

COMPETENCIES FOR PUBLIC HEALTH NUTRITION

**Background Paper for the Australian Public
Health Nutrition Academic Collaboration
(APHNAC)**

DRAFT

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Preamble

This paper is presented in response to the Australian Public Health Nutrition Academic Collaboration (APHNAC) project objective of developing a competency framework to inform advanced-level public health nutrition training in Australia. This paper begins by providing a synopsis of the literature relating to the competency development movement and competency development efforts in fields related to public health nutrition. This provides an important contextual background for considerations about competency requirements of the public health nutrition workforce. Data from different research methods and sources investigating public health nutrition competency issues are then presented and interpreted via triangular analysis to identify commonalities, informing a drafting of competency elements for public health nutrition. These are then compared with the recently released competency framework proposed in the National Public Health Education Framework [1].

A synopsis of the competencies movement and its relevance to public health nutrition

Competencies, competency standards and credentialing are all variations on a world-wide movement within the education, training and professional sectors. Competency based training (CBT) has been embraced by government and industry in Australia as a result of the economic rationalistic drive for efficiency since the 1980's. This movement is based on the premise that people need to be taught knowledge, skills and attitudes required in the workforce. This is supported by an argument that CBT would enhance the education sectors responsiveness to the economy and produce reliable outcomes [2, 3].

Credentialing is the establishment of a self-regulatory process instituted by the relevant profession to determine and acknowledge that an individual has demonstrated competence to practice [3]. Competency standards are

defining statements about a profession or work role that can be used to assist credentialing.

There is now a considerable literature debating the merits and limitations of the competencies movement [3-8]. This debate has been mostly related to the broader training and education environment rather than specifically applied to nutrition or public health, but it is worth considering in any deliberation about the value of competency development for public health nutrition. Differences in the theoretical and philosophical underpinnings of the competencies movement have been the basis for this disagreement and debate.

The behavioralist approach, which has its origins in the efficiency movement [9], sees competency as the ability to complete discrete behaviours. This conception tends to atomise tasks, making them easier to measure, but makes training and assessment task focused, which is reductionist rather than holistic. A preoccupation with tasks ignores underlying attributes such as the ability to make judgements and perform multiple tasks simultaneously, overlooking the complexity of performance in the real world [3].

The holistic or integrated approach draws from the progressive education movement [9] and is concerned with teaching attributes such as critical thinking, under the assumption that they will be applied in the workplace in specific contexts. This view is concerned with the way knowledge, attitudes, values and skills are used in combination, in particular situations. In this perspective, competencies are relational, involve reflective practice and place importance on context [3].

CBT has aroused much controversy, especially amongst educationists with a commitment to preparing people as citizens in society rather than just for the workforce. An overemphasis on competencies can mean that people only become skilled in relation to a particular occupation [10]. Advocates of the CBT approach see it as a countervailing force against education producing people who know but cannot do [10].

A summary of the arguments in favour and against CBT is provided in Table 1.

Table 1 *Summary of the arguments for and against competency based training*

Arguments in favour of CBT	
Role clarity and delineation	Competency standards aim to define the work and performance of the profession and therefore help define and delineate roles. Preventing overlap between professions may improve efficiency and this has been a compelling argument in favour of competencies.
Accountability and credibility	Standards help define the nature of the work of a profession and help communicate the complexity of work which may increase the credibility of the profession amongst the community.
Education	Competencies provide clearer goals for educators, learners and assist with curriculum design and assessment
Consistency	Competencies can assist universities produce graduates with consistent minimum competencies because they provide a common ground for discussion between teachers and the profession.
Equity	Competency measurement can increase equality between people from different backgrounds. i.e. assessed based on ability to perform rather than academic path or course completed.
Cross profession movement	The common language of competencies that are consistent between professions can enable transfer across disciplines or overseas recognition
Arguments against CBT	
Reductionism	The tendency of competencies and competency assessment to isolate components of performance ignores the complexity of work.
Efficiency does not mean effectiveness	A more competent worker does not necessarily lead to a more effective worker
Control and sameness	Competencies and the use of competencies as a basis of credentialling can constrain workforce construction and behaviour leading to lack of innovation and diversity
Checklists	Competency assessment can become complicated leading to a simplistic use of competencies as checklists. Skills performance without knowledge and context can be life threatening in the health sector .
Towards mediocrity	Competencies prescribe minimum standards that might discourage excellence by reducing everything to the lowest common denominator.
Teaching to the test	Competencies may encourage a believe that if something is not measureable as a competency it is not worth doing or learning and threatens learning processes.
Questionable reliability	There is no evidence to support CBT as a reliable measure.
Reduced liberal education	The tendency of competencies to be reductionist may reduce elements of liberal education such as experimentation, attributes like learning how to learn and problem solving.

From: [3-8, 10]

Literature addressing competencies in fields related to public health nutrition

Public health workforce development scholarship over the last few years has emphasized the importance of developing a competent public health workforce as a precursor to increasing societal capacity to protect and promote the public health [11-15]. As a result, there has been an emphasis on developing competency standards to provide the architecture for workforce development in public health [16, 17], preventive medicine [18, 19], health promotion [20, 21] and health education fields [22]. It has also been of interest to public health nutrition scholars internationally [23-27]. Most recently in Australia, the development of a National Public Health Education Framework (NPHEF) has provided a public health competency framework for the public health workforce[1]. Many of the competencies identified in this literature are similar with considerable overlap across fields.

Public health nutrition competencies scholarship in Australia

The limited scholarship relating to nutrition and dietetic workforce development published in Australia up until the early 2000s, has focused on entry-level dietetics competencies [28] and the training needs associated with the developing work roles of dietitians [29]. Public health nutrition specific workforce scholarship in Australia has been limited to the work of the Public Health Education and Research Program (PHERP) funded Specialty Program in Public Health and Community Nutrition in the mid 1990s [30] and an unpublished community nutrition workforce survey conducted as part of a masters research project [31]. This work and more recent reviews of entry-level dietetic competencies [28] have identified a need for public health nutrition specific competencies and systems for continuing competency development.

Recently there has been a concentrated research effort to explore competency requirements specific to public health nutrition practice, partly in response to a recognition of the need for competency-based workforce development [30] and the mandate for workforce development provided by the National Public Health Nutrition Strategy (Eat Well Australia)[32]. These different research projects are summarised in Table 2 to provide a context for the triangular analysis that has informed the drafting of a framework of PHN competency units and elements in Table 4, and provide the intelligence to answer the following questions relating to competencies for public health nutrition. These questions include:

- Why not use the competency framework developed for public health rather than develop a specific set for public health nutrition?
- What are the functions of competencies for public health nutrition?
- At what levels do the competencies target (individuals, work groups or the workforce)?

Responses to these questions are provided with reference to the research described in Table 2.

Table 2 Summary of recent public health nutrition related competency scholarship in Australia, 2001-2003.

Year	Authors	Method description	Data type/use	Reference
2001	Coveney and Mackerras	Stakeholder interviews (n=?) in key state and federal agencies including South Australian Department of Human Services, New South Wales Department of Health, Commonwealth Department of Health and Aged Care, ANZFA, AIHW, ABS, AFGC. Content analysis of interviews.	Attitudinal data reported as aggregated themes from stakeholder interviews with respect to areas identified for knowledge and skill development. Reflects opinions of officials (employers/senior technocrats) in 7 key organisations relevant to public health nutrition.	[33]
2001	Hughes	Qualitative analysis of semi-structured interview transcripts from 41 advanced level public health nutritionists (ALPHNs) employed in academic or senior technocratic position in state and federal health systems.	Attitudes from ALPHNs about competencies (skills, knowledge and attitudes) considered as necessary for effective public health nutrition practice.	[34]
2001/2	Hughes	Cross-sectional national public health nutrition workforce survey (WFS) amongst 240 practitioners (87% RR) from each state and territory. Self-completing questionnaire with items asking respondents to rate opinions against a list of competency items summarised from the literature and informed by earlier qualitative study[34]	Practitioners attitudes about the: <ul style="list-style-type: none"> • the importance of, • confidence in own ability and • training needs Against 37 pre-defined competency items.	[35]
2002/3	Hughes	Qualitative content analysis of job descriptions obtained from a sample of the known community and public health nutrition workforce in Australia and collation of positions descriptions advertised in the February 2002-August 2002 period. Job descriptions acting as a proxy of employer or organisational expectations.	Descriptive qualitative data about employer's expectations of the core functions, competencies and credentials of community and public health nutritionists, as expressed by position descriptions.	[36]
2002/3	Hughes	Modified 3 round Delphi study amongst a 20 member international expert panel to assess and develop consensus on competencies for effective public health nutrition practice.	International agreement on essential competencies and competency levels required by different tiers of the public health nutrition workforce.	[37]
2003	Lloyd	Mix of literature review, telephone interview survey with 24 employer organisation, review of structure and content of public health training programs, one-day disciplinary competency drafting workshop and alignment with core function statements.	"Off the cuff" opinions of employers (Director and Managers of state health departments, NGOs and area health services) regarding skills and knowledge of MPH graduates. Academics analysis and construction of competency framework from discipline area input.	[1]

Why not use the competency framework developed for public health (NPHEF) rather than develop a specific set for public health nutrition?

This is a question that has been recently posed within the APHNAC membership and is based on an assumption and viewpoint that public health nutrition practice is essentially public health practice that addresses nutrition issues. The definition of public health nutrition adopted by APHNAC is consistent with this view because it adapts a popular definition of public health to focus on food and nutrition issues (i.e. 'An organised effort by society in the areas of food and nutrition to promote and protect the health of the population').

There are a number of arguments why a specific competency framework for public health nutrition is required. Consultation with advanced-level PHN practitioners in 2001 identified that there was broad agreement amongst interviewees that;

- public health nutrition competencies are consistent with most generic public health competencies, but with a consistent qualifier that the public health nutrition workforce requires additional competency units in nutritional sciences.
- public health nutrition is a specialisation within public health and that a tendency towards generalising the workforce was counterproductive to developing workforce effectiveness [34].
- There was broad agreement that training and experience in nutrition was critical to competency development in public health nutrition [38].

Many of the areas of knowledge and skill identified in the 2001 consultation with public health nutrition stakeholders as a prelude to the formation of APHNAC [33] have a food and nutrition specific emphasis, reinforcing practitioners views about the importance of content and contextual aspects of practice. This is summarised by the following quote from one of the practitioner interviews [34]:

“I think it is difficult for a public health graduate without nutrition training to be effective...its like an epidemiologist without nutrition background doing nutrition studies that produce odds ratios based on dietary exposures that are ridiculous...understanding of the nutrition science is crucial”

Reliance on the NPHEF as the competency framework, without consideration of the additional or specialty competency elements required for effective public health nutrition practice is therefore problematic. It should also be recognised that the compilation of this framework has been generic to the core disciplines of public health with limited input from public health nutritionists (limiting the contextual relevance of the results obtained?).

What are the functions of competencies for public health nutrition?

Competencies serve a overarching function of providing the architecture for workforce development by codifying the knowledge, skills and attitudes necessary to effectively practice or work (perform) in the field. These provide a structure for:

- *Curriculum design and evaluation* - ensuring competency development through teaching and learning corresponds with agreed competency needs (the primary rationale relevant to APHNAC),
- *Credentialling* - by providing standards that can be used as benchmarks for practitioner recognition or registration (eg. Nutrition Society PHN Registration system[39])
- *Performance review*-by providing standards enabling employers and practitioners to review practises and development needs
- *Recruitment*- by providing a framework for articulating competency and qualification expectations in position descriptions (duty statements, selection criteria)[36], and
- *Career planning*- by providing direction for individual practitioners considerations about further development needs.

At what levels do the competencies target (individuals, work groups or the workforce)?

Traditionally most competency standards are aimed at entry-level competence (eg. Dietitians Association of Australia[40]), although some focus on defining experienced practitioners[4]. The funding of APHNAC and mid 1990's work by the PHERP funded Specialty Program in Public Health and Community Nutrition identified the need for competencies to inform advanced-level workforce development.

One of the conceptual difficulties with assessing the importance of competencies relevant to public health nutrition identified in the International Delphi Study conducted by Hughes in 2002/3 [37] relates to a question of "are we referring to an individual practitioner or the broader workforce or work group?"

The concept of competencies is increasingly being used to define the required knowledge, skills, attitudes and experience of work groups, ranging from small teams through to the collective workforce. This conceptualisation of competencies is similar to the notion of organisational competencies described briefly in the NPHEF [1]. Considerations about competency requirements of the public health nutrition workforce amongst Australian advanced-level practitioners[34] and international experts [37] have been based on this broader application of competencies.

The large and varied range of competencies listed from the analysis in Table 4 (and this broader view of competency applications) suggest that it may be unrealistic to expect an individual practitioner to have proficiency in all the competency units identified, emphasising the need to develop work teams that ensures a competency mix required for effective work effort. This view is consistent with earlier views about the need for inter-disciplinary approaches

to public nutrition [26,27,34] and the multi-disciplinary composition of public health nutrition workforces [30, 34].

Despite this view, the reality is that the composition of the public health nutrition workforce (at least those employed in designated positions with a mandate for preventive nutrition action) in Australia has been and is still largely uni-disciplinary[41], and this workforce infrequently collaborates outside the health sector[42]. Competencies therefore should reflect the work needed rather than what currently exists.

Basic assumptions underpinning this competency framework?

This background leads to the following summary assumptions that underpin the competency framework detailed in Table 4.

- Public health nutrition practice is public health practice that addresses food and nutrition issues.
- The generic competency framework of the NPHEF inadequately presents the nutrition specific competency requirements for advanced-level public health nutrition practice, but does codify many of the core competencies needed. A PHN specific competency framework is needed to specifically inform advanced-level PHN workforce development which is aligned with the NPHEF.
- Competencies refer to the workforce or workgroups rather than a specific individual or professional group.
- Different tiers of the workforce will require different levels of competency, depending on roles, responsibilities and jurisdictions
- There are a core or essential set of competencies consistently required for effective PHN practice regardless of jurisdiction or context.
- The existing workforce requires practice reorientation and practice enhancement. Much of current practices do not represent the work needed.

How this competency framework was drafted

Triangular analysis of the findings from research described in Table 2, with relevant literature has been used to organise competency elements and compare with those developed in the NPHEF. Triangulation of the different data sources in order to identify common competency units is presented in Table 4 (including those identified by Coveney and Mackerras in their earlier consultation with stakeholders leading to the development of APHNAC-presented in Table 3). The competency elements identified in the studies by Hughes [34-36] formed the basis of consensus measurement in the International Delphi study[37].

Table 3 *Competency themes identified in consultation with key PHN stakeholders in 2001 [33]*

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1. Analysis and synthesis of technical data (scientific and epidemiological) concerned with food and population health
 2. Policy development and analysis in general and food governance specifically, particularly the ways in which public and private sector agencies concerned with food and health relate to each other in the development of policy issues
 3. Rapid and timely synthesis and presentation of policy and other material for consideration at strategic levels
 4. Issues of risk, especially an appreciation of assessment and forecasting frameworks for health and environment
 5. Advanced level food and dietary modelling and survey analysis, including statistical packages and databases to assist this
 6. Food industry needs in terms of consumer attitudes, food choice and retail trends
 7. International food regulation and implications for Australia
 8. Social and cultural issues relevant to food and population health, especially the needs of indigenous groups and non-english speaking background
 9. Advanced level program management, implementation and evaluation.
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One of the principal advantages of using a multi-method analytical approach is the opportunity to enhance the trustworthiness or validity of the data via the process of methodological triangulation. Exclusive reliance on one method may bias or distort the picture of reality under investigation [43]. Triangular techniques in the social sciences explain more fully the richness and

complexity of human behaviour and experience by studying it from more than one perspective, making use of both quantitative and qualitative data [44]. It arguably serves a number of purposes, including assessment of convergence or confirmation of results across methods [45] and in the assessment of concurrent validity (do results from method A concur with method B and method C?) [44].

In the following tabulation and comparison of competency elements tested in the International Delphi Survey[37], triangular analysis was used to identify convergence in the information obtained using more than two different methods. It served as an important process in identifying consistencies in the literature and data collected relating to public health nutrition competencies.

Table 4 *Triangulation and categorisation of competency units/ elements for public health nutrition*

From Hughes Bold competency units rated as essential in Delphi study [37] [>80% agreement after Rd 3]	Consistent with other literature sources	Corresponds with Coveney & Mackerras [33] (number as listed in Table 3)	Corresponds to NPHEF competency unit category and element no.[1]
ANALYTICAL			QUANTITATIVE AND QUALITATIVE METHODS APPLIED PUBLIC HEALTH SKILLS
<ul style="list-style-type: none"> • Nutrition monitoring and surveillance 	[16, 21, 23, 24, 35, 38, 47-49]	1,4,5	B1, B3, B4
<ul style="list-style-type: none"> • Assess the evidence and impact of health and healthcare interventions, programs and services and apply these assessments to practice 	[16, 48]		B1, B2, B3, B4, C3, C4, C5, D1, D4, D5
<ul style="list-style-type: none"> • Needs assessment- assessing population needs using various methods 	[21, 22, 35]	1	All
<ul style="list-style-type: none"> • Applied research, research and development- appraise, plan and manage research, interpret research findings and apply in practice 	[16, 21, 23, 24, 27, 28, 35, 36, 38, 47-51]	1	D1
<ul style="list-style-type: none"> • Analysing the determinants of nutrition issues using a range of information sources 		1	B1-4,C1-5,D1-D3,D6
<ul style="list-style-type: none"> • Food monitoring and surveillance 		1,5,6	B1,B3,B4
<ul style="list-style-type: none"> • Scientific writing and dissemination of research 	[35]		Generic skills
<ul style="list-style-type: none"> • Improve the quality of health and healthcare services and interventions through audit and evaluation 	[16, 21, 47, 50, 52]		D1
<ul style="list-style-type: none"> • Health economics and economic evaluation applications 	[24, 27, 35, 47]		A3,C5

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SOCIO-CULTURAL AND POLITICAL		PUBLIC HEALTH IN CONTEXT	
<ul style="list-style-type: none"> • Social sciences: Knowledge and understanding of the psychological, social and cultural factors which influence food and dietary choices 	[21, 23, 27, 49]	6,7	C4
<ul style="list-style-type: none"> • Policy processes: policy development skills, influence policy development, evaluate policy impacts, organizational politics 	[16-18, 23, 27, 36, 38, 47, 49, 53-55]	2,3,6	A3
<ul style="list-style-type: none"> • Building community capacity building: community engagement, collaboration, partnership, coalition building and community dimensions of practice skills 	[16, 17, 21, 24, 35, 36, 47-49, 52, 53, 55]	6,7	D6
<ul style="list-style-type: none"> • Advocacy- at government, organization, profession levels 	[27, 35, 36, 38, 48, 49, 52, 54]	3,6	D6
<ul style="list-style-type: none"> • Cultural competency : awareness , knowledge and skills that enable a system, agency, or professional to work effectively in cross-cultural situations* 	[17, 35, 38, 47-49, 53]	7	C4, E

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PUBLIC HEALTH SERVICES			PUBLIC HEALTH IN CONTEXT APPLIED PUBLIC HEALTH SKILLS
• <i>Public health risk assessment and management*</i>		4	C2
• Intervention management: Design, plan, implement, monitor and evaluate nutrition strategies and programs for promoting health and well-being of the population, that reduce inequalities	[16, 18, 22, 23, 27, 38, 47-49, 51, 53] [35, 36]	9	D4,D5
• Principles and practice of health education, health promotion theory, behaviour change and health promotion policy and programs, public health methods	[21, 23, 35, 36, 38, 49, 53, 56]		D5
• Knowledge of food and nutrition systems and community food needs	[53]		A1, A3, C1-C5
• Provision of preventive nutrition programs	[22, 48, 52]		D1-D6
• Building capacity of the health workforce through training, up-skilling and mentoring	[16, 35, 38]		D6
• Service and program prioritisation based on identified needs, their potential impact, as defined by objective measurable criteria	[18]		D3
• Provide nutrition information/ intelligence to various target groups	[47, 48, 52]		D5
• Health care systems knowledge	[21]		A1, A2, A3
• Provision of clinical nutrition services	[22, 48, 52]		

* Not identified or tested in Hughes’s studies[37], added from Coveney and Mackerras consultation results[33]

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From Hughes Bold competency units rated as essential in Delphi study [37] [>80% agreement after Rd 3]	Consistent with other literature sources	Corresponds with Coveney & Mackerras [33] (number as listed in Table 3)	Corresponds to NPHEF competency unit category and element no.[1]
COMMUNICATION			GENERIC
• Interpersonal communication	[17, 18, 21, 22, 24, 27, 36, 47-54]		E
• Written communication	[36, 50]		E
• Grantsmanship-submission writing to access resources to enable intervention and service delivery	[21, 24, 35, 36, 38, 49]		A1,A2,A3,C1-5,D1-6,E
• Social marketing	[52, 55, 56]		D5
• Media utilisation	[22, 35]		D5, E
• Able to speak more than 1 language*			
• Dietary counselling	[36, 56]		D5,E
MANAGEMENT AND LEADERSHIP**			APPLIED PUBLIC HEALTH SKILLS
• Strategic planning	[16, 21, 35]		A1-A3, D1-D6, E
• Negotiation skills	[55]		E
• Systems thinking skills	[27, 55]		A3
• Team building	[21, 35, 49, 55]		E
• Computing and technology utilisation/ Information technology	[18, 21, 35, 48, 49, 52, 56]		E
• Leadership : motivation, dedication, vision (personal attributes)	[27, 47, 48, 52]		E
• Organizational behaviour, organizational management and organisational change	[24, 47, 55]		A2,A3
• Personnel (staff) management	[21, 24, 35, 36, 38, 49, 55-57]		D4
• Financial planning/ management skills	[16-18, 24, 35, 38, 47, 48, 50, 56]		D4

**Noticeable lack of identification of leadership related competencies in NPHEF

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NUTRITION SCIENCE			DISCIPLINE SPECIFIC COMPETENCY***
<ul style="list-style-type: none"> • Assessment of food, nutrient and dietary intakes and status in populations 	[23, 24, 27, 35, 49-54]		
<ul style="list-style-type: none"> • Food composition 	[23, 24, 27, 35, 49-54]		
<ul style="list-style-type: none"> • Food guidance and goals 	[23, 24, 27, 35, 49-54]		
<ul style="list-style-type: none"> • Nutritional requirements 	[23, 24, 27, 35, 49-54]		
<ul style="list-style-type: none"> • Nutrition intervention strategy options and selection 	[23, 24, 27, 35, 49-54]		
<ul style="list-style-type: none"> • Lifespan nutrition 	[23, 24, 27, 35, 49-54]		
<ul style="list-style-type: none"> • Physical activity assessment * 			
<ul style="list-style-type: none"> • Food science 	[50]		
<ul style="list-style-type: none"> • Dietetic management of disease 	[21, 36, 49, 51]		
<ul style="list-style-type: none"> • Physical fitness assessment* 			
<ul style="list-style-type: none"> • Assessment of food, nutrient and dietary intakes and status in individuals 	[23, 24, 27, 35, 49-54]		

*** Discipline specific competencies not identified by NPHEF (ie. nutrition)

Table 4 *Triangulation and categorisation of competency units/ elements for public health nutrition*

From Hughes Bold competency units rated as essential in Delphi study [37] [>80% agreement]	Consistent with other literature sources	Corresponds with Coveney & Mackerras [33] consultation	Corresponds to NPHEF competency unit category and element no.[1]
PROFESSIONAL			GENERIC
<ul style="list-style-type: none"> • Professional accountability and social responsibility 	[54]		E
<ul style="list-style-type: none"> • Ethics of public health nutrition practice 	[47, 54]		E
<ul style="list-style-type: none"> • Commitment to continual competency development and lifelong learning 	[47]		E
<ul style="list-style-type: none"> • Able and willing to consult and refer to others when extra competencies are required 			E
<ul style="list-style-type: none"> • Values and participates in peer review 	[50]		E
<ul style="list-style-type: none"> • Reflective practice to enhance performance 	[36, 54]		E
<ul style="list-style-type: none"> • Knowledge of the roles and cultures of other health professions in public health 			E

Proposal on how this competency framework listing can be used

The framework of competency units and elements in Table 4 is yet to be structured in the competency standards format used by the National Training Authority, as outlined below.

Unit	Element	Performance Criteria	Range of variables	Evidence guide
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Suggestion:

- Members of APHNAC organise into writing groups (groups of 2-3) based on expertise areas and interests to draft competency standards based on the framework in Table 4 and using wording/ structure etc already developed by the NPHEF and other sources (i.e. a similar process as that used in the NPHEF process).

For example:

Unit	APHNAC Writing team (<i>suggestions as example only</i>)
Analytical	Dorothy, Malcolm, John
Socio-cultural and Political	Mark, John
Public health services	Karen W, Roger
Communication	Etc etc
Management and leadership	
Nutrition science	
Professional	

- The outcome would be APHNAC's *Competency Standards for Public Health Nutrition*- a tangible outcome of the virtual faculty promoted widely via the website, students, work settings etc.

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