

SCHOOL HEALTH NURSING

Perceiving, recording and improving schoolchildren's health

Eva K. Claussion



*"Each affects the other and the other affects the next, and the world are full of stories,
but the stories are all one"*

M. Albom: The Five People You Meet in Heaven

Doctoral Thesis at the Nordic School of Public Health,
Göteborg, Sweden, 2008



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SCHOOL HEALTH NURSING

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ABSTRACT

Aim: The overall aim of this thesis is to explore School health nursing through school nurses' descriptions of schoolchildren's health and to analyse factors influencing the recording of schoolchildren's health in the School Health Record (SHR). An additional aim is to evaluate family nursing interventions as a tool for the school nurses in the School Health Service (SHS).

Methods: The thesis comprises four papers. A combination of qualitative and quantitative methods was used through individual interviews with a strategic sample of school nurses (n=12) (PI), a national survey to a representative sample of school nurses (n=129) (PII, III) and the implementation of family nursing models developed in Canada with girls in their early adolescence with recurrent health complaints and their families (n=4) in co-operation with their school nurses (n=2) (PIV). The Strengths and Difficulties Questionnaire (SDQ) was used as pre and post test. Evaluation interviews were conducted with the families and the nurses separately. Qualitative content analyses were used to analyze the interview text with the school nurses and the families. Manifest content analysis was used to analyze the free text answers of the survey and the evaluation interview with the school nurses. Descriptive statistical analyses were used to describe demographic data in all four papers. The SDQ was hand-scored statistically.

Findings: The findings showed that nurses judged the schoolchildren's mental health as deteriorated, especially in socially disadvantaged areas and more generally among girls expressed as psychosomatic symptoms. Individual factors related to lifestyle affected the schoolchildren's physical health, and the mental health was, to a large extent, affected by the school environment and family relations. The latter seemed to be the most important factor affecting schoolchildren's mental health. The basis for the school nurses judgement of the physical health was health check-ups and the health dialogues. Spontaneous visits were more commonly used to judge the mental health. Recording schoolchildren's mental health was a challenge for school nurses. Difficulties were related to ethical considerations, tradition, lack of time and the improper structure of the SHR. Fears of marking the schoolchild for life related to the schoolchild itself, the parents or to other authorities/successive caregivers were brought up as hindrances for recording mental and social health. Family sessions may be useful within the profession when handling recurrent health complaints among adolescence girls. The girls and their families experienced relief, they felt confirmed and that their feelings and reactions were normal in that situation. The families became aware of their own strengths and possibilities and this was supported by the SDQ which showed an increased well-being. The school nurses valued this way of working and meant that the sessions seemed to start a changing process within the families.

Conclusions: The results indicate that school nurses have a deep knowledge about schoolchildren's health which is not used to its full potential in a public health perspective. However, the experienced difficulties recording schoolchildren's mental health seem obvious, which would demand developing the SHR for the needs of today. Family sessions in SHS with the school nurse as a collaborator with the family seemed useful and may be transferable to other health problems expressed by the schoolchildren. Bronfenbrenner's ecological systems theory and other models for health determinants are used to illustrate the school nurse as a mediator working on the bridge over different health streams with schoolchildren's health on an individual and a population level.

Key words: Schoolchildren's health, school health service, school nurse, school health record, ethic, family, intervention, SDQ, Bronfenbrenner

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SVENSK SAMMANFATTNING

Syfte: Avhandlingens övergripande syfte är att undersöka skolsköterskors uppfattning om skolbarns hälsa och att analysera faktorer som påverkar dokumentation av skolbarns hälsa i skolhälsovårdsjournalen. Ett ytterligare syfte är att utvärdera modeller för familjeinterventioner som redskap för skolsköterskor i skolhälsovård.

Metoder: Avhandlingen består av fyra delarbeten. En kombination av kvalitativa och kvantitativa metoder användes. I delarbete **I** genomfördes intervjuer med ett strategiskt urval av skolsköterskor (n=12). I delarbeten **II** och **III** distribuerades en nationell enkät till ett representativt urval av Sveriges skolsköterskor (n=129). I delarbete **IV** genomfördes en interventionsstudie med familjesamtal, inspirerad av modeller för familjefokuserad omvårdnad utvecklade i Kanada. Skolflickor i tidig adolescens med återkommande subjektiva hälsoproblem (n=4) och deras föräldrar i samarbete med deras verksamma skolsköterskor (n=2) ingick i studien. The Strengths and Difficulties Questionnaire (SDQ) användes som före/efter test vid interventionen. Separata utvärderingsintervjuer genomfördes med familjer och skolsköterskor. Intervjuerna med skolsköterskorna och familjerna analyserades med kvalitativ innehållsanalys. Manifest innehållsanalys användes vid analys av de öppna frågorna samt vid utvärderingsintervjun av skolsköterskorna. Deskriptiv statistik användes för analys av demografisk data i samtliga delarbeten. SDQ bearbetades statistiskt manuellt.

Resultat: Resultatet visade att skolsköterskorna bedömde skolbarnens mentala hälsa som försämrad särskilt bland flickor och i socioekonomiskt utsatta områden. Individuella livsstilsfaktorer påverkade skolbarnens fysiska hälsa och den mentala hälsan var i stor utsträckning påverkad av skolmiljö och familjerelationer. Det sistnämnda verkade vara den mest betydelsefulla påverkansfaktorn för skolbarnens mentala hälsa. Bedömningen av den fysiska hälsan baserades på hälsokontroller och hälsosamtal medan spontana besök var vanligare för bedömning av den mentala hälsan. Dokumentation av mental hälsa var en utmaning för skolsköterskorna. Svårigheterna kunde relateras till etiska överväganden, tradition och tidsbrist samt till skolhälsovårdsjournalens struktur som inte ansågs uppfylla dagens krav. Skolsköterskorna uttryckte en rädsla för att journalanteckningarna skulle märka skolbarnet för livet. Framtida tolkningar relaterade till skolbarnet själv, föräldrar eller andra/påföljande vårdgivare uttrycktes som hinder för att dokumentera mental och social hälsa. Familjesamtal visade sig vara användbara i skolhälsovården. De medverkande flickorna och deras familjer kände sig bekräftade i att deras känslor och reaktioner var normala. De sade sig bli medvetna om egna styrkor och möjligheter vilket styrktes av SDQ som visade ett ökat välbefinnande efter sammankomsterna, både hos skolbarnen och hos föräldrarna. Skolsköterskorna var positiva till att arbeta med familjesamtal och upplevde sig mer som samverkanspartner än som expert. Samtalen ledde till att en förändringsprocess startade i familjerna enligt skolsköterskorna.

Slutsatser: Resultatet indikerar att skolsköterskor har en djup kunskap om skolbarns hälsa som sannolikt kunde tas tillvara på ett bättre sätt ur ett folkhälsoperspektiv på såväl nationell som lokal nivå. Behovet av att utveckla skolhälsovårdsjournalen efter dagens behov och fördjupad kunskap om de upplevda svårigheterna att dokumentera skolbarns mentala hälsa är uppenbar. Familjesamtal, där skolsköterskan intar en roll som samverkanspartner, visade sig användbara och kan sannolikt överföras till andra hälsoproblem bland skolbarn. Bronfenbrenners utvecklingsekologiska systemteori och andra modeller för hälsodeterminanter används för att illustrera skolsköterskans arbete med skolbarns hälsa på såväl en individuell nivå som folkhälsönivå.

Nyckelord: Skolbarns hälsa, skolhälsovård, skolsköterska, skolhälsovårdsjournal, etik, familj, intervention, SDQ, Bronfenbrenner

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ORIGINAL PUBLICATIONS

This thesis for the degree of doctor in public health is based on the following papers referred to in the text by their Roman numerals:

- I. Clausson, E., Petersson, K. & Berg, A. (2003). School nurses' view of the schoolchildren's health and their attitudes to document it in the school health record – a pilot study. *Scandinavian Journal of Caring Sciences*, 17, 392-398.
- II. Clausson, E., Köhler, L. & Berg, A. Schoolchildren's health as judged by Swedish school nurses – a national survey. (Accepted, *Scandinavian Journal of Public Health*).
- III. Clausson, E., Köhler, L. & Berg, A. (2008). Ethical challenges for school nurses in documenting schoolchildren's health. *Nursing Ethics*, 15(1), 31-42.
- IV. Clausson, E. & Berg, A. Family intervention sessions in School health service – a way to improve schoolchildren's mental health. (Accepted, *Journal of Family Nursing*).

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ABBREVIATIONS

CFAM the Calgary Family Assessment Model

CFIM the Calgary Family Intervention Model

CHS Child Health Service

HBSC Health Behaviour in School aged Children

HP Health Promotion

IBM the Illness Belief Model

LU Lund University

SDQ Strengths and Difficulties Questionnaire

SHR School Health Record

SHS School Health Service

SPSS Statistical Package for the Social Sciences

WMA World Medical Association

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PREFACE

My interest in schoolchildren's health and well-being arose from a ten year working period as a school nurse in a compulsory school during the 1980s and 1990s. Working with schoolchildren's health and well-being includes cooperation with parents, teachers and other professionals. The experience of increasing frequency of spontaneous consultations from schoolchildren with health complaints sometimes led to insecurity of how to handle schoolchildren's confiding talk in relation to their families and other involved. The tradition in the profession focusing on the physical health also led to discussions with other school nurses of how to document and handle schoolchildren's increasingly frequent expressions of mental and social health problems. During my master studies I became interested in how to deal with schoolchildren's health from a family perspective. School Health Services (SHS) is a multidisciplinary issue, and public health science was an obvious choice for further in depth studies.

INTRODUCTION

Children's health is a wide concept, including not only medical aspects, such as freedom from disease, but also positive elements in the physical, mental and social spheres (Köhler & Barnard, 1995). Schoolchildren's self-reported health during the past decades has continuously been followed by the World Health Organisation (WHO) in their recurrent studies of Health Behaviour in School-Age Children (HBSC, 2004). School nurses' experiences and perceptions of schoolchildren's health as well as methods for improving schoolchildren's health have not been studied to a larger extent. This thesis explores schoolchildren's health through school nurses' descriptions and evaluates a model for family nursing intervention. Traditionally school nurses work on an individual level with a public health commission. The introduction describes the concept health from an overall view followed by public health with health promotion incorporated in that section. Child public health with SHS as an agency in this field is described, followed by a literature review of schoolchildren's health and well-being emphasising Swedish conditions. Determinants of schoolchildren's health in context are illustrated by selected theories and models. School nurses' different roles and family nursing models for health promotion are also described.

Health

WHO, in 1946 defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. WHO adopted in 1981 the strategy “Health for All by the Year 2000” (HFA 2000). This strategy states that health is a resource for everyday life, not the objective of living (WHO, 1981). The underlying ideology is equity in health and it has developed into Targets for Europe (WHO, 1998a, WHO, 1998b). The European policy has two main aims and three basic values on ethics. The aims are: to protect and promote people’s health throughout their lives, and to reduce the incidence of main disease and injuries. The basic values are: health as a fundamental human right; equity in health and solidarity in action; and participation and accountability of individuals, groups, institutions and communities for continued health development. One of four main action strategies is integrated family- and community-oriented primary health care. The 21 targets in Health 21 constitute a framework to inspire developing health policies in the European countries (WHO, 1998a). Nordenfelt (1995) characterises a person’s health as his ability to achieve his vital goals. A healthy person feels well and can function in his social context (ibid). According to Lindström (1994) the child’s resources for a good life are found in external, interpersonal and personal spheres, both objective and subjective. Considering these spheres, protecting children’s health is a concern for health professionals on an individual as well as on a population based level.

Public Health

The concept Public Health, developed by Winslow in the 1930s and by WHO in the 1950s, is defined in many different ways, and commonly in terms of it aims - to reduce disease and maintain health for the population as a whole (Acheson, 1988, Beaglehole & Bonita, 2001). The Swedish National Committee of Public Health (SOU 2000:91), defines Public Health as a multi scientific area of knowledge with special focus on the influence of society structure, environment health care system on the health of a society’s population and the efficiency of the health care. The task of Public Health is to protect and improve the health and includes co-operation of many sectors and professions (UNESCO, 2007). Basic topics of Public Health are social medicine, environmental health, epidemiology and health care management, but additional competence is to be found in social and behaviour science, nursing science, health economy, medical ethics, scientific theory and political science (SOU

2000:91). Health Promotion (HP) is defined by WHO as a process of empowerment of individuals, families and communities, by which people gain greater control over decisions and actions affecting their health (WHO, 2005b). One of four key commitments in the Bangkok Charter for Health Promotion in a Globalized World (2005b) is focused on communities and civil society and points out the needs for amplifying and sustaining resources in the area (ibid). The document also stresses the effectiveness of well organized and empowered communities to determine the citizens' health. Naidoo and Wills (2000) put forward the importance of HP as an integrating approach to identify and do healths work. This encompasses interventions and activities intended to prevent ill health, promote a healthier lifestyle, or address wider social and environmental factors influencing people's health. HP means encouraging collaboration with children, families and between various professionals and is also emphasized in the recent guidelines for the School Health Service stated by the Swedish National Board of Health and Welfare (Socialstyrelsen, 2004). Public health includes the whole population and there are several major reasons why children's health and well being are of special importance in this connection (Köhler, 1998).

Child Public Health

Child Public Health is defined by Köhler as "the organised efforts of society to develop healthy public health policies to promote children's and young people's health, to prevent disease in children and young people and to foster equity for children and young people, within a framework of sustainable development" (Blair, Stewart-Brown, Waterston & Crowther, 2004, p 2). Children make up 20 per cent of the population in European countries, represent a vulnerable group which is depending on others for survival and health and which has no political power (Köhler, 1998). Child public health implies a broad concept, and in order to better understand children's health problems, the professionals need to be aware of the social context and the need to promote inter- professional team working. The three principal concerns for child public health is: education and training of child health workers; research in various forms designed to increase understand of different child health phenomena and improvement of children's health; and lastly working with different groups and sectors where actions have a potential impact on children's health (ibid). The strength of child public health work is its base in WHO Health for All Strategy, which places children's and young people in their social, economic and political context (Köhler, 2006). Child health

service and school health service are existing components in child public health, however, there is a need for clear strategies for common goals and collaboration (Köhler, 1998).

Moreover, health in childhood determines health throughout life and into the next generation (WHO, 2005c). The family is the core structure for children and, thus, supporting parents is a key task for those concerned with child public health (Blair et al, 2004). Sweden's new public health policy, identified by the National Institute of Public Health (Statens folkhälsoinstitut, 2003), is based on eleven general objectives with an overall aim to create good health on equal terms for the entire population. Goal number three, concerning children and young people, states the importance of preventive measures for e.g. developing health promoting schools (ibid). Four cornerstones considering the school have been developed including the classroom environment; the parents; the pupil welfare (elevhälsa); and spare time (Statens folkhälsoinstitut, 2007). These aspects are all important for the work of the school nurse. The importance of more actively promoting health and medical care is emphasized in goal number six for e.g. combating mental ill health early in life and thereby avoiding treatment later in life (Statens folkhälsoinstitut, 2003). The Convention of the Rights of the Child (UN, 1989), states the right of the child to enjoy the highest attainable standard of health, article 24. Additionally, article 3 emphasises that the best interests of the child shall be a primary consideration in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies (ibid).

School Health Services

School Health Services (SHS) is a part of child public health in Sweden, and a community agent in the field of HP for schoolchildren's health and well-being. The activity comprises almost every individual aged 6-19 as well as their families (Socialstyrelsen, 2004). In the light of the Bangkok charter the SHS is of great importance for HP in the communities, provided that resources spent on the activity are well-balanced (WHO, 2005b). SHS is also a part of the pupil welfare team with the principal as overall responsible for the activity (SOU 2000:19). Social workers and psychologists are included as special pupil welfare resources together with the SHS. However, the SHS is, according to the law, the only compulsory part and the

distribution of the resources varies considerably, from one half-time to seven full-time workers per 1000 pupils (Backlund, 2007). The municipalities have the responsibility for the SHS (Socialstyrelsen, 1998) and several official reports stress the importance of pupils' access to a well-established SHS (SOU 1997:116, SOU 1997:119, SOU 1998:31). The main objective of the SHS is, according to the Swedish School Act (SFS, 1985a), "to follow, maintain and recover the pupils' physical, mental and social health". School nurses and physicians are employed by the municipality authorities. One of the tasks of the SHS is early detection of delayed development and other impairments. The nurse carries out the child health program together with the physician. Traditionally the SHS has had an individual perspective. The special needs of the schoolchildren should, in consultation with parents/custodians and the pupil, be paid attention to, investigated and be acted upon within the school. Since school nurses regularly have their consulting room located in school, they work close to the schoolchildren during their school age years. This gives them the opportunity to follow and promote health as well as care for their ill health in collaboration with school physicians, parents, teachers and other involved professionals, within or outside the school environment (Socialstyrelsen, 2004).

School children's health and well-being

During the past decades, in Sweden as well as internationally, several studies have shown an escalating amount of mental health problems among schoolchildren (Berntsson, 2000, Sawyer, Arney, Baghurst, Clark, Graetz, Kosky, et al, 2001, HBSC, 2004, Grøholt & Nordhagen, 2005, Statens Folkhälsoinstitut, 2005, Brown, Teufel, Birch & Kancherla, 2006, Hagqvist & Forsberg, 2007). Schoolchildren rating their own health as poor are increasingly frequent. Girls rate their health poorer than boys, more so with increasing age. Health inequity has increased in Sweden as in most other countries and schoolchildren living in socioeconomic disadvantaged areas report their health as poorer. In the Nordic countries Norwegian schoolchildren rated their health as rather poor compared to Finland, with Sweden and Denmark somewhere in between (HBSC, 2004). Adolescence is usually considered to be a very healthy part of life, both objectively and subjectively (Statens Folkhälsoinstitut, 2005) although recent reports show an alarming increase in subjective health complaints and long-term illnesses (Natvig, Albrektsen, Anderssen & Qvarnström, 1999, Berntsson, 2000, Danielsson & Marklund, 2000, Danielsson, 2003). The reasons are not clear, but it is

thought that the accelerating stress in society, combined with economic strains and changes in family structures are important factors in this development (Berntsson, Köhler & Gustafsson, 2001). Bredablik, Meland and Lydersen (2008) found that self-rated health in adolescence is a complex relation of medical, psychological, social and lifestyle factors with mental health and general well-being strongly interrelated. Obviously, the health and well-being of children as well as adults is a multifactor issue, where individual traits, family networks and social structures are closely involved and interlinked (Bremberg, 1999, Berntsson, 2000, Blum Beuhring, Shew, Sieving & Resnick, 2000, Statens Folkhälsoinstitut, 2003). The consequences of the increased mental health problems are met in many areas, but most notably in school (WHO, 1997) and a lot of information about health of the individuals is collected in schools (Grøholt & Nordhagen, 2005). However, the knowledge about schoolchildren's mental health is sparse (ibid). The Children Psychiatry Committee emphasises the importance of prevention and early efforts when working with mental health/ill health (SOU 1998:31).

Schoolchildren's expressions of mental health problems

Mental health is an integral part of the WHO definition of health and can be conceptualised as a state of well-being in which the individual realizes his or her own abilities and can cope with the normal stresses of life (WHO, 2007). The recurrent WHO studies show that adolescent girls more frequently report health complaints as signs of mental health problems (Danielsson, 2003, HBSC, 2004). Expressions of mental health problems such as frequent headache and stomach pain are often used in terms of psychosomatic with no organic aetiology (Knishkowsky, Palti, Tima, Adler & Gofin, 1995). Dorland's Illustrated Medical Dictionary (1988) defines psychosomatic as pertaining to the mind-body relationship; having bodily symptoms of psychic, emotional, or mental origin. There seems to be different theories of its origin, heredity weakness is one and another is conflicts and emotional disturbances (Cederblad, 2001). Several studies have shown that the pattern of interplay in the family can be of importance for the developing of psychosomatic symptoms among children and youths (ibid) and socioeconomic factors in the family are associated with the occurrence of headache among schoolchildren (Kristjánsdóttir, 1996). Psychosomatic pain is common in childhood and approximately 50-75 per cent of all school children sometimes have non-organic pain (Alfvén, 1997). Recurrent abdominal pain is one of the most

common types of chronic non-malignant pain in children (McCaffery & Beebe, 1994) and recurrent headache one of the most common health problem amongst children and adolescents (Olsson & Jylli, 2001). Pain that has lasted three months or longer, recurs on a regular basis, and does not respond to currently available treatment methods can be defined as chronic pain (McCaffery & Beebe, 1994). A study by Petersen, Brulin and Bergström (2006) showed that half of the children with recurrent pain reported pain symptoms from several locations and two out of three children with weekly symptoms reported multiple pains. Kristjánsdóttir and Rhee (2002) showed that life style and social factors are associated with frequent back pain among schoolchildren. Consequently, recurrent pains are a Public Health concern in school-age children (Kristjánsdóttir, 1996). In this thesis “health complaints” are used referring to psychosomatic symptoms.

Schoolchildren’s health in context

Children’s and families’ conditions are always a part of the social context (Bronfenbrenner, 1977, Lagerberg & Sundelin, 2000, European commission, 2002). Bronfenbrenner’s (1977) Ecological Systems Theory can be used as a model to illustrate factors influencing schoolchildren’s health. The theory looks at a child’s development within the context of the system of relationships forming his or her environment. The process is seen as an ongoing development throughout life which depends on relations inside and between local environments and larger social contexts (Lagerberg & Sundelin, 2000). The theory is built on four systems, each encompassing the other (Bronfenbrenner, 1977). The *micro system* is closest to the child and contains structures as family, school and mates. At this level the relationships have impact in directions both away from and towards the child. The *meso system* provides the connections and relations between the different micro systems. The *exo system* defines the larger social systems in which the child does not function directly but has impact on the micro level structure such as parent’s workplace and authorities. The *macro system* level comprises of e.g. cultural values, customs and laws influencing the interactions of all other layers (ibid). A subsequent level, the *chrono system*, encompasses a time dimension, either external as the timing of a parent’s death or internal, such as physiological changes through aging (Paquette & Ryan, 2001). A framework for socioeconomic determinants of children’s health and development context is adapted by the Child Health Indicators of Life and Development (CHILD) project (European Commission, 2002). The framework illustrates the complex environment that children grow up in, influenced by

physiological, familial, domestic, social, and physical elements which can have positive or negative influences on health. Policies and service responsibilities are also included (ibid). Another framework for socioeconomic determinants of health, developed in Australia, is outgoing from Upstream, Midstream and Downstream levels (Turrell, Oldenburg, McGuffog & Dent, 1999). The *Upstream* includes macro-level factors such as policies, welfare and culture, the *Midstream* describes intermediate-level factors like health care system and health behaviours connected to contexts. The *Downstream* contains micro-level factors connected to physiological and biological systems in turn connected to e.g. mortality and quality of life (ibid).

School nursing

According to the International Council of Nurses (ICN), nursing in general encompasses autonomous and collaborative care of individuals of all ages and families, sick or well and in all settings and includes, the promotion of health, prevention of illness, and the care of ill and/or disabled people (ICN, 2005). The nursing role includes advocacy and promotion of a safe environment (ibid). Nursing in SHS encompasses children in the school-age period from 6-7 to 19 years of age. The school nurse is the key person in the SHS and continues the health surveillance and immunisations from the Child Health Services (CHS) (Socialstyrelsen, 1998). The first Swedish school nurse was employed by the City of Stockholm in the beginning of the 20th century and was called “the louse teacher”. The most common public health problem was infectious diseases (Vårdförbundet, 1991). The health problems of today are often connected to psychosocial circumstances. Early diagnoses of problems, psychological or physical, are of great importance for the condition of the schoolchildren in the future (Wang & Köhler, 1998). SHS work for healthy lifestyles can be carried out in different ways, e.g. through individual contacts, in groups and/or through general efforts towards a special age group or school (Socialstyrelsen, 2004). According to Krantz (1998), school nurses activities can be divided into three main areas, namely individual pupil-related, group-related and administration, planning and education. More than two-thirds of the working time is spent on individual and group related health care activities such as the health dialogues, including individual health status, and health education (Krantz, 1998). Nevertheless, school nurses’ working role is ambiguous and in one interview study by Morberg, Delllve, Karlsson & Lagerström (2006) school nurses’ role was found to be unclear with difficulties to argue for the importance of their work.

Health dialogue

The Health dialogue is developed by school nurses as a natural part of recurrent health visits and as an opportunity to meet the individual school child and talk about health from their own point of view (Socialstyrelsen, 2004). One intention of the health dialogue is to give schoolchildren an opportunity to reflect and be aware of causal connection between possible health problems and their own life situation (ibid). Borup & Holstein (2004) studied schoolchildren's self-reported outcome of the health dialogue with school nurses. Most schoolchildren discussed the content of the dialogue with others and made decisions based on the dialogue. Schoolchildren from lower social classes seemed to benefit more (ibid). Prerequisites for a good mental health-promoting dialogue of school nurses from adolescents' perspective were studied by Johansson & Ehnfors (2006). Essential dimensions in promoting a good health dialogue between the adolescent pupils and the school nurse were trustfulness, attentiveness, respectfulness, authenticity, accessibility and continuity (ibid).

Recording

Good nursing comprises a reliable documentation (Ehnfors, Thorell-Ekstrand & Ehrenberg, 1991). The keeping of records is regulated by law and by a number of regulations published by the National Board of Health and Welfare (SFS, 1980, SFS, 1985b, Socialstyrelsen, 1989). The knowledge about school children's health is seldom systematised and data from SHS is incomplete and unreliable (Köhler & Jacobsson, 1991). The present School Health Record (SHR) is standardized and used nationally since 1989 (Socialstyrelsen, 1998). The record contains specific diagrams and columns for growth (updated version 2001), vision and hearing related to recurrent health checkups. There are columns for health history and health status. The record manual, prepared by the Swedish National Board of Education, recommends keywords when documenting reasons for schoolchildren's physical (n=14), mental (n=6) social (n=2) and unspecified (n=2) health consultations to SHS (Skolöverstyrelsen, 1990). Nursing interventions are not mentioned but there is space for handwritten notes (ibid). Nursing models for documenting in patient records have been used in Sweden since 1991 and the Wellbeing, Integrity, Prevention, Safety model (VIPS), inspired by Donabedian's (1986) Nursing process model, is used in varying care context (Ehnfors, Thorell-Ekstrand & Ehrenberg, 1991, Ehrenberg, Ehnfors & Thorell-Ekstrand, 1996). Examination of SHR and interviews with school nurses have shown that

most information of mental health and relational problems are missing in the records (Rydell & Sundelin, 1988). A reliable documentation is important for describing school children's health and can be used as a source for community planning (Socialstyrelsen, 1998). The content of records in the Child Health Service, a closely related area to SHS, was studied by Hagelin (1998). The result showed insufficient completeness, reliability and concordance in relation to health check ups, health information and assessments. Documentation about psychosocial conditions was lacking in the majority of the records (ibid). There are reasons to believe that these results are transferable to SHS.

Nursing ethics

Ethical practice in nursing can be described as both a way of being and a process of enactment (Doane Hartrick & Varcoe, 2005). The International Council of Nurses has developed standards of ethical conduct based on four principal elements; nurses and people; nurses and practice; nurses and profession; and nurses and co-workers (ICN, 2005). The first mentioned element comprises the respect for human rights and sensitiveness to values and beliefs of all people. The importance of ensuring confidentiality when managing recording and information systems is also emphasized (ibid). However, maintaining confidentiality of schoolchildren's health and family apprehensions can be a greater concern in a small community where people know each other in and beyond the school setting (Solum & Schaffer, 2003). The school nurses, in accordance with the Swedish school act, are supposed to promote and prevent all aspects of schoolchildren's health. The role includes advocating children's highest attainable health during the school age period and thereby follows the intention of the Convention of the Right of the Child in Article 12, which states the right of the child to form his or her own views and the right to express those freely and given due weight in accordance with age and maturity (UN, 1989). This could also mean advocating schoolchildren's rights in relation to teachers, other caregivers and/or custodians. The Swedish Official Secrets Act (SFS, 1980) comprises the SHS and points out the importance of secrecy in relation to other authorities and, in specific cases for protection of a child's health and welfare, also against the parents. On the other hand the Social Services Act emphasises that the SHS is duty bound to immediately notify the social services about matters, which can imply a need for intervention to protect a child (SFS, 2002). Furthermore, recording sensitive health information, such as mental

illness, is discussed by Schwab & Pohlman (2004) and it is stated that documentation of the nurse's assessment and interventions or other matters related to the nursing process is essential to safe care and critical problem solving.

School nurses' changing role

Schoolchildren's changing health patterns with increasing subjective expressions of mental ill health demand a health promotive way of working (Socialstyrelsen, 2004). Moreover, an active co-operation with the custodians and professionals involved in schoolchildren's health is emphasized. In a qualitative interview study with school nurses (Ahlnäs, 1999) it is hypothesised that improved communication and collaboration between schoolchildren, school nurse, other school professionals, and parents facilitates the promotion of mental health and wellbeing of schoolchildren. Social support seems to prevent the negative consequences of stress experience (Natvig et al, 1999) and involving parents and family can benefit young people (Blum et al, 2000).

Family nursing

Using theoretical nursing knowledge in practice was founded already by Florence Nightingale although the existing of mature theories in nursing is a continuing debate (Kim & Kollack, 1999). The concept family nursing can be described as "a scientific discipline based in theory" (Harmon Hanson, Gedaly-Duff & Kaakinen, 2005, p 6) and using family nursing models may be one way of working with schoolchildren expressing recurrent health complaints. The adolescence signifies a developing phase where the own identity is formed and a gradual liberation from the family of origin takes place (Erikson, 1969). This phase can be obstructed among young people with health problems (Wright, Watson & Bell, 1996). Family nursing interventions are inspired by different forms of family therapy but normally related to illness or disease within the family and developed as working tools connected to the nursing profession (Kirkevold, Strömsnes-Ekern, 2003). Calgary Family Assessment Model (CFAM) is developed in Canada by Wright and Leahey (1994) for nurses who work with families where one of the members suffers from a chronic disease or illness. The Calgary Family Intervention Model (CFIM) is a companion to the CFAM, and is the first model for family treatment developed in the field of healthcare (Wright & Leahey, 1994). The underlying theoretical presumptions of the clinical models are founded

in The Illness Belief Model (IBM) focusing on the significance of constraining and/or facilitating beliefs connected to illness and disease (Wright, Watson & Bell, 1996). Challenging family members' different beliefs of causal connections of the origin of disease/symptoms, treatment and compliance is a way for nurses to promote healing (ibid). CFAM has its basis in System Theory, Cybernetics, Communications Theory and Theory of Change and consists of three main categories, namely the structural, the developmental, and the functional. The structural assessment implies mapping the family structure and their relations both inside and outside the family. The family is defined as persons living together and/or who have emotional ties and obligations toward one another. The developmental assessment estimates the life cycle the family finds itself in, along with connection patterns within the family. The functional assessment deals with how the persons act towards each other, from the description by the family, but also from the observations of the nurse. It can be divided into an instrumental part and an expressive part. These two parts often coincide, since in a family with instrumental problems there are often expressive problems as well. The instrumental function includes daily routines like food and sleep. In families with health problems this is often an important issue and could imply adjustments for the other family members, e.g. meal hours and food composition. The expressive function embraces nine subcategories. Four of these signify how the family communicates and the others are problem solving, roles, influence, convictions, and alliances. The focus of the assessment should be the family as a unity and not the individual members (Wright & Leahey, 1994).

CFAM includes a genogram and an eco-map, which are two instruments for evaluation of the inner and outer structure of the family. The genogram describes the family constellation and the eco-map drafts the contacts outside the family. Both instruments are simple to use and only demand paper and pen. The family can actively participate in the creation of the genogram and the eco-map. The instruments can increase the nurses', as well as the families', understanding of the interacting with the surroundings. The purpose is to find the family's strengths and contacts with the surroundings to be able to develop these (Wright & Leahey, 1994). CFIM focuses on, through care measures in consensus with the family, promoting, improving, and/or maintaining the family function within the cognitive (e.g. knowledge about and attitudes towards symptoms), affective (e.g. feelings of anxiety and fear), and

behavioural (e.g. symptoms control) areas. After the implementation of a thorough family evaluation, where the result indicates needs for family treatment, the nurse considers the factors that need to be addressed to promote change. The family can be offered different measures but an essential factor for change to take place is the family's choice. The deepest and the most profound change is often the one that affects the family's perceptions and beliefs (cognition). It is of importance for the measures to be tailored to fit the family (Wright & Leahey, 1994). An apparently simple but powerful care measure to promote change in the cognitive, affective, and behavioural areas of the family's function is to use intervening questions which in the CFIM model are developed from Tomm's (1989) systemic interview methodology. It is essential to be clear about when, how, and to what purpose questions should be asked. Intervening questions can roughly be divided into linear (investigative) and circular (explaining). Linear questions can detect the convictions and the means to describe problems, i.e. cause and effect, of the family. The circular questions can, in turn, be divided into "difference questions" (investigates differences between people, convictions, etc.), behavioural effect questions (investigates effects of behaviour), hypothetical/future oriented questions (investigates alternatives in the future), and triadic questions (questions to one person about the relationship between two others). In the model it is emphasised that it is not the question in itself that is important, but how effective it is to promote change. Examples of other interventions that can be initiated by the nurse are to emphasize the family's resources, give information, rephrase, educate, and externalise problems, all in the field of cognition; in the affective area, to confirm/normalise emotional reactions, let the family talk about its experience of the illness, and mobilise the family support; in the field of behaviour, to encourage the care responsibilities of the family members, offer relief of pressure, and perform rituals (Wright & Leahey, 1994). The models are well known and used in practice and research during the last twenty years; however, there is a lack of intervention studies (Wright, Bell & Moules, 2005). Since the models are developed in a Canadian care context their applicability need to be examined before using these models in a Swedish context.

Background for the specific studies

To sum up, Swedish school nurses are in a position where they meet practically all schoolchildren in the country several times during the school period. This means they have the opportunity to get an overview of, as well as follow, changes in the health panorama of the schoolchildren over time, both as individuals and as a group. However, there is no tradition in the profession for proper recording of the findings from health dialogues or other contacts with schoolchildren, and scientific publications are sparse from the school nurses' point of view. A reliable recording of the health status is the basis for a safe care and quality assurance of the activity. It is also the foundation for a systematic reporting of schoolchildren's health status. Approved practice dominates the content of the work and evidence based methods are less described, used and evaluated in SHS, both for individuals and for groups. In order to explore schoolchildren's health from a school nurse perspective and open up for a discussion about the role of the school nurse in the future it seems important to mirror the school nurses' perceptions of the schoolchildren's health and their experience of recording in the SHR. An increased awareness of the importance of reporting schoolchildren's health status properly could influence child public health in a longer perspective. Previous research shows the increasing mental ill health among schoolchildren in which the family plays an important role. Developing and assessing methods that can be used by school nurses in their work therefore seems important both from a scientific and a practical point of view. Implementation and evaluation of family nursing models from Canada will be used for schoolchildren suffering from health complaints, their families and active school nurses. Hopefully the results from this thesis will contribute to the use of evaluation based working models within the profession as well as show opportunities to make the school nurses' work apparent.

AIMS

The overall aim of this thesis is to explore school health nursing through school nurses' descriptions of school children's health and to analyse factors influencing the recording of schoolchildren's health in the SHR. An additional aim is to evaluate family nursing interventions as a tool for the school nurses.

Specific aims:

- to describe school nurses' view of the schoolchildren's health and their attitudes towards documenting it in the SHR. A further aim was to develop a national questionnaire (**Paper I**).
- to use school nurses' knowledge and experience for a better understanding of schoolchildren's health problems and their association to socioeconomic background and gender (**Paper II**).
- to further explore factors influencing the school nurses' documentation in the SHR and thereby create a reservoir of knowledge that could be opened up for broader discussion on developing a safe documentation for the benefit of schoolchildren's health and well-being (**Paper III**).
- to evaluate the use of family interventions as a tool for school nurses to handle mental health problems among schoolchildren (**Paper IV**).

MATERIAL and METHODS

Research design

The research design is determined by the overall aim of the study. Since school health nursing is a rarely explored research area an inductive approach was natural. The presumption of reality and knowledge as a process emanating from different paradigms with interdisciplinary effort is the basis for the studies. In accordance with this an explorative design combining quantitative and qualitative research methods was chosen since different methods complement each other by revealing, clarifying and understanding various aspects of the research questions (Polit & Beck, 2004). Quantitative methods are based on the scientific approach used in the natural sciences rooted in the positivistic tradition and qualitative methods are based on a naturalistic tradition with roots in social science and humanism (Lindholm, 1998, Polkinghorne, 2006). Blending different research methods raise questions such as the commensurability of different paradigms. However, Lincoln & Guba (2005) imply that blending elements of one paradigm into another may represents the best of both views. Since Public Health is a multidisciplinary research area the standpoint in this thesis is in accordance with these ideas.

Quantitative data from representative samples are often strong in generalizability but the validity can be called into question since the human experiences are reduced into numbers and capture only a limited variety of such experiences. Qualitative research on the other hand is not generalizable but is strong in its potential to gain insight and deepen knowledge in complex questions. The inquirer interacts with those being researched, findings are created in interactive processes and patterns are sought after (Polkinghorne, 2006). The researcher is the data collection instrument and creates the analytic process, and thus may be regarded as subjective. A clarification of the researchers' personal connections to the people, topic or community under study is necessary to enhance credibility (Polit & Beck, 2004). Qualitative methods deal with questions, such as what are the dimensions of the phenomenon, what variations exist, and what is important about the phenomenon (Polit & Beck, 2004 p 19). The weakness of a single approach may be diminished or overcome by integrating different methods and modes of analyses (Polit & Beck, 2004)

This thesis was formulated with the purpose to explore school health nursing from school nurses' perspective and to evaluate a family intervention from the perspective of school children, their families and school nurses. These different perspectives claim for methods revealing varying understanding in enhancing comprehension of the topic being studied. A pilot study, with qualitative approach, describing school nurses' experience of schoolchildren's health and recording in the SHR (paper **I**) created a picture of schoolchildren's health and how to document it from a school nurse perspective and formed the basis for a questionnaire in order to try out the result from the pilot study on a national basis (paper **II** and **III**). The greatest advantage of survey research is its flexibility and the possibility to include a wide range of topics (Polit & Beck, 2004). Disadvantages are e.g. the risk for low response rates.

The family intervention study (paper **IV**) was evaluated with both qualitative and quantitative methods. The intervention was achieved through the implementation of family nursing models developed in Canada by Wright & Leahey (1994). The rationale for using multi methods was that data can complement each other in interpreting the findings (Polit & Beck, 2004). When evaluating complex interventions the use of qualitative data is especially useful. The reason for that is that when e.g. approaching new ways of interacting in care settings it can be difficult to understand what really

caused the differences. In this study there was a need to understand how people perceived the intervention and reacted to it. Interviews with people from different perspectives were well suited for this purpose (ibid, p 282). In this study the family and the school nurses were interviewed separately about their perceptions. Pre- and post-test with a self-rating questionnaire was used to evaluate the intervention from the schoolchildren's and the parents' perspective. An overview of the papers is shown in Table 1.

Table 1. An overview of Paper I-IV

Paper	I	II	III	IV
Year	1996-2001	2005	2005	2004
Design				
Explorative, descriptive Intervention	X	X	X	X
Participants				
Active school nurses	n=12	n=129	n=129	n=2
Families/Family members				n=4/11
Data collection				
Questionnaires	X	X	X	X
Data analysis				
Qualitative content analysis	X			X
Manifest content analysis		X	X	X
Descriptive statistics		X	X	X

Settings

All studies were performed in Sweden in an SHS context. The studies in paper **II** and **III** were accomplished in 2005 on a national basis and the studies in paper **I** and **IV** were performed in the southern part of the country. Municipalities of varied sizes and social structures were represented in the pilot study during a period between 1996 and 2001 (Paper **I**). Both compulsory schools (CS) and upper secondary schools (US) were represented as well as public and independent schools. The school nurses were divided into two socio-economic areas based on the nurses' judgement of their main service (paper **II – III**). The family intervention study (paper **IV**) was performed 2004 and included school nurses, schoolchildren and their families in two middle-sized municipalities. The settings in paper **I-IV** are described in Table 2.

Table 2. Descriptions of the settings in Paper I-IV

Characteristics	Paper I (n=12)	Paper II-III (n=129)	Paper IV (n=2)
Main service		(1 respondent missing)	
CS* grade 0-6	2	37	
CS grade 0-9	6	55	2
CS grade 7-9/US**	4	36	
Municipality structure			
Rural area	4	48	
City/Built up area	8	80	2
Socioeconomic area			
Mixed strata	8	87	2
Disadvantages area***	4	41	

*CS = Compulsory school

** US = Upper Secondary School

*** Predominantly social assistance/immigrants

Samples

In the pilot study (paper **I**) twelve school nurses from six different municipalities were asked to participate, representing two rural municipalities, one big city and three middle-sized municipalities. In the rural municipalities all employed school nurses were included (n=4). In the big and middle-sized municipalities the coordinating school nurse made the sample of two nurses in each municipality (n=8). The majority of the informants was employed part-time and responsible for several schools (paper **I**). Some of them worked as district or pediatric nurses during the summer vacations. In paper **II** and **III** a random, computer selected, sample of ten per cent (n=183) of active (pensioners excluded) Swedish school nurses (n=1830) connected to the National Association of School Nurses were included. The majority, (approximately 80 per cent), of Swedish school nurses are connected to the organisation (Sveriges kommuner och landsting, 2005). Two school nurses, educated in family nursing models, participated in the intervention study (paper **IV**). Descriptions of the participating school nurses are shown in Table 3.

Table 3. Descriptions of the participating school nurses in the studies

Characteristics	Paper I (n=12)	Paper II-III (n=129)	Paper IV (n=2)
Sex			
Female	12	129	2
Age			
Year	Md 51,5 (range 40-60)	Mean 52,8 (SD 6,7)	39/46
Professional background			
District nurse (DN)	5	68	
Paediatric nurse (PN)	7	36	
DN/PN		8	1
Other*		17	1
Work experience			
Years in school nursing	Md 8,5 (range 1-22)	Md 7 (range 0-31)	6/6
Work situation			
Available time min/pupil/week	Md 2,89 (range 2,4-4,0)	Mean 3, 56 (SD 0,95) trimmed mean	3/3

* Other means e.g. mental nurse, midwife

In the intervention study the two practicing school nurses asked schoolchildren, aged 11 - 17 years, with recurrent, subjective health complaints, and their families to participate (paper IV). The children, all girls, and their families were able to communicate without an interpreter. A total number of four schoolchildren and their families were included. The schoolchildren were all girls in their early adolescence living together with both biological parents. Descriptions of the families are shown in Table 4 and the families are further presented in paper IV.

Table 4. Description of the participating families in paper IV (n=4).

	Family Tilde	Family Ida	Family Jenny	Family Linda
Sex	Female	Female	Female	Female
Age - year	14	13	12	14
Health complaints				
Recurrent headache	X		X	
Recurrent stomach pain	X	X	X	
Sleeping problems	X		X	
Other complaints/health problems		Anxiety	Tiredness	Worries, overweight
Health status in the family				
Life threatening illness	X		X	
Chronic illness	X		X	X
Other illness		Psychiatric disorders - extended family		
Participation in the sessions				
Father	All	Session three	Session two and three	None
Mother	All	All	All	All

Intervention

The framework for the intervention was inspired from family nursing models developed in Canada, namely the IBM, the CFAM and the CFIM which are previously described in the introduction part in this thesis (Wright & Leahey, 1994, Wright et al, 1996). The intervention consisted of three family sessions with each family with different purposes related to the past, the present and the future. A closing letter, with a summary of the content in the sessions and suggestions for the future, based on the family members' own quotations was sent to each family after the last session and before the follow up interview. The author of this thesis, special trained in the models, was the session leader and the school nurses' role was supportive. The sessions had three different purposes.

- The first session focused on the illness story and the family history, including constructing of the family structure with a genogram
- The second session focused on the present status and included the family

- contacts with larger systems forming an ecomap
- The third session focused on the future and included an evaluating part

All sessions included intervening questions which were a part of the semi structured interview guide inspired by Wright & Leahey (1994). Intervening questions can enable self-healing. Reflexive and circular questions have a higher probability to promote respectfulness and are new for the family in contrast to linear and strategic questions that can preserve and/or restrain conceptions of the situation. The intentions of circular questions are to influence change (Tomm, 1989). Circular questions were asked on an affective (A), behavioural (B) and cognitive (C) level (Wright & Leahey, 1994). Examples of intervening questions are described in paper IV. Each session lasted 1-1.5 hrs and there were approximately 2-3 weeks between the sessions. An audio tape recorder was used during the sessions which were transcribed verbatim. The intervention process is described in Figure 1.

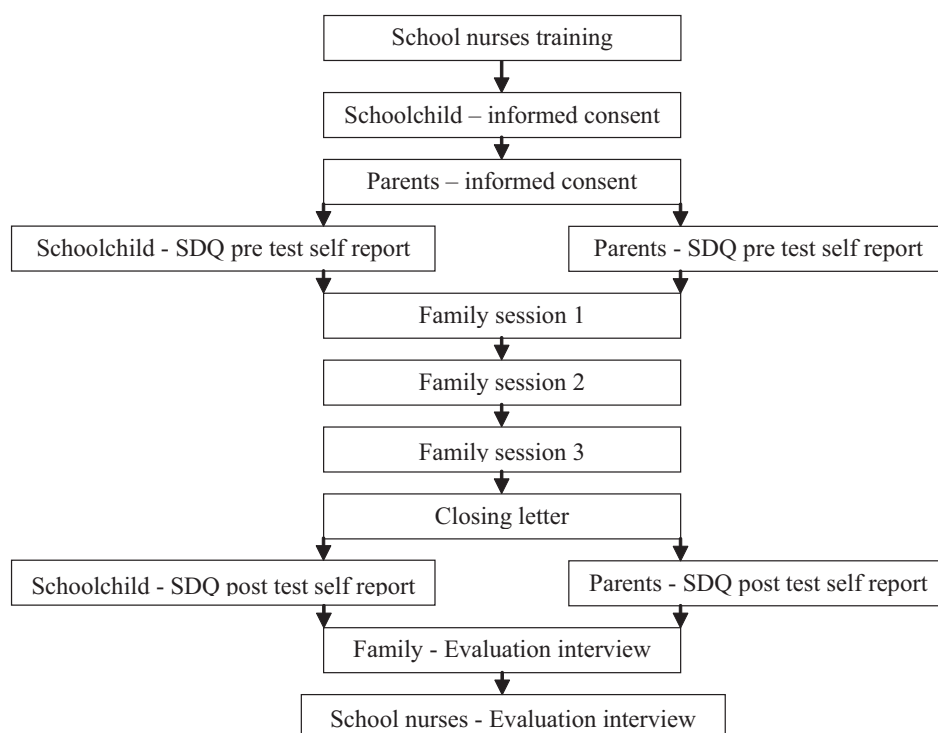


Figure 1. Flow chart describing the family intervention

Data collection

The interviews with the school nurses in the pilot study were conducted by the author of this thesis (paper **I**). The interviewer had no connection with the nurses ensuring them to feel free to talk openly about their views. In the intervention study (paper **IV**) the last part of the third session included reflections and evaluation of all sessions. A final question was “What did you find most and least helpful during our work together?” The evaluation interviews with the families were performed by a researcher, not participating in the sessions, approximately two – three weeks after the intervention. The participating school nurses were interviewed one month after all family interventions by an independent researcher. The reasons for that were the opportunities for the participating families and nurses to feel free to talk about their experience without considering the intervener. All interviews (paper **I** and **IV**) took place in connection to the school nurses’ consultation room, except for the evaluation interview with the school nurses which took place in a neutral place (paper **IV**). The self-rating questionnaires were collected from the schoolchild and the parents separately at baseline and after the intervention (paper **IV**). The national survey was distributed by mail together with a postage-paid reply envelope. Two written reminders, two and six weeks after the first survey were sent out to increase the response rate (paper **II** and **III**).

Interviews

Qualitative interviews were used to collect data in paper **I** and **IV**. The interviews were based on open-ended questions which are conversational in nature (Kvale, 1996) and aimed at obtaining an understanding of school nurses’ view of and work with schoolchildren’s health (paper **I**). The interview manual focused two main areas: the school nurses’ views of the schoolchildren’s health, and how they document it in the SHR. Each informant was asked, as freely as possible, to tell their views of the schoolchildren’s health and secondly, their views of how they document it in the SHR. In paper **IV** the evaluation interviews with the families were mainly focusing their experience of participating in the sessions and receiving a closing letter. Open requests were: Please tell how you as a family experienced the sessions, did the sessions influence you in any way and if so, in what way? The evaluation group interview with the participating school nurses focused on their experiences of working with family nursing models. In all interviews, follow-up questions were asked to deepen, further develop or clarify the answers (Kvale, 1996).

Questionnaire

A questionnaire was developed based on the previous interview study (paper I). It was pilot-tested on and approved by 10 practicing school nurses (paper II and III). The questionnaire covered topics about schoolchildren's physical and mental health and the documentation in the SHR. One part of the questionnaire consisted of both structured and semi structured questions dealing with school nurses' judgement of schoolchildren's physical and mental health, their experiences of changes over the previous two years, grounds for their opinion, factors affecting schoolchildren's health and reasons for schoolchildren's spontaneous visits to the school nurse considering gender (paper II). The other part of the questionnaire included questions about school nurses' documentation models, when and how they document, if, what and, in that case, why they have difficulties to select the content of what to document according to schoolchildren's physical and mental health (paper III). The questionnaire included demographic data (Appendix 1). The response rate was 78 % after two reminders and adjustment for non active non-responders (Figure 2).

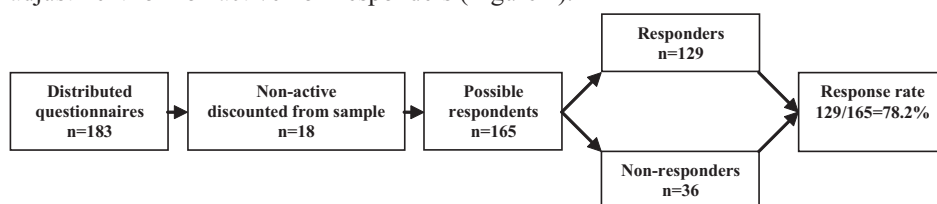


Figure 2. Description of data collection in Paper II and III

Self-rating questionnaire

The measurement chosen for evaluating the effects of the intervention on the schoolchildren's health was based on the assumptions that family sessions might decrease the subjective health problems and increase the well being (paper IV). The measurement used in this thesis focus on both positive and negative outcomes such as if the intervention has made the problems much worse or much better and if the symptoms become easier or worse to live with. The measurement was considered to be sensitive enough to measure changes. The effects of the intervention were measured by The Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1999, Smedje, Broman, Hetta & von Knorring, 1999). SDQ is a brief, behavioural screening questionnaire for children 4-16 years old. It exists in several versions and from

different perspectives including a self-report for children between 11-16 years of age, parents and teachers, with or without impact supplement. SDQ is a well known and validated questionnaire translated into several languages all over the world. It is available on a website, free of charge and easy to use (SDQ, 2006). The SDQ versions chosen in this study included an impact supplement and were used at baseline and after the intervention for measuring schoolchildren's mental health and the impact of the symptoms. The schoolchild and the parents filled in separate versions. The SDQ is described more in detail in paper **IV** and one version is exemplified in (Appendix 2).

Analyses

Qualitative analyses

Qualitative research study approach has been seen as a socially constructed heterogeneous tradition of ideas and influenced by different ideas in due to time and traditions (Allwood in Hallberg, 2002) and has been increasingly popular in the health and health care sciences. According to Polit & Beck (2004) qualitative analyses is challenging for three major reasons. Firstly, because it lacks universal rules for analyzing and presenting data, secondly it requires an enormous amount of unstructured data and a finally challenge is reducing data to readability reports.

Content analysis

Content analysis is a technique for analyzing and interpreting data which have been used by a variety of disciplines (Berg, 2006, p 304) in order to identify e.g. pattern, themes and meanings. In this thesis two different forms of Content analysis were used to analyze the interview text (paper **I** and **IV**) and the free text answers (paper **II** and **III**). Qualitative content analysis was the method used for the interview text in paper **I** and the evaluation of the family session from the families' perspective in paper **IV**. Manifest content analysis was used to analyze the free text answers of the survey (paper **II** and **III**) and the evaluation interview with the school nurses (paper **IV**). Qualitative content analysis involves the underlying meaning of the text (Graneheim & Lundman, 2004 p 106) and is thereby extended to an interpretative reading underlying the physically presented data (Berg, 2006). Creating categories is central in qualitative content analysis and often includes sub-categories at varying levels of abstraction (Graneheim & Lundman, 2004 p 107). The analysis was performed stepwise although the process of analysis involved a back and forth movement between the whole and

parts of the interview text (paper **I** and **IV**). The interview text was read several times to get a sense of the whole. All statements were numbered to ensure identification and transformed to one text document. The text was read as open-mindedly as possible to obtain ideas for further analysis and identify central areas. Then statements were marked and sorted according to how they related to the areas and divided into meaning units. Central categories and subcategories were identified and all the meaning units were then sorted into subcategories. The categories and subcategories were then compared with the statements and the original text (paper **I** and **IV**).

Manifest content analysis is stated by Berg (2006) as comparable to the surface structure in the text, and not the deep structural meaning conveyed by the text. The beginning of the analysis process in this thesis was similar to the earlier described qualitative content analysis and started with several readings of the statements in order to acquire a sense of the whole. Then the statements were split into elements that appeared to share the same content. The greatest differences between the two used methods of content analysis in this thesis are the interpretative depth (paper **II**, **III** and **IV**).

Statistical analyses

Descriptive statistical analyses were used to describe demographic data in all four papers and were performed by the software Statistical Package for Social Sciences (SPSS/PC, version 12.0) in paper **II** and **III**. Median (Md) was used to estimate the average of the following variables: age, work experience and work situation in paper **I** as well as of the variable “work experience” since there was a positive skewness (paper **II** and **III**) (Altman, 1991). To compare schoolchildren’s health with their living conditions the sample was divided into two areas based on the school nurses’ judgement of the school district (paper **II**). Area A meant that a predominant part of inhabitants benefited from social assistance and/or were immigrants. Area B consisted of mixed strata of the population. School nurses’ available time for the schoolchildren was calculated using a formula where the school nurses’ degree of employment was converted into minutes and divided with schoolchildren’s schooldays converted into minutes (paper **II** and **III**) to facilitate comparisons.

The SDQ was hand-scored statistically according to templates available on the SDQ website (Goodman, 1999). The total difficulties score can range from 0-40. Normal score is between 0-15, borderline from 16-19 and abnormal 20-40. A total impact score can range from 0-10, 0 is normal, 1 is borderline and >2 is abnormal. The result is presented in Table I, paper IV.

ETHICAL CONSIDERATIONS

The ethical issues in this thesis are following the guidelines for good ethical conduct based on the Helsinki declaration (WMA, 2004) and are in accordance with the Swedish law (Vetenskapsrådet, 2002). This means that the studies are following the three primary ethical principles in research based on: beneficence (doing good and freedom from harm), respect for human dignity (the right to self-determination, full disclosure and respect) and justice (the right to fair treatment and privacy) (Polit & Beck, 2004). In accordance with the Swedish law approval from ethics committees is compulsory when the research is involving vulnerable groups (SFS, 2003). Children as research subject call for special attention in this connection. The intervention study (paper IV) was approved by the Research Ethics Committee at the Medical Faculty, Lund University, Sweden (LU 854-02). All informants gave their informed consent to participate in the studies (paper I and IV). Informed consent means that the participants are fully informed of the nature of the research and have the power of free choice (Polit & Beck, 2004). There was no relationship of dependence between the interviewer and the interviewees.

In the intervention study (paper IV) permission was asked for at the Child and Youth Board in each municipality and at the local Education Authority. The schoolchildren and their families were separately asked to participate in the study by the school nurses. The families were further assured that a refusal to participate would not affect future school health service quality (Polit & Beck, 2004). The families were also assured the possibility of medical consultations by the responsible school doctor in case of arising needs related to the sessions. Asking questions about personal views, weakness or fears requires close attention and sensitivity. This could mean that it is necessary to carefully consider the phrasing of questions and to permit the participants to ask questions after the sessions. The investigator provided the participants with written information of how they may contact the researcher later.

The participants were assured that they had the right to decide at any point to terminate their participation in the study.

All data collected during the studies is kept in strictest confidence and treated confidentially. This means that any information from the participants will not be possible to relate back to individuals in the research report (Beauchamp & Childress, 2001, Vetenskapsrådet, 2002, Polit & Beck, 2004).

FINDINGS

The findings are presented under the following headings; **Schoolchildren's health from the school nurses' perspective; Recording schoolchildren's health and Family sessions within school health nursing.**

Schoolchildren's health from the school nurses' perspective (paper I and II)

The findings from the pilot study indicated that Swedish school nurses viewed schoolchildren's mental health as increasingly poor. The findings were confirmed in the survey and the major part of the school nurses judged the mental health as poor and increasingly worse during the previous two years. In addition they paid attention to the particularly poor mental health among schoolchildren living in socioeconomically disadvantaged areas. Also gender was pointed out as an important factor and confirmed the findings from the pilot study with girls showing an increasingly poor mental health, expressed as frequent visits to the school nurses with health complaints. Disrupted family relations and a school situation characterized by a stressful environment were also pointed out as contributors to the increasing mental health problems.

Mental health had deteriorated over the previous two years, especially among girls in socio-economically disadvantaged areas. Put together, expressions of mental health problems such as recurrent headache, stomach pain, worries and sleeping problems were the most common reasons for frequent visits to the school nurse. The needs among the schoolchildren to talk with and entrust to someone seemed insatiable according to the school nurses. The interviewed school nurses considered the schoolchildren as generally physically healthy, with few chronic diseases although a changing lifestyle caused growing problems with overweight. The national survey confirmed the findings from the pilot study and school nurses judged the

schoolchildren's physical health unchanged during two previous years. Their growth and a few physical diseases were used as indicators for a good physical health. Nonetheless, physical complaints such as sport injuries, wounds and infections were the most common reasons for spontaneous visits to the school nurse, especially among boys. A changed lifestyle with less exercise, irregular eating habits and stress caused overweight and other health problems. Chronic diseases e.g. diabetes and allergy were also increasing among schoolchildren and the nurses mentioned their effects on the schoolchildren's daily life and an increased vulnerability, especially during adolescence.

The family situation was considered as one of the most important factors of the schoolchildren's health. Family structures as well as conditions of the housing areas were pointed out as especially related to mental health. Living in socioeconomic disadvantages areas with predominantly public assistance and/or immigrants indicated an increased frequency of mental health problems. Disrupted family situations with alternating homes every other week and the presence of illness and/or abuse were thought to be the dominating causes of mental ill health. Girls from other cultures were said to be particularly affected by mental health problems. The girls were surrounded by restrictions and not allowed to live like their Swedish class mates. On the other hand the school nurses also highlighted health promotive family situations characterized by engaged parents. Reciprocity and active spare time together with the family were factors that strengthened the schoolchildren as individuals and contributed to wellbeing.

The school situation was described as increasingly stressful. A high working speed in school, ambitious schedules and strong demands for top grades led to stress symptoms. A working environment with violent behaviour and bullying among the schoolchildren was common and an everyday experience in some schools. Negative factors contributing to this were decreasing economic resources leading to more pupils in each class and fewer adults working in school. Fewer opportunities to physical exercise during schooldays led to a large group without any exercise and apprehensions of increasing obesity. In higher ages lots of pupils were tired of school and non-attendance was a common phenomenon, in some cases up to ten per cent of the schoolchildren on a daily basis. On the other hand some school

nurses described an increased professionalism and awareness among teachers about schoolchildren's individual needs and early attention to their absence. The significance of bullying prevention and an accessible, well-functioning SHS for early detection of ill health among schoolchildren were also emphasized. The figure below illustrates factors influencing schoolchildren's health in their context as described by the school nurses inspired by Models for health determinants of schoolchildren's health and Bronfenbrenner's Ecological Systems Theory (Figure 3).

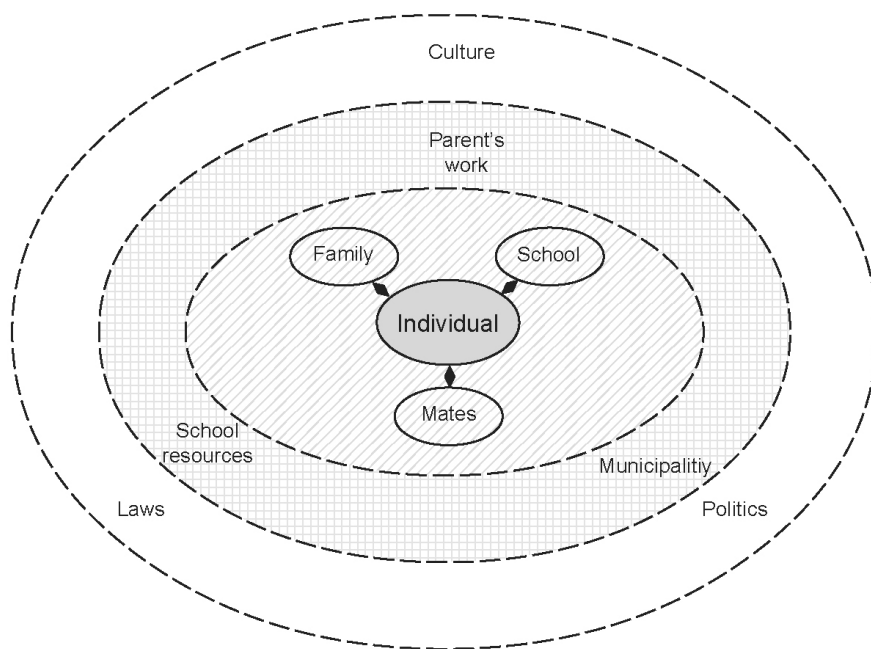


Figure 3. Factors influencing schoolchildren's physical and mental health as described by the school nurses and illustrated by models for health determinants of schoolchildren's health and Bronfenbrenner's Ecological Systems Theory

Recording schoolchildren's health (paper I and III)

The findings from the pilot study indicated that the school nurses' found it difficult to record mental health status and easy to record physical health status in the SHR. The findings were confirmed in the survey study where fifty per cent of the school nurses reported difficulties in relation to mental health and ten per cent of the school

nurses reported difficulties to select what to record in relation to physical health. The possibilities and difficulties when recording different aspects of health were related to tradition, time, the structure of the SHR and ethical considerations.

Recording schoolchildren's mental health was interpreted as an ethical and practical challenge for the school nurses. Grounds for this were said to be the shape of the SHR focusing on physical health while judgement of mental health mostly had to be expressed in free texts. The school nurses described a tradition in the profession with oral communications between school nurses when delivering SHR to subsequent caregivers to elucidate non-existent notations. Loose notes in the record or brief summaries inside the record were also present. The most outstanding explanations of the difficulties were ethical considerations and an apprehension of stigmatizing or hurting the schoolchild for the future in case of misinterpretations from the schoolchild itself, other caregivers, insurance companies or parents. The most sensitive issues to document were confiding talks when schoolchildren entrust the school nurse about problematic relations in the family or verified/suspected maltreatment and abuse in the family. Other problematic issues were the schoolchildren's self-harming behaviour. Girls' sexuality, e.g. pregnancy/abortions or referrals to midwives, were also stated as hard to record. Justifications for not documenting these issues were exemplified as the girl's wishes to withhold the information from the parents and/or referring it to other caregivers. Cooperation with other professionals, exemplified as building networks and/or meetings with the social welfare together with the family was stated as opportunities to facilitate documenting schoolchildren's total health. More professional guidance and supervision were asked for by the nurses.

The school situation with problematic relations to schoolmates and teachers were also stated as hard to evaluate and record in the SHR. Formal or informal meetings, where schoolchildren's being bullied or bullying was discussed, were also difficult to record. The school nurses justified non-documentation of these issues as giving the schoolchildren an opportunity to make a fresh start when moving to other schools.

Recording the physical health was elementary and supported by the long tradition in the profession focusing on physical health. The structure of the SHR also made it easy to record these aspects of health. Some difficulties, related to lack of time were

expressed, such as queuing-up in the waiting room. On the other hand, it was described as timesaving to have it recorded in case of follow-ups. School nurses' descriptions of factors influencing recording schoolchildren's mental health are described in figure 4.

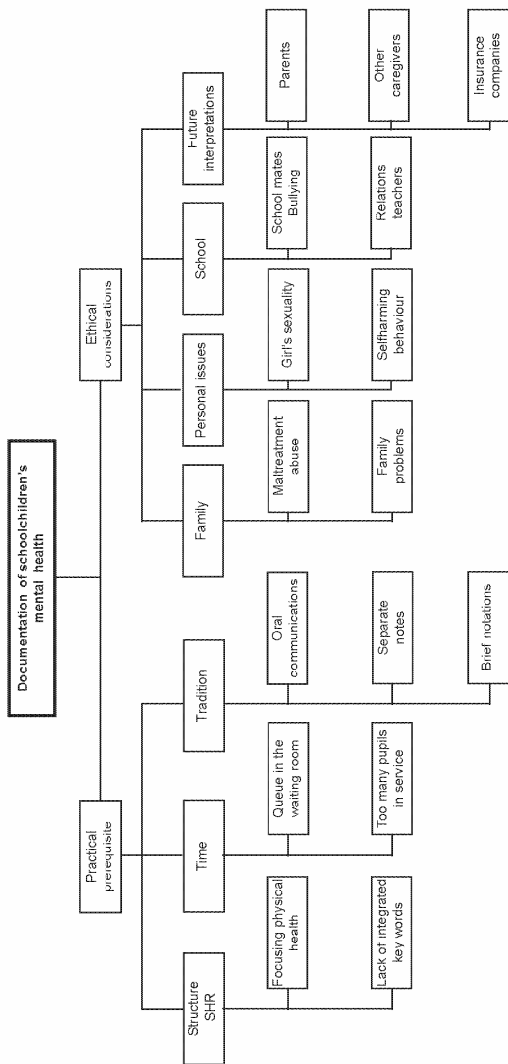


Figure 4. Factors influencing school nurses' recording of schoolchildren's mental health

Family sessions within school health nursing (paper IV)

The findings from the evaluation of the intervention were interpreted to mean that the sessions had led to changes in the families' way of thinking, communicating and behaving. The families also expressed an increased understanding and awareness of their own feelings, as well as teenagers' needs and reactions, especially in relation to when illness appears in the family. Genograms and ecomaps gave the family and the nurses an overview of resources and the closing letters offered the family hope and incitement for the future. The families expressed an increased well-being with decreased dimension of the health problems. The school nurses meant that this way of working was timesaving by rapidly giving an overview of the situation. The nurses had become more inclined to invite to family sessions and felt confident in their new role as a collaborator instead of an expert.

Family sessions

The family gatherings gave the nurses the opportunity to talk more directly in a more profound way. The families valued the sessions as a way of telling the illness story and being confirmed in feelings and reactions. The sessions as an important way to find new solutions and ways to handle the situation were described by the families. In addition the sessions seemed to increase the capability to take responsibility and other ways to remain and act in different situations. The school nurses meant that the extra time spent on the sessions was a way to save time later since the schoolchildren were consulting them less after the sessions. Furthermore, working with the models implied a professional growth and satisfaction with their work.

Genograms, ecomaps, closing letters

Creating genograms and eco maps seemed useful in this connection and made the situation evident. Among the families there was an improved understanding of the family as a system of individuals depending on each other and how things could be viewed from different perspectives. The nurses meant that creating the tools together with the family and/or the individual made the family members involved and aware of their own opportunities and strengths.. The tools made it easier to resume the case in follow up meetings. The nurses used the maps not merely in family sessions, but in other individual contacts with schoolchildren as well and they found it valuable to cooperate with the schoolchild around the situation. According to the families, the

closing letter seemed to be a motivating factor and prepared for future challenges by pointing out strengths and possibilities. The closing letters stood out for the nurses as a way to affirm the family and commend strengths in a well reasoned way as well as to summarize the sessions. Furthermore the letter stood out as a fine way to end a longer period of contacts with a schoolchild or a family. This way of working was said to be something the nurses wanted to practise more.

The SDQ

The SDQ showed reduced total difficulties score in the parents' forms as well as in Tilde's and Ida's self report (table I, paper **IV**). The additional questions showed that Ida, Jenny, their mothers and Tilde all meant that the problem had decreased and been quite a lot better to live with after the sessions. Tilde's mother meant that it has been a great deal better to live with the problem.

DISCUSSION

The overall aim of this thesis was to explore school health nursing through school nurses' descriptions of school children's health and to analyse factors influencing the recording of schoolchildren's health in the SHR. An additional aim was to evaluate family nursing interventions as a tool for the school nurses in the SHS. Focus for the studies was a strategic sample of twelve school nurses in municipalities of different sizes and population structures, a national random sample of school nurses connected to the Swedish National Association of School Nurses (n=129), and four girls in their early adolescence with health complaints together with their families and two school nurses. The structure of the discussion will follow the overall aim and the findings in paper **I-IV**. The discussion of the findings is concentrated on the following four areas: Schoolchildren's health panorama; School nurses' function and role; Ethical challenges in school nursing; and Strengths and weakness in Swedish School Health Services. The last section deals with methodological considerations of validity and trustworthiness. Bronfenbrenner's ecological systems theory together with models for child health determinants are used to illustrate the school nurse as a mediator working on the bridge over the different "streams" with schoolchildren's health from an individual and a population level in the conclusion part.

Schoolchildren's health panorama

The findings show that school nurses judge schoolchildren's mental health to have deteriorated during the previous years (paper II). The condition was especially noticeable among school nurses working in disadvantaged housing areas (paper I and II). The findings correspond with the results from a literature review by Bremberg (2002) concluding that mental health problems are more common among children in families with less good social and economic circumstances. Also the recent Public Health Report (Socialstyrelsen, 2005a) confirms that health inequalities in Sweden are increasing. The main conclusion from the recent national Social report (Socialstyrelsen, 2006a) is that health and wellbeing is polarized. Inequalities in health at present can also be seen as a risk for the future health status. The school nurses' judgement of schoolchildren's mental health as deteriorated can be coloured by general opinions in society. However, the findings seem important since they are based on school nurses' authentic knowledge and hands-on experience. The fact that the increasing rate of mental health problems among young persons is met in many settings also corroborates the findings in this thesis. For instance, the admission rates to Child and Youth Psychiatry and the consumption of psycho pharmaceuticals have increased greatly among children in recent decades (Socialstyrelsen, 2005a).

Recurrent health complaints, especially among adolescent girls, were seen as signs of mental health problems by the school nurses. Recurrent headaches and stomach pains were the most common reasons for spontaneous visits to the nurses (paper I and II). Several other Nordic studies show that psychosomatic complaints are increasing among schoolchildren (Berntsson, 2000, Danielsson, 2003, Petersen, Brulin & Bergström, 2006). Gender differences seem to arise after puberty (Socialstyrelsen, 2005a), and Olsson (2006) found a higher degree of psychosomatic symptoms among school girls in upper secondary school compared to the boys. Another study showed almost four times higher frequencies of depressions among 16–17-year-old girls (Olsson, 1998) and the recent Status report describes young woman's mental health as still deteriorating (Socialstyrelsen (2006b). This is in line with the results from the present study, where the school nurses perceived the girls, as more inclined to consult school nurses with health complaints, while the boys more often consulted the nurses with physical injuries. According to a current National commission report (SOU 2006:77) reliable explanation is lacking. However, Murberg & Bru (2004) found school-related stress

associated with psychosomatic symptoms in both genders, in different ways. Girls reported significantly more symptoms and seemed to worry about school achievement while boys more often worried about conflicts with teachers, peers and parents. Several research questions are raised by these results, and further investigations are required. How can we stop this disadvantageous development? We know that girls express their mental health problems differently from boys, but how to capture boy's mental ill health? The fact that the majority of the school nurses are female may be of importance in relation to this; in Sweden only 15 male nurses are active as school nurses (Riksföreningen, 2007).

The findings indicate an association between mental health problems and family related problems. Stressful family situations such as disrupted homes and busy parents were seen as negative factors for schoolchildren's mental health. In contrast, engaged and present parents were emphasized as positive factors (paper I and II). The importance of the family for 11-12 year-old schoolchildren's experience of stress in everyday life was also seen by Brobeck, Marklund, Haraldsson & Berntsson (2007). Nurses are in key positions to assess family weaknesses and strengths (Friedman, Bowden & Jones, 2003), and school nurses can play an important role in detecting health problems among schoolchildren. In one study by Johansson & Ehnfors (2006) the health dialogue was seen as a positive way to discuss physical as well as psychological things including home and family life, by 15 year-old schoolchildren. Other opportunities may be inviting the parents together with the child to discuss the self-perceived ill health and thereby support the schoolchildren and their families. Lightfoot & Bines (2000) identified family support as one of four key elements of the school nurse's role. Rhee (2001) has presented a framework of clinical practice for nurses or other child health providers when working with schoolchildren experiencing chronic headache. The approach is psychosocial intervention, founded in holistic knowledge capturing the interplay between individual factors and context (ibid). However, in the recently elaborated guidelines for the SHS (Socialstyrelsen, 2004) psychosocial factors and family relations are mentioned peripherally. A development of the guidelines seems necessary, taking into account the school nurses' knowledge about schoolchildren's health and the importance of family relations, as well as a deeper knowledge for the SHS of how to encounter and handle these situations.

Since the SHS meets almost all schoolchildren several times during the school age period, their systematic monitoring of schoolchildren's health could be a forceful tool in a continuous health surveillance system. The spontaneous visits to the school nurse with health complaints seemed to be more common as a basis for judging schoolchildren's mental health than the organized health checkups (paper I and II). In Sweden there are no traditions of regular and consistent measurements of mental health. This could lead to a risk of delayed attention and detection of mental health problems. Furthermore, the area is defined as one of the most important for a good population health, and a model for measuring and monitoring children's and adolescents' mental health on a regular basis is proposed (Hagqvist, 2004). A recent Swedish Public Health Policy Report (Statens Folkhälsoinstitut, 2005) proposes a more systematic investigation of health determinants for children such as relations between children and parents and the school environment. Some of these will be covered by school nurses and fit well into goal number three in the new national public health policy (Statens folkhälsoinstitut, 2007). This implies time and support in the profession from the municipalities. Health indicators for Swedish children have been developed by Köhler (2006). A further development of health indicators for Swedish schoolchildren seems important. A forceful action is necessary and, as stressed by a report from The National Institute of Public Health, it also has long-term benefits for the national economy (Statens Folkhälsoinstitut, 2004).

Bronfenbrenner's (1979) Ecological Systems Theory is, together with models for health determinants, used to illustrate the factors that influence schoolchildren's health as described by the school nurses (Figure 3). The model can furthermore be used to understand and explain schoolchildren's health status in a wider context. On a micro level this can be understood as when one family member is stricken by illness it affects the others too and is commonly shown among children as health complaints. This was clearly expressed in three of the families in the intervention study where chronic and/or life threatening illness was present. The school environment, expectations of the individual, relations with teachers and school mates are also important for schoolchildren's health as well as the connections between the different micro systems on the meso level. The exo level includes parent's work situation, childcare, media and spare time, and can, to a great extent, influence schoolchildren's health and their opportunities to a safe growing condition. Ideologies, laws, and ways of thinking are

permeating the society. This macro level includes cultural values and can perhaps explain some of the problems of living in two different cultures, one at home and one in society. The values from the parents' culture of origin can be challenged by the growing child who is meeting different values in society as an additional strain on top of the ordinary teenage liberation.

School nurses' function and role

The changing health panorama calls for a different approach in the SHS. Traditionally the SHS has a medical direction primarily focusing on the individual with emphasis on diagnosis and treatment. New threats against schoolchildren's health are to be sought in their physical, social and psychological environment. Changing life patterns with heavy demands can lead to symptom of illness which can be difficult to interpret (Socialstyrelsen, 2005b). Since the reasons for mental health problems have to be sought in relation to others instead of in organic systems it seems reasonable to work with the individual as a part of the immediate environment. The health dialogue is an important tool to meet the individual school child (Borup & Holstein, 2004). Genograms and ecomaps may be useful tools in this connection as a way to help the individual schoolchild, as well as the school nurse, to be aware of influencing factors in the surrounding environment. Further studies using these tools are required. Family sessions may be one model to work with schoolchildren expressing recurrent health complaints and probably also in relation to other forms of ill health although further studies are necessary. Also Mäenpää & Åstedt-Kurki (2008) stress the importance of enhancing the opportunities of parents being involved in their children's well-being in cooperation with school nurses. Professional dialogues with individuals as well as families call for skills in communication, interview methodology and different nursing models to manage the individual health problems. Intensified education and training in these skills are important, and so is support and systematic supervision.

Although an individual perspective is important in school nursing, the SHS responsibility also comprises a public health perspective on schoolchildren's health. An increasing number of mental health problems is important, not only for the individual and his/her family, but in fact also for the whole society. The effects can be seen as increasing expenses in the form of reduced work capacity and long periods of sick listing in higher ages. A recent report recommends a public health perspective

when attending young people's increasing mental health problems (SOU 2006:77). A need for further education of school nurses to meet increasing demands and fulfil their public health role is proposed by Merrell, Carnwell, Williams, Allen & Griffiths (2007) when studying school nurses' provision in the United Kingdom. These needs may also be applicable in Sweden. Public health work includes cooperation with other professionals in school as well as with e.g. social workers and health services. The school nurses expressed uncertainty in how to provide a proper cooperation and this part of the SHS needs to be developed. A lot of data about schoolchildren's health are collected in SHS but are seldom systematized and presented for politicians or other decision makers' political actions. Framing models for cooperation seems necessary in order to promote a comprehensive view of the health panorama as well as finding solutions of how to deal with it. A clarification of their role as public health worker in the educational system may also facilitate their legitimacy as proposed by Morberg, et al (2006). In relation to the upstream, midstream and lowstream model (Turrell et al, 1999) the school nurses' role can be seen as a mediator working to bridge the individual perspective and the public health perspective.

Ethical challenges in school nursing

Several ethical challenges were described by the school nurses (paper I and III). One aspect was ethical considerations related to documentation of confidential talks with the individual schoolchild. The considerations were fear of misinterpretations in the future from subsequent caregivers, parents or even to the schoolchild itself. There does not seem to be any easy solution of how to manage this issue. However, discussions with other school nurses, professional guidance and/or supervision in ethical decision models can facilitate this task. It is also important to consider the needs of a safe care and not documenting these issues could later be interpreted as a lack of assessment (Socialstyrelsen, 1993). The opportunity to considerate detriment ("menprövning") for the individual schoolchild when parents insist on reading the notations is another way to handle these issues. This could mean that a parent can be denied to read notations which could be judged as harmful for the schoolchild's health and well-being. However, the most useful way in relation to parents may be to cooperate with them and invite them to sessions together with the schoolchild before conflicts arise, even though this is not possible in all cases.

Another aspect of ethical challenges was when the nurse had a feeling of something and did not know how to handle it. This creates a conflict between several ethical principles, such as beneficence, non-maleficence, justice and autonomy, and the duty to report suspicions of maltreatment to the social authorities (Beauchamp & Childress, 2001, Socialstyrelsen, 2002). One way to deal with it can be cooperation with the social services for guidance, in the individual cases, or in principle. It is also important to remember not to promise the child professional secrecy since the duty to report is superior to the Secrecy law (SFS, 1980). The need for deepening the knowledge and guidance in these issues is obvious.

In the Public Health area ethical conflicts between the goal for preventive work and clinical work can arise (Hermerén, 2006). Health promotion involves choices and actions which affect other people including judgements about what is right or wrong (Naidoo & Wills, 2000). This may be of special importance when acting in the best interest of children. To respect autonomy and avoid victim blaming is central in health promotive work but can involve complex ethical decision-making about what it means to do good and avoid harm. An open debate about ethical principles and their application in practice can be valuable in the context of SHS.

Strengths and weaknesses in SHS

The strength of the Swedish SHS is the availability with an almost 100 year tradition (Skolverket, 1994). SHS is a network all over the country, in big as well as in small municipalities. The school nurse is often located in the school and near the schoolchildren's environment. This inside perspective makes it easy to cooperate with other school professionals and gives opportunities for a comprehensive picture of the children's situation. SHS is a natural continuation of the CHS and the activity is voluntary, free of charge and available to everybody. The schoolchildren show up to almost 100 per cent and no social stigmatization is attached to the visitors. The SHS is highly valued and appreciated for the work with schoolchildren with difficulties (Skolverket, 1994). The activity has been developed from purely medical check ups and immunisations to comprising mental and social health as well. The weaknesses can be described in terms of variable quality since the economics of the municipality also reflect the resources spent on different activities. Several studies have shown the differences of the school nurses' demographic area, which also means differences in

the work load of the nurses. The National Associations of School Nurses as well as the Association of School Physicians have claimed the necessity of limiting rules for the number of schoolchildren per professional. The opportunities for the SHS to develop the activity in accordance with the guidelines (Socialstyrelsen, 2004) are dependent on reasonable resources. Promoting children's health should be of high priority in all countries in accordance with the WHO Child and Adolescent Mental Health program (WHO, 2001) as a means to protect a vulnerable group and as an investment for the future!

The School Health Record is also an area for development on a national level. An appropriate working tool, corresponding the needs of today, as well as the intentions of the school law, must, with all possible speed be developed, comprising measurements for mental health as well as appropriate key words for documenting it in the SHR. There is good hope for the future, since a new digital record for both CHS and SHS is now under development (Alm, 2007).

Methodological considerations

Findings from a combination of quantitative and qualitative studies may add knowledge and contribute to a better understanding concerning public health research (Hallberg, 2002, Guba & Lincoln, 2005). However, the use of different methodological approaches requires that the validity or trustworthiness of the results must be considered in relation to the basic ideas behind each method. The qualitative approaches are based on a naturalistic tradition (papers **I** and **IV**) and the quantitative methods are based on the scientific approach of the natural sciences (papers **II**, **III** and **IV**) (Polit & Beck, 2004). In qualitative research the inquirer interacts with those being researched, findings are created in interactive processes and patterns are sought after. Qualitative research deals with questions, such as what are the dimensions of the phenomenon, what variations exist, and what is important about the phenomenon (Polit & Beck, 2004 p 19). The approach is suitable when little is known about a topic. In quantitative research the inquirer is independent in relation to those being researched and seeks generalizations (ibid). In paper **IV** an intervention was implemented and evaluated by using quantitative and qualitative data. All scientific investigations have their strengths and weaknesses which must be taken into consideration when the results are interpreted. No method is absolutely weak or strong but more or less appropriate in relation to its purpose (Sandelowski, 2000).

Qualitative data

Participants

The school nurses were strategically chosen to cover different school settings, school levels and living conditions. The selection procedure was made by the coordinating school nurses except for two rural municipalities where all school nurses were included. This purposive sampling tried to obtain a wide range of views and perspectives (Polit & Beck, 2004). All school nurses were females which is a weakness. However, only 15 male are active in the profession (Riksföreningen, 2007) and no male school nurses were available among the participating municipalities.

Datacollection

Evaluation interviews were accomplished with the families and the school nurses after the intervention. The qualitative interview data in papers **I** and **IV** were obtained by face to face semi-structured interviews. The scientific rigour or the trustworthiness of qualitative studies can be discussed in terms of credibility, dependability, confirmability and transferability (Lincoln & Guba, 1985). The credibility of the findings corresponds with internal validity and includes information about the research process, description of own pre-understanding and demonstration of steps taken to enhance credibility. Triangulation (Polit & Beck, 2004) refers to the use of multiple referents to draw conclusions about what represents the “truth” and includes data triangulation; investigator triangulation; method triangulation and theory triangulation. Data triangulation is relevant in this thesis in the form of person triangulation which was used in papers **I** and **IV**. This means that the school nurses were carefully chosen to represent multiple perspectives on the phenomenon. They had various experience of the profession and represented different municipalities and school settings (paper **I**). In paper **IV** person triangulation involves collecting data from the school children, the families and the school nurses. The former experience of being a school nurse may influence the opportunities to gain access to the research field in a positive way and may also contribute to a common bond, thereby explaining the freely expressed thoughts of the school nurses and the families despite any possible lapse in interview technique at times (Paper **I** and **IV**) (Kvale, 1996). On the other hand the pre understanding could be a risk for forming a basis for understanding in the interview context and a rigour for follow up questions. The interviews were substantially rich, however, with various narratives of experiences. The researcher is the research tool in

qualitative studies (Polkinghorne, 2006, p 75) and the strength of its findings depends on the diligence and judgments of the researcher. This could be of special interest when analysing and interpreting the data in order to enhance credibility. Investigator triangulation was used when analysing and interpreting the data in papers **I** and **IV** in order to secure the interpretation and eliminating the risk for bias. This was accomplished through co-researchers, who were familiar with the used methodology, which validated and evaluated the description categories and the choice of quotations. Dependability refers to the stability of the data and the conditions and confirmability to the objectivity of the data (Polit & Beck, 2004). During the analysis the findings were repeatedly presented to a research group to ensure dependability. The carefully chosen interview citations make it possible also for the reader to act as a co-examiner, which further strengthens dependability and confirmability. Transferability refers to the extent in which the findings can be transferred into other groups or settings (Lincoln & Guba, 1985). The condition is that it can sufficiently give the readers of the study report an opportunity to evaluate the applicability of the data to other contexts. The intervention (paper **IV**) is described carefully step by step which probably can make it possible for others to consider a possible transference (Polit & Beck, 2004).

Quantitative data

Sample

The aims of paper **II** and **III** were to explore the school nurses' judgement of schoolchildren's health on a national base for a better understanding of schoolchildren's health problems and to further explore factors influencing the school nurses' documentation in the SHR. Validity refers to the degree to which an instrument measures what it is supposed to measure and reliability to the degree of consistency and dependability with which the instruments measure the attributes they are intended to measure (Polit & Beck, 2004, p 422-423). The questionnaire, used to explore the school nurses' judgement of schoolchildren's health and documentation in the SHR, were developed from the results of a pilot study (paper **I**). The questionnaire was face validated by ten active school nurses. These facts may increase the reliability of the instrument. The sample was randomized, with an even distribution throughout the country and with a high response rate (78%) which increases the validity of the findings. A cross-sectional study does not give space for causal interpretations. The results are based on school nurses' judgement of schoolchildren's health and, thus, do

not give a full picture of the children's health. On the other hand, school nurses have a genuine knowledge of schoolchildren's health since they meet almost all schoolchildren several times during their school-age period and are familiar with the school environment and the residential area. To compare schoolchildren's health with their living conditions, the sample was divided into two areas (A and B) based on the school nurses' judgement of the school district (paper **II**). In area A, a predominant part of the inhabitants benefited from social assistance and/or had a main part of immigrants. The classification is based on subjective judgement from the school nurses but coincides with a recent demographic report from Statistics Sweden (Statistiska Centralbyrån, 2007) which describes socioeconomic disadvantaged areas, as areas with a majority of immigrants.

Descriptive statistics was used to analyse demographic data in all studies. Small samples in papers **I** and **IV** and the positive skewness of the variable "work experience" in papers **II** and **III** justify the use of median instead of mean when estimating the average.

SDQ

The SDQ was chosen for the study in paper **IV** because it is a well known and validated questionnaire translated into several languages all over the world. Studies using the SDQ along with research interviews and clinical ratings have shown that the SDQ is sensitive to treatment effects (SDQ, 2006). "Before" and "after" SDQs can be used to evaluate specific interventions. Added value score based on SDQ can be used to measure how much help the intervention provides. The fact that the instrument includes items of strengths and is not only focusing on problems was an additional decisive factor for the choice. In spite of that one of the families refused to fill in the questionnaire deeming the questions as impertinent. Maybe the information of the purpose of the study and the function of the SDQ was insufficient. The short time between the pre and post test and the lack of control groups (Lazenbatt, 2002) as well as the fact that the special attention the families were provided could mean that the positive outcomes of the study is not mainly related to the specific models used. Also the testing process in itself can stimulate change (Campbell & Stanley, 1963) and further studies are required.

CONCLUSIONS

The thesis confirms the picture of schoolchildren's mental health as increasingly deteriorated during the past decades. The mental ill health is expressed as an increasing frequency of recurrent health complaints, especially among girls and in socioeconomic disadvantaged areas. The reasons for the increasing mental ill health can be sought in problematic family relations. The need for appropriate tools for measuring mental health and a development of the SHR in relation to how to document these issues are obvious. The increasing mental ill health also calls for different methods of treatment and should include the family as co-operators. Using family sessions, in combination with working tools as genograms, ecomaps and closing letters can be useful. The school nurse's role as a health promoting co-operator suits well into this approach. The school nurses need supervision and support in how to document and handle mental ill health and/or ethical challenges in their roles when working on an individual as well as on a population based level. A proposal of a model for school health nursing emanating from the findings in this thesis is a pragmatic way to use theories and models facilitating the understanding of school nurses' complex roles in the SHS context. The model is connected to the upstream, midstream, lowstream model determinants of children's health and Bronfenbrenner's Ecological Systems Theory. The model illustrates the school nurse as a mediator working on the bridge over the different socioeconomic determinant "streams" of health, as is described in Figure 5.

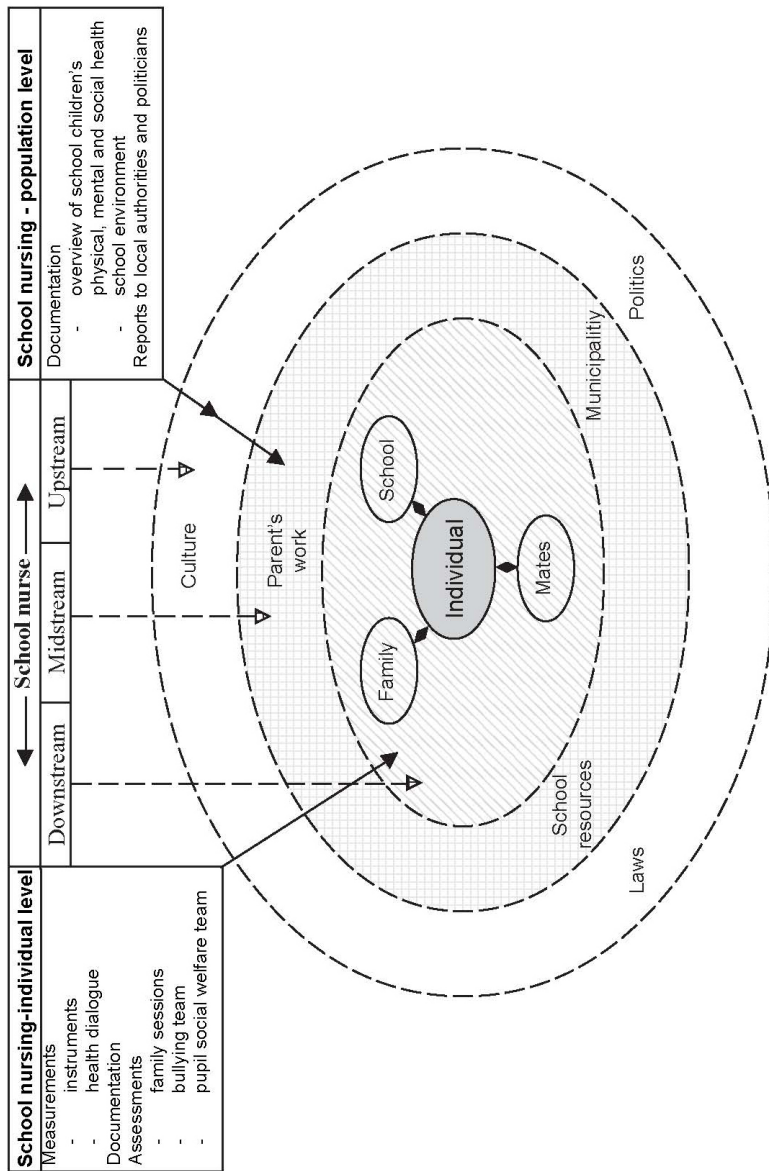


Figure 5. A model for school nursing working on an individual and population level related to Bronfenbrenner's Ecological Systems Theory and The Upstream, Midstream and Down stream model for socioeconomic determinants of health.

IMPLICATIONS FOR NURSING PRACTICE AND FURTHER RESEARCH

The findings in this thesis may lead to an increased awareness of school nurses' deep knowledge about schoolchildren's health within the public health area and inspire further development within the profession. Hopefully, the thesis will also contribute to the use of evaluated based working models within the profession as well as show opportunities to make the school nurses' work apparent. Schoolchildren's health is a concern on a national as well as on a local level. The SHS can contribute to basic data about schoolchildren's actual health status and thereby create foundations for efforts to promote and improve public health. Schoolchildren's increasing mental ill health has to be taken seriously and forceful actions are necessary. Future research is important in order to explore schoolchildren's health, and to do it from the perspective of schoolchildren, school nurses, parents and teachers. The following areas may be of special interest for further research:

- The mental health problem distribution among schoolchildren in different groups
- The differences of expressions of mental ill health in relation to gender, culture and socio-economic status.

A reliable documentation is a prerequisite for reliable knowledge. The documentation of mental health was problematic, especially in relation to ethical considerations. Hopefully some of the findings in this thesis can contribute to a wider discussion of what, how and to what extent mental health problems should be recorded. The following areas may be of special interest for further development and research:

- The recording in the SHR, emphasizing notations related to mental health and troublesome ethical issues
- Systematic and ethical supervision in order to support the documentation process.

The family session model can be used by school nurses in their work with schoolchildren's health in accordance with nursing supervision. A further development and assessment of the CFAM and CFIM models when handling different kinds of ill health among schoolchildren in the context of SHS could be a subject for further development and research. The following areas may be of special interest:

- Special groups of high priority could be e.g. schoolchildren with alternating

living and schoolchildren with immigrant parents expressing ill health

- The use of genogram and ecomaps when schoolchildren are moving between schools
- School nurses' roles as co-operators.

SUMMARY IN SWEDISH

Populärvetenskaplig sammanfattning

Skolsköterskors uppfattning om, dokumentation av samt modeller för att arbeta med att förbättra skolbarns hälsa

Avhandlingens övergripande syfte var att undersöka skolsköterskors uppfattning om skolbarns hälsa och att analysera faktorer som påverkar dokumentation av skolbarns hälsa i skolhälsovårdsjournalen. Ett ytterligare syfte var att utvärdera modeller för familjeinterventioner i skolhälsovård. Studierna är genomförda genom intervjuer med ett strategiskt urval av skolsköterskor, en nationell enkät till ett representativt urval av Sveriges skolsköterskor samt en interventionsstudie där familjesamtal genomfördes med skolbarn med subjektiva hälsoproblem och deras föräldrar i samarbete med deras verksamma skolsköterskor. Studien var inspirerad av modeller för familjefokuserad omvårdnad utvecklade i Kanada. The Strengths and Difficulties Questionnaire (SDQ) användes som före och efter test. Separata utvärderingsintervjuer genomfördes med familjerna och med deltagande skolsköterskor.

Skolsköterskorna bedömde skolbarnen som övervägande friska men med försämrad mental hälsa uttryckt som subjektiva hälsoproblem. Detta förekom särskilt i områden med hög andel invånare med socialbidrag och/eller invandrare och mer allmänt bland flickor. Grunden till den fysiska hälsan kunde sökas i individuella livsstilsfaktorer, medan grunden till den mentala hälsan kunde sökas i skolmiljö och i familjerelationer. Skolsköterskornas bedömning av den fysiska hälsan baserades på hälsokontroller och hälsosamtal. Spontana besök var vanligare för bedömning av den mentala hälsan. Dokumentation av den mentala hälsan visade sig vara en utmaning för skolsköterskorna. Svårigheterna var relaterade till etiska överväganden, tradition och tidsbrist samt till skolhälsovårdsjournalens struktur, som är uppbyggd kring den fysiska hälsan. En rädsla för att negativa anteckningar skulle märka skolbarnet för livet i relation till skolbarnet själv, föräldrar/vårdnadshavare, försäkringsbolag eller andra/påföljande vårdgivare fördes fram som hinder för att dokumentera mental och social hälsa. Familjesamtal, inspirerade av modeller från Kanada, visade sig vara användbara i skolhälsovården för att hantera subjektiva hälsoproblem hos skolbarn. Skolbarnen och deras familjer upplevde lättnad, de fick bekräftat att deras känslor och reaktioner var normala i en onormal situation. De blev medvetna om sina egna styrkor

och möjligheter. SDQ visade ett ökat välbefinnande efter sammankomsterna, både hos skolbarnen och hos föräldrarna. Modellerna visade sig vara användbara i skolhälsovård då de som enkla verktyg underlättade bedömningen, sparade tid och snabbt gav en bild av familjen och deras situation. Att sitta ner och samtala med familjer och ge tid för reflektion startade en förändringsprocess.

Det första av de fyra delarbetena fokuserade på skolsköterskors uppfattning av skolbarns hälsa samt hur den dokumenteras i skolhälsovårdsjournalen och baserades på kvalitativa intervjuer med 12 strategiskt utvalda skolsköterskor. Studien utgjorde även underlag för en nationell enkät. Resultatet visade att skolsköterskorna uppfattade skolbarnens fysiska hälsa som god och den mentala hälsan som mindre god. Tillfredställande tillväxt och utveckling samt frånvaro av kroniska sjukdomar hos det stora flertalet var mått på en god fysisk hälsa enligt skolsköterskorna. Å andra sidan beskrevs bilden av ökande frekvens av elever med diabetes och allergi där särskilt tonåringarna drabbas existentiellt, dvs. hämmas i sin personliga utveckling på grund av sin sjukdom. Subjektiva symtom, såsom trötthet, huvudvärk och magont, var vanliga anledningar till spontana besök hos skolsköterskorna. En livsstil med ökning av stillasittande framför dator och video, stress, oregelbundna matvanor och rökning bland eleverna lyftes fram som exempel på orsaker till symtomen men också som en hälsorisk för framtiden med bland annat övervikt som följd. En ökning av återkommande subjektiva symtom såsom återkommande huvudvärk, magont och ångest beskrevs av skolsköterskorna som mått på den ökande mentala ohälsan bland elever, särskilt bland skolbarn i ekonomiskt utsatta områden samt hos flickor med låg självkänsla. Vanliga orsaker till den mentala ohälsan var problemfyllda relationer inom familjen. Barn med alternerande boende samt flickor från andra kulturer som inte tillåts leva som sina svenska kamrater pekades ut som särskilt utsatta grupper. Skolsituationen beskrevs också som en källa till stress. En ökning av våld och mobbing i skolan samt skoltrötthet med skolk var vanligt i vissa skolor. En ökad samverkan med socialarbetare och andra professionella inom området lyftes fram som en möjlighet att arbeta med och förebygga dessa problem.

Dokumentation av skolbarns fysiska hälsa var oproblematisk, enligt skolsköterskorna, men att dokumentera den mentala/sociala hälsan innebar svårigheter relaterade till tradition, tidsbrist, journalens struktur samt etiska överväganden. En tradition av

korta notat, lösa lappar och/eller muntliga överlämningar då elever flyttar mellan skolor var förekommande, särskilt i relation till mental och/eller social ohälsa. En annan förklaring till bristande dokumentation var tidsbrist då flera elever köade i väntrummet. Strukturen på skolhälsovårdsjournalen, med förtryckta rutor, underlättade dokumentationen av den fysiska hälsan. De beskrivna svårigheterna med att dokumentera den mentala och sociala hälsan var särskilt uttalade i fall med känslig information mellan vårdgivare eller från eleven själv, där föräldrars/vårdnadshavares rätt att läsa journalen ibland kolliderar med dokumentationsskyldigheten. Ett sätt att arbeta med detta skulle, enligt skolsköterskorna, kunna vara ett ökat samarbete och gemensamma träffar med t ex barnhälsovård och familjen i samband med skolstart.

Det andra delarbetet fokuserade skolsköterskors uppfattning om skolbarns hälsa ur ett nationellt perspektiv och baserade sig på postenkäter till ett representativt urval skolsköterskor anslutna till Riksföreningen för skolsköterskor (n=129). Respondenterna delades in i högrisk- respektive lågriskområden utifrån skolsköterskornas egen bedömning där lågriskområden utgjordes av en blandad befolkning. Högriskområden utgjordes av en befolkning med hög andel invandrare och/eller socialbidragsberoende. Resultaten från det andra delarbetet styrker resultaten från det första delarbetet. Skolsköterskorna bedömde eleverna som övervägande friska men att den mentala hälsan hade försämrats under de föregående två åren. Skolsköterskor verksamma i högriskområden bedömde i större utsträckning skolbarns mentala hälsa som sämre. En ökande besöksfrekvens av skolbarn med subjektiva symptom såsom återkommande magont och huvudvärk var mått på den ökande mentala ohälsan, särskilt bland flickor. Pojkar konsulterade i högre grad skolsköterskor med fysiska skador. Familjerelationer framstod som den mest betydelsefulla påverkansfaktorn för skolbarns mentala hälsa. Resultaten indikerar också att skolsköterskor har en genuin kunskap om skolbarns hälsa men att de verkar vara en outnyttjad resurs i forskning kring skolbarns hälsa.

Det tredje delarbetet fokuserade skolsköterskors erfarenheter av dokumentation i skolhälsovårdsjournalen. Resultaten baserar sig på postenkäter till samma urvalsgrupp som delarbete 2. Enkäterna innehöll såväl slutna som öppna frågor om vad som var svårt att dokumentera samt varför det var svårt. I resultatet framkom att femtio procent av skolsköterskorna upplevde svårigheter att dokumentera skolbarns mentala och sociala hälsa. Skolsköterskorna uttryckte en rädsla för att skada barnen i framtiden

då föräldrar och/eller andra vårdgivare/myndigheter kan kräva att läsa journalen. Framför allt var svårigheterna kopplade till känslig information om skolbarns beteende på individnivå och problematiska relationer eller missförhållanden inom familjen. På individnivå ansågs samtal, där eleven anförtror sig åt skolsköterskan, särskilt svåra att dokumentera. Flickors sexualitet med abortfrågor och remisser till ungdomsmottagningar eller liknande ansågs också svårt att dokumentera liksom självskadebeteende med t ex elevers missbruk och självmordstankar. Även mobbing och formella eller informella möten kopplat till skolsituationen ansågs svårt att dokumentera. Fysisk hälsa nämndes i liten utsträckning, däremot en svårighet att ibland separera den fysiska hälsan från den mentala och sociala samt att dokumentera när skolbarn söker upprepade gånger för småblesstyrer. Familjerelationer såsom svårigheter att kommunicera inom eller med familjen ansågs som svårt att dokumentera. Detta var även fallet med misstankar om eller verifierad misshandel och missbruk av olika slag. Även anmälan till sociala myndigheter ansågs problematiskt och lösningar för att gå runt problemen och inte dokumentera i journalen var att skriva tillfälliga notat vid sidan om journalen. Den övervägande orsaken till varför det var svårt att dokumentera ovanstående uttrycktes som etiska överväganden i relation till såväl skolbarn, familj, andra vårdgivare/myndigheter samt till skolsköterskorna själva. En rädsla för att journalanteckningarna kunde misstolkas och därmed skada barnen på sikt uttrycktes. Osäkerhet hos skolsköterskorna om riktigheten i informationen samt när de ”hade en känsla av någonting” var andra anledningar till varför det var svårt att dokumentera. Strukturen på journalen, med tyngdpunkt på det fysiska hälsotillståndet, ledde även det till osäkerhet om hur den mentala och sociala hälsan skulle dokumenteras till såväl innehåll som omfattning.

Resultaten från de tre första delarbetena som visade att skolbarns mentala hälsa försämrats med en ökning av subjektiva symtom, att orsakerna ofta sågs som familjerelaterade och svåra att dokumentera ledde till studie fyra. Syftet med interventionsstudien var att utvärdera en modell för familjesamtal, ursprungligen utvecklad i Kanada, i svensk skolhälsovårdskontext. I studien användes SDQ för att mäta den mentala hälsan före och efter familjesamtalen. Fyra flickor i nedre tonåren med subjektiva symtom och deras familjer ingick i studien som genomfördes i samarbete med två verksamma skolsköterskor. Interventionen bestod av tre hälsofrämjande familjesamtal med cirkulär frågeteknik och med fokus på styrkor och resurser samt med olika syften:

1. Historik med familjebedömning (med genogram), 2. Nuläge (med ekokarta) och 3. Strategier för framtiden. Ett sammanfattande brev sändes till respektive familj efter det sista samtalet. Utvärderingsintervjuerna som genomfördes av en oberoende forskare visade att skolbarnen och föräldrarna upplevde lättnad, de kände sig bekräftade och att deras känslor var normala i en onormal situation. De kände sig medvetna om sina egna styrkor och möjligheter. Samtalen hade satt igång en förändringsprocess kognitivt, affektivt och beteendemässigt menade familjerna. SDQ visade ett ökat välbefinnande efter samtalen, både ur barnens och ur föräldrarnas perspektiv. De deltagande skolsköterskorna ansåg att metoden var enkel att arbeta med och att den var värdefull i arbetet med skolbarn som har återkommande subjektiva symtom. Genogram och ekokarta användes även av skolsköterskorna i enskilda samtal med elever och visade sig vara tidsbesparande och ge en lättöverskådlig överblick av skolbarnens hälsosituation och nätverk. De sammanfattande breven upplevdes positivt av familjerna och var något som skolsköterskorna ville använda sig mer av.

De delstudier som omfattade skolsköterskornas uppfattning om skolbarns hälsa visade på en samstämmighet i att skolbarns fysiska hälsa var övervägande god och att den mentala och sociala hälsan hade försämrats under senare år. Behovet av flera studier inom området med djupare analyser av samtliga aspekter på skolbarns hälsa synes angeläget för att kunna arbeta förebyggande på olika nivåer. Skolsköterskor finns nära barnen i skolan och resultaten tyder på en djupgående kunskap om skolbarns hälsa som inte utnyttjas fullt ut i ett folkhälsoperspektiv. Samstämmigheten var också god i de studier som omfattade dokumentationen av skolbarns hälsa där svårigheterna att dokumentera den mentala och sociala hälsan var entydiga. Behovet av flera studier synes angeläget för att fördjupa kunskapen om de svårigheter som skolsköterskorna upplever i dokumentationen av skolbarns hälsa. Resultatet av interventionsstudien visade att modeller för familjesamtal är möjliga att använda av skolsköterskor när barnen söker för återkommande subjektiva symtom men flera studier behövs. Förhoppningen är att resultaten av avhandlingen kan bidra till ökad aktivitet inom skolhälsovården avseende forskning och utveckling. Förhoppningen är även att strukturer för dokumentation av skolbarns hälsa kan utvecklas till att omfatta den mentala och sociala hälsan i högre grad och därmed bidra till en fullständigare bild av skolbarns hälsotillstånd. Detta kan även i förlängningen underlätta en systematisk sammanställning och rapportering av skolbarns hälsotillstånd. En modell för arbete

med skolbarns hälsa utifrån Bronfenbrenners ekologiska utvecklingsteori och modeller för bestämningsfaktorer av barns hälsa och med skolsköterskan i en roll som folkhälsoarbetare på såväl individuell som befolkningsnivå presenteras.

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Enkät - skolbarns hälsa och dokumentation i skolhälsovårdsjournalen - Appendix 1

Del 1. Bakgrundsfrågor

1. Hur många år har du arbetat som skolsköterska? _____
Antal år
2. Vilket år är du född? _____
År
3. Vilken specialistutbildning har du?
- | | |
|-------------------|--------------------------|
| Ingen | ☐ |
| Barnsjuksköterska | ☐ |
| Distriktsköterska | ☐ |
| Annan | ☐ |
- _____
Ange vilken
4. Hur stor omfattning har din tjänst?
- _____
% av heltid
- | | |
|-----------------|--------------------------|
| Semestertjänst | ☐ |
| Uppehållstjänst | ☐ |
- _____
Uppehållsfaktor
- Antal skolor _____
5. Vid vilken typ av skola är tjänsten förlagd?
- | | |
|----------------|--------------------------|
| Kommunal skola | ☐ |
| Friskola | ☐ |
- _____
Ange ev. profil
(använd baksidan om flera skolor)
6. Var är tjänsten huvudsakligen förlagd?
- | | |
|---------------|--------------------------|
| Årskurs 0-6 | ☐ |
| Årskurs 0-9 | ☐ |
| Årskurs 7-9 | ☐ |
| Gymnasieskola | ☐ |
| Annat | ☐ |
- _____
Ange vad

7. Hur många elever ansvarar du för? _____

8. Vilken huvudsaklig befolkningsstruktur finns i skolans upptagningsområde?

- Landsbygd/mindre tätort ☐
- Större tätort ☐
- Stad ☐
- Storstad ☐
- (Stockholm, Göteborg eller Malmö)

9. Hur vill du beskriva befolkningen i upptagningsområdet?

(mer än ett svar kan anges)

- Hög andel unga/barnfamiljer ☐
- Hög andel invånare med utländsk härkomst ☐
- Hög andel socialhjälpstagare ☐
- Hög andel höginkomsttagare ☐
- Blandad befolkning ☐
- Annat _____ ☐

Ange vad:

Del 2. Skolbarns hälsa

10. Hur uppfattar du *skolbarns fysiska hälsa* på din(a) skola(or)?

- Mycket god ☐
- God ☐
- Mindre god ☐
- Dålig ☐

Vad grundar du denna uppfattning på?

11. Hur bedömer du *flickors fysiska hälsa* idag jämfört med för ett par år sedan?

- Mycket bättre ☐
- Bättre ☐
- Ingen förändring ☐
- Sämre ☐
- Mycket sämre ☐

Om förändring, i vilket avseende?

Ange troliga orsaker till ev. förändring

12. Hur bedömer du *pojgars fysiska hälsa* idag jämfört med för ett par år sedan?

- Mycket bättre ☐
- Bättre ☐
- Ingen förändring ☐
- Sämre ☐
- Mycket sämre ☐

Om förändring, i vilket avseende?

Ange troliga orsaker till ev. förändring

13. Hur uppfattar du *skolbarns psykiska hälsa* på din(a) skola(or)?

- Mycket god ☐
- God ☐
- Mindre god ☐
- Dålig ☐

Vad grundar Du denna uppfattning på?

14. Hur bedömer du *flickors psykiska hälsa* idag jämfört med för ett par år sedan?

Mycket bättre ☐

Bättre ☐

Ingen förändring ☐

Sämre ☐

Mycket sämre ☐

Om förändring, i vilket avseende?

Ange troliga orsaker till ev. förändring

15. Hur bedömer du *pojgars psykiska hälsa* idag jämfört med för ett par år sedan?

Mycket bättre ☐

Bättre ☐

Ingen förändring ☐

Sämre ☐

Mycket sämre ☐

Om förändring, i vilket avseende?

Ange troliga orsaker till ev. förändring

16. Hur många spontana besök har du i genomsnitt under en vecka?

_____ st
antal

17. Vilka är de **tre vanligaste** anledningarna till **flickors** spontana besök?

- | | |
|----------------------------------|--------------------------|
| Idrottsskador | ☐ |
| Sårskador | ☐ |
| Allergi | ☐ |
| Tillfällig huvudvärk | ☐ |
| Återkommande huvudvärk | ☐ |
| Tillfälligt magont | ☐ |
| Återkommande magont | ☐ |
| Oro över sin kropp | ☐ |
| Ätstörningar | ☐ |
| Övervikt | ☐ |
| Infektioner | ☐ |
| Relationsstörningar i familjen | ☐ |
| Relationsstörningar med kamrater | ☐ |
| Annat _____ | ☐ |
| Ange vad | |

18. Vilka är de **tre vanligaste** anledningarna till **pojgars** spontana besök?

- | | |
|----------------------------------|--------------------------|
| Idrottsskador | ☐ |
| Sårskador | ☐ |
| Allergi | ☐ |
| Tillfällig huvudvärk | ☐ |
| Återkommande huvudvärk | ☐ |
| Tillfälligt magont | ☐ |
| Återkommande magont | ☐ |
| Oro över sin kropp | ☐ |
| Ätstörningar | ☐ |
| Övervikt | ☐ |
| Infektioner | ☐ |
| Relationsstörningar i familjen | ☐ |
| Relationsstörningar med kamrater | ☐ |
| Annat _____ | ☐ |
| Ange vad | |

19. Nämn tre faktorer som du menar positivt påverkar skolbarns hälsa i dagens samhälle.

20. Nämn tre faktorer som du menar negativt påverkar skolbarns hälsa i dagens samhälle.

Del 3. Dokumentation i skolhälsovårdsjournalen

21. Vilken typ av skolhälsovårdsjournal använder du?

Datajournal ☐
Pappersjournal ☐

22. Vilken typ av system för sökord använder du?

Datajournalens ☐
VIPS ☐
Annat ☐

Ange vilket

23. *När* dokumenterar du elevers besök?

	alltid	oftast	ibland	sällan	aldrig
Under besöket tillsammans med eleven	☐	☐	☐	☐	☐
I direkt anslutning till besöket	☐	☐	☐	☐	☐
Efter mottagningens slut	☐	☐	☐	☐	☐
Senare när tid finns	☐	☐	☐	☐	☐

24. Händer det att du har svårigheter att välja ut vad som ska dokumenteras när det gäller fysisk hälsa?

Ja ☐
Nej ☐

Om ja, ge exempel på svårigheter du upplevt

25. Händer det att du har svårigheter att välja ut vad som ska dokumenteras när det gäller psykisk hälsa?

Ja ☐
Nej ☐

Om ja, ge exempel på svårigheter du upplevt

26. Kan du ge exempel på något som är *särskilt svårt* för dig att dokumentera i skolhälsovårdsjournalen?

27. Om du svarat på fråga 26 – varför är det svårt?

Fortsätt gärna på baksidan!

Tack för din medverkan!

Styrkor och svårigheter (SDQ-Swe)

Appendix 2

S11-16

Var vänlig kryssa för det alternativ (Stämmer inte, Stämmer delvis eller Stämmer helt) som du tycker passar bäst. Det är bra om du besvarar alla frågor, även om du inte är helt säker eller tycker att frågan verkar konstig. Frågorna gäller hur du har haft det de senaste 6 månaderna.

Ditt namn.....
Födelsedatum.....

Pojke/Flicka

	Stämmer inte	Stämmer delvis	Stämmer helt
Jag försöker vara vänlig mot andra. Jag bryr mig om deras känslor	☐	☐	☐
Jag är rastlös. Jag kan inte vara stilla länge	☐	☐	☐
Jag har ofta huvudvärk, ont i magen eller illamående	☐	☐	☐
Jag delar ofta med mig till andra (mat, spel, pennor, annat)	☐	☐	☐
Jag blir mycket arg och tappar ofta humöret	☐	☐	☐
Jag är ofta för mig själv. Jag gör oftast saker ensam	☐	☐	☐
Jag gör oftast som jag blir tillsagd	☐	☐	☐
Jag oroar mig mycket	☐	☐	☐
Jag är hjälpsam om någon är ledsen, upprörd, eller känner sig dålig	☐	☐	☐
Jag har svårt att sitta stilla, jag vill jämt röra och vrida på mig	☐	☐	☐
Jag har en eller flera goda vänner	☐	☐	☐
Jag slåss/bråkar mycket och kan få andra att göra som jag vill	☐	☐	☐
Jag är ofta ledsen, nedstämd eller gråtfärdig	☐	☐	☐
Andra i min ålder brukar gilla mig	☐	☐	☐
Jag är lättstörd, jag tycker det är svårt med koncentrationen	☐	☐	☐
Jag blir nervös i nya situationer. Jag blir lätt osäker	☐	☐	☐
Jag är snäll mot yngre barn	☐	☐	☐
Jag blir ofta anklagad för att ljuga eller fuska	☐	☐	☐
Andra barn eller ungdomar mobbar eller retar mig	☐	☐	☐
Jag ställer ofta upp och hjälper andra (föräldrar, lärare, andra barn)	☐	☐	☐
Jag tänker mig för innan jag handlar/gör något	☐	☐	☐
Jag tar saker som inte tillhör mig, hemma, från skolan eller andra ställen	☐	☐	☐
Jag kommer bättre överens med vuxna än med jämnåriga	☐	☐	☐

Jag är rädd för mycket, jag är lättskrämd	☐	☐	☐
Jag gör färdigt mina uppgifter, jag är bra på att koncentrera mig	☐	☐	☐

Har du andra kommentarer eller bekymmer du vill ta upp?

Var god vänd –det är några fler frågor på andra sidan

Sammanfattningsvis, tycker du att du har svårigheter på ett eller flera av följande områden:
med känslor, koncentration, uppförande eller med att umgås/komma överens med andra människor?

	Nej	Ja, små svårigheter	Ja klara svårigheter	Ja allvarliga svårigheter
	☐	☐	☐	☐

Om du svarade ”Ja”, var vänlig besvara de följande frågorna:

●Hur länge har du haft dessa svårigheter?

Mindre än 1 månad	1-5 månader	6-12 månader	Mer än 1 år
☐	☐	☐	☐

●Oroas eller lider du av dina svårigheter?

Inte alls	Bara lite	Ganska Mycket	Verkligen Mycket
☐	☐	☐	☐

●Stör svårigheterna ditt vardagsliv på något av följande områden?

	Inte alls	Bara lite	Ganska Mycket	Verkligen Mycket
HEMMA/I FAMILJEN	☐	☐	☐	☐
MED KAMRATER	☐	☐	☐	☐
I SKOLARBETET	☐	☐	☐	☐
VID FRITIDSAKTIVITETER	☐	☐	☐	☐

●Blir dina svårigheter en belastning för människorna omkring dig (familj, vänner, lärare etc.)?

Inte alls	Bara lite	Ganska Mycket	Verkligen Mycket
☐	☐	☐	☐

Din underskrift.....

Datum.....

Tack så mycket för hjälpen

Förteckning över NHV-rapporter

1983

- 1983:1 Hälsa för alla i Norden år 2000. Föredrag presenterade på en konferens vid Nordiska hälsovårdshögskolan 7–10 september 1982.
- 1983:2 Methods and Experience in Planning for Family Health – Report from a seminar. Harald Heijbel & Lennart Köhler (eds).
- 1983:3 Accident Prevention – Report from a seminar. Ragnar Berfenstam & Lennart Köhler (eds).
- 1983:4 Själv mord i Stockholm – en epidemiologisk studie av 686 konsekutiva fall. Thomas Hjortsjö. Avhandling.

1984

- 1984:1 Långvarigt sjuka barn – sjukvårdens effekter på barn och familj. Andersson, Harwe, Hellberg & Syrén. (FoU-rapport/shstf:14). Distribueras av Studentlitteratur, Box 141, SE-221 01 Lund.
- 1984:2 Intersectoral Action for Health – Report from an International Workshop. Lennart Köhler & John Martin (eds).
- 1984:3 Barns hälsotillstånd i Norden. Gunborg Jakobsson & Lennart Köhler. Distribueras av Studentlitteratur, Box 141, SE-221 01 Lund.

1985

- 1985:1 Hälsa för äldre i Norden år 2000. Mårten Lagergren (red).
- 1985:2 Socialt stöd åt handikappade barn i Norden. Mats Eriksson & Lennart Köhler. Distribueras av Allmänna Barnhuset, Box 26006, SE-100 41 Stockholm.
- 1985:3 Promotion of Mental Health. Per-Olof Brogren.
- 1985:4 Training Health Workers for Primary Health Care. John Martin (ed).
- 1985:5 Inequalities in Health and Health Care. Lennart Köhler & John Martin (eds).

1986

- 1986:1 Prevention i primärvården. Rapport från konferens. Harald Siem & Hans Wedel (red). Distribueras av Studentlitteratur, Box 141, SE-221 01 Lund.
- 1986:2 Management of Primary Health Care. John Martin (ed).
- 1986:3 Health Implications of Family Breakdown. Lennart Köhler, Bengt Lindström, Keith Barnard & Houda Itani.
- 1986:4 Epidemiologi i tandvården. Dorthe Holst & Jostein Rise (red). Distribueras av Tandläkarförlaget, Box 5843, SE-102 48 Stockholm.
- 1986:5 Training Course in Social Pediatrics. Part I. Lennart Köhler & Nick Spencer (eds).

Förteckning över NHV-rapporter

1987

- 1987:1 Children's Health and Well-being in the Nordic Countries. Lennart Köhler & Gunborg Jakobsson. Ingår i serien Clinics in Developmental Medicine, No 98 och distribueras av Blackwell Scientific Publications Ltd, Oxford. ISBN (UK) 0 632 01797X.
- 1987:2 Traffic and Children's Health. Lennart Köhler & Hugh Jackson (eds).
- 1987:3 Methods and Experience in Planning for Health. Essential Drugs. Frants Staugård (ed).
- 1987:4 Traditional midwives. Sandra Anderson & Frants Staugård.
- 1987:5 Nordiska hälsovårdshögskolan. En historik inför invigningen av lokalerna på Nya Varvet i Göteborg den 29 augusti 1987. Lennart Köhler (red).
- 1987:6 Equity and Intersectoral Action for Health. Keith Barnard, Anna Ritsatakis & Per-Gunnar Svensson.
- 1987:7 In the Right Direction. Health Promotion Learning Programmes. Keith Barnard (ed).

1988

- 1988:1 Infant Mortality – the Swedish Experience. Lennart Köhler.
- 1988:2 Familjen i välfärdsstaten. En undersökning av levnadsförhållanden och deras fördelning bland barnfamiljer i Finland och övriga nordiska länder. Gunborg Jakobsson. Avhandling.
- 1988:3 Aids i Norden. Birgit Westphal Christensen, Allan Krasnik, Jakob Bjørner & Bo Eriksson.
- 1988:4 Methods and Experience in Planning for Health – the Role of Health Systems Research. Frants Staugård (ed).
- 1988:5 Training Course in Social Pediatrics. Part II. Perinatal and neonatal period. Bengt Lindström & Nick Spencer (eds).
- 1988:6 Äldretandvård. Jostein Rise & Dorthe Holst (red). Distribueras av Tandläkarförlaget, Box 5843, SE-102 48 Stockholm.

1989

- 1989:1 Rights, Roles and Responsibilities. A view on Youth and Health from the Nordic countries. Keith Barnard.
- 1989:2 Folkhälsovetenskap. Ett nordiskt perspektiv. Lennart Köhler (red).
- 1989:3 Training Course in Social Pediatrics. Part III. Pre-School Period. Bengt Lindström & Nick Spencer (eds).

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- 1989:4 Traditional Medicine in Botswana. Traditional Medicinal Plants. Inga Hedberg & Frants Staugård.
- 1989:5 Forsknings- och utvecklingsverksamhet vid Nordiska hälsovårdshögskolan. Rapport till Nordiska Socialpolitiska kommittén.
- 1989:6 Omstridda mödrar. En studie av mödrar som förtecknats som förståndshandikappade. Evy Kollberg. Avhandling.
- 1989:7 Traditional Medicine in a transitional society. Botswana moving towards the year 2000. Frants Staugård.
- 1989:8 Rapport fra Den 2. Nordiske Konferanse om Helseopplysning. Bergen 4–7 juni 1989. Svein Hindal, Kjell Haug, Leif Edvard Aarø & Carl-Gunnar Eriksson.

1990

- 1990:1 Barn och barnfamiljer i Norden. En studie av välfärd, hälsa och livskvalitet. Lennart Köhler (red). Distribueras av Studentlitteratur, Box 141, SE-221 01 Lund.
- 1990:2 Barn och barnfamiljer i Norden. Teknisk del. Lennart Köhler (red).
- 1990:3 Methods and Experience in Planning for Health. The Role of Women in Health Development. Frants Staugård (ed).
- 1990:4 Coffee and Coronary Heart Disease, Special Emphasis on the Coffee – Blood Lipids Relationship. Dag S. Thelle & Gerrit van der Stegen (eds).

1991

- 1991:1 Barns hälsa i Sverige. Kunskapsunderlag till 1991 års Folkhälsorapport. Gunborg Jakobsson & Lennart Köhler. Distribueras av Fritzes, Box 16356, SE-103 27 Stockholm (Allmänna Förlaget).
- 1991:2 Health Policy Assessment – Proceedings of an International Workshop in Göteborg, Sweden, February 26 – March 1, 1990. Carl-Gunnar Eriksson (ed). Distributed by Almqvist & Wiksell International, Box 638, SE-101 28 Stockholm.
- 1991:3 Children's health in Sweden. Lennart Köhler & Gunborg Jakobsson. Distributed by Fritzes, Box 16356, SE-103 27 Stockholm (Allmänna Förlaget).
- 1991:4 Poliklinikker og dagkurgi. Virksomhetsbeskrivelse for ambulant helsetjeneste. Monrad Aas.
- 1991:5 Growth and Social Conditions. Height and weight of Stockholm schoolchildren in a public health context. Lars Cernerud. Avhandling.
- 1991:6 Aids in a caring society – practice and policy. Birgit Westphal Victor. Avhandling
- 1991:7 Resultat, kvalitet, valfrihet. Nordisk hälsopolitik på 90-talet. Mats Brommels (red). Distribueras av nomesko, Sejrøgade 11, DK-2100 København.

Förteckning över NHV-rapporter

1992

- 1992:1 Forskning om psykiatrisk vårdorganisation – ett nordiskt komparativt perspektiv. Mats Brommels, Lars-Olof Ljungberg & Claes-Göran Westin (red). sou 1992:4. Distribueras av Fritzes, Box 16356, SE-103 27 Stockholm (Allmänna förlaget).
- 1992:2 Hepatitis virus and human immunodeficiency virus infection in dental care: occupational risk versus patient care. Flemming Scheutz. Avhandling.
- 1992:3 Att leda vård – utveckling i nordiskt perspektiv. Inga-Maja Rydholm. Distribueras av shstf-material, Box 49023, SE-100 28 Stockholm.
- 1992:4 Aktion mot alkohol och narkotika 1989–1991. Utvärderingsrapport. Athena. Ulla Marklund.
- 1992:5 Abortion from cultural, social and individual aspects. A comparative study, Italy – Sweden. Marianne Bengtsson Agostino. Avhandling.

1993

- 1993:1 Kronisk syke og funksjonshemmede barn. Mot en bedre fremtid? Arvid Heiberg (red). Distribueras av Tano Forlag, Stortorget 10, NO-0155 Oslo.
- 1993:2 3 Nordiske Konference om Sundhedsfremme i Aalborg 13 – 16 september 1992. Carl-Gunnar Eriksson (red).
- 1993:3 Reumatikernas situation i Norden. Kartläggning och rapport från en konferens på Nordiska hälsovårdshögskolan 9 – 10 november 1992. Bjarne Jansson & Dag S. Thelle (red).
- 1993:4 Peace, Health and Development. A Nobel seminar held in Göteborg, Sweden, December 5, 1991. Jointly organized by the Nordic School of Public Health and the University of Göteborg with financial support from SAREC. Lennart Köhler & Lars-Åke Hansson (eds).
- 1993:5 Hälsopolitiska jämlikhetsmål. Diskussionsunderlag utarbetat av WHO's regionkontor för Europa i Köpenhamn. Göran Dahlgren & Margret Whitehead. Distribueras gratis.

1994

- 1994:1 Innovation in Primary Health Care of Elderly People in Denmark. – Two Action Research Projects. Lis Wagner. Avhandling.
- 1994:2 Psychological stress and coping in hospitalized chronically ill elderly. Mary Kalfoss. Avhandling.
- 1994:3 The Essence of Existence. On the Quality of Life of Children in the Nordic countries. Theory and Practice. Bengt Lindström. Avhandling.

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1995

- 1995:1 Psykiatrisk sykepleie i et folkehelseperspektiv. En studie av hvordan en holistisk-eksistensiell psykiatrisk sykepleiemodell bidrar til folkehelsearbeid. Jan Kåre Hummelvoll. Avhandling.
- 1995:2 Child Health in a Swedish City – Mortality and birth weight as indicators of health and social inequality. Håkan Elmén. Avhandling.
- 1995:3 Forebyggende arbeid for eldre – om screening, funn, kostnader og opplevd verdi. Grethe Johansen. Avhandling.
- 1995:4 Clinical Nursing Supervision in Health Care. Elisabeth Severinsson. Avhandling.
- 1995:5 Prioriteringsarbeid inom hälso- och sjukvården i Sverige och i andra länder. Stefan Holmström & Johan Calltorp. Sprit 1995. Distribueras av Spris förlag, Box 70487, SE-107 26 Stockholm.

1996

- 1996:1 Socialt stöd, livskontroll och hälsa. Raili Peltonen. Socialpolitiska institutionen, Åbo Akademi, Åbo, 1996.
- 1996:2 Recurrent Pains – A Public Health Concern in School – Age Children. An Investigation of Headache, Stomach Pain and Back Pain. Gudrún Kristjánsdóttir. Avhandling.
- 1996:3 AIDS and the Grassroots. Frants Staugård, David Pitt & Claudia Cabrera (red).
- 1996:4 Postgraduate public health training in the Nordic countries. Proceedings of seminar held at The Nordic School of Public Health, Göteborg, January 11 – 12, 1996.

1997

- 1997:1 Victims of Crime in a Public Health Perspective – some typologies and tentative explanatory models (Brottsoffer i ett folkhälsoperspektiv – några typologier och förklaringsmodeller). Barbro Renck. Avhandling. (Utges både på engelska och svenska.)
- 1997:2 Kön och ohälsa. Rapport från seminarium på Nordiska hälsovårdshögskolan den 30 januari 1997. Gunilla Krantz (red).
- 1997:3 Edgar Borgenhammar – 65 år. Bengt Rosengren & Hans Wedel (red).

1998

- 1998:1 Protection and Promotion of Children's Health – experiences from the East and the West. Yimin Wang & Lennart Köhler (eds).
- 1998:2 EU and Public Health. Future effects on policy, teaching and research. Lennart Köhler & Keith Barnard (eds) 1998:3 Gender and Tuberculosis. Vinod K. Diwan, Anna Thorson, Anna Winkvist (eds)

Förteckning över NHV-rapporter

Report from the workshop at the Nordic School of Public Health, May 24-26, 1998.

1999

- 1999:1 Tipping the Balance Towards Primary Healthcare Network. Proceedings of the 10th Anniversary Conference, 13-16 November 1997. Editor: Chris Buttanshaw.
- 1999:2 Health and Human Rights. Report from the European Conference held in Strasbourg 15-16 mars 1999. Editor: Dr. med. Stefan Winter.
- 1999:3 Learning about health: The pupils' and the school health nurses' assessment of the health dialogue. Ina Borup. DrPH-avhandling.
- 1999:4 The value of screening as an approach to cervical cancer control. A study based on the Icelandic and Nordic experience through 1995. Kristjan Sigurdsson. DrPH-avhandling.

2000

- 2000:1 Konsekvenser av urininkontinens sett i et folkehelsevitenskapelig perspektiv. En studie om livskvalitet hos kvinner og helsepersonells holdninger. Anne G Vinsnes. DrPH-avhandling.
- 2000:2 A new public health in an old country. An EU-China conference in Wuhan, China, October 25-29, 1998. Proceedings from the conference. Lennart Köhler (ed)
- 2000:3 Med gemenskap som grund - psykisk hälsa och ohälsa hos äldre människor och psykiatrisjuksköterskans hälsofrämjande arbete. Birgitta Hedelin. DrPH-avhandling.
- 2000:4 ASPHER Peer Review 1999. Review Team: Jacques Bury, ASPHER, Franco Cavallo, Torino and Charles Normand, London.
- 2000:5 Det kan bli bättre. Rapport från en konferens om barns hälsa och välfärd i Norden. 11-12 november 1999. Lennart Köhler. (red)
- 2000:6 Det är bra men kan bli bättre. En studie av barns hälsa och välfärd i de fem nordiska länderna, från 1984 till 1996. Lennart Köhler, (red)
- 2000:7 Den svenska hälso- och sjukvårdens styrning och ledning – en delikat balansakt. Lilian Axelsson. DrPH-avhandling.
- 2000:8 Health and well-being of children in the five Nordic countries in 1984 and 1996. Leeni Berntsson. DrPH-avhandling.
- 2000:9 Health Impact Assessment: from theory to practice. Report on the Leo Kaprio Workshop, Göteborg, 28 - 30 October 1999.

2001

- 2001:1 The Changing Public-Private Mix in Nordic Healthcare - An Analysis John Øvretveit.

Förteckning över NHV-rapporter

- 2001:2 Hälsokonsekvensbedömningar – från teori till praktik. Rapport från ett internationellt arbetsmöte på Nordiska hälsovårdshögskolan den 28-31 oktober 1999. Björn Olsson, (red)
- 2001:3 Children with asthma and their families. Coping, adjustment and quality of life. Kjell Reichenberg. DrPH-avhandling.
- 2001:4 Studier av bruket av dextropropoxifen ur ett folkhälsoperspektiv. Påverkan av ett regelverk. Ulf Jonasson. DrPH-avhandling.
- 2001:5 Protection – Prevention – Promotion. The development and future of Child Health Services. Proceedings from a conference. Lennart Köhler, Gunnar Norvenius, Jan Johansson, Göran Wennergren (eds).
- 2001:6 Ett pionjärbete för ensamvargar
Enkät- och intervjuundersökning av nordiska folkhälsodoktorer examinerade vid Nordiska hälsovårdshögskolan under åren 1987 – 2000.
Lillemor Hallberg (red).

2002

- 2002:1 Attitudes to prioritisation in health services. The views of citizens, patients, health care politicians, personnel, and administrators. Per Rosén. DrPH-avhandling.
- 2002:2 Getting to cooperation: Conflict and conflict management in a Norwegian hospital. Morten Skjørshammer. DrPH-avhandling.
- 2002:3 Annual Research Report 2001. Lillemor Hallberg (ed).
- 2002:4 Health sector reforms: What about Hospitals? Pär Eriksson, Ingvar Karlberg, Vinod Diwan (ed).

2003

- 2003:1 Kvalitetsmåling i Sundhedsvæsenet.
Rapport fra Nordisk Ministerråds Arbejdsgruppe.
- 2003:3 NHV 50 år (Festboken)
- 2003:4 Pain, Coping and Well-Being in Children with Chronic Arthritis.
Christina Sällfors. DrPH-avhandling.
- 2003:5 A Grounded Theory of Dental Treatments and Oral Health Related Quality of Life.
Ulrika Trulsson. DrPH-avhandling.

2004

- 2004:1 Brimhealth 1993-2003
- 2004:2 Experienced quality of the intimate relationship in first-time parents – qualitative and quantitative studies. Tone Ahlborg. DrPH-avhandling.

Förteckning över NHV-rapporter

2005

- 2005:1 Kärlek och Hälsa – Par-behandling i ett folkhälsoperspektiv.
Ann-Marie Lundblad. DrPH-avhandling.
- 2005:2 1990 - 2000:A Decade of Health Sector Reform in Developing Countries
- Why, and What Did we Learn?
Erik Blas. DrPH-avhandling
- 2005:3 Socio-economic Status and Health in Women
Population-based studies with emphasis on lifestyle and cardiovascular disease
Claudia Cabrera. DrPH-avhandling

2006

- 2006:1 "Säker Vård -patientskador, rapportering och prevention"
Synnöve Ödegård. DrPH-avhandling
- 2006:2 Interprofessional Collaboration in Residential Childcare
Elisabeth Willumsen. DrPH-avhandling
- 2006:3 Innkomst-CTG: En vurdering av testens prediktive verdier, reliabilitet og
effekt. Betydning for jordmødre i deres daglige arbeide
Ellen Blix. DrPH-avhandling

2007

- 2007:1 Health reforms in Estonia - acceptability, satisfaction and impact
Kaja Põlluste. DrPH-avhandling
- 2007:2 Creating Integrated Health Care
Bengt Åhgren. DrPH-avhandling
- 2007:3 Alkoholbruk i tilknytning til arbeid – Ein kvalitativ studie i eit folkehelsevitskapeleg
perspektiv
Hildegunn Sagvaag. DrPH-avhandling
- 2007:4 Public Health Aspects of Pharmaceutical Prescription Patterns – Exemplified by
Treatments for Prevention of Cardiovascular Disease
Louise Silwer. DrPH-avhandling
- 2007:5 Å fremme den eldre sykehuspasientens helse I lys av et folkehelse og holistisk-
eksistensielt sykepleieperspektiv
Geir V Berg. DrPH-avhandling

2008

- 2008:1 Diabetes in children and adolescents from non-western immigrant families –
health education, support and collaboration
Lene Povlsen. DrPH-avhandling

Förteckning över NHV-rapporter

- 2008:2 Love that turns into terror: Intimate partner violence in Åland – nurses' encounters with battered women in the context of a government-initiated policy programme
Anette Häggblom. DrPH-avhandling
- 2008:3 Oral hälsa hos personer med kognitiva och/eller fysiska funktionsnedsättningar – ett dolt folkhälsoproblem? Ulrika Hallberg, Gunilla Klingberg
- 2008:4 School health nursing – Perceiving, recording and improving schoolchildren's health
Eva K Clausson. DrPH-avhandling

