

Norwegian public health nurses' competence areas

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Abstract

Objective: To explore the competence areas of public health nurses in Norway.

Design: A qualitative and comparative design was employed.

Sample: A purposive sample of 41 public health nurses participated.

Measurements: Data were gathered from focus groups and individual interviews. The interviews centered around an open question about public health nurses' knowledge. They also discussed 10 proposed competence areas for public health nursing, developed from the literature. A qualitative content analysis was conducted on the interview transcripts, followed by a synthesis of the data from the interviews and earlier developed competencies. The 10 competence areas for Norwegian public health nursing were then refined. Finally, we compared the affirmed competence areas with earlier developed cornerstones and the new educational guidelines.

Results: The interviews revealed 10 competence areas. These 10 competence areas were synthesized with the 10 proposed competencies from literature. Ten affirmed competence areas, which mostly corresponded with the competencies from literature, were developed. The affirmed competencies were supported by the previously developed cornerstones and new educational guidelines.

Conclusions: The affirmed competencies will help promote and explain the content and focus of PHNs' work in Norway and may have implications for education and international research.

KEYWORDS

competence, disease prevention, health promotion, interviews, public health nurse

1 | BACKGROUND

1.1 | Public health nurses' professional expertise

In Norway, public health nurses (PHNs) have expertise in nursing science, the social sciences and public health. These competencies equip

PHNs for community-oriented health promotion and prevention work, with a special focus on children, young people, and their families (Dahl & Clancy, 2015). PHNs' work involves interactions with children, young people, family members at individual, family, and group levels. Norwegian public health services are extended to all pregnant women including routine child health examinations free of charge at a universal

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level, including detection of a range of environmental and family issues that influence children's safety and health (Norwegian Directorate of Health, 2017).

PHNs in Norway work independently, with responsibility for public health nursing: This work to improve the population's health occurs in homes, at schools and in child health centers, and thus at an individual, community and system level (Glavin et al., 2019). The municipalities (local districts) are responsible for managing the services within Norwegian laws and regulations (Norwegian Directorate of Health, 2017). The PHNs' leader may be a PHN him/herself or have a different background; these decisions are made at the municipal level.

1.2 | Professional competence

PHNs must develop and enact professional competence. Professional competence, as defined by the World Health Organization (WHO, 1988), is the ability to perform the duties required by a specific profession. This repertoire of professional practices requires specific knowledge, attitudes and practical or intellectual skills: the latter include language skills, and the ability to think critically and solve problems based on previous experience. This competence enables professionals to perform a specific service (WHO, 1988). For PHNs in Norway, this service consists of public health work around children, young people, and their families.

Abbott (1988) points out that professional competence is what distinguishes one profession from another. This professional competence involves the ability to practice within an advanced clinical field in both nursing and public health. Internationally, public health nursing practice is defined as population-based work in various arenas, involving five competence areas: (1) assessments are made in sub-groups that share health problems or characteristics; (2) the health status of the overall population's health is assessed; (3) health determinants for the overall population and the sub-groups are assessed; (4) assessments take place at the individual/family, community and system level; and (5) health promotion and prevention at all levels are emphasized (Minnesota Department of Health, 2019). Public health nursing competencies specify standards for PHNs to practice at the entry level. Stated as expectations for practice, these competencies integrate the skills, knowledge and attitudes that equip PHNs to intervene effectively with individuals, communities, and systems (Keller et al., 2011; Schaffer et al., 2011).

1.3 | Public health nurses' professional practice competencies

The cornerstones of public health nursing provide the foundation for PHNs' practice. They encompass the values and beliefs reflective of both public health and nursing that guide the actions of PHNs (Keller et al., 2011; Schaffer et al., 2011). In the Norwegian context, Glavin et al., 2014, (p.163) have suggested nine cornerstones for public health nursing practice: (1) focuses on the health of entire popula-

tions; (2) reflects community priorities and needs; (3) establishes caring relationships with communities, systems, individuals and families; (4) is grounded in social justice, compassion, sensitivity to diversity and respect for the worth of all people, especially the vulnerable; (5) encompasses mental, physical, emotional, social, spiritual and environmental aspects of health; (6) uses evidence-based practice to promote health in the community; (7) collaborates with community resources to achieve those strategies, but can and will work alone if necessary; (8) derives its authority for independent action from national laws; and (9) promotes equality for all by offering universal health care services. While these cornerstones address the values and beliefs that guide public health nursing practice, the competencies state the standards for PHNs' actions. The competencies of PHNs, based on their experiences from their practice, have been to a small degree studied and reported in Norway. To develop and strengthen the public health nursing profession in Norway, it is of importance to identify the competencies of Norwegian PHNs. Our study aims to clarify and elaborate previous work that has been done, in identifying Norwegian public health nursing competencies and their selected practice examples.

In 2018, the Association of Norwegian Nurses' National Group of PHNs (NSFLAH) created a committee to further clarify and develop areas of competence for public health nursing practice (Steffenak et al., 2019). This endeavor drew on national regulations and guidelines for child health clinics and school health services (Ministry of Health and Care Services, 2018; Directorate of Health, 2017); current legislation and literature (Health and Care Act, 2011; Public Health Act, 2011; Schoon et al., 2018); recommended attitudes and values for PHNs (Glavin et al., 2014); and the Public Health Intervention Wheel (PHIW) (Minnesota Department of Health, 2019; Glavin et al., 2019). The PHIW is a framework that defines and describes the scope of public health nursing in the public health service. Interventions are described as actions that PHNs take on behalf of individuals/families, communities, and systems, to improve or protect their health status. Using the PHIW as a framework for PHNs' practice thus provides a common language with which to describe their practice; this, in turn, enables the justification of necessary resources for the work to funding authorities (Minnesota Department of Health, 2019). The PHIW framework is found applicable to a Norwegian setting (Glavin et al., 2019).

A final consideration in our efforts to elucidate contemporary PHN competencies and practice in Norway is a discussion of the educational preparation for a PHN. Public health nursing education is offered at the post-graduate or master's level following a bachelor's degree in nursing. PHNs can finish their education after 90 ECTS (one ECTS is 25–30 hours of work) or continue with writing a master's thesis (120 ECTS.). In both cases you become a PHN, so you do not need a master's degree to work as a PHN. This program is based on the new regulations on national guidelines for PHN education (Ministry of Education and Research, 2021). Here, learning outcomes for PHNs' competence areas are described, stating that the public health nurse education is close to practice- and research-based and must meet society's demands for equal and knowledge-based services. Upon completion of their education, the candidate must be able to contribute to a sustainable development of the health service in step with global, demographic, social,

environmental, and technological changes. The new Norwegian national guidelines for PHN education describe five competence areas: (1) public health work; (2) children, young people and their family/caregivers; (3) communication, relationship and interaction; (4) management, service improvement and innovation; (5) research, dissemination and professional development (part I); and (6) a master's thesis (part II).

As such, Norwegian standards for the actions and role of PHNs must be clear to users, management, partners and the PHNs themselves. This may strengthen the PHNs' professional role and enable them to fulfil the social mandate around health promotion and prevention work at the individual, group, community, and system levels. However, we do not know how the PHNs perceive the ways in which their work fits into the defined competence areas. The present study therefore examined Norwegian PHNs, and public health nursing leaders' perception of competencies in public health nursing practice, based on interviews with open questions to reaffirm the 10 proposed competence areas for Norwegian PHNs developed from the literature (Steffenak et al., 2019). After synthesizing these data sources we compared the affirmed competence areas with the earlier-developed cornerstones (Glavin et al., 2014) and the competence areas from the new Norwegian regulation's guidelines (Ministry of Education and Research, 2021).

2 | OBJECTIVE

This study aimed to explore the competence areas of PHNs in Norway.

3 | DESIGN AND METHODS

The study employed a qualitative and comparative design. Data were collected during focus groups and individual interviews. Data were analyzed using a content analytic framework (Graneheim & Lundman, 2004) and the findings were synthesized with proposed competences developed from literature (Steffenak et al., 2019). The result of this synthesis was compared with earlier developed cornerstones (Glavin et al., 2014) and the educational guidelines (Ministry of Education and Research, 2021).

3.1 | Sample

The interview sample included a purposive sample of 41 PHNs. Inclusion criteria were working more than 1 year as a PHN, and working at child health clinics, in primary or secondary school health services or as a public health nursing leader. The PHNs were recruited from six different counties and 23 municipalities in Norway. Their experience varied from 1 to 26 years.

Access to the participants was established through an oral and written inquiry to the public health nursing service. Nursing leaders informed the PHNs and PHN leaders, who made direct contact with the researcher for interviewing. The informants filled out a form addressing demographic data, age, years in PHN practice, level of education and practice setting (Table 1).

TABLE 1 Sample characteristics (n = 41)

Gender	N
Male	0
Female	41
<i>Participant age</i>	
Range	N
20–35	2
36–45	19
46–55	14
56–60	5
> 60	1
<i>Level of education</i>	
Public health nursing-postgraduate studies	41
Master's in PHN	0
Other master's degree	3
PhD	0
Other education with credits	21
<i>Setting worked in the longest</i>	
Rural	20
City	20
Large city	3
<i>Municipality size</i>	
2500–10,000	6
11,000–30,000	13
40,000–80,000	21
700,000	3
<i>Years worked as PHN</i>	
Range	n**
1–5	11
6–10	6
11–15	11
16–25	8
> 25	3
<i>Work per week</i>	
80% and more	36
50–79%	3
Less than 50%	0

*Two informants responded in two places

**Two informants did not respond

3.2 | Data collection

The interview guide comprised two open questions: *What must a PHN know?* and *What work areas can this knowledge and skills (competencies) be linked to?* Six focus group interviews and 13 individual interviews were carried out between September 2020 through May 2021. Interviewees were told they would be discussing some claims about public health nursing competencies and introduced them to the 10 proposed competence areas. The open questions were asked

TABLE 2 Overview of data collection method, working area and competence area discussed

Research method	n	Working area	Competence area discussed
Focus group	5	Child health clinic	1–5
Individual interview	1	Child health clinic	1–10
Individual interview	1	Child health clinic	1–10
Individual interview	1	Child health clinic	1–10
Focus group	6	Primary school health services	1–5
Focus group	5	Primary school health services	6–10
Individual interview	1	Primary school health services	1–10
Individual interview	1	Primary school health services	1–10
Individual interview	1	Primary school health services	1–10
Focus group	3	Youth health services	1–5
Focus group	3	Youth health services	6–10
Individual interview	1	Youth health services	1–10
Individual interview	1	Youth health services	1–10
Individual interview	1	Youth health services	1–10
Focus group	6	PHN leader	6–10
Individual interview	1	PHN leader	1–10
Individual interview	1	PHN leader	1–10
Individual interview	1	PHN leader	1–10
Individual interview	1	PHN leader	1–10

in all interviews. In the focus group interviews, numbers 1–5 or 6–10 of the proposed competence areas were discussed (Table 2). In the individual interviews, all the 10 proposed competence areas were discussed.

All five researchers conducted the interviews. The focus group interviews (2), and some individual interviews (3) were conducted at a university, child health clinic (two focus groups, three individual interviews) or suitable room at a school (two focus groups). The rest of the individual interviews were conducted via phone (7). The focus group interviews lasted from 45 to 95 min and the individual interviews lasted from 25 to 52 min.

3.3 | Data analysis

The data were transcribed verbatim from the recordings. A qualitative content analysis was conducted, inspired by Graneheim and Lundman's (2004) analytic framework. The interviews were read several times by all the researchers to obtain a sense of the whole. Meaning units were identified from the transcripts and then condensed into a description corresponding closely to the text. The condensed meaning units were then abstracted with a code. After comparing these codes with regards to differences and similarities, they were sorted into categories and then themes based on the research question. Comparison of the results of the coding increased the level of understanding about their meaning (Table 3). Data were gathered until categories and themes became repetitive and redundant. After interviewing 41 PHNs, the

researchers determined that no new information could be obtained via further data collection. We then synthesized the competencies identified in the interviews from practice with the 10 proposed competencies framework developed from the literature sources (Steffenak et al., 2019).

3.4 | Ethical considerations

The Norwegian Centre for Research Data (NSD) approved the study (No. 852233), and the study followed ethical research guidelines. The interviews were audio recorded following the completion of a consent form by the participants. The interview data were securely stored, ensuring the anonymity of each participant throughout the process.

4 | FINDINGS

The analysis of the interviews revealed 10 themes or competence areas that are related to each other: (1) health promotion and disease prevention; (2) competence in children and young peoples' health and development; (3) holistic thinking; (4) cultural competence; (5) ethical competence; (6) evidence-based practice; (7) communication skills; (8) relational competence; (9) collaboration competence; and (10) management and organizational competence. Details relating to each theme are presented below. The findings are supported with quotations from the informants.

TABLE 3 Examples of meaning unit, condensed meaning unit, code, category and theme from the content analysis of the focus group and individual interviews, compared with a preliminary competence

Meaning unit theme	Condensed meaning unit	Code	Category	Theme	Competence
<i>The longer I work, I see how important it is with interprofessional collaboration. To know the agencies that can contribute to helping, whether it is the child, the adolescent or the parents who need help.</i>	Important to collaborate around children, young people and parents	Collaboration important	Prioritizes collaboration	Collaboration competence	Collaborates with relevant agencies, groups and individuals to achieve goals for improving public health
<i>... think I am a mediator, many times, ... between the parents and the school, the cooperation</i>	Important to be a mediator in the collaboration process	A mediator role	Mediator in the collaboration		

4.1 | Health promotion and disease prevention

The findings indicate that the PHNs in the study perceived that they had competence in health promotion and prevention work at the individual, group, community, and system level. As one PHN reported:

We will work with prevention. We will work to ensure that no more children become overweight. Of course, we will take care of those who have already become so, but we are paid to work with prevention.

The PHNs in the present study knew that they should work at the individual, group, community and system level towards children, young people and families; however, they prioritized individual work when necessary due to time pressure.

Some PHNs reported that when they did not see any improvement with a child or an adolescent, they would refer them further in the system for treatment. However, this was often difficult due to a lack of capacity at the specialist level. One PHN said:

I always think that what I am doing now must have a purpose, and about what is the challenge here, and what will we achieve with it, and when have you achieved it, and can quit, or when you must move on—all the time there is an assessment there.

4.2 | Competence in children's and young peoples' health and development

The PHNs emphasized that their main knowledge area was about normal development and the health of children and young people. One PHN explained:

First and foremost, we need to know a lot about children and children's development—children's general development—

but you must also know a lot about disease or diagnoses around children, then, and what to look for.

Some PHNs highlighted that they had medical knowledge about children and young people, which their collaborators from the social and pedagogical professions did not have; this enabled them to see cases from a different perspective.

The PHNs also expressed having general competence in physical, mental, and social issues related to children and young people. When a situation demanded specific knowledge, however, they had to update themselves on that topic. As this PHN stated:

We are not experts in everything, we are more like—we should know a little about most things.

Many of the PHNs requested methods and procedures in their health promotion and prevention work towards children and young people. They reported that the national framework was too vague on methods and standardized procedures. Moreover, some methods that PHNs used—several family counselling programs, for instance—were developed for PHNs, while others were developed for other professions and then adapted to public health nursing.

4.3 | Holistic thinking

The PHNs had a holistic approach to the service users. For example, as one PHN explained:

We are experts at seeing the whole person. Both in himself and in his life...it is we who often ask questions about the whole picture

Another PHN said:

[We] see the whole. Both the whole at school and the whole towards the family and children [...] Nursing education is



important as a basis because we learn a lot about seeing the whole and not just the individual problem.

They experienced that it was very important to look for threads—connections with family, school and friends—when there were challenges related to a child or adolescent.

4.4 | Cultural competence

Findings revealed that having cultural competence (i.e., cultural understanding and sensitivity) was important when PHNs worked with families and young people from different cultures. The PHNs encountered a diversity of students at school, and thus a diversity of families; in challenging cases, they tried to look for possibilities and discuss these with the families, drawing on their cultural competence. One PHN described this as follows:

There are many ways to solve things in different families. It is not a recipe you can have for things to get better. Some families have a tradition of solving things like this, and others have it like that.

4.5 | Ethical competence

The PHNs reported being conscious of their own values in their practice, and being non-judgmental, tolerant and respectful based on their nursing education. One PHN noted:

It is very important to be aware of your values and attitudes and your way of being. It is also the basis of the relationship and this recognition and respect...it is crucial at work.

4.6 | Evidence-based practice

The PHNs emphasized the need to take an evidence-based approach, to be able to apply theoretical/research-based knowledge, experience-based knowledge and the national framework for child health clinics and school health services in their work with the service users. To create trust, they needed to feel confident in their competence related to children's general health and growth, vaccination, nutrition, and sleep. They reported that service users needed to know that PHNs had competence related to what they said. However, one PHN noted that they sometimes lacked the time to stay up to date with these competence areas:

I miss having time to actively search for new knowledge...time to stay more professionally updated.

4.7 | Communication skills

The findings show that communication skills are crucial to the PHNs in our study. PHNs communicate in different ways physically and to some extent digitally at the individual, group and system levels. They emphasized competence in communication as important. One PHN said:

It is true for all PHNs that you must, you must have good communication skills, otherwise it does not work, because the whole job is about that.

PHNs in the present study experienced that it was important to have the competence and ability to establish good relationships with both service users and collaboration partners.

Some PHNs highlighted their lack of understanding regarding their role—and how to communicate that role to others. One PHN explained it in this way:

Role clarification, clear voice, stand out in the media... The PHNs quickly becomes uncertain when communicating what they are doing.

4.8 | Relational competence

The PHNs discussed how developing and maintaining good relations with service users and collaborators at all levels in the community was a foundational aspect of PHN work. Relatedly, the PHNs experienced that it was highly important that families trust them so they will turn to PHNs for support and help. One PHN related the following:

It is a very low threshold, to talk to a PHN, so there are many who think it is very good to start there, and then, eventually, maybe they can go ahead and get help at another place, if needed. So, people are incredibly good at getting in touch.

4.9 | Collaboration competence

All the PHNs reported having competence in collaboration. Indeed, they experienced extensive collaboration at the individual level with other health professionals and families in their work with children or adolescents and their families. One PHN emphasized the importance of this collaboration:

The longer I work, I see how important it is with inter-professional collaboration—to know the agencies that can contribute to helping, whether it is the child, the adolescent or the parents who need help.

Most of the PHNs also had experience with collaboration at the group level. One PHN explained:

It is important to know the municipality in the interdisciplinary work—where, what, who. ... Psychiatry, if there are mentally ill parents, for example... So, I sometimes feel like we're a little bit like a catalyst, that we're presented with a situation, and then I often think that I can help to channel, or wonder... together with them [the collaborators] where this really belongs.

Another PHN said:

I think I am a mediator, many times... between the parents and the school, the cooperation... parents who have had different experiences with the school system themselves. There are many things that are involved... before making contact on behalf of the child.

4.10 | Management and organizational competence

The PHNs who were not formal leaders reported needing strong competence around self-management. One PHN explained this as follows:

Yes, [one must] lead one's own work because this public health nursing profession is an extremely independent profession.

They saw themselves as administrators and coordinators of children and families with whom they followed up, while public health work at the system level was seen more as a management responsibility.

4.11 | Synthesis of the interview data and the competence areas developed from research

We identified that all the proposed competence areas were affirmed by the PHNs. This synthesis resulted in 10 affirmed competence areas for Norwegian PHNs. Finally, we compared the affirmed competence areas with the earlier-developed cornerstones (Glavin et al., 2014) and the competence areas from the new Norwegian regulation's guidelines (Ministry of Education and Research, 2021; see Table 4). When synthesizing the competence areas from the interviews and the literature, 10 competence areas were affirmed. These affirmed competence areas were supported both by the Norwegian cornerstones for PHNs and the competence areas in the new educational regulations. The results of the synthesis and this comparison are shown in Table 4.

5 | DISCUSSION

The 10 proposed competence areas from literature (Steffenak et al., 2019), were to a great extent supported by the competence areas

revealed from the interviews from practice. The synthesis of these two data sources resulted in 10 affirmed competence areas for Norwegian public health nursing. The affirmed competencies reaffirm the competencies in the educational guidelines (Ministry of Education and Research, 2021), even though there are fewer and more collapsed competence areas in the educational guidelines. The affirmed competence areas also elaborate and augments the cornerstones of public health nursing in Norway (Table 4; Glavin et al., 2014).

The Norwegian PHNs have a mandate to work both with health promotion and disease prevention interventions at the individual level towards children, young people, and families—but also at the population level (Ministry of Education and Research, 2021). The competence areas we identified also mandate work at all levels of practice, from individuals and families to communities and systems. Still, our findings suggest that the PHNs in our study work mostly at the individual level, and often find it difficult to find time to work at a system level. However, Glavin et al.'s (2019) study showed that PHNs intervene at all practice levels, that is, individual/family, community and systems—but that PHNs have difficulty in promoting and explaining the content and focus of their work. This is in line with the findings of Haron et al. (2019), who studied PHNs' practice areas in Israel, and found that PHNs provided individual-level interventions, and fewer activities focused on population health. Although Haron et al. (2019) show that PHNs have fewer population-focused interventions, they also found that PHNs are using interventions on all levels. In the United States, a set of competencies for public health nursing were developed by the Quad Council—a coalition of four nursing organizations—with the aim to guide professional nursing practice, curricula, research, and policy development (Campbell et al., 2020). They employ a focus on the population, to strengthen PHNs' capacity to positively impact the health and wellbeing of populations (Cross et al., 2006), and not merely individuals. When exploring the U.S.-developed PHIW in a Norwegian context, Glavin et al. (2019) conclude that the PHIW framework, which also focuses on population health, is applicable to a Norwegian setting. Dahl (2018) argues that the implementation of practice models (such as the PHIW and administrative directives and resources), as well as explicit emphasis on population health in public health nursing education, may contribute to increased population-based interventions. Kempainen et al. (2013) conclude in their Finnish study that nurses have not yet demonstrated a clear political role in implementing health promotion activities, and that barriers may be due to an organizational culture.

The findings further show that Norwegian PHNs have competence in children and young peoples' health and development, but in many situations, they need—and request—tools for intervention, as the national guidelines (Norwegian Directorate of Health, 2017) are too vague. As PHNs' work takes place at the complex intersection of evidence-based practice, standardization and expectations of user participation, standards and protocols have become common. The PHNs reported having adapted standardized programs and guidelines developed for other professions, which may not be evidence-based, as they lack protocols developed specifically for PHNs. The PHNs requested more standardized methods, but standardized protocols may weaken PHNs' clinical judgement, and their individual approach to the children and families.

**TABLE 4** Comparison of PHNs' areas of competencies

Competence areas developed from literature Steffenak et al. (2019)	Competence areas developed from interviews	Affirmed competence areas for PHNs	Cornerstones Glavin et al. (2014)	PHNs competence area from the educational guidelines Ministry of Education and Research (2021)
Applies national laws and frameworks to perform health-promotive and preventive public health nursing	Health promotion and disease prevention	<i>Draws on national laws and guidelines to perform health-promotive and preventive public health nursing</i>	Derives its authority for independent action from national laws	Public health work
Applies a holistic understanding of health in the assessment, planning, implementation and evaluation of health work	Holistic thinking	<i>Applies a holistic understanding of health when assessing, planning, implementing and evaluating specific practices</i>	Encompasses mental, physical, emotional, social, spiritual and environmental aspects of health	
Performs public health work based on social justice, empathy, sensitivity to diversity and respect for the value of all people	Cultural competence	<i>Practices public health work based on social justice, empathy, sensitivity to diversity and respect for all</i>	Grounded in social justice, compassion, sensitivity to diversity and respect for the worth of all people, especially the vulnerable	
Has a non-judgmental, unconditional acceptance of others	Ethical competence	<i>Is non-judgmental, tolerant towards and accepting of everyone</i>	Promotes equality for all through offering universal health care services	
Applies scientific and up-to-date knowledge about connections between health and the environment to promote the upbringing environment around children, young people and their families	Competence in children and young peoples' and their families health and development	<i>Applies up-to-date knowledge to improve the living situations of children, young people, and their families</i>	Focuses on the health of entire populations	Children, young people and their family/caregivers
Uses epidemiological and evidence-based sources as a basis for systematic public health work	Evidence-based practice	<i>Uses epidemiological and evidence-based sources as a basis for practice</i>	Uses evidence-based practice to promote health in the community	Research, dissemination, and professional development
Communicates purposefully with systems, communities, families, individuals and collaborators	Communication skills	<i>Can communicate well with agencies communities, families, individuals and collaborators</i>	Establishes caring relationships with communities, systems, individuals and families	Communication, relationship, and interaction
Establishes and maintains good relationships with systems, communities, families and individuals	Relational competence	<i>Has strong working relationships with agencies, communities, families and individuals</i>		
Collaborates with relevant agencies, groups and individuals to achieve goals for improving public health	Collaboration competence	<i>Works with agencies, groups and individuals to improve public health in communities</i>	Collaborates with community resources to achieve those strategies, but can and will work alone if necessary	
Administers and leads public health work related to families, children and young people and collaborators in public health services	Management and organizational competence	<i>Administers and leads public health work in the public health services to promote and implement public health practices</i>	Reflects community priorities and needs	Management, service improvement and innovation

When PHNs implement evidence-based approaches, this must be combined with the PHNs' best judgement'. Moreover, Dahl and Clancy (2015) argue that guidelines and protocols can lead to good results, but they may also weaken the clinical judgement of PHNs if they hinder the nurses from being flexible and meeting individual needs.

Knowledge about epidemiology and vaccination is seen as a basic skill among the participants, in the competencies identified in the literature and in the national regulations and education guidelines (Ministry of Education and Research, 2021). Vaccination is a prevention method used by health personnel around the world, and Nikula

et al. (2012) point out the importance of vaccination competence among health care professionals in preventing the spread of disease. The importance of infection control was highlighted during the recent COVID-19 pandemic (Ministry of Health and Care Services, 2020). Norwegian PHNs use interventions like surveillance, disease and health event investigation, outreach, screening, and case finding in their work (Glavin et al., 2019).

PHNs' ethical competence is prominent in our findings, and this is in line with the competence in non-judgmental acceptance of others found in the literature. For example, Glavin et al. (2014) compared the values and beliefs of Norwegian public health nursing with the values and beliefs reflected in cornerstones of U.S. public health nursing and found many similarities.

Permeating our findings was the PHNs' holistic thinking: This dovetails with the competence area we identified in the literature, which described a holistic understanding of health at all levels of public health nursing work. Fukada (2018) maintains that nursing competency is a holistic and integrated concept and core ability that is required to fulfil one's role as a nurse.

Communication, collaboration, and relational competence are also important skills, and correspond to the literature, which highlights competence in communication, relationships, and collaboration (Steffenak et al., 2019). Our findings show that PHNs look upon themselves as catalysts, and mediators between the family and the other professional collaborators. This is in line with the Norwegian PHNs' description of their most-used interventions as health teaching, counselling, consultation, collaboration, and coalition building (Glavin et al., 2019). Dahl and Crawford (2018) assert that interprofessional collaboration is aimed at making the most of the competence of the various professions to ensure quality of work.

In a rapidly changing society, cultural competence is crucial, and something that our findings also reflect. However, a major challenge is to provide care to an increasingly diverse society, where service users have varying needs, beliefs, behaviors, and family dynamics unique to their culture (Starr & Wallace, 2009). Highlighting the competencies of PHNs is particularly important to safeguard the public and ensure effective practice and optimal public health outcomes (Swider et al., 2013).

5.1 | Strengths and limitations

The trustworthiness and rigor were maintained by including the aspects of credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985). The sample was purposive, based on certain inclusion criteria (Table 1), which ensured credibility. The researchers were all PHNs working at universities, and the close connection with the public health nursing field can be seen both as a strength and a limitation. We have strived for a clear description of the context, sample, data collection and interpretation process. Internal consistency and other possible interpretations were taken into consideration. Dependability—or stability of the data—was reached by asking the

same questions for all the informants. However, five authors collected the data; the questions may therefore have been asked in different ways, perhaps generating different follow-up answers from the participants. To mitigate this issue, the authors collaborated and discussed the interview transcripts to ensure dependability. An additional strength is that we started with open questions, enabling rich descriptions of the knowledge field, which were further developed in our focused questions regarding the 10 competence areas. Confirmability was achieved by presenting representative quotations in the results section to show similarities and differences in the transcribed text. While the culture of Norwegian public health nursing is reflected in the findings, the theme of competence in public health nursing is universal and of international interest. Though the developed competence areas may not be automatically applicable in all other countries, the results can be transferred to similar contexts.

6 | CONCLUSION

Study findings indicate that the competence areas that we developed from interviews with Norwegian PHNs and identified in the literature are consistent with studies on PHNs' attitudes and values and overlap with the competencies in Norway's new national educational guidelines. This is expected to help Norwegian PHNs promote and explain the content and focus of their work. The competencies thus have implications for practice, as well as for education and research. The selected practice examples can also inform policy makers, educators and administrators of areas that need further attention. For instance, the PHNs' request for methods and protocols in their work was an important finding and should be investigated further.

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AUTHOR CONTRIBUTIONS

Study design: Kari Glavin, Anne Kjersti Myhre Steffenak, Berit Misund Dahl, Anne-May Teige, Anne-Gerd Karlsen, data collection: Kari Glavin, Anne Kjersti Myhre Steffenak, Berit Misund Dahl, Anne-May Teige, Anne-Gerd Karlsen; analysis: Berit Misund Dahl, Anne Kjersti Myhre Steffenak, Kari Glavin, Anne-May Teige, Anne-Gerd Karlsen, and manuscript preparation: Berit Misund Dahl, Kari Glavin, Anne Kjersti Myhre Steffenak, Anne-May Teige, Anne-Gerd Karlsen.

CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.



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