

AN EXPLORATION OF FACTORS INFLUENCING PUBLIC HEALTH NURSES'
CAPACITY TO ENGAGE IN HEALTH PROMOTION

by

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Abstract

In the 1980s Canada was viewed as a leader in health promotion with the articulation of a framework to move health promotion into nursing practice, which was influential in structuring public health programs (Crichton, 2000; Richard et al., 2010; Stewart, 2000). Over time, public health nursing has experienced a shift in emphasis from health promotion—characterized by building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services (Ward & Verrinder, 2008)—to population health, with its emphasis on the management of risk factors through activities such as screening, disease prevention, and immunizations. The objective of this research inquiry was to understand the range and nature of influences on Public Health Nurses’ capacity to engage in health promotion work in a public health agency. Institutional ethnography methodology was utilized to understand the ruling relations, the forces that have the power to shape the day-to-day realities for Public Health Nurses and the agencies they work in. Interviews from 12 experienced Public Health Nurses, from different practice settings, were examined as an “entry into the social relations of the setting” (Smith, 2006, p. 92). The following influences have diminished the Public Health Nurse’s role in health promotion: (a) the changing context and increasing acuity of public health nursing practice; (b) operational influences on Public Health Nurses’ capacity to engage in health promotion (including time, budget, and other factors); (c) weakening relationships with community partners; (d) organizational leaders’ perceived lack of understanding of the Public Health Nurse’s role; and (e) centralized decision making. Public Health Nurses’ conceptualizations of health promotion are affected by these factors. The implications of these findings for public health nursing practice are discussed and recommendations for future research are made.

Preface

The research conducted in this study received approval from the University of British Columbia Behavioural Ethics Board (Certificate number: H11-03312) and Vancouver Coastal Health Research Institute (Certificate number: V11-03312).

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Dedication

I dedicate this thesis to my mother Surjit Kaur Dulay who, back in the 1970s, broke cultural traditions to allow me to pursue my dream of going to university. My mother was a strong advocate of higher education, although she never had the opportunity to attend school.

Without her belief and support I would not be here.

Chapter One: Background to the Problem

Community health nurses and Public Health Nurses play important roles in fostering the health of individuals, families, communities, and populations. One mandate of nurses in these roles is to engage in health promotion work and to respond to and address the needs of members of their communities, especially those most vulnerable. Although community health nurses work with all populations, in this thesis I use the case of Public Health Nurses working with infants, children, and youth.

Currently, the terms community health nurse and Public Health Nurse are used in different ways across Canada (Canadian Public Health Association, 2010). The use of these two terms has caused confusion regarding the role of nurses working in public health. The Community Health Nursing Association of Canada is a voluntary national association of nurses that provides a unified voice for community health nurses across Canada (Community Health Nurses of Canada, 2011). In 2003, the association created the *Canadian Community Health Nursing Professional Practice Model & Standards of Practice* (Community Health Nurses of Canada, 2011) clarifying the role of all nurses who work in community health nursing, particularly public health and home health. These standards identify practice principles that establish expectations for safe and ethical care and inspire excellence in community health nursing. The Community Health Nurses of Canada standards of practice were revised in 2011 and include the following: health promotion, prevention and health protection, health maintenance, restoration and palliation, professional relationships, capacity building, access and equity, and demonstrating professional responsibility and accountability. Knowledge of the Community Health Nurses of Canada's standards is an expectation of every community health nurse working in public health, home health, education, administration, or research, as these

standards define scope and guide practice (Community Health Nurses of Canada, 2011). The first standard guides the community health nurse to integrate health promotion into practice and provides 17 listed strategies.

In 2006–2007, Vancouver Coastal Health rolled out the *Canadian Community Health Nursing Professional Practice Model & Standards of Practice* (Community Health Nurses of Canada, 2011). At the same time the title Community Health Nurse was changed to Public Health Nurse in the Infant Child and Youth Program within the community in Vancouver, British Columbia. Other service delivery areas of Vancouver Coastal Health, such as Richmond Community, were already using the title Public Health Nurse for nurses working in public health. This renaming reflected a more focussed attention to the practice aspects of the role, emphasizing the shifting role of nurses in public health while maintaining community health nursing as a broader category that encompasses public health nursing.

In the fall of 2012, the name of the Infant Child and Youth Program was changed to Public Health to be more consistent with the Community Health Nurses of Canada (2011) standards and with practice across Canada (V. Munroe, personal communication, December 18, 2012). This change has provided uniformity across public health nursing programs in Vancouver Coastal Health, as Richmond currently uses the term public health when referring to the same program in their community. Throughout this paper I use the term Public Health Nurse to refer to all nurses working in the Infant Child and Youth Program in the Vancouver community.

Background to the Research Question – Public Health Nursing

Public health is the “science and art of preventing disease, health surveillance, prolonging life and promoting health through the organized efforts of society (Committee of Inquiry, 1988, as cited in National Advisory Committee on SARS and Public Health, 2003)” (Government of

British Columbia, Ministry of Health Services, 2005, p. 63). The fundamental tasks of public health are “reducing the burden of disease, disability, and injury and improving the overall health and well-being of the people” (Government of British Columbia, Ministry of Health Services, 2005, p. 7). “The programs, services, and institutions involved tend to emphasize two things: the prevention of disease and the health needs of the population as a whole” (Public Health Agency of Canada, 2004, Defining Modern Public Health Practice section, para. 2). The Advisory Committee on Population Health recommended the following list of functions: health protection, health surveillance, disease and injury prevention, population health assessment, and health promotion (Public Health Agency of Canada, 2004). Public health activities in each province are governed by a public health act (or equivalent) by its regulation and other specific legislation. In 2008, British Columbia established a new Public Health Act to replace the outdated Health Act legislation (Government of British Columbia, Ministry of Health, n.d.c).

[In British Columbia] the Ministry of Health Services acts as a steward of the health system. Using strategic plans, legislation, policy, performance expectations and other tools, the Ministry works with health authorities and health providers to achieve the goals set out by the Service Plan. (Government of British Columbia, Ministry of Health Services, 2005, p. 1)

Originally, the management of public health services was shared by the federal, provincial, and municipal governments (Stewart, 2000). Prior to the early 1990s, Public Health Nurses working in Vancouver were employed by the City of Vancouver in what was then known as the Vancouver Health Department (Crichton, 2000). Nurses worked in a generalist public health nursing role, providing services to families ranging from prenatal to children aged 24 years. Public Health Nurses were situated in what were then known as public health units, which

were located in the community with geographical boundaries. These units were situated for easy access to the public.

In 1996, the Government of British Columbia passed the Health Authorities Act (1996), which led to the restructuring and reformulation of health services (Crichton, 2000). These changes impacted public health services. In the early 1990s, with the regionalization and decentralizing of health services and the establishment of regional health boards as new governance health structures (Crichton, 2000), public health services were transferred to the Vancouver Regional Health Board, established in 1994, which in 1997 became the Vancouver–Richmond Regional Health Board (Crichton, 2000). In 2001, the health board merged with the hospital acute sector becoming part of Vancouver Coastal Regional Health Authority. The joining of the acute and community sector led to structural changes of public health services. However, the governance and the budget of public health continued to be managed separately until 2004, when public health program budgets and leadership were amalgamated with the acute sector. This streamlined the governance and management of public health in Vancouver Coastal Health.

Vancouver Coastal Regional Health Authority, one of six publicly funded health care regions in British Columbia, provides services to 25% of British Columbia’s population and services to over 1 million people through administration of 13 hospitals and 15 community health centres in Vancouver, Richmond, the North Shore and Coast Garibaldi, Sea-to-Sky, Sunshine Coast, Powell River, Bella Bella, and Bella Coola (Vancouver Coastal Health, 2013j). Currently, Vancouver Coastal Health provides direct and contracted services, including primary, secondary, tertiary, and quaternary care; home and community care; mental health; and population and preventive health and addictions services (Vancouver Coastal Health, 2013a).

These services are provided within the Vancouver Coastal Region, which includes 12 municipalities, four regional districts, and 14 Aboriginal communities. Vancouver Coastal Health receives \$2.8 billion in funding and employs 13,000 full- and part-time staff (Vancouver Coastal Health, 2013j). In what follows, I provide a brief introduction to the mandate of public health programs (prevention and health promotion) in the Vancouver Coastal Health Authority since the late 1990s.

In the 1990s, public health services in Vancouver centred on addressing the health needs of the community. The focus of nursing practice was extensive; using community, neighbourhood, and school-based approaches, Public Health Nurses supported people in achieving healthy lives through case finding, health education and disease prevention (Stewart, 2000). During this time, Vancouver played a leading role in introducing health promotion strategies for engaging with a population that was becoming increasingly socially and culturally diverse. Following the Lalonde (1974) report, the health promotion movement led to the shift from a biomedical model of health care to a social model of care (Crichton, 2000), which was seen in public health nursing as a shift from the focus of illness and disease to creating relationship-based practice with a focus on building collaborative partnerships for the promotion of health (Doane & Varcoe, 2005). This approach of encouraging Public Health Nurses to build collaborative partnerships with individual, families, and communities was due to the theoretical underpinning of this health promotion model. Public Health Nurses engaged in the health promotion movement through strengthening community action and community development, which led to the creation of many health promotion initiatives in the Infant Child and Youth Program.

The Infant Child and Youth Program provides public health services, mostly nursing, to young children and their families. In the 1980s, following the release of the Lalonde (1974) report, Vancouver Public Health Nurses' capacity to work within the health promotion framework was fostered through educational workshops that challenged, encouraged, mentored, and supported nurses to begin health promotion activities in all aspects of their work. This focus on health promotion spread throughout the Infant Child and Youth Program and across the city. The successful integration of health promotion into nursing practice in Infant Child and Youth services was demonstrated through Public Health Nurses' involvement and development of numerous health promotion initiatives and activities for children and families. It was at this time that Public Health Nurses began to organize and facilitate groups, such as the parent–infant group, a program for postpartum families, and a parenting program for parents of adolescent children.

Using health promotion concepts such as building healthy public policy, creating supportive networks, strengthening community action, building capacity and reorienting health services (Nutbeam & Harris, 1999; Ward & Verrinder, 2008), Public Health Nurses engaged in community development work, taking a leadership role to develop programs that addressed the social determinants of health and supported families and children to attain optimum health. For example, the Youth Pregnancy and Parenting Program, which is still in existence today, began in 2004 and were developed by frontline Public Health Nurses to address the needs of vulnerable community members. It received initial funding as part of primary care services, with the nursing component provided by the Infant Child and Youth Program. Some of these initiatives began as pilot projects and went on to become established funded services that are still in existence today, such as the Healthiest Baby Possible Program.

Rising costs of health care in the 1990s resulted in health reform and restructuring of health authorities (Bliss, 2010; Falk Rafael, 1999a). These changes affected all sectors of health care services, including public health, and influenced the context of Public Health Nurses' work and how they practiced and delivered services (Falk Rafael, 1999a). Public Health Nurses who work with families of young children have voiced concerns about the erosion of health promotion work (Cusack, Hall, Scruby, & Wong, 2008). Nurses have expressed that they no longer have the time, organizational support, human resources, or skills and financial support to build collaborative relationships to respond, reorient, and develop health services tailored to meet the needs of families with young children (Cusack et al., 2008; Richard et al., 2010). Some factors that impacted the shift in Public Health Nurses' health promotion work were changes in the mandated work, such as the shift in nurses' practice focus to early postpartum discharge implemented in the 1990s (Cusack et al., 2008). Public health nursing services shifted to screen and manage acute maternal newborn health problems due to early discharge and the reduced length of hospital stay (Cusack et al., 2008). Other factors are the continuous changes in the immunization schedule with increased number of vaccines provided to young children and the rise in screening initiatives and clinics (Cohen, 2006; Richard et al., 2010). Canadian Public Health Nurses have continued to discuss the need to focus on vulnerable populations through health promotion endeavours (Cohen & Reutter, 2007; Cusack et al., 2008; Raphael, 2006, 2008b).

Over the past decade in Vancouver, Public Health Nurses have developed limited numbers of health promotion initiatives to address the growing health issues of families with young children due to inequalities and social determinants. Social determinants, such as the living conditions, education, access to social and health services, also influence health

(Mikkonen, & Raphael, 2010). One new initiative is the RICHER Program, a collaborative partnership between Vancouver Coastal Health and University of British Columbia – School of Nursing and the British Columbia Children’s Hospital (Lynam et al., 2010). Lynam et al.’s (2010) research has examined the components in an innovative model of health services delivery fostering access to care along the continuum from prevention to specialized supports for children on the margins in British Columbia.

Although the mandate of the Infant Child and Youth Program has remained the same—providing health services to families with young children—over time, the nature of Public Health Nurses’ work has shifted, with a diminished role in health promotion addressing health disparities. “Major health disparities exist in Canada and the most important relate to socio-economic status, Aboriginal identity, gender and geographic location” (Public Health Agency of Canada, 2005, p. 1). There is a growing gap between the rich and poor in Canada, with continuing high poverty and homelessness rates, poor living conditions on Aboriginal reserves, and epidemic rates of obesity and early on-set diabetes (Raphael, 2008b). With many Canadians facing food insecurity, there is increasing use of food banks (Raphael, 2008b; Public Health Agency of Canada, 2005), and low-income families are more likely to experience poor health outcomes. Obesity rates have been rising across Canada, and research has shown there is link between obesity and income levels—it is not just about poor healthy behaviour choices (Mikkonen & Raphael, 2010). In the meantime, the “death rate from injury among Aboriginal infants is 4 times the rate for Canada as a whole, among preschoolers 5 times and among teenagers 3 times” (Public Health Agency of Canada, 2005, p. 1). It is crucial that a concerted effort be made to reduce health disparities, create a stronger Canadian society, and contain the rising costs of health care (Public Health Agency of Canada, 2005). Public Health Nurses have

historically played a leadership role in addressing these disparities using the concepts of health promotion, keeping alive the vision of Florence Nightingale and Lillian Wald (Buhler-Wilson, 1993).

Over the past decade, Public Health Nurses have experienced continuous organizational restructuring, which has impacted their role and work. As an experienced practitioner working in public health my perception is that, over the years, the Public Health Nurse role of using health promotion strategies to address some of the health disparities listed above has diminished—but has it really? If so, what are the factors contributing to the decline of Public Health Nurses’ health promotion work? These are the questions I explored in this research.

The Research Question

The focus of this research study was to explore and discover the nature of Public Health Nurses’ practice and determine what has influenced its evolution and change over the past decade. This research explored the question: What are the influences on the changing nature of Public Health Nurses’ health promotion work? This research study traced the social and contextual influences that have shaped the evolution of Public Health Nurses’ health promotion work over the past decade in the Vancouver community. Using institutional ethnography, data were collected from professional key informants employed in a public health agency in Vancouver, British Columbia. These texts were examined to identify influences on Public Health Nurses’ practice context and to understand the effect of organizational, philosophical, and political impacts on their health promotion work with families of young children. The factors influencing Public Health Nurses’ health promotion work and the context from which they arise are illustrated in this report.

Canada's Health Care System

Canada's health care system is guided by the terms of the Canada Health Act (1985), which boasts universal access to care for all Canadians and is touted as one of the finest publicly funded health care systems in the world (Raphael, 2008b). Lalonde's landmark report, released in 1974, placed Canada as a forerunner in health promotion (see also Raphael, 2008b; Raphael, Curry-Stevens, & Bryant, 2008; Stewart, 2000). In 1986, Jake Epp, then Minister of Health, released the *Ottawa Charter for Health Promotion* (World Health Organization, Health and Welfare Canada, & Canadian Public Health Association, 1986), which provided a framework for moving health promotion into practice. Canada became a recognized leader in public health approaches and in the conceptualization of health promotion strategies (MacDonald et al., 2009; Raphael, 2008b, 2011; Raphael et al., 2008; Richard et al., 2010). Since that time, health promotion and disease prevention have played a central role in public health service delivery (Stewart, 2000).

Defining Health Promotion

The World Health Organization (2005) defined health promotion as “the process of enabling people to increase control over their health and its determinants, and thereby improve their health” (p. 1). The *Ottawa Charter for Health Promotion* (World Health Organization et al., 1986) identified five strategies for health promotion. Norton (1998) summarized the charter's strategies in this way:

- Building healthy public policy.
- Creating physical and social environments supportive of individual change.
- Strengthening community action.

- Developing personal skills such as an increased self-efficacy and feelings of empowerment.
- Reorienting health services to the population and partnership with patients. (p. 1270)

Health promotion aims at building community, as it strengthens the individual by building capacity through providing information, motivation, and training; linking to resources; and mobilizing communities in different settings, such as schools, community centres, and neighbourhood houses (Labonté & Laverack, 2008; Nutbeam & Harris, 1999). Health promotion is characterized by empowering individuals and the community to take control of their health and advocate for resources (Nutbeam & Harris, 1999). Health promotion uses participatory action to build individual capacity, empowerment to mobilize communities, and partnerships to address health disparities and create change for social justice (Labonté & Laverack, 2008; Nutbeam & Harris, 1999). Health promotion is a political activity, focussed on improving the living conditions of the people by empowering them to take control in addressing the determinants of health to reach their optimal health and maintain wellness (Raphael, 2008b, 2011).

The aim of health promotion is to achieve health for all; it attempts to reduce inequities, increase disease prevention, and enhance coping (Labonté & Laverack, 2008; Raphael, 2008b). The mechanisms used to achieve this are self-care, mutual aid, and healthy environments and by implementing strategies of fostering public participation, strengthening community health services, and coordinating public policy (Labonté & Laverack, 2008; Nutbeam & Harris, 1999). Health promotion is about modifying the environment and individual behaviour; it involves education in individual lifestyles, community development, organizational change, legislation, and is accomplished through political action and information dissemination (Labonté & Laverack, 2008).

The role of the Public Health Nurse is to build relationships with people, work with people and not for them; to treat patients as advocates, and to act as consultants, teachers, coordinators of service, and facilitators of the process (Norton, 1998, p. 1270). Despite changes in the organization of health services, health promotion remains a central component of public health nursing practice. This study sought to examine the influences that have shaped the nature of Public Health Nurses' health promotion work.

Background to Public Health Nursing in Vancouver

Public health is “the organized efforts of society to keep people healthy and prevent injury, illness and premature death. It is a combination of programs, services and policies that protect and promote the health of all Canadians” (Canadian Public Health Association, 2010, p. 7). The discourse of public health nursing has been influenced by the political, social, and economic forces, and also by the national and provincial government policies, which have set the course for nurses. Public Health Nurses “play key roles in disease, disability, and injury prevention, as well as in health promotion” (Canadian Public Health Association, 2010, p. 6). Public health nursing is a universal service (Stewart, 2000) with the primary goal to promote health by engaging, empowering, and building population capacity to achieve optimal health. Certain groups such as the Aboriginal people, new immigrants, and vulnerable populations of families with children living in poverty face a higher burden of disease over the life course (Public Health Agency of Canada, 2005; Raphael, 2008b). Consequently, public health have typically focussed attention on and developed expertise in working with these groups who are at risk because of their material and social circumstances.

Health promotion is an integral part of public health nursing and plays a central role in public health service delivery (Stewart, 2000). As stated previously, the first standard of practice

outlined by the Community Health Nurses of Canada is health promotion. Despite this rich history of health promotion work in Canada, and in British Columbia, there has been a steady decline in the Public Health Nurse's role in health promotion over the past decade (Cusack et al., 2008; Labonté & Laverack, 2008; Raphael, 2006; Stewart, 2000).

Health promotion in public health nursing in the 1980s. In the 1980s, Public Health Nurses in Vancouver Coastal Health practiced public health in a generalist role, providing services across a spectrum of ages, spanning prenatal up to 24 years of age with the support of a school immunization team. Deploying a separate team to deliver immunizations allowed Public Health Nurses time to focus on health promotion initiatives. It was during this era that a number of initiatives were specifically developed to address the health promotion needs of groups who were particularly vulnerable because of their social and material circumstances. Some concrete examples of this health promotion work include the prenatal nutrition program Healthiest Babies Possible Program (Vancouver Coastal Health, 2013d) and the Bridge Clinic for government-sponsored refugees (Vancouver Coastal Health, 2013b). These programs were developed and established by nurses who worked in the community and developed trusting relationships with agencies to create initiatives in response to the needs of the public. Both these initiatives were initiated in the 1990s and are now fully funded, well-established health programs of Vancouver Coastal Health. The Bridge Clinic is now a primary care clinic with minimal involvement by public health, while the Healthiest Babies Program is resourced by a Public Health Nurse from the Infant Child and Youth Program.

Health promotion in public health nursing in the 1990s. Some creative ventures in the early 1990s were the Pops and Tots Program, a postpartum group for new fathers, and a support group for parents whose children experienced intense separation anxiety. These programs were

initiated out of a need identified by the Public Health Nurses and community members. These and other health promotion programs engaged families with public health services, allowing Public Health Nurses to build relationships with community members and provide opportunities to educate and support families of young children through different developmental stages. Through a variety of preventative and health promotion initiatives, Public Health Nurses reduced the negative impact of adversities and engaged families to strive for optimal health. For instance, one study conducted in preventing scald burn, which has enormous cost for parents and the health care system, found there was significant difference in parents' implementations of safety measures after Public Health Nurses provided the teaching (Corrarino, Walsh, & Nadel, 2001).

Internationally in the late 1990s, there was health care restructuring that accompanied the global economic recession (Falk Rafael, 1999a). In an effort to improve efficiency, decrease spending, and balance budgets, there was considerable scrutiny on all aspects of practice in all sectors of health care. Public health nursing was impacted by the changes that accompanied this global economic shift and restructuring. The focus of the Public Health Nurse's practice shifted from health promotion to individual risk factors, focussing on lifestyle to improve population health (Falk Rafael, 1999a, 1999b; Raphael, 2008b).

In 1989 the Canadian Institute for Advanced Research introduced the population health concept: "In 1994, the population health approach was officially endorsed by the federal, provincial and territorial Ministers of Health in a report entitled *Strategies for Population Health: Investing in the Health of Canadians*" (Public Health Agency of Canada, 2001, History section, para. 4). In 1995, John Millar (as cited in Crichton, 2000), the chief medical health officer at that time, wrote a discussion paper on the population health approach. With the Vancouver Coastal Health's shift from a generalist to a population focus in 1997, Public Health Nurses in

Vancouver Coastal Health were reorganized into population aged-focussed teams to deliver public health services. Three nursing teams were established in the Infant Child and Youth program: Healthy Beginnings (for patients 0–2 years of age), Early Childhood (for patients 2–5 years of age), and School Health (for patients 5-24 years). I was a Public Health Nurse in the Infant Child and Youth Program during this time and my practice changed from a generalist role to a focussed role when I became a member of the 2–5 years team, delivering services to preschool-aged children and their families.

Health promotion in public health nursing in the 2000s. Another round of restructuring occurred in the 1999 with elimination of the Immunization Team. The Immunization Team consisted of approximately 5–7 staff members and was part of the school health program, supporting Public Health Nurses' work in the schools. In 1999 the Immunization Team was disbanded, and as a result services, screening and, immunizing the school-age population, were incorporated into the Public Health Nurse's role and workload. With the Immunization Team ceasing to exist, there were significant changes in the Public Health Nurse's role in schools. Public Health Nurses had always been involved in working collaboratively with the Immunization Team to organize and assist in carrying out clinics at the schools, but nurses did not participate in the actual immunization of students in schools. Prior to these changes, Public Health Nurses had been in the schools on a regular scheduled basis as part of the school community to provide health promotion and prevention services to children, families, and school personnel. With the disbandment of Immunization Team, Public Health Nurses spent more time on immunizations and had less time available for developing relations to build collaborative partnerships with schools and other agencies to address the health issues of children and families (Cusack et al., 2008; Raphael & Bryant, 2006).

At this time, the Early Childhood team was amalgamated with the Healthy Beginnings team. Presently, there are two population-focussed public health nursing teams in Vancouver's Infant Child and Youth Program: Healthy Beginnings for clients 0–5 years of age and Child & Youth Health for clients 5–19 years of age (Vancouver Coastal Health, 2013c). Over the past two decades there have been explicit changes in the structure and nature of Public Health Nurses' practice contexts. Public Health Nurses' workloads continue to increase with the early discharge of acute complex mothers and babies from hospitals (Cusack et al., 2008; Richard et al., 2010), the addition of vaccines to the immunization schedule, and the use of technology in the day-to-day work. These changes have diminished Public Health Nurses' capacity to engage effectively with families, especially children, to promote health and address social determinants of health (Raphael, 2008b).

Shifting Discourse in Public Health Nursing

In the 1980s Canada was viewed as a leader in health promotion with the articulation of a framework to move health promotion into nursing practice, which was influential in structuring public health programs (Crichton, 2000; Richard et al., 2010; Stewart, 2000). More recently, the professional discourse has shifted to focus on population health, with a concomitant shift in practice to focus on health risk factors and healthy lifestyles (Raphael, 2008b; Raphael et al., 2008). Raphael (2008b) stated there is an “overwhelming emphasis on modifying individual risk behaviours” (p. 491). Raphael (2008b) also stated public health agencies focus on “lifestyle messaging that promotes healthy diets, physical activity, and reducing tobacco use” (p. 488), rather than addressing the “broader determinants of health” (p. 488) with concepts of health promotion. Raphael (2008b) contended this is due to the influence of the neo-liberal government policies. For example, public health nursing has experienced a shift in emphasis from health

promotion—characterized by building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services (Ward & Verrinder, 2008)—to population health, with its emphasis on the management of risk factors through activities such as screening, disease prevention, and immunization.

A change to the Public Health Nurse's practice has led to a diminished role in the traditionally valued health promotion work with communities (Cusack et al., 2008; Falk Rafael, 1999b; Raphael, 2008b). In essence, the role of public health nursing has shifted from engaging the community, building collaborative relationships, and addressing disparities, to delivering standardized programs designed to respond to the prevalence and incidence of health issues in the population. At times, the health intervention may be providing health information to build individual capacity. McGibbon (2009) stated, "Within the traditional health sciences approach, health problems remain individualized, localized, desocialized, and de-politicized (Hofrichter, 2003)" (p. 324). Public Health Nurses' health promotion work has been restricted with the shift to the traditional health sciences approach, which is influenced by the biomedical model (Cusack et al., 2008; Falk Rafael, 1999b). The following elements of health promotion are currently the main focus of public health nursing practice: (a) standardized education topics, such as how to safe proof the home or puberty change; (b) immunizations, such as screening of records to provide the appropriate vaccines; and (c) screening, such as growth and development, postpartum depression, sexually transmissible infections. The introduction of standardized population based practices has limited the opportunities for Public Health Nurses to engage in broader aspects of health promotion such as community engagement, creating supportive environments, strengthening community action, building healthy public policy, and reorienting health services.

Health Profiles of Children and Families

The future of Canadian society lies in the hands of generations to come. For Canada to continue playing a strong role in the global economy, it is imperative that children are born healthy and provided with every opportunity to reach their optimal development (factors such as cognitive development, physical growth, language, and social emotional) to become successful participatory members of society (World Health Organization, 2013). Healthy child development in the early years is critical to lifelong health outcomes, learning, and achievement of the population (Vancouver Coastal Health, 2009c). Unfortunately, British Columbia continues to have the highest child poverty rate in Canada (City of Vancouver, 2011). The 2011 report from the City of Vancouver stated, “40% of Vancouver’s kindergarten aged children are vulnerable—at risk of failing to develop into healthy, well educated, innovative and productive adults” (p. 6).

Social determinants, such as income, education, occupation, and the psycho-social environment in which people live and work, influence health (City of Vancouver, 2011; Marmot & Wilkinson, 2006; Mikkonen & Raphael, 2010). With the change in makeup of the family over time (City of Vancouver, 2011), income disparities between the wealthy and the poor continue to rise, making it difficult for poor families to provide a warm stimulating environment for their children to achieve developmental milestones and succeed in school (City of Vancouver, 2011; Hertzman, 2004). **Error! Bookmark not defined.** Parents’ level of education and incomes influence early childhood development (Vancouver Coastal Health, 2013g). Research has demonstrated the first 5 years of life are critical for impacting school readiness (City of Vancouver, 2011; Hertzman, 2004). These early years are a determinant of lifelong health as an adult. Meanwhile the prevalence rate of mental disorders in children and youth is 15% (Waddell & Shepherd, 2002). Research has shown there are social conditions that are protective against

adversities (particularly for children) and that help build resiliency (Benard, 2004; Hertzman, 2004). Health promotion initiatives can focus on nurturing these protective influences through policy and practice.

The Vancouver Coastal Health (2008) *VCH Population Health Report* found there is health disparities amongst the population served by Vancouver Coastal Health, with, for example, Richmond's population living to an average of 84.81 years, while the Vancouver Downtown Eastside population is surviving to an average of 75.01 years. The disparities between the health and socio-economic status of Aboriginal compared to other British Columbians are also documented (Vancouver Coastal Health, 2008). In some parts of the Vancouver Coastal Health region 40% of children are considered vulnerable and at risk for developing health problems (Vancouver Coastal Health, 2009a). There is a higher population of vulnerable children (18%) within the Downtown Eastside (Vancouver Coastal Health, 2008, 2009c), and these children have limited access to resources (Lynam et al., 2010).

Currently, several government initiatives have taken place to improve the health of young children and families to create a healthier society. Some of these programs include Act Now BC, "a cross-government health promotion initiative that seeks to improve the health of British Columbians by taking steps to address common risk factors and reduce chronic disease" (Government of British Columbia, 2006, para. 1); the Active Living Program created to address the obesity epidemic with a focus on physical activity (Government of British Columbia, Ministry of Health, n.d.b); and the Healthy Schools BC Program, a school health comprehensive program that is a "framework for supporting improvements in students' educational outcomes while addressing school health in a planned, integrated and holistic way" (Healthy Schools BC,

2011, para. 1). Different service providers including Public Health Nurses are engaged in these initiatives.

Public Health Nurses have delivered health services addressing the health needs of children and families using concepts of health promotion, striving to achieve optimum health and build healthy communities. As their role in health promotion has shifted, it is important for leadership to examine and support ways for public nurses to again use concepts of health promotion to address the rising health disparities so that they may create healthy lives and healthy communities.

Summary

Health services delivery is faced with managing many complex health issues caused by rapid change in the global environment, the aging of baby boomers, and escalation in chronic disease. To deal with these complex issues, health care leaders must find creative ways to tackle the problems. It is also important that health care leaders determine the role that Public Health Nurses should play in using health promotion for upstream thinking in addressing these issues. Health care professionals need to have a clear understanding of the tools being used to deliver services and expected outcomes.

Public Health Nurses have played an important role in the health of individuals, families, communities, and populations, using health promotion work to respond to and address the needs of their communities, especially those most vulnerable. Health promotion is an integral part of the Public Health Nurse's work in addressing health concerns of young children and families in the Infant Child and Youth Program in the Vancouver community, but this has been observed to be declining. Scholars have argued that health promotion is crucial to addressing the future

health of populations; therefore, there is a need to continue to ensure that the underlying principles of health promotion are enacted in practice (Raphael, 2008b).

Despite increasing evidence of marked inequities in health, particularly for vulnerable families and children (City of Vancouver, 2011), and despite the calls for broad-based engagement with and within communities to address social determinants of health (Raphael, 2008a, 2008b, 2011; Raphael & Bryant, 2006), public health's capacity to engage and respond has diminished in Vancouver, British Columbia, and across Canada. It is this trend that this research inquiry was designed to examine.

This thesis is organized as follows. In Chapter 2, I critically review literature concerning community and public health nursing and health promotion. In Chapter 3, I introduce the methodology used, institutional ethnography, and describe how the research study was conducted. Chapter 4 presents an analysis of the study data. Finally, in Chapter 5, the implications and recommendations of the findings for public health nursing practice are discussed.

Chapter Two: Review of the Literature

In this chapter, I describe how the literature search was conducted, and I provide a review of the literature on public and community health nursing and health promotion. I also identify the knowledge gap this study seeks to address.

Background Literature Search

An extensive literature search of peer-reviewed research journals was completed on public and community health nursing health promotion work to explore research conducted in this field in the past 10 years. A thorough systematic review was conducted through searching the following four data bases: Cumulative Index to Nursing and Allied health Literature, Cochrane Review, Web Science, and MEDLINE using PubMed. Using Boolean operators “and” and “or,” truncated free text exploded, and medical subject and terms, the following keywords were used to search for relevant literature: barriers, inhibit, enhance, community health nurses, community health nursing, public health nurses, public health nursing, health promotion, organizational culture, empowerment, interview questionnaires, and interviewing questionnaires.

From this literature search, only a small number of relevant Canadian research studies were found, revealing limited research conducted in Canada on influences impacting community and Public Health Nurse role in health promotion. One study was conducted across Canada by a team of Canadian researchers (Underwood et al., 2009); this was the only published study found that had been conducted in British Columbia. There were some published research studies on the community and public health nursing role in health promotion that were undertaken in other provinces: Manitoba (Cohen, 2006); Québec (Richard et al., 2010); Saskatchewan (MacDonald & Schoenfeld, 2003); and Ontario (Falk Rafael, 1999a, 1999b). This low number of published

Canadian research studies on the Public Health Nurse's role demonstrates a gap and need for further research in this field.

Nurses' Health Promotion Practice

The relevant studies explored various aspects of Public Health Nurses' understanding of and practice of health promotion. One study conducted by a team of researchers in Québec investigated conceptualization of prevention and health promotion with a group of local Public Health Nurses in Montréal (Richard et al., 2010). This study used semistructured interviews with a purposive sample of 41 Public Health Nurses and found nurses use the standard definition for prevention (i.e., in terms of risk factors and the avoidance of problems). Richard et al. (2010) found Public Health Nurses defined health promotion as health education at a larger scale, while empowerment and health determinants including social environments dimensions of health were absent from the discourse. Many study participants also had difficulty differentiating between health promotion and prevention. The authors concluded that Public Health Nurses' conceptual confusion resulted in a narrow focus of health promotion practices (Richard et al., 2010).

MacDonald and Schoenfeld's (2003) study in Saskatchewan revealed similar findings; in their research Public Health Nurses did not engage in broader activities of health promotion. Public Health Nurses in Saskatchewan were surveyed using an instrument to explore their roles and activities (MacDonald & Schoenfeld, 2003). The study results indicated Public Health Nurses felt somewhat prepared for all their roles. They engaged in activities for which they felt most prepared, such as caring for individuals and families; immunizing; educating individuals, families, and groups; acting as a resource person for clients and lay helpers; linking those needing services to appropriate community resources; and using marketing strategies (MacDonald & Schoenfeld, 2003). In the Saskatchewan context these authors noted that Public

Health Nurses participated less in activities associated with the roles of community developer, policy formulator, researcher and evaluator, and resource manager, planner, or coordinator, as they felt less prepared for these roles (MacDonald & Schoenfeld, 2003).

Falk Rafael (1999b) undertook an oral history research study on health promotion practices with 14 Public Health Nurses with an average 20 years of experience in Ontario. The study focussed on the distinct practice of public health nursing (district nursing and program-focussed practice) between 1980 and 1996. Falk Rafael (1999b) found that in district nursing the community was the client and nurses were well connected to their communities; when the program became focussed there was a loss of connection to and distancing from communities due to the limiting of direct services to community members. Falk Rafael (1999b) concluded Public Health Nurses need support from the organization to engage in health promotion, particularly in community development.

In Manitoba, Cohen (2006) conducted a descriptive exploratory qualitative research study on the perspectives of Public Health Nurses on health promotion practice and their perceptions about the barriers to population-focussed health promotion. Standardized open-ended interviews with 24 Public Health Nurses in diverse regions in Manitoba were carried out. The Public Health Nurses in Cohen's (2006) study identified the following barriers to population-focussed health promotion: individual Public Health Nurses; organizational (i.e., culture, policies, and processes); and the organizational barriers at the community or provincial level. Cohen's (2006) study discovered that population-focussed health promotion is not at the heart of public health nursing practice, as believed in theory. Instead Public Health Nurses carry out health promotion work with individuals and families where they feel most comfortable and competent. Cohen (2006) determined there is a gap between the theory and population-focussed health promotion

and identified the need to build Public Health Nurses' knowledge and skills on population-focussed health promotion. Other important factors to consider were Public Health Nurses' lack of time and flexibility due to increased demands for mandatory programs and lack of organizational support (Cohen, 2006).

In their study, Underwood et al. (2009) conducted 23 focus groups with public health policy makers and frontline Public Health Nurses and surveyed 13,000 community health nurses across Canada. Their data indicated that study participants placed a strong emphasis on promoting and valuing of public health by government, organization, and management. Underwood et al.'s study participants identified the following supports that enable Public Health Nurses to practice to their full scope: professional confidence, good team relationships, workplace environment, and community context. Public Health Nurses also identified the following organizational supports employed by nurses: good management practices, a supportive culture within the organization, and sound government policy (Underwood et al., 2009).

These challenges experienced by Public Health Nurses in regards to health promotion and workplace environment will be discussed later in this chapter. Next I will discuss the history of community and public health nursing in Canada.

Canada's Health Care System

The social organization and mandate of Canada's health care system is guided by the terms of the Canada Health Act (1985), which secures universal access to care for all Canadians (Stewart, 2000). As discussed in Chapter 1, the release of the Lalonde report in 1974 led to Canada becoming a recognized leader in the conceptualization of health promotion strategies and public health approaches (Raphael, 2008b; see also Stewart, 2000). From the time of the release of the *Ottawa Charter for Health Promotion* (World Health Organization et al., 1986), health

promotion and disease prevention have played a central role in public health service delivery (Stewart, 2000), which continues to today.

Today, many contend that the Canadian health care system is in crisis—budget constraints, long waits lists, rapid technological changes, an aging population, and shortage of health care workers has burdened a system struggling to provide excellent care (Dion & Dodge, 2011). It is a complex system grappling to meet the health needs of the changing population. Canada's population demographics have changed, life expectancy is rising, the immigrant population is increasing, chronic illness is increasing, obesity rates are escalating, and more complex mental health issues have placed pressures on the health care system (Dion & Dodge, 2011; Woermke, 2008). The system is also influenced by the surrounding sociopolitical economic environment (Stewart, 2000) and is struggling to meet Canadians' health care needs. The social cultural environment of health care organizations impacts Public Health Nurses' work and the discourse of public health nursing.

Discourse of Public Health Nursing

As briefly noted in the introductory chapter, health promotion and disease prevention are fundamental parts of public health nursing (Stewart, 2000). Public health services are funded by both federal and provincial governments and have evolved to focus on communicable disease control, healthy child development, prevention of chronic illness, health promotion and identification of mortality, and morbidity risk factors (Stewart, 2000). Florence Nightingale, a nursing leader, created the vision of the Public Health Nurse by advocating for the poor and needy (Falk Rafael, 1999b). Over 100 years ago, Lillian Wald carried forward this vision and coined the term “public health” (Falk Rafael, 1999b, p. 27; see also Buhler-Wilson, 1993). Wald went on to establish a nationwide public health service in the United States, envisioning a broad

focus for nurses to address the needs of the community (Buhler-Wilson, 1993). Nightingale's and Wald's visions of public health played an integral role in the development of community health nursing in Canada, influencing the evolving Canadian health care system (Buhler-Wilson, 1993; Falk Rafael, 1999b; Stewart, 2000). Stewart's (2000) review of the history of public health nursing in Canada drew attention to the enhanced educational preparation of nurses working in public health. Stewart (2000) noted that when the role was first introduced in Canada, Public Health Nurses were required to graduate from established nursing schools and complete an additional 6 months of training in preparation for home visiting (Stewart, 2000). In 1884, Ontario passed the first legislation for public health and created the public health movement (Stewart, 2000), thereby establishing public health nursing in Canada. Over time, public health nursing began to form from province to province, shifting the focus from individual to family, home, and the community, with broader application of services to health and social matters. By 1933, public health nursing was established in each province "with emphasis on health teaching, case finding and preventative care in a variety of community settings" (Stewart, 2000, p. 23).

In 1978, the World Health Organization conference in the Union of Soviet Socialist Republics approved the definition of primary health care, which contained the following five principles: health promotion, public participation, intersectoral and interdisciplinary collaboration, accessibility, and appropriate technology (Stewart, 2000). The World Health Organization identified the implementation of primary health care to be a crucial strategy, recognizing the leadership role nursing could play in achieving "Health for All by the Year 2000" (World Health Organization et al., 1986, p. 1; see also Stewart, 2000). In the 1980s, this paradigm shift to primary health care in community health nursing changed the public health nursing practice from the medical to the primary health care model.

British Columbia's public health program was established in the early 20th century in Canada, with a focus on immunization and communicable diseases, including sexually transmitted diseases. During the past 100 years public health has gone through tremendous changes with the establishment of public health departments, school health services, and public health nursing roles. Over the years in some regions Public Health Nurses have moved from district nursing to population-focussed nursing.

Currently, Public Health Nurses practice autonomously in “diverse settings, such as community health centres, schools, street clinics, youth centres, and nursing outposts, and with diverse partners, to meet the health needs of specific populations” (Canadian Public Health Association, 2010, p. 7). Public health nursing programs in Vancouver Community are currently situated in community health centres, which were developed in Vancouver in 1999 to provide a range of services in one location accessible to the public. These publically funded community health centres were created as a one-stop shop for health services in the community.

Community health centres provide a range of health care services in a single location, including access to public and community health nurses, mental health and addiction counsellors, dental clinics for children, speech therapists, nutritionists, youth drop-in health clinics and more. (Vancouver Coastal Health, 2013h, para. 3)

Public Health Nurses are the majority of staff in community health centres who collaborate with other disciplines and community agencies to provide a range of health services to children, youth, and their caregivers.

Public Health Nurses are regulated by provincial regulatory bodies, which set the scope of practice for registered nurses. In British Columbia, the College of Registered Nurses regulates nursing practice standards (College of Registered Nurses of British Columbia, 2012), and the

Canadian Nurses Association (2008) has developed codes of ethics guiding nurses working in Canada. The Canadian community health nursing standards (Community Health Nurses of Canada, 2011), discussed in Chapter 1, guide the scope and depth of public health nursing practice. Furthermore, the Public Health Agency of Canada (2008) has developed 36 core competencies that are organized under the following seven categories: public health sciences; assessment and analysis; policy and program planning, implementation, and evaluation; partnerships, collaboration, and advocacy; diversity and inclusiveness; communication; and leadership.

Public Health Nurses are one of the largest groups of health professionals in the public health infrastructure and are well placed in the community to work with at-risk populations (Stewart, 2000; Zerwekh, 1993). Over time, nurses have demonstrated their ability to target and provide appropriate care to vulnerable populations, keeping alive Florence Nightingale's and Lillian Wald's visions (Buhler-Wilson, 1993). Zerwekh (1993) wrote about Public Health Nurses and contended that the mission of public health has always included health promotion.

Discourse on Health Promotion

Canada was instrumental in the development of the concept of health promotion (Dorland & Davis, 1996). The Lalonde (1974) report, *A New Perspective on the Health of Canadians*, outlined strategies that have since become incorporated into the current definition of health promotion, thus establishing the roots of health promotion in public health within the Canadian health care system. The *Ottawa Charter for Health Promotion* (World Health Organization et al., 1986) defined health promotion as “the process of enabling people to increase control over and to improve their health” (p. 1). The Ottawa charter listed five actions for health promotion work: (a) build public policy, (b) create supportive environments, (c) strengthen community action,

(d) develop personal skills, and (e) reorient health services (World Health Organization et al., 1986, pp. 2–3).

Health promotion aims at building the community, as it strengthens the individual by building capacity through information, motivation, training, linking to resources, and mobilizing the communities in different settings such as schools and community centres (Labonté & Laverack, 2008). Health promotion uses participatory action to build individual capacity, empowerment to mobilize communities, and partnerships to address health disparities and create change for social justice (Labonté & Laverack, 2008). Health promotion is a political activity focussed on improving the living conditions of the people by empowering them to take control in addressing the determinants of health to gain health (Raphael, 2008a).

Public Health Nursing in Health Promotion

Health promotion is a central concept of public health and community health nursing (Stewart, 2000), as demonstrated by the Community Health Nurses of Canada's (2011) standards of practice, which list health promotion as the first standard guiding their practice. Historically, Public Health Nurses worked as district nurses closely connected with their communities, engaging in health promotion for the well being of communities by facilitating access to health care services, building capacity, and working in partnerships to improve the health of the community (Falk Rafael, 1999a, 1999b; Stewart, 2000; Wilhelmsson & Lindberg, 2009).

Health promotion in practice. At one time health promotion was embraced as a model for public health service delivery in Canada and across the world (Labonté & Laverack, 2008; Raphael, 2008a, 2008b; Wilhelmsson & Lindberg, 2009). In the 1980s, Public Health Nurses' engagement in health promotion initiatives flourished. Public Health Nurses attended to the social determinants of health, such as economics, living conditions, and social services, and were

the link in addressing the health needs of the families. The focus of the nursing practice was broad. Later, by using community-, neighbourhood-, and school-based approaches, Public Health Nurses included healthy lifestyle, healthy aging, and reproductive health in their work. At this point in time, Public Health Nurses played a leadership role and were actively involved in health promotion initiatives (Falk Rafael, 1999a, 1999b).

In the early 1990s, health promotion was blossoming in public health nursing in lower mainland British Columbia and across Canada. In the 1980s and 1990s, Vancouver again played a leading role in introducing health promotion strategies for engaging with a population that was becoming increasingly diverse. Public Health Nurses began grassroots initiatives in response to community needs, which later became established service delivery programs. Some of these programs were discussed in Chapter 1.

Over the past 20 years, public health nursing has undergone tremendous changes, and the Public Health Nurse's role has shifted to become restricted in health promotion (Falk Rafael, 1999a, 1999b; Raphael, 2008a, 2008b). Canadian scholar Raphael (2008a, 2008b) stated health promotion in Canada has become subordinate to population health and invisible in public health. This shift has led to conflict in the conceptualization and philosophy of health promotion (Falk Rafael, 1999b). Scholars have suggested that this move away from comprehensive engagement with all aspects of health promotion has been due to this confusion in definition, difficulties in evaluating and measuring the outcomes of health promotion work, effectiveness of health promotion interventions, and cost-effectiveness of health promotion work (Cohen, 2006; Falk Rafael, 1999a, 1999b; Killoran & Kelly, 2010; Labonté & Laverack, 2008; Raphael, 2008b; Richard et al., 2010).

In the next section I review literature that examined conditions that have influenced sustained engagement with health promotion in public health nursing. These influences include the conceptualization of health promotion itself, the effectiveness and efficiency of health promotion programs and practices, and the impact of population health perspectives on health promotion. I end with an analysis of influences on the future of health promotion.

Conceptualizing health promotion. A number of scholars contended that since its inception over 29 years ago health promotion has remained ambiguous, difficult to define, and hard to conceptualize (Falk Rafael, 1999a, 1999b; Labonté & Laverack, 2008; Richard et al., 2010). Scholars in Canada and across the world have written about the confusion and difficulties practitioners have of moving health promotion theory into practice (Cohen & Gregory, 2009; Whitehead, 2001). Such ambiguities make it difficult to enact the full scope of health promotion in practice (Cohen, 2006; Wilhelmsson & Lindberg, 2009; MacDonald & Schoenfeld, 2003; Richard et al., 2010).

A number of research studies undertaken in Canada (Cohen, 2006; Falk Rafael, 1999a, 1999b; MacDonald & Schoenfeld, 2003; Richard et al., 2010), as well as studies conducted globally (Wilhelmsson & Lindberg, 2009), have also outlined challenges nurses have defining health promotion along with difficulties in differentiating between the practice of providing health information and engaging in community development work. Falk Rafael (1999b) stated there are significant variations on definition of health promotion in public health within nursing literature and that over the last half of the 20th century there has been a “(r)evolving conceptualization of health promotion” (p. 24) with the “longstanding definition of disease prevention strategy” (p. 23). Richard et al. (2010) found in their study that Public Health Nurses had difficulty defining and conceptualizing health promotion in practice, while Cohen (2006)

found there is a gap between the theory and practice of population health promotion. Meanwhile, MacDonald and Schoenfeld (2003) discovered Public Health Nurses were less involved in associated roles (i.e., community developer, policy formulator, researcher and evaluator, and resource manager, planner, or coordinator) because they felt less prepared for those roles.

Over the years, confusion between the differences in health promotion and health education has continued (Richard et al., 2010; Whitehead, 2011). Health education involves providing information in an effort to influence change in behaviour, while health promotion is more than just giving information; health promotion includes health education, but it also seeks to foster community mobilization and political action in order to achieve patient and community empowerment and social change that impacts the conditions that underlie poor health (Labonté & Laverack, 2008; Raphael, 2008a). Falk Rafael (1999b) and other Canadian scholars (Cohen, 2006; Richard et al., 2010) have contended that persistent confusion regarding the principles of health promotion has affected engagement of health care professionals, particularly nurses, in broader health promotion initiatives such as advocacy to address social determinants of health and community development work.

Effectiveness and efficiency of health promotion. Another challenge for administrators and practitioners alike is the need to demonstrate that health promotion is both efficient and effective in fostering health and reducing illness. The impact of health promotion programs has historically been difficult to evaluate and measure; this lack of evidence of effectiveness, particularly in the era of evidence-based practice, has been instrumental in the decline of health promotion in public health (Killoran & Kelly, 2010; Wills, Evans, & Samuel, 2008).

Impact of population health discourse. With the introduction of new technologies and the development of new databases, population health has emerged as an influential discourse

focussing on “population-level interventions, which seek to improve the health of the entire population” (Frohlich & Potvin, 2008, p. 218). Through collection of epidemiology data with a focus on risk factors and causes of disease, population health identifies health issues and provides direction for health service planning (Frohlich & Potvin, 2008; Raphael & Bryant, 2002; Raphael, 2003, 2008b).

Population analyses plays an important role in providing direction for program planning by identifying population groups at risk or by identifying behaviours to be encouraged or discouraged. Scholars contend it does not provide insight on the most effective strategies for engaging with the target population to effect change (Frohlich & Potvin, 2008; Raphael, 2003, 2008b; Raphael & Bryant, 2002, 2006). However, the broad definition of health promotion outlines strategies that could be used to address the identified health issues, particularly for vulnerable populations by focussing on the determinants of health (Frohlich & Potvin, 2008; Raphael, 2003, 2008b; Raphael & Bryant, 2002, 2006). In the next section I will discuss the barriers to health promotion practice, government and organizational support, and the future of health promotion.

Barriers to health promotion practice. In Manitoba, Public Health Nurses identified the following three categories of barriers to the promotion of population health: individual Public Health Nurses; organizational barriers (culture, policies, and processes); and extra-organizational barriers at the level of community or province (Cohen, 2006). One key barrier identified in the literature is the confusion that exists amongst staff on health promotion and community development work (Cohen, 2006). Several studies revealed Public Health Nurses’ lack confidence to commence health promotion and community development initiatives (Cohen, 2006; MacDonald & Schoenfeld, 2003; Richard et al., 2010). Nurses are more comfortable

providing individual care in comparison to engaging in health promotion and community development initiatives (Cohen, 2006). This could be why there is a decline of Public Health Nurses' involvement in health promotion activities. The literature identified building knowledge and skills as a way to increase confidence of Public Health Nurses' engagement in health promotion projects, especially community development work (Cohen, 2006; MacDonald & Schoenfeld, 2003; Richard et al., 2010).

Government and organizational support. Much of the research identified a need for organizational support and leadership for Public Health Nurses to be effective in their roles. Frontline leaders who had a strong background in public health were supportive and effective (Cohen, 2006; Meagher-Stewart et al., 2010; Underwood et al., 2009). Underwood et al.'s (2009) research study found Public Health Nurses thrive when they have a clear, shared vision and goals; are allowed to develop creative autonomous practice in a supportive workplace environment; and are given time, flexible funding, and management support to build relationships within their communities. Participants in Underwood et al.'s study placed a strong emphasis on the government, organization, and management promoting and valuing public health. Their study also identified the following supports that enable community health nurses to practice to their full scope: a supportive workplace environment, community supports, professional confidence and good team relationships for effective practice (Underwood et al., 2009).

Meagher-Stewart et al. (2010) found that Public Health Nurses were effective in their work if they were involved in the decision-making process and also if their knowledge from community assessment was utilized. Several times interviewees in Meagher-Stewart et al.'s research discussed lack of voice and lack of utilization of their community knowledge in

program planning by health leaders. Meagher-Stewart et al. also identified that public health leaders who were visionary, clear, consistent, and supportive helped Public Health Nurses work to full scope.

Health promotion is about addressing the determinants of health and health disparities to create healthier populations. Cohen and McKay (2010) conducted research on the role of health organizations and Public Health Nurses in addressing child poverty. The Public Health Nurses in Cohen and McKay's study identified organizations' lack of understanding of their role as a barrier to organizations' attempts to address poverty issues. Nurses discussed concerns about the erosion of Public Health Nurses' scope of practice, with the focus being on mandated programs rather than developing innovative initiatives to address community needs and social determinants of health (Cohen & McKay, 2010). Cohen and McKay also identified that Public Health Nurses were given little opportunity to be involved in program planning when addressing the needs of vulnerable families with young children. Instead of health promotion work, nurses focussed on tasks in the programs. An important principle of health promotion is the role of advocacy; however, research demonstrated this is not clearly articulated for Public Health Nurses (Cohen & McKay, 2010).

Cohen and Reutter (2007) conducted a study reviewing professional standards and competencies to examine the framework for the Public Health Nurse's practice in addressing family and child poverty in Canada between 2005 and 2006. Cohen and Reutter discovered the Public Health Nurse's advocacy role to address poverty was not clearly articulated in the standards, and, although nurses work daily with families living in poverty, they do not engage at the sociopolitical policy level to address these issues. Cohen and Reutter recommended organizations make a commitment to expand the role of Public Health Nurses to address child

poverty by building nurses' knowledge and skill level. Scholars support expanding Public Health Nurses' engagement in broader concepts of health promotion (Cohen & McKay, 2010; Cohen & Reutter, 2007; Meagher-Stewart et al., 2010), however Public Health Nurses' activities to build partnerships, community mobilisation and advocacy in addressing health disparities has been diminishing (Falk Rafael, 1999a; Cohen, 2006).

Future of health promotion. Over time, public health nursing's role in health promotion has been observed to shift and diminish (Falk Rafael, 1999a, 1999b; Raphael, 2008b). Scholars have noted health promotion in Canada has evolved to become subordinate to population health and invisible in public health (Raphael, 2008b). Raphael (2008b) stated there is a need to continue with the underlying principles of health promotion and to build upon them, not to replace or supplant them.

Wills et al. (2008) observed that the revitalization of health promotion is on the rise. Efforts are being made to reclaim ground that has been lost. The Public Health Association of BC (2011), for example, is seeking to reintroduce health promotion. In Vancouver, the Public Health Association of BC (2011) and partners held "The Ottawa Charter for Health Promotion: Critical Engagement from a Health Equity Perspective" conference in November 2011. The conference was organized to examine the course of health promotion over the past 25 years (Public Health Association of BC, 2011). The presenters at this conference noted that health promotion has continued to thrive in other parts of the world. One presenter shared a case study from New Zealand involving a health promotion initiative to address the health issues of their indigenous population (J. Raeburn, personal communication, November 29, 2011). These professionals are seeking to articulate a multipronged strategy to strengthen health promotion in

public health programs in British Columbia and elsewhere in Canada. These efforts coincide with initiatives in other jurisdictions.

Summary

In this chapter I described how the literature search was conducted. I also discussed Canada's health care system, provided a discourse of community and public health nursing, and discussed health promotion, social determinants of health, and the role of community and public health nursing in health promotion. The next chapter explains the methodology and methods applied in this research.

Chapter Three: Methodology and Methods

Smith's (2005, 2006) institutional ethnography methodology was selected to carry out this qualitative research study. The aim of the institutional ethnography approach is to make visible influences that create contexts that shape the day-to-day practice of women's (or the target population's) work and lives (Smith, 2005, 2006, 2010). Institutional ethnography guides the researcher in exploring connections between everyday lives of people (Smith, 2005, 2006, 2010) and the influences of surrounding environments—economic, sociological, and political.

In this chapter, I provide an overview of the key methodological premises of the institutional ethnography approach, describe the methods used to gather and analyze the data, and discuss ethical issues relating to this research. I close the chapter with a discussion on the challenges of enacting institutional ethnography methodology.

Research Methodology

Institutional ethnography is a feminist methodology, originally developed by a Canadian sociologist named Dorothy Smith, who looked at the lives of women and how the surrounding sociopolitical environment impacted them (Rankin & Campbell, 2009). It was an ideal methodology to explore and discover the shifting role of Public Health Nurses in health promotion work and to gain an understanding of the day-to-day work of Public Health Nurses. The majority of the nurses working in community health are women; this was true 20 years ago and continues to be true today. Most male nurses upon graduation work in the acute sector, and very few end up in community health nursing roles. Therefore, this methodology was well suited to exploring and discovering how the work of Public Health Nurses (the majority of whom are women) was and continues to be affected by reform and restructuring due to the ever-changing sociopolitical environment of health care.

Institutional ethnography was ideal because it explores the everyday experiences of those working or living with the phenomena under study (Smith, 2005, 2006). The methodology began by exploring the work experience of Public Health Nurses, which was the starting point to understand the ruling relations—the surrounding institutional policies that coordinate and organize women’s lives (Smith, 2006, 2010).

The focus in this study was on health promotion. I believed that starting with nurses’ accounts of the organization of Public Health Nurses’ work could illuminate the social contexts of their daily health promotion work. I expected that examining work activities of these nurses could provide information on influences organizing and coordinating their health promotion work. Smith (2005) found that this type of data could “track the macroinstitutional policies and practices that organize those local settings” (p. 29). In exploring how translocal and extralocal powers affect the sociocontextual work environments, which shape nurses health promotion work, I expected to gain an understanding of the factors that influence how nurses engage in health promotion work. It was my hope that the results of this study would shed light on what is influencing the discourse of public health nursing and the future ramifications for creating a healthier society. This knowledge could guide future decision making of public health leaders and agencies.

Methodological Premises and Overview of Institutional Ethnography

Initially, institutional ethnography was developed as a feminist methodology to look at the lives of women in organizations and institutions and to consider how social contexts created by ruling relations influence women’s interactional practice and social connections (Smith, 2005, 2006). Institutional ethnography encourages the researcher to inquire and discover the impact of the political and economic environment on women’s lives by examining public and local

policies, including implicit and the explicit discourses. Institutional ethnography encourages the researcher to explore and discover how these policies are understood, interpreted, and enacted in the day-to-day experiences of women (or the target population of interest). Institutional ethnography also delves into the social relations in the institutions that the women are connected to through employment, use of resources, or access to services.

Institutional ethnography uses an inductive approach that begins by examining specific observations for patterns in order to make broader generalizations and theories (Polit & Beck, 2008). The researcher begins by exploring experiences of the focus population and proceeds to examine broader social institutional policies and practices that shape participants' experiences (Smith, 2005, 2006). The institutional ethnography methodology is designed to illustrate or trace the ways individuals' experiences are organized by broader institutional policies and practices. The research focus was on the exploration and discovery from the workings of everyday lives, how people are socially organized, in an attempt to help them understand institutional work processes and their own location within the institution (Polit & Beck, 2008; Smith, 2005, 2006). The best sources for providing information are people who have lived with the experience (Smith, 2005, 2006).

This research study sought to understand, from the viewpoint of Public Health Nurses (i.e., the target population), the complex array of influences on the role of Public Health Nurses and the evolving scope of their daily work, particularly health promotion with families of young children. Public Health Nurses were the best source to provide information and shed light from their day-to-day experience of why their role in health promotion work has shifted. Ruling relations, as mentioned earlier in this chapter, are the surrounding institutional policies that effect women's lives (Smith, 2006). Examination of other sources of data relating to the social context

(or ruling relations) was conducted. Texts that could expose the power influencing study participants' health promotion work were analytically studied. Documents such as policy statements, organizational changes records, and work mandates were examined; these documents provided second level of analysis or another level of information to complement the insights gained through the interviews I had conducted (Thorne, 2008).

The organizational context in which the research was undertaken involved a large health care institution in an urban area. This organization's programs and services are impacted by public policies, which create and influence the social context within which Public Health Nurses work. In this study, the Public Health Nurses' experiences were the starting point to understand the influences shaping their health promotion practices.

The concept of a standpoint is used to focus attention on the study population's viewpoint. The standpoint concept guides the researcher to look at how the ruling relations intersect with the organization and where the Public Health Nurses are situated. "Ruling relations are defined as textual venues . . . where power is generated and perpetuated in society" (Wright, 2003, p. 244). Power is a central concept of Smith's (2005, 2006) institutional ethnography, as it is a manifestation of the surrounding sociopolitical economic context that influences and coordinates the social connections of women's everyday work and practice. To understand situations in which power is embedded, influencing Public Health Nurses' health promotion work, I conducted an inductive analytical examination of texts such as government and clinical agency documents to discover and understand the underlying beliefs and attitudes (Thorne, 2008).

An ethnographic lens was used to inquire into the evolving Public Health Nurse practice to understand the ruling relations (Smith, 2006), which shape the context in which nurses carry

out their health promotion work. By focussing on Public Health Nurses' work, I had hoped to understand their experiences and feelings about the nature of their day-to-day health promotion work and to also understand the ruling relations, institutional policies, and mandates that influence the social contexts of Public Health Nurses' work. Local policy documents were examined to understand the social organization influences on the context of study participants' work, job mandates, and work processes. These documents provided insights into the ruling relations (i.e., where the power is) that influence and coordinate the social contexts of Public Health Nurses' health promotion work.

Using the theory of language as a medium, Smith (2005) reasoned that one could capture thoughts and ideas of people in texts. Through examination of these texts one can make visible ruling relations, social coordinates, and connections of people in the institution. Smith (2005) explained that, in intuitionist ethnography, interviews are conducted by "talking with the people" (p. 22) to "learn how things work" (p. 23). I undertook these principles of institutional ethnography by engaging in dialogic interviews with Public Health Nurse study participants to understand the forces influencing their engagement in health promotion work. The participants were interviewed on their day-to-day activities and experiences to discover what was actually occurring in the workplace. To understand the social environment of their workplace, study participants were asked to describe a regular workday in their current job, including experiences, activities, and processes. Further exploration was carried out to gain a deeper comprehension on sequencing of processes and practices, the coordination of their work, and influences affecting their role in health promotion.

The aims of the analysis were to identify disjunctures or points of congruence between the stated organizational and program goals and the participants' accounts of their experiences.

Within the methodological stance, the identification of such points offers insight into the broader relations of ruling. Thus, the goal of the analysis was to discover influences that may support or shift the nature of public health nursing health promotion work.

In this study, the data of interest were the transcribed texts from interviews with the nurses. These texts were examined to discover the social contexts from which Public Health Nurses carried out their daily activities. During data analysis, I examined the texts in order to gain an understanding of the study participants' perspectives of their role in health promotion work by exploring how Public Health Nurses' work was organized and coordinated. From this information I was able to become aware of what Public Health Nurses were actually doing and how these activities fit within Public Health Nurses' understanding of their role in health promotion work. I completed this analysis using Smith's (2005) text-reader concept, in which the reader of the text brings the text to action. In this case, I took on the role to activate the text and become the text's agent.

As this study was concerned with understanding the broader contextual influences shaping nurses' capacity to engage health promotion, I also examined documents pertaining to the Public Health Nurse's role and work. Smith (2005) contended that the character of organizations is reflected in their policy documents. Such policies organize and shape how the institution functions (Smith, 2005).

The socio-organizational context of health promotion for this study was considered by examining publicly available documents that outlined the organizational structure, strategic directions, mandates, logic model, and goals of the program in which the study participants practice. Similarly, the institutional relations that govern and influence the clinical agency were explored by examining government and other related documents.

As practice is also influenced by emerging scientific and scholarly discourse, I undertook a literature review on the discourses of health promotion and public health nursing. In undertaking the analysis of the study data I sought to make visible assumptions that underpin Public Health Nurses' perspectives and how they aligned with conjectures inherent in the broader discourses of practice. In the case of this study, such analysis enabled me to identify the ways in which these broader discourses and the organizational structures support and shape the study participants' health promotion and community development practice. The data analysis revealed influences shifting and shaping the study participants' role in health promotion, drawing attention to the congruencies and disjuncture in the discourse of public health nursing.

Enacting Institutional Ethnography in this Study

In this section I discuss the sampling strategy, ethics approval process, and how I recruited participants. I also discuss the process used for data gathering and analysis.

Sampling strategy. A central premise of institutional ethnography is that the researcher begins with the viewpoint of those living the experience of interest. The primary source of data was in-depth interviews with nurses who have expert knowledge of public health practice and who could provide information on health promotion, the phenomena under study. In order to trace the range and nature of influences on the Public Health Nurse's health promotion role, nurses with a minimum 10 years of experience in public health practice working with children and family were invited to participate in the study. As this research sought to examine the evolution of public health nursing health promotion practice over a period of 10 to 15 years in a specific program, it was important to recruit experienced Public Health Nurses who could provide the data on the changing role of the Public Health Nurse in health promotion work, particularly with infants, children, and youth. To choose the best subjects who could provide the

most valuable information about the phenomena under study, selection criteria were created and closely adhered to during the recruitment of participants. The following inclusion criteria were used to select Public Health Nurses to participate in the study: nurse participants were required to have 10 years of experience in public health, be employed in the Infant Child and Youth programs in public health in British Columbia, work full- or part-time; and be able to reflect on changes in the organization. The following inclusion criteria were used to select public health nursing leaders to participate in the study: nursing leader participants were required to currently hold a position as a nursing leader, have 2 to 3 years of experience as a leader, be employed in the Infant Child and Youth programs in British Columbia, have a nursing background, and work in public health sector for 10 years (see Appendix A). As the researcher, I did not attempt to select certain types of informants.

Participant recruitment. This study commenced once ethics approval was received from both the University of British Columbia Human Behavioural Ethics Board and the clinical agency at which the research was conducted. Managers in the Infant Child and Youth Program were informed of the research once ethics approval was received from the two institutions. Initial information on the research study was provided to all managers and clinical educators in the Infant Child and Youth Program. These managers were informed that ethics approval had been received from both The University of British Columbia and the clinical agency. Invitational recruitment letters and consent forms were provided to the leadership team (see Appendices B and C). The clinical agency is an organization with six practice settings at which Public Health Nurses provide health services to families of young children. Each setting has a designated manager, educator, and Public Health Nurses. Infant Child and Youth Program managers were provided with letters of introduction and were asked to forward the initial invitational letter to

Public Health Nurses and clinical educators through the internal mail. The invitational recruitment letter provided information on the project, inviting nurses to contact me directly to express interest in the study or to seek more information about the study (see Appendix B). The managers endorsed the project by forwarding the recruitment letters to Public Health Nurses. Managers were not informed whether Public Health Nurses volunteered from their site nor did they have access to any information about the research participants or data.

After the invitation went out to staff, I was immediately contacted by several Public Health Nurses who wished to enrol in the study. Although the leadership interview quota of two was easily reached, on review of the study data and in discussion with my supervisor, I decided that interviewing one or two more clinical educators would be beneficial in order to gather more data from those in a leadership role, but also closely linked to nurses in frontline practice.

Purposive sampling was used to select key informants (Polit & Beck, 2008; Thorne, 2008). Due to limitations of time and resources, the sample size was limited to 12 study participants. Majority of the study participants had worked for over 20 years as Public Health Nurses in the community. One study participant had worked less than 10 years in British Columbia, although she had over 10 years of public health experience elsewhere in Canada. The sample group was made up of females, reflective of the nursing population 20 years ago when very few male nurses were employed in community health nursing as Public Health Nurses. The research sample included nurses from all six community health centres who hold different roles in the practice setting (i.e., point of care nurses, clinical educators, and manager). As I currently work in a different health service delivery area, none of the participants were my coworkers.

Data gathering. Once an interested nurse contacted me, I emailed the potential participant the study details, consent form (see Appendix C), and information on setting up an

interview (see Appendix D). Each nurse who responded to the invitation was asked to send the researcher a date, time, and suitable place for an interview. The interviews were conducted several days or weeks after the initial contact at a place of the participant's choosing where the participant felt safe and was away from their colleagues. All attempts were made to meet the interviewees at their requested time and place. The majority of participants chose to conduct the interviews at their workplace.

Before beginning each interview, the consent form was reviewed (see Appendix C) and all of the participant's questions were answered. The study participants were given a copy of the signed consent form. All consent forms have been kept separate from any other data and are in a secure cabinet. To protect participants' identities, each study participant was given a number. The key numbering code has been kept separate from the consent forms, demographic information, and other data, and has been stored in a secure place. After signing the consent forms, each participant was asked to complete a demographic survey questionnaire (see Appendix E).

All participation in this project was voluntary. None of the participants received any compensation for participating in the study, although I did buy coffee and lunch for two participants, as these interviews took place in a coffee shop and a restaurant. There were no incentives or reimbursements offered to participants in the project.

Study participants appeared keen to take part in the study and to have their voices heard. However, one person withdrew from the study a few days after the first interview, due to fear of being identified by her colleagues by what she had shared in the interview. I reassured this participant that confidentiality would be maintained, her wishes to withdraw from the research were respected, and information from her interview was not included in the data analysis.

One interviewee was interviewed twice, several months apart. The follow-up interview was conducted to confirm and check some of the findings from the data analysis. This study participant was interviewed briefly a third time over the phone to determine how a new government initiative was being received by frontline Public Health Nurses, as this initiative had not been discussed in participants' interviews; one interviewee was chosen for this follow-up interview because she has been with the agency for a long time in a leadership role, over the years has experienced numerous structural changes, and she has historical information of these changes, when they occurred, and why.

As one member of my researcher supervisory committee is a senior leader in Vancouver Coastal Health, the organization from which the participants were recruited, the consent form described the measures taken to ensure confidentiality of the participants' data. This committee member did not have access to uncoded raw data, and participants were informed of this. Although I did not reveal the identity of study participants to the research committee, to other participants, or within the thesis document, as the study unfolded there were times when the behaviour of study participants made it difficult for me to ensure their identities were kept confidential. For instance, a participant approached me at a social or work function to discuss the project's progress or to confirm an interview appointment. In such situations, I tried to maintain confidentiality by manoeuvring the conversation away from the research project or indicating that I would contact the participant at a different time to discuss the issue raised.

The research interview. Public Health Nurses were the primary source of data, in keeping with qualitative research practices, and data were obtained through individual, face-to-face, digitally recorded interviews (Holloway & Wheeler, 2010; Thorne, 2008). An in-depth interview was the ideal method to explore and gather information on study participants'

perspective of their changing role in health promotion work. Open-ended and semi-structured questions were used for the interviews (see Appendix F). I began each interview with some guiding questions designed to gain an understanding of the nature of the study participants' day-to-day work and the forces that shape it. Interviews began with the study participants focussing on their activities with families of young children. As the interview progressed, further questions were posed to explore the social relations of study participants within the clinical agency during their day-to-day work.

The first two interviews began with the prompt: "Tell me about your regular workday," or "Walk me through your regular day." The participants went into great detail describing their day-to-day work. During the first two interviews I did not feel a comfortable rapport was attained, so for subsequent interviews the first prompt was changed to, "Tell me how you came to be in Public health," or "Tell me about your Nursing career." This revised approach appeared to quickly establish rapport between the researcher and the study participants, creating a comfortable atmosphere and increasing the participant's comfort of being audio recorded (Karnieli-Miller, Strier, & Pessach, 2009).

The comfortable interview environment engaged and fostered study participants, who shared and elaborated on their stories. Study participants were treated in a respectful manner and were regarded as knowledgeable, competent practitioners. They were encouraged to talk about their activities, and they willingly provided detailed accounts of their work processes. As I am very familiar with this work, I was able to guide the interview dialogues to daily organizational processes, work practices, and experiences. However, I had to be mindful not to influence and shape the data collection because of my disciplinary orientation (Thorne, 2008). From my knowledge as a Public Health Nurse, I was able to make sense and understand the relevance of

documents or programs mentioned by the study participants. For example, when study participants discussed the clinical computer charting program, I was knowledgeable and knew how the program is used by Public Health Nurses in their daily work. This familiarity, although helpful in understanding processes, may have been detrimental in blinding me, making it difficult for me to see what was taken for granted (Smith, 2005). Due to my working knowledge of Public Health Nurse's practice, I sometimes made assumptions about topics being discussed. I attempted to prevent this reoccurring through internal rigour, using reflexivity, and self-awareness (Polit & Beck, 2008). I began asking clarifying questions to elicit detailed dialogues of work processes. For example, when a Public Health Nurse provided information on child health infant clinic at her site, initially I did not seek details on her work process, as I made assumptions about the procedures. However, as I realized this, I refocused the dialogue to her work processes. When interviewing the manager and clinical educators, the focus of the interviews was on their roles and work in relation to health promotion. Each interview was unique and different in the manner it was conducted; therefore, interview narratives were shaped differently.

A central issue that emerged from the study data was the nature of the study participants' work and the conceptions that inform it. As the data gathering process evolved, the need for a better appreciation of participants' views on health promotion was identified. All research participants were asked to provide a definition of health promotion. I began by asking participants such questions as, "What does health promotion mean to you?" I also asked probing questions, such as, "How does it show up in the day-to-day work?"

All study participants appeared comfortable during the interviews and conversed easily with me. They were all articulate and eager to share their experiences. Participants appeared to

enjoy talking about their careers, and were keen to share highlights of their work in public health. Participants appeared to receive great pleasure in discussing and reminiscing about their past roles, even though much frustration was expressed at the changes that have occurred. Several study participants expressed sadness that the historical work done in public health in the Infant Child Youth Program is not being captured. Participants stated long-term Public Health Nurses were retiring or near retirement age and that their vast knowledge of health promotion and community development work would be lost. Several times study participants raised the issue that the history and stories of public health nursing in lower mainland British Columbia should be captured. The study participants enjoyed having an opportunity to share their experiences and wisdom. They appreciated being recognized for the knowledge they have of public health nursing and welcomed the opportunity to speak honestly, and share feelings about their changing role in public health nursing and health promotion.

Each digitally recorded interview lasted 45–90 minutes. I downloaded the recordings from the digital recorder and stored each in a separate file from any other information that could link the participant's identity to the participant's data in a locked filing cabinet. All identifying information was removed from transcripts and any other data. The paper copies have been kept in a secure and locked filing cabinet. Transcripts in electronic format have been stored in the computer separate from other files that might link participants' identity to their data.

I transcribed two interviews, and the remaining 11 interviews were completed by a trained transcriptionist, who signed a confidentiality agreement prior to assisting with the transcriptions, as she had access to the original data (see Appendix G). For the one follow-up interview done over the phone (to clarify specific points) the brief hand written points I had made were stored with the other transcripts.

I compared each transcript with the interview tape to ensure accuracy. By listening to the interview tapes I became immersed and engaged with the data. This provided me with the opportunity to listen to the words, phrases, and nuances of each study participant's interview.

As the researcher, I found my experience as a Public Health Nurse and being an employee of the clinical agency was an asset when organizing and conducting the interviews. As I am familiar with all six clinical settings and surrounding geographical regions, I was able to arrive for the interviews fully focussed. From my knowledge of daily workflows, I knew what times Public Health Nurses would be less busy and less stressed. When study participants asked my opinion about interview times, I would recommend these time frames. Having knowledge of community health nursing and the Vancouver community was a benefit and in part contributed to the smooth running of the project.

Data Analysis

In keeping with institutional ethnography, the first stage of analysis was transcribing the recorded interviews. Then descriptive analysis was carried out to understand the context of the nature of study participants' work and to discover the social relations between the interviewees and the clinical agency (Smith, 2005). The data were coded for themes and insights. I considered using a computer program such as NVivo (QSR International, 2010) for coding; however, after attending an introductory workshop on the program, I decided not to use an electronic program for data analysis due to resource and time constraints.

While analyzing the data, I kept key questions in mind. These questions were:

- How are decisions made by Public Health Nurses?
- How are Public Health Nurses engaged in decisions related to or around service delivery?

- What are the policies or practices that are currently or have in the past influenced the role of nurses?
- How is policy influencing the Public Health Nurse's role?

I followed four steps when analyzing the data: descriptive coding; conceptual mapping and interpretive analysis; identification of the core process; and document, policy, and discourse analysis. I explore each step in the following subsections.

Step one: Descriptive coding. The focus of the analysis was on the everyday work being done by nurses and how their work is influenced and shaped by the powers of various systems or ruling relations. I began the process of data analysis by immersing in the data to synthesize the interview texts and to become intimately familiar with each informant's knowledge and contribution to the phenomena under study. Interview transcripts were examined for information on the social environment in which the participants carry out their daily work. I read the texts many times for information on the internal and external social environments in order to discover the social contexts of study participants' everyday work and to discover the influences of the clinical agency and institutional processes and practices on their work. The texts were examined also for reoccurring descriptions of participants' practice and influences. These repeated descriptions were coded with headings, and the codes were then categorized into themes with main heading and subheadings. I identified a total of 12 themes from the interview data collected from the study participants. On review of these themes and their relationship to the social organization of nurses' work, I grouped and conceptualized the themes as they related to major areas of influence. I also examined interview texts for study participants' definitions of health promotion when discussing their work, reviewing their definitions for similarities, differences, and then comparing these to definitions found in the literature.

Step two: Conceptual mapping and interpretive analysis. The interview data revealed many forces impacting the study participants' social context, influencing and shaping their role in health promotion work. Concept maps are tools that can be used to organize and understand new knowledge (Novak & Cañas, 2008; Polit & Beck, 2008). One step of the analytic process was to visually map concepts, which I used to engage in dialogue with my committee as I organized the presentation of my descriptive and conceptual analysis. See Appendix H for an example of concept map.

Step three: Identification of core process – challenge. From analysis of the interview texts, the major theme became the nature of work, identifying nurses' day-to-day activities. From this information, several social and institutional processes were identified that influence the participants' nature of work. These processes were put into themes and categories. For example, under the category heading "organization" some themes were constant change, workplace structure, school program, and resource allocation.

Step four: Document, policy, and discourse analysis – conditions that shape the challenge. The study participants' experiences were explored in relation to Smith's (2005) relations of ruling to discover the influences affecting their nature of work by examining the structures of the institution and the surrounding environment. I carried out the document analysis for this study by examining various governmental and institutional documents and websites relating to public health nursing and health promotion.

Key publicly available documents were identified and examined for pertinent and prevailing discourse affecting public health nursing. The purpose of examining these documents was to draw attention to the ways practice is structured and shaped and to illustrate both intentional and unintentional consequences. I examined the following documents: the

Government of British Columbia, the Ministry of Health Services (2005) report, *A Framework for Core Functions in Public Health*; the Public Health Agency of Canada's (2008) *Core Competencies for Public Health in Canada* report; the Community Health Nurses of Canada's (2011) document titled *Canadian Community Health Nursing Professional Practice Model & Standards of Practice*; the Canadian Public Health Association's (2010) document on the roles and activities of public and community health nursing titled *Public Health – Community Health Nursing Practice in Canada*; the College of Registered Nurses of British Columbia (2012) *Professional Standards for Registered Nurses and Nurse Practitioners*; the Canadian Nurses Association (2008) *Code of Ethics for Registered Nurses*; and the Government of British Columbia Provincial Health Officer's annual reports (British Columbia Provincial Health Officer, 2003, 2008, 2011). The following websites were also explored: Government of British Columbia, Ministry of Health (n.d.a), the Public Health Agency of Canada (2013), Community Health Nurses of Canada (n.d.), and the Canadian Nurses Association (2011).

To further understand the conditions shaping nurses' practice in health promotion work, documents from the clinical agency were examined, such as the organizational chart (Vancouver Coastal Health, 2012b), the strategic direction (Vancouver Coastal Health, 2013i), the 0–5 Public Health Nursing Program Review (Vancouver Coastal Health, 2009d), and the Infant Child and Youth logic model (Vancouver Coastal Health, 2009b). The agency's website was explored for information on mission and vision statements, the structure of the agency, public health nursing services, and population health programs (Vancouver Coastal Health, 2012b, 2013a, 2013b, 2013c, 2013d, 2013e, 2013f, 2013g, 2013i, 2013j).

Documents pertaining to Public Health Nurses' practice within the agency were also examined. For example, the checklists used in the child health immunizations clinics were

examined. Also the new practice guideline for postpartum depression screening at 4 months at the child health immunization clinic was studied. This new work mandate was rolled out in 2012 to be incorporated into the regular appointment time at the clinic. Documents and books outlining history of the agency were also examined to understand the historical context and how it has evolved over time (City of Vancouver, Health Department, 1990; Vancouver/Richmond Health Board, 1997). However, it was challenging to find any historical accounts of the Vancouver public health nursing services, especially in relation to restructuring and reforming.

Ethical Issues

During this institutional ethnography research project, ethics guiding the research were held to the highest level. I have worked in community health nursing for a long time and am well known to the majority of Public Health Nurses; therefore, it was important for me to pay particular attention to confidentiality and anonymity to limit the possibility of participant coercion. To reduce power relations (Karnieli-Miller et al., 2009), avoid conflict of interest, and maintain rigour and trustworthiness of the research (Holloway & Wheeler, 2010), I did not recruit participants who were working on the same team or in the same community health centre as me.

The institutional ethnography method precluded anonymity between the participants and me, as the researcher; therefore, the procedures of the research study were structured to consider and avoid coercion or power over the targeted population. These considerations were enacted during recruitment and data gathering by undergoing the following steps: (a) I used indirect recruitment methods; (b) all participants contacted me, the researcher, to express interest in the study; (c) interview appointment times and places were chosen by study participants; and (d) interviews that were carried out in the workplace were conducted away from visibility of

other employees to maintain confidentiality and anonymity and to prevent influences on the interview dialogue and undesirable consequences for the participants. Confidentiality was maintained for all study participants. Managers or other leaders in the organization were not informed of how many participants took part in the research or who was recruited from their sites.

In research of this nature, the researcher is the instrument (Holloway & Wheeler, 2010; Thorne, 2008). I am a community health nurse, employed by the clinical agency from which study participants were recruited; therefore, confidentiality was very important. Midway through an interview one participant enquired about confidentiality of the data. This interviewee was reassured all data would be kept confidential and that the anonymity of the participant would be protected by all members of the research team at all times. Information was shared on how I, as the researcher, would handle the data to maintain confidentiality and anonymity.

Data gathered during this research study have been kept on a computer, password-protected and encrypted. Paper documents containing consent forms and demographic information have been stored in a locked filing cabinet. Access to raw data is available only to me, as the researcher; Dr. Lynam, the Principal Investigator; and Dr. Phinney, a Supervisory Committee Member.

Ensuring the Quality of the Research

One of the challenges that I experienced was the unfamiliarity with research processes, and particularly the methodology of institutional ethnography. Institutional ethnography is difficult to understand, especially when analyzing the data. Smith (2005, 2006) has several books published that were particularly helpful with this research project. While analyzing the data I drew upon my own experiences as a long-time Public Health Nurse; however, this could have

been detrimental, as doing so could cloud my perception. I maintained a rigorous stance and examined the statements carefully. During the interview and analysis processes I was incredibly mindful and scrutinized all my actions and asked myself: Am I being open-minded or am I being blinded by my own preferences and preconceptions?

This first phase of analysis was descriptive. I reviewed all of the study transcripts and identified 12 themes. However, after having developed these themes I struggled to move forward. My own viewpoint about the decline of health promotion work in public health nursing kept me focussed on the nurses' experiences. At times I was challenged, especially during the data analysis, to move from descriptions of Public Health Nurses' work to examining the bigger picture, the social organizational influence on the experiences. Recognizing my viewpoints, inherent assumptions, and hearing others' perspectives compelled me to look beyond descriptions of nurses' experiences. It was a difficult process for me to move to the conceptualization of analysis. I related well to the four cognitive process of data analysis that Morse (as cited in Thorne, 2008) identified, which Thorne (2008) discussed in her chapter "Conceptualizing Findings." These processes include comprehending, synthesizing, theorizing, and recontextualizing. I moved through these stages and was eventually able to arrive at the theorizing stage. The outcome was that I developed a much greater understanding and appreciation of public health nursing discourse.

Reflexivity

I am passionate about community health nursing and needed to ensure I did not influence the participants, either through the manner in which I asked the questions or through nonverbal cues. I monitored and was mindful of my communication, both verbally and nonverbally, during the interviews.

I expected some study participants might be anxious about being interviewed and audio taped, the questions being asked, and how confidentiality would be maintained. All attempts were made to create a comfortable environment for the participants and the taping device was as unobtrusive as possible. All of the study participants were known to me, and they appeared comfortable entering into the interviews. All attempts were made to decrease the limitation of social desirability—answering questions to please the researcher (Polit & Beck, 2008)—by encouraging participants to be honest and frank. Some participants did express much frustration while discussing the changes that have occurred in their practice. I displayed sensitivity and empathy when interviewing participants. For example, I arranged to pick up a study participant at a location that was not near her worksite in order to address the participant's concerns and ensure anonymity and confidentiality were maintained. For some study participants, changes in work environment and processes had been particularly challenging, and some participants became emotional when sharing their feelings. One study participant became teary during the interview. I displayed thoughtfulness and respect by stopping the interview and taping while I provided comfort and support to the nurse. Once the nurse felt better, I offered her the choice to terminate or proceed with the interview, and she chose to continue on.

Institutional ethnography is not prescriptive with a set standard of processes or guidelines for data collection. Therefore, this methodology needs to be conducted in a reflexive manner. As I am passionate about community health nursing, I critically reflected on my views throughout this research project. A reflexive approach enabled me to recognize my own assumptions, attitudes, and how they operate. As a researcher, I tried to be mindful about my own values and actions and endeavoured to monitor my verbal and nonverbal communication during the interviews (Karnieli-Miller et al., 2009; Thorne, 2008). As a strong advocate of health

promotion, I was mindful not to influence and shape the data collection, especially when participants shared definitions that were incongruent with my own philosophy of health promotion. I tried not to influence the perspectives nurses were putting forth with my own views. Maintaining the integrity of the research was challenging; however, I believe I carried out the research ethically and with integrity.

There were a few times when I felt myself moving into the role of a colleague rather than the researcher. For example, when a study participant shared her negative views regarding organizational changes, I desired to commiserate with her, but through observation and reflection managed to check myself. By disciplining my reactions I strived to be an “encouraging and judgmentally neutral facilitator” (Thorne, 2008, p. 129).

After the interviews were conducted, reflexive notes (Polit & Beck, 2008) of observations were made to examine the ways in which I brought into view my assumptions about key concepts. Sometimes immediately after the interview a few notes were jotted in the car. Other times, much later, I would type up observations at home. For example, after one interview, I captured notes about the passion with which an interviewee shared her thoughts. This internal dialogue encouraged me to reflect on my own beliefs on this topic. As I progressed in this project, I also observed and reflected on how my interviews skills were developing.

I found writing the institutional ethnography analysis was challenging, as I was learning the methodology. I struggled to find my “voice” (Thorne, 2008, p. 183) when organizing and writing the findings. The report was written using exemplars from data grounding the research findings.

Summary

To summarize, using institutional ethnography methodology, I interviewed Public Health Nurses to explore and understand the influences impacting their day-to-day work in initiating and engaging in health promotion activities. Interview texts were analyzed for reoccurring themes to discover these influences, and organizational and governments documents were also examined to further understand the influences on the day-to-day work of Public Health Nurses employed in the Infant Child and Youth Program located in Vancouver. To illustrate findings from the data, conceptual maps of influences on Public Health Nurses' work were created. In the next chapter the findings of the investigation and influences impacting and changing the Public Health Nurse's scope of work will be discussed.

Chapter Four: The Evolving Health Promotion Practice of Public Health Nurses

The objective of this research inquiry was to understand the range and nature of influences on Public Health Nurses' day-to-day health promotion work in a public health agency. Interviews from 12 experienced Public Health Nurses who currently work in a program with a focus on youth and families with young children were examined as an "entry into the social relations of the setting" (Smith, 2006, p. 92). To understand the ruling relations, the forces that have the power to shape the daily realities for Public Health Nurses and the agencies they work in, I examined interview descriptions and documents relevant to Public Health Nurses' health promotion work. By examining interview texts, organizational policies, work mandates, practice processes, and government documents I discovered the powers that influence Public Health Nurses' work and shape the context of their health promotion practice and determined where these powers are embedded.

This chapter presents the analysis of the data gathered from interviews with Public Health Nurses who work in community health centres in a program providing universal and targeted health services to children aged 0–19 years and their caregivers. Before presenting the data from the interviews I will briefly describe the programs and services provided by Public Health Nurses.

The Nature of the Public Health Nurse's Work

Health promotion is a strategy used to build capacity of the individual and community to reach optimal health through the following five action areas: (a) build healthy public policy, (b) create supportive environments, (c) strengthen community action, (d) develop personal skills, and (e) reorient health services (World Health Organization et al., 1986, pp. 2–3).

Public Health Nurses work in community health centres in a population-based framework practice providing health services with the goal “to promote the optimal level of physical, emotional and social well-being of children, youth and their families” (Vancouver Coastal Health, 2009d, p. 10). Nurses provide a wide range of public health strategies and nursing interventions to individuals or groups in diverse community-based settings in collaboration with other disciplines from community health centres and community agencies.

Public Health Nurses offer health services to the maternal and newborn population by connecting and providing care in the early days after hospital discharge. These nurses provide early breastfeeding support in a number of ways, including in the home, over the phone, in a breastfeeding clinic, or at a parent–infant group. Public Health Nurses promote healthy development during the early years by providing developmental assessments and health information in a variety of settings, including homes, immunization clinics at community health centres, parent–infant and toddler groups, and community family drop-in programs. Public Health Nurses work with early childhood educators in licensed daycares and preschools to identify, assess, screen, and refer young children to appropriate services for treatment and for school readiness (Vancouver Coastal Health, 2009d).

Some Public Health Nurses’ work is done in partnership with community agencies, in which the community agency provides space or other resources for a service or intervention by a Public Health Nurse. For example, Public Health Nurses work in schools through a collaborative partnership with the school board and the individual school personnel. Public Health Nurses also partner with nearby recreational community centres to provide community-based programming; where Public Health Nurses also offer parent–infant groups and provide health information to new parents. These groups are based in recreational community centres, with the centres

providing a free space and the Public Health Nurse organizing, coordinating, and facilitating the groups. During the flu (influenza) season, Public Health Nurses partner with local malls and other agencies to deliver flu clinics. Some of these partnerships are primarily institutional arrangements that allow nurses to use space that is accessible and familiar to the public.

Currently, Public Health Nurses support the health and well-being of infants, children, and their families, individually and in groups, with an emphasis on the management of risk factors through methods such as screening, disease prevention, immunizations, and providing health education on standardized health topics. Public Health Nurses help prevent communicable diseases amongst children and their caregivers by offering immunizations and screening clinics (where they also provide health information) at community health centres and schools. Public Health Nurses also work to create a healthy school population by providing health education in the classrooms or acting as a resource for school personnel. In youth clinics, Public Health Nurses provide reproductive health services to the school-aged population through screening, treatment, and health education.

Consensus on the Shifting Public Health Nurse Role in Health Promotion

Given the focus of the research, participants were asked to describe their current health promotion work and how this has shifted over time. Many study participants indicated their role in health promotion has shifted over the past 10–15 years. Study participants said changes in the organizational culture, policies, and the organization of their work have shifted and diminished the Public Health Nurse's capacity and autonomy to engage in health promotion work. Study participants stated Public Health Nurses were historically viewed by the public as prominent, credible, and trusted figures who were sought out by community members to address health concerns. Study participants indicated their role has shifted to providing health education and

resource information with a focus on risk factors and healthy lifestyles to members of the public who may or may not accept this advice: “So Public Health Nurses, their role has evolved to be more of a consultant, basically around where to find the information or some of the resources” (Interviewee #4). Interviewee #2 expressed that nurses no longer hold the public’s trust as they had in the past. Interviewee #2 discussed the shift in the Public Health Nurse’s role from a recognized authority to being a consultant:

I think, in the past, [the] Public Health Nurse was an authority, a recognized authority, and I see that changing a bit. A Public Health Nurse might be someone that you ask but not necessarily believe her or take her advice to heart or she might be one of the a series of people you consult about the issue. It’s very interesting.

Instead of partnering with community agencies to address health disparities, Public Health Nurses are focussed on individuals to address risk factors and healthy lifestyles. The impact of the changing context of practice is reflected in the study participants’ accounts. Over time Public Health Nurses’ autonomy and credibility has changed: “I think Public Health Nurses had more autonomy, back a few years prior, that they were given credence in terms of knowing their population, being actually a member and part of the community” (Interviewee #4).

The loss of autonomy over their practice has decreased Public Health Nurses’ presence in the community contributing to their loss of visibility to the public.

I definitely think it’s shifted, I mean it it’s shifted tremendously from my early days, where we were district nurses and really sort of part of the community and, [in] a much different way, we were more prominent, and people knew we were the school nurse . . . to now being way more anonymous, way more corporate. (Interviewee #2)

Interviewee #2 stated, historically, Public Health Nurses were engaged and more present in community settings, such as the local church, which increased their visibility and credibility, allowing them to develop relationships with community members who sought them out for health concerns:

Doing CHC [child health clinics] in a church in the community, and you know everybody knew that the nurses would be there on Thursday afternoon; they would come by whether they had an appointment or not. It was different. (Interviewee #2)

Presently, most child health clinics are offered in the community health centres (instead of local neighbourhood places), which are not always easy to access or community friendly and can create barriers for the public to connect with nurses.

Interviewee #1 explained that 25 years ago Public Health Nurses “were generalist[s]. . . . We have more baby clinic[s] for sure and . . . in the old days we didn’t even have to immunize. . . . We just did the counselling, [and] . . . the immunization team that actually [did] the poking then.”

Over time the Public Health Nurse’s role has changed from a generalist to population focussed, changing nurses’ connections with their communities. The Public Health Nurse’s role has also changed in communicable disease control; with increase in antigens, Public Health Nurses spend a great deal of time in immunization clinics, the majority of which are offered in community health centres.

Offering services in these community health centres has taken nurses out of the local neighbourhood settings, thereby decreasing their presence, visibility, and credibility with the public. Throughout the interviews, study participants raised the concern of decreased visibility.

One study participant talked about changes in the structure of community health centres and what this means for the public:

It's . . . one step removed, and I mean even the physical nature of the health unit is, you know, we are locked up there on the second floor, and the public does not go there or cannot go there. . . . That's very different, I think . . . from when people could stop in.
(Interviewee #2)

These shifts in the Public Health Nurse's role have influenced changes in partnerships and relationships with community agencies, changing the context of nurses' health promotion work. One study participant discussed how relationships with school partners were severed when Public Health Nurses' work shifted from being present in the schools on scheduled days as part of the school team to now being in the schools with a focus on immunization clinics (Interviewee #3). This shift in the work focus was a result of organizational structural change with the school immunization team being disbanded in 1997–1998 and the work being moved to the school Public Health Nurse. Once Public Health Nurses became responsible for immunizations, nurses were no longer able to provide the same level of public health service to the schools, which has caused longstanding relationships and connections to be lost. This influenced how Public Health Nurses are viewed by the community (i.e., they are no longer seen as a credible resource).

We've had more of a longstanding relationship in terms of the elementary and secondary school population. But even that relationship has changed and shifted significantly when PHNs [Public Health Nurses] were by and large removed from schools and placed primarily in immunizing [clinics for] children. We lost that relationship and connection with that community in terms of being seen as a resource. (Interviewee #4)

Another participant reinforced Interviewee #4's point regarding loss of relations, partnerships, and connections with communities:

The way things have changed with us; it's pulling us away from having the ability to form those partnerships. I'm thinking of the role of the school nurse, which I mean there has always been a big health promotion role there, and I guess I didn't talk about it earlier because it's been so long, but I mean that has changed tremendously, and . . . not necessarily for the better I think. (Interviewee #2)

The shift in the Public Health Nurse's role with an increased focus on immunizations has decreased Public Health Nurses' time in the school, diminishing their involvement in addressing rising health issues. Interviewee #3 described the changes in the school nurse role:

I was able to do a lot more health promotion activities when I was more of a school nurse. . . . At one of my schools, . . . [an] inner city school, I had 2.5 days a week there, . . . [I] would go out and do home visits . . . [with people who] were having some issues, [and] connecting a lot of families to resources in the community. There was a lot more of that happening. If there were issues, we would get involved and be part of that. Don't see that happening as much anymore.

The changing context of Public Health Nurses' work was also raised by another participant who discussed the shift in her work from home-based to telehealth interactions (i.e., assessing and providing services over the phone): "There is room for a different way to focus our work . . . the change in shifting from visiting everybody to doing a lot more telephone assessments" (Interviewee #2).

Public Health Nurses' credibility has been further eroded by advances in technology because the public are able to access information from various Internet sources: "I think we're

really competing with the Internet, which is now the source of all knowledge for a lot of people” (Interviewee #2).

In summary, these participants’ accounts illustrated how the organization of practice and societal changes in access to information have influenced the nurse’s relationship within the community and eroded the nurse’s visibility with a concomitant impact on health promotion work. The shift, according to the Public Health Nurses interviewed, has been a loss from being a prominent, credible, trustworthy health professional to becoming anonymous, invisible, and lacking credibility with the community members, partnering agencies, and within the institution. These changes have contributed to a decline in engagement and developing partnerships with community agencies.

All of the Public Health Nurses who participated in the interviews for this study characterized health promotion as an integral part of their work in addressing health needs of individuals, families, and communities. As interviewee #6 emphatically stated when discussing health promotion: “It’s so integral to our work!” Public Health Nurses understand health promotion leads to creating healthier populations. However, their role in health promotion work is diminishing, as Interviewee #7 reiterated: “I think it’s our role. Maybe I’m wrong; I feel our role is teaching and health promotion. I think we’re bumped out of that big time.”

In summary, participants felt health promotion should be part of Public Health Nurses’ work and scope of practice. However, they felt that this is currently not the case.

Conceptions of Health Promotion

In this research it was important for me to ascertain how Public Health Nurses conceptualize health promotion. In Chapter 2, health promotion definitions and concepts from

the professional and academic literature were discussed. In this section I share how study participants conceptualized health promotion in their practice.

To understand how Public Health Nurses conceptualize and give meaning to health promotion in practice, all participants were asked: What does health promotion mean to you? This question made it possible to establish the commonalities and variations among nurses' use of the term health promotion and to consider nurses' knowledge as it influences their practice. The participants' responses to this question varied, with some study participants clearly articulating the nature of health promotion work in ways that align with the World Health Organization et al.'s (1986) definition, while others referred to the tasks performed in the course of their day-to-day nursing work as health promotion.

Building healthy public policy. One study participant discussed the concept of health promotion work at all levels—from individual to system and policy. Despite being aware of the full World Health Organization et al.'s (1986) definition of health promotion, the nurse focussed her definition in a theoretical way on working and supporting individuals to make healthier choices. This participant was the only nurse who referred to public policy in her definition of health promotion. The concept of building healthy public policy was not mentioned by other study participants.

It's working with the population from an individual, family, community, systems, policy level. It means on an individual level, supporting individuals in families to make decisions they want to make that are along the healthier line. Provide them a system, [and] help walk the path with them. How can they make healthier decisions, is there something they could be doing differently, [and] do they want to? (Interviewee #9)

Creating physical and social environments supportive of individual change. Only few study participants discussed creating supportive environments for change. One study participant talked about creating supportive networks for building individual capacity. She commented on capacity building to create a healthy society not only with individuals but also with groups and community:

Health promotion, for me, means building capacity in people to be healthier, and you can get there from many different ways, but ultimately, it's a combination of building individual capacity and building group capacity—community capacity so that when somebody goes out and says what do you think about this, their neighbour is giving them information that's good. So that is constantly being reinforced, almost like you're creating new norms in society around health and how to be healthy. (Interviewee #6)

Interviewee #6 discussed building supportive networks so that a person is surrounded by community members providing the correct health messages. Interviewee #10 also discussed this concept of building community connections and the role nurses play in bringing together community members to create a healthier society. She shared the example of supporting people to take control of their lives through organizing a walking club for Aboriginal parents from a local daycare:

[For me,] health promotion means . . . trying to empower, inform people about precaution for health, risks. . . . Trying to see things in the community where you can maybe make these little connections to make it a healthier community. So it's not just working with individual people with families, which we do with babies, it's the linking of the community and . . . seeing an initiative that maybe would work in some place. . . . That's

health promotion, is trying to inform people, make them aware of how they can take control of their health, and support them. (Interviewee #10)

Developing personal skills. Several study participants defined health promotion using the principle of developing personal skills (World Health Organization et al., 1986). Study participants frequently discussed health promotion as providing information and education using a variety of methods and settings to develop knowledge and build personal skills, particularly focussing on addressing risks and changing behaviours for healthier lifestyles.

One study participant defined health promotion as providing information with a focus on healthy behaviours and lifestyle: “Healthy behaviours by educating, offering information so that the family can choose the healthier option” (Interviewee #1). Another participant further expanded this definition of health promotion on changing behaviours and lifestyles:

To me it means promoting a better way of living, lifestyle, so you can be healthier. It can be anything environmental, to looking at your diet, or anything. It could be quite a big range of how people can improve their health. . . . Have a healthier society to me is what health promotion should be about. (Interviewee #7)

Another participant discussed how the goal of providing information is a long-term investment for future health outcomes: “It means helping the client achieve the best health that they can for now and for the future, so it’s a long process” (Interviewee #2).

One study participant spoke of Public Health Nurses’ role to provide information to new parents and help them acquire knowledge for caring for their children:

Health promotion activities can include supporting new mothers learning to breastfeed and learning how to cope with being a parent, a new parent, there are so many new things to know and to learn about growth and development and providing care to young

children. So Public Health Nurses provide support in terms of child health clinics, in terms of looking at the anticipatory guidance and counselling, around growth and development we also have a number of different parent infant groups that we connect with parents and help them with various topics they're interested in terms of health, their own health, or their children's health and also looking at what resources in the community can support them in terms of maintaining or improving their health.

(Interviewee #4)

Participants also saw health promotion as facilitating access to information and resources for improving health.

Health promotion means, to me, really enabling individuals to be able to really facilitate access to resources and information in order to improve or sustain their own health. So health promotion is really about helping people find the resources that they need with which in order to be able to do that. (Interviewee #4)

For other participants, health promotion meant not only providing health information but also breaking down barriers for accessing resources:

Helping, especially young people in the population that I'm working with, helping them realize their full potential in terms of staying healthy. Physical, mental, and social health. Promoting that in any way that I can. . . . Breaking down barriers, for my teenagers to get the services they need to be healthy, staying healthy, preventing STIs [sexually transmitted infections], preventing pregnancy, or if they are pregnant, making sure that a healthy promotion of a health pregnancy. . . . All spheres of somebody's life to maximize the health they have and get information so that can maximize it if they're not healthy.

(Interviewee #8)

Only one participant discussed the importance of assessing health determinants. This participant commented,

It's an assessment of the client and seeing where they are now and where they need to be to be the healthiest that they can be. And that's a lot of determinants of health—your economic, your language skills, your culture, where you come from, how you were brought up. (Interviewee #11)

Summary of conceptions of health promotion. As observed from the above accounts, study participants (frontline Public Health Nurses, clinical educators, and one manager) in this research did not share the same understanding of health promotion, although all of their descriptions fit some aspect of the broader definition of health promotion (World Health Organization et al., 1986). It is interesting that most of the participants' examples were of ways that they approached practice operationalized at the one-to-one level. For example, in the above interview excerpts, nurses discussed health promotion as providing health information to change behaviours at an individual level. However, there were some examples shared of providing health education to groups.

For some participants, health promotion means providing information at newborn visits, while for others it means targeting population groups with key messages. For example, during newborn maternal home visits Public Health Nurses provide health information to increase parents' knowledge and skills in caring for themselves and their newborns. Interviewee #2 confirmed this by stating, "If you're visiting someone with a new baby, it means giving them lots of information." For others, health promotion means health education with a focus on population health. One participant provided the following examples: "Educating, being out in community, bringing key health message to population group" (Interviewee #12).

When providing the definitions, study participants did not raise the principles of strengthening community action and reorienting health services, which are aspects of health promotion described in the *Ottawa Charter for Health Promotion* (World Health Organization et al., 1986). One reason might be that, over the years, Public Health Nurses' work has shifted to individual care with less focus on partnering and collaborating with community agencies. In the past few years, Public Health Nurses' day-to-day work has focussed on disease prevention and risk factors such as screening and immunization clinics. This may have contributed to the conceptualization of health promotion in practice to be providing health information with individuals in community-based settings, as was defined by the majority of the study participants. However, while health promotion can include providing health information to build individual capacity and skills for disease prevention, enacting health promotion work (e.g., strengthening community action) requires a long-term commitment, time, and a conscious effort, as was voiced by one study participant:

Sometimes you can do a clinic every second day. Which is very time consuming, and you love it, you enjoy it, but there's all the other things, if you want to do health promotion, you do have to have time to sit and plan and think. (Interviewee #10)

Depending on their roles, Public Health Nurses use different aspects of health promotion in their work. The majority of the study participants defined health promotion as health information and education or implementing a strategy for creating healthy choices to change behaviour to achieve long-term outcomes. Implicit in this view was the focus or intention to build individual skills and capacity to manage and improve one's health. The literature showed that nurses have difficulties defining health promotion, with significant definition variations, most of which focus on strategies for disease prevention (Falk Rafael, 1999b; Richard et al.,

2010; Whitehead, 2011). This difficulty was also evident in my study findings. An example of this is in interviewee #1's excerpt below. This study participant defined health promotion as screening and providing information to prevent disease in a child health immunization clinic: "[In a] child health clinic . . . when we're talking to mom . . . or screen[ing] them or talk[ing] about safety. You know, those are all kind[s] of health promotion information" (Interviewee #1).

Although the majority of participants in this study initially defined health promotion as providing health information, later on in the interviews study participants brought up several rich health promotion community-focussed initiatives, demonstrating an understanding of the community development aspects of health promotion. The following are two unique health promotion examples from practice shared by study participants.

One study participant gave an example of an initiative that involved facilitating development of partnerships with several agencies, including working with the food bank to build individual capacity to access and connect with resources (Interviewee #1). This initiative was an outcome of the food bank approaching the health centre with a request for health services for their population. Historically, relationships between the agencies had existed with the person from the food bank having an understanding of public health programs. Each month two nurses attended the food bank to connect with families of young children, assess their health needs, provide information, and make appropriate referrals to health services.

Another study participant shared an example of partnering with several agencies in addressing the needs of parents whose children were experiencing emotional stresses (Interviewee #6). In this case, the Public Health Nurse was well connected with all the agencies, as she has worked closely with them for many years. The Public Health Nurse stated that, as a

result of spending many years being present in her neighbourhood and engaging with community agencies, she had built strong collaborative partnerships and is seen as a prominent health figure. This nurse was approached by the community agency to help address an identified health issue that was on the rise. The outcome of this was a workshop that was organized by the nurse and the community partners to provide knowledge and strategies on how to manage the health issue. This built the capacity of the parents to care effectively for their children.

In each of these cases, the health promotion initiatives occurred due to leadership and colleagues valuing such initiatives and supported the Public Health Nurses' time and commitment to engage in this type of work. Due to long-term relationships with the partnering agencies, there was also an understanding of the Public Health Nurse's role. The team members saw this work as important and provided support to their colleagues by taking on some of their clinical work. While some nurses were still engaged in the partnership aspects of health promotion work, they are in the minority.

Factors Behind Shifts in Health Promotion Activities

The nurses who were interviewed discussed several factors that they believed were related to shifts in Public Health Nurses' engagement in health promotion work. These factors constitute what Smith (2006) would call the ruling relations in the changing organizational context within which the Public Health Nurses work. According to the nurses interviewed, these changes have narrowed the focus of Public Health Nurses' health promotion work. The following key factors were identified through the analysis of the interviews: (a) changing context and increasing acuity of public health nursing practice; (b) operational influences on Public Health Nurses' capacity to engage in health promotion (including time, budget, and other factors); (c) weakening relationships with community partners; (d) organizational leaders'

perceived lack of understanding of the Public Health Nurse's role; and (e) centralized decision making.

The changing context and increasing acuity of public health nursing practice.

Several participants discussed the influence of the new service delivery model created by the regional health authority, which changed the culture of the organization to be biomedicalized and resulted in the loss of Public Health Nurses' ability to respond to the community. Participants discussed the influence of biomedical culture, stating it had a major impact on the organizational context in which Public Health Nurses engage in health promotion work. The participants linked the increased influence of the biomedical culture to the integration of the public health organization with the acute care sector in 2004. Interviewee #8 stated, "Once we joined from being public health separate to being part of Vancouver Coastal Health and Acute [there was] lot of change for us."

From the study participant's perspective, the integration of public health with the acute care sector changed the priority, focus, and depth of Public Health Nurses' health promotion work. One study participant voiced this by stating that the agenda of her work is driven by others who are higher up and removed from the frontline. This is the practice context from which nurses carry out their daily health promotion work.

There seems to be less opportunity to be creative and to initiate new programs. . . . At times, it feels that we've become more isolated from working with our community and our community partners and really the agenda is being driven. (Interviewee #4)

Prior to 2004, public health programs and services in Vancouver were delivered through a separate public health agency that had its own organizational structure and budget. The rising costs of health care in the 1990s resulted in health care reform and restructuring of health

authorities in British Columbia (see Chapters 1 and 2 for more detail on the history of the Vancouver Regional Health Authority). In 2004, hospitals' and community health agencies' governance and budgets were merged into one organization, resulting in many changes. The participants indicated that the reorganization changed how the agency views, supports, and allocates resources for their work, particularly health promotion work. Participants noted a shift in the agency's philosophy from "less emphasis on working directly with community, more emphasis on delivering specific programs predetermined" (Interviewee #4), which has led to a lack of organizational support for health promotion work. Study participants voiced concerns about the shift in their work from using health promotion strategies to design programs in response to community needs to now delivering clinical services predetermined by external forces, government agencies, and the leadership of the organization. Participants discussed being restricted in their responsiveness to community needs by constraints of time, financial resources, and human resources. During the interviews most of the nurses voiced some concerns about this shift in philosophy. Interviewee #4 discussed how there was less emphasis on working with community and more on delivering specific predetermined programs, and she attributed this to integration of public health with the acute care: "One of the big overriding factors is when we went from being a public health organization to being coupled with acute care. That had a huge impact on, I think, the organizational philosophy and the strategic direction." This change in service delivery model and philosophy shifted the organizational contexts of Public Health Nurses' health promotion work, and it implicitly challenged notions of the ground-up philosophy that informs health promotion, which Lalonde (1974) had initially conceptualized.

These changes in the organizational context of practice have narrowed the focus of nurses' health promotion role, shifting from working in collaborative partnerships with local

agencies and communities responding to community needs, to now addressing risk factors in predetermined programs and providing information to individuals in clinical settings. This change in philosophy has led to a medicalization (Conrad, 2007) of Public Health Nurses' work. One study participant voiced her concerns relating to the medicalization of public health nursing practice:

I like to call it the clinicalization of public health. That somewhere along the line if we offer a clinic, then we're meeting the needs of the community, and I would agree that certainly child health clinics, immunization, youth clinics do meet the needs of the community. But in terms of looking at that community development, health promotion and prevention role, doing those kinds of activities that, traditionally, I would say prior to 1998, we were actively engaged in. (Interviewee #4)

Interviewee #4's notion of clinicalization encompasses the shift to problem-based thinking, rather than capacity building, which is an integral component of health promotion (Labonté & Laverack, 2008; Nutbeam & Harris, 1999).

Another change study participants frequently discussed was the shift in the school nurse role, which nurses said had significantly changed over the years. Nurses are now less present in schools, with less of a focus on health promotion and more time in school immunization clinics with a focus on individual care (as Interviewee #4 stated above). As mentioned earlier in this chapter, Public Health Nurses had been an integral part of the school team prior to these organizational changes. Public Health Nurses were present in the schools on a scheduled basis to provide health promotion and prevention services, including consultation and support to children, parents, and school personnel, until budget cuts caused organizational changes. This

changed nurses' functions in the school and their capacity to engage in aspects of health promotion that are related to community development.

We were more true school nurses and then a few years ago, with some major cuts, they changed our focus to immunizations for the most part. It's pretty hard to do a lot of health promotion, unless it's talking about keeping your vaccines up to date and all that.

(Interviewee #3)

Participants perceived that changes to the school nurse's role have affected long-term relationships between schools and Public Health Nurses, weakening collaborative partnerships established earlier to address health disparities within the school population.

Several participants also discussed the issue of human resources and several commented that if staffing resources were increased then Public Health Nurses would be able to engage in health promotion and prevention initiatives: "I think definitely that if we had more staff to be able to devote to those kinds of activities that we would be focussing more on public health, on health promotion and prevention" (Interviewee #4).

The influence of the biomedical culture is visible with increased acuity, as nurses have moved into clinics to provide individual health services with a focus on disease prevention instead of proactively responding to community needs and addressing social determinants of health through health promotion initiatives.

So although I think we talk a good talk around the social determinants of health, I think the understanding of how we interface with clients in order to help mitigate some of those social determinants of health has fallen off. There's more once again acute care focus on the skills. (Interviewee #4)

In summary, nurses' accounts draw attention to the inherent tension between the biomedical conceptions of illness and prevention and the social conceptions of health promotion and capacity building. The interview findings illustrate the ways in which organizational structures, policies, and practices have shifted to be more reflective of the former.

Factors influencing Public Health Nurses' capacity to engage in health promotion.

There were several influences within the organization that study participants said impacted their capacity to engage in health promotion work. In this section I discuss how time, budget constraints and staffing, as well as other factors, such as communicable disease control work, mandated programs and workspace, have impacted Public Health Nurses' health promotion work.

Time. The study participants said the impact of the organization's shifting agendas has increased emphasis on immunizations and reduced their time for health promotion, particularly for community development work. Decreased resources and the need to provide acute clinical care to complex postpartum mothers and newborns has diminished nurses' capacity to be responsive to community needs, build collaborative partnerships, and engage in health promotion initiatives.

So there appears to be less and less time to do that health promotion, community development part of public health nursing. To spend the time to go out and actually gather the information, look at the data, and then work collaboratively with community to see what kind of health promotion prevention activities that we could actually be involved with. (Interviewee #4)

Study participants discussed the issue of lack of time, which they linked to budget cutbacks affecting their capacity to engage in health promotion:

Health promotion takes time. With the time cutback that I keep hearing, that's beginning to impact some of the health promotion that we can be involved in. It takes planning, partnership and collaboration, at a bigger level, the safe injury prevention at a mall, planning that takes time. (Interviewee #12)

On several occasions study participants made reference to needing time to be creative for health promotion work. The study participants affirmed that time is required to be creative, plan, and implement health promotion (Interviewee #10). One study participant talked about trying to fit health promotion work into her workload:

Looking at where, because we have time constraints with resources, workload, priorities. . . . Where can your nursing practice have the biggest impact on the health outcome, the idea of health promotion is good. What I'm finding is operationalizing and implementing that. They have the knowledge of health determinants, they know, quite experienced Public Health Nurses with great skills, it's fitting that in. (Interviewee #12)

Interviewee #12 shared the challenges (i.e., time constraints, resources, and workload priorities) affecting the ability of experienced skilled nurses to operationalize and implement health promotion.

Some study participants said time is needed to develop and nurture trusting relationships with community partners to engage in health promotion work. They said this requires long-term commitment, creativity, and energy. Study participants consistently raised loss of time for health promotion work as a key issue for Public Health Nurses.

Several study participants discussed the pressures of early hospital discharge of acute complex patients into the community, which has increased nurses' workloads. These patients need more resources, time, and supports in their follow-up care, but nurses stated such resources

have not been forthcoming. The rise in patient acuity has increased Public Health Nurses' workloads, leading to time constraints for other work. The following excerpt from a participant interview illustrates the ways the shifting organizational structures of health care have introduced new considerations for nurses' practice in community health (more acutely ill patients needing support) with a concomitant impact on their capacity to engage in health promotion initiatives.

Every day you're prioritizing what's happening. The other thing is early discharge from hospitals. In theory, people should go home when they're stable, etc., but that doesn't always happen. Whether it's the client who doesn't want to stay in hospital and wants to go home, no staff in hospital, or a bed crunch, we get a lot of clients being sent home that need more care. So it's not just a phone call or one visit. You could potentially be looking at them for a number of days, and mental health issue is huge. (Interviewee #11)

In the interviews, several participants reinforced that increased client acuity attributed to the changing context of Public Health Nurses' practice.

The acuteness of the care that we provide and the maternal newborn, in my infant and child youth program, the trend of 0–5 is much more acute. . . . The complexity of the patient is increasing in the community. Same with the toddler [and] preschool population. We're seeing more autism, those kinds of things. (Interviewee #12)

Two participants discussed the impact of the rising immigrant population, which requires extra time and resources for service delivery. Interviewee #1 stated,

But I think in general the families are more needy, I think more high-risk family, you know, . . . the immigrant. I work lot with immigrant family, and . . . mental health, accessibility services . . . yes the family is changing in that they seem to . . . [have] more needs in the community, and so therefore more contact . . . more referral, that kind of

thing, and the children. . . . I work a lot with the ESL [English as a second language] families, and [they] are more needy.

Interviewee #2 noted, “[There are a] lot of new Canadians, so cultural factors are so different they may not know what a Public Health Nurse is or what our role is, really understand our role, so that takes a lot of work.”

Some study participants discussed the agency’s philosophy on outcome measurements and implications for their health promotion work; with changes in how the Public Health Nurse’s work is being evaluated and measured, nurses are required to maintain records of clinic immunizations or screenings. Such measurements impact daily work, require extra time for record keeping, and take away valuable time needed elsewhere. Several study participants said that this type of validation of public health nursing work demonstrates a change in the organization’s focus and philosophy. Some of the participants understood the reason for the necessity of outcome measurements for accountability and funding. Participants raised the challenges of outcome measurements for health promotion, which makes it difficult for Public Health Nurses to justify their health promotion work:

So it’s a philosophy that the agency has. It’s the direction the agency is going, whether they’re counting quantitative numbers for immunization and disease prevention, which I totally agree with, but the things around mental health with youth and children, not easily measurable, more qualitative, not easy to do within an agency. (Interviewee #8)

Although accounting for, and demonstrating that the impact of, a specific practice is essential, the documentation does not capture the full range of nurses’ health promotion work and it can eclipse the focus and impact of practice.

In summary, study participants indicated all these pressures are due to government policy changes that cause financial constraints in the acute sectors resulting in early discharge of complex and acutely ill patients into the community. Participants said decreased budgets and resources lead to increased workloads and reduced staffing, resulting in time constraints, and thereby affecting Public Health Nurses' capacity and autonomy to engage in health promotion work. For Public Health Nurses, time constraints are linked to budget constraints. Study participants discussed the need for increased resources to engage in health promotion work, particularly to have time to build collaborative partnerships to create future healthy communities.

Budget constraints and staffing. Study participants continuously raised the issue of decreased budget and resource allocations shaping their health promotion work. One particular community health centre has experienced rising birth statistics over the past several years, while staffing numbers have stayed the same (Public Health Nurse, personal communication, January 14, 2013). Many participants voiced concerns regarding the lack of increase in funds for public health nursing work, especially since the acuity of patients and new immigrant populations continue to rise, resulting in an increased need for services: "So I think overwhelmingly acute care is the largest driver of whatever happens within the organization and I would like to see more resources spent on the public health part" (Interviewee #4).

Interviewee #4's concerns regarding lack of funding for Public Health Nurses were also reinforced by other interviewees:

The really higher ups that get to decide where the money gets spent. I don't think they see the value. . . . It's where the money goes, the prevention as a pot gets 3–5% of health care dollars and acute gets the rest. (Interviewee #3)

As discussed previously increased client acuity is changing the context of Public Health Nurses' practice.

You'd think the money would shift from acute to community. I don't think that ever happened . . . because of the acuity, the money seems to stay there but our acuities have gone up exponentially in all of our programs. (Interviewee #11)

Study participants' perceived that funding for public health nursing programs has decreased, making it difficult to continue with health promotion work. Several participants raised concerns about government funding allocations. Interviewee #4 stated, "I think in terms of the current state, current economic state, there's less money to do various kinds of activities and health has certainly suffered. We have seen the erosion of full-time equivalents." Interviewee #7 also raised this concern:

[It's] really sad, because I know that health promotion will, for every dollar spent, save \$7 in acute care. . . . That number sticks in my head; I know that that's way more important than building these massive heart clinics . . . these acute care hospitals. To me, it really bothers me they can't come up with funding for what we do. We're getting the short shift when it comes to government spending.

One participant voiced concerns at the lack of acknowledgment by the leadership of Public Health Nurses increasing workloads: "All of these programs are coming with no more resources, . . . but that will be an additional workload, and no one seems to be acknowledging that" (Interviewee #8).

Most participants voiced concerns about the increase in communicable disease prevention work, such as the addition of new vaccines to the immunization program without increase in staffing or resources. This appeared to have the most influence on changing the nature of Public

Health Nurses work, as it has led to increased workloads causing time constraints to engage in health promotion work. Interviewee #1 stated, “As I said sometime with the addition of the vaccine that we are giving it seems to be take you know longer.”

The need to provide more immunization clinics leads to staffing challenges, as discussed by many participants who raised concerns about limited staff resources impacting their daily work. Interviewee #2 stated, “[I] think every aspect of our job is important, there is no taking back. I think we need more nurses. Interviewee #12 also reinforced this concern, “Our team was not staffed properly. Not enough nurses for the amount of work. The acute care drove what we had to do. . . . Without having extra resource, where would you get the time?”

School nurses particularly vocalized concerns about a lack of resources leading to decreased participation in health promotion due to the shift in their work to disease prevention with a focus on immunizations. Interviewee #8 discussed how the impact of the immunization team being disbanded affected her health promotion work:

We had an immunization team, [and we] would coordinate things with them. I would help them if I had a role in the school or population. They would come in, and I would be free to do my other health promotion activities. The team was disbanded and that become my role as well, that really gobbled up time and took it away from health promotion. Many participants said that reduced staffing levels significantly diminished their engagement in health promotion work with communities. Interviewee #4 stated,

We certainly haven’t had more Public Health Nurses added to the complement, rather there are fewer Public Health Nurses, and certainly there are fewer experienced Public Health Nurses. So, if we had more Public Health Nurses to be able to provide those

services, I think that would make a huge, huge difference in terms of what we're able to deliver and how we're able to engage with our community.

Interviewee #11 shared,

School programs [experience the] same thing because they spend so much time doing immunizations that other things are falling off. They try as best they can to get into the schools to do the teaching to build the relationships, but again even that part is hard.

Another Public Health Nurse talked about the change in maternal and newborn care work, which has shifted from providing home-based services to telephone services (Interviewee #2).

In summary, all study participants raised the issue of budget restraints and staffing shortages, which resulted in increased workloads constraining Public Health Nurses' capacity and autonomy to engage in health promotion. Interviewees explained increase in communicable disease prevention work and early discharge of complex acute clients into the community was causing time constraints for Public Health Nurses engagement in health promotion. In particular the school nurse role had significantly been impacted due to disbanding of the immunization team.

Other factors. Two particular service delivery areas that Public Health Nurses discussed in the interviews were the maternal newborn area and Communicable Disease Prevention Services, with most of the discussions focussed on the latter.

During the interviews, one area that was discussed a great deal was the child health immunization clinics for infants and preschoolers, which usually take place in the community health centres. All nurses agreed this was an important part of their work, but were concerned how much they are expected to accomplish in a 20-minute appointment. One participant stated,

We are doing counselling, we're doing general assessment, and checking in with the parent about how things are going, it's hard to get it all done in 20 minutes . . . then of course the EPDS [Edinburgh Perinatal Depression Screening] clients at four months, that's a whole new thing. (Interviewee #2)

Interviewee #1 also discussed immunizations:

As I said, sometime with the addition of the vaccine that we are giving it seems to take you know longer. . . . Getting consent, looking over their immunization, looking over their development breastfeeding, young infant, looking at their feeding, nutrition any kind of feeding stuff, plotting their growth and height, appropriate for the child at the time going over it with the parent, [recording it] on the chart, going over the checklist, we have that checklist, whatever age is appropriate for child. [They are given a] referral back to the team if they need further support.

However, several participants felt child health clinics were an important aspect of their role, as Public Health Nurses connected with families when they came in for immunizations, which provided an opportunity for nurses to give health information. Interviewee #7 stated, "I'd like to see us doing more immunizations, even though it's a technical thing; it gives us an opportunity to do health promotion" (Interviewee #7).

The need to hire more nurses with increasing workloads due to communicable disease control work and increase in immunizations was also stressed time and again by Public Health Nurses. One nurse stated,

[The] baby clinic is important too. I think that is a good way to meet parents . . . because they are a new family; we don't know where they are hiding. Those are also very good. I

think every aspect of our job is important; there is no taking back. I think we need more nurses. (Interviewee #1)

The majority of the Public Health Nurses stated communicable disease prevention is an important part of public health services. Interviewees also noted that doing immunizations allowed Public Health Nurses to assess the child and family and to provide health information to individuals whom they might otherwise not connect with. A participant shared,

I work diligently with communicable disease control to help them understand how we deliver service. It's integral to public health service delivery. And I also support nurses to understand the key role that they play in immunization. They can often put it down, but it is a pure public health service. Keeping the population healthy, this keeps the population healthy. (Interviewee #9)

One nurse was concerned that if Public Health Nurses do not do communicable disease work, then other disciplines like pharmacy could take over public health work. She stated:

We're losing a lot of what we did and so I am concerned. I have been very concerned, where is public health going then? Where is it going to be? Pushed into the corner and other people taking over. Losing a lot of what we do. . . . I think we can do so much for health promotion, we will lose that, if we're not immunization; we don't have access time to do child health, which I think what we specialize in. I think we're really good at what we do. (Interviewee #7)

Nevertheless, Public Health Nurses want a balance in their work. One nurse discussed how the bulk of her time was spent on doing immunizations:

And now the big emphasis seems to be on an ongoing basis on communicable disease and immunization, which is a very important part of public health, but at the same time, I

think we need to also have a balance. . . . Currently the child and youth nurses spend I would say at least 80% of their time doing immunization and then the rest of that time gets divvied up between being present at youth clinics and also trying to doing any health promotion activities while they can. (Interviewee #4)

Other participants indicated that physical workspace issues demonstrated that leaders did not value their work (Interviewees #2, #7, and #10). One example shared was lack of space to run child health clinics in a safe and private manner. Interviewee #2 stated clinic office space was allocated to primary care physicians and other staff, while Public Health Nurses were expected to run the child health clinic in one large room with several immunizing stations, which made the workspace, noisy, crowded, and chaotic. This study participant talked about the impact of this on the safety and confidentiality of services as well as the toll on nurses' stress and personal health.

Public Health Nurses found that ongoing organizational restructuring and changes in programming caused constant disruption in their daily work, making it difficult to balance their work. New mandated initiatives (e.g., the postpartum depression screening questionnaire to be conducted at a certain time); change in work processes; or change in the clinical charting processes all impact the nature of nurses' daily work activities. As a result, nurses were unable to be proactive in health promotion and community development work.

We spend a lot of time on immunization issues and documentation issues with the electronic health records. That has sucked up enormous amount of nursing time. . . . So how does [a] PHN [Public Health Nurse] balance that, antenatal, postnatal, CDC [communicable disease control] issues, CHC [child health clinics], parent infant groups,

look at health promotion and prevention activities, community development pieces, how do we balance all of those? (Interviewee #4)

One nurse talked about reshuffling her daily program work due to sick calls, low staffing numbers, and being pulled away to cover other work (Interviewee #1).

In summary, shifts in work priorities have diminished the opportunities for Public Health Nurses to be creative in building partnerships and engaging in health promotion work.

Participants said this has led to weakening relationships with community partners. Study participants indicated health promotion is diminishing in their program.

Weakening of relationships with community partners. Several study participants expressed concerns of weakening relationships with community partners. They expressed concerns about the decrease in opportunities to build collaborative partnerships and to engage in health promotion initiatives.

Some study participants explained that time is needed to nurture relationships with community partners to carry out health promotion work. Participants discussed the importance of investing in building collaborative partnerships and being responsive to community needs. One study participant spoke of the importance of being in the community to build trusting relationships for health promotion work. This nurse remarked,

I think health promotion works best when you have a relationship that's trusted: when you know the key players, when you know the other resources in the area, when you're hearing things from different sides. . . . If you come in to do something in one place, and that's all you're focussed on, but there may be other places that have something to say that may influence that. If you're really going to have a successful health promotion, you

need somebody who is going to mentor it over time or nurture it along over time.

(Interviewee #6)

Interviewee #6 also voiced the concern of being separate from the people and community partners, with less opportunity to respond, create, or initiate health promotion programs.

For some participants a shift in priorities associated with changes in the organization of work contributed to the diminished role of health promotion in public health nursing. Therefore, instead of responding to observed trends in health issues (e.g., high obesity and diabetes rates in the school population), study participants said their roles and time in the schools have been refocused and reduced.

In terms of actually knowing the needs of the community and creating health initiatives that will actually meet the needs of that particular community; I think that piece has really gone by the way side. . . . We don't look at the initiatives that we should be involved within, in terms of the high rate of diabetes within our school-age population, the high rate of obesity, working with parents in terms of looking at how to increase physical activity as a family. Looking at how to strengthen those family relationships through activity and enjoying different community even. . . . In terms of school health, we've really backed away from that role. I think it shows. (Interviewee #4)

In the past, Public Health Nurses were visible, prominent, trusted health figures within the community, which allowed them to engage in building collaborative partnerships with community agencies, such as neighbourhood houses or schools, to address the social determinants of health. When nurses are visible in the community the public understands the role of the nurse and seeks her out for addressing their health concerns. When nurses are invisible then the public is confused and does not know whom to contact for accessing public health

services. One nurse validated this with her experience, stating, “I finally decided that the more you get into the community, the more you see, and the more you find, and people end up phoning you” (Interviewee #10).

Another participant discussed the importance of being present in community agencies, as it leads to increased referrals for children needing health services. Her outreach activities have to be scheduled with set days or her time becomes filled up with maternal newborn home visits.

If you don’t go out to your sites at every opportunity, even if you don’t think it’s critical, . . . If you don’t do that, they don’t think about . . . every single time I go out there, I get a referral, simply because I’ve shown my face. (Interviewee #6)

A second nurse also emphasized the importance of being out in the community, which she saw as being foundational for health promotion practice:

You have to get to know your community. You have to go out and experience. You have to be familiar with where you are sending people. You need to build confidence, and you need to help them get there. If we don’t build that piece and create those relationships, you have nothing to build the rest of practice on. (Interviewee #4)

Another study participant said that a shift in the priority of the focus of her daily duties has isolated her from building collaborative relationships with community partners for health promotion initiatives in response to community needs (Interviewee #6). This study participant found health promotion to be effective when nurses established trust with key partners, understood the resources and different perspectives of the community, and were given the time they need to mentor and nurture health promotion initiatives (Interviewee #6). Interviewee #12 discussed time constraints: “Health promotion takes time. With the time cutback that I keep

hearing, that's beginning to impact some of the health promotion that we can be involved in. It takes planning, partnership, and collaboration, at a bigger level" (Interviewee #12).

In summary, Public Health Nurses in this study said, due to time constraints (linked to restricted budget), changes in nursing practice to provide clinical focussed care to postpartum mothers and newborn babies, and communicable disease, there has been a decrease in building partnerships with community agencies. Nurses are spending more time in the clinical settings rather than being present in local community, which has resulted in decreased engagement with community partners for health promotion work, particularly community development.

Organizational leaders' perceived lack of understanding of the Public Health Nurse's role. Several Public Health Nurses in this research inquiry perceived that some leaders in the organization lack an adequate understanding of public health nursing work. Study participants perceived that acute care leaders (who lack knowledge and understanding of health promotion, community development, community health nursing, and public health) have become the predominant influence on their daily practice. Participants indicated that health promotion has been undermined by their organization's focus on acute care: "I don't think the organization supports in a big way, understands community development, understand health promotion in the same way as they used to" (Interviewee #6).

Participants shared that Public Health Nurses were, at one time, highly regarded health care providers with access to adequate resources. Now they feel they are "not placed high on the list of importance in the programs here" (Interviewee #7) and need to continuously advocate for resources and more staff. Participants said the change in the organization has influenced the structure of Public Health Nurses' work, resulting in less appreciation for Public Health Nurses and health promotion. Interviewee #6 stated, "I think it's diminishing. I think that health

promotion needs a certain spirit of creativity; it needs a trust in nurses, that nurses can make good decisions, and they can make good assessments, and they can do that.”

Participants said the integration of public health with acute care shifted not only the organization’s structures and processes but also the philosophy. This has influenced public health nursing practice. With this biomedical influence, there is a change in how Public Health Nurses’ work is measured and evaluated for quality improvement. One study participant said that the agency’s shift in philosophy, focussing on quantitative measurements such as counting immunizations, does not consider qualitative measurements of such things as mental health with young children and youth (Interviewee #8).

Some study participants stated the organizational changes have led to a different type of leadership. With the restructuring, the organizational leadership changed with the majority of management positions filled by professionals from the acute sector with biomedical backgrounds. Study participants felt this change in leadership led to a lack of understanding and appreciation for their health promotion work, particularly its community development aspects, which has led to lack of organizational support and is a shift from previous times (Interviewees #6 and #7). This lack of appreciation has affected the support and resource allocation for Public Health Nurses’ work.

One study participant shared her frustration regarding the leadership’s lack of response and direction to address escalating rates of obesity and diabetes in the school population (Interviewee #3). Instead, as a school nurse, she was advised to shift her work priority from health promotion to immunizations. The participants in this study discussed how easy it is to measure the number of screening examinations or immunizations done (i.e., to measure program

outputs) and how difficult it is to provide relevant data to demonstrate the efficacy of health promotion work (i.e., to measure outcomes and impacts).

You can't always qualify the work that we do, and you would have to do really long-term studies and account for all the other variables to say because that the nurse did that, to have a positive outcome. But if they can't prove it, does it mean you don't get to do it? Sometimes that's how I feel when we were told we had to become part of the immunization team, a certain person higher up said these are hard stats, immunization rates are hard stats. Teaching family life in a class, sorry, no hard stats, which to me really devalues the work, health promotion, disease prevention, and you look at all the stuff coming out on type 2 diabetes, smoking, and injury prevention. All these stuff we should have a role in. (Interviewee #3)

Some interviewees discussed the lack of communication within the organization causing feelings of insecurity. Interviewee #7 provided the example of "poor communication about the future of public health, medical system and acute care."

When conducting interviews in this study I did not ask a specific question about leadership, but if the subject came up then participants were questioned on the topic. Therefore, some of the participants discussed leadership in their interviews, but sometimes it was not clear which leadership they were referring to (i.e., government, organization, and program or site leadership).

Study participants said leaders for their public health program must have a clear understanding of health promotion and public health practice. There were various thoughts, which at times were contradictory, on what makes someone an ideal leader; with multiple viewpoints on whether leaders need to have public health nursing or public health backgrounds

to be the best leaders. Some participants indicated that managers need to have a background in public health nursing. Interviewee #7 stated,

Management should have people who have worked in public health and know what is important and why it's important. . . . It's very difficult for someone who doesn't understand unless they've done that kind of work themselves. I think it makes a big difference, personally.

This idea was also supported by interviewee #4:

I think if we had public health leaders who were managers and directors who came from a background of public health practice and perspective, I think then we would see a shift I think we need to attract leaders who have a background in public health nursing. So it's really important that we have public health nursing leadership; they have strong clinical backgrounds in public health nursing.

Interviewee #4 continued on to say, "I think if we had public health leaders who were managers and directors who came from a background for a public health practice and perspective, I think then we would see a shift." However, other participants indicated a public health nursing background was not necessary. Interviewee #12 stated, "I don't necessarily think they all need to be. There [are] management skills and leadership skills. Sometimes it's helpful to have someone from the outside asking those questions: why are you doing what you're doing?" (Interviewee #12). Interviewee #11 indicated that a nursing background is useful but not always necessary:

Some of it is easier when you have a nursing background. But as long as you have a manager who is keen and interested in knowing about the nursing aspect and actually listens to what you say and how you see it, then I think it works.

Interviewee #3 affirmed that leaders need to be able to influence the culture of the organization and advocate strongly for community health nursing:

I think it's important to have nursing leadership. We can't advocate for ourselves always, and when we do, we're seen as self-serving. To me, the managers who know exactly [what supports are needed] have worked in that field, they know the issues, and they are our advocates.

In summary, study participants perceived that the organizational leadership does not understand public health nursing and health promotion work. The participants felt this lack of understanding has influenced the context of their practice and their capacity to engage in health promotion. They feel disempowered and devalued by the leadership within the organization. Participants expressed there are limited resources, lack of support, and unclear direction from the leadership regarding their role in health promotion.

Centralized decision making. Study participants shared their frustration at what they perceived as a lack of power and credibility due to leadership's lack of trust in nurses' abilities to make decisions. This disempowerment and the decline of Public Health Nurses' involvement in decision making was felt to have occurred over the years. Study participants said decisions are now made at a higher central level and programs are initiated from the top down. Interviewee #4 stated, "I think there's less credence now to that knowledge and wisdom that's on the ground, and now much more of a top-down approach."

For the study participants, this lack of credence undermined their creativity, excitement, and engagement in health promotion initiatives: "When some of that control and trust is passed up the line, and nurses are no longer being involved to the same degree, it undermines your creativity, undermines your excitement about doing something new" (Interviewee #6).

Study participants spoke about the lack of voice they have in program planning. Programs come from the top down, are mandated, and specifically determine nurses' day-to-day work. Study participants were frustrated by the powerlessness they have experienced over the past several years. They said nurses are no longer able to focus on the needs of vulnerable families with young children. As one participant stated, "We have moved to being top-down, centralized, centralized, centralized, and top-down . . . so nobody is asking the question: What are the health issues of children?" (Interviewee #6)

Study participants stressed how centralized decision making is increasing mandated programs and constantly changing the organizational context of their practice making it a stressful workplace. Interviewee #4 stated,

More and more programs that are must-do programs. So they're really coming from the Ministry of Health down to the health authorities who need to look at implementing those programs . . . less emphasis on working directly with community. More emphasis on delivering specific programs [that are] predetermined.

A shift in Public Health Nurses' role from being creators to implementers is obvious in the following example:

These programs are being rolled out by the higher level coming down to the nurses. . . . In the past, it was the Public Health Nurses that identified issues and then they would work on them. They identified a need, they got a group together, and they went forth. Now I think it happens somewhat, but not as much, more things coming up from the higher. (Interviewee #11)

The study participants stated that their work has shifted to meet requirements of programs initiated by the organization's leadership or government agencies. Participants voiced concerns

about mandated programs, such as the new Nurse–Family Partnership Program (Vancouver Coastal Health, 2013f), which is a new, evidence-based initiative that has gone through multiple clinical trials and is being implemented as a clinical trial in British Columbia to evaluate its effectiveness in this context. During the interviews most study participants voiced some concerns about the Nurse–Family Partnership initiative being rolled into public health without any additional resources or funding (i.e., it is to be implemented within existing budgets). Participants also stated that this initiative is being implemented due to external pressures and not in response to community needs. This program is one example study participants discussed when voicing their concerns about increasing workloads, demonstrating that changes in the organizational context take time away from other work. Interviewee #7 stated, “I don’t agree of how they’re coming down with these programs for us and taking away nursing time. We need those people. I’m not trying to bash the program; it might be a fantastic program.”

Several times interviewees discussed their perceived lack of voice and utilization of their community knowledge in program planning by health leaders. One study participant commented:

And I think it has to be the PHNs [Public Health Nurses] who have to say, “Why aren’t we involved in initiatives in the school,” in which to be able to start to reduce the trends that we’re seeing that are affecting the health of our children. It has to come from Public Health Nurses. They have to have a voice in terms of saying, “You know, we have expertise to offer in this area.” And so I’m hoping Public Health Nurses will start to have more dialogue around this. (Interviewee #4)

However, some interviewees indicated that nurses were reluctant to speak up and question changes due to fear of being labelled and fear of repercussions, as they are government employees. Several participants suggested the need for Public Health Nurses to find their voices

and advocate for their practice. Some participants also suggested Public Health Nurses need to become proactive leaders in making health promotion happen instead of doing these activities underground.

Study participants also discussed what they viewed as the problematic city-wide standardization of processes, such as how and when toddler assessment screening should be done, even though population health needs are different from one geographic area to another. One study participant explained how the work focus has changed from being client- and community-centred to a new format in which the work is standardized with a set formula to follow.

That all the many, many reorganizations that have gone on from the top down have really changed things. . . . We are so corporate now. Everything is so rule bound, so protocol bound. . . . It seems like every month there is some new thing that we have to do in compliance with the health authorities that really has often nothing to do with clients at all. (Interviewee #2)

With changes to the British Columbia immunization program, an increasing number of vaccines are being developed to prevent communicable disease outbreaks. Since public health is mandated to roll out the vaccination program, nurses discussed the effect of expanding communicable disease prevention initiatives on health promotion work.

More things coming up from the higher. The biggest one being CD [communicable disease] and immunizations, it's huge. That will impact us; we'll have to do more clinics.

When we do more clinics, it takes us away from other things. (Interviewee #8)

The majority of Public Health Nurses interviewed voiced strong concerns regarding mandated programs, such as communicable disease prevention, impacting their work. Such programs cause

time constraints not only for health promotion work but also for nurses' ability to be responsive to community needs. Public Health Nurses summarized the impact of the Communicable Disease Control program. One participant stated, "When I think back, certainly, the whole vaccines, immunization is massively bigger than it used to be. . . . It's also, well, we have no more resources" (Interviewee #12).

The school nurse role and health promotion work in the schools appear to have changed the most as a result of the immunization program. Due to budget constraints in the 1990s, the agency's immunization team was disbanded, with the bulk of their work allocated to the school nurses. Several study participants said these decisions were made centrally, and Public Health Nurses' input about these decisions was disregarded (Interviewees #3 and #8). This had a tremendous impact on the comprehensive school health program. One nurse summarized what this has meant for her:

That's where it got stalled out a bit, when the focus became communicable disease and immunization; our time was really constrained in terms of putting energy into our mental health promotion work, for sure. . . . And then narrow it down to communicable disease and all the emphasis on prevention of communicable disease. (Interviewee #8)

Interviewee #8 went on to explain that these changes were extremely time consuming. The initial format with an immunization team allowed this nurse to help coordinate, but she was still free to do her other health promotion activities. When the team was disbanded, the team's work became part of her workload, taking her time away from public health (Interviewee #8).

These continuous organizational changes affected nurses' daily work schedules, time, and energy for engaging in creative innovative health promotion initiatives. Nurses felt overwhelmed by these organizational pressures, which have been ongoing since the integration with the acute

sector. Instead of being client-centred, nurses are now engaged in program-centred work. This has taken away their capacity and autonomy for population-focussed health promotion work.

Discussion

How health care is provided is influenced by policy, systems, and organizations—what Dorothy Smith (2006) called the ruling relationships of the environment. This research inquiry discovered that Public Health Nurses' view that the nature of their health promotion work is influenced by their organizational context (i.e., the agency structure and changes in factors such as funding and organizational philosophy) and also by the surrounding sociopolitical environment (i.e., decisions made by the provincial government and Ministry of Health). These external and internal forces changed the organizational context from which Public Health Nurses engaged in health promotion work. Their understandings, as reflected in the research interviews is that a major, and continuing influence on the social organization of their work is provincial government policy, which has, among other things, led to the integration of public health and the acute sectors. Several factors arose from the integration and contributed to the shift in Public Health Nurses' organizational practice context. Government policies influence the policies, processes, and mandates of the organization, which in turn influence the nature of Public Health Nurses' work.

The shifting role – implementers but not creators. Public Health Nurses in this study stated their role in health promotion has declined. Interviewee #4 stated public health nurses are implementers and no longer creators. Study participants identified several forces influencing their capacity and autonomy to engage in health promotion work. These factors in the organizational structure arise from change in the organization's philosophy and budget constraints: (a) changing context and increasing acuity of public health nursing work;

(b) operational influences on Public Health Nurses' capacity to engage in health promotion (including time, budget, and other factors); (c) weakening of relationships with community partners; (d) organizational leaders' perceived lack of understanding of the Public Health Nurse's role; and (e) centralized decision making. Public Health Nurses said these factors have influenced their practice and diminished their role in health promotion. Another aspect affected by these factors is how Public Health Nurses conceptualized health promotion.

Conceptualizing health promotion. In this study Public Health Nurses did not share the same definition of health promotion. They lacked capacity to articulate core elements of health promotion and had diverse notions of what health promotion is. The most frequent definition of health promotion study participants offered was providing health information in established routine settings, mainly with individuals, with the implicit purpose to build personal skills for achieving health. Nurses defined health promotion narrowly due to the nature of their work and according to the activities they engage in, not by the broader concepts of health promotion such as strengthening community action or reorienting health services in response to meet community needs or building healthy public policy. The Public Health Nurses I interviewed are not engaged in developing and nurturing partnerships with agencies for community mobilisation to address health disparities. The accounts suggest that with organizational restructuring, Public Health Nurses' practice has become biomedicalized, narrowing the focus of their work to more clinically-oriented tasks that are focussed on individuals. With this narrow focus, Public Health Nurses engage in health promotion to provide health information concentrating on disease prevention, risk factors, and healthy lifestyles. The findings from my study are congruent with the findings of Cohen's (2006) study conducted in Manitoba, Richard et al.'s (2010) research

conducted in Montréal, and Cusack et al.'s (2008) research in Manitoba. Public Health Nurses in my study said their role in health promotion has diminished and become clinicalized.

As discussed in Chapters 1, 2, and 4, the literature stated health promotion is ambiguous, difficult to define, and leads to confusion (Falk Rafael, 1999a; Stewart, 2000; Whitehead, 2011). Difficulty of implementing health promotion in practice is an issue identified and articulated by other researchers across Canada (Cohen, 2006; Cohen & Gregory, 2009; Labonté & Laverack, 2008; Stewart, 2000; Whitehead, 2011). Whitehead (2011) stated that the nursing literature contains numerous and incongruent perspectives of health promotion, with health education and health promotion being used interchangeably. This lack of clear definition can cause difficulties for nurses engaging in the range of health promotion practice. Researchers also indicated that nurses are influenced by the biomedical model with the concepts of diagnosis and treatment in the surrounding practice, which makes it challenging for them to engage in health promotion work, particularly community development (Cohen, 2006; Richard et al., 2010; Whitehead, 2011).

Although study participants used the example of providing health information to define health promotion, at a deeper level they see themselves as continuing to be engaged in this work. The stories participants shared in their interviews demonstrated that Public Health Nurses have a strong commitment to health promotion and want to be engaged in it.

On the frontlines, health promotion is less than what it was 15 years ago. Given the current sociopolitical economic environment, the current day-to-day reality of Public Health Nurses' engagement in broader concepts of health promotion such as community development is challenging. The ruling relations, the surrounding forces, have created pressures, with restricted budgets and changing priorities that have eroded Public Health Nurses' decision-making power

over their practice, constraining Public Health Nurses' capacity to engage in health promotion work. This has led to a decline in health promotion work at the point of care. Public Health Nurses need a clear direction from their leaders regarding their work mandates and limitations. There is confusion at the point of care for Public Health Nurses regarding their role and work in the current shifting context of practice.

The frontline Public Health Nurse's role in health promotion has evolved over the past 10–15 years. With the changing context of practice, nurses' capacity for implementing health promotion at the point of care has shifted. In the next section I discuss the changing context shifting Public Health Nurses' role in health promotion and the focus of care to risk factors.

Changing context – shifting the role in health promotion. Public Health Nurses' practice context and work have shifted over the past decade in response to the reorganization of public health and the acute sector, increase in mandated programs, and a pattern of decision making that mandated the introduction of new initiatives without any additional funding. In this same era, the nature of work in the community was also impacted by early hospital discharge of acute and complex clients, including newborns and their mothers. All these changes have shifted the Public Health Nurse's capacity to engage in health promotion work.

Public Health Nurses' health promotion work has been influenced by several discourses (population health and communicable disease control) at play in the surrounding environment. The discourse of population health offers insight into the problems and issues that need to be addressed in practice. Health promotion offers insight into how practice can be effective in addressing these identified health issues. In the present context, population health is driving the focus and organization of services without consideration for how this might most effectively be accomplished. The lack of nurses' dialogue on processes of care delivery has eroded the Public

Health Nurse's practice and may ultimately undermine the broader goals of service delivery in creating healthier populations.

The need to prevent communicable diseases has given rise to an increase in antigens, changing the Public Health Nurse's process of care to individual clinical tasks. This discourse has contributed to the shift in focus of Public Health Nurses' work to tasks that are easily quantifiable or to strategies for which there is quantitative evidence (e.g., the new Nurse–Family Partnership program) and undermined their role in health promotion work.

Focus of care on risk factors. In my study, Public Health Nurses mentioned their work of identifying risk factors and providing information to promote healthy lifestyles numerous times; however, very few participants brought up addressing social determinants of health or empowering the community to action. As the political environment surrounding the agency has changed, it has influenced organization processes of care to align with government initiatives, affecting the work realities of Public Health Nurses in the field and undermining their health promotion work to address health disparities. This has shifted their work to become medicalized (Conrad, 2007) with a focus on problem-based thinking, rather than strengths-based thinking or capacity building, which is inherent in the conceptions of health promotion (Labonté & Laverack, 2008; Nutbeam & Harris, 1999).

The premise of health promotion is competing with the social organization model of the agency, which is biomedicalized, thereby changing the context and increasing acuity of public health nursing practice. Public Health Nurses' work mandates compete with the core concepts of health promotion, such as engagement, partnerships, and capacity building. The findings from this study are supported by other studies (Cohen, 2006; Cusack et al., 2008).

Similar to the data gathered in this study, Cohen and McKay (2010), observed that public health nursing work has shifted from a neighbourhood, client-centred model to program-based service delivery model. Raphael (2008b) discussed that over time health promotion has become invisible in public health practice. The findings from my study are congruent with this statement, as Public Health Nurses in my study said their role in health promotion has declined due to the shift in the nature of their work to focus on clinical tasks.

With the current emphasis on process of care outcome measurements, health promotion in public health nursing is seen as a lower priority than clinical work. Also the influence of the surrounding biomedical culture and discourse of evidence-based practice have shaped Public Health Nurses' work to become clinicalized with standardized processes. However it is not clear whether with these standardized processes the same goals are achieved. McQueen and Anderson (2001) stated, "Practice should depend less on quantitative analysis and more on qualitative approaches" (p. 63). To ensure program quality improvement, it is also important that Public Health Nurses' inputs on key indicators of health promotion outcomes are sought and included (Poulton, 2009).

Difficulty of evaluating and proving the effectiveness of health promotion could be another reason why the Public Health Nurse's role in health promotion has declined and become narrow. There is much discussion and debate on the difficulties in measuring health promotion outcomes (Healey & Zimmerman, 2010; McQueen & Anderson, 2001; Rootman et al., 2001). Public health nursing, much like health promotion, struggles to prove its effectiveness with quantifiable health outcomes (Healey & Zimmerman, 2010; McQueen & Anderson, 2001; Rootman et al., 2001).

The Public Health Nurse's shift to a narrow focus on specific tasks has been seen across Canada and globally (Richard et al., 2010; Whitehead, 2011; Wilhelmsson & Lindberg, 2009). Raphael (2008b) asserted that the focus on risk factors rather than addressing the social determinants of health is due to the political economic situation in Canada. Raphael (2008b) also reported neoliberal policies have shifted to focus on lifestyles rather than creating policies to address the underlying factors of disparities of health.

Many nurses interviewed believed they have the knowledge, skill and talent for engaging in health promotion work with communities, as they have a clear understanding of the community issues and have, over the years, built relationships with community members and agencies. Over time, a clear vision of health promotion for Public Health Nurses at the point of care has been lost. Some participants experienced and voiced disjuncture in the discourse of public health nursing and health promotion (Interviewees #3 and #10); this appeared to cause conflict and moral distress for the nurses (Pauly, Varcoe, & Storch, 2012). Public Health Nurses need to have a clear vision of what their role in health promotion is at the point of care.

The erosion of relationships that are central to health promotion. Nursing is a relational practice, and Public Health Nurses are situated ideally to create and build relations and partnerships with other community agencies (Doane & Varcoe, 2005). Health promotion is effective when nurses (and other practitioners) engage in collaborative partnerships with their community partners to respond to and address the identified health issue or concerns of the community (Falk Rafael, 1999a). Historically, as district nurses, Public Health Nurses were strongly connected to the community; due to continuity of care, long-term partnerships, and commitment, nurses had the capacity to build relationships with community stakeholders, which made it viable for Public Health Nurses to carry out health promotion work (Falk Rafael, 1999a).

Over the past decade, public health nursing work has been refocused to individual care (Falk Rafael, 1999a), and this is partly due to the early discharge of complex acute postpartum mothers and babies (Cusack et al., 2008). This has led to the erosion of relationships that are central to addressing some of the complex health issues facing families and young children (Cusack et al., 2008). When Public Health Nurses' connections to the community are cut off or distanced there is a decline in health promotion practice (Falk Rafael, 1999a).

In this inquiry, Public Health Nurses stated lack of time linked to budget constraints has been one factor in the erosion of their relationships with community partners and agencies. Time availability can play a key role in the quality of relationships; with more time, Public Health Nurses are able to create more innovative health promotion practices. Cusack et al. (2008) found Public Health Nurses linked the acuity and intensity of postpartum care to time being taken away from their health promotion activities.

As Public Health Nurses' work has changed over time due to dealing with acute and complex cases, acquisition of medical clinical skills and knowledge is needed to care for acute clients discharged home early from hospital (Aranda & Jones, 2007). One change has been in the *0-5 Program-Healthy Beginnings program* (postpartum newborn) program (Vancouver Coastal Health, 2013d), which provides less home-based care and more telephone care than it had in the past. The long-term health implications for this shift are yet unknown, as these new approaches have not been evaluated in this agency. With the move to nursing clinical assessments and interventions over the phone, Public Health Nurses' capacity to provide care in a different format needs to be further enhanced through developing communication and telehealth skills. The long-term impact on further declining the Public Health Nurse's role in health promotion is not clear.

Nurses' power and autonomy in the organization. Nurses discussed the loss of power and autonomy to make decisions about their work, which has led to a diminished role in health promotion. This loss of power has compromised and impacted their capacity to advocate within the organization and profession. In this section I explore the following themes arising from this inquiry: mandated programs, top-down versus grassroots initiatives, and the erosion of nurses' capacity to make decisions about the care they provide. I will now further expand on these factors in the next sections.

Mandated programs – a shift in professional autonomy. Public Health Nurses' autonomy around their practice, particularly in their ability to be responsive to community needs and working with community agencies in collaborative partnerships to address health disparities has been compromised by mandated programs. The shift in Public Health Nurses' work organization has been influenced at the macro level by the surrounding political context and by the organizational philosophy and strategic direction of the agency. Also influenced by several discourses (such as population health and communicable disease control), Public Health Nurses' mandated work and service delivery practice has changed, becoming more clinically oriented with a focus on risk factors. Public Health Nurses' activities include disease prevention initiatives, immunizations, and risk screenings, as well as working with individuals and families on a one-to-one basis in clinical settings. These mandated programs are rolled out in existing budgets, increasing Public Health Nurses' workloads and time constraints and reducing their capacity to engage in health promotion work.

In other researchers' work, nurses also discussed concerns about the erosion of the Public Health Nurse's scope of practice, with the focus being on mandated programs rather than developing innovative initiatives to address community needs and social determinants of health

(Cohen & McKay, 2010; Cusack et al., 2008). Public Health Nurses' health promotion work, although important, has been invisible due to limited research and difficulties in evaluating and measuring the effectiveness by quantifiable population health outcomes. As some participants' suggested, if Public Health Nurses' engagement in health promotion is to be supported, then upstream thinking and new models of service delivery need to be considered for mandated programs.

Top-down versus grassroots initiatives. The Public Health Nurse's role in nurturing emerging grassroots health promotion initiatives to address health disparities has been compromised by centralized decision making in response to government initiatives mandated at the macro level due to sociopolitical forces. Top-down decision making has taken away nurses' capacity and autonomy for population-focussed health promotion work.

Public Health Nurses have become implementers of mandated programs, which are decided centrally, rather than being created in response to the local community needs. These decisions about the process of care, which have also become standardized, are not made by frontline nurses at the grassroots level, nor are they in response to local needs.

The theoretical underpinnings of health promotion are empowerment, participation, and social action (Nutbeam & Harris, 1999). Historically, Public Health Nurses' health promotion work involved developing grassroots initiatives in response to community health needs through establishing trusting relationships; such initiatives were able to build the capacity of the population to address health issues (Cusack et al., 2008; Falk Rafael, 1999a). Instead of being client centred, Public Health Nurses are now engaged in program-centred, problem-based work. Instead of being proactive and engaging in addressing the social determinants of health and social inequities that exist in the community, Public Health Nurses now work by reacting to

incoming referrals. These findings are consistent with discoveries and conclusions from other studies (Cusack et al., 2008; Falk Rafael, 1999a, 1999b; Richard et al., 2010). Public Health Nurses in Cusack et al.'s (2008) research identified erosion of their health promotion role due to the early postpartum discharge program in Manitoba.

The erosion of nurses' capacity to make decisions about the care they provide. Public Health Nurses in this study said decisions about the care they provide are made centrally by organizational leaders who lack understanding of community needs. This hierarchal decision making has impacted nurses' power, capacity, and autonomy to be responsive in the process of care they provide to their client and the community, thereby weakening partnerships with community agencies.

Public Health Nurses identified that over time the social organizational context of their work environment has altered from community-oriented, based in easily accessible neighbourhood agencies, to now being in community health centres, corporate and distant from the people they serve. Over time, the culture of the organization has become corporate, functioning as a business with standardized care processes, consequently shaping their daily work.

Cohen and McKay (2010), in their research study on the role of health organizations and Public Health Nurses in addressing child poverty, found that Public Health Nurses felt the organizational culture is like a business and functions in that manner. In Cohen and McKay's study, Public Health Nurses identified their organization's lack of understanding of their role as a barrier for Public Health Nurses' practice in addressing poverty issues.

The nurses in my study shared their frustrations at what they perceived as a lack of power, credibility, and trust in their decision making, which they felt has changed over time.

Several times interviewees brought up the lack of voice that Public Health Nurses have in decision making regarding their practice and work. Interviewees stated that centralized administrators are making an increasing number of top-down decisions without any consultation with frontline nurses prior to implementation.

Public Health Nurses are most effective in their work when involved in the decision-making process and when their knowledge from community assessment is utilized (Meagher-Stewart et al., 2010). Cohen and McKay (2010) also identified this to be an issue in their study with Public Health Nurses in Manitoba who were given little opportunity to be involved in program planning when addressing the needs of vulnerable families with young children.

Public Health Nurses' capacity to advocate within their organization and profession has been compromised. During the interviews, nurses voiced concerns about the lack of value placed on their work by the organization and its leadership. Lack of resources, staffing, and issues with workspace were discussed. At one time, Public Health Nurses were visible and highly regarded by the public; these nurses were viewed as an authority and leaders in health promotion. However, with restructuring, there is an implicit lack of value placed on Public Health Nurses within the organization and by the public. As the health care teams have expanded in community health centres, with primary care clinics providing medically focussed services, space for programs has become a challenge.

The face of leadership in health care has been changing with demands to cut health care costs as the system has continued to become more complex (Cortada, Gordon, & Lenihan, 2012). Organizational leadership can play a crucial role in how Public Health Nurses' work is regarded within the organization (Meagher-Stewart et al., 2010) and can advocate for removal of organizational and structural barriers (Cohen, 2006).

Vancouver Coastal Health's (2013i) current new slogan is "People First" (para. 1), which refers to both the public served and the employees of the agency. This contrasts sharply with the interview texts, as study participants' perceive that they are not valued by the agency nor is the agency putting community members' needs first. Organizational barriers can hinder Public Health Nurses' work; in the literature, several researchers discussed the lack of resources, recognition, and value of health promotion work provided by management (Stewart 2000; Whitehead, 2006b). It is vital that managers understand and respect the full scope of public health nursing practice (Cohen & McKay, 2010; Meagher-Stewart et al., 2010; Underwood et al., 2009) and advocate for it (Cusack et al., 2008). In their study, Meagher-Stewart et al. (2010) argued that public health leaders were effective provided that they were visionary, clear, consistent, and demonstrated support for Public Health Nurses working to full scope. Managers can play a key role in acknowledging and promoting Public Health Nurses' contributions to organizational leaders, other health professionals, and the public. Medical health officers and upper managers need to raise public awareness of community health nursing, programs, and services (Meagher-Stewart et al., 2010).

Public Health Nurses' capacity to advocate within the community has been compromised. Recently, the Canadian Nurses Association (2012) gathered a national commission and produced a report titled *A Nursing Call to Action*; this report stated it is "the social responsibility of nurses to take a strong leadership stand on behalf of Canadians" (p. 1). Several nurses in my research indicated that Public Health Nurses need to start advocating for their communities and for Canadians, especially those on the margins of society. Participants discussed the need for stronger leadership from frontline nurses in advocating for their work and increasing engagement in health promotion.

One participant raised the issue of whether nurses being government employee compromises' their ability to advocate for resources due to fear of repercussions from employers. Raphael (2008a) urged public health workers to become active and advocate for resources and changes in government policies to create a healthier society and decrease the burden on health care. He stated, "However, providing information on how public policies impact the social determinants of citizens' health would seem to be an appropriate public health activity" (Raphael, 2008a, p. 18).

As outlined in Chapters 1 and 2, due to restructuring and reform in the 1990s resulting from budget constraints, community health (of which public health is a part) was joined with the acute sector and combined in regional health authorities. However, the Public Health Agency of Canada (2004) acknowledged that merging of the two sectors has not resolved the funding problems of public health services:

Despite the instability of these arrangements, they have the major advantage of promoting the integration of clinical and public health services under unified governance that is locally responsive to some degree. Regional structures, however, have not solved the problem of under-investment in public health. (Organization of Public Health Services section, para. 3)

The organization's mission statement still reflects the core concepts of the health promotion model with the statement, "Healthy Lives in Healthy Communities" (Vancouver Coastal Health, 2013i, Our Mission section, para. 1). However, this is not congruent with study participants' perspectives, as they stated the shift in their work has led to decreased time and resources to respond or engage with communities to create healthy lives. Nevertheless, Public

Health Nurses strive and work towards the goal of creating healthy lives and communities by delivering health care services with the constrained resources they have.

There is a disconnect between what governments and organizational leaders state regarding investing in health promotion strategies and what is taking place in frontline practice. A recent document released by the Provincial Health Officer of BC, *Investing in Prevention* (Kendall, 2010), discussed the importance of investing in health promotion. The BC Auditor-General recently criticized the Ministry of Health for devoting such a small proportion of its budget to prevention. The Canadian Press (2013) said, “BC’s auditor general says the province spends less than five per cent of its annual \$15.5 billion health-care budget on population wellness and disease prevention — despite a healthy-living theme touted by the provincial government” (para. 1). In the new 2012–2015 agency service plan created to meet the direction set out by the Ministry of Health, the first goal listed is: “Effective health promotion, prevention and self-management to improve the health and wellness of VCH [Vancouver Coastal Health] residents” (Vancouver Coastal Health, 2012a, p. 8). How this new plan and its goals are being rolled out into public health, particularly into the work of public health nursing, is unknown at this time. However, it is important for the organization to outline a clear plan on implementing this goal. Whitehead (2006b) recommended several organizational capacity building strategies for health promotion, one being “a genuine commitment to the processes that foster health promotion capacity” (p. 64).

Nurses working in public health need to explore ways they might draw upon their knowledge and skills and engage with their organizations and public policy makers to halt the erosion of practice and to demonstrate the potential contributions of their engagement in health promotion work to address priority health concerns (Cohen, 2006). Much of the research on

determinants of health and social determinants of health have pointed to issues that need to be addressed, but the literature does not provide direction on how to go about this. Health promotion can play a role in addressing these identified issues. To decrease the burden of cost on health care, the broader concepts of health promotion strategies could be used for prevention of illness, rather than spending money on treatment of illness. Upstream thinking necessitates funding allocations be increased to public health, prevention, and health promotion.

Limitations of the Research

In qualitative research the researcher aims to introduce new perspectives and understandings of the phenomenon of interest in order to contribute to ongoing scholarly dialogue. As such, any qualitative study offers a partial understanding. In this case I sought to introduce the perspectives of nurses engaged in the practice of public health nursing into the broader discourses on health promotion practice and health care policy. I sought to locate the analysis in context so that the reader can trace the logic of the argument and understand the multiple contextual influences on nurses' achievement of the aims of health promotion in their practice. The study is also limited by my presentation of the analysis, as it offers one interpretation of the data shared by participants. While I was successful in obtaining detailed accounts of the nurses' practice, the study is limited in that the perspectives of patients—children, youth, or families—as recipients of services were not sought.

The sample was homogenous, as the participants were recruited from one particular program in one urban area. The majority of the nursing population in the selected program are women, with only a few male nurses in this program. Therefore, the sample included only women, even though attempts were made to recruit both men and women.

The selection criteria required participants had 10 years of experience in public health and excluded new nurses and younger Public Health Nurses, whose experiences and perceptions would be interesting to capture. However, due to time limitations and resources, as well as the focus of the research on historical trends in health promotion practice, strict inclusion criteria were maintained.

Prior to conducting the research, I was concerned that it might be challenging to recruit enough Public Health Nurses with over 10 years of experience in the public health sector, particularly for the public health leaders with a nursing background. All attempts were made to recruit leaders with nursing backgrounds and maintain the inclusion and exclusion criteria, for this reason the sample size was kept low.

Strengths of the Research

Many participants took pleasure in discussing their role and reminiscing about the past. They provided rich and detailed descriptions of their work. Public Health Nurses also told me that they enjoyed sharing their knowledge and being recognized for their wisdom and experience in public health. The participants benefitted by having the opportunity to honestly share their feelings, thoughts, and ideas about the Public Health Nurses change in scope of practice and role. As I am known in the public health sector, I found that it was easy to build trust and recruit participants for the research study.

Currently there is lack of Canadian research on this topic, which was revealed by the literature search done in preparation for this inquiry. This inquiry also brings into focus the incremental changes made in public policy and the impacts on the health care workers and their communities. Currently, little attention is being paid to this issue. Leaders in public health could use the findings of this research for future planning of care.

Summary

This chapter presented the analysis of the data gathered from a research inquiry to understand the range and nature of influences on Public Health Nurses' day-to-day health promotion work in Vancouver, British Columbia. The factors that influenced the social organizational context within which nurses engage in health promotion work were discussed in this chapter. The Public Health Nurses who participated in this study work in community health centres in a program providing universal and targeted health services to children aged 0–19 years and their caregivers

Historically, Public Health Nurses have provided care to individuals, families, and communities by being responsive to arising needs by partnering and mobilizing communities to address health issues using health promotion concepts (Cusack et al., 2008). Nurses were catalysts and facilitators, using the broader aspects of health promotion to build community capacity to solve health problems. They acted as mediators and advocates with a focus on marginalized groups, addressing health disparities, and promoting social justice. As discussed in Chapters 1 and 2, Public Health Nurses pursued many grassroots initiatives to meet the needs of their communities.

The Public Health Nurse's role has evolved and shifted over the years, with a diminished engagement in daily health promotion work. According to the nurses interviewed, reorganization of public health and the acute sector was associated with a decreased budget, increase in mandated programs, and a pattern of decision making that mandated the introduction of new initiatives without any additional funding. In this same era, the nature of work in the community was also impacted by early hospital discharge of acute and complex clients, including newborns and their mothers.

All these influences have shaped the Public Health Nurse's role to be implementers of top-down programs but not creators of programs that are responsive to community needs. Nurses said changes in their autonomy and capacity to engage in health promotion have contributed to a diminished role with a narrow focus on more clinically oriented work with individuals. This has led to erosion of relationships that are central to health promotion processes. The perspectives of the nurses in this study are congruent with findings from other research conducted on the role of Public Health Nurse (Cusack et al., 2008; Richard et al., 2010).

The literature provided the following reasons for Public Health Nurses' declining role in health promotion: (a) confusion about the public health nursing role and discipline (Poulton, 2009; Stewart, 2000; Whitehead, 2004a, 2004b); (b) Public Health Nurses' health promotion work is invisible (Whitehead, 2004a, 2004b); and (c) it is challenging to evaluate and measure the effectiveness of health promotion (Stewart, 2000; Whitehead, 2006b). Rootman, Warren, and Catlin's (2010) research also affirmed that it is difficult to measure the outcomes of health promotion, as it is complex and requires a sustained time commitment.

In this study, several participants voiced concerns regarding their inability to provide timely and responsive care to their clients and the community. The health outcomes and long-term implications of this on the health of the community are unknown, as evaluations have not been conducted in this area. In the current culture of the organization, with health promotion being a low priority, it is important that there are leaders who are strong advocates for public health nursing and health promotion. Public health leaders need to create an environment in which the Public Health Nurse's work is valued within the organization and outside in the community. It is important that public health nursing and organizational leaders consider different ways of assessing the outcomes of Public Health Nurses' health promotion work.

Chapter Five: Study Recommendations

In this chapter I present recommendations based on the discoveries and insights from the research inquiry into the evolving role of Public Health Nurses in health promotion work. I conclude the chapter with insights and recommendations on future research.

The role of Public Health Nurses in health promotion has evolved over time in association with continuous restructuring in health services delivery. The literature search revealed a limited amount of research conducted on factors influencing Public Health Nurses' engagement in health promotion work in British Columbia, Canada. From my own observations as a practitioner, I have also seen a decline in Public Health Nurses' health promotion activities with a shift to more clinical work. Therefore, I engaged in this research study to explore and discover the social and contextual influences shaping the Public Health Nurse's role in health promotion work, with a particular focus on the past decade. Using institutional ethnography methodology I interviewed Public Health Nurses to discover their insights into the influences shaping and shifting their daily health promotion work. I interviewed 12 Public Health Nurses working in a public health program in a large urban health agency.

Conclusions

In the late 1990s, reform and restructuring of health care influenced the social organizational context of Public Health Nurses' practice. This new context from which nurses engaged in their work contributed to their perceptions of a diminished role in health promotion with a narrow focus on clinically oriented tasks. Public Health Nurses stated their capacity and autonomy to engage in health promotion has been constrained due to several conditions and associated processes. These constraints and conditions were caused by the power of the ruling relations (Smith, 2006)—the budget constraints, the biomedicalization of public health, the

weakening of the health promotion discourse and the dominance of the population health discourse. As illustrated in Chapter 2, conceptions of public health have been increasingly influenced by biomedicalization. This perspective carries with it a particular understanding of health care intervention that stands in contrast to the goals of health promotion, which focus on mobilizing and strengthening protective influences through partnership and capacity building.

The analysis of the data in this study illustrated these inherent tensions and traced their influences on the nature of public health nursing. The influences on public health nursing practice include:

1. Conceptual underpinnings of goals of care, such as (a) the changing context and increasing acuity of public health nursing practice, (b) the weakening of relationships with community partners, and (c) organizational leaders' perceived lack of understanding of the Public Health Nurse's role (i.e., health promotion processes of care, partnership, and capacity building).
2. Operational influences on Public Health Nurses' capacity to engage in health promotion work, including time, budget, mandated programs, and the constrained capacity to engage in shaping the approaches to practice that, through the introduction of a new organizational model, has centralized decision making.

From the analysis of my research data and the research literature it is apparent that, over time, health promotion in public health nursing is becoming invisible (Raphael, 2008b). In my inquiry, Public Health Nurses identified several factors, including the current focus on biomedical care, which influence the decline of their role in health promotion and narrow the focus of their work to clinically oriented tasks. This has changed Public Health Nurses' practice significantly. The discoveries of this inquiry are congruent with the findings of other research

studies conducted across Canada and globally on the Public Health Nurse's role and practice (Cohen, 2006; Cusack et al., 2008; Poulton, 2009; Richard et al., 2010; Wilhelmsson & Lindberg, 2009).

Numerous scholars have written about the important role of health promotion in addressing health disparities to create healthier societies (Cohen & Reutter, 2007; Healey & Zimmerman, 2010; McDonald et al., 2009; Raphael 2008b; Whitehead, 2006b). Healey and Zimmerman (2010) stated that with the rise of chronic diseases to epidemic proportion it is important to develop health promotion programs to prevent these chronic diseases: "There is an increasing body of evidence of the real value of health promotion for individuals and society, and that without it society will be increasingly plagued with chronic diseases" (p. 19).

In the current environment of evidence-based practice it is challenging to demonstrate the outcomes of health promotion, yet Public Health Nurses in my study felt health promotion has a role in public health and in creating healthy societies. As discussed previously, it is difficult to measure the outcomes of health promotion to prove its effectiveness (Healey & Zimmerman, 2010; McQueen & Anderson, 2001; Rootman et al., 2001). This issue of cost-effective service delivery and lack of resources is visible in all health areas, and it is clear that the current health expenditure crisis is not about to go away.

Given all this, what is in the future for Public Health Nurses and their role in health promotion? What role do governments and public health leaders want Public Health Nurses to play in health promotion? Nursing organizations and employers both need to take part in answering these questions and clarifying the role of public health nursing (Whitehead, 2008).

Public Health Nurses in my study were challenged by the tensions caused by two approaches to health: the biomedical care model and health promotion. The biomedical model is

hierarchical with centralized decision making requiring an evidence-based practice of care focussed on treatment of disease with individual patient. Conversely, the social model of health promotion can be emergent, grassroots, and ground up, providing responsive care with concrete activities focussed on families, groups, and communities to prevent disease. Both models of care are complex. Both of these models are simultaneously influencing Public Health Nurses' practice context, which is creating tension for nurses at the point of care. Nevertheless, both models could play a potential complementary role, with population health data identifying what health problems exist and with health promotion offering a range of potential strategies to address those problems, especially the social determinants of health. Public Health Nurses require clarification and support from leaders regarding the influence of these two discourses on their role and practice in health promotion. Some thoughtful discussions and considerations need to occur at the higher level with governments, organizational leaders, and nursing organizations, with input from Public Health Nurses regarding their future role in health promotion work.

Valuing of partnerships as a strategy for health promotion. The discourse of population health using epidemiology data provides direction on health issues that need to be addressed. The health of the population may well be improved by strengthening community partnerships and employing health promotion strategies to address health disparities. Public Health Nurses, through their community assessments, have knowledge of community resources and possess the ability to build networks of connections, not only amongst different agencies and community groups, but also within different disciplinary groups of health care providers (Cohen & Reutter, 2007). Health promotion can be used as a long-term strategy for prevention of disease and promotion of health. Public Health Nurses need to work with organizational leaders and

government officials to advocate and look for innovative solutions with community partners to create healthier communities.

Funding. Public health and public health nursing services are an integral part of health authorities. Over the years, public health has experienced system-wide underfunding. The Public Health Agency of Canada (2004) acknowledged that despite the integration into regional authorities public health remains underfunded: “Regional structures, however, have not solved the problem of under-investment in public health” (Organization of Public Health Services section, para. 3). Policy makers need to make coherent decisions about long-term investments in health care, with appropriate budget allocations for prevention, health promotion, and acute care.

Leadership. The literature and the Public Health Nurses in this study stated that public health nursing leaders need to become strong advocates for Public Health Nurses. Leaders must seek resources for appropriate staffing levels to prevent fatigue and burnout (Richard et al., 2010).

Although public health plays an important role in preserving the health of Canadians, there are reports of chronic underfunding. These PHNs’ [Public Health Nurses’] concerns about inadequate funding for their varied and diverse workload are similar to concerns raised by other PHNs across Canada. (Cusack et al., 2008, p. 209)

Although leaders in health care are also constrained by the ruling relations and the mandates of the organization, the internal and external forces that have the power to make decisions concerning funding allocation and programs, it is important that leaders advocate for the Public Health Nurses who work for and with them. Public health nursing requires increased funding for more nurses even if the Public Health Nurse’s role continues to evolve as it has been doing.

Leaders can also play a crucial role in removing barriers and increasing visibility of Public Health Nurses' work in the current biomedicalized environment.

As stated previously in Chapter 4, during the interviews I did not explore the relationships between Public Health Nurses and the leadership when related topics were raised by the study participants. However it appears from the texts better communication and information sharing needs to take place between organization leaders and field nurses. Public health leaders need to create channels of communication with Public Health Nurses at point of care so that they can understand some of the decisions and changes being made to their practice due to policy and external forces. There needs to be more dialogue by leaders with frontline nurses on how the changes to practice are going to better the health of the public.

Increase visibility of Public Health Nurses' work. Nurses in this study voiced their concerns regarding the invisibility of public health nursing work. Several participants raised the need for Public Health Nurses to increase their visibility and advocate for resources for health promotion work. Public Health Nurses need to develop networks of relationships with each other and their professional bodies to empower and form a collective to advocate for resources. In order to promote and increase the visibility of their work, Public Health Nurses must find ways to demonstrate their effectiveness. Whitehead (2006a) stated,

If nursing wishes to become “visible” amongst the health promotion community it needs to ensure that the current context for health promotion practice is acknowledged and measured – and appropriate competencies and programmes put forward for the task at hand. (p. 650)

Public Health Nurses' engagement in social activism can increase the visibility of their work and move towards changing the social, political, and economic structures that influence

health care. Public Health Nurses need to become vocal in defense of their nursing practice and health promotion work. Raphael (2008a) suggested Public Health Nurses could begin to use stories from their practice to increase the visibility of their work. He suggested using ethnography methods to bring to surface the rich work carried out by Public Health Nurses (Raphael, 2008a). Several nurses in my study also expressed the need to capture some of the stories of community development work done historically by Public Health Nurses in Vancouver, British Columbia.

Education and preparation of Public Health Nurses. Several studies identified that Public Health Nurses lack confidence to engage in the broad-spectrum aspects of health promotion, particularly community development work (Cohen & Gregory, 2009; Richard et al., 2010). Recommendations from Richard et al.'s (2010) study aimed at providing education and support through mentorship to implement health promotion into practice. Whitehead (2008) suggested further education and training is needed for Public Health Nurses to decrease their confusion in operationalizing the broader concepts of health promotion and increase their knowledge and confidence.

New models for communicable disease control. Public Health Nurses recommended new solutions be explored for providing, managing, and staffing communicable disease control services. Currently, 20 minutes are allotted for child health immunization clinic appointments, and in that time many tasks and screening questionnaires need to be completed. Public Health Nurses in this study were committed to this important work, as it provided an opportunity to connect with families whom they otherwise would not interact because nurses are spending less time in the community.

Public Health Nurses in this study discussed the child health clinics many times and the stress experienced by staff as a result of these clinics. The need to have young children immunized in a timely manner is of the utmost importance. However, the pressures on Public Health Nurses' time resulting from increases in demands for immunization and the question of whether and how to balance these demands with other priorities should be carefully considered as part of the larger dialogue about the role of Public Health Nurses recommended earlier.

Implications of this Research and Recommendations for Future Research

I believe the knowledge gained from this research study will help to guide the discourse of public health nursing and lead to a clarification of the future role of Public Health Nurses in community health nursing. The practice of public health nursing has been impacted by the surrounding sociopolitical environment. It is important for health care leadership to gain an understanding of the influences (mentioned earlier in this chapter) shaping Public Health Nurses' practice in British Columbia. The role of Public Health Nurses in health promotion has evolved with health care reform and continues to shift with the changing political and economic environment. More research is warranted to appreciate the impact of these changes and further broaden understanding of public health nursing practice. When conducting this study, the following areas arose as possibilities for future research:

1. What role does education play in the confidence level of Public Health Nurses in relation to health promotion?
2. New and younger nurses were excluded from participating in this research. Their experiences and perceptions would have been interesting to capture and would have further enriched the data. What are their experiences as they transition into public health? How do they define health promotion? What are their perceptions of the

changes occurring in health promotion nursing practice? Do they value health promotion practices? Why?

3. Research into the history of Public Health Nursing in the Vancouver community in regards to health promotion initiatives and community development would be beneficial. During my research study it was challenging to find any historical data on public health nursing in Vancouver community. Many study participants also brought up the need to capture the rich health promotion stories from the past. These areas warrant further research.
4. The Public Health Nurse's shift away from being a trusted authority figure might be attributed to the influence of the technological era. Availability and access to health information on the Internet or through other social media by the public has risen over the past decade, which may have altered the public's current view of Public Health Nurses as credible health authority figure. This is an area that would warrant further research.
5. Further research is needed to assess the qualities of effective leadership and the types of leaders required in community health nursing. Also further research is warranted to explore ways to strengthen the communication and relationships between organization public health leaders and Public Health Nurses.

Summary

In this chapter the implications from the research findings for Public Health Nurses' health promotion work and public health nursing discourse were discussed. The focus of this research inquiry was to understand the influences on Public Health Nurses' capacity to engage in health promotion work in the Vancouver community in British Columbia.

The previous chapter discussed how nurses defined health promotion. Public Health Nurses stated two major areas influencing their autonomy and capacity for health promotion work: government policy and organizational structures such as work processes and policies. Under these two categories Public Health Nurses identified several factors that have caused a decline in their capacity to engage in health promotion work. Gorin and Arnold (2006) stated, “Health promotion between the client and the health care professional emerges in a context of policies, influential groups and monetary exchanges. Healthy public policy provides the overall framework in which health promotion can occur” (p. 67). It is important that open discussions with all those involved, including the public, take place to decide on the future of health promotion in health care.

Health promotion is important for the health care sector and the future well being of healthy populations (Wilhelmsson & Lindberg, 2009) and is a central part of community and Public Health Nurses’ work (Stewart, 2000; Wilhelmsson & Lindberg, 2009). However, with the current forces at work influencing the day-to-day work of public health nursing and moving in the direction of increased clinicalization, it is unknown what future role Public Health Nurses will play in health promotion. Currently, there is a possible resurgence and call for prevention and health promotion activities in Canada and British Columbia. What implications this has for public health nursing is unknown. It is essential that Public Health Nurses remain focussed on the community as a client and ensure their services are comprehensive to meet the needs of the whole community.

I hope this research has increased the understanding of public health nursing role in health promotion and the valuable role nurses can play towards creating healthier populations.

My hopes is that leaders in public health will have an increased understanding of the influences on Public Health Nurses' capacity to engage in health promotion and will use this as a basis for future discussions on how Public Health Nurses can play a greater role in health promotion work.

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Appendix A: Criteria for Participant Selection

GROUP	INCLUSION CRITERIA	EXCLUSION CRITERIA
CHN/PHN	<ul style="list-style-type: none"> ○ 10 years in public health ○ Employed in the infant child and youth programs in public health in BC ○ Full time or part time employment ○ Ability to reflect on changes in the organization 	<ul style="list-style-type: none"> ○ Less than 10 years in public health sector ○ Casual employee ○ Not a nursing background
Public health nursing leader	<ul style="list-style-type: none"> ○ Two to three years in current role as a leader ○ Employed in the infant child and youth programs in BC ○ Nursing background ○ Worked in Public health sector for 10 years 	<ul style="list-style-type: none"> ○ Not a nursing background ○ Less than 2 years in a leadership role ○ Worked less than 10 years in public health
Other		<ul style="list-style-type: none"> ○ Any staff who I might supervise or be intimidated by my role as colleague and a researcher ○ Any staff who work on the same team or community health centre as myself ○ Not employed with the infant child and youth programs

Appendix B: Invitational Recruitment Letter

[Date]

Hello

As you know I am currently doing my Masters of Science Nursing at UBC. I am researching the Community health nurse\Public Health Nurse role and the shift in practice over time with health promotion activities and initiatives. I am interviewing nurses and leaders who have been in the public health sector, Infant Child Youth program for over ten years. I would like to invite you to participate in this research study by allowing me to interview you. The interviews, one-two, will be 60 minutes, digitally taped, conducted away from the worksite. Your confidentiality will be maintained at all times.

If you are willing to participate or would like further information on the study you can contact me at: [email address]

Thank you

Ranjit Dhari

Appendix C: Consent Form

[Date]

I understand that I am being invited to participate in a research study with Ranjit Dhari who is a graduate student in the Masters of Science of Nursing Program at UBC, under the supervision of Dr. Judith Lynam. The purpose of this study is to learn about the role of Community health nursing in health promotion activities and initiatives with families of young children within a healthcare institution. The study is being undertaken as part of the requirements for the MSN degree and will be presented as a publicly available thesis document. There are no known risks associated with this study.

If I agree to participate in the study, I will be interviewed 1-2 times for approximately 60 minutes each time, over a 2 month period, about my experience as Community health nurse/Public Health Nurse in the Infant Child and Youth program in British Columbia (BC). All interviews will be audio recorded and conducted at a private location away from the worksite that is convenient for me. The interviews will be transcribed by the researcher or a typist and no identifying information will be included when the interview is transcribed. Confidentiality will be maintained at all times, the data will be kept confidential and stored in a secure locked cabinet.

I realize that my participation in this research study will be entirely voluntary, and I may withdraw from the study at any time I wish. If I decide to discontinue my participation in this study, I will continue to be treated in the usual and customary manner. I understand that all study data will be kept confidential. However, this information may be used in nursing publications or presentations.

I realize the knowledge gained from this research may help to better understand the Community health nursing role in regards to health promotion with families of young children in the Infant Child and Youth program.

If I have questions about the research I may contact the investigators: Ranjit Dhari at [telephone number] or Dr. Judith Lynam at [telephone number].

If I have concerns about my rights as a research participant I may contact the UBC Research Subject Information Line at [telephone number].

The study has been explained to me. I have read and understand this consent form, all of my questions have been answered, and I agree to participate. I have been given a copy of the signed consent form for my records.

Signature of Participant

Date

Signature of Investigator

Date

Appendix D: Information for Setting Up Interviews

Hi [Nurse's Name],

Thanks for your email and agreeing to participate in my research study.

I am in the process of setting up interviews. What is your availability? I can meet you at your home or at another location convenient to you.

I look forward to hearing from you.

Take care,
Ranjit

Appendix E: Demographic Survey

Name _____ Code # _____

Circle your age group:

20-30 yrs 31-40 yrs 41-50 yrs 51-60 yrs 60-65 years

Circle your degree level:

Bachelors Masters PhD

Circle your current employment status:

Full time Part time

Title of current role _____

How many years in a Community Health Nurse role _____

How long with present institution _____

Previous community health nursing experience before joining this organization

Appendix F: Interview Questions

1. Tell me about your regular workday.

Probing question: What are some activities you were involved in today in your role as CHN\PHN?

2. What does health promotion mean to you?

Probe: share the definition of health promotion as set out by the WHO, what are your thoughts on this definition?

3. What trends have you observed over the past 10-15 years in the CHN\PHN role?
4. In your opinion what is the current status of health promotion in public health?
5. What do you see the future of health promotion in public health?

Appendix G: Confidentiality Agreement – Transcriptionist

[Date]

I understand that all information to which I may have access or learn during transcribing of taped interviews of a research study with Ranjit Dhari who is a graduate student in the Masters of Science of Nursing Program at UBC, under the supervision of Dr. Judith Lynam will be kept confidential and is not to be communicated to anyone or divulged in any manner except as authorized by law or regulation, nor is such information to be altered, copied, interfered with, destroyed or taken except upon authorization by Ranjit Dhari. Once translation has been submitted to the Researcher, Ranjit Dhari, any and all documents pertaining to this research must be deleted or destroyed and all files must be removed from the computer.

Confidentiality will be maintained at all times, the data will be kept confidential and stored in a secure locked cabinet.

Signature

Date

Printed Name

Date

Appendix H: Final Concept Map – Influences From Research

