

Third East African Continuing Professional Development (CPD) Consultation,
Royal Palm Hotel, Dar-es-Salaam, Tanzania
28th & 29th October 2004.



Unity and Development



Kenya



Tanzania



Uganda

Recommendations of the Third Consultation to
Implement CPD in East Africa

By

The Medical Associations of Kenya, Tanzania and
Uganda

&

Associated Regulatory Boards & Medical and
Dental Councils

Dar-es-Salaam, Tanzania

29th October 2004

1.0 Introduction

The Third East African CPD Consultation convened in Dar-es-Salaam under the auspices of the Tanzanian Medical Association to review CPD developments in Uganda, Kenya and Tanzania since the last consultation twelve months previously in Nairobi Kenya. It explored the process of implementing CPD for all healthcare professionals in East Africa, identified objective ways of measuring CPD uptake such as through the maintenance of diaries and suggested ways of determining CPD accreditation at individual and institutional levels. Funding of CPD, its integration into the existing structure of the Ministries of Health and the role of the professional associations and councils were explored and defined.

1.1

At the plenary sessions, presentations were made by representatives of the Medical Associations of Uganda, Kenya and Tanzania to inform the Consultation of achievements, failures and difficulties encountered in the implementation of the recommendations of the Second CPD Consultation. Though Uganda appeared to have made significant inroads into implementing the recommendations of the Second Consultation, much needed to be done in Kenya and Tanzania. Eluzai Hakim, United Kingdom CPD resource to the Consultation proposed a model of CPD

implementation in East Africa. His presentation drew a great deal on his experience in the United Kingdom but conceded that the principles of CPD in the UK would need to be adapted to local East African circumstances and not imported wholesale. A realistic picture of how the donor sector might fund CPD was presented by Dr Inke Mathauer from the GTZ, a German Technical Cooperation Agency in Kenya. Both Eluzai Hakim and Inke Mathauer emphasised the importance of embedding the culture of learning into Health Institutions in East Africa, pointing out that funding CPD might be accessed more easily if this were the case. Intense interactive discussions ensued generating a plethora of useful ideas. Mrs Mary Makowfu, East African Community (EAC) Social Sector coordinator, refocused the deliberations on how to take CPD forward by offering a succinct review of the Second CPD Consultation in Nairobi in 2003. She pointed out that in an East African Community Health Sector meeting in April 2004 in Nakuru, Kenya, the recommendations of the Second CPD Consultation were considered and agreement on the following reached :

- ❖ The EAC will ensure harmonisation of the Medical Boards/Councils.
- ❖ The EAC will urge the Ministries of Health (MOH) in partner states to develop resource policies.

- ❖ Kenya and Tanzania were to make CPD mandatory for re-certification in their countries (this was already the case in Uganda).
- ❖ EAC health coordinator, Dr Stanley Sanoiya, was appointed to monitor implementation of the Council recommendations and decisions on CPD in the East African Region.
- ❖ Outcome of the recommendations of the Third CPD Consultation would be considered at subsequent meetings in Kampala on the 29 November 2004 and Nairobi in April 2004.

1.2

The Meeting resolved that the deliberations of the Third CPD Council be synthesised into a coherent report by midday 29 October 2004, and to facilitate this process, four discussion groups were formed to consider effective ways of delivering/implementing CPD in the East Africa region.

2.0 Recommendations

2.1

Definition of the roles of Professional Associations/Councils, MOH.

a) Professional Associations

- ❖ I identify suitable courses for members.
- ❖ Run courses for members.

- ❖ Bring in speakers to lead or deliver CPD activities for members. Strategic coordinators who are already in place at Regional level in Uganda may be empowered to lead CPD activities.
- ❖ Mobilise members to attend CPD and to consider discounts for members on the cost of course fees to encourage attendance.
- ❖ Organise peer review with regard to CPD.
- ❖ Disseminate evidence-based information such as peer review journals, educational leaflets, booklets etc to keep members up-to-date.
- ❖ Initiate and sustain the development of libraries or resource centres within their own professional groups. Such an initiative is likely to strengthen CPD at the Regional level.

b) Councils

- ❖ Identify failing members such as may become known through public concern, whistle blowing and through the justice system and to offer appropriate retraining in suitable departments locally, within the region or even overseas.
- ❖ Carry out an investigation of those not renewing their registration and offer help, if in difficulty.

- ❖ Safeguard the public interest by ensuring that members meet the minimum ethical and professional competence through recognition of personal and professional limits.
- ❖ Encourage the acquisition and use of new knowledge to update practice and enhance adaptation to changing circumstances in medicine/healthcare. This is achieved through accreditation and appraisal.
- ❖ Ensure that members embrace clinical audit as an effective CPD tool for self improvement and enforcement of standards through the Ministries of Health or in future bodies such as an “East African College of Physicians”.
- ❖ Ensure that knowledge is shared across professional boundaries through multi-professional teamwork and timely and appropriate referral for second opinion, if in difficulty.
- ❖ Set and administer standards and criteria for providers of quality CPD. Supervision and evaluation of CPD and application of new knowledge/skills were also recognised as important roles of the Councils

- | |
|---|
| <ul style="list-style-type: none">❖ Withhold registration from those practitioners who persistently fall short of required standards of safe professional performance until such practitioners have been retrained. |
|---|

c) **Ministries of Health (MOH)**

The MOH should facilitate the implementation of professionally developed guidelines and standards of care to ensure that they are enshrined in the Health Policy for the benefit of the public it serves.

2.2

Institutional Capacity Building

This activity is vital to CPD through the following :

- a) Setting up and maintenance of practitioners participating in CPD to monitor progress and facilitate audit of CPD uptake and impact.
- b) Provision of appropriate information technology (IT) & facilities to healthcare professionals.
- c) Development of secretariats with responsibility for CPD administration ensuring that non medical administrative staff of good quality are employed to provide continuity of service. It was recognised that deployment of doctors from administrative positions in the MOH would disrupt the smooth running of the service.
- d) Ensure adequate funding to support the CPD infrastructure and the continuous provision of CPD.

- e) Build in a system of review to ensure that all necessary information on individual/institutional CPD is captured and properly utilised in audit and further development.
- f) Develop an inspectorate within the CPD secretariat with a brief to review adherence to CPD, performance of different clinics, hospitals and single handed practitioners to ensure that they remain accredited and are plugged into the CPD system.

3.0 Creating Demand for CPD

3.1

- a) CPD should be made mandatory for the licensing and re-registration of all healthcare professionals.
- b) Periodic evaluation of performance should be initiated to ensure a defined quality of CPD and healthcare delivery.
- c) Incentives for taking up CPD and adhering to it should include compulsory link to promotion, increased funding to institutions which embed the culture of learning in their clinical work and national recognition for setting up exemplary CPD related activities.
- d) Promotion of evidence-based practice and introduction of such learning methods such as problem-based learning.

- e) Develop and promote work based learning which may be accessed through distance education or on-line. This will widen the learning opportunities for those who may never have the chance to attend local or international conferences/seminars/workshops, use of electronic resources and accessing material on the worldwide web (Internet).

3.2 Sharing CPD content/material in the East Africa region

- a) CPD contents should be standardised across the region by spelling out what is useful in promoting learning, for example, *hospital grand rounds, role play in clinical situations, clinico-pathological seminars, mortality and morbidity meetings, clinical audit meetings, x-ray meetings, multiprofessional discussions involving nurses, physiotherapists, pharmacists, academics, hospital consultants, public health specialists and clinical officers*, to name a few. Other non clinical CPD activities include, *undertaking specified modules of study in computing (IT technology), research methodology, writing a thesis, teaching, examining, attendance of management courses/meetings or undertaking literature searches.*

- b) Common issues should be addressed using evidence based guidelines to ensure use of a commonly understood language to improve delivery of quality healthcare across the region.
- c) The region should endeavour to improve access to information technology through the provision of computers to hospitals and health centres. This tool will enhance accessing knowledge to improve CPD even in the remotest areas of East Africa.

3.3 Assessment of Impact of CPD

- a) Currently there are no validated scales of measures in universal use in the countries where CPD has been established for several years to measure the impact of CPD. However, **clinical audit** whose principles are well known is used to assess CPD uptake amongst those registered for CPD and to establish if those claiming CPD credits are doing so legitimately.
- c) CPD attendance should be assessed using any of the following tools until validated tools become available in the future :
 - ❖ **Attendance certificate** issued by the provider of the relevant CPD activity (appendix 3).
 - ❖ A completed **personal reflection form** (appendix 4). This is a crucial though blunt assessment tool, in that it indicates what the individual participant in CPD perceives as a gain he or she

has derived from a named CPD activity. If such a gain is translated into improved healthcare delivery it may be inferred that the impact of CPD has been assessed for the individual.

❖ Evaluation of CPD meetings/activities (appendix 2). All CPD activities of meetings will be evaluated anonymously at the conclusion of the activities by all participants and the results of the evaluations analysed to inform the organisation and content of future meetings. Meetings not deemed useful may not attract future attendance or funding and as such the evaluation may also be used as a surrogate for assessing the providers of CPD.

❖ **Audit**

This will continue to be the gold standard for assessing the improvement in the quality of healthcare delivered. *Audit is a clinically led initiative to improve outcomes of patient care through structured review whereby clinicians examine their practice against agreed standards and modify their practice where indicated.*

Useful reference :www.nice.org.uk

d) **Support supervision**

In the initial stages of implementing CPD in the region, a randomly selected group of health facilities, hospitals or departments will

be given support on a regular basis from the Human Resource Development Group. A comparable number of health facilities, hospitals or departments will be given written instructions only without active support and both arms of the CPD implementation will be analysed at 3, 6, 9 and 12 months respectively to see if support supervision impacts positively on CPD uptake and quality of care. If it does, then support centres to address areas of concern on the delivery of CPD will be set up and funded appropriately. Such results might be presented at the Fourth East African CPD Consultation scheduled for Kampala in October 2005.

4.0 Accreditation of CPD in the Region

4.1 Accrediting Health Professionals

Kenya and Tanzania should introduce laws providing for the mandatory accreditation of healthcare professionals as a prerequisite for recertification or registration renewal with their board and medical council, respectively.

4.2

Boards, professional councils and any other bodies charged with CPD accreditation of professionals should reinforce the need for this process to be carried out rigorously in the East Africa Region. Standard Databases need to be

developed in the Region and Councils/Boards should share information on a regular basis.

4.3

Boards and councils need to develop mechanisms for accreditation of health professionals as part of the overall strategy for implementing CPD in the region.

4.4

Appropriate funding must be made available to boards and professional councils to facilitate the accreditation, implementation, monitoring and evaluation of CPD.

4.5

A database of all healthcare professionals eligible to partake in CPD in each of the three countries in the region must be set up as soon as possible as part of the implementation process. These should have a standards format to facilitate the exchange of information between Councils/Boards.

4.6

An audit trail (or process) must be built into the accreditation process to assess the uptake and quality of accreditation.

4.7

Accreditation of health professional training institutions and health facilities.

- a) Professional councils must develop criteria and mechanisms for accrediting institutions which provide CPD activities. This will include facilities for trainers who deliver quality CPD to the three countries.
- b) Financial allocation earmarked for this exercise must be made available to the professional councils to visit and inspect institutions which provide CPD to enable them to make logical judgment on accreditation.
- c) There should be region wide agreement on what constitutes a unit of **CPD credit** and what **minimum CPD credits** must be achieved by each professional group in a calendar year to be accredited, re-certificated or re-registered.
- d) The accreditation system must be harmonised across the East Africa region. This includes existing training materials of the vertical programmes of the respective Ministries of Health in Kenya, Uganda and Tanzania, **the non-governmental organisations**

operating in these countries, colleges and accredited providers of CPD.

5.0 **Budgetary Allocation for the Implementation of CPD**

5.1

A ring-fenced budget for implementing CPD should be allocated to each CPD council by each of the three Ministries of Health in Kenya, Tanzania and Uganda.

5.2 **CPD Levy**

To promote and improve CPD financing a CPD levy payable to the CPD Councils regulatory bodies and training institutions by vertical programmes, donor agencies and pharmaceutical companies should be considered. To justify this levy CPD must be made an integral part of the strategic health planning.

5.3

The regulatory bodies (boards, councils) should play a significant role in fund raising through such efforts as dinner dances, raffle tickets during Christmas or Easter, soliciting funds from companies or financially well endowed citizens who support improvements in healthcare. Newspaper and television advertisements to raise the profile of CPD may be considered as well.

5.4

- a) It should be enshrined in the statute books of the three East African countries (Kenya, Tanzania and Uganda) that **pharmaceutical companies** should provide educationally valuable and appropriately accredited training for health professionals at substantially reduced cost instead of putting on product promotional meetings for doctors, dentists and nurses. Those pharmaceutical companies that are unable to set up educationally valuable meetings should be asked to contribute sums of money to the CPD councils annually to support CPD activities.
- b) Product promotional meetings to which doctors, dentists, nurses and other health professionals are invited must have an educational component whose content must receive prior CPD council accreditation.

5.5 Individual Health Professional Contribution

Health professionals will be charged nominal fees for attending those CPD activities where reading material is provided as a reference resource to cover administrative and printing costs.

6.0 Annual Regional CPD Meetings

The East African community will organise a regional CPD meeting annually based on a specific theme such as **cardiovascular disease**

in Africans, HIV/AIDS, diabetes, tuberculosis etc. Original research, audit, evidence-based practice etc will be featured and promoted. The annual CPD meeting will be funded by the East African community and held in rotation in each of the three East African countries to enable many health professionals attend.

6.1 Other Cost Effective Means of Delivering CPD

- a) *Self-directed learning*.
- b) Use of Internet based sources of learning, for example :
 - ❖ BMJ learning.
 - ❖ www.medscape.com (a very important CPD resource for which members may register free of charge.
 - ❖ www.rcplondon.ac.uk - The journal, "Clinical Medicine" is available free online after one year and contains CPD modules in various specialties which members may undertake in the quiet of their study to improve their knowledge base.
 - ❖ Courses through the Department for Lifelong Learning at the University of Edinburgh (usually costs £90 - £120 a module).
 - ❖ Cochrane reviews.
 - ❖ WHO/INASP

- ❖ Medical Education Resource Africa (MERA) Journal published by FSG in the UK.
- ❖ www.sign.ac.uk (Scottish inter collegiate guideline network), a useful website with evidence based guidelines which may be applicable to East Africa.
- ❖ www.clinicalevidence.com.

Through interchange of information within the region, no doubt, many web-based cost effective learning resources will become available.

Appendix 1

Third East African CPD Consultation,
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13. Dr Samson K. Ndge
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15. Dr Margaret Mungherera
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17. Dr Benjamin Mtinangi
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18. Dr Lugemwa Myers
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19. Dr Joseph Aluoch
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20. Dr Amos Odea Mwakilasa
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22. Mrs Mary Kitundu
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23. Dr Eluzai Hakim
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24. Mr Bryan Pearson
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Appendix 2.

Federation of East African Continuing Professional Development (CPD) Councils.
Arusha, Tanzania.

Evaluation of Meeting

Title of meeting

Provider

Date of Meeting

1. How do you rate the relevance of this meeting to your educational needs ?
please tick.

No part relevant Little relevance Fairly relevant
Mostly relevant Highly relevant

2. How do you rate the overall quality of the education offered by this meeting ?
please tick.

Poor Mediocre Satisfactory Good Excellent

3. How do you rate the effectiveness of the meeting for CPD purposes ?
please tick.

Ineffective Partly effective Quite effective Quite effective
Definitely effective Very effective

4. How do you rate the catering/venue for the meeting ? *please tick.*

Poor Satisfactory Good Excellent

5. How do you rate the administration of the meeting ? *please tick.*

Poor Satisfactory Good Excellent

6. Any comments to help colleagues in the Region in the organisation of similar meetings.

The results of the evaluation of this meeting will be submitted to the Regional Specialty Adviser in due course to help in the development of future meetings.

Thank you very much for your time.

Name

Title
Meeting Organiser.

Appendix 3.

*East African Federation of Continuing Professional Development
Councils.*

The Tanzanian Medical Association



Third East African Continuing Professional Development

(CPD) Consultation, Royal Palm Hotel, Dar-es-Salaam,

Tanzania

28th and 29th October 2004

This is to certify that

.....

Attended and participated in the above symposium

which has been registered for,

5 external non clinical CPD credits

Signed

Name

Chairman Tanzanian Medical Association

Appendix 4.

East African Federation of Continuing Professional Development (CPD) Councils
Arusha, Tanzania.

Personal reflection on Institutional Learner Centred CPD Activities.

NameCPD ref no.....

Topic of Course or
CPD activity.

Date(s) attended or
Undertaken.

.....

Provider
(Institution/Web or other)

Reflection (minimum 300 words)

Notes:

- ❖ *What was gained from activity.*
- ❖ *What might be done differently now.*
- ❖ *What further learning or reading is planned.*

Signed Date

Appendix 5

Glossary

Boards/Councils :

In East Africa, the professional councils such as the Medical and Dental Council which maintains a register of all duly qualified medical doctors and dentists who are fit to practice in the respective countries or across national boundaries are referred to as "Councils" in Uganda and Tanzania or "Board" in Kenya. Other councils include the nursing, midwives and health visitors councils.

Association

This term refers to the professional bodies such as the Uganda Medical Association, the Kenya Medical Association and the Tanzanian Medical Association, respectively.

CPD Council

This is a term which was introduced at the First East African CPD Consultation in Kampala, Uganda October 2002. This is the body charged with the overall coordination and supervision of CPD in each country.

Appendix 6

Audit Standards

In the initial stages of implementation, each CPD Council in the three respective East African countries may want to audit CPD uptake and other aspects of CPD. The following standard was suggested by Dr Eluzai A Hakim, United Kingdom external CPD resource to the East African Consultation :

50% of those health professionals registered for CPD should demonstrate compliance with participation in CPD by the end of the first year of undertaking CPD. This means that if less than 50% of registered practitioners eligible to undertake CPD do not demonstrate compliance with participation in CPD, the uptake of CPD is deemed to be below the expectations of the CPD council and as such strategies must be put in place to ensure that more work needs to be done to encourage more professionals to undertake CPD.

Evidence Required in Assessing Compliance with CPD

- ❖ *Completed diaries.*
- ❖ *Appropriate attendance certificates issued by the providers of CPD.*
- ❖ *Reflective notes on the CPD activities attended.*
- ❖ In the absence of all the above documents, an endorsed copy of the CPD programme by the provider to indicate that the person claiming CPD credits actually attended that activity.
- ❖ Swipe cards, used for entering and exiting a CPD activity.

The Audit will be conducted nationally by the local CPD council and Human Resource Departments to assess **CPD uptake and compliance using agreed rules on implantation**. The results of each country will be shared with the other two sister countries and strategies to improve uptake discussed.

Acknowledgement

This document on the Third East African Consultation on Continuing Professional Development, Dar es Salaam, Tanzania was prepared on behalf of the Medical Associations of Kenya, Tanzania and Uganda by Dr Eluzai A Hakim, MB., ChB, FRCP, FRCP (Edinburgh), DTM&H, External UK resource on CPD to the East African Consultation and Consultant Physician with Specialist Interest in Neuro Rehabilitation at St Mary's Hospital, Newport, Isle of Wight (UK), PO30 5TG. Eluzai.Hakim@iow.nhs.uk.

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The proposal was typed by Mrs Madeleine Emmett, Personal Assistant and Medical Secretary to Dr Eluzai A Hakim.