provider	Description of Activity/Accreditation Number	Date		Cat 1 Lev 1	Cat 2 Lev 2	Cat 3 Lev 3	Total
		From	To				

**GRAND TOTAL**

I, the undersigned, certify that the information contained in this Individual Activity Record and the attached certificates are correct in all respects.

\_\_\_\_\_  
**SIGNATURE**  
 /hds

\_\_\_\_\_  
**DATE**

## APPENDIX 4

### Survey questionnaire

#### QUESTIONNAIRE Evaluating the SA CPD System for Dietitians

*(Please answer ALL questions and put an asterisk (\*) in the box where appropriate. Unless otherwise stated, please choose only 1 answer/option per question.)*

#### SECTION A: BIOGRAPHIC DETAILS

##### 1. Gender

Male	
Female	

##### 2. What is your age in years?

.....

##### 3. What is your highest qualification?

Bachelors / Bachelors & postgraduate diploma	
Honours	
Masters	
Doctorate	
Other (specify)	

##### 4. What is your current work status?

Employed, full time	
Employed, part time	
Unemployed	
In compulsory community service	
Other (specify)	

##### 5. If employed, what is your *major* practice area?

Education/academia	
Foodservice management	
Community Nutrition	
Food industry/ Food Company	
Pharmaceutical industry	
Private practice	
Nutritional consultant	
Hospital/clinic –therapeutic	
Nutrition information/publications	
Research	
Registered with the health professional Council of South Africa (HPCSA), but not practicing as a dietitian	



Other (specify)	
-----------------	--

**6. In which province do you live?**

Gauteng		Eastern Cape	
Mpumalanga		Western Cape	
Limpopo		Northern Cape	
North West		Free State	
Kwazulu-Natal			

**7. Are you an ADSA (Association for Dietetics in South Africa) member?**

Yes	
No	

**SECTION B: THE CPD SYSTEM**

**8. Do you understand the way the CPD system is run as a whole?**

Yes	
No	

**9. If not, what is it that you do not understand?**

.....

.....

.....

**10. If you had a CPD related query, who do you usually contact *first*?**

The CPD Office	
ADSA	
HPCSA	
Other (specify)	
Completely Unsure	
Did not need to contact anyone as yet, but have information at hand	

**11. How do you usually communicate with the CPD office, ADSA and HPCSA respectively on CPD- related matters? (1 tick for each for CPD office, ADSA, HPCSA)**

CPD Office	Phone	
	Fax	
	E-mail	
	Post	
	Did not need to contact thus far	
HPCSA	Phone	
	Fax	
	E-mail	
	Post	
	Did not need to contact thus far	
ADSA	Phone	
	Fax	
	E-mail	
	Post	
	Did not need to contact thus far	

**12. How would you rate the quality of service when communicating with the HPCSA about CPD matters?**

HPCSA	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Applicable
Friendly					
Helpful					
Easily contactable					
Query handled efficiently and feedback provided					

**13. How would you rate the quality of service when communicating with ADSA National Office on CPD matters?**

ADSA National Office	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Applicable
Friendly					
Helpful					
Easily contactable					
Query handled efficiently and feedback provided					

**14. How would you rate the quality of service when communicating with the CPD OFFICE?**

The CPD Office	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Applicable
Friendly					
Helpful					
Easily contactable					
Query handled efficiently and feedback provided					

**15. Letters and updates about rules, regulations and changes to the system from the Professional Board or the CPD office is...**

	Easy to understand	Complicated to understand	Never read them	Only scan through because too lengthy to read	Do not receive regularly
Letters from the Professional Board(HPCSA)					
Letters from the CPD office					

**16. Indicate your opinion regarding all CPD-related correspondence received.**

	Too little	Sufficient	Too much	Do not receive regularly
Letters from HPCSA , Professional Board				
Letters from the CPD office				
ADSA e-mails				
CPD information in the South African Journal of Clinical Nutrition (SAJCN)				

**17. Please indicate your feelings about the following time frames...**

	Adequate	Insufficient time	Unfamiliar with time frames	Not applicable to me
Time allocated to request points				
Time allocated for paying CPD fees				

**18. How familiar are you with the procedure and forms involved in applying for points?**

Very familiar	
Have never personally applied for points	
Not sure but have information at hand if needed	
Completely unsure	

**19. The CPD3 form is...**

Easy to complete	
Unnecessary information is required	
Too complicated to complete	
Have not completed one as yet	
Unsure what this is	

**20. How do you feel about the cost of CPD administration fees versus the services rendered?**

.....

.....

.....

**SECTION C – CPD ACTIVITIES AND POINTS**

**21. Have you been keeping a record of all activities attended?**

Yes	
No	

**22. Are you aware that an audit could be carried out on all CPD activities that you have attended and points requested?**

Yes	
No	

**23. Please indicate your usual method(s) of receiving continuing education (Choose a maximum of 3 options only)**

CPD Method	
Attending conferences, congresses and symposiums	
Attending lectures or seminars	
Attending workshops	
Attending journal clubs or small discussion groups	
Reading articles in journals and answering questions	
Reading internet articles and answering questions	
Writing articles	
Presenting a paper, lecture	
Postgraduate studies	
Interactive TV conference	
Other (specify)	
Do not participate in CPD	

**24. If given a choice or preference, please indicate 3 methods of continuing education you would most like to attend/receive?**

- (1<sup>st</sup> most preferred – assign a score of 3)  
 (2<sup>nd</sup> most preferred – assign a score of 2)  
 (3<sup>rd</sup> most preferred – assign a score of 1)

CPD Method	RATING
Attending conferences, congresses and symposiums	
Attending lectures or seminars	
Attending workshops	
Attending journal clubs or small discussion groups	
Reading articles in journals and answering questions	
Reading internet articles and answering questions	
Writing articles	
Presenting a paper, lecture	
Postgraduate studies	
Interactive TV conference	
Other (specify)	

**25. Do you make use of cross-accreditation opportunities?**

Yes	
No	
Not sure what this means	
Did not know that this is available to us	

**26. With regard to CPD activities, how do you feel about the requirement of “not more than 80% of points from any 1 category?” (You may choose more than 1 option)**

Easy to achieve	
Difficult to achieve	
Should be a recommendation rather than a rule	
Not aware of this rule	

**27. What are the main barriers to you participating in CPD activities?  
(Please choose a maximum of 3 only)**

Financial limitations	
Family obligations	
Getting leave from work	
Little/no activities in my geographical area	
Limited or no access to the internet	
Topics are not relevant to my field	
No transport	
Distances too far to travel	
Poor or no notification of CPD events	
Disinterest in CPD activities	
Uninteresting topics with little variety	
There are no barriers to me participating in CPD	
This is not applicable to me as I am not practicing as a dietitian	
Other (specify)	

**28. What was your point status last year (2004)?**

< 25	
25-49	
>50	
Don't know	
Did not participate	

**29. Do you feel that the new ruling to achieve only 30 points annually is...  
(You may choose more than 1 option)**

More reasonable and easier to achieve	
Still too much to achieve	
Too little	
Does not make a difference to me	
Am unaware of this change	

**30. How achievable is the 2 Ethics points required a year?**

Easy to achieve	
Difficult to achieve	
It is possible if I try harder	
Not applicable to me	

**31. With regard to CPD activities to obtain the ethics points, there are...**

Sufficient opportunities available	
Insufficient opportunities available	
Not enough new information presented	
Not applicable to me	

**32. Please indicate which of the following applies to you (You may choose more than 1 option)**

I am unable to attain the annual points	
I barely make the required points	
I easily obtain the points	
I apply for all possible points?	
Participate in CPD mainly for points. Once I am assured that I have all required points, I do not apply further/attend other activities	
I forget to apply for points for myself	
I plan my accrual of points in advance for the year	
I link the attendance of CPD activities to my own career planning	
I don't try to obtain any points at all	

**33. Would you like to be able to access your CPD point status directly via the internet?**

Yes	
No	

**34. Currently, the CPD office keeps a record of all points. How would you feel about keeping your own records entirely, of all activities attended and points accumulated?**

Yes, I would prefer to keep my own records	
No, I would not like to keep my own records	
Do not mind either way	

**35. How much did you spend on CPD activities (approximately) last year (2004)?**

Nothing	
Less than R250.00	
R251.00 – R750.00	
R751.00 – R1500.00	
R1501.00 – R3000.00	
More than R3000.00	

**36. This amount was paid by...**

Yourself	
Yourself and your employer & / a sponsor	
Employer & / a sponsor	

**37. How do you feel about the cost of CPD activities?**

.....  
.....  
.....

**38. What do you think is a strength of the current CPD system?**

.....  
.....  
.....

**39. What do you think is a weakness of the current CPD system?**

.....  
.....  
.....

**40. Do you have a comment or suggestion to improve the current CPD system or would you like it to remain the same?**

.....  
.....  
.....

***Thank you for completing the questionnaire***



**APPENDIX 5**

**Pilot study: Comments on the questionnaire**

1. Was the covering letter & consent form clear and understandable? If not, what changes do you suggest?

.....  
.....  
.....

2. Are the instructions given to complete the questionnaire clear and adequate? If not, what would you change or add?

.....  
.....  
.....

3. Did you understand all questions? If not, which question(s) were difficult to understand and why?

.....  
.....  
.....

4. How long did it take you to complete the entire questionnaire?

.....

5. What additional suggestions do you have to improve the clarity and understanding of the questionnaire?

.....  
.....  
.....

6. Did you experience any difficulty in receiving the questionnaire from your e-mail?

.....

7. Did you experience any difficulty in sending it back to the e-mail address given?

.....

8. Did you have any difficulty contacting the researcher if required?

.....

9. Any additional comments to improve the completion of the questionnaire?

.....  
.....

**APPENDIX 6****Consent form accompanying the survey questionnaire****STUDY INFORMATION AND INFORMED CONSENT TO PARTICIPATE IN  
COMPLETION OF A QUESTIONNAIRE****RESEARCH PROJECT:**

A survey evaluating the South African Continuing Education System for Dietitians:

**STUDY REFERENCE NUMBER...N05/05/080**

**PRINCIPAL INVESTIGATOR:** Mrs. C J Martin  
**ADDRESS:** P O Box 3007  
Lyttelton South  
0176  
Tel: 012-664 7574 / 072 386 2358  
e-mail: clairejm32@yahoo.co.uk

**1. You are invited to participate in the above mentioned survey, which is being conducted as part of an M Nutrition degree research project through the Department of Human Nutrition, Faculty of Health Sciences at Stellenbosch University.**

2. The details of the study are as follows:-

**2.1 Aim:**

The primary aim of this study is to conduct an evaluation of the South African CPD system for dietitians by determining the perception of dietitians as well as the views and experiences of key personnel involved in the management and administration of the system.

**2.2 Procedure:**

You will be required to complete a questionnaire and return it via post or e-mail. The questions will be based on your perceptions on how the CPD system for dietitians in South Africa is operating and possible ideas you may have for improvements.

**2.3 Confidentiality:**

All information will be used in a thesis, a publication in a professional journal and supplied to those involved in the administration and management of the CPD system. However, the identity of you the participant will remain undisclosed at all times.

**2.4 Access to findings:**

Upon request, you will be informed of where and how the results will be made available.

**2.5 Voluntary Participation:**

Participation in the project is voluntary and you have the option to refuse to participate.

*2.6 Questions:*

The researcher can be contacted at the above mentioned telephone numbers, e-mail or postal address to ask any questions.

**VOLUNTARY CONSENT:**

**By completing and returning the questionnaire via post/e-mail, you will be consenting to voluntary participation in this project.**

Thank you for participating in this study. Should you at any time require further information, please contact me at the above mentioned contact details.

**APPENDIX 7****Covering letter to the questionnaire**

**Address:** P O Box 3007, Lyttelton South, 0176  
**Tel:** 012-6647574 / 072 386 2358  
**Email:** [clairejm32@yahoo.co.uk](mailto:clairejm32@yahoo.co.uk)

17 October 2005

Dear Dietitian,

**Questionnaire evaluating the SA CPD system for dietitians**

In December 2004, dietitians in South Africa completed their 3<sup>rd</sup> compulsory CPD cycle. Since its introduction as a voluntary system in 1995, the CPD system for dietitians has undergone several changes and has evolved into one that we are all using, and are familiar with today. However, any system that strives for optimum operation should be continually revised and examined for improvements. It is therefore important to conduct some type of evaluation to highlight any problems that may affect our current system in its day-to-day operation. In this regard it is vital to obtain the views and perceptions of all dietitians participating in the CPD system.

As part of an M Nutrition research project through Stellenbosch University, it is hoped that this survey will reveal how **YOU** perceive the system to be running. You are therefore invited, in fact urged to participate in this nationwide survey by completing a questionnaire which will take only 10 minutes of your time. This is really your opportunity to air your opinions about the system that you are part of. Your views and comments are valuable to the decision makers. You can be assured that all information will be handled by the researcher with complete confidentiality, so please answer the questions fully and honestly. The closing date for returning the questionnaires is 4 November 2005.

**To complete the questionnaire and return it electronically, this is what you need to do:**

1. **Save the files attached to this email onto your computer.**
2. **Open the file attached i.e. the "questionnaire.doc" in your word processing application such as Microsoft word.**
3. **The first page in the attachment is a consent form for your information, so please read through and then complete the actual questionnaire.**
4. **Once you have answered all the questions, save the completed "questionnaire.doc" onto your computer for your own records, and reply to this email attaching this completed questionnaire. The email address to reply to is [clairejm32@yahoo.co.uk](mailto:clairejm32@yahoo.co.uk)**
5. **Alternatively, if you do not wish to e-mail it back, you may print the questionnaire and return it via the post to Mrs. C Martin, P O Box 3007, Lyttelton South, 0176 OR fax it to 011 - 500 5900.**

If you do not wish to complete the questionnaire electronically and prefer to receive and complete a printed copy, please e-mail me at the above address or call me at 012-6647574 or 072 386 2358 and a printed questionnaire will be posted to you.

If you have any queries at all in understanding, completion or return of the questionnaire, please feel free to contact me at the above numbers at any time.

I look forward to your contribution.

Yours Faithfully

Claire Martin RD (SA)

## APPENDIX 8

Internal reliability (demonstrated by Chronbach's Alpha) of items from the questionnaire

<b>Item Number</b>	<b>Variable measured</b>	<b>Number of respondents (n)</b>	<b>Chronbach's alpha value</b>
<b>12</b>	<b>Quality of service received by dietitians from the HPCSA in terms of friendliness, helpfulness, contactable, handling of queries.</b>	<b>277</b>	<b>0.97</b>
<b>13</b>	<b>Quality of service received by dietitians from the ADSA office in term of friendliness, helpfulness, contactable, handling of queries.</b>	<b>288</b>	<b>0.98</b>
<b>14</b>	<b>Quality of service received by dietitians from the CPD Office for Dietitians in term of friendliness, helpfulness, contactable, handling of queries.</b>	<b>290</b>	<b>0.97</b>
<b>15</b>	<b>Dietitians understanding of letters regarding rules, regulations and updates from the HPCSA, CPD Office for Dietitians and ADSA.</b>	<b>312</b>	<b>0.65</b>
<b>16</b>	<b>Dietitians' opinion about CPD correspondence from the CPD Office for Dietitians, HPCSA, in ADSA e-mails and journal information.</b>	<b>273</b>	<b>0.69</b>

**APPENDIX 9**

**Consent form for focus groups participants**

**STUDY INFORMATION AND INFORMED CONSENT DOCUMENT FOR INDIVIDUALS PARTICIPATING IN THE FOCUS GROUPS**

**TITLE OF RESEARCH PROJECT:**

Implementation evaluation of the South African Continuing Education System for Dietitians: A survey of views and perceptions.

**REFERENCE NUMBER...**

**PRINCIPAL INVESTIGATOR:** Mrs. C J Martin

**ADDRESS:** P O Box 3007  
Lyttelton South  
0176  
Tel: 012-6647574/ 072 386 2358  
E-mail: clairejm32@yahoo.co.uk

**DECLARATION BY PARTICIPANT**

**I the undersigned,** ..... (Name)  
..... (Address)  
.....  
.....

**I HEREBY CONFIRM THAT:-**

- 1. I have been invited to participate in the above mentioned research project, which is being conducted through the Department of Human Nutrition at Stellenbosch University.
- 2. The following details about the study have been explained to me:-

**2.1 Aim:**

The primary aim of this study is to conduct an implementation evaluation of the South African CPD system (the way the system is running) for dietitians by determining the perception of dietitians as well as the views and experiences of key personnel involved in the management and administration of the system.

**2.2 Procedure:**

During the focus group discussion, I will be required to discuss with the researcher my views and perceptions of its operation/implementation and possible ideas for improvements, if any. The discussion will last between half an hour to 1 hour. I could be further contacted if any information requires clarity or follow-up. The interview may be audio and or video recorded.

*2.3 Confidentiality:*

I agree that all information will be used in a thesis. The information will also be supplied to those involved in the administration and management of the CPD system. No names will be used in analysis or reporting of all material discussed at the focus group.

*2.4 Access to findings:*

Upon request, the researcher will inform me of how the results obtained in the project will be made available.

*2.5 Voluntary Participation:*

Participation in the project is voluntary and I have the option to refuse to participate at any stage.

*2.6 Questions:*

I was given the opportunity to ask questions about all these points and they were answered to my satisfaction.

**I HEREBY CONSENT TO VOLUNTARY PARTICIPATION IN THE ABOVE MENTIONED PROJECT.**

Signed at ..... (Place) on ..... (Date)

.....  
Participant signature

.....  
Witness signature

**STATEMENT BY INVESTIGATOR**

I, declare that I have  
- explained the information in this document  
- given the participant an opportunity to ask questions

Signed at ..... (Place) on ..... (Date)

.....  
Investigator signature

.....  
Witness signature

Thank you for participation in this study. If you have any questions at any time, kindly contact me at the above mentioned contact details.



## APPENDIX 10

### In-depth interviews - Structure and questions

Thank you for agreeing to the interview which I hope will be more in the form of a discussion. The points raised will be based on those brought up in the questionnaire that went out to the dietitians. So, while the dietitians had their say in the questionnaire, I would now like to get the point of view of people like you involved in the overall administration and management of the CPD system.

Although I the points I bring up will just give our discussion a general direction, please feel free to respond to these points from your own perspective or include other comments you may wish to add.

#### **Questions:**

1. Participant to clarify his/her role and title in the old and new CPD system for dietitians.
2. Do you feel that dietitians understood the CPD system based on the comments and queries that you receive from them?
3. Can you tell me about the CPD Office? Do you feel that it was easy for dietitians to communicate with someone at your office at all times? Were all communications responded to promptly? Did you have the resources to respond promptly?
4. How did you feel dietitians communicated with you and responded to you. For example in response to documents you requested or adhering to the rules, time frames, filling in forms updating their details and so on.
5. What was the majority of complaints you received from dietitians?
6. What were the complements you received?
7. What are your views on the CPD administration fees?
8. Do you feel that all dietitians in South Africa are adequately reached or corresponded with?
9. Even under the old system, dietitians were supposed to keep a record of activities? Were they good at it?
10. Do you have an opinion about the cost of attending CPD activities?

11. Some of the comments about activities were that they provided little new/useful information, and articles are either too complicated, answers are finicky and limited to community nutrition. Can you comment?
12. What do you perceive are the barriers to dietitians attending/participating in CPD activities?
13. Are there sufficient CPD activities in all geographical locations in South Africa for dietitians to attend? Are there activities offered in all practice areas?
14. In your opinion, do we have sufficient activities to accommodate both employed and unemployed dietitians?
15. *The New System:-*
16. One of the complaints is that the system is continually changing. What is your opinion about that?
17. The new system is in place as of....? When will the first audit take place?
18. In the questionnaire, accumulation of ethics points was a big issue, where do we stand with that?
19. Who /where can dietitians turn to for help with the changes and related queries?
20. Who /where will written documents come from?
21. Are you looking forward to being part of the new system, What do you think may be some of the old problem areas in the operation of the old system that will be sorted out in the new system
22. If you could tell dietitians one thing/advice about helping the CPD system function smoothly, what would it be?
23. Close Interview:
24. Thank interviewees
25. Mention that interviewee may need to be contacted again if necessary.

## APPENDIX 11

## Statistical analysis of selected variables – observed frequencies

<b>PRACTICE AREA</b>			
Observed frequencies in percentage; Chi-square test: $p= 0.00$			
	Paid for by the dietitian only	Paid for by the dietitian and sponsor	Total sponsorship for CPD
Education/academia	42.1	52.6	5.3
Foodservice management	42.9	42.9	14.3
Community Nutrition	47.4	26.3	26.3
Food industry/ Food Company	42.9	42.9	1.3
Pharmaceutical industry	66.7	33.3	0
Private practice	84.7	13.9	1.4
Nutritional consultant	69.2	30.8	0
Hospital/clinic – therapeutic	42.5	47.1	10.3
Research	33.3	33.3	33.3
Registered (HPCSA), but not practicing as a dietitian	91.7	8.3	0
Other e.g contract work	71.4	14.3	14.3
<b>PROVINCE</b>			
Observed frequencies in percentage; Chi-square test: $p= 0.00476$			
Gauteng	66.8	29.5	5.7
Mpumalanga	54.6	45.5	0
Limpopo	73.3	20	6.7
North West	87.5	12.5	0

<b>Kwazulu-Natal</b>	62.5	37.5	0
<b>Eastern Cape</b>	57.1	28.6	14.3
<b>Western Cape</b>	57.6	34.9	7.6
<b>Northern Cape</b>	50.0	0	50.0
<b>Free State</b>	56.3	43.8	0
<b>Abroad</b>	32.0	36.0	32.0

<b>BARRIERS TO PARTICIPATION IN CPD</b>					
Observed frequencies in percentage; Chi-square test: $p= 0.00826$					
	<b>Barrier 1</b>	<b>Barrier 2</b>	<b>Barrier 3</b>	<b>Barrier 4</b>	<b>Barrier 5</b>
<b>Gauteng</b>	67.6	7.2	9.0	0	0.9
<b>Mpumalanga</b>	64.3	7.1	0	2.4	0
<b>Limpopo</b>	60	6.7	0	33.3	0
<b>North West</b>	75	12.5	0	0	0
<b>Kwazulu-Natal</b>	37.04	11.1	11.1	3.7	7.4
<b>Eastern Cape</b>	62.5	6.3	6.3	18.8	0
<b>Western Cape</b>	65.7	12.9	4.3	4.3	0
<b>Northern Cape</b>	57.1	14.3	0	14.3	0
<b>Free State</b>	70.6	5.9	0	11.8	0
<b>Abroad</b>	53.9	0	7.7	3.9	0

*Barrier 1- Financial limitations-*

*Barrier 2- Family obligations*

*Barrier 3- Getting leave from work*

*Barrier 4- Little or no activities in my geographical area*

*Barrier 5- Limited or no internet access*

**Appendix 12**

**Personal CPD activity evaluation form**

***Why did I select this activity?***

.....  
.....  
.....  
.....

***What have I learnt from this activity or experience? (List only a few things)***

.....  
.....  
.....  
.....

OR

***I learnt nothing today, why? How can I change this?***

.....  
.....  
.....  
.....

***What can I use from this learning experience in my practice?***

.....  
.....  
.....  
.....