Advances in Nursing Science
Vol. 34, No. 4, pp. E1–E12

Advancing Population-Based Health-Promotion and Prevention Practice in Community-Health Nursing

Key Conditions for Change

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Community-health nursing practice is a pivotal aspect of present-day health reforms. In Quebec, Canada, the recent introduction of a population-based approach has entailed increasing the resources allocated to health promotion and disease prevention. Semistructured interviews were conducted with nurses and managers (N = 69) in an effort to understand how these new resources are reflected in nursing practice. Three classes of factors emerged as key conditions for change: contextual and historical, training and professional-development, and work-organization factors. The authors propose courses of action respecting these conditions to provide support for community-health nursing practices that incorporate a contemporary population-based approach. **Key words:** *Canada*, *health organizations*, *nursing practice*, *health promotion*, *public health*, *prevention*

A KEY component of health care reform in jurisdictions around the world has been the wider adoption of a population-health model for health-delivery systems. This model entails integrating the health-determinants approach to health promotion into the traditional public-health functions of protection, education, and surveillance[1] and linking them all more closely to primary care systems.

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Funding for this study was provided by the Montreal Public Health Department, Montreal Health and Social Services Agency. L.R. holds a National Scholar Award from the FRSQ (Fonds de la recherche en santé du Québec).

We thank the members of our team who conducted the research activities, Annie Bisaillon of the Bordeaux-Cartierville-Saint-Laurent Health and Social Services Center, Christiane Gendron of the Jeanne-Mance Health and Social Services Center, and all the decision makers and nurses who gave their time to participate in the study.

The authors have disclosed that they have no significant relationships with, or financial interest in, any commercial companies pertaining to this article.

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DOI: 10.1097/ANS.0b013e3182300d9a

In 2004, the Province of Quebec, Canada, adopted a population-based approach as part of an organizational model for the regionalization of health-care delivery. Responsibility for all health services and for overall population health in a territory was devolved to regional and subregional health networks. The emphasis in Quebec's approach to population health has been on providing a continuum of care from prevention through acute care to rehabilitation. The continuum includes health promotion, which involves interventions that address the social determinants of health. This development creates a social space for new roles and practices to emerge, but it also challenges health care professionals with the concomitant issue of whether they possess or can exercise the expected competencies.

Nursing practice is of particular interest in this context. Nurses comprise a large segment of the traditional public-health workforce and the values of their discipline and many of their competencies are consistent with health-promotion philosophies.[2-9] However, the capacity of nursing practice to evolve in this new era of public health may be limited by the legacy of earlier reforms that assigned nurses a major role in ambulatory care coupled with a shortage of nursing personnel.[10] Furthermore, a review of the recent literature shows that the concept of health promotion is often misunderstood among nurses. Their perception, description, and practice of health promotion and prevention are more in keeping with a traditional health education approach and more focus on changing individual behavior.[9,11-13] According to authors such as Irvine[11] and Whitehead,[14] nurses have not yet demonstrated a clear comprehension of the strategies of empowerment, community development, and sociopolitical action in formulating and implementing health promotion and prevention agendas.

Apart from Underwood's work on nursing practice in population health[15] and Casey's work on nurses' perceptions, understanding, and experiences of health promotion,[13] few studies of nursing practice in health promotion and prevention have considered the professional and organizational dimensions that shape practice.[10,16-18] Published research has instead focused on nurses' attitudes to, knowledge of, and beliefs about health promotion, on the meanings they attribute to it[9,11,12,19-22] and on descriptions of practices that have been implemented. These studies have not sought to analyze the influence exerted by organizational actors or by the contexts in which nurses conduct their population-health practice.[16,17] Moreover, there has been an ongoing concentration on health education rather than on the broader, health-determinants approach to health promotion.[11,12]

The Quebec health reform presents an opportunity to broaden our understanding of nursing practice in population health. As evidenced by the 2004 legislation, governmental priorities have opened the door to significant changes in practice by attributing the responsibility of population's health to local health institutions and requiring a reexamination of professional and administrative practices in light of their new role. While the reform may have been intended to facilitate the adoption of a new population-based health-promotion and prevention (PB-HPP) paradigm across the health continuum, it has, in fact, met with resistance from the curative sector, where resources are proving less and less adequate to meet growing needs. In addition, although standards of nursing practice elsewhere in Canada highlight contemporary concepts of public health,[23] in Quebec there are no formal statements or standards to define and guide nursing practice in population health, nor is there a distinct public-health specialty in nursing. This situation of adaptation and tension over the course of implementation of the reform since 2004 provided us with an excellent, real-time opportunity to document whether and how nursing practice in the PB-HPP approach would evolve.

The study reported here was conducted in 4 *Centres de santé et de services sociaux* (CSSS; Health and Social Services Centers), which are the organizations responsible for local health delivery in the province. In Canada, publicly funded health care comes under provincial jurisdiction. The overall

organization of health care, resource management, and budget allocation are generally delegated to regional agencies. Since the 2004 reform, service delivery in Quebec has been managed at the subregional level, with the CSSSs acting as headquarters for the provision of health and social services on the basis of local population needs and resources. In addition to offering short- and long-term health care and social services, they provide health-promotion, disease-prevention, and health-protection services in accordance with regional and local public-health priorities and plans.[24] There are 95 CSSSs in Quebec. Each serves a population ranging from 3 700 to 37 000. Health-promotion and prevention services are delivered mainly through subregional components of the CSSSs called *Centres locaux de services communautaires* (CLSCs).

Given a lack of knowledge about how this latest reorganization of the public-health system has affected nursing practice, the approach we adopted in this study was exploratory and guided by two research questions: What are the health-promotion and prevention practices of nurses working in CSSSs? What are the professional and contextual factors that influence those practices?

METHODS

Design and sample

This collaborative, qualitative study was conducted by a group of community-health nurses, managers, and researchers from 4 CSSSs, 1 regional public-health authority, and a university. The community-health nurses were closely involved in all the aspects of study design, data collection and analysis, and knowledge transfer.

The CSSSs were affiliated with the University of Montreal. This facilitated the participation of community-health nurses as coinvestigators on the research team. Each organization serves an urban population in a district of Montreal. The target study population consisted of CSSS-CLSC nurses who provide direct services to the population as well as their managers. A purposive sampling strategy was used to maximize participant heterogeneity by program affiliation, type of nursing degree, years of experience, and degree of involvement in population-health activities. Lists of potential participants were drawn up in consultation with the community-health nurses on the team who, in turn, consulted their managers to ensure pertinence and feasibility. Sixty-one nurses were approached in person or by e-mail and asked to participate; 20 declined or did not respond. The main reasons cited for refusal were lack of time or interest. The final number of participants was 41. Twenty-eight managers, with or without a nursing background, were also interviewed. They were selected to ensure a maximum diversity of perspectives. In each CSSS, the executive director, the director of nursing services, the director of public health services, 2 program directors, and 2 middle managers were approached. All but 2 accepted; they were replaced by a senior nursing consultant or associate manager reporting to the originally selected manager.

The study protocol was approved by 3 of the CSSS ethics review committees. A fourth CSSS endorsed the decision of the other 3 committees.

Procedure

Data were collected through in-person, semistructured interviews conducted between July 2006 and January 2007. Each participant first received an information package that included a consent form and a list of the themes to be investigated. Interviews lasted 1 hour, on average, and took place at the participant's workplace during work hours. A short questionnaire on professional characteristics (education, employment status, experience) was administered at the end of the interview.

Interview themes

The interview themes explored the context of PB-HPP, facilitating factors and barriers, nursing roles, and the meanings

ascribed to health-promotion, prevention, and population-health practices (see Table 1 for a list of the interview themes). This article focuses on how PB-HPP is translated into everyday practice by CLSC nurses and reports on the relevant influencing factors.

Analytic strategy

Interviews were transcribed verbatim and a brief summary was forwarded to each participant for validation. All subsequent analyses were conducted with the complete interview transcripts using a constant-comparison method.[25] Coding was conducted by 3 team members, with weekly verification and adjustments to the coding scheme to ensure intercoder reliability and credibility of the interpretations. Nurses' and managers' responses were grouped into the same conceptual categories, and each category was substantively developed and illustrated with extracts from the interviews to highlight general trends in the responses, as well as contrasts between respondent groups. At each stage of the analysis, team meetings allowed comparison of competing interpretations, careful selection of emergent themes, and identification of new threads of analysis. Results reported below provide a synthesis of responses from both nurses and managers, by major study themes. When there are differences between nurses and managers, they are conveyed.

Table 1. Interview Guide

Main Theme: Health Promotion and Prevention Nursing Practice	
Nurse's Interview	**Manager's Interview**
Narrative account of a recent health-promotion or prevention activity	Description of health-promotion or prevention activities in the CSSS
Factors that influence nursing HPP practice	Factors that influence HPP nursing practice
Organizational context and working conditions	Organizational context and working conditions
Professional training and development	Professional training and development activities
Description of an ideal PB-HPP team	Description of an ideal PB-HPP team
Nursing's role in HPP	Vision of nurses' role in PB-HPP
Definitions: PB-HPP approach, prevention, and health promotion	Definitions: PB-HPP approach, prevention, and health promotion

RESULTS

Participant characteristics

Nurses

As Table 2 shows, the participant nurses had 21.3 mean years of experience in their career (range, 5–40) and 6.9 mean years of experience in their current position (range, 0.5–24.0). Most worked full-time. Nearly half worked in infant-child-youth programs, and the rest were mainly involved in programs for elders with varying degrees of loss of independence; general clinical services (eg, blood-test center or medical consultation); or services for specific populations (drug users, street people, sex workers). A majority of nurses had a bachelor's degree, and 17% had acquired graduate education. The most common terminal degree declared was in nursing. Not quite 10% held a terminal degree in community health.

Managers

Eighteen of the managers interviewed had nursing backgrounds, and 10 did not. Table 2 shows that participating managers had fewer mean years of experience in their current position (2.4 years; range, 0.5-12.0) than the

Table 2. Participant Characteristics

Characteristics	Nurses (n = 41)		Managers (n = 28)	
	n (%)	Mean	n (%)	Mean
Years of experience				
In their current position		6.9		2.4
In their nursing career (nurses only)		21.3		28.4
Program				
Infant-Children-Youth	20 (48.7)		2 (7.1)	
Loss of Independence	7 (17.1)		4 (14.3)	
General Services	5 (12.2)		4 (14.3)	
Services to Specific Groups	5 (12.2)		3 (10.7)	
Public Health Planning	2 (4.9)		. . .	
Nursing services	. . .		4 (14.3)	
Senior management	. . .		4 (14.3)	
Research/teaching	. . .		1 (0.4)	
Multiprograms[a]	2 (4.9)		6 (21.4)	
Employment status				
Full time	35 (85.4)		27 (96.4)	
Part time	6 (14.6)		1 (0.4)	
Terminal degree—level				
College	4 (9.8)		3 (10.7)	
Undergraduate certificate	3 (7.3)			
Bachelor's	27 (65.9)		7 (25.0)	
Graduate diploma	3 (7.3)			
Master's	4 (9.8)		18 (64.2)	
Terminal degree—sector				
Nursing (bachelor of nursing)	22 (53.7)		4 (14.3)	
Nursing (Undergraduate certificate)	8 (19.5)		. . .	
Community health	4 (9.8)		. . .	
Administration/management	1 (2.4)		12 (42.8)	
Bioethics	1 (2.4)		1 (0.4)	
Sciences			3 (10.7)	
Other	5 (12.2)		8 (28.6)	

[a]Participants affiliated with 2 or more programs.

nurses interviewed. About two-thirds (64%) had a master's degree, and many of them (43%) were in administration or management.

NURSING PRACTICE IN THE PB-HPP APPROACH: MISALIGNMENT BETWEEN DESIRE AND REALITY

While a shared desire to see nursing practice evolve successfully to embrace the PB-HPP approach was manifest, the interview data revealed significant misalignments between the desired state and actual practice. Our analysis suggests that everyday nursing practice in a CLSC is compartmentalized, with little integration of health promotion and prevention. Nurses are continually engaged in action; however, their action tends to focus more generally on clinical services and rarely incorporates health promotion or prevention into the continuum of care. Nurses' interventions tend to be with individuals or small groups. Only rarely are they oriented to a wider community or to the population as a whole. When they do engage in PB-HPP

practices, nurses take on prevention rather than health promotion activities. Their actions are aimed largely at behavior change, on an individual level, rather than addressing the socioenvironmental determinants that influence health more generally.

Factors shaping PB-HPP practice

Historical and contextual factors

Participants' narratives suggest that several factors constrain the capacity of nursing practice to embrace a PB-HPP approach. First, there are historical and contextual factors that threaten the fragile balance and combination of resources that support accessibility to clinical or curative services. For instance, the 2004 Quebec health reform is the latest of a series of reforms dating back to 1972, when community health was first recognized as a focus for the health system. According to the participants, this reform has raised hopes for a more efficient health care system, although it has also led to misunderstandings and anxieties. In particular, the nurses expressed that they were worn out by the seemingly endless succession of reforms and needed some stability to develop their capacities in health promotion and prevention. Otherwise, throughout these reforms, the CSSS, as an organizational culture, remains centered on clinical services. In the context of limited resources and competing demands to provide ambulatory care, clinical intervention receives higher priority than health promotion and prevention programs. The context of a severe, ongoing, province-wide shortage of nursing personnel creates additional pressure for this entrenchment of clinical services and against the integration of health promotion and prevention into the care continuum. Finally, by their very nature, the outcomes of health-promotion and prevention activities are not readily discernible in the short term, in comparison to the observable outcomes of clinical services and direct care. HPP activities are thus afforded less value and weight in the face of choices for resource allocation. According to the study participants, this hinders nurses' capacity to further develop the PB-HPP practice.

Training and professional development factors

The interview data also revealed significant gaps in nurses' and managers' understanding of the PB-HPP approach, particularly as it pertains to nursing work. Most notably, there was some confusion in terms of highlighting clear distinctions between the concepts of health promotion and prevention. When asked to define the terms, nurses were able to characterize "prevention" and focused on the avoidance of problems. However, their definition of "health promotion" was generally vague and summed up to "large-scale health education" oriented toward the attainment of "positive" results, such as health and well-being. Almost entirely absent from participants' discourse were such core notions as "empowerment," "health determinants," and the "socioenvironmental dimensions of health."[26] Managers had a somewhat better understanding of these concepts. This reflected their recent access to professional development in these areas.

Respondents' views converged regarding the necessity for nurses to acquire specific knowledge and skills if they are to work successfully in PB-HPP. Both nurses and managers acknowledged that nurses' initial training is limited to individually oriented intervention and that insufficient attention is paid to health-promotion and prevention strategies that address change at other levels, from a socioecological perspective. They also agreed that resource shortages hinder access to continuing education and professional development activities. Managers stressed the difficulty of replacing nurses during such training activities and recognized that there was an absence of strategic planning and incentives to facilitate ongoing professional development in PB-HPP. When some activities were implemented, nurses deplored the lack of follow-up and supportive resources posttraining to help put into practice their newly acquired

knowledge. In the view of both managers and nurses, training and professional development did not motivate changes in PB-HPP practice because of the absence of coaching that is necessary to assist knowledge transfer processes. One nurse respondent accordingly: "What I can't stand is that there is never anything after our training sessions. It's great to get some training, but there should be a follow-up!" Meanwhile, a manager stated, " . . . we aren't very structured in the way we plan training; there is no overall plan based on a systematic process of needs analysis and prioritization."

Work-organization factors

Nurses reported that their health-promotion and prevention mandates were often vague. They described the integration of the PB-HPP approach into their daily work, as fragmentary and partial, given that they were already overburdened with curative services. They saw a disconnect between the organizational discourse promoting PB-HPP and the actual choices that were "top priority." Health promotion and prevention activities were the first to be suspended in order to cope with resource shortages and demands for curative services. This contributed to fragmentation and discontinuity of health promotion and prevention interventions, while consolidating the perception that PB-HPP is a low priority for their organizations. One respondent declared: "Everyone says it's important, but when it's time to plan activities or to allocate human resources, less importance is attributed to this than they say." Both nurses and managers agreed that prevention and health-promotion resources should be clearly identified in their organizations and strictly protected from other demands.

It was also noted that CSSSs, as complex organizations, were generally driven by centralized decision-making processes. For most respondents, this has resulted in a gap between planning and intervention. Nurses underscored their limited participation in decision-making processes that were key to setting priorities and orienting service and resource allocation in their organizations, although they represent nearly 50% of the workforce in CSSSs. Moreover, they have not been involved in either planning or evaluation functions with regard to prevention and health promotion. Being excluded from these processes clearly undermines their capacity to understand and contribute to the ongoing PB-HPP reform in their organizations and contributes to the observed status quo in their practice. Our interviews with managers lead some of them to conclude the discussion with the intention to be more inclusive of nurses in planning and evaluative processes as "they are essential to our health agenda."

Finally, the role nurses perform in their organizations, particularly with regard to PB-HPP, appears to be more supportive than strategic. They "support their team," rather than engage in action to mobilize and network with the various other actors involved in population health. One nurse clearly summarized a generalized observation: "It's not my professional role . . . it's not part of what a nurse does." Conversely, one manager declared, "Nurses do not see the importance of their broader role. It's not in that role that they are recognized. It would help if we valued them for that role in the same way we do for their clinical role." On the contrary, in the course of their work, nurses do have several opportunities to network, exchange, and interact with many actors from different services and sectors. However, they remain in a referral role, which contributes to their reported sense of isolation, with few opportunities to share their concerns, observations, experiences, or ideas for intervention. They expressed the wish they had more opportunities to reflect upon their practice with other nurses, public health professionals, and the myriad of other actors engaged in action on health determinants in communities. One nurse yearned for a community of practice, "a space for exchange or discussion, to know what to do in a particular case . . . so that we don't re-invent the wheel every time."

They viewed intersectoral collaboration as an opportunity to benefit from other available resources and improve service capacity and PB-HPP.

DISCUSSION

This study examined organizational and professional constraints on the integration of a population-based health-promotion and prevention (PB-HPP) approach into contemporary nursing practice. The perspectives of both nurses and managers involved were elicited through in-depth qualitative interviews, and consideration was given to the context in which nurses' practice evolves. The implementation of a health-system reform aimed at producing a shift to PB-HPP provided us with the opportunity to obtain an in-depth description of the forces and factors that shape nursing practice in population-based health promotion and prevention. The findings are perhaps not immediately generalizable to other contexts or types of organizations, but many of them are mirrored in the literature.

Factors influencing population-based health promotion and prevention

Similarly to other studies,[11,13] this research found that nursing practice, in the health-delivery systems studied, remains largely focused on approaches centered on individual behavior modification. There are few observable, enduring, or irreversible changes in nursing practice, despite efforts to create a favorable context for nursing activities that are more deeply rooted in health promotion and prevention across the entire continuum of care.[12-14,19,27-30] Furthermore, although managers view nurses as potential strategic actors in advancing population health in their organizations,[31,32] nursing practice currently places little emphasis on community development, community mobilization, or, more generally, action on the social and environmental determinants of health.[13,19,21,26,30,33-35] The literature posits a number of factors that may explain this situation and that are consistent with the findings of our own study.

The first such factor concerns training, knowledge, and skills development in the area of population-based health promotion and prevention. From the start, action on population health is constrained by a narrow and incomplete understanding of health promotion. Indeed, little attention is afforded to the socioenvironmental determinants of health and to health-promotion intervention in nurses "initial training."[11,13,14,31] It appears that solutions to this problem compete with other priorities. In Quebec, as elsewhere, initial training in nursing takes a number of forms (in colleges and university degree programs) and tends to focus on disease and curative services. Notions of population health are often considered "add-ons" in undergraduate training and appear only to be addressed in clearer terms in master's programs for postgraduate nurses.

To further support skills development in PB-HPP in nursing practice, it would be desirable for health organizations to hire nurses who already have an appropriate training in population health to occupy some leadership positions and effect change. Given current nursing shortages for curative services, such a hiring policy has hardly been feasible.[13] The need for professional development thus remains acute. Access to continuing education and on-the-job training in such domains as advocacy, community intervention, and program development are not readily available to nurses.[8,16,27,36] Professional development programs, this study shows, are fragmentary and are not part of strategic planning in the organizations, and they generally fail to address the need for increased knowledge and skills in population-based health promotion and prevention. Given training opportunities at postgraduate levels, concerted strategic efforts to meet this need, through the involvement of postsecondary institutions and the various levels of the health system, ought to be considered.

Another possible explanatory factor is the relatively scant participation of nurses in decision-making processes pertaining to service organization that affects their capacity to integrate PB-HPP; otherwise, there are few opportunities to participate in wider networks to critically reflect upon and participate in the development of PB-HPP practices. To date, nurses have rarely been involved in multisector partnerships for community development or PB-HPP initiatives partly because the demands of providing clinical services are so great, but also because of the expectations and the lack of clarity regarding their professional role in these areas.[31,37] This has implications for practice diversification and for the recognition of wider competencies, beyond those that are traditionally held within and outside the profession. More broadly speaking, although systemwide reforms may place greater emphasis on population and public health, local agencies can take years to catch up.[35]

Finally, the study participants' perceptions of the context, issues, and conditions necessary to support nursing practice in PB-HPP highlight the fact that, unlike managers, nurses do not seem to have appropriated the changes proposed by current reforms. A study of a similar systems change in Finland[38] yielded findings that mirror ours: despite positive perceptions of proposed changes, nurses did not feel strongly engaged in the reform as it related to population health. In addition, they were also critical of their lack of involvement in the planning and implementation of the reforms. Most of all, this reform leads to few changes in their practice.

PRACTICE IMPLICATIONS

This study has a number of implications for practice. First, it is important to recognize that nurses and other health care personnel are undergoing a structural and paradigmatic reorientation, one that requires a shift both in targets (the population and its health needs in place of clients and their health demands) and in the way to envision health services (on a continuum from health promotion to rehabilitation).[39,40] One clear implication for practice is that health care professionals, including nurses and health-system managers, must develop a common vision of population health, health promotion, and prevention[35,41] that integrates health promotion into the continuum of services. This vision must be supported by concrete measures, including a clear organizational stance in favor of population-health practice as well as explicit mandates and targets.[10,15,31] According to our study, one major obstacle to population-based health-promotion and prevention practice in nursing is the paramount position occupied by clinical services to the detriment of health promotion and prevention. A compounding factor is the almost total lack of performance standards or indicators to measure the achievement of health-promotion and prevention objectives. Other studies have yielded similar findings. They have confirmed that the development of PB-HPP nursing practice is constrained by an organizational culture grounded in curative services and hampered by fuzzy mandates and quantitative performance indicators that do not adequately reflect key professional actions in health promotion and prevention, exceedingly high workloads, and the shortage of skilled human resources and financial means.[13,35,42]

Similar results emerged from a study with another professional group in CSSS organizations.[43] Professional community workers' capacity to integrate community development into their practice required that their managers and coworkers become familiar with concepts, issues, socioenvironmental health determinants, and conditions of success in the field. Supportive organizational and professional conditions were identified to ensure the effective integration of a new intervention paradigm. For instance, it was recommended that both managers and staff engage in knowledge-exchange and capacity-development activities; that a vision of the desired practice was clearly

articulated in the organization; and that their population-oriented approach be granted greater prominence in the continuum of services. Finally, they further recommended that this new approach be championed by senior management.

A second implication for practice is the need for initial training and continuing professional development, although educational initiatives, in themselves, are unlikely to be sufficient to drive systemwide change.[13] We suggest participatory training approaches that include systematic efforts to facilitate knowledge translation into practice.[9,12] Knowledge development, in terms of both individual risk factors and socioenvironmental determinants of health, should progress simultaneously and be taken into account in university curricula and professional-development regimes. It is generally recognized that partnership development, community intervention, action on policies, and program development are key areas of practical knowledge that should be reinforced among nurses.[8,27,36] Most importantly, continuing education and skills development opportunities in population health should reinforce nurses' leadership abilities and support their capacity to occupy strategic roles, not only supportive ones.[35] As managers have agreed in our study, nurses must develop their competencies to fulfill their strategic potential in health promotion.[31]

A final implication for practice is the creation of infrastructures and networks to support the codevelopment of a shared vision of PB-HPP in our health organizations and the deployment of strategic potential: spaces in which nurses, managers, and other health-system actors can share their knowledge and experiences. These socioprofessional and intersectoral spaces should be designed to foster reflexivity[39,43–45] and collaboration, as well as the mobilization of participants to achieve common objectives as they develop shared understandings and orientations for change. Such network systems could be beneficial in that they could enhance intersectoral collaboration, a determinant of population-health practice in nursing,[38] and open the way for nurses to adopt a more strategic role in population-health delivery systems.

STUDY LIMITATIONS

This qualitative study must be interpreted in its context. Since participating nurses and managers were recruited from 4 institutions of a single type, the findings cannot be generalizable to the range of different health organizations. Moreover, the purposeful sampling strategy, while designed to maximize heterogeneity, was limited to nurses and managers within the organizations, thus limiting the opportunity to examine the context from a larger perspective. Finally, because the study took place in the context of an ongoing reform, our window of observation may have missed key changes that were slower to occur.

CONCLUSION

In general, the results of this study confirm those of other investigators[13,19,21,26,30,34,35] to the effect that population-based public-health practices in nursing are still quite narrowly defined and are slow to gain momentum in contemporary health systems. Our findings show that much is yet to be accomplished to address organizational and professional constraints on nursing practice in PB-HPP. Participating nurses described a fragmentary and partial integration of health promotion and prevention into a daily practice already overburdened with the demands of clinical services in a context of limited resources. Clearly, additional support mechanisms are required in terms of organizational vision, PB-HPP indicators, training and professional development, and collaborative networks. Although the intention behind the reform of our health structures was to foster stronger integration of population-based practices, it has, nonetheless, had the merit to help elucidate essential factors that influence

PB-HPP nursing practices in local public-health organizations. This study should provide decision makers and practitioners with the inspiration to better realize current health reforms with a population health perspective.

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