DIETETICS AND NUTRITION NEWS 2012
Newsletter for the Professional Board for Dietetics and Nutrition
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HPCSA
Health Professions Council of South Africa

CHAIRPERSON'S NOTE

Prof Edelweiss Wentzel-Viljoen
Chairperson

Optimal nutrition for all South Africans

Nutrition is high on the global agenda, but South Africa has not yet reached all the milestones set for the Millennium Development Goals (MDGs). The United Nations held its first High-Level meeting on non-communicable diseases (NCDs) on 19 – 20 September 2011. The Scaling up Nutrition (SUN) initiative is a well-known global movement to improve nutrition at national levels. Recently the Copenhagen Consensus 2012 expert panel placed fighting malnutrition as the top priority for policy-makers and philanthropists and salt reduction campaigns to reduce chronic disease in the eleventh place.

It is estimated that more than 60% of all deaths worldwide are caused by NCDs - it is no longer a 'diseases of affluence'. In 2008, four out of five NCD deaths occurred in low- and middle-income countries. NCDs also account for 48% of the healthy life years lost (DALYs). Worldwide maternal and child under-nutrition is the underlying cause of 3·5 million deaths, 35% of the disease burden in children younger than five years and 11% of total global DALYs.

This picture is also seen in South Africa with about a third of South African children suffering from under-nutrition, and at the same time, already more than a half of South African adults suffer from overweight, obesity, and a high risk of NCDs. It is projected that 39 million children will be malnourished in the Sub-Saharan Africa by 2025.

As outlined by the Integrated Nutrition Programme (DoH, 1995), Roadmap for Nutrition in South Africa (DoH, 2010) and the Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition in South Africa (DoH, 2012) and more recently tabled in parliament the National Development Plan 2012-2030, government recognizes and accepts the obligations that improving nutritional status of South African's and in particular of children is critical to their survival, health, growth and development and is central to broader national development goals.

To break the poverty-malnutrition cycle we need to ensure food and nutrition security, empower the population to make healthier food choices (also for infants and children), and improve the food environment by forming partnerships and a common ethical agenda between all role-players responsible for this environment. We need to treat those with disease as well as develop, implement and evaluate cost-effective nutrition intervention and prevention programmes. This is the domain and practice area of Dietitians and Nutritionists. Now is the time for us to break this cycle - without the dedication of all nutrition health professionals it would be impossible to do so. A multi-sectoral trans-disciplinary approach is needed and appropriate partnerships must be formed if we want to be successful in our attempts to address the double burden of disease in South Africa.

Our common goal is clear – "Optimal nutrition for all South Africans". As Dietitians and Nutritionists we complement one another and by working in partnership we can achieve this goal. The task at hand is enormous. Let us take up this challenge and focus our efforts and energy on making a difference in the lives of every South African. As Board members we are committed to serving and growing both the dietetic and nutrition professions to achieve this common goal.

In an attempt to assist everybody with ethics CPD points we have included two accredited articles on ethics. Please complete the questions and submit before 15 December 2012 to accrue 6 CEUs for ethics – enough for a 12 month period! Thank you to ADSA and NSSA for working with and supporting the Board with this initiative. Thanks also to The Specialist Forum who provided the articles for reprinting.

Prof Edelweiss Wentzel-Viljoen
Chairperson of the ProfessionalBoard

HIGHLIGHTS IN THIS ISSUE:

INDEMNITY COVER FOR PRACTITIONERS

By Emmanuel Chanza

Following the introduction of a mandatory indemnity cover for private health establishments in terms of the National Health Act 61 of 2003, the various Professional Boards have urged all practitioners in private/independent practice to comply with the new legislation.

Indemnity cover for practitioners protects both the consumers of healthcare services as well as healthcare practitioners in terms of practitioners' financial ability to comply with court judgments. It will further compel practitioners to be more mindful of the standards of professional practice and conduct in their daily dealings with their patients.

The public is becoming increasingly aware of their patient and civil rights and some of our practitioners are realising they could face litigation for unprofessional conduct. As a result of the high standards of care our public have become accustomed to, and in an effort to maintain these standards of practice and conduct, the Board will ensure compliance with the provisions of the National Health Act is observed and encourages registered healthcare practitioners to have indemnity cover for their practices.

According to Section 46 of the National Health Act, (2003 passed by parliament) every private health establishment must maintain insurance cover to indemnify a user for damages that he or she might suffer as a consequence of a wrongful act by any member of its staff.

For practitioners registered to practice their professions in the public sector, the Department of Health is held responsible

if a practitioner is sued for malpractice. In the case of those in private practice, no one but the practitioner is held responsible and in some cases the practitioner's property may end up being attached by a court of law for damages resulting from malpractice.

The indemnity cover, in guiding the country's healthcare professionals, needs to ensure that practitioners are adequately covered to indemnify themselves for malpractice claims and that the service providers offering this cover are regulated by the laws of the Republic.

It is important to indemnify practitioners and ensure that they are protected within the relevant legal provisions for the ultimate benefit of patients.

MEETING WITH IMPORTANT STAKEHOLDERS

The Board is continuing to improve the communication and collaboration by meeting with important stakeholders.

Following a meeting held with stakeholders on 3 March 2011, representatives requested that a meeting between Heads of Departments (HOD's) and Provincial Nutrition Managers be held annually with the Board to discuss issues affecting the Dietetic and Nutrition professions.

As part of the strategic objectives to improve communication and collaboration, an annual meeting was held on 23 February 2012 between HOD's of educational institutions, Provincial Nutrition Managers and representatives from the professional organistations ADSA and NSSA.

General educational and policy issues were considered such as-

- Continuing Professional Development;
- Green Paper on Post – School Education and Training;
- Ten point Plan of the Department of Health;
- National Nutrition Strategy;
- The Guidelines on Internship for Dietetic Students;
- Credit Count for Dietetic Programme;
- Tshwane Declaration on breastfeeding;
- Specialisation in Dietetics;
- Community Service for Nutritionists;
- Designations for Dietitians and Nutritionists.

This is seen as a way forward to improve communication channels between the Board, Head of Departments and provincial Nutrition Managers, as well as associations and societies.

WARNING ON HIGH PROTEIN, LOW CARBOHYDRATES DIET

The Professional Board for Dietetics and Nutrition has expressed alarm at the recent spate of people encouraging the following of a high-protein, high fat and low carbohydrate diet, as these diets have severe health consequences for those who follow them long term.

The Board has had no option but to warn the public and express its concern over the controversial unhealthy diets that have been recommended in the media by individuals, who are not specialized in the dietetics and nutrition fields.

"Although low carbohydrate diets containing less energy may have short term beneficial effects on weight control and insulin resistance in some individuals, a healthy diet remains a balanced diet," Prof Edelweiss Wentzel-Viljoen, Chairperson of the Board said.

A recent study, published in the *British Medical Journal* found that low carbohydrate–high protein diets, used many years on a regular basis are associated with increased risk of cardiovascular disease. In the study over 43 000 Swedish women, aged 30 – 49 years, were followed-up for an average of 15.7 years. The researchers found that a 20g decrease in daily carbohydrate intake and a 5g increase in daily protein intake would correspond to a 5% increase in the overall risk of cardiovascular disease. In 2010 in another study published in *Circulation*, a positive association between intake of red meat and risk of heart disease among women was reported based on the large Nurses' Health Study.

"Exercise plays a very important role in the reaching and maintaining a healthy weight. A healthy diet remains one that is balanced in terms of carbohydrates, protein and fats as well as vitamins and minerals. The best way to reach a healthy balanced way of eating is to follow the South African Food Based Dietary Guidelines," she explains.

OWNERS OF HEALTHCARE PRACTICES HAVE SIX MONTHS TO COMPLY

The HPCSA has given all non-registered persons who are involved in the ownership of healthcare practices six months to unbundle their corporate structures and comply with legislation.

The Health Professions Act makes provision for healthcare practitioners as well as juristic persons to own practices. However, the regulations only provide for registered healthcare practitioners to serve as directors, shareholders, partners or associates in corporate entities. Furthermore, group practices across professions are also not permitted.

As a result, any corporate structure that includes unregistered professionals is non-compliant and these structures have to unbundle their entities in order to comply with the Act and applicable regulations and policy guidelines.

The Council has given healthcare practices until February 2013 to comply, where after all non-compliant practices will have their practice numbers deregistered with the Board of Healthcare Funders (BHF).

THE USE OF PROFESSIONAL DESIGNATIONS

A professional designation is a good way to document your knowledge, skills and abilities. A designation is required in some careers.

The Board therefore decided that professional designations for Dietitians and Nutritionists are as follows:
Dietitian: RD(SA)
Nutritionist: RNT(SA)

This will help to professionalise the interaction with the Board by assessing and recognising the practical abilities and skills of practitioners and drawing a correct distinction between the professions.

WHAT IS THE DIFFERENCE BETWEEN AN ASSOCATION AND THE BOARD

PROFESSIONAL BOARD (Professional Board for Dietetics and Nutrition)	**PROFESSIONAL ASSOCIATION/SOCIETY** (ADSA AND NSSA)
Membership is compulsory	Membership is optional/ voluntarily
The main function is protecting the public and guiding the professions	The main function is to promote the interests of the professionals

COUNCIL APPOINTS A NEW REGISTRAR /CHIEF EXECUTIVE OFFICER

Dr Buyiswa Mjamba-Matshoba took up her new position as Registrar/Chief Executive Officer of the Health Professions Council of South Africa from 2 May 2012.

Dr Mjamba-Matshoba was appointed after a rigorous selection process from across the country which saw applications from leaders in the South African healthcare industry.

Dr Mjamba-Matshoba takes over the post from Acting Registrar and CEO, Dr Kgosi Letlape, who has steered the HPCSA in the last few months while the selection process was underway.

Well-known in the medical industry, Dr Mjamba-Matshoba was previously the General Manager/Chief Director of the Eastern Cape Department of Health, a position she served in since 2002. She also held the post of General Manager: Quality Health Care Assurance Systems at the Eastern Cape Department of Health. Before that she was Chief Superintendent at the East London Hospital Complex (which included the Frere and Cecilia Makhiwane Hospitals).

This Medical Practitioner, who was born and bred in the Eastern Cape, has come to Pretoria with two key focus areas – to bring around a turnaround in service delivery and to create partnerships between practitioners, the public and the Council.

Her past experiences in the service delivery and quality assurance fields made her the obvious choice to lead the regulator into the future.

"One of my first priorities will be looking at our processes and systems and see how we could better serve our practitioners." Having been involved in healthcare her entire career, she understand the frustration some practitioners are experiencing and is busy looking at areas that may have been perceived as being slow in the organisation. "We need to make things as effective as possible for our practitioners – that is one of the reasons why the Council was established", she passionately explains.

President of the HPCSA, Professor Sam Mokgokong, welcomed Dr Mjamba-Matshoba to her new position, and said it was a dawn of a new era. "We are ecstatic at being able to secure someone like Dr Mjamba-Matshoba to lead the HPCSA into the future," Professor Mokgokong said, "Right now South African healthcare professionals face an immense number of challenges and opportunities, and we feel she is the right person to lead the HPCSA forward."

ACCREDITATION OF CLINICAL TRAINING FACILITIES

Aspects pertaining to education and training is crucial for the HPCSA in caring its mandate, and the accreditation of training facilities forms a very part of the Council's function in regulating the professions.

It is crucial to have accredited training facilities. The purpose of accreditation is to foster the institutions excellence, to provide recognition to accredited facilities, and to attract qualified individuals to training facilities of excellence. This process is intended to assure the student that the standards of education and training are consistent with the progress of their professions.

The driving vision of the HPCSA is to ensure "quality healthcare standards for all" members of the population of South Africa. This vision is pursued through the mission of HPCSA which is to enhance the quality of health by developing strategic policy frameworks for effective co-ordination and guidance of the professional boards in:

- Setting healthcare standards for training and discipline in the professions registered with the Council;
- Ensuring ongoing professional competence; and
- Fostering compliance with those standards.

The purpose of the Professional Board in setting and reviewing standards for education and training and professional practice is to ensure delivery of competent practitioners who will render healthcare services that meet health care needs.

The Professional Board will consider any training or satellite training facility attached to a Faculty of Medicine/Health Sciences at a University, provided such facility is recognised for education and training in a recognised training area. Such unit would also have to comply with the requirements of the Professional Board.

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Training areas in Dietetics include Therapeutic Nutrition, Community Nutrition and Food Service Management. The Faculty of Medicine/Health Sciences of the University must submit a duly compiled application to the Professional Board. All the relevant information must be provided. Please refer to Annexure E of Form 271, which is available from the Board.

Accreditation for education and training in a recognised satellite training facility will be valid for a period of five years, after which time the facility will be subject to re-evaluation by the Professional Board, if training is to continue in the given facility.

What are the benefits of registering with the HPCSA?

The Health Professions Council of South Africa (HPCSA or the Council) is a statutory body, established in terms of the Health Professions Act No 56 (Act 56 of 1974). The Council is committed to serving and protecting the public and providing guidance to registered healthcare practitioners.

The mandate is achieved by regulating the health professions in the Republic of South Africa in aspects pertaining to education and training, registration, professional conduct and ethical behavior, ensuring continuing professional development, and fostering compliance with healthcare standards.

Regulatory requirements:

- Registration with the HPCSA is a pre-requisite for professional practice;
- Practicing without current registration constitutes a criminal offence;
- It is a legal requirement to keep personal details current and up to date and failure to comply could result in erasure from the Register;
- Registration is dependent on compliance with all criteria, including validation of qualification and in certain instances includes a Board Examination.

Personal Professional Protection:

- Upon registration with the HPCSA you as practitioner will receive professional status, inclusive of the right to practise the profession that you are qualified for;
- You will be assured that no unqualified person may practise your profession;
- You will be recognised as a competent practitioner who may command a reward for services that you render.

Uncompromised standards of professional behaviour:

Upon registration with the Council you will:

- Have access to guidance on best practices in healthcare delivery;
- Contribute to high quality standards that promote the health of all South Africans;
- Receive the assurance that unethical practitioners will be brought to justice.

It is imperative your registration be up-to-date at all times. The annual fee is payable by the end of March of each year and failure to do so, will result in suspension from the Register.

In order to be restored, a practitioner is required to apply for restoration and pay penalty and outstanding fees.

Provision has been made in the Act for voluntary erasure in terms of Section 19(1) (c) if a practitioner does not intend to practice his/her profession in South Africa for a given period of time.

REQUIREMENTS FOR RESTORATION TO THE REGISTER

The annual fee is payable by the end of March of each year and failure to do so, will result in suspension from the Register in terms of Section 19 A (1) (b) of the Act.

In order to be restored, a practitioner is required to apply for restoration and pay penalty and any outstanding fees.

An application for restoration is being made by completing Form 18 which is obtainable from the website, www.hpcsa.co.za.

Dietitians and Nutritionists who have been erased for more than two years up to four years may be restored under the following conditions:

- Submission of proof of payment of the restoration fees and the duly completed application form, Form 18;
- The healthcare professional have to obtain the necessary 30 CEU's within 12 months of restoration;
- The professional will then be audited after 12 months to ensure that he/she have accrued the CEUs;

Dietitians and Nutritionists who had been erased for more than four years may be only restored after successful passing of the Board examination at one of the accredited higher educational institutions.

ENJOYING A GLASS TOO MANY EVERY NIGHT **TO ESCAPE THE EVERYDAY STRESSORS?**

Long working hours, societal and family expectations, fear of failure, dysfunctional relationships and increasing debt are the perfect recipe for "clutching out" every now and then. Add to that a pre-existing

or new medical and mental problem and you have a perfect recipe for a disaster.

If you had to have a glass of wine every night to forget about the day, used scheduled medicine to sleep at night or was involved in an accident and you do not know how to cope with your disability, you might want to talk to the Health Committee Secretariat.

The HPCSA realises that being a healthcare professional is one of the most stressful professions in the world. However help is available. The Council is responsible for ensuring that practitioners are fit to practice and are not impaired due to any physical or mental ill health.

The Health Committee assesses and manages the impairment of students and healthcare practitioners. It employs a non-punitive approach to the rehabilitation of practitioners in a bid to ensure that a complete recovery is made where possible and the practitioner is able to optimise his or her work potential.

As substance and alcohol abuse affects a practitioner's competence, judgment and performance, the Board is calling on practitioners to contact the Health Committee Secretariat for assistance, treatment and rehabilitation in order to work again as a highly esteemed practitioner. Self-referrals, referrals from colleagues, who are required in terms of the ethical rules to report such cases, and reporting by family members would enable the Health Committee to provide support to such practitioners and to act in protecting the interests of the public.

Health Committee Secretariat
Tel: 012 338 9446
Email: healthcom@hpcsa.co.za

Continuing Professional Development

The purpose of CPD is to help improve the quality of care provided to the public. It is essential that health care professionals remain competent and update their knowledge throughout their working years.

The Council has a statutory duty to promote high standards for all health care professionals. It places a responsibility on all health care professionals to comply with the requirements for CPD.

Random audits were done since January 2009. From January 2009 to 31 March 2012 a total of 3 254 practitioners were audited. Of the 3 254 practitioners audited 2 136 (66%) submitted their portfolios. 1 110 (34%) did not submit their portfolios. Of the 3254 practitioners who were audited, a very low percentage of 22.3% were compliant and 77.6% were non-compliant. Of the non-compliant practitioners 57.1% are because they just did not respond to the audit call, which means they do not take it seriously or they did not update their postal address with the Council.

After several audits it is evident that practitioners are non-compliant for the following reasons:

- practitioners do not submit portfolios when randomly selected;
- non-compliant with the ethical component;
- do not change their postal addresses with the Council;
- to a lesser extend practitioners are non-compliant with both the clinical and ethical component; and
- practitioners are not working or are working in a rural area.

The following suggestions are made to assist practitioners to be compliant:

- Attend activities that are accredited for CPD purposes, if you are attending activities that are not approved, submit it to the Accreditor of the Board for approval;
- Keep your contact details and your postal address updated at the HPCSA;
- Employers should have all their training approved by an accreditor;
- Providers are encouraged to make more electronic activities/journals (with MCQs) available;
- Postgraduate studies (personal and professional growth);
- Learning portfolio could be attended to (guidelines on website);
- Comprise Small groups/journal clubs/ discussion groups that meet every month or bi-weekly to discuss topics of interest in your specific scope of practice (This has to be approved by the Accreditor). These small groups could ensure that if you attend all those meetings you may be compliant with the CPD requirements every year at no or very minimal cos
- Employers should afford employees time off to attend CPD activities;
- More activities for ethics should be made available;
- Send an email to the CPD section to find out if you were audited; cpd@ hpcsa.co.za.

For contact details of the Accreditor please visit our website www.hpcsa.co.za/ professional. Go to the CPD section and access the Dietetics and Nutrition CPD page.

Frequently Asked Questions: CPD

1. **What is CPD?**

   Continuing professional development

2. **What is a CEU?**

   Continuing Education Unit

3. **I am on maternity leave; do I have to comply with CPD?**

   Yes

4. **I am retired; do I have to comply with CPD?**

   Yes

5. **I am working abroad; do I have to comply with CPD?**

   Yes, however, if you are compliant with the CPD requirements in the country where you are currently working, the Council will accept your CPD certificates or a letter from that licensing authority stating that you are compliant.

6. **I am not working and do not practise my profession, do I have to comply?**

   Yes, if you are registered you will have to comply or alternatively –

a. apply for voluntary erasure (no annual fees payable and you do not have to comply with the CPD requirements)
b. request to put your name on the non-clinical register (pay the full annual fee and you do not have to comply with CPD requirements.
Please note that in both cases if your name is off the Register longer than 2 years, certain conditions as set by the Board will apply.
Further note that if your name is erased from the Register or if you are registered in non-clinical practice, you cannot write prescriptions or practise your profession in any way.

7. **If I am registered in two different categories, do I have to obtain CEUs in both?**

   Yes

8. **I am doing community service; do I have to comply with CPD?**

   No

9. **I am currently in an academic post; do I have to comply with CPD?**

   Yes

10. **How many CEUs do I need to be compliant in a two year period?**

    Dietitian: RD(SA) 50 CEU's and 10 ethics points
    Nutritionist: RNT(SA) 50 CEU's and 10 ethics points

11. **I am currently studying; do I need to comply with CPD?**

    No

The HPCSA appoints a new Board Manager

In terms of the process of capacity building and staff development, Emmanuel Chanza was appointed as Board Manager to the Professional Board for Dietetics and Nutrition effective from April 2012.

Emmanuel has 13 years' experience as a Board Manager and has managed a number of Professional Boards including the following:

- Emergency Care;
- Dental Therapy and Oral Hygiene;
- Optometry & Dispensing Opticians;
- Environmental Health Practitioners; and
- Psychology

He is also serving as Board Manager for the Professional Board for Radiography and Clinical Technology as well as the Professional Board for Medical Technology.

He is committed to ensuring practitioners and the various Professional Boards are served with courtesy and expedience.

Welcome Emmanuel!

Emmanuel Chanza

WHO GUIDELINES ON HIV AND INFANT FEEDING

By Lynn Moeng

The World Health Organisation (WHO) reviews guidelines on HIV and infant feeding as new evidence becomes available. The first guidelines were published in 2001, followed by the 2006 and the latest are the 2010 guidelines.

WHO recommendations on HIV and Infant Feeding, 2001

"When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected mothers is recommended. Otherwise, exclusive breastfeeding is recommended during the first months of life" and should then be discontinued as soon as the above conditions are met. In addition abrupt cessation of breastfeeding was recommended.

The 2001 guidelines were ambiguous and left decisions to healthcare professionals about the duration of exclusive breastfeeding.

Significant programmatic experience and research evidence regarding HIV and infant feeding have accumulated since 2001 to 2006. In particular, evidence has been reported that antiretroviral (ARV) interventions to either the HIV-infected mother or HIV-exposed infant can significantly reduce the risk of postnatal transmission of HIV through breastfeeding.

This evidence has major implications for how women living with HIV might feed their infants, and how health workers should counsel and support them.

2006 WHO recommendations on HIV and Infant Feeding

The most appropriate infant feeding option for an HIV-infected mother depends on her individual circumstances, including her health status and the local situation, a mother should take consideration of the health services available and the counseling and support she is likely to receive;

Exclusive breastfeeding is recommended for HIV-infected mothers for the first six months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe for them and their infants before that time;

When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected mothers is recommended;

All breastfeeding should stop once a nutritionally adequate and safe diet without breast milk can be provided.

The recommendation was based on a few studies and there was no conclusive evidence on the contribution of ARV prophylaxis to prevent transmission through breastfeeding.

2010 WHO recommendations on HIV and Infant Feeding

After 2006 a systematic review of all available evidence was conducted. The review led to the 2010 recommendation that were based on certain principles and strong evidence.

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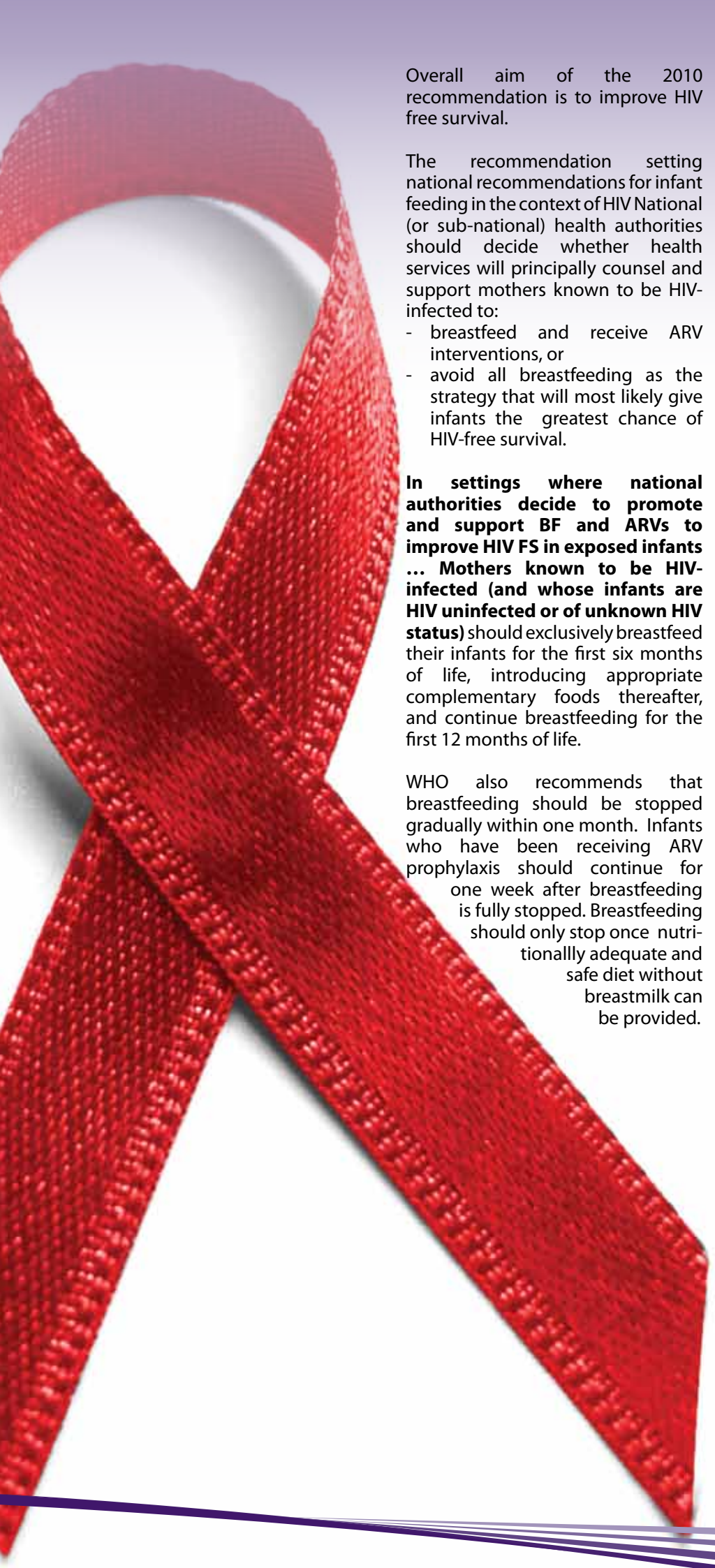

Overall aim of the 2010 recommendation is to improve HIV free survival.

The recommendation setting national recommendations for infant feeding in the context of HIV National (or sub-national) health authorities should decide whether health services will principally counsel and support mothers known to be HIV-infected to:

- breastfeed and receive ARV interventions, or
- avoid all breastfeeding as the strategy that will most likely give infants the greatest chance of HIV-free survival.

In settings where national authorities decide to promote and support BF and ARVs to improve HIV FS in exposed infants … Mothers known to be HIV-infected (and whose infants are HIV uninfected or of unknown HIV status) should exclusively breastfeed their infants for the first six months of life, introducing appropriate complementary foods thereafter, and continue breastfeeding for the first 12 months of life.

WHO also recommends that breastfeeding should be stopped gradually within one month. Infants who have been receiving ARV prophylaxis should continue for one week after breastfeeding is fully stopped. Breastfeeding should only stop once nutritionallly adequate and safe diet without breastmilk can be provided.

Clear guidance is also given to mothers who may choose not to breastfeed

Mothers on the PMTCT programme who may still decide to exclusively formula feed after counseling, should meet specific conditions as per WHO guidelines. (referred to as AFASS – affordable, feasible, acceptable, sustainable and safe in the 2006 WHO recommendations on HIV and Infant Feeding)

- Safe water and sanitation are assured at the household level and in the community; and,
- The mother, or other caregiver can reliably provide sufficient infant formula milk to support normal growth and development of the infant; and,
- The mother or caregiver can prepare it cleanly and frequently enough so that it is safe and carries a low risk of diarrhoea and malnutrition; and,
- The mother or caregiver can, in the first six months, exclusively give infant formula milk; and,
- The family is supportive of this practice; and,
- The mother or caregiver can access health care that offers comprehensive child health services.
- These conditions are intended to give simpler and more explicit meaning to the concepts represented by define the the acronym AFASS (affordable, feasible, acceptable, sustainable and safe).

It is therefore not acceptable for any healthcare professional to decide what is good for the infant unless it is for acceptable medical conditions.

THE TSHWANE DECLARATION OF SUPPORT FOR BREASTFEEDING IN SOUTH AFRICA

By Lynn Moeng

Rationale for escalating promotion of breastfeeding in South Africa

Optimal nutrition during infancy and childhood is critical to child health and development. Globally, under nutrition is a leading cause of childhood mortality. Inappropriate feeding practices, sub-optimal or no breastfeeding and inadequate complementary feeding, remain a significant threat to child health and survival.

South Africa is one of only 12 countries in the world where infant mortality has been on the increase and is also one of the countries with the lowest rate of exclusive breastfeeding in the world – at eight per cent according to the 2003 South African Demographic and Health Survey.

Other countries have increased their exclusive breastfeeding rates for infants 0-6 months, namely Benin 70%, Madagascar 67%, North Korea 65%, India 46% and Brazil 60% and this contributed significantly to the reduced infant and under-five mortality.

Role of healthcare professionals

The declaration therefore commits all healthcare practitioners to strengthen implementation of strategies aimed at promoting breastfeeding and for training institutions to equip healthcare professionals with the appropriate skills. Healthcare providers have the responsibility to undergo relevant training to update their knowledge and skills in line with current recommendations.

Commitments of the Tshwane Declaration

At the National Breastfeeding Consultation Meeting held on 23 and 24 August 2011 South Africa positioned itself as a country that actively promotes, protects and supports breastfeeding as a key infant survival strategy. The Department of Health also committed itself to take actions to demonstrate its support of breastfeeding and call on all stakeholders to support and strengthen efforts to promote breastfeeding. Some of the commitments include:

- The International Code of Marketing of Breast milk Substitutes be legislated by August 2012,
- Implementing the Mother Baby Friendly Initiative in all public health facilities by 2015,
- All private hospitals and health facilities are partnered to be BFHI (Baby Friendly Hospital Initiative) accredited by 2015,
- Community based interventions and support are implemented as part of the continuum of care to promote, protect and support breastfeeding. Legislation regarding maternity among working mothers to be reviewed in order to protect and extend maternity leave, and for measures to be implemented to ensure that all workers, including domestic and farm workers benefit from maternity protection, including an enabling work place;

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- Human milk banks to be promoted and supported as an effective approach, especially in post natal wards and neonatal intensive care units, to reduce early neonatal and postnatal morbidity and mortality for babies who cannot breastfeed;
- Continued research, monitoring and evaluation should inform policy development and strengthen implementation;
- Formula feeds will no longer be provided at public health facilities with the following exception:
  - Nutritional supplements including formula feeds will be available on prescription by appropriate healthcare professionals for mothers, infants and children with approved medical conditions.

At this meeting South Africa adopted the 2010 WHO guidelines on HIV and Infant feeding that recommends that all HIV infected mothers should breastfeed their infants and receive anti-retroviral drugs to prevent HIV transmission.

The meeting changed the name of the Baby Friendly Hospital Initiative (BFHI) to Mother-Baby Friendly Initiative (MBFI), since the initiative aims to improve care of the mother and the baby. Expansion to MOU's, CHC and clinics warranted an all inclusive name.

Relevancy of legislating the International Code of Marketing of Breast milk Substitutes

Although the decline in breastfeeding rates can be attributed to numerous of complex inter-related factors, the unethical marketing and promotion of artificial infant feeding by the producers of artificial infant foods, has consistently been identified as one of the major contributors to the decline in breastfeeding practices.

The World Health Assembly (WHA) adopted the International Code of Marketing of Breast milk Substitutes as well as related WHA resolutions to strengthen the Code in subsequent years, in response to concern over the toll that the aggressive marketing

of artificial feeding was having on infant health and survival. The Assembly recognised that improper practices in the marketing of breast milk substitutes were contributing to inappropriate feeding practices and causing infant malnutrition, morbidity and mortality in all countries.

The Code has largely been implemented on a voluntary basis at an international and national level since its inception, and as a result, despite the expressed commitment of infant feeding companies, compliance of the Code has repeatedly been called into question. Violations of the Code have consistently been reported throughout the world and in South Africa since 1981.

As a result, the WHA has called on all member states to translate the Code into effective national legislation on many occasions as a matter of priority. In 2010 the World Health Assembly again expressed its concern over the ineffectiveness of voluntary measures to ensure compliance with the Code. It then urged governments to develop and/or strengthen legislative, regulatory and/or other effective measures to control the marketing of breast-milk substitutes.

To improve this situation, as Dietitians and Nutritionists need to promote and support breastfeeding, but also to PROTECT it from the unethical and aggressive promotion of breast milk substitutes, bottles and teats. This can only be achieved through implementation and enforcement of the International Code of Marketing of Breast milk Substitutes and subsequent relevant World Health Assembly Resolutions at the national level.

It is against this backdrop the National Department of Health is working on the adoption of effective regulations in South Africa.

The current status of Mother-Baby Friendly Initiative (MBFI)

This initiative has experienced tremendous growth with more than 20 000 health facilities in more than 150 countries around the world have been declared Baby Friendly. The

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BFHI initiative was introduced in SA 1994. Since then, South Africa has seen a growing number of health facilities achieving Baby-Friendly accreditation. Today we have 44% of our healthcare facilities with maternity beds declared mother-baby friendly.

All healthcare facilities with maternity beds are encouraged to undertake the changes required to achieve Mother-Baby Friendly Initiative to meet the 100% target by 2015 in order to improve breastfeeding rates and the health and wellbeing of mothers and babies. However, sustainability of the initiative remains a challenge. Achieving required outcomes of increasing exclusive breastfeeding rates and to positively contribute to child survival, community support for breastfeeding needs to be strengthened.

Community based interventions and support are implemented as part of the continuum of care to promote, protect and support breastfeeding.

Because mothers and their babies stay for a very short period of time in the healthcare facility it is important to strengthen Step 10 of BFHI related to facilitating BF promotion at community level.

A strong link through infant feeding support group involvement should be established between the healthcare facility and the community to achieve success in promotion of breastfeeding in the community. The Department of Health is in the process of introducing a clinic based MBFI. This initiative will strengthen breastfeeding promotion at community and PHC level.

Role of healthcare professionals

Health Professionals have a major role to play in ensuring that infants get the very best start in life.

In a country like South Africa, where the majority of births take place in a healthcare facility, healthcare professionals can provide the support and encouragement that is vital to the establishment of good breastfeeding practices. Clients place great faith in the opinions and attitudes of their healthcare professionals, who therefore exercise considerable influence. Follow up support is also crucial to ensure continued support.

Healthcare professionals should

- Encourage healthcare facilities to adopt the Ten Steps to Successful Breastfeeding and to participate in the BFHI and implement Kangaroo Mother Care where necessary.
- Provide women with evidence-based objective and unbiased infant feeding information independent of commercial influence,
- Provide accurate information and appropriate skills to support mothers to breastfeed and start complementary feeding at six months of age, and
- Make themselves familiar with their responsibilities under the Code.

A DIETITIAN'S COMMUNITY SERVICE EXPERIENCE

By Lynn Moeng

Community service became compulsory for Dieticians in 2002 to ensure that newly qualified health professionals do a year of community service for the Department of Health before they can register for Independent Practice. The aim of Community Service was to ensure availability of professionals in remote communities that are disadvantaged and underserved. Since 2003 there has been on average 100 Dietitians employed in compulsory community service each year.

Even though Community Service Dietitians (CSDs) are qualified professionals they still need to be mentored and supported during their community service year, to introduce them to government policies and practices, but unfortunately this has not been possible in some instances.

Most Community Service Dieticians have found themselves being placed alone in facilities where they had to establish a dietetic department and market dietetic services to other health professionals whilst providing services to patients and in some instances be involved in community outreach services. In facilities where there had never been a Dietitian employed it is even more difficult for CSDs to put systems in place to function, hence the despondency and frustration.

In 2009, the Health Professions Council of South Africa (HPCSA) commissioned a study to evaluate how Community Service Dieticians experience and perceive community service year and secondly to evaluate their knowledge, skills and competencies to successfully complete duties during the community service year.

The study revealed that despite the challenges that CSDs experience during their community service year, 60% of those interviewed reported to have enjoyed their year of community service.

CSDs in this study, similar to other previous studies on community service, still reported that health facilities and or district offices were not entirely prepared for their arrival such that some CSDs were not allocated a working space, and some of those that were allocated space reported that the space was not adequate for the services that they needed to provide.

Other challenges that community service professionals experienced mainly centered on the lack of supervision and support, lack of resources and equipment, inadequate staffing levels and language barriers. Some CSDs also reported that there seemed to be confusion about their role and job description.

To ease placement and to create a conducive working environment and experience during the community service year for CSDs, various stakeholders need to work together to address the gaps amongst employers expectations and competencies of newly qualified Dietitians.

The Department of Health, provincial and district level could play a pivotal role by developing clear guidelines and orientation packages for CSDs. In addition, all CSDs need to be orientated to the relevant policies, guidelines and protocols. Training institutions also have a role to play in familiarising students during training with the realities of the environment where they will be working.

In instances where there is no experienced dietitian in the facility for mentorship, there should be a mechanism whereby CSDs are linked with other dietitians within their vicinity for support or have access to the province or district nutrition manager.

Community Service Dietitians are an important component of the health system, and it is therefore in the interest of all stakeholders to ensure their smooth entry into the profession.

The HPCSA appreciates the contribution made by CSDs during the evaluation it will contribute to the strengthening of the profession.

NUTRITION SOCIETY OF SOUTH AFRICA APPOINTED AS PROFESSIONAL ORGANISATION FOR NUTRITIONISTS IN SOUTH AFRICA

By Prof Marius Smuts (NSSA President)

The Nutrition Society of South Africa (NSSA) has been appointed by the Professional Board for Dietetics and Nutrition of the HPCSA as the professional organization for Nutritionists in South Africa.

On behalf of the NSSA, let us congratulate all Nutritionists on becoming a registered Nutritionist or one in training.

The NSSA is in negotiations with the Professional Board for Dietetics and Nutrition on the way forward, but will send you documentation on how the Society with structure within the NSSA. In the mean time it is important for all registered Nutritionists and Nutritionist in training to join NSSA. Through membership practitioners will receive communications regarding scientific meetings, as well forthcoming Biennial Nutrition Congress that will be hosted in Bloemfontein, amongst others.

Please visit the NSSA www.nutritionsociety.co.za and ADSA (www.adsa.org.za) websites for more information. After joining NSSA, Nutritionists will be automatically linked to a NSSA branch depending on where they stay in SA.

The NSSA has three established branches in the country, namely, the Western Cape, Northern and Eastern Branches. These branches will be your first point of communication practitioners will receive all information regarding activities at branch-level directly from them. The branch chairperson will soon be in contact with members.

The NSSA has negotiated with the Association for Dietetics in South Africa (ADSA) who will be the Accreditor for purposes of CPD (Continuous Professional Development) for the profession of Nutrition.

It remains the practitioners responsibility to attend CPD activities as it is critical as health professionals to continually your knowledge and skills for the benefit of the people you serve.

The society will recommend that Nutritionists register with the NSSA, if not already registered, at their earliest convenience to also receive a free copy of the South African Journal of Clinical Nutrition and all future communications. If members have any questions, please do not hesitate to send it to the Administrative Secretary, Jacqui Lochner (nssa@mweb.co.za).

Ethics Article 1/2012

Retention of medical records

CPD Activity DT/A01/2012/00109

Reprinted with permission from the Medical Protection Society: www.medicalprotection.org
Correct as of September 2011

All healthcare professionals should appreciate the value of keeping accurate, detailed medical records for each patient. However, many doctors are unaware of how to manage medical records and do not know when it is permissible to dispose of them. This factsheet outlines the principles for retaining medical records.

Retention of medical records

Good records management is essential for the continuity of care of your patients, and can reduce the risk of adverse incidents through misplaced or untraceable records. Problems with medical records - lack of accessibility, poor-quality information, misinformation, poorly organised notes, misfiling, and many others - are known to lie at the root of a high proportion of adverse incidents.

It is good practice for every healthcare organisation to have a records management policy in place. An individual should be nominated as the person responsible for reviewing the policy on a regular basis and ensuring it is up-to-date with legislative requirements. Familiarise yourself with the following two record management standards:

- ISO standard ISO/IEC 27002: 2005 - which contains information on security issues such as staff responsibilities and training, premises, business continuity, protocols and procedures, email and internet usage policies and remote access. This standard has been approved for use in South Africa as SANS 27002:2008.
- ISO 27799: 2008 - Health Informatics: Information Security Management in Health - which contains all the relevant guidance in ISO/IEC 27002 as it relates to the healthcare sector.

Retention

The HPCSA offers the following guidance on the retention of medical records:

- Records should be kept for at least six years after they become dormant.
- The records of minors should be kept until their 21st birthday.
- The records of patients who are mentally impaired should be kept until the patient's death.
- Records pertaining to illness or accident arising from a person's occupation should be kept for 20 years after treatment has ended.
- Records kept in provincial hospitals and clinics should only be destroyed with the authorisation of the deputy director-general concerned.
- Retention periods should be extended if there are reasons for doing so, such as when a patient has been exposed to conditions that might manifest in a slow-developing disease, such as asbestosis. In these circumstances, the HPCSA recommends keeping the records for at least 25 years.
- The cost and space implications of keeping records indefinitely must be balanced against the possibility that records will be found useful in the defence of litigation or for academic or research purposes.
- Statutory obligations to keep certain types of records for specific periods must be complied with (see HPCSA, Guidelines on the Keeping of Patient Records (2008), paragraph 9.)

Disposal of medical records

An efficient records management system should include arrangements for archiving or destroying dormant records in order to make space available for new records, particularly in the case of paper records. Records held electronically are covered by the Electronic Communications and Transactions Act, which specifies that personal information must be deleted or destroyed when it becomes obsolete.

A policy for disposal of records should include clear guidelines on record retention and procedures for identifying records due for disposal. The records should be examined first to ensure that they are suitable for disposal and an authority to dispose should be signed by a designated member of staff.

The records must be stored or destroyed in a safe, secure manner. If records are to be destroyed, paper records should be shredded or incinerated. CDs, DVDs, hard disks and other forms of electronic storage should be overwritten with random data or physically destroyed.

Be wary of selling or donating second-hand computers – 'deleted' information can often still be recovered from a computer's hard drive.

If you use an outside contractor to dispose of patient-identifiable information, it is crucial that you have a confidentiality agreement in place and that the contractor provides you with certification that the files have been destroyed.

You should keep a register of all healthcare records that have been destroyed or otherwise disposed of. The register should include the reference number (if any), the patient's name, address and date of birth, the start and end dates of the record's contents, the date of disposal and the name and signature of the person carrying out or arranging for the disposal.

Protecting paper records

If you keep a large quantity of paper records, you must ensure there are systems in place to protect them.

Paper records can be easily damaged by moisture, water, fire and insects. As paper records are irreplaceable, it's a good idea to carry out a risk assessment to identify ways in which to safeguard them. If you keep a large quantity of paper records, you must ensure there are systems in place to protect them in case of fire, flood or other circumstances that could damage the records.

You must ensure you install smoke and fire alarms to allow you to act quickly in the event of a fire breaking out. Water sprinkler systems can damage electronic equipment so install chemical fire extinguishers to protect your paperwork.

Avoid storing archives of paper records in a basement as they are prone to flooding - instead, store records above floor level and ideally on a high shelf.

It is also important to conduct regular inspections of your premises and have control measures carried out by experts to keep damaging insects and rodents at bay.

Protecting electronic records

Electronic records should be regularly backed up and the back-up disk should be kept at a secure off-site location. Do not be tempted to keep your computer back-up drive in a fire-proof safe - if a fire breaks out, it can melt. Instead, use secure off-site storage wherever possible. If you have sprinklers in areas that house computers which contain electronic copies of medical records, put waterproof covers on the computers before going home at night.

CPD Questions

CPD Activity Reference Number: DT/A01/2012/00109

HOW TO EARN YOUR CEUs

1. Complete your personal details below.
2. Read the article titled "Retention of medical records." and answer the questions.
3. Indicate your answers to the questions by making an "X" in the appropriate block at the end.
4. You will earn 3 CEUs if you answer 70% or more of the questions correctly. A score of less than 70% will unfortunately not earn you any CEUs.
5. Make a photocopy for your own records in case your answers do not reach us.
6. Scan the area indicated below into an e-mail message and e-mail it to info@factssa.com or post to P.O. Box 565, Milnerton 7435. The answers should not reach us later than 30 November 2012.
   Answer sheets received after this date will not be processed.

PLEASE ANSWER ALL THE QUESTIONS

(There is only one correct answer per question.)

1. **True or False:** Good records management can reduce the risk of adverse incidents through misplaced or untraceable records.
   a. True
   b. False

2. **True or False:** Misfiling is one of various problems with medical records known to lie at the root of a high proportion of adverse incidents.
   a. True
   b. False

3. **True or False:** The ISO 27799: 2008 - Health Informatics: Information Security Management in Health is a record management standard which contains all the relevant guidance in ISO/IEC 27002 as it relates to the healthcare sector.
   a. True
   b. False

4. **True or False:** Medical Records should be kept for at least five years after they become dormant.
   a. True
   b. False

5. **True or False:** The records of minors should be kept until their 18th birthday.
   a. True
   b. False

6. **True or False:** Records pertaining to illness or accident arising from a person's occupation should be kept for 20 years after treatment has ended.
   a. True
   b. False

7. **True or False:** If records are to be destroyed, paper records should be shredded or incinerated. CDs, DVDs, hard disks and other forms of electronic storage should be overwritten with random data or physically destroyed.
   a. True
   b. False

8. **True or False:** Deleted information can often still be recovered from a computer's hard drive which prompts caution when selling or donating second-hand computers.
   a. True
   b. False

9. **True or False:** It is advised to store archives of paper records in a basement on a high shelf.
   a. True
   b. False

10. **True or False:** Protect electronic records by performing regular back-ups and keeping it at a secure on-site location.
    a. True
    b. False

After completion, scan the section below and e-mail OR Mail to PO Box 565, Milnerton 7435

Retention of medical records.
CPD Reference number: DT/A01/2012/00109

HPCSA number: DT or NT .....

Initials: .....

.....

Surname as registered with the HPCSA:

Contact number: .....

E-mail address: .....

Please make an "X" in the appropriate block for each question:

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Ethics Article 2/2012

Consent - children and young people

CPD Activity DT/A01/2012/00108

Reprinted with permission from the Medical Protection Society: www.medicalprotection.org
Correct as of September 2011

Consent - children and young people

Valid consent is just as important when treating children and young people as it is with adults. In some situations children are able to give consent themselves, and sometimes others need to take the decision on their behalf. This factsheet sets out the basic information to enable you to obtain the appropriate consent from children and young people.

Key principles

The overriding principle is that the child's best interests take precedence. There are several pieces of legislation in force that govern the issue of minors and consent to medical treatment, but even with this guidance, there are grey areas. These may include the maturity of the child concerned, the wishes and opinions of the parents/guardian, and the clinical circumstances - and it is possible that some of these may conflict. The overriding principle in such situations is that the child's best interests take precedence.

In law, assistance by a parent or legal guardian is required if a child is under the age 12 years for surgical procedures. In practice, however, it is fair and reasonable to seek the consent of a minor who has the capacity to grasp the nature and implications of the proposed treatment or procedure. Regarding parental consent, if there are two people with parental responsibility, it is usually enough for one to give consent; however, where decisions may have irreversible consequences, both parents should be consulted.

In an emergency, where a person with parental responsibility is not available to give consent, required treatment may proceed with the consent of the superintendent of a hospital, or the person in charge if the superintendent is unavailable. If neither is available, HPCSA guidance states that a healthcare practitioner may treat the child, provided it is in the child's best interests and that the treatment given is "limited to treatment which is reasonably required in [the] emergency".

In state hospitals, the decision to give emergency treatment should be taken by the clinical manager. In non-urgent situations, an application should be made to the Minister, who is empowered to give consent in lieu of the child's parent or guardian.

Age and consent

In the absence of a parent, guardian or care-giver, the superintendent of a hospital can consent, in an emergency, to a child's medical or surgical treatment

Children aged 12 years or more

Provided they have the maturity "to understand the benefits, risks, social and other implications of the treatment", children of this age may consent to medical treatment on their own behalf. If the proposed treatment involves a surgical procedure, a sufficiently mature child may still consent, if he or she is "duly assisted by his or her parent or guardian".

Minors aged 12 years or more who are themselves parents ('child parents') may also, if they possess the maturity to do so, consent to medical examinations and treatment for their child. They may also consent to surgical treatment for their child, but only with the assistance of someone who has parental responsibility for them.

Children under 12 years or over 12 years but lacking the maturity to make an informed decision

A parent, guardian or care-giver of the child may consent on behalf of the child to medical treatment. A parent or guardian may also consent to surgical treatment on the child's behalf.

In the absence of a parent, guardian or care-giver, the superintendent of a hospital can consent, in an emergency, to a child's medical or surgical treatment if it is necessary to preserve the child's life or "to save the child from serious or lasting physical injury or disability".

Continuing treatment when a child withholds consent

If a minor with decisional capacity refuses life-saving treatment, any decision to overrule the patient's withholding of consent should be made by the courts, rather than the treating clinicians, except in an emergency where immediate action must be taken to preserve the child's life or prevent serious harm.

Continuing treatment when parents withhold consent

Occasionally, parents may disagree with the orthodox management of certain conditions and, as a result, make a decision on consent that is likely to affect the child adversely. Even if this decision is not life-threatening, there may still be a degree of suffering on the child's part.

If there is reason to believe that a parent's refusal to consent to a child's medical treatment is placing that child at risk, the matter should be referred to the hospital's legal department, who may either petition the court for a ruling or apply to the Minister of Health for consent.

In the event of either a legally competent child or a child's parent or guardian "unreasonably refusing to consent" to treatment, either the Minister or the High Court may overrule the refusal.

Virginity tests

Virginity testing of children under the age of 16 years is prohibited and may only be performed on children over 16 with their consent, obtained after proper counselling. The results of a virginity test may not be disclosed without the child's consent.

Circumcision

Every male child has the right to refuse circumcision. Female circumcision is prohibited, regardless of age. Male circumcision is prohibited under the age of 16, unless it conforms to prescribed religious or cultural practices or is medically necessary. Circumcision of boys 16 years and older must be carried out in a prescribed manner and only with the boy's consent, given after appropriate counselling. The Children's Act 2005 states: "Taking into consideration the child's age, maturity and stage of development, every male child has the right to refuse circumcision."

CPD Questions

CPD Activity Reference Number: DT/A01/2012/00108

HOW TO EARN YOUR CEUs

1. Complete your personal details below.
2. Read the article titled "Consent - children and young people." and answer the questions.
3. Indicate your answers to the questions by making an "X" in the appropriate block at the end.
4. You will earn 3 CEUs if you answer 70% or more of the questions correctly. A score of less than 70% will unfortunately not earn you any CEUs.
5. Make a photocopy for your own records in case your answers do not reach us.
6. Scan the area indicated below into an e-mail message and e-mail it to info@factssa.com or post to P.O. Box 565, Milnerton 7435. The answers should not reach us later than 15 December 2012.
   Answer sheets received after this date will not be processed.

PLEASE ANSWER ALL THE QUESTIONS

(There is only one correct answer per question.)

1. **True or False:** Valid consent is not as important when treating children and young people as it is with adults.
   a. True
   b. False

2. **True or False:** Children are never able to give consent themselves.
   a. True
   b. False

3. **True or False:** Some factors may conflict with legislation that governs consent for medical treatment of minors, but the overriding principle should always be the child's best interest.
   a. True
   b. False

4. **True or False:** If there are two people with parental responsibility, only one has to give consent where decisions may have irreversible consequences.
   a. True
   b. False

5. **True or False:** In law, assistance by a parent or legal guardian is required if a child is under the age 12 years for surgical procedures.
   a. True
   b. False

6. **True or False:** In the absence of a parent, guardian or care-giver, the superintendent of a hospital can consent, in an emergency, to a child's medical or surgical treatment.
   a. True
   b. False

7. **True or False:** Children aged 15 years or older may may consent to medical treatment on their own behalf provided they have the maturity to understand the benefits, risks, social and other implications of the treatment.
   a. True
   b. False

8. **True or False:** If a minor with decisional capacity refuses life-saving treatment, any decision to overrule the patient's withholding of consent should always be made by the courts.
   a. True
   b. False

9. **True or False:** If there is reason to believe that a parent's refusal to consent to a child's medical treatment is placing that child at risk, the matter should be referred to the hospital's legal department.
   a. True
   b. False

10. **True or False:** The Children's Act 2006 states that every male child has the right to refuse circumcision.
    a. True
    b. False

After completion, scan the section below and e-mail OR Mail to PO Box 565, Milnerton 7435
Consent - children and young people.
CPD Reference number: DT/A01/2012/00108

HPCSA number: DT or NT .....

Initials: .....

.....

Surname as registered with the HPCSA:

Contact number: .....

E-mail address: .....

Please make an "X" in the appropriate block for each question:

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ANNUAL FEES REMINDER

A friendly reminder that Annual Fees are due before 1 April 2013.

Annual fees are determined by the amount needed to cover all financial obligations of the Professional Board, including the Professional Board's contribution to the running of the Council.

During the budget discussion Professional Board members always negotiate for the lowest fees possible.

Alternative strategies are investigated by the Professional Board in an attempt to limit further increases in annual fees.

Please note that we do not accept cash on our premises Please retain receipts or evidence and submit with relevant documentation.

For your convenience, you have three easy payment options to choose from:

1. Direct or Internet Banking.

2. Debit order - Please consult our website for more information and complete the debit order form and send back to us;

3. Credit card – Please consult our website for more information and the Credit card authorisation form.

    - Please use your seven digit registration number and correct Register (e.g. DT 0000000as the reference;
    - Please note that electronic payments into the HPCSA account will take 2-3 working days to reflect, and 24 working hours if done by direct transfer;
    - Please take note of the above, especially if you intend visiting our offices to register.

BANKING DETAILS FEES
Bank: ABSA
Branch: Arcadia
Branch Code: 33 49 45
Account number: 405 00 33 481 (Annual fees ONLY)
Include your HPCSA registration number as reference

KINDLY QUOTE YOUR HPCSA REGISTRATION NUMBER AS THE REFERENCE NUMBER TO ENSURE PAYMENT IS ALLOCATED TO YOUR NAME.

GENERAL INFORMATION

For any information or assistance from the Council direct your enquiries to the Call Centre.
Tel: 012 338 9300/01
Fax: 012 328 5120
Email: info@hpcsa.co.za

Where to find us:
Physical address
553 Madiba (Vermeulen) Street
Corner Hamilton and Madiba
(Vermeulen) Streets
Arcadia; Pretoria

Postal address
P O Box 205
Pretoria 0001

Working hours:
Mondays - Fridays: 08:00 - 16:30
Weekends and public holidays – closed

Communication with the Board should be directed to:
P.O. Box 205
Pretoria
0001

Board Manager
Emmanuel Chanza
Tel: 012 338 9339
Email: emmanuelc@hpcsa.co.za

Committee Coordinator
Sibusiso Nhlapo
Tel: 012 338 9403
Email: sibusison@hpcsa.co.za

Secretary
Abegail Nkosi
Tel: 012 338 9380
Email: abegailn@hpcsa.co.za

Annual Fees, payments and reminders, general information and forms, registration of locally qualified practitioners

Client Contact Centre
Tel: 012 338 3901
Fax: 012 328 5120
Email: info@hpcsa.co.za

Certificate of Good Standing/Status, certified extracts, verification of licensure
Susan Ndwalane
Tel: 012 338 3935
Email: hpcsacgs@hpcsa.co.za

Continuing Professional Development (CPD)
Helena da Silva
Tel: 012 338 9413
Email: cpd@hpcsa.co.za

Hilda Baloyi
Tel: 012 338 9432
Email: hildab@hpcsa.co.za

Raylene Symons
Tel: 012 338 9443
Email: raylenes@hpcsa.co.za

Change of contact details
Email: records@hpcsa.co.za

Ethical queries, human rights, ethics and undesirable business practice:
Ntsikelelo Sipeka
Tel: 012 338 3946
Email: ntsikelelos@hpcsa.co.za

Service Delivery
Email: servicedelivery@hpcsa.co.za
Tel: 012 338 9301

Complaints against practitioners
Legal Services
Fax: 012 328 4895
Email: legalmed@hpcsa.co.za

e-Bulletin

This is a monthly electronic newsletter, if you have not received it; it means your e-mail details are not correct or not submitted. Please send us an email to update your details to: records@hpcsa.co.za

Dietetics News is a newsletter for practitioners registered with the Professional Board for Dietetics and Nutrition.

It is produced by the Public Relations and Service Delivery department, HPCSA building, 2nd floor, 553 Madiba (Vermeulen) street, Arcadia, Pretoria.

Practitioners are encouraged to forward their contributions to Sipho Mbele at siphom@hpcsa.co.za