

Résumé

Les obstacles à la promotion de la santé axée sur la population : l'expérience des infirmières hygiénistes du Manitoba

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Tout porte à croire qu'un ensemble de grands facteurs socio-environnementaux influent sur la santé de la population, ce qui nécessite l'adoption de stratégies de promotion de la santé axées sur cette dernière. L'auteure rapporte les conclusions d'une étude sur les perceptions des infirmières hygiénistes à l'égard de leur travail dans la province canadienne du Manitoba, notamment en ce qui concerne les obstacles à la promotion de la santé axée sur la population. L'étude repose sur un plan expérimental descriptif et exploratoire; on a mené des entrevues qualitatives auprès de 24 infirmières hygiénistes, qui travaillent sous trois autorités sanitaires présentant chacune des caractéristiques géographiques et démographiques distinctes. On a défini trois catégories d'obstacles à la promotion de la santé axée sur la population : obstacles d'ordre individuel, liés aux infirmières; obstacles d'ordre organisationnel (culture, politiques, processus); obstacles d'ordre extra-organisationnel, concernant l'ensemble d'une localité ou de la province. Dans chacun des trois sites étudiés, on a constaté un écart entre la théorie, voulant que la promotion axée sur la santé de la population constitue l'essence même du travail des infirmières hygiénistes, et l'expérience de celles-ci. L'auteure conclut que seul un effort concerté permettra de lever ces obstacles, pour faire en sorte que les infirmières hygiénistes du Manitoba puissent jouer un rôle déterminant dans la création d'un système de santé qui investit réellement dans la santé de la population.

Mots clés : Infirmières hygiénistes, promotion de la santé, obstacles, Manitoba, Canada

Barriers to Population-Focused Health Promotion: The Experience of Public Health Nurses in the Province of Manitoba

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There is growing evidence that population health is influenced by broad socio-environmental factors that require population-focused health promotion strategies. The author reports on a study of the perspectives of public health nurses (PHNs) on the nature of their health promotion practice in the Canadian province of Manitoba, highlighting their perceptions about barriers to population-focused health promotion. A descriptive, exploratory research design was used to conduct standardized open-ended interviews with 24 PHNs in 3 geographically and demographically diverse health authorities. There were remarkable similarities in PHNs' perceptions about their practice. Three categories of barrier to population-focused health promotion were identified: barriers at the level of individual PHNs; organizational barriers (culture, policies, processes); and extra-organizational barriers at the level of the community or province. The results point to a gap between the theory that population-focused health promotion is at the heart of PHN practice and the experience of PHNs at the 3 sites. A concerted effort to address the barriers is needed so that PHNs in Manitoba can play a leadership role in creating a health-care system that truly invests in population health.

Keywords: Public health nursing, health promotion, population level, barriers, Manitoba, Canada

Introduction

In 1997 the health ministry in the province of Manitoba, Canada, developed a framework for health planning that recommended a shift in focus from a *medical*-care system based on short-term action with sick individuals to a *health*-care system emphasizing health promotion among groups and populations (Manitoba Health, 1997). One year later a health ministry document outlining the role of the public health nurse (PHN) within the newly established Regional Health Authorities noted that "PHNs provide the leadership in health promotion" (Manitoba Health, 1998, p. 9). This suggests that PHNs, the largest group of community health nursing practitioners in Manitoba, should be in the forefront of population-focused efforts to create a health system that truly invests in

health. Does the reality of PHNs' practice in Manitoba fit with the rhetoric? This is the question that will be explored in this paper.

The Discourse on the Health Promotion Practice of PHNs: Literature Review

There is mounting evidence that population health is influenced by broad socio-environmental factors that require population-focused health promotion strategies such as advocacy for healthy public policy, strengthening of community action, and the creation of supportive environments (Community Health Nurses Association of Canada [CHNAC], 2003; Raphael, 2004). A salient feature of the discourse on the health promotion practice of PHNs is the tension between two ideas, one articulated frequently in the theoretical literature and the other articulated primarily in empirical studies of PHNs' practice. The former is that the heart of PHNs' health promotion practice is a population focus (Anderson & McFarlane, 2000; Baldwin, O'Neill Conger, Abegglen, & Hill, 1998; Butterfield, 1997; McKnight & Van Dover, 1994; Norton, 1998; Williams, 1996) and the latter that nurses most commonly focus on promoting health at the individual and family level — *and feel most comfortable and competent when doing so* (Chalmers & Bramadat, 1996; Craig, 1991; O'Brien, 1994; Reutter & Ford, 1998).

The general preference of nurses for working with individuals has been attributed to an uncritical acceptance within nursing of the dominant societal ideology of individual responsibility for health, an ideology that is perpetuated by many of the popular nursing models and texts, by course content in nursing, and even by clinical placements in nursing curricula (Latter, 1998; O'Brien, 1994; Rush, 1997; Williams, 1989). Some authors argue that nurses historically have been shaped by society to be passive and non-confrontational (Chalmers & Kristjanson, 1989; Laffrey, 1989; Maben & MacLeod Clark, 1995). This could be an inhibiting factor in terms of nurses' involvement in social change activities such as community development (CD) and advocacy for policy change. The lack of well-developed collaborative skills and difficulty relinquishing professional control are additional barriers to effective community development work by PHNs (Chalmers & Bramadat, 1996).

One of the barriers to population-focused health promotion is the organizational structures within which PHNs practise. Chalmers and Bramadat (1996) state that the public health agencies and community health centres that employ nurses may support the CD role to various degrees, in that articulated policies may be lacking or may not be backed up with adequate resources. In addition, few standards exist for the evaluation of nurses' CD work. There are other organizational barriers to

population-focused practice: the non-participatory structures within which nurses work, and the process of role socialization within those structures (Chambers, Underwood, & Halbert, 1989; Williams, 1996); conceptual frameworks that are based on the individual and on observable and measurable behaviour, as well as the manner in which nurses' work is audited (e.g., numbers of patient and client contacts as a measure of performance) (Latter, 1998); and the inability of community nursing administrators to serve as role models for frontline nurses because they have never developed the skills necessary for population-focused nursing (Chalmers & Kristjanson, 1989).

Chalmers and Bramadat (1996) note that some barriers to population-focused health promotion originate outside of the health organizations in which PHNs practise. For example, there may be resistance from sections of the community to particular CD initiatives that are not perceived to meet their interests, including initiatives that challenge established gender roles. Demand for government-mandated programs such as postpartum visiting and communicable disease follow-up is another factor that may preclude CD work.

Whatever the reason or reasons for the phenomenon, at least one nursing educator has concluded that, right or wrong, and in spite of rhetoric to the contrary, in reality the nurse's role is and will likely continue to be that of health educator with a focus on individual-level change, primarily behavioural (Norton, 1998).

Another salient feature of the literature is that there are relatively few first-person accounts of what frontline PHNs view as the main challenges to their health-promoting practice, especially in the context of the Canadian health-care system. Several Canadian studies have explored the perceptions of community and public health nurses about their role (Craig, 1991; Leipert, 1996; Meagher-Stewart, 2001; Rafael, 1999; Reutter & Ford, 1998), but only a few have specifically explored PHNs' perceptions regarding barriers to population-focused practice. In one of the earliest such studies, Craig documented the experience of nurses in two Ontario public health units following the implementation of a new (1989) public health policy requiring practitioners to develop, implement, and evaluate programs and services using a CD approach. The findings demonstrated a strong sense of loss among PHNs about giving up traditional practice, considerable confusion about the concept of community development, a lack of confidence in the knowledge and skills required, and fear that individuals and families with complex needs would no longer be served.

In Reutter and Ford's (1996) study of the perceptions of 28 PHNs in the province of Alberta regarding their practice, the nurses admitted feeling powerless to bring about changes that might benefit their socially

and economically disadvantaged clients, due to a lack of the skills and resources necessary to address the underlying social problems. Barriers to their population-focused health promotion practice included insufficient time for planning and implementing innovative programs in the community; the organizational constraint of having to provide mandated programs, which prevented them from engaging in CD work and advocacy for healthy public policy (which most PHNs viewed as part of their expanded role); uncertainty about their own job security and the future direction of public health nursing, which negatively affected their commitment of time and energy for new initiatives; and a perception that other professionals and the general public did not fully grasp what their role was, associating PHNs with concrete tasks such as immunization but not with broader functions such as CD work where the outcome is not immediately apparent.

Meagher-Stewart (2001) explored the discourse of 13 PHNs in a large urban public health department in southern Ontario regarding their CD practice with women in high-risk environments. A predominant concern was the gap between the rhetoric about CD in departmental policies along with verbal support by nurse managers and the reality, which was characterized by a lack of resources and the absence of valuing of the PHNs' CD practice.

Lastly, MacDonald and Schoenfeld (2003) surveyed Saskatchewan PHNs regarding their ability to function in an expanded role. The nurses stated that they lacked the time, flexibility, autonomy, knowledge, and skills to implement population-focused strategies — in spite of the fact that many of them acknowledged that those strategies would best address the needs of the population that they served.

In summary, a review of the literature suggests that there are several types of barrier preventing PHNs from feeling comfortable and confident engaging in community- or population-focused health promotion. However, the literature addressing this issue is largely theoretical in nature. The study reported here contributes to our knowledge by specifically exploring the views of PHNs regarding barriers to their engaging in population-focused health promotion within the context of an integrated, regionalized health-care system in Manitoba.

Research Objective

This study was part of a larger research project exploring the discourse on health promotion within selected Regional Health Authorities (RHAs) in Manitoba. Key stakeholders in governance, administrative, and public health practitioner positions were asked to describe the climate

for, content of, and barriers to health promotion within their RHAs. This paper reports on the discourse among PHNs, with a focus on perceived barriers to their population-focused health promotion practice.

Methods

A descriptive, exploratory design was used. According to Marshall and Rossman (1989), the purpose of an exploratory study is to investigate little-understood phenomena, while the purpose of a descriptive study is to document the phenomenon of interest. An exploratory design was chosen because the intention was to document the perceptions of PHNs in Manitoba RHAs regarding a phenomenon (the nature of their health promotion practice) about which little was known. Three geographically and demographically diverse RHAs were selected (a northern, primarily resource-based region with a large aboriginal population; a southern, primarily rural region with two prominent non-aboriginal cultural communities; and a small urban region with a sizeable aboriginal population). This allowed the researcher to determine which aspects of the discourse on health promotion were present in all three regions (in spite of their very different contexts) and which aspects were unique to each area.

The primary method of data collection during the phase of the study reported here was the standardized open-ended interview. All PHNs in the three regions were invited to participate. Twenty-four PHNs (80% of PHNs in each region) agreed to take part in an interview, which was conducted by the author. According to Patton (1990), a standardized open-ended interview consists of a set of questions carefully worded and arranged, with the intention of taking all respondents through a similar sequence and asking them the same questions using essentially the same words. Any clarifications, elaborations, or probing questions are written into the interview itself. The main advantage of this type of interview design is that it minimizes the potential for the interviewer to pose questions on a single topic in a different way with different respondents and thus to obtain more comprehensive data from some respondents than from others (Patton). The PHNs were asked about the organizational context of their health promotion practice, the nature of their health promotion practice, and the barriers to their engaging in population-focused health promotion activities. A small pilot test of the question guide was conducted in an RHA that was not part of this phase of the study and adjustments were made accordingly.

The interviews were audiotaped and transcribed verbatim. The transcript files were entered into a qualitative data management program

(ATLAS.ti) in order to facilitate analysis of the large volume of data, which was conducted by the author using “question analysis,” a type of content analysis that is carried out via question number (Berg, 1998). Each transcript was read twice in order to identify and refine specific categories of information, or themes, for the three sites. Codes were used to indicate both the origin (individual, organizational, extra-organizational) of barriers to health promotion practice and the type of barrier (e.g., attitudes, educational background, funding, policies, processes). This method allowed for comparison of answers to similar questions within and between the three study sites. Answers or comments that were unclear or ambiguous were not included in the analysis.

Approval for the study was obtained from the Research Ethics Board at the University of Manitoba. While there is no risk of physical harm to participants in a study such as this, the issue of anonymity is an important one — especially since employees of the RHAs were being asked to express their opinions about organizational changes or issues related to their workplace. Every effort was made to protect the anonymity and security of participants. Although RHA administrators were aware that PHNs were eligible to participate in an interview, all comments are reported in a manner that protects individual identity. The participants were given the option of being interviewed at a location of their choice, such as away from the workplace.

Findings

In spite of three very different geographic and demographic contexts, there was remarkable similarity in the PHNs’ perceptions about the climate for, nature of, and barriers to health promotion practice. For example, there was consensus across the sites that the discussion within the RHAs about the need to increase the emphasis on health promotion continued to be overshadowed by the priorities of the acute-care system and the need to respond to public demand for acute services. There was also consensus across the sites regarding the nature of PHNs’ health promotion practice. In spite of the universal acknowledgement of the importance of population-focused health promotion, for the most part the PHNs’ own practice was characterized by a strong focus on providing health information and emotional support to individuals and families, especially childbearing families.

The level of consensus across the three sites regarding the barriers to population-focused health promotion was especially noteworthy and will be the focus of the remainder of this paper. Three categories of barrier to population-focused health promotion were identified.

Barriers Originating at the Level of the PHN

PHNs at all three sites acknowledged that they were often more comfortable working with individuals on a one-to-one basis or with families than engaging in health promotion at the community or population level. They attributed their discomfort with the latter to individual personality traits, attitudes, and beliefs; their professional education; and a perceived lack of population-level health promotion skills. Each of these factors will be discussed below.

PHNs at all three sites stated that population-level health promotion strategies such as advocacy for healthy public policy (ADHPP) and community development (CD) require a certain personality type or maturity level. "I'm not a political person," "It's not my style," or "I'm a cautious person" were typical comments made by PHNs to explain their discomfort with ADHPP or CD work. Many PHNs stated that it was simply a matter of personal interest — that there is quite a bit of variety in nursing practice and everyone has his or her favourite areas of concentration.

PHNs at all three sites stated that there are still some nurses who view health promotion as primarily teaching people about healthy behaviour, who believe they know what is best for people, and who would have great difficulty giving up control if they were involved in CD work (although no respondents admitted to holding these views themselves). There also seemed to be a persistent view among PHNs that ADHPP might represent a conflict of interest due to their previous position as a government employee or that it might conflict with current RHA policy.

The majority of PHNs stated that resistance to engaging in health promotion strategies beyond the level of the individual was often due to lack of confidence and perceived lack of competence as a result of inexperience with this type of work. This was especially true for nurses who had just transferred from a hospital setting (a common situation in the northern RHA). The PHNs suggested that it was natural for these nurses to be more comfortable working on a one-to-one basis with individuals and families. CD work was something new and perhaps frightening for many of these nurses. "Sometimes there's safety in just doing what you've been doing...you're a little bit more out there and in the public eye and vulnerable when you're doing some of the community development [work]."

All but one of the PHNs stated that their nursing education program had prepared them to work primarily at the individual/family level. Although PHNs who had recently completed a nursing degree program

felt they had theoretical knowledge about population-level strategies such as ADHPP and CD, they all believed they could learn more and very few stated that they had much practical experience with these strategies. Most frontline practitioners stated that if one is not involved with something on a regular basis, one will not feel comfortable doing it:

...the group dynamic skills you need, and the facilitation skills, are really very important. And I don't know if we have those. We're learning. We've had our workshops and we've practised. But it's kind of a scary place out there. I mean, you are in a position that people look to for knowledge and information and leadership. And you're saying to them, well, what would you like to do about that? How do you see that happening? ...you have to be able to know how to work a group.

Participants felt that, even when nurses see the value of engaging in population-level practice, there are differences of opinion regarding the amount of time that should be spent on this type of work versus individual-level work. Many frontline practitioners stated that they were reluctant to get involved in such initiatives because they had many other responsibilities. One PHN expressed this sentiment particularly eloquently:

I think that some of my co-workers at times resent or are fearful that they're being pulled away from field work and one-to-one situations.... A good example of that is if you're away at a meeting in the community all day...you're not available to that new mom who's home breastfeeding and maybe there's concern about whether the baby's getting enough milk, so the whole risk business of dehydration in newborns is an issue. How can you feel comfortable that you've covered and are still providing safe practice for your individual clients [when you're] undertaking these broader things at the same time? It's a juggling act. And some people aren't as prepared to juggle.

Barriers Originating at the Level of the Organization

One set of barriers at this level related to organizational attitudes towards health promotion in general. PHNs at all three sites stated that staff in the acute and long-term-care sectors were reluctant to “buy into” the health promotion philosophy. The PHNs noted (sympathetically, for the most part) that facility-based direct-care providers were having enough difficulty coping with their roles as it stood without having to adjust to a whole new way of thinking. While there was general agreement among participants that staff in the acute and long-term-care sectors showed greater resistance to increasing the emphasis on health promotion, not all PHNs blamed the problem on their colleagues' mindset. There were

PHNs in each region who placed the blame at the top of the organization, criticizing their board of directors and senior administrators for “buying into” the need for more doctors and for lacking commitment to the idea of stepping up health promotion. One PHN stated that she thought her board was not ready to commit itself to a health promotion focus because this might require it to withdraw some other service.

PHNs in all regions expressed a belief that their supervisors viewed population-focused health promotion as something you do if you have time left over after finishing your “regular” work. Several participants stated that taking the time to make a presentation in the community or to attend a community meeting was not valued by their supervisors. PHNs in all regions also expressed concern that public health managers often lack the background and skills in health promotion needed to act as role models for frontline practitioners.

Participants in all regions commented on the lack of human resources available for adequate health promotion. In the northern RHA, participants said that the difficulty of recruiting and retaining qualified personnel in general, and a high turnover of community health and mental health staff in particular, posed unique challenges that drained energy and attention away from any form of health promotion. In the other two regions PHNs also mentioned staff shortages, especially in the area of community/public health. PHNs practising in outlying areas, especially in the north, pointed out that nurses are often requested to carry out many tasks beyond those included in their job description, leaving little time for health promotion. If the PHN was the only health professional in the area, then the demand for individual care increased. One nurse remarked, “You can’t say to someone who walks into your office and needs help, ‘Sorry, but this time is reserved for health promotion work’.” In outlying areas of the northern region, this problem was compounded by the fact that PHNs were responsible for providing home care in addition to their public health duties. One PHN stated, “We’re too busy dealing with all of these diabetics that are getting diagnosed, which prevents us from focusing on health promotion.”

Another organizational barrier to population-focused health promotion mentioned at all three sites was a workload measurement system based on the number of individual client contacts. One PHN described the problem very succinctly:

I always have enjoyed community development work. But compared to the one-to-one type of involvement that we have with clients, it doesn't seem to have quite as much validity or something when you look at the time spent. And I say that because we realized that our ratio of nurses to population is one of the lowest in the province of all the health regions... We've

been lobbying with our CEO and board members whoever we can to try to improve upon that. But one of the things they looked at were our daily stats forms. And actually, over the past year, they came to realize that our number of [individual] patient contacts, based on these statistical forms, had dropped quite substantially because we're doing more community development. But that was seen as a negative.

Addition barriers identified were a lack of resources for both internal in-servicing and continuing education in the field of population-based health promotion and a dearth of opportunities for PHNs to share their experiences with population-focused work.

Extra-organizational Barriers

PHNs at all sites identified several extra-organizational factors that reinforced an individual/family-level focus at the expense of a community- or population-level one. One drain on human resources was cited by virtually every PHN in all three regions. This was the dramatic increase in the workload of frontline PHNs related to expansion of mandatory provincial public health programs, leaving less and less time for population-focused health promotion. Three contributing factors were mentioned by participants in all regions: the expansion of provincial immunization programs (especially the hepatitis B program for Grade 4 pupils); the introduction of the provincial Baby First program (requiring PHN assessment and supervision of home visitors); and a change in health policy resulting in early discharge from hospital of mothers and infants postpartum (requiring PHNs to make immediate, and more frequent, home visits, involving in-depth maternal-child physical assessments as well as health education). One PHN summed up the general frustration expressed by the participants: "They keep piling more and more things on the plate, but no one ever took anything away."

Several other extra-organizational barriers to population-focused health promotion were cited by nurses at all sites: the difficulty of engaging in an activity such as ADHPP in a relatively small community when one lives in the community and may know (or even be related to) those involved; public ignorance about the scope of the PHN role (e.g., failure to see that ADHPP and CD are valid activities for PHNs); the lack of public understanding about the broad determinants of health and the need to act on them; and the tendency for the public, the media, and politicians to focus exclusively on acute-care issues. One participant explained:

When we were out doing the community health needs assessment...we talked about the determinants of health, what they were and why we were doing the community health needs assessment. And you could tell,

depending on what group you got to speak to, that they were not with it. Like, this terminology is news to them. It's just not where they're at. Where they're at is, why can't I have my MRI when I need it? Why did my mother have to wait 6 months or 10 months before she could have this done? Those are the kinds of questions that are asked, not whether or not Suzy Smith is out there doing prevention kinds of activities. So, until you get the population to start thinking that's where the money should go, it's not going to happen.

Other issues brought up by nurses at all sites were lack of human and material resources, on the part of potential or actual community agency partners, needed to engage in collaborative work; the inability of some communities to engage in CD work due to a high degree of social dysfunction; and a dearth of potential leaders with whom to partner.

It is worth noting that PHNs at all sites mentioned the loss, following regionalization, of the traditional link to a centralized health promotion infrastructure that had provided them with support and resources. Although not a barrier to population-focused health promotion specifically, this change did cause the nurses to feel isolated with regard to their health promotion efforts.

Discussion

The experience of PHNs at the three Manitoba study sites does not bear out the claims in the literature that population-focused health promotion is at the heart of PHN practice. These nurses identified many of the individual, organizational, and extra-organizational barriers to engaging in population-focused health promotion that were found in the theoretical and empirical literature, as well as additional ones (e.g., specific challenges facing PHNs working in rural, northern, and isolated areas). A few of these barriers related to the specific context of the transformation to a regionalized, integrated health-care system (demands for acute-care services dominating the RHA agenda; loss of traditional links to a centralized, provincial health promotion infrastructure). However, most barriers appeared to be related more to individual practitioner attitudes, professional education, organizational infrastructure and culture, and extra-organizational constraints at the community and government levels. Very much in evidence at all three sites was the tension that runs through the literature between the idea that the heart of the health promotion practice of PHNs is a population focus and the idea that nurses most commonly focus on promoting health at the individual/family level — *and feel most comfortable and competent when doing so*. While lack of knowledge and skills for population-focused health promotion work was a factor in PHNs' greater involvement in individual-level health

promotion, lack of time and flexibility (primarily related to increased demands for mandatory programs) and lack of organizational support were equally important. These findings support those cited in the literature and suggest that a focus on improving knowledge and skills for population-focused health promotion will not on its own be a sufficient strategy for building PHNs' capacity for engaging in this type of work.

One limitation of this study relates to the generalizability of the findings. Although the three study sites were selected to represent the geographic and demographic diversity of Manitoba RHAs, any commonalities found in these sites cannot be assumed to exist among PHNs practising in other Manitoba RHAs or in other jurisdictions. It must also be acknowledged that, in the period since data collection ended, some of the barriers identified by key informants may have been eliminated and new barriers may have arisen.

Nevertheless, the findings have important implications for PHN policy, practice, and research. The Community Health Nurses Association of Canada recently developed a set of *Canadian Community Health Nursing Standards of Practice* (CHNAC, 2003), which are expected to be met by each community health nurse after 2 years of experience. The *Standards* reflect a strong emphasis on population-focused community health nursing: support for collaborative interdisciplinary and intersectoral partnerships to address risks to community or population health; support for community action to influence policy change with respect to health; and use of a comprehensive mix of community-based and population-based strategies such as coalition-building, intersectoral partnerships, and networking to address issues of concern to groups or populations. Several Canadian studies exploring the perspectives of PHNs on their population-focused health promotion practice have reported similar findings, which points to a gap between theory and practice. Two questions in particular require further research: (1) What is a realistic expectation regarding PHNs' role in population-focused health promotion versus individual/family-focused health promotion? (2) How should we go about building capacity for PHNs' population-focused health promotion practice, at the level of both the nursing education system and the organizations in which PHNs are employed?

In conclusion, it has been suggested that nurses in general and PHNs in particular have a leadership role to play in health promotion (MacDonald, 2002; Manitoba Health, 1998). Individual/family-focused health promotion has traditionally been, and will likely continue to be, an important part of PHN practice, and it can serve as a basis for identifying issues that require further action at a community or population level (Diekemper, Smith-Battle, & Drake, 1999). However, PHNs in this Manitoba sample, as in other Canadian jurisdictions, have identified

multiple barriers to population-focused health promotion, originating both within and outside of the health-care systems in which they work. Without a realistic assessment of the capacity of the public health system to truly invest in population-focused health promotion, and without a concerted effort to address the barriers to doing so, the noble goal of developing a health-care system that emphasizes health promotion among groups and populations will never be attainable and PHNs will never have an opportunity to play the leadership role in health promotion that has been envisioned for them.

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