

Keeping Up to Date: Continuing Professional Development for Health Workers in Developing Countries

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In order for health workers to provide quality care and meet their communities' changing health care needs, they must become lifelong learners dedicated to updating their professional knowledge, skills, values, and practice. Continuing professional development (CPD) encompasses all of the activities that health workers undertake—both formal and informal—to maintain, update, develop, and enhance their professional skills, knowledge, and attitudes. CPD is a systematic and ongoing process of education, in-service training, learning, and support activities that build on initial education and training to ensure continuing competence, extend knowledge and skills to new responsibilities or changing roles, and increase personal and professional effectiveness.

This technical brief summarizes the literature concerning current best practices and innovative ideas in CPD. It is targeted toward people who run or advise CPD programs.

Formal continuing education

One component of CPD is continuing education or training opportunities held in formal educational environments for professional health workers, such as physicians, nurses, and dentists, as well as allied workers such as dental, laboratory, and pharmaceutical technicians. Formal CPD should focus on “enhancing roles and competencies...and organization of work..., communication, medical ethics, teaching, research and administration” (World Federation for Medical Education [WFME] 2003).

Informal learning and development

While CPD is often achieved through systematic learning opportunities integrated into health facility protocols and on-the-job training, less structured mechanisms for learning and development are also available to health workers. Informal opportunities for learning via spontaneous interactions with colleagues, professional reading, and reflections on one's own experiences are essential aspects of a health worker's professional development. These informal opportunities can be heavily influenced by location and working conditions. For example, a health worker in a remote, rural clinic with no other professional colleagues nearby will not have the same opportunities for spontaneous professional dialogue as a peer working in an urban or periurban



environment (Ndege 2006). A number of programs have shown the power of information and communication technologies for linking health workers in remote areas to their peers in order to enhance both clinical practice and opportunities for learning (McNamara 2007).

Continuing professional development providers

In most countries CPD is not required by law, and is generally considered to be the responsibility of professional associations and/or individual health workers. Typically, medical associations and other professional organizations initiate, provide, and promote CPD. Other CPD providers may include for-profit health care companies, the pharmaceutical/medical technology industry, consumer organizations, academic institutions, nongovernmental organizations, ministries of health, district health offices, donor agencies, and for-profit CPD providers (WFME 2003; Muula et al. 2004).

Mandatory continuing professional development

There is ongoing debate and inconclusive evidence as to whether mandatory continuing education for relicensure leads to more professional growth and enhanced performance. In a study of continuing education participation in the US, nurses mandated to attend continuing education courses did take significantly more courses than those who were not required to do so. They were also more likely to take courses on topics unrelated to their specialty, simply to meet the requirement (ibid.).

From another perspective, Ndege (2006) argues that “to further facilitate the development of CPD in Africa, there is a need to give CPD legitimacy by establishing a legal framework for CPD...clear policies and structures to support CPD should be put in place.” Across Africa, countries are at different levels of developing CPD systems. In some countries, such as Uganda and South Africa, regulatory bodies require a specific number of professional development credits or continuing medical education (CME) credits in order to reregister or relicense certain health worker cadres (Ndege 2006). In most African countries, however, there are no systematic approaches to regulating CPD programs, and documentation of CPD completion is not required for relicensure (Muula et al. 2004).

Requirements in Asia are likewise diverse. Singapore has required CME for physicians to maintain their licenses since 2005 (van der Velden et al. 2010). Japan has no mandatory system, but the Japan Medical Association conducts a voluntary certifying program. Approximately 70% of its membership is certified (Pelletier 2010). India’s individual states have differing requirements, but none has been in place long enough to evidence compliance (ibid.) Public-sector professionals in Malaysia are required to participate in CPD, but private doctors are not (ibid.). Vietnam, in accordance with an agreement to mutually recognize nurses’ licenses within Association of Southeast Asian Nations (ASEAN) countries, is working to institute an internationally recognized licensing system. In 2009, the Law on Examination and Treatment (LET) called for licenses to be issued to physicians, nurses, midwives, and assistant doctors by 2016. LET includes a requirement that all practitioners participate regularly in CPD, or their license can be revoked. However, LET does not specify the number of hours or types of CPD required (van der Velden et al. 2010). In Southwest Asia, the Abu Dhabi Health Authority in the United Arab Emirates requires physicians to attain at least 50 hours of CME per year for license renewal, of which 25 must be in the form of formal education from either an accredited medical school or a professional body (Younies, Berham, and Smith 2010).

In the European Union (EU), 17 of the member states require CPD for some cadres of health workers, and many of the remaining 10 have guidelines encouraging participation. The number of credits expected of medical practitioners varies widely, from a low in Slovenia of 10.7 credits per year to a high in Bulgaria at 150 (Costa et al. 2010). In keeping with the EU’s cross-border principles, CME attained in two-thirds of EU countries is certified by the European Accreditation Council for Continuing Medical Education. Such credits are acceptable in all affiliated states (ibid.). Garattini et al. (2010) found that compulsory continuing development programs in Austria, France, Italy, and the UK had few or no legal enforcement mechanisms. Austrian physicians noted that they were encouraged to comply with requirements because the likelihood of being subject to litigation increases without such compliance (ibid.). Rather than implementing mandatory CME participation, Belgium and Norway encourage participation through financial incentives. In Belgium, non-hospital physicians receive yearly bonus payments and can ask higher fees per patient when they accumulate 20 credits of CME per year. General practitioners in Norway have no CME requirements, but specialists will lose their specialization (and 20% higher fee) if they fail to participate in specialty-specific CME courses (ibid.).

In Latin America, many policies regarding professional education are guided or provided by professional associations. Argentina's medical societies have long been responsible for accreditation and provision of CPD, though the country's medical schools are beginning to involve themselves in the process to a greater degree. In Mexico, a large number of specialty boards require CPD for members to maintain specialty certifications. Moreover, many private-sector hospitals and clinics require physicians in their employ to participate in CPD/CME courses. The Mexican government is considering a compulsory program (Pelletier 2010).

Developing continuing professional development systems

The scientific evidence base for how to design and implement CPD is weak, and health workers lack a dependable way to identify CPD options.

Campbell and Mackay (2001), writing about nursing in Canada, define the key components of a "continuing competence program" as 1) determining the purpose of such a program, 2) defining competence, 3) identifying performance standards, 4) developing assessment methods and tools, 5) developing a professional development system, 6) evaluating the benefits of the education, and 7) communication.

The Citizen Advocacy Center proposes the following steps for a road map to continual competence development: "collaboration between stakeholders; continuous quality assurance rather than relying on the 'bad apple' approach; an evidence-based approach to link continued competency assessment with improved clinical outcomes; building on programs already in existence; mandated competency assessment and assurance; clinician responsibility which embeds competency assessment and assurance into professional practice" (Bryant 2005).

In a 2009 report, the Institute of Medicine of the National Academies (IOM) provided a literature review of CPD-related evidence, undertook international comparisons of CPD programs, and identified promising steps that countries can take to put in place a systematic, effective, and holistic CPD program. The IOM report underscores that continual learning is necessary for health workers to provide quality care, but having a CPD program is not an end in itself. Ineffective, wasteful, or demotivating CPD programs are counterproductive and, especially when implemented in low-resource settings, could exacerbate rather than mitigate health workforce issues. The IOM states that an effective CPD system should prepare health professionals to provide



Continuing professional development is *ineffective* if:

- Health workers are spending time away from their practice participating in classes or workshops that are irrelevant to their practice setting
- Attended only because participants receive per diem
- Geared toward improving a skill for which there is no demonstrated need
- Taken only to meet regulatory requirements rather than to close a competency gap
- Simply unsuccessful in developing skills and competencies (IOM 2009; Muula et al. 2004).

Continuing professional development is *effective* if:

- There is a clear need or reason for the particular CPD to be undertaken
- Learning is based on such an identified need or reason
- Follow-up provision is made for reinforcing the learning accomplished (WFME 2003)
- In-service training is linked to preservice faculties as far as possible to create a seamless CPD system (Global Health Workforce Alliance 2008).

patient-centered care, work in interprofessional teams, employ evidence-based practice, apply quality improvement, and use health informatics.

Good CPD planning begins with a health education needs assessment. Without a reasonable understanding of the health workforce's past education, its weaknesses, and its needs, the possibility that CPD will fill critical knowledge gaps is constrained (WFME 2003; Schaefer 2005; Uganda Health Professionals Councils [UHPC] 2008). In this regard, one of the lessons learned is that there is benefit in engaging institutional stakeholders and practitioners throughout the process—from the CPD needs assessment to design, implementation, and evaluation.

Principal stakeholders should be involved in formulating the mission and purpose of CPD, as well as the regulatory framework (WFME 2003). With respect to institutions, these include professional organizations such as nurses' and midwives' associations, regulatory bodies (e.g., national nursing or medical councils), health facilities and other employers, and preservice institutions that educate and train health workers. Further, linkages between rural health facilities and high-end, urban-based research and training institutions should be established in order to support remote workers' professional development (Ndege 2006).

Given frontline health providers' pivotal role in the system's ability to achieve health outcomes, they should be involved at each step of the CPD process, including system planning and design. What frontline health workers request, learn, and apply (or not) will be the ultimate test of any CPD system's efficiency. Often rural practitioners are neglected or given less prominence in CPD decision-making, despite being among the best information sources on the relevance of what is being offered and the prospects for and problems encountered in its application. Sensitivity to rural CPD programming needs must be highlighted and well-integrated into the approach.

Supervisors and managers should encourage health workers to take advantage of CPD opportunities. Without this support, the likelihood that health workers will apply what is learned to their jobs, and thereby increase health system performance and productivity, is reduced (Schaefer 2005; PRIME II and JHPIEGO Corporation 2002).

Materials that are of high technical quality but not absorbed or translated into health worker actions are of limited value to the health system. The purpose and mission of CPD and expected outcomes should be

clearly articulated, taking into account the national health profile, priorities, and workforce distribution and capacity (WFME 2003; UHPC 2008).

In order to achieve its intended purpose, appropriate participants must be selected for CPD interventions. Clear participant selection criteria must be developed and enforced for in-service continuing education courses (Schaefer 2005). The intended beneficiaries must have the prerequisite supporting skills to master the new skill being taught. For example, continuing education training on intrauterine device (IUD) insertion may require that participants can already conduct a pelvic examination (ibid.). Further, the skills being taught

Key components of continuing professional development training:



- Content should be evidence-based and relevant to the area of practice (WFME 2003).
- Desired learning outcomes should be communicated to the target audience before the activity is conducted (UHPC 2008).
- Two-way communication between learners and training facilitators, and between learners, is necessary for effective learning and should be incorporated into CPD (Khan and Coomarasamy 2006).
- The best CPD systems are multifaceted and provide different types of formal and informal learning opportunities and support, such as structured courses supported by on-the-job training, mentoring, and peer support (WFME 2003).
- In order to transfer clinical skills, hands-on teaching is more effective than classroom teaching and should be used when feasible (Khan and Coomarasamy 2006).

should fall within the participants' job descriptions or professional scopes of practice, and the participants should work in a facility capable of providing the service being taught (e.g., one with sufficient clients in need of the health services identified, with adequate medical supplies, equipment, and complementary staff to perform such services) (ibid.).

Any commercial sponsorship of CPD activities and any commercial conflict of interest must be disclosed during the planning of the CPD activities. Potential participants should be made aware of these disclosures (UHPC 2008).

Continuing professional development formats

The educational format used should be the most effective and efficient method for meeting the learning objectives (UHPC 2008). Approaches such as on-the-job training and blended learning can be used to minimize the amount of time health workers must spend away from their jobs (Schaefer 2005). Distance learning opportunities and information technology can be used to address the limited professional development experienced by health workers in remote locations (Ndege 2006).

Similarly, follow-up of trainees after the CPD intervention is an important step in the process, one used to determine if the intervention was effective and to learn what changes might improve it in the future.

Program evaluation

CPD programs should integrate evaluation of the effect of the activity on the health practices of the targeted cohort. Formal CPD program evaluation should be introduced early in the process so there is a baseline against which to measure effectiveness in meeting identified needs and make improvements based on feedback (UHPC 2008).

Finance

Another element of CPD concerns the financial aspects of implementing such programs. Building on a needs assessment and a planning process, one which takes into account realistic costs of such efforts, CPD should be:

- Integrated into the sectoral health care approach
- Appropriately reflected in national health sector budgets—providing for both programmatic and administrative needs, with multiyear resource allocations

- Not subordinated to other health service demands (WFME 2003; Ndege 2006).

CPD programs should be administered in such a way that expenditures and revenue are documented, the CPD activities are adequately budgeted for, and policies and procedures regarding human resources, financial resources, and legal obligations are followed (UHPC 2008).

This is invariably a challenge because of competing priorities and operational needs. Thus there is a need to develop and improve resource mobilization strategies as a way of addressing financial constraints facing CPD program implementation. This could involve pooling resources from various sources (e.g., donors, nongovernmental organizations, the private sector) and consumers of CPD.

Conclusion

Continuing professional development is an essential component of successful health care systems. The systematic and ongoing provision of opportunities to maintain, update, develop, and enhance professional skills, knowledge, and attitudes can lead to improved health care experiences and health outcomes for the community. CPD programs must be planned, financed, delivered, and evaluated in an effective manner. With proper attention paid to lessons learned and best practices identified by previous CPD interventions, these interventions can result in effective and successful learning experiences.

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