Early Parental Support in Child Healthcare Parental groups - a challenge in a changing society

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Early Parental Support in Child Healthcare

Parental groups - a challenge in a changing society

Thesis for licentiate degree

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“It takes a village to raise a child”

African proverb

Contents

Abstract

Ninety-nine per cent of all parents visit child healthcare centres (CHCs) and all parents in Sweden are invited to parental groups organized by the child health service (CHS) during their child's first year, but only 40% choose to attend. The overall aim of this thesis was to elucidate the group-based early parental support provided by the Swedish CHS from the perspective of CHC nurses and parents. A total of 156 CHC nurses from 31 of 33 municipalities (Paper I) and 143 parents from 71 different parental groups at 27 CHCs (Paper II) in one Swedish county completed two different online questionnaires about their experiences of the parental groups provided by the CHS.

The findings showed that almost all CHC nurses managed several parental groups for both first-time parents and parents with more than one child. Specialized parental groups, e.g. groups for single parents, parents of twins and parents with a foreign background, were managed by half of the nurses and were more common at those CHCs organized as family centres. The nurses defined parental groups primarily as a place where parents could connect and create a network and secondarily as a place for education. Parents reported that the meetings were meaningful and felt that their role as parents was strengthened due to the parental groups. More than half of the parents had met someone who they socialized with outside of the meetings. Many of the topics addressed in the parental groups were found to be important by both the CHC nurses and the parents, but the parents desired a greater focus on topics such as parenting, child-related community information and sex and relationships. CHC nurses were found to be knowledgeable, committed and well-prepared, and parents felt that they could express their opinion and talk to the other parents as much as they wanted. The nurses however, felt that group leadership was a difficult and challenging task and expressed a need for education in group dynamics and group leadership.

Original papers

This thesis for the degree of licentiate is based on the following papers:

Paper I **Lefevre Å.**, Lundqvist P., Drevenhorn E., Hallström I. Managing parental groups during early childhood: New challenges faced by Swedish child health-care nurses. Journal of child health care: for professionals working with children in the hospital and community. 2013 Dec 2. Doi.10.1177/1367493513509421.

Paper II **Lefèvre, Å**., Lundquist, P., Drevenhorn, E., Hallström, I. "Parents' experiences of parental groups in Swedish child healthcare – do they get what they want?". *Submitted.*

Paper I has been reprinted with the kind permission of the Journal of Child Health Care.

Abbreviations

CHC	Child healthcare centre (Barnavårdscentral, BVC)
CHC nurses	Child healthcare centre nurses (BVC-sjuksköterskor)
CHS	Child health service (Barnhälsovård, BHV)

Introduction

The close relationship between young children's living conditions and their physical and mental health later in life is well documented and a safe and healthy environment during early childhood promotes cognitive functions and social development, as well as mental and physical health (Irwin & Hertzman, 2008; Kieling et al., 2011; McCrory, De Brito, & Viding, 2010). Throughout the world, the incidence of mental and behavioural disorders among children and adolescents is high and expected to rise further (Barlow & Parsons, 2003; Kieling et al., 2011; WHO, 2001), with symptoms like anxiety, depression, insomnia, fatigue and headache having become more common among children and adolescents over the last 20 years (Barlow & Parsons, 2003; Kieling et al., 2011; WHO, 2001). In Sweden, mental and behavioural disorders is currently one of the largest public health problems in this age group (Hallberg, Lindbladh, Petersson, Rastam, & Hakansson, 2005; Swedish Ministry of Health and Social Affairs, 2009) and the number of young people being treated for depression and anxiety has risen (Swedish Ministry of Health and Social Affairs, 2009).

The benefit of universal early intervention programmes and parental support has been highlighted both internationally (Irwin & Hertzman, 2008; Kieling et al., 2011) and nationally (Lagerberg, Magnusson, & Sundelin, 2008; Swedish Ministry of Health and Social Affairs, 2009) and it is argued that investments in such interventions are highly cost effective (Bremberg, 2004; Irwin & Hertzman, 2008). However, there has been limited research into the effects of early support for parents and children and further knowledge is required (Bremberg, 2004; Irwin & Hertzman, 2008; Swedish Ministry of Health and Social Affairs, 2009).

Parental groups provided by the Swedish CHS were integrated into the CHC program in 1978 (Swedish Ministry of Health and Social Affairs, 1978) when the CHS was changed to focus more on health promotion and family-centred

care (Sundelin, Magnusson, & Lagerberg, 2005), and the groups are still designed and implemented in more or less the same way (Swedish Paediatric Society). They are offered to almost all parents in Sweden during their child's first year, but only 40% of parents chose to participate (Centre of Excellence for Child Health Service, 2012; Wallby, 2008) and it can be questioned whether the parental groups offer what parents desire. To further develop the early parental support provided by CHCs, it is important to gain knowledge about CHC nurses' and parents' experiences of parental groups.

Background

Parents

The Western world is characterised by a rapidly changing society with new conditions for parenthood (Nystrom & Ohrling, 2004; Plantin & Daneback, 2009; Sarkadi & Bremberg, 2005). The average age for first-time parents in Sweden has risen since 1970 from 24 to 29 years of age (2011) for mothers and from 27 to 32 years of age for fathers (Statistics Sweden, 2011). Unemployment increased during the economic crisis of the 1990s, with competition for jobs and education becoming greater than before (Bäck-Wiklund & Johansson, 2012) and it has been suggested that the increasing age of first-time parents is a result of a desire to have a job and a career before having children (Skoog Svanberg, Lampic, Karlstrom, & Tyden, 2006).

A family can be defined as two or more persons who are related in any way, whether biologically, legally or emotionally, as defined by the family members themselves (IPFCC, 2010). Family patterns are changing in Sweden (Bäck-Wiklund & Johansson, 2012) and, even though the nuclear family still appears to be regarded as the ideal family by most parents (Wissö, 2012), the biological way of defining the family seems to be changing into a definition that is more relationship-oriented (Bäck-Wiklund & Johansson, 2012; Wissö, 2012). The divorce rate has been increasing since the 1980s, which makes various family constellations more common today (Lagerberg et al., 2008). In 2012, 82% of one-year-old children lived with their biological mother and father, about 8% lived in a family with new constellations of parents and siblings and 10% lived with a single parent (Statistics Sweden, 2012).

Becoming a parent is a major life transition and it is often described as a stressful and vulnerable time involving changes to lifestyle and routines (Deave, Johnson, & Ingram, 2008; A. M. Fagerskiold, Wahlberg, & Ek,

2001; Nolan et al., 2012). Parents attempt to shape their role as parents and both fathers and mothers sometimes report feeling isolated (Premberg, Hellstrom, & Berg, 2008; Tiitinen, Homanen, Lindfors, & Ruusuvuori, 2013). It is important to establish a sense of security in early parenthood as this appears to influence the parents' continued wellbeing (E. Persson, 2010).

Social insurance

Regulations concerning parental leave and benefits differ widely throughout the world. The objective of the European Union, as of 2012, was for all parents to be entitled to at least four months of parental leave before the child reaches the age of eight years (European law EUR-LEX, 2010). Sweden has a long tradition of providing families with comprehensive social insurance (Swedish Social Insurance Agency, 2013). The development of parental insurance is concurrent with times of decreasing fertility rates (see Figure 1), aims to promote childbearing and began with the introduction of a small benefit for the mother in the 1930s (Moderskapsförsäkringen) (Swedish Social Insurance Agency, 2004). During the 1970s and 80s, family policy in Sweden became focussed on the economic welfare of children (Stenhammar, Ohrlander, & Föreningen *Mjölkdroppen* (Stockholm), 2001) and in 1974 maternity insurance was replaced by a parental benefit for both parents that was based on the parents' income (Swedish Social Insurance Agency, 2004).

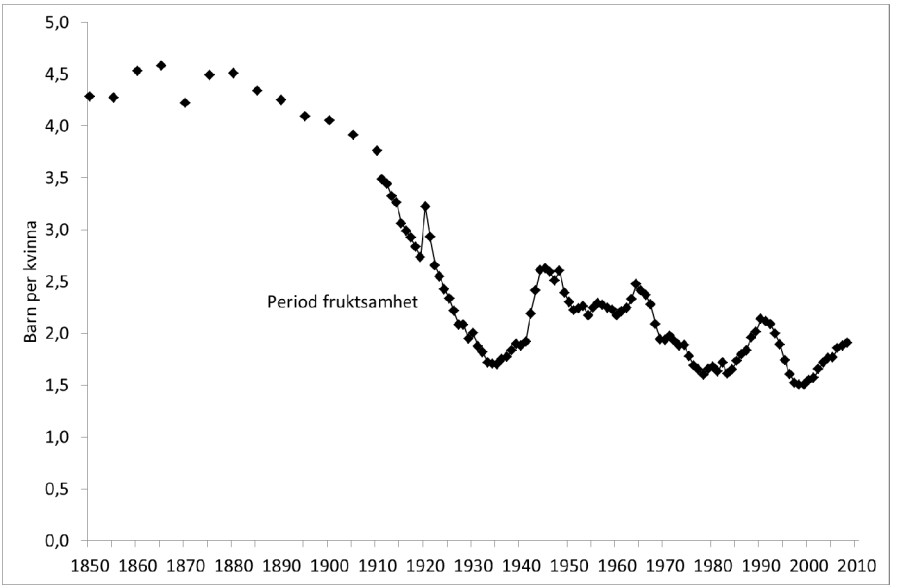

Figure 1. Total fertility rate in Sweden 1850-2008 (Dribe & Stanfors, 2010). Showing the average amount of children at a certain time point. Translation of Swedish text: Barn per kvinna: Child per woman. Period fruktsamhet: Period of fertility.

The current Swedish parental benefits make it possible for parents to stay at home from work with their child for 480 days, 240 days for each parent, of which 60 are reserved for each parent, while the remaining 180 days can be transferred between the parents as they wish. Some of the days can be used in the final three months of pregnancy and can also be used by both parents at the same time in order to attend pre- and post-natal parental groups (Swedish Social Insurance Agency, 2013).

In order to promote equality, a month that could be used only by the father was introduced in 1995, followed by a second month in 2006 (Swedish Social Insurance Agency, 2013). An equality bonus was implemented in 2008 to encourage parents to share the parental leave equally (Swedish Social Insurance Agency, 2013).

Parental support in Sweden

Parental support is defined by the Swedish Government as an activity for parents with children between 0 and 18 years of age that aims to promote children's health and psychosocial development and strengthen the parents' social network (Swedish National board of health and welfare, 2008). The definition is based on that of the United Nations Convention on the Rights of the Child (UNCRC), which defines a child as all persons under the age of 18 and refers to universal support directed at all parents, regardless of family constellation (Swedish National board of health and welfare, 2008). Parental support encompasses a broad spectrum of universal and targeted activities within several different disciplines, including early parental support within maternity care and the CHS, and parental support in preschool, school, social services, the police, non-profit organizations and industry, with the aim of reaching all parents with children in different age groups (Swedish National board of health and welfare, 2008). In 2009, the Swedish Government developed national guidelines for parental support in order to improve coordination amongst the different associations working within parental support (Swedish Ministry of Health and Social Affairs, 2009). During the preparation of these guidelines, it became clear that the existing parental support was disorganized and varied widely between different parts of the country.

The CHS has a long tradition of providing both group-based and individual parental support during the child's first year as part of its regular activities, but few structured methods are used and it has often been found that there is a lack of any evaluation of the methods and activities used (Sundelin & Hakansson, 2000; Sundelin et al., 2005; Swedish National board of health and welfare, 2008).

Swedish child healthcare

Development

Sweden and Scandinavia appear to be unique in Europe in providing an extended universal nurse-led CHS programme that includes both parental support and health surveillance targeted at all families (Swedish Ministry of Health and Social Affairs 2012; I. Wolfe et al., 2013). Sweden has a long history of CHCs, led by the CHS, not only aiming to reduce disease, mortality and disability but also to support parents in their parenting role (Sundelin et al., 2005; Swedish National board of health and welfare, 1991; Swedish Paediatric Society).

The predecessor to the present CHCs, "*Mjölkdroppen*", was imported by the paediatrician Doctor Blumenthal from Europe in 1901 into a Swedish society characterized by high infant mortality rates (10%) that were the result of malnutrition, overcrowding, poor hygiene and infectious diseases (Hallberg et al., 2005; Stenhammar et al., 2001). *Mjölkdroppen* started as a charitable reception centre where indigent mothers could receive healthy nutrition for their infants and strict advice concerning childcare. There were few educated nurses at this time and most women working at *Mjölkdroppen* lacked a formal education (Erlöv & Petersson, 1998; Stenhammar et al., 2001). The main tasks were to prepare nutritious milk, advocate breast feeding and advise mothers on how to care for their children. They also spent much of their time making unannounced home visits to ensure that their advice was followed.

Gradually, these activities were expanded, further health controls were added and in the 1930s the functions of *Mjölkdroppen* were taken over by the state. Nursing schools were founded in the country and developed from private schools for bourgeois women into state-approved schools with a formalized content (Erlöv & Petersson, 1998), resulting in the personnel working in CHCs becoming better educated. Vaccinations were distributed through the CHCs during the 1940s and 50s and a health check-up for the child at the age of four was included during the 1970s. The institution went from being a reception centre for less wealthy infants to CHCs for all parents and children

between 0 and 7 years of age (Hallberg et al., 2005; Stenhammar et al., 2001; Sundelin et al., 2005).

At the end of the 1950s, a change was observed in the CHS. The infant mortality rate had fallen to 2%, parents knew more about children's health than ever before and the opportunity to buy premade food for children made the CHC nurses nutritional advice less crucial to the survival of the child (Stenhammar et al., 2001). The nurses' authority and control were questioned and the unannounced home visits were criticized (Stenhammar et al., 2001).

The 1970s and 80s were the years of psychosocial orientation, with a focus on the family and parental support becoming key (Hallberg et al., 2005). Nurses were now to focus on the family as a whole and support the parents in their parenting instead of providing them with very strict, time-specific advice about how and when they should attend to their children. Methods that were too restrictive were seen as carrying a risk of impeding the child's development (Stenhammar et al., 2001). The infant mortality rate in Sweden became one of the lowest in the world, about 0.3%, and family health and interactions in the family became the new assignment of the CHS. Parental education and interaction with preschool became officially-integrated parts of the CHS (Hallberg et al., 2005; Magnusson, 1999; Stenhammar et al., 2001). The birth-rate decreased and family policy in Sweden focussed on the economic welfare of children, with the introduction of parental benefits based on the parents' income (Stenhammar et al., 2001; Swedish Social Insurance Agency, 2004) (see Figure 1). The organization of the CHS was questioned and it was argued that primary healthcare nurses should focus on the whole lifespan of the individual, which resulted in CHC nurses working with both children and adults (Erlöv & Petersson, 1998; Jansson, 2000; Magnusson, 1999). The work with children became less prioritized in some parts of the country and it was argued that this threatened the skills and knowledge of the CHC nurses (Erlöv & Petersson, 1998).

Child healthcare today

Today, all families in Sweden are invited to participate in a CHS program, starting when the child is born and lasting until it reaches the age of six and is transferred to the school healthcare program. The program is free of charge

and includes home visits, health examinations, a vaccination program and group-based parental support.

Most CHCs are situated in a primary healthcare centre, but may also be organized as family centres that also offer maternity care, social workers and an open preschool in the same building. The CHS is led and organized by a CHC nurse, with a physician performing some predefined health check-ups. Other experts such as psychologists and speech pathologists are referred to when needed. All nurses working in the CHS in Sweden have a specialist nursing education in paediatrics or public health nursing, both containing education within healthcare for children and adolescents (Swedish National board of health and welfare, 1991; Swedish Paediatric Society). The CHC nurses should work with children for at least 50% of their time and see no fewer than 25 newborn children every year in order to maintain their skills (Swedish National board of health and welfare, 1991; Swedish Paediatric Society). The CHS is well-appreciated and reaches about 99% of families (Swedish Ministry of Health and Social Affairs, 2009).

Group-based parental support during the child's first year

Early group-based parental support, "parental groups" or "parental education groups" as they was called in the beginning, have been provided by the Swedish CHS since 1978 (Swedish Ministry of Health and Social Affairs, 1978). The aim of these groups is to provide knowledge of children's needs and rights, strengthen parents' social networks and create awareness of family and child-related issues and the opportunity to influence society in such matters (Swedish Ministry of Health and Social Affairs, 1978; Swedish Paediatric Society). The form, objectives and topics addressed in the parental groups are more or less the same as they were 1978 (Swedish Ministry of Health and Social Affairs, 2009), although the aim for the parental group to be a place where parents can extend their social networks has become more explicit.

It is recommended that parents first attend a parental group when their child is 6 to 8 weeks old and the group meets every third or fourth week, a total of eight to ten times, during the child's first year. The recommended size of a group is five to eight families and the meetings last about 1½ hours (Swedish

Ministry of Health and Social Affairs, 1978; Swedish Paediatric Society). The content of the meetings will be based on the requirements of the parents, but different parenting topics such as nutrition, sleep and child safety almost always appear (Table I) (Swedish Paediatric Society; Wallby, 2008). Some CHCs organize parental groups for a specific group of parents such as young parents, parents of twins, parents of adopted children and parents with first languages other than Swedish. The incidence varies, however, and it is up to the individual CHC nurse to initialize such groups (Wallby, 2008).

Table 1. Recommended topics in parental groups (Swedish Paediatric Society, 2012).

Meeting	**Recommended topics**
1. Introduction	Social networks, sleep (child), tiredness (parents), crying and comforting, breastfeeding, child safety, the joys and challenges of parenthood
2. Adaption to a life with child	Childhood needs and development, equality, expectations, sibling issues, sex and relationships, jealousy, parental leave
3. What does the child need to thrive?	Childhood needs and development, child safety, children's sleeping patterns, self-care, children's health and diseases, vaccination, the joys and challenges of parenthood
4. Eat grow and feel well	Breastfeeding and nutrition, tobacco, alcohol and drugs
5. Everyday life	Everyday life in family, working, parental leave, bad conscience, couple relationships, child needs and development
6. Guiding your child	The child convention, parenting, outdoor activities, physical activities, nutrition and eating habits, tobacco, alcohol and drugs, TV habits reading
7. Child safety	Child development, child safety
8. Language and play	Development of languages and speech, reading together, child development, screen time, outdoor play
9. The world at large	Family life, social networks, expectations on life, kindergarten, child development, eating habits dental health, child safety, tobacco, alcohol and drugs
10. Conclusion	Child development, completion

Parents participating in parental groups

The national aim is for all parents to be invited to a parental group and for at least 75% of first-time parents and 40% of parents with more than one child to participate (Centre of Excellence for Child Health Service, 2012). First-time parents are the most likely to attend and 60-80% of them do so. The participation rate of parents who have more than one child is about 30% (H. M. Fabian, Radestad, & Waldenstrom, 2005; Wallby, 2008). The participation rate varies throughout the country, but the average participation rate for all parents is 40% (Bremberg, 2004; Petersson, Petersson, & Hakansson, 2004; Swedish National board of health and welfare, 2008; Wallby, 2008).

Parental groups were attended by 46% of all parents in Skåne in 2012. The spread was large and the participation rate varied from 8 to 91%. The participation rate of fathers was 3.4%, varying from 0 to 20% between different CHCs (Centre of Excellence for Child Health Service, 2013). Studies show that parents who are young, unemployed, have a low education level, live in the countryside or have considered abortion are under-represented in parental groups (H. Fabian, Radestad, Rodriguez, & Waldenstrom, 2008). Fathers' participation in parental groups varies from 2 to 30% (Bremberg, 2004; Centre of Excellence for Child Health Service, 2012; Hallberg, Beckman, & Hakansson, 2010; Wallby, 2008).

The prevalence of and participation in parental groups varies and, on average, only 40% of parents participate. There is a lack of national guidelines on how parental groups provided by the CHS are to be managed, which might imply that the nurses' views on the management of parental groups influence how parental groups are managed. Parents' and CHC nurses' views of parental groups have been only sparsely investigated and more knowledge about how parental groups are experienced could be valuable for the further development of such groups.

Aims

The overall aim of this thesis was to elucidate group-based early parental support provided by the CHS from the perspective of CHC nurses and parents. The thesis is based on two papers, one from the perspective of the CHC nurses and one from the perspective of the parents, each with its own specific aim.

Paper I: To describe CHC nurses' views of managing parental groups during early childhood in a county in Sweden.

Paper II: To describe parents' experiences of participating in parental groups at the CHC centres during their child's first year with focus on content, management and experience.

Method

Design

A cross-sectional method involving questionnaires was used for data collection. An overview of the sample and methodology can be seen in Table 2.

Table 2. Sample and methodology of the study presented in this thesis.

Paper	Design	Sample	Data collection	Analyses
I	Cross-sectional	156 CHC nurses from 31 different municipalities	Questionnaires Nov 2011- March 2012	Descriptive statistics Fishers' exact test
II	Cross-sectional	143 parents from 71 parental groups at 27 different CHCs	Questionnaires March 2012-May 2013	Descriptive statistics Fishers' exact test Mann-Whitney U test

Context of the study

The study was conducted in Skåne between November 2011 and May 2013. Skåne is a county in the south of Sweden consisting of both rural and urban areas with 1.2 million inhabitants. Every year, 16,000 children are born in the county (Statistics Sweden, 2011). Skåne has 140 CHCs employing more than 350 CHC nurses. About 95,000 children between 0 and 6 years of age are registered at the different CHCs (Centre of Excellence for Child Health Service, 2013).

In 2010, a manual for group-based parental support was implemented in the CHS in Skåne. The manual consists of an agenda for eight meetings with different topics at each meeting, followed by a guide pointing out important knowledge for the CHC nurse to emphasize. The aim is for the manual to serve as a source of inspiration and it should be used as a guide for which topics and knowledge should be mediated by the CHS in Skåne (Development Units for Child Health Care, 2009).

Data collection

Permission to conduct the study was obtained by the managers responsible in March 2011. Addresses for each of the 377 CHC nurses working at the CHCs in Skåne were provided by the Centre of Excellence for CHS (Paper I). A test letter was sent by e-mail in November 2011 to test whether all of the addresses were in use, resulting in 66 invalid addresses. This test was followed by an information letter sent by e-mail to the remaining 311 CHC nurses with information about the study, information about the Swedish Personal Data Act (Swedish Ministry of Justice, 1998), a unique study participation number and the web link to the questionnaire. Of the 311 CHC nurses, 13 responded that they did not have time to participate and 14 that they were not involved in parental groups. Two reminders were sent to the nurses who had not answered the questionnaire and a final phone call was made to those nurses who had still not answered. A statement confirming the participant's informed consent needed to be filled in in order to access to the questions.

To reach the parents participating in parental groups (Paper II), updated addresses for each of the CHC nurses were requisitioned from the Centre of Excellence for CHS in March 2012. A letter with information about the study was sent out to all 384 CHC nurses. There were 19 invalid addresses, 12 CHC nurses answered that they did not want to participate and 5 CHC nurses were not working during the study period. The letter included standardized information about the study to be read out by the nurses for the parents in their parental groups. To encourage the CHC nurses to inform their parental group participants about the study, two announcements about the study were published in the newsletter for CHC nurses from the Centre of Excellence for

CHS in Malmö during the study period. The first author also attended six of the regularly arranged meetings for CHC nurses held by the Centre of Excellence for CHS during the autumn of 2012 in order to inform the CHC nurses about the study.

Parents who were interested in participating wrote their name and e-mail address on a form that was forwarded by the CHC nurse to the author of this thesis. Two hundred and seventy four parents volunteered and a letter containing information about the study and the Swedish Personal Data Act (Swedish Ministry of Justice, 1998) was sent to these parents, together with a unique participation code and the link to the online questionnaire. Informed consent was filled in before entering the questionnaire. Three reminders were sent to those parents who did not answer.

Questionnaires

The two questionnaires have been used in other national studies in large contexts (Friberg, 2001; Wallby, 2008). They were developed and evaluated by professionals with extensive experience in this field. The questionnaire for the CHC nurses (Paper I, Appendix I) was developed and piloted by 15 CHC nurses nationally before being used in a national survey in 2008 (Wallby, 2008). The questionnaire contained 30 questions about the structure, content and extent of the CHC nurses' parental groups. For the present study, eight questions about the CHC nurses' views on their group leadership and the newly implemented manual were added, as was the opportunity to add open-ended comments to some of the questions.

The questionnaire used by the parents (Paper II, Appendix 2) was developed, tested, slightly modified and tested again in 2001 in the Stockholm area, i.e. a different part of Sweden, by professionals with lengthy experience working in the CHS (Friberg, 2001). The 34 questions focussed on the topics addressed in the parental groups, how parents found the groups to be managed and their overall experience of the parental groups. There was one final open-ended question where parents could leave comments about parental groups in general.

Both questionnaires included questions about background characteristics, e.g. education and occupation. Most of the questions were multiple-choice.

For the present study, the questionnaires were converted into an online questionnaire in the Verity Teleform 9 and Cardiff Teleform 10 versions of HP Teleform. The online questionnaires were tested in a pilot study in the spring of 2011. Eight CHC nurses from four different CHCs answered the questionnaire for CHC nurses and 14 parents answered the questionnaire intended for parents. To test face validity, i.e. explore whether the questionnaires were perceived by the relevant participants to be measuring what they were meant to be measuring (Kazdin, 2003), they were all asked afterwards about their experience of the questions. Minor corrections to resolve technical issues were made following the pilot study.

Study participants

One hundred and fifty six CHC nurses (55%) from 31 of the 33 municipalities in Skåne (Paper I) were represented (see Figure 2). The nurses who participated varied in terms of their education and experience of working at CHCs and all child healthcare organizations (e.g. family centres, CHCs, CHC nurses working only with children and CHC nurses working with both children and adults) were represented (for more information see Paper I, Table I). Most nurses (70%) had a public healthcare education, 38% had been working for 1-5 years and 42% had been working for more than 10 years. The majority of the nurses (81%) came from ordinary CHCs (i.e. not a family centre) and 43% of the nurses only worked with children (for detailed descriptions see Paper I, Table 1).

In total, 143 (53%) parents from 71 different parental groups at 27 CHCs (Paper II) participated, of the 274 parents who volunteered (see Figure 2). Eleven parents did not finish their parental group within the set time limit and therefore only answered up to question number 16 and were thus not included in the analyses of the remaining questions. Most parents were mothers (93%) with their first child (62%), born in Sweden (92%), living together with the child's father (97%), had a college or university degree (68%) and were employed when they were not on parental leave (87%) (for further details see Paper II, Table 1).

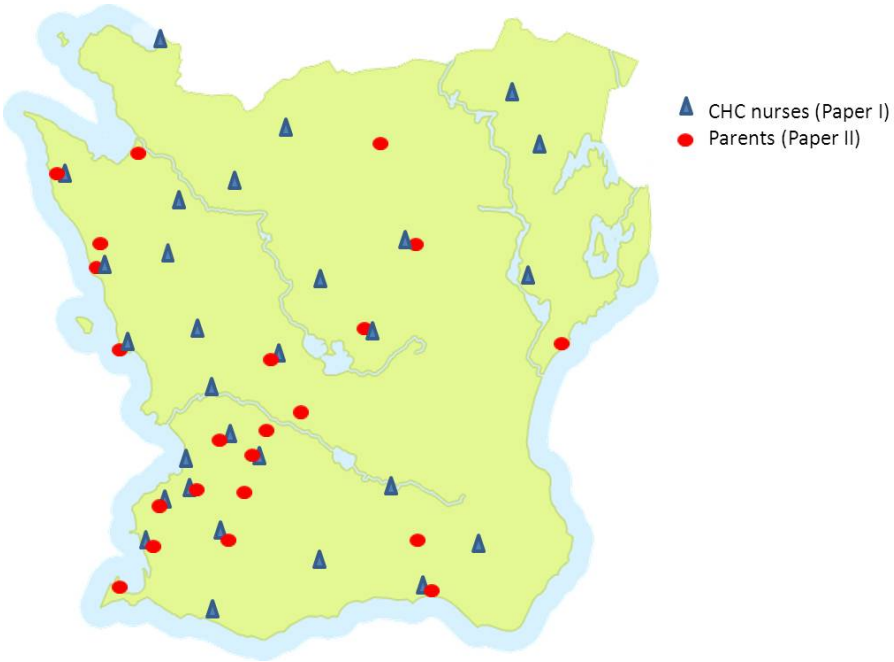

Figure 2. The locations of the participating centres in Skåne (larger towns with many centres are only shown once)

Statistics

Analyses were conducted using the IBM SPSS version 20.0©. The results are presented with descriptive statistics (numbers, percentage and mean). In Paper I, Fishers' exact test was carried out to test whether child healthcare organization, educational background or experience (e.g. number of years working in the CHS) were of significance to the nurses' experiences of managing parental groups and whether there were any differences in the specialized parental groups that were offered that related to the child healthcare organization.

In Paper II, Fishers' exact test was used to compare the parents' education level, what topics they found important to address in the parental groups, whether they felt that their parental role had been affected in any way as a result of the parental group, and their perception of the CHC nurse as group leader. The Mann-Whitney U test was used to test whether there were differences between groups (mothers and fathers). The significance level was set to $p<0.05$.

The open questions and comments were read through carefully, first to gain familiarity with the content and then to identify similarities between the comments.

Ethical considerations

The study was planned and conducted in accordance with the WMA Declaration of Helsinki of 2008 (WMA, 2008), the Swedish Act concerning the Ethical Review of Research Involving Humans (Swedish Ministry of Justice, 2008) and the Swedish Personal Data Act (Swedish Ministry of Justice, 1998), balancing benefits against risks, non-maleficence and beneficence, considering autonomy and justice. The study was approved by the Regional Ethical Review board in Lund (2011/3).

Non-maleficence and beneficence

The scientific benefits of a study shall outweigh the risks and inconveniences for the participants (Swedish Ministry of Justice, 2008; WMA, 2008). The questionnaires were short, taking approximately 15 minutes to answer, and did not consist of any delicate questions. CHC nurses might have felt that they were being evaluated and parents could have found it unpleasant to criticize their CHC nurse. Any possible inconvenience to the participants in this study was, however, considered to be minor and the information from the study results can be of value to the outcome of future parental groups.

Autonomy

With respect for the autonomy of the study participants all persons in the study were informed in writing about its aims, methods, risks and benefits, and were encouraged to contact the author of this thesis if they had any questions so that they would be able to provide their informed consent.

The CHC nurses (Paper I) were informed about the study through an information letter and the parents (Paper II) were informed about the study using written information that was read aloud by the CHC nurses followed by a written information for the nurses who volunteered. It was emphasized in the information that participation was voluntary and would not affect their further care in any way. Written informed consent was signed before it was possible to enter the questionnaire.

Confidentiality

A code number was given to each of the participants and the study data were kept safely apart from personal data in order to maintain confidentiality. Data is presented at group level to prevent any individual participant from being recognized and unique citations are presented with code number.

Justice

The principle of justice refers to the recruitment of study participants being performed in a non-discriminatory way. In this cross-sectional study, all CHC nurses in Skåne and all parents participating in parental groups during a certain time frame were asked to participate in the study regardless age, origin and gender. Participation in the study required at least some knowledge of the Swedish language as the information and questionnaires were produced in Swedish. CHC nurses were informed that the services of an interpreter could be used by the parents and there was a box in the questionnaire that could be filled in by the parents if further language help was needed. However, no one asked for this, which could indicate that we have not reached these groups.

Findings

Participation and frequency in parental groups

Most CHC nurses (98%) offered parental groups. A majority of the nurses managed groups for both first-time parents and families with more than one child (86%) (Paper I). Parental groups for families with children younger than one year were the most common (90%), but 8% also offered parental groups for older children. In total, 57% of the nurses offered specialized parental groups for parents of twins or young parents, for example. These groups were more commonly organized by nurses working at family centres ($p=0.004$) (for more details see Paper I, Table 3). The nurses started, on average, four to six parental groups annually and had six to eight meetings with each group.

Parental participation

It was mostly mothers who attended the parental groups and more than half of the participants (64%) reported that only one parent from each family attended. All of the fathers who participated in this study reported that the mother also attended some or all of the meetings ($p<0.01$). Nurses estimated the fathers' participation in general to be between 10 and 20% (Paper I) and 16% responded that they did not have any fathers in their groups. Most nurses stated that they did not employ any specific strategies to make the fathers attend the parental groups, but among the nurses who responded that they did (30%), the most frequent strategies were to emphasize the importance of the fathers' attendance in the invitations and to offer parental groups at times that would suit the fathers' working hours.

Management of parental groups

Most of the nurses (83%) (Paper I) organized new groups at the CHCs and did not take over pre-existing antenatal care groups. The groups were organized and led by the CHC nurses themselves (55%) or together with another CHC nurse (24%). Other professionals, for example, librarians, dental hygienists or psychologists, were sometimes invited (18%).

The CHC nurses (66%) defined parental groups as parental support which primarily aims to be a place where parents can connect and create a network and secondly as a place for learning. The nurses responded that they found group leadership to be both easy (45%) and difficult (45%). Many CHC nurses (n=92) made additional comments on the question about how they perceived group leadership. Of these, 60 CHC nurses commented that it was both difficult and easy to lead the parental group, depending on the group's dynamics. One CHC nurse expressed this in the following way: "if the dynamics within the group are good then it is easy, but otherwise it is difficult – I get nowhere and end up giving a lecture and there will be no cohesion in the group" (code number 112). Several nurses expressed a need for education and training in group leadership and they also commented that they had to be very much up to date with the various topics as parents found a wide variety of information on the internet and were in need of guidance. Overall, 85% of the nurses responded that they were content with the support they received from their employer concerning the parental groups; however, 52% of the nurses responded that they had no regular supervision.

The majority of the parents (73%) (Paper II) found parental groups to be very or rather meaningful. Half of the parents (52%) reported that they felt that their parental role had been strengthened by the parental group, while 30% stated that their participation in the parental group had made no difference to their parental role. Two parents felt that the parental group had made them feel more insecure. Parents (Paper II) found the CHC nurse to be very or quite well prepared (82%), very or quite committed (82%) and very or quite knowledgeable (85%) about the topics they addressed in their parental groups. Many of the parents who reported the nurse to be prepared, committed and knowledgeable also reported that they had become more secure in their parental role ($p=0.04$). Most parents (82%) felt that they had the opportunity to express their opinion and that they could talk to other

parents as much as they wanted (78%). More than half of the parents (62%) responded that they had met someone with whom they socialized outside of the parental group and several parents commented that the parental group was a good way to meet other parents in the same situation in order to discuss parenthood and childcare.

Structured tools for managing parental groups

Many nurses (78%) (Paper I) attended the training sessions held when the manual for parental groups was implemented in the region and most nurses (81%) felt they were supported by these training sessions. The Region Skåne manual was used by 83% of the nurses and many of them commented that they used it to create a structure for their parental groups or used it as a source of inspiration. Some nurses used it as a checklist and someone used it to plan their whole agenda. Most nurses (88%) responded that they found it useful. The booklet provided by the CHS and the Swedish National Institute of Public Health about group leadership was read by 28% of the nurses and the majority of them found it to be helpful. Other structural programmes for parental support were used to a minor extent by the nurses in their daily work at the CHCs, e.g. ICDP (International Child Development Program) (5%) (Hundeide, 2009) and Marte Meo (2%) (Aarts, 2008).

Content of the parental groups

Most CHC nurses (88%) (Paper I) had a pre-planned structure for their parental groups, but responded that they were, nonetheless, open to suggestions from the parents. The CHC nurses (93%) found sleep, child safety and family and relationships to be the most important topics to address and also prioritized such topics as nutrition (92%), breastfeeding (86%) and pregnancy and child birth (84%). They found however smoking habits (58%), child-related community information (53%) and sex and relationships (51%) to be topics that was less important to address (for details, see Paper I, Table 2).

A majority (64%) of the parents (Paper II) responded that they were informed about the content of the parental group before starting, but most of them (83%) also felt that the nurses had, to at least some extent, considered their

wishes about what should be addressed in the group. The most important topics from the parents' perspective were children's needs and development (90%), health and diseases (89%), child safety (88%) and interaction between parent and child (87%); topics that they also felt had been addressed by the CHC nurses. They also found child-related community information (67%), parenting (79%) and tobacco, alcohol and drugs (62%) to be important topics, they did however not find that these were addressed that much in their parental groups. Parents with a non-academic education seemed to be more interested in children's health and diseases ($p=0.026$), immunizations ($p=0.003$) and childhood accident prevention ($p=0.015$) than the parents with an academic education.

In total, 69% of the parents felt that they had gained further knowledge about children's development and needs and 41% about relationships in general. Nevertheless, 20% of the parents' felt that they had gained little or no knowledge about children's development and needs and 47% of the parents felt they had gained no knowledge about relationships in general. Many parents (60%) did not feel that they had become any wiser concerning child and family-related community issues.

Discussion

Methodological considerations

There is a limited amount of research into nurses' and parents' experiences of parental groups. Studies investigating the relationship between CHC personnel and parents in general (Fägerskiöld, 2002; Hallberg, Lindbladh, Rastam, & Hakansson, 2001; Magnusson, 1999) are more common and both quantitative and qualitative methods have been used for this purpose. In this cross-sectional study, questionnaires were used to describe parents' and CHC nurses' experiences of parental groups. For all studies the chosen method and instrument may impose restrictions as well as strengths on the study results which it is essential to discuss in order to assess the generalizability and quality of the study (Kazdin, 2003; Olsson & Sörensen, 2007).

Validity

Validity refers to the ability of the study to scientifically answer the questions it is intended to answer (Kazdin, 2003; Olsson & Sörensen, 2007). Validity is often discussed in terms of internal and external validity, where the internal validity refers to the validity of the conclusion drawn – most commonly used in causal studies – whereas the external validity refers to the opportunity to generalize the results to other populations and settings (Kazdin, 2003). There can be various threats against validity in studies and those found to be relevant to this study are discussed below.

Internal validity

Using questionnaires can be advantageous when attempting to reach a large population from different geographic areas and the risk of influencing the responses is likely to be low (Hansagi & Allebeck, 2004; Olsson & Sörensen, 2007). Online questionnaires were used, which has its advantages as well as

its limitations. Apart from being more efficient and reducing the amount of work with secondary data entry (Bot, Menendez, Neuhaus, Mudgal, & Ring, 2013), it is sometimes found to be more successful than other ways of conducting studies because populations which are difficult to recruit, e.g. adolescent females, appear to be more willing to participate in online studies (Fenner et al., 2012). On the other hand, paper questionnaires can be answered at different time points when respondents have spare time, but there is also thus a risk that the questionnaires are never completed and posted. Both the parents and the nurses were offered the opportunity to ask for paper questionnaires. The questionnaires used in this study; "Barnhälsovårdens föräldrastöd" and "Frågor om föräldragrupperna på barnavårdcentralen", were developed, tested and used by professionals with extensive experience of the CHS (Friberg, 2001; Wallby, 2008), which ensures their relevance. However, the questions might reflect the parental groups through the perspective of the CHS and the possibility that the parents might have found other questions to be of importance cannot be ruled out. There was one open-ended summary question about the parents' thoughts on parental groups in general at the end of the questionnaire. This made it possible for parents to add their own comments. The face validity of both questionnaires was tested in a pilot study before actual study began, with parents and CHC nurses being encouraged to provide their opinions and suggestions concerning the questions and the way they were distributed. No opinions concerning the questions were raised, however, which may be interpreted as confirming that the questions were considered relevant.

That the questions were multiple choice might restrict the answers of some respondents. The opportunity to add comments was added for the CHC nurses (Paper I). This opportunity was used by many respondents and added strength to the study because the comments confirmed the answers to the questions.

Defining the concepts carefully is fundamental (J. Persson & Sahlin, 2013) and sometimes different terms for the same thing were used within and between the questionnaires. Certain concepts, for example, "relationships", were sometimes described more accurately, for example, as "relationships to own parents", "relationship within the couple" or "relationship between child and parents", but in some questions "relationships" was not specified which

limited the opportunity to make a comprehensive comparison between the nurses' and the parents' experiences.

Selection bias is one of the most common threats to the internal validity of a study (Björk, 2010; Kazdin, 2003) and refers to the risk of the study population not being representative of the intended population (Björk, 2010; Kazdin, 2003). This study aimed to reach an overall population where all nurses and parents were invited to participate, which is considered to be a strength. However, there are some limitations that should be considered when generalising the results of this study. A 50% response rate is common when using postal questionnaires (Olsson & Sörensen, 2007) and could be considered acceptable, depending on how the respondents are distributed. In Paper I, 133 CHC nurses did not answer at all and the reasons for this are unknown. A new computerized system for medical records was implemented and annual statistics were collected for the first time during the study period, which probably affected the response rate as the nurses might have been occupied with these administrative duties. Nevertheless, almost all municipalities in the county were represented and the CHC nurses who participated displayed variation in terms of their education, experience and the organization in which they worked. It would, however, have been good to capture the experiences of those nurses who did not answer the questionnaire due to, for example, lack of time or because they had few parental groups as these nurses might have given us more information on what obstacles could be found in the management of parental groups. In Paper II some CHC nurses did not fill in the total amount of parents in their parental groups and could not remember when asked afterwards. It is not possible to obtain information on the total number of parental groups in Skåne, which makes it difficult to analyse the drop-out further. The variation in the study population was however similar to other study populations with higher response rates (Bremberg, 2004; Friberg, 2001), which reflects the group of parents who usually participate in parental groups.

The internal drop-out was low. Almost all questions were answered by more than 96% of the participants. In total, 14 CHC nurses did not answer the question about how they found the management of parental groups. This is also the question which had the most additional comments. The possible response alternatives were "Easy" or "Difficult" and many CHC nurses pointed out that they would have liked to choose both alternatives as it was

sometimes difficult and sometimes easy for different reasons. The comments made concerning this question gave us valuable information about what the CHC nurses found both difficult and easy with regard to group leadership.

Recruiting respondents through caregivers (Paper II) always carries a risk of bias and involuntary selection (Fenner et al., 2012; Fletcher, Gheorghe, Moore, Wilson, & Damery, 2012). However, all of the CHC nurses were encouraged to invite all parents to participate in the study, but the possibility that the CHC nurses who informed the parents attending their parental groups are those that are more interested in parental groups cannot be excluded. Recruiting the parents randomly through a birth register might have provided a broader population. However, recruiting through registers is argued to lead to a lower response rate (Olsson & Sörensen, 2007).

External validity

In total, 156 CHC nurses from 31 of 33 different municipalities participated in the study (Paper I). A variation is seen in terms of their education, the CHC organisation they work for and their experience (e.g. working years) (for an overview, see Table 1 in Paper I). The 143 participating parents (Paper II) represented 71 parental groups at 27 different CHCs. Well-educated, Swedish-born mothers in employment were overrepresented in this study, which is the group most commonly found to attend parental groups (H. M. Fabian, Radestad, & Waldenstrom, 2006; Lagerberg et al., 2008; Petersson et al., 2004).

This study confirms the results of other studies that had both higher response rates and different study designs, used quantitative as well as qualitative methodology and were performed in different geographical areas, which might imply that it is possible to generalize these results to other CHC nurses and parents.

General discussion of the results

The CHC nurse as a parental group leader

The nurses in our study defined parental groups primarily as a place where parents could connect and create a network and secondarily as a place for learning. Previous studies have shown discrepancies in the expectations placed on parental groups by nurses and parents, with the parents expecting to socialize and meet new people at the parental group meetings, and the nurses considering it as an opportunity to educate the parents (Bremberg, 2004; Fägerskiöld, 2002; Hallberg et al., 2005). Our findings reflect a change in attitudes among the CHC nurses which tracks the development of the CHS and general educational methods over the course of the 20th century. The focus in child healthcare has shifted from surveillance towards health promotion, aiming to strengthen the parents in their roles as parents (Bellman & Vijeratnam, 2012; Blair & Hall, 2006; Hallberg et al., 2005; Sundelin et al., 2005) and the role of the professional nurse has changed, from having been medically and technically oriented throughout most of the 20th century to become holistic and psychosocially oriented in the latter stages of the last century (Erlöv & Petersson, 1998). The teaching methods used in parental groups have, at the same time, changed in line with the educational reforms, from lectures to learning by reflection and understanding (Egidius, 2009) and the role of the CHC nurse in parental groups has expanded, from that of the expert into that of a facilitator of processes and of communication among the group members. The expertise provided by the CHC nurse might, however, be as important as ever. Technological development is progressing fast and the media supply looks different than it did 30 years ago (Plantin & Daneback, 2009; Sarkadi, 2003). The internet has created new ways for parents to communicate and search for information through an almost unlimited number of parental websites (Plantin & Daneback, 2009; Sarkadi, 2003). Advice and information found on the internet can sometimes conflict (Sarkadi, 2003) and it has been suggested that there is a need for guidance in assessing this information and these opinions (Plantin & Daneback, 2009; Sarkadi, 2003). The internet has created new ways to communicate and has not only made it possible for parents to obtain information and socialize in alternative ways, but has also rapidly changed our communication patterns (Sarkadi, 2003). People are getting used to having access to information and

chat functions around the clock. Integrating the new technology into parental groups could, perhaps, be a way to maintain the interest of parents today.

The majority of the parents in the study found the parental groups to be meaningful and more than half of the parents had met someone with whom they socialized outside of the meetings. The family can be seen as a social system partly open to societal demands and changes (Nichols, 2000), where parenthood, the relationship between parents and the child's development are intimately related (Belsky, 1981). By exchanging experiences in parental groups, the parents seem to be able to strengthen and confirm their parental role in this new transformative period of their lives (Guest & Keatinge, 2009; Petersson et al., 2004), which is likely to have a positive effect on the family as a whole, as well as on the individual family members.

Most parents found their nurse to be knowledgeable, committed, well-prepared and experienced, and that they had the opportunity to express their opinions and talk to other parents as much as they wanted. Parents who reported a high level of satisfaction with the nurse's performance also reported that they had become more secure in their parental role due to the parental group. The nurses, however, felt that group leadership was difficult and challenging and expressed a need for education in group dynamics and group leadership. The CHC nurse, the residential area and the age of the child are often the only known common factors in a parental group. Studies have shown that being able to identify with the other members of the parental group is important (Hanna, Edgecombe, Jackson, & Newman, 2002; Nolan et al., 2012; Wissö, 2012). If the differences between group members are too prominent there could be a risk of the group engendering feelings of insufficiency rather than promoting the parents' self-esteem (Wissö, 2012). However, there are educational methods that can be used to facilitate social interaction between group members and to create a trusting and permissive climate in the group (Elwyn, Greenhalgh, & Macfarlane, 2004; Nolan et al., 2012). Therefore, it is not surprising that our results show that the attitude and actions of the CHC nurse may be of importance to how the parental role is affected by the parental group and to how the members of the group connect with one another; which is supported by other studies (Hanna et al., 2002; Nolan et al., 2012). Most CHC nurses have not received any education in group facilitation, group dynamics and group processes as part of their nursing education, which may explain why several nurses in our study felt

insecure in their group leadership role. As the interaction between members of the parental groups has become more essential over time, the need for tools to tackle obstacles in group dynamics and group processes may have increased. Knowledge in these areas is often overlooked as something that does not have to be taught or trained (Elwyn et al., 2004) even though these are advanced skills that require guidance and practice if they are to be used successfully (Elwyn et al., 2004). Most parents participating in parental groups do, however, report that they are content with how the parental groups are conducted, but it is impossible to exclude the possibility that the participation rate might have been higher if the nurses felt confident in their management of their groups and had the tools to try new alternative ways to manage them.

Specialized parental groups and family centres

Specialized parental groups were offered by half of the nurses and more frequently by nurses working at family centres than those at ordinary CHCs. Parents who do not attend parental groups or report their dissatisfaction when they do are often those parents who represent a minority in the groups (H. M. Fabian et al., 2005). There are, however, studies showing that, for example, single parents (Lipman et al., 2010), young parents (Hägglöf, Hjelte, Hyvönen, & DSjöberg, 2013; R. B. Wolfe & Haddy, 2001) and less well-educated parents (Feinberg & Kan, 2008) could benefit from group-based parental support and it is regrettable that this universal support does not reach these groups. Specialized parental groups are suggested as one way of reaching these parents (H. M. Fabian et al., 2006). However, there are likely to be too few of these parents for such groups to be run frequently in all CHCs and it could thus be difficult for the nurses to acquire experience. The nurses have already been found to find group leadership challenging and difficult, and leading a group that might require additional knowledge and experience, for example, a multi-cultural group (Berlin, Johansson, & Tornkvist, 2006; Campinha-Bacote, 2002), might create a reluctance to start such groups. Coordination of such groups between CHCs could be beneficial and family centres, with their wide range of staff, are, perhaps, better prepared to meet the different needs of these groups of parents.

Fathers

In present study, the majority of participants are mothers, which reflects the participation patterns seen in parental groups (Petersson et al., 2004; Sundelin & Hakansson, 2000) and, just as in other studies investigating parental groups, fathers is an underrepresented group (Hallberg et al., 2010). Nurses estimated fathers' participation to be low in their parental groups, but little effort was made to get them to join in. The fathers who participated in parental groups in this study did so together with the mother. It has been well-documented that the fathers' involvement in their child's development is of great importance (Premberg et al., 2008; Wilson & Prior, 2011) and the Swedish Government has attempted to encourage fathers to increase their participation in their young children's lives using several initiatives such as the parental benefit exclusively for fathers and the equality bonus (Swedish Social Insurance Agency, 2013). The use of the parental benefit by fathers increased from 10.6% in 1999 to 23.7% in 2011 (Cedstrand, 2012), but progress is slow. More attention has been paid to the fathers' experiences of becoming a father (Johansson, 2012; Lundquist, 2008; Plantin, 2001) and it has been suggested that the lack of role models and the complexity of being both the breadwinner and the committed father makes the transition to fatherhood difficult (A. Fagerskiold, 2008; Plantin, 2001; Premberg et al., 2008). CHC personnel have been criticized for being mother-centric (Deave et al., 2008; A. Fagerskiold, 2008; Hallberg et al., 2010; Sarkadi, Kristiansson, Oberklaid, & Bremberg, 2008) and fathers have reported that they find the parental groups to be mostly for mothers (Hallberg et al., 2010). The timing of the meetings and a lack of interest are said to be reasons why fathers do not participate in parental groups (Hallberg et al., 2010), yet fathers report feeling isolated in their transition to fatherhood (Deave et al., 2008; Premberg et al., 2008). A recent study showed that CHC nurses often used the mothers' behaviour as the norm and compared the fathers actions or lack of action with those of the mother (Ahlden, Ahlehagen, Dahlgren, & Josefsson, 2012), which is understandable considering the long tradition in the CHS of focusing on the mother and child. However, as fathers' involvement in their young children's lives increases, there is a need for the CHS to change its perspective and to facilitate fathers' adaptation to their new role. This may mean that parental groups need to be conducted differently, at different times, covering different topics and in different forms in order to attract fathers.

Content of the parental groups

The CHC nurses in our study made plans and prepared the structure of their parental groups in advance, but seemed to be open to parents' suggestions and parents felt that they had an influence over the topics that were addressed in their parental groups. Many of the topics that were addressed were found to be important by both CHC nurses and parents, but parenting, child-related community information and sex and relationships, for example, were found to be considered less important by the CHC nurses, while parents wanted more focus on those topics. The physical and emotional effects of childbirth, the potential effect of life changes caused by becoming parents on their relationships and the need for more focus on the relationship between the mother and the father in parental groups has been raised in earlier studies (Petersson et al., 2004). Traditionally, CHC nurses have focussed more on natural sciences and medical issues (Jansson, 2000) and might feel less comfortable in addressing these topics (Petersson et al., 2004). Some nurses have chosen to share the role of group leader with a social counsellor or psychologist, which is likely to favour discussion of those topics. This might be facilitated by those CHCs that are organized as family centres, where the nurse and the counsellor already work closely together. Child-related community information was a topic that the nurses in our study reported was less frequently addressed in parental groups. This accorded with the parents' experiences; however, this is a topic that the parents were interested in discussing. One of the explicit aims of parental groups is to create awareness among parents about how their family's situation is dependent on the society and thereby improve the parents' chances of influencing the society in child and family related matters (Swedish Ministry of Health and Social Affairs, 1978; Swedish Paediatric Society, 2012) In the guidelines from 1978 concerning parental groups, it was suggested that the parental group were to be visited by representatives from various public-sector organizations, who would present valuable information to the parents (Swedish Ministry of Health and Social Affairs, 1978). Parental groups were previously visited by representatives from the Swedish Social Insurance Agency and open preschools or kindergartens. This was an opportunity for parents to learn more about the parental social security system and the different alternatives for preschool activities. The meetings with the Social Insurance Agency have, however, been replaced by information on its official website (Swedish Social Insurance Agency, 2013).

Parent satisfaction

Most parents (Paper II) found parental groups to be meaningful and half of the parents reported that they felt that their parental role had been strengthened by the parental group. Parents' opinions about parental groups are important as they will affect whether or not the parents choose to participate. However, satisfaction is difficult to measure and the results from satisfaction studies should be used with caution (Ortenstrand & Waldenstrom, 2005; van Teijlingen, Hundley, Rennie, Graham, & Fitzmaurice, 2003). Parents might feel reluctant to criticize caregivers, may have difficulty verbalizing what they have found to be good or bad and could find it difficult to see the alternative options (Ortenstrand & Waldenstrom, 2005; van Teijlingen et al., 2003). Our findings are, however, consistent with those of other studies with a variety of different designs in showing that parental groups are felt to serve as an important social support to parents (H. M. Fabian et al., 2005; Hanna et al., 2002; Nolan et al., 2012). Parents feel that parental groups are a good way to extend their social networks, gain self-confidence and exchange information about children's health and parenting (Hanna et al., 2002; Nolan et al., 2012).

Conclusions and clinical implications

Parents feel strengthened in their parental role and find parental groups to be a place where they can meet and socialise with other parents. Despite the fact that most CHC nurses manage several parental groups every year, they feel insecure in their group leadership role and would like to receive education in group dynamics and group processes. New demands on group leadership increase the importance of educating CHC nurses in group leadership and group dynamics in order to enable them to provide a high quality service to parents. The topics discussed during parental group meetings mostly accorded with those the parents felt needed to be covered. However, parents wanted the parental groups to have a greater focus on, for example, child-related community information, existential questions and parenting in general. Specialized parental groups occurred sporadically and more frequently at family centres. These groups might benefit from being organized centrally in the region as there are likely to be few parents in need

of such groups. It could be that family centres, with their wide range of staff, would be good locations for such groups to take place.

Further research

The parents who participated in this study were a rather homogenous group, consisting mainly of Swedish-born, well-educated mothers, reflecting the demographics of the parents who normally participate in parental groups. However, there is a great need to find out both what would make those parents who would not normally participate in parental groups interested in participating, and about their experiences of parental groups when they actually choose to participate.

CHC nurses expressed a need for education in group dynamics, group processes and group leadership and it might be interesting to develop and further investigate the group leadership role in parental groups in order to provide a high quality service to future parents.

Summary in Swedish

Barns fysiska hälsa i Sverige är god men psykisk ohälsa är ett av de största och snabbast växande folkhälsoproblemen i denna åldersgrupp idag. Tidigare forskning visar att en trygg uppväxtmiljö i den tidiga barndomen främjar den kognitiva och sociala utvecklingen såväl som den fysiska och psykiska hälsan senare i vuxenlivet. Att bli förälder innebär en stor förändring i livet och föräldrar uppger att de kan känna sig isolerade och osäkra och föräldrastödjande verksamhet efterfrågas. I Sverige inbjuds alla föräldrar att delta i ett basprogram inom barnhälsovården som förutom hälsoundersökningar och vaccinationer innehåller föräldrastöd individuellt och i grupp. Föräldragrupperna leds av en BVC-sjuksköterska och består av ett antal gruppträffar under barnets första år där föräldrar får möjlighet att diskutera olika barn- och föräldraskapsrelaterade ämnen. Målet är att stärka föräldrars sociala nätverk och öka kunskap om barns utveckling och rättigheter. Föräldragrupper har haft ungefär samma utformning sedan starten på 70-talet och frågan är om föräldragrupperna, som de ser ut idag, ger det stöd som föräldrar behöver och vill ha. Den snabba tekniska utvecklingen av media och internet har medfört nya sätt att kommunicera och umgås. Stödet tycks inte alltid nå de som behöver det bäst och i genomsnitt deltar endast 40 % av alla föräldrar. Det övergripande syftet med den här studien var att belysa föräldrastöd i grupp inom barnhälsovården utifrån BVC-sjuksköterskors och föräldrars erfarenheter.

Under perioden 2011-2013 ombads BVC-sjuksköterskor (Paper I) och föräldrar som deltagit i föräldragrupp (Paper II) i Skåne att besvara två olika webbaserade frågeformulär angående erfarenheter av föräldragrupper på BVC. Svaren presenterades med hjälp av deskriptiv statistic.

156 BVC-sjuksköterskor från 31 olika kommuner svarade på sjuksköterskeenkäten och 143 föräldrar från 71 föräldragrupper vid 27 olika barnavårdscentraler svarade på föräldraenkäten. Sjuksköterskornas enkät visade att

majoriteten av alla BVC sjuksköterskor bedriver föräldragrupper, vanligen både för förstagångsföräldrar och för föräldrar med flera barn. Föräldragrupper som riktar sig till en speciell grupp av föräldrar, t.ex. adoptivföräldrar, fäder och unga föräldrar visade sig vara mer sporadiskt förekommande men var något vanligare på familjecentraler. I genomsnitt startade varje BVC-sjuksköterska fyra till sex grupper varje år och hade sex till åtta möten med varje grupp. Det viktigaste målet med föräldragrupper definierades av BVC-sjuksköterskorna som att skapa en plats för föräldrar att mötas på och i andra hand som utbildningstillfälle. Föräldrarna rapporterade att de upplevde föräldragrupper som meningsfulla och att deltagandet stärkt dem i deras föräldraroll. Över hälften av föräldrarna uppgav att de träffat någon som de gjorde saker tillsammans med utanför föräldragruppsträffarna. Ämnena som togs upp i gruppträffarna stämde relativt bra överens med vad föräldrarna uppgav sig ha behov av att prata om, men till exempel barnrelaterad samhällsinformation, föräldraskap i allmänhet och samtal om tobak, alkohol och droger var något som föräldrar efterfrågade i högre grad. Trots att BVC-sjuksköterskorna hade stor vana av att bedriva föräldragrupper upplevde de osäkerhet i sitt gruppledarskap och önskade utbildning i gruppdynamik och grupprocesser. De flesta föräldrarna upplevde att BVC-sjuksköterskorna var förberedda, pålästa och engagerade i sina föräldragrupper och resultaten visar att de föräldrar som upplevde detta också i högre grad uppgav sig vara stärkta i sin föräldraroll efter föräldragrupperna.

Utbildning i gruppledarskap och information om vilka ämnen föräldrarna önskar ska tas upp i föräldragrupperna kan stärka BVC sjuksköterskorna i sin roll som föräldragruppsledare. Vi behöver ytterligare kunskap om vad som gör att många föräldrar inte deltar i föräldragrupper.

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Paper I

Article

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Managing parental groups during early childhood: New challenges faced by Swedish child health-care nurses

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Abstract
The purpose of this study was to describe child health centre (CHC) nurses' views of managing parental groups during early childhood. All 311 CHC nurses working within the Swedish CHC system in one county were asked to complete a web-based questionnaire. Findings showed that although the CHC nurses were experienced, several found group leadership challenging and difficult. The need for specialized groups for young parents, single parents and parents whose first language was not Swedish was identified by 57% of the nurses. The CHC nurses found the participation of fathers in their parental groups to be low (an estimate of 10–20%), and 30% of the nurses made special efforts to make the fathers participate. Education in group dynamics and group leadership can strengthen CHC nurses in managing parental groups. It is recommended that specialized parental groups are organized by a few family centres so CHC nurses can develop their skill in managing such groups.

Keywords
Education, family-centred care, health promotion, nurse–family relationships, parenting support

Background

Parental support is an important part of the Swedish child health service (CHS), including parental groups to provide knowledge and strengthen the parents' social network. However, the support does not always reach the families that need it the most (Fabian et al., 2006; Lagerberg et al., 2008). Countries in Western Europe are struggling with the question whether the CHS should be universal

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or targeted towards families whose children are at risk (Bellman and Vijeratnam, 2012; Blair and Hall, 2006; Wolfe et al., 2013). The Scandinavian model with a comprehensive universal nurse-led CHS programme including both parental support and health surveillance directed to all children and their parents seems to be unique in Europe (Swedish National Board of Health and Welfare, 2012; Wolfe et al., 2013).

The prevalence of mental and behavioural disorders among children and adolescents throughout the world is high and is expected to rise (Barlow and Parsons, 2003; WHO, 2001; Kieling et al., 2011). In Sweden, the proportion of young people in care for depression and anxiety is high and increasing (Department of Health, 2009). Research had identified that a healthy environment during early childhood promotes both cognitive and social development as well as mental and physical health (Irwin et al., 2008; Kieling et al., 2011; McCrory et al., 2010).

Sweden has a long tradition of CHS aiming to reduce disease, mortality and disability but also to support parents in their parental role (Swedish Children Medical Association, 2013; Swedish National Board of Health and Welfare, 1991). The child health centre (CHC) is led by a CHC nurse specialized in health care for children and adolescents (Swedish Children Medical Association, 2013; Swedish National Board of Health and Welfare, 1991). The CHC can be located either at a health centre or a family centre, where CHC nurses, social workers, antenatal care and an open nursery school are situated in the same building. All families in Sweden are invited to participate in the CHS programme, starting when the child leaves the maternity unit until the child reaches the age of six and is transferred to the school health-care programme. The programme includes home visits, health examinations, a vaccination programme and parental groups. The CHC nurse organizes parental group meetings 8 to 10 times during the child's first year (Department of Health, 1978; 2009, Swedish Children Medical Association, 2013). In accordance with theories about group leadership and group facilitation, parental groups are closed groups with 6-8 couples in each group in order to facilitate a trusting climate (Elwyn at al., 2004; Puskar et al., 2008). The groups are meant to serve as a place where parents can meet and share experiences and extend their social network. The agenda should be decided in a cooperative way together with the parents to ensure that themes are addressed according to parents' wishes. This increases the feeling of informality and promotes future independence from the group facilitator (Elwyn et al., 2004). The nurse's role is to give information about the themes chosen and serve as a group facilitator. By observing the group dynamics and managing the group processes, the nurses should work to obtaining the best possible outcome in the group (Elwyn et al., 2004; Puskar et al., 2008). There is no structured manual to follow for the meetings, but there are some recommended themes to be included, such as child development, nutrition and interaction between parent and child (Swedish Children Medical Association, 2013).

Although parental support is important within CHS, few evidence-based methods are used (Sundelin and Hakansson, 2000; Sundelin et al., 2005, Swedish National Board of Health and Welfare, 2008, 2012). The International Child Development Programme (ICDP) aimed at improving communication and interaction between parents and children (Hundheide, 1996) and motivational interviewing, a communication methodology (Rollnick et al., 2008), are evidence-based methods recently introduced within the CHS, but they are not yet frequently used.

The CHS program is appreciated by the parents and reaches about 99% of the families (Department of Health, 2009), but only about 40% of the parents participate in parental group activity (Center of Excellence for Child Health Service, 2012; Wallby, 2008), and the accessibility and participation varies greatly in different regions of Sweden (Petersson et al., 2003; Wallby, 2008). Young parents, single or unemployed parents, parents with a low education level and/or with a non-Swedish background are significantly under-represented in the parental groups (Fabian

et al., 2006; Lagerberg et al., 2008). Parental groups directed exclusively to, for example, parents of twins, young parents, parents with adopted children or single parents, the so-called specialized parental groups, only occur sporadically in the country (Wallby, 2008).

In a national survey previously conducted in Sweden, CHC nurses pointed out that they found it difficult to manage parental groups (Wallby, 2008), and as a result a booklet about group leadership was developed by the Swedish National Institute of Public Health (Heimer and Semb, 2009). In addition, a regional manual, designed as a detailed checklist containing suggestions for themes to be addressed and suggestions of problems to be highlighted and discussed was developed and implemented in a county in the south of Sweden (Development Units for Child Health Care, 2009), aimed at supporting CHC nurses in their work with parental groups.

Even though there are regional guidelines used at some CHCs, there are no national guidelines on how to manage parental groups in Sweden. This might imply that the individual nurses' views of managing parental groups influence how the parental groups are held. Therefore, the aim of this study was to describe CHC nurses views of managing parental groups during early childhood in a county in Sweden.

Method

Settings

The study was conducted in Skåne, a county in the southern part of Sweden, with 1.2 million inhabitants and 16,000 children born every year (Statistics Sweden, 2011). Skåne consists of both urban and rural areas and has 138 CHCs with about 300 nurses employed. More than 95,000 children between 0 and 6 years of age are registered at the CHCs (Center of Excellence for Child Health Service (Kunskapscentrum för barnhälsovård), 2012). During the year 2011, 86% of the parents in Skåne were invited to participate in parental groups and the average participation among all was 45%, but the spread was large (17–80%) between the different CHCs (Center of Excellence for Child Health Service, 2012).

Study population/data collection

The addresses of all 377 CHC nurses working in the county of Skåne were requested from the Centre of Excellence for CHS in Skåne; 66 of these were no longer in use. The remaining 311 CHC nurses were asked to complete a web-based questionnaire previously used in 2008 (Wallby, 2008). The questionnaire contained 30 questions concerning the structure, content and extent of the nurses' parental groups and how they define parental support as well as what they find important to address in the groups. Furthermore, background characteristics such as organization, education, years of working and how many children the nurses are responsible for are included. Eight questions concerning the nurses' views of their own personal group leadership and the manual implemented in 2010 were added to further illuminate these subjects. Most questions were of a multiple-choice character with the possibility of adding comments. A pilot study including eight CHC nurses was conducted in early 2011 in four CHC centres in order to test the questionnaire and the technical procedures. Minor corrections were made concerning technical issues (Figure 1).

The study was performed between December 2011 and April 2012. Study information, a unique study participation number and the link to enter the survey were provided to the participants by email. Two reminders were sent by email to those who did not answer. As a last reminder, a telephone call was made to the nurses who still had not answered.

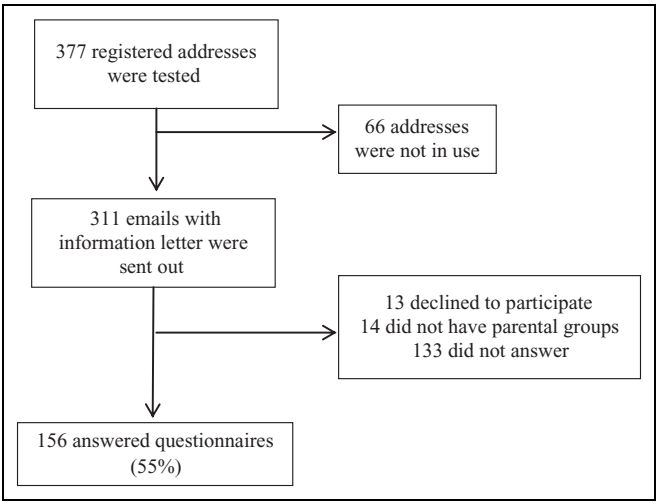

Figure 1. Flow chart of participating CHC nurses. CHC: child health centre.

Statistics

Descriptive statistical analyses were conducted using Statistical Package for Social Sciences (IBM, SPSS version 20.0). Fisher's exact test was carried out to explore whether CHC organization, educational background or experience (e.g. number of years working within CHC) were of any importance for the nurses' experiences of managing parental groups. The significance level was set to $p < .05$. Comments expressed in open questions were summarized in a structured way.

Ethical considerations

The study was planned and conducted in accordance with the WMA Declaration of Helsinki 2008 (WMA, 2008). Permission was given by all responsible managers. All the participating nurses gave written informed consent and were given a code number. The study was approved by the Regional Ethical Review Board (2011/3) and possible inconveniences for the participants were considered to be small and compensated by the benefits of the study results.

Results

Of the 311 CHC nurses, 156 nurses (55%) from 31 of 33 different municipalities completed the survey. Nurses with different educational background and different experiences (working years) were represented (as set out in Table 1).

In all, 66% of the nurses defined parental groups as parental support, which in turn was defined as availability, continuity and personal knowledge. The nurses defined the primary aim with the parental groups as a place where parents could connect and create a network and secondly as a place for learning. Parental groups were offered by almost all the nurses (98%) during the child's

Table 1. Background characteristics of the participating CHC nurses.

Characteristics	Percentage
Education	
Public health care	70
Paediatric	22
Public health care + paediatric	5
Other specialist education	3
Years working in CHC	
1–5 years	38
6–10 years	19
>10 years	42
Organization	
CHC organized as family centre	19
CHC centre	81
Nurses working only with children	43
Nurses working with both children and adults	57
Responsible for children under the age of 2 years	
20–40 Children	47
41–60 Children	27
61–80 Children	18
81–90 Children	6
175–450 Children	2

CHC: child health centre.

first year. Most nurses held groups for both first-time parents and parents with more than one child (86%), but 10% of the nurses primarily had groups for first-time parents alone. On average, the nurses started four to six new parental groups annually and had six to eight meetings with each group. Mostly the parental groups were organized and started by the nurses and not transferred from the antenatal care. The subjects most commonly addressed were nutrition and sleep (Table 2). In all, just over half of the nurses (55%) led all their group meetings themselves, while 24% managed their parental groups together with another nurse. In all, 18% invited other professionals, for example, librarian, dental hygienist or psychologist to some meetings.

Overall, 85% of the nurses expressed that they were content with the overall support they received from their employer in order to facilitate the parental groups. However, 52% of the nurses did not have regular supervision, whilst 45% of the nurses found it difficult to manage their groups and 45% found it easy. No relationship between background characteristics of the nurses and their experience of conducting parental groups was found.

In 92 of the 156 answered questionnaires, nurses made comments on the question about group leadership, and of these, 60 CHC nurses mentioned that it was both easy and difficult to lead parental groups due to the dynamics within the groups. For example, some nurses stated 'It is difficult in quiet groups and with dominant parents' (code number 288); 'if the dynamics within the group is good then it is easy, but otherwise it is difficult – I get nowhere and end up giving a lecture, and there will be no cohesion in the group' (code number 112). Several of the nurses expressed a need for education and training in group leadership and group dynamics. Some nurses expressed that great expectations were put on them as parental group leaders as they had to keep more up to date. For example, a nurse commented that 'Many different subjects are brought up and I need to

Table 2. Themes addressed in parental groups.

Themes	$N = 156$
Sleep (%)	93
Child safety (%)	93
Family and relationship (%)	93
Nutrition (%)	92
Self-care (%)	92
Interaction between parent and child (%)	90
Breast feeding (%)	86
Pregnancy and child birth (%)	84
Parental role and parenting (%)	85
Other subjects according to parent's wishes (%)	83
Children with difficult temper (%)	76
Drinking habits (%)	72
Vaccination (%)	70
Languages and speech (%)	60
Smoking habits (%)	58
Dental health (%)	56
Child-related community information (%)	53
Sex and relationships (%)	51

be very up to date, the parents have a lot of worries because they surf on the Internet and find a lot of different information, I have to sort out and give guidance' (code number 286).

The booklet about group leadership provided by the CHS was read by 28% of the nurses, and 84% of them felt that it was useful. Most nurses (87%) attended the training sessions that were held when the regional parental group manual was presented, and 93% of them found that they were helped by these sessions. It was found that 83% of the nurses used the parental group manual in their work with parental groups, and 88% of them felt that the manual was useful in supporting them. Other structural programmes were used to a minor extent by the nurses in their daily work at the CHC, such as the ICDP (5%) and Marte Meo (2.4%) (Aarts, 2008).

It was estimated that only between 10 and 20% of fathers participated in the parental groups and 16% of the nurses did not have any fathers in their groups. In all, 30% of nurses indicated that they made efforts to increase the participation of the fathers. The most common effort to increase the fathers' participation was to offer parental groups at hours that could suit the father's working hours better and to orally emphasize the importance of both parents participating. Specialized parental groups, for example, groups of parents of twins, young parents or parents with a foreign background (Table 3) were held by 57% of the nurses and were more common among nurses working at family centres ($p < .004$).

Discussion

The result showed that the CHC nurses were experienced in managing parental groups, but in spite of this several nurses found the group leadership challenging and difficult. They expressed a need for education in group leadership and many of them felt that they were in need of more supervision.

The nurses primarily defined parental groups as a place where parents can connect and create a network and secondly as a place for education. This reflects a change in the group leader role,

Table 3. Specialized parental groups held in Skåne reported by CHC nurses.

Specialized parental groups	Percentage
Parents with twins	25.4
Young parents	14.7
Parents with mother tongue other than Swedish	9.6
Parents with adopted children	4.5
Fathers	3.2
Single parents	3.2

CHC: child health centre.

which follows the change of CHS in general, where focus has shifted from surveillance towards health promotion, aiming to strengthen parents' self-esteem (Bellman and Vijeratnam, 2012; Blair and Hall, 2006; Hallberg et al., 2005; Sundelin et al., 2005; WHO, 2005). The parental group leader has extended from being a teacher and expert to a facilitator for processes and communication among the group members, two group facilitating roles that can be difficult to combine (Elwyn et al., 2004). This is a result not only of decreased economic resources within health care (Sundelin et al., 2005; Hallberg et al., 2005) but also of educational reforms during the 20th century, where expert-controlled curricula have been replaced by brief guidelines where teachers and students are responsible for the students educational development (Egidius, 2009). Pedagogics has changed from teaching factual knowledge towards teaching by reflection and understanding (Egidius, 2009).

Knowledge about group facilitation and group leadership is often overlooked as something that does not have to be taught or trained (Elwyn et al., 2004), but in reality profound knowledge in group dynamics, decision-making and process consultation is needed to be an efficient group facilitator (Elwyn et al., 2004; Petersson et al., 2003; Puskar et al., 2012). Most CHC nurses do not have any formal group leadership training in their education, and despite the efforts made in terms of CHS continuing professional education to strengthen nurses in their role as parental group leaders, they still report uncertainty regarding managing parental groups. The education given seems to be mostly focused on the content of the parenting themes, while our results imply that CHC nurses need education and training in group dynamics and processes. Supervised groups where the nurses are given the basic elements in group facilitation and are encouraged to try new ideas would be a good way to maintain and obtain skills (Hundheide, 2009).

Another reason for the uncertainty felt by the nurses might be that the CHC nurses meet parents with more needs and other demands than they did before. The exposure to media has increased (Plantin and Daneback, 2009; Sarkadi, 2005) and with the immense amount of parental sites on the Internet, it has become part of the daily life for parents to socialize and search for information through the Web (Plantin and Daneback, 2009; Sarkadi, 2005). The CHC nurses have to compete with this stream of parental information available around the clock, and there is a new need for the nurses to help the parents navigate through the jungle of information and opinions. In this study, it was found that nurses did not receive regular supervision, a result that not only confirms the findings showed in the survey by Wallby (2008) but also shows that no improvement has been made. Supervision should be provided by the CHS and be a part of the CHC nurses' work (Center of Excellence for Child Health Service (Kunskapscentrum för barnhälsovård), 2012), but there is no definition of the form and frequencies and in practice this seems to vary.

Specialized parental groups were held by 57% of the nurses and were more common among CHC nurses working at CHCs located as family centres. Young parents, single parents and parents with a foreign background are under-represented in ordinary parental groups, and it is suggested that having specialized parental groups could be one way of reaching these parents (Fabian et al., 2006). It is likely that there are too few eligible parents in order for such groups to be run frequently at all of the CHCs (Department of Health, 2009; Wallby, 2008); therefore, the CHC nurses are less experienced in managing such groups that could create reluctance to start them. One way of addressing this could be to organize specialized parental groups centrally in the area. However, the importance of being able to identify oneself with others in the same situation in order to create a supportive friendship has to be considered (Nolan et al., 2012) together with the idea of parental groups to facilitate a growing and long-lasting network in the neighbourhood, which suggests that the areas should not be too wide. Family centres have been found to have more parental groups and higher participation rates than those in CHCs (Wallby, 2008), and using a greater variety of co-workers serves as a base for more specialized parental groups. Little, however, is known about what parents feel they would benefit from within these groups, and further research in this area is therefore suggested.

The CHC nurses found the participation of the fathers in their parental groups to be low; despite this, only 30% of the nurses made any alterations. The actions taken by the CHC nurses to make the fathers participate in parental groups were all actions to increase the fathers' participation in already existing groups. It is well documented that the father's involvement during the childhood period is of great importance both for the family's well-being and the development of the child (Sarkadi et al., 2008; Wilson and Prior, 2011). Parental leave exclusively for fathers and gender equality bonuses are actions taken by the Swedish government to increase the father's involvement in the lives of their young children (Hallberg et al., 2010; The Swedish Social Insurance Agency, 2013). Previous studies show that reasons for fathers not to participate in parental groups are not only that the meetings are being held at inconvenient times but also that the fathers felt they had no need for this kind of activity (Hallberg et al., 2010). There is a need to further investigate mothers' and fathers' needs in terms of parental support.

Strengths and limitations

One limitation of this study was the nurses' low response rate (55%). A new computerized system for medical records was implemented, and annual statistics were collected for the first time during the period for the study, which probably affected the response rate. Nevertheless, nurses from 31 of 33 different municipalities took part in this study with different educational and organizational backgrounds. The questionnaire had been developed by experts and tested previously. Using this approach meant we could not only compare the results over time but also compare our results across a large population of nurses. To get deeper insight, qualitative interviews with CHC nurses might capture a wider range of nurses' perceptions.

Conclusions

New demands on group leadership increase the importance of education for CHC nurses in group leadership and group dynamics in order to provide a high-quality service to parents. Nurses with little experience in managing specialized parental groups might create a reluctance to start such groups. To organize the specialized parental groups centrally in the region, preferably at family

centres, would probably increase the opportunities for parents with special needs to participate in parental groups. Further research about what would attract the parents who do not attend to the parental groups is needed in order to increase their involvement.

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Paper II

“PARENTS’ EXPERIENCES OF PARENTAL GROUPS IN SWEDISH CHILD HEALTHCARE - DO THEY GET WHAT THEY WANT?”

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ABSTRACT

All parents in Sweden are invited to parental groups organised by the child health service (CHS) during their child’s first year, but only 40% choose to attend. The aim was to describe parents’ experiences of participating in these parental groups. A total of 143 parents from 71 different parental groups at 27 child health care (CHC) centres in one Swedish county completed an online questionnaire. A majority of the parents found the parental groups to be meaningful and more than 60% met someone in the group who they socialized with outside the meetings. Parents wanted a greater focus on child-related community information, existential questions, relationships and parenting in general. Group leadership seems to be of significance to how parents in a group connect and whether the parental role is affected. Making CHC nurses more aware of the topics parents desire could help them meet parents’ needs. Education and training in group dynamics and group leadership could be of value in further improving the high quality service CHC nurses already offer parents. More knowledge is needed about what would attract those parents who do not already participate.

Keywords: parental groups, parental education, parenting support, family-centred care, health promotion

BACKGROUND

Parental groups organised by the child health service (CHS) during the child´s first year are shown to serve as an important social support to parents. Besides information about children's health and parenting, they also gain self-confidence and develop their social network (Nolan et al., 2012; Hanna et al., 2002; Fabian et al., 2005). All parents in Sweden are invited to parental groups organised by the CHS during their child's first year, but only 40% chose to attend (Wallby, 2008). The Western world is characterised by a rapidly changing society with new ways to communicate and socialize and new conditions for parenthood (Nystrom and Ohrling, 2004; Plantin and Daneback, 2009; Sarkadi and Bremberg, 2005). Increased exposure to media and information being only a click away creates new parental requirements (Plantin and Daneback, 2009; Sarkadi, 2005). Parental groups in Sweden have had a similar format since their introduction in 1978 (Swedish department of health, 1978; Swedish Children Medical Association, 2013) and it can be questioned whether these groups offer what the parents desire.

Becoming a parent is a major life transition and is often described as a stressful time involving lifestyle changes, with both fathers and mothers attempting to shape their parental roles (Hanna et al., 2002; Nystrom and Ohrling, 2004; Nolan et al., 2012). New mothers have reported that they sometimes feel isolated and that social support is important (Fagerskiold et al., 2001; Feinberg and Kan, 2008; Nolan et al., 2012; Tiitinen et al., 2013) and parental groups are a good way to break such isolation (Fagerskiold et al., 2001; Deave et al., 2008; Nolan et al., 2012; Hanna et al., 2002; Guest and Keatinge, 2009).

Parental support is an important part of the Swedish CHS, and the Scandinavian model of a universal nurse-led child healthcare (CHC) program involving parental groups seems to be rather unique in Europe (Wolfe et al., 2013), where targeting parental support groups at at-risk families or those with existing problems appears to be more common (Blair and Hall, 2006; Bellman and Vijeratnam, 2012).

The Swedish CHC program is free and includes health surveillance, immunizations and individual and group-based parental support (Swedish department of health, 1978; Swedish department of health, 2009; Swedish Children Medical Association, 2013). Group-based parental support aims to provide knowledge of children's needs and rights and strengthen parents' social networks (Swedish department of health, 1978; Swedish National board of health and welfare, 2008). The groups meet eight to ten times in fixed groups at the CHC centres and discuss different topics such as child development, nutrition and parent and child interaction, according to the parents' wishes (Swedish department of health, 2009; Socialstyrelsen, 1991; Swedish Children Medical Association, 2013). Managing parental groups requires expertise in group leadership and group dynamics, which is something Swedish CHC nurses desire (Lefèvre et al., 2013)

Earlier studies indicate that the form and content of parental groups primarily appeal to white well-educated middleclass mothers (Sundelin and Hakansson, 2000; Petersson et al., 2004; Lu et al., 2003) while it is harder to attract fathers, less well-educated parents, single parents, immigrants and unemployed (Petersson et al., 2004; Lagerberg et al., 2008; Fabian et al., 2006). Parents who participate in parental groups are mostly satisfied and consider such groups an important parenting support (Guest and Keatinge, 2009; Petersson et al., 2004; Nolan et al., 2012; Hanna et al., 2002; Deave et al., 2008). They present an opportunity to learn and to meet with other parents going through the similar experiences (Guest and Keatinge, 2009; Petersson et al., 2004; Deave et al., 2008). However, studies also show that parents request a greater focus on the parental role and interaction between family members and that too little time is spent on social issues concerning families and children, e.g family counselling and the social security system (Petersson et al., 2004; Deave et al., 2008). Parents also suggest that the groups should be more homogeneous with, for example, first-time parents in separate groups, and that the antenatal care groups should remain together in order to retain the sense of security established prior to delivery (Petersson et al., 2004). Parents underrepresented in parental groups are likely to find them less helpful (Fabian et al., 2005). Few fathers participate

(Wallby, 2008; Hallberg et al., 2010), and some participating fathers have reported that they feel neglected and excluded from the group and from discussions (Deave et al., 2008) and found the parental groups to be mostly for mothers (Premberg et al., 2008).

Parents' views on participating in parental groups within CHS are sparsely studied and further studies are asked for (Petersson et al., 2004; Bremberg, 2004). Therefore the aim was to describe parent's experiences of participating in parental groups at the CHC centres during their child's first year with focus on content, management and experience.

METHOD

Settings

The study was conducted in Skåne, a county in southern Sweden with 1.2 million inhabitants (Statistics Sweden, 2011) in both rural and urban areas. About 16.000 children are born in Skåne every year. At the time of the study there were 138 CHC centres with about 95.000 children aged between 0-6 years registered at all the different centres (Centre of Excellence for CHS, 2012). According to the annual report for 2012 from Centre of Excellence for CHS parental groups 46% of all parents, 61% of all first-time parents and 33% of parents with more than one child attended parental groups. The spread is large and the participation varies from 8% at some CHC centres to 91% at others. Fathers' participation was 3.4% varying between 0-20% at the different CHC centres. The CHC centres with high levels of participation by first-time parents have a correspondingly high participation rate among parents with more than one child (Centre of Excellence for CHS, 2013).

Population/data collection

The CHC nurses' addresses were obtained from the Centre of Excellence for CHS in Skåne and they were all asked to inform every parent participating in parental groups from March 2012 to May 2013 about the study. The CHC nurses received standardized information about the study to be read aloud in their parental groups. Parents wishing to participate provided their e-mail addresses to the CHC nurse, who forwarded them to the first author (ÅL). An e-mail to confirming the address was sent to all interested parents followed by information about the study, information about the Personal Data Act (Swedish department of Justice, 1998), a study participation number and the link to the online questionnaire. Three reminders were sent to parents during the study period. The questionnaire consisted of 34 questions concerning the content of their parental group, how the group was managed and the parents' overall experiences of the parental group. Except for one open question, all questions were multiple choice questions and included questions about the parents' background. The questionnaire had been validated and tested in another part of the country (Friberg, 2001). The questionnaire was adapted into an online form for this study, and a pilot study involving 14 parents were conducted in 2011 to test the questionnaire and the technical procedures. Minor corrections were made concerning technical issues.

STATISTICS

Descriptive and comparative statistical analyses were performed using IBM Statistical Package for Social Sciences version 20.0. Mann-Whitney-U and Fishers' exact test were used to compare different variables. The significance level was set to $p < 0.05$.

ETHICAL CONSIDERATIONS

The study was planned and performed in accordance with the WMA Declaration of Helsinki 2008 (WMA, 2008). To maintain confidentiality, a code number was assigned to all participating parents. Written informed consent was obtained before access was given to the on-line questionnaire. The potential inconveniences to the participants was considered to be small and counteracted by the benefits of the study results. The study was approved by the Regional Ethical Review Board (2011/3).

Result

The questionnaire was completed by 143 parents (53%) from 71 parental groups at 27 different CHC centres (Figure 1), of these, 11 parents responded that they had not finished their parental group during the study period and therefore only answered up to question number 16. Background data on the participating parents are described in Table 1.

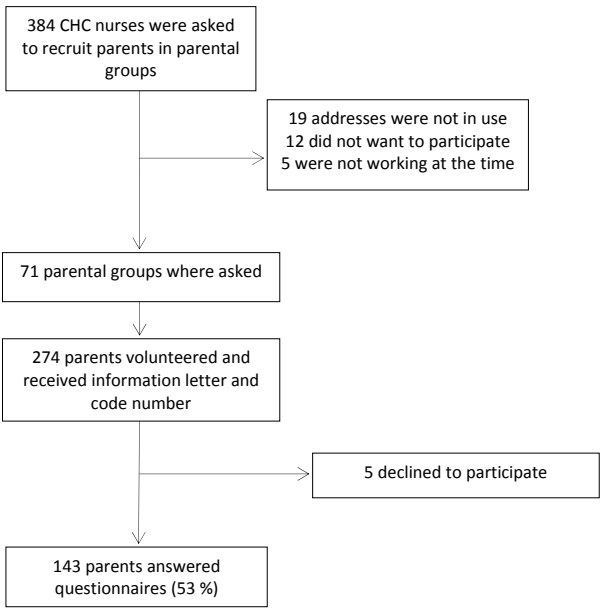

Figure 1. Flow-chart of participating parents.

Table 1. Background characteristics of the parents (%).

Gender of respondent	
Mother (n=133)	93
Father (n=8)	6
Marital status	
Married/ cohabiting (n=138)	97
Single parent (n=4)	3
Number of children	
First child (n=89)	62
More than one child (n=51)	36
Country of origin	
Sweden (n=131)	92
Other* (n=9)	6
Grandparents' country of origin	
Sweden (n=124)	87
Other** (n=16)	11
Education	
2-year upper secondary school (n=2)	1
3-year upper secondary school (n=36)	25
College/University (n=97)	68
Other (n=4)	3
Employment status	
Working (n=125)	87
Student (n=5)	4
Unemployed (n=8)	6
Other (n=1)	1

* Turkey, Norway, Syria, Finland, Denmark, Lithuania, Hungary, Iran
** Bangladesh, Croatia, Denmark, Finland, Germany, Hungary, Iran, India, Iran, Iraq, Norway, Poland, Turkey

The parents stated that 5-8 meetings were offered by the CHC centres and that they attended 3-6 meetings. It was most common that only the mother attended the parental groups (64%), but all eight of the fathers who responded reported that both parents attended either all or at least some meetings ($p< 0.001$). The majority of the parents (64%) responded that they were informed about the content of the parental group before starting. Some invitations (10%) highlighted the importance of the father's attendance to the meetings but mostly did not (56%).

Most parents thought that the CHC nurse was very or quite well prepared (82%), was very or quite committed (82%) and had a very or quite good knowledge about the subject matter (85%). Parents who reported the nurse to be prepared, committed and knowledgeable also reported that they had gained more confidence and had become more secure in their parental role due to the parental group ($p=0.04$). The parents felt that they had the opportunity to express their opinions as much as they wished (82%) and that they had as much opportunity to talk to other parents as they needed (78%). However, 10% of the parents would have liked to have more time for talking to others and 8% felt that they had not had the chance to express their opinions as much as they wanted.

In all, 73% of the parents found parental groups to be very or rather meaningful and 52% responded that they felt more or somewhat more safe and secure in their parental role due to their participation. Of all parents, 62% stated that they had made contact with one or more people who they had been on excursions and socialized with. Furthermore 29% of the parents said that they had made contact with

someone who gave them emotional support. Several parents commented that they thought participating in the group was a good way to meet other parents in the area and to discuss parenthood with people in the same situation. One expressed this as "… very good to have a parental group and be able to discuss with people that are in the same situation and might have come across the same joy or problem" (code number 187), another stated "… very important meetings. As a first-time-parent who just moved here, lots of support and new friends" (code number 008). However, 23% responded that they had not met anyone to socialize with and two people reported having become less safe and secure in their parental role; "I felt incredibly alone, being a step-parent having my first biological child. Where do we fit in? My group was for first-time parents and their situation was nothing like mine, they were always walking in pairs and I was always walking alone" (code number 075).

Differences were found regarding what the parents thought was important to address in the parental group and what they found was actually addressed (Table 2). For example, parents found topics like "child related community information", "tobacco, alcohol and drugs" and "parenting" to be important, but did not report that they were addressed much in their groups, whereas parents felt that "the joy and difficulties of being a parent", "children's health and development" and "child safety" were important and were also addressed in the groups. Parents with a non-academic education were found to be more interested in talking about children's health and child diseases ($p = 0.026$), immunizations ($p = 0.003$) and child accident prevention ($p = 0.015$) than parents with a higher education.

Table 2. Topics reported by the parents to be of importance in parental groups and topics that were actually addressed.

Themes	Topics of importance in parental groups (%)	Topics addressed in parental groups (%)
Children's' needs and development	89	83
Children's health and diseases	89	81
Child safety	88	78
The joys and challenges of parenthood	87	78
Relations between parent and child	87	71
Children´s environment	80	58
Couple relationships	79	65
Parenting	79	53
Vaccination	73	59
Sibling issues	70	48
Child-related community information	67	25
Tobacco, alcohol and drugs	62	34
Relationship to own parents (the child's grandparents)	55	36
Existential questions (the meaning of life)	46	14
Work and finances	36	20

By participating in parental groups, 69% of the participating parents felt that they had largely or somewhat accomplished knowledge about children's development and needs. In all, 41% of the parents thought that they had gained knowledge and deeper understanding about relationships in general. The majority of the parents (60%) had not gained further knowledge about the community and community support for families with children.

DISCUSSION

The majority of the parents found the parental groups to be meaningful and more than 60% had met someone in the group who they socialized with outside the meetings. The parents found the CHC nurses to be knowledgeable and well prepared and were content with the opportunities to express their opinions and talk to the other parents in the group. Parents who expressed that they had good experiences of the nurses' knowledge and commitment also reported that they felt more secure and confident in their parental role due to the parental group. New parents seem to be open for new friendships with people going through the same change in life as themselves (Nolan et al., 2012). The findings in our study are consistent with other studies showing that parents are content with parental groups and that new supportive friendships have been formed (Guest and Keatinge, 2009; Nolan et al., 2012; Petersson et al., 2004; Fabian et al., 2005). Identification seems to be an important ingredient, and parents look for other parents with more or less the same background and thoughts as themselves (Hanna et al., 2002; Nolan et al., 2012; Fabian et al., 2005; Petersson et al., 2003; Wissö, 2012). Parents who do not attend parental groups or report to be dissatisfied when they do, for example, young, single and less well-educated parents, often represent a minority in parental groups (Fabian et al., 2005) and could thus be less likely to identify with other group members. The feeling of being different might create a feeling of exclusion rather than promoting self-esteem (Hanna et al., 2002; Petersson et al., 2004) and could be a reason for not wanting to attend the groups (Petersson et al., 2004; Fabian et al., 2005; Wissö, 2012). There are studies suggesting that group-based support is beneficial for poorly educated parents (Feinberg and Kan, 2008) and single (Lipman et al., 2010) and young mothers (Hägglöf et al., 2013; Wolfe and Haddy, 2001), for example. It is regrettable that this universal parental support does not reach these groups as they might be those who need it most. Separate groups for these parents might be a good idea and exists at some CHC centres, but the availability varies considerably across the country (Petersson et al., 2004; Fabian et al., 2006; Wallby, 2008; Lefèvre et al., 2013).

The present results, that the attitude and actions of the CHC nurse in the parental groups seems to be very important to group interaction and how the parental role is affected, is supported by others (Hanna et al., 2002; Nolan et al., 2012). Several pedagogical methods can be used to help the group members to get to know each other and to create a trusting climate (Nolan et al., 2012; Elwyn et al., 2004). Parents associate good parental group leadership with the nurse's ability to create a relaxed and trusting climate in the group, consider the parents' wishes and let all parents speak; whereas poorly planned sessions, unanswered questions and leaving group members on their own were considered deficient (Wolfe and Haddy, 2001; Petersson et al., 2004; Nolan et al., 2012). Recent studies shows that CHC nurses feel insecure in their role as group leader and that additional skills and knowledge in group facilitation and group dynamics are needed (Wallby, 2008; Lefèvre et al., 2013).

Few fathers attend parental groups and those who participated in this study did so together with the mother. It is well known that the fathers' involvement in their young child's upbringing is very important for the child's development and wellbeing (Sarkadi et al., 2008; Wilson and Prior, 2011; Premberg et al., 2008), and an independent relationship between father and child is suggested to be vital to fathers' transition to fatherhood (Premberg et al., 2008). The Swedish Government has implemented several initiatives such as gender equality bonus and parental leave exclusively for fathers to encourage greater participation by the fathers in their young children's lives (The Swedish Social Insurance Agency, 2013), but still only 24% of fathers, compared with 76% of mothers, received parental benefits for parental leave from the Swedish social security system during 2011

(Cedstrand, 2012). The role of the father changed vastly towards the end of the 20th century, and it is suggested that the lack of role models and the complexity in being both the breadwinner and a committed father makes the transition difficult (Fagerskiold, 2008; Premberg et al., 2008; Nystrom and Ohrling, 2004; Plantin, 2001). Fathers report sometimes feeling alone in their transition to fatherhood (Deave et al., 2008; Premberg et al., 2008) and CHC personnel have been criticized for being mother-centric (Hallberg et al., 2010; Sarkadi et al., 2008; Deave et al., 2008; Fagerskiold, 2008). CHC nurses are aware of fathers being underrepresented in parental groups, yet little action is taken to make fathers attend (Wallby, 2008; Lefèvre et al., 2013). Increased awareness about the challenges of becoming a father is needed among CHC nurses (Hallberg et al., 2010; Deave et al., 2008; Fagerskiold, 2008; Nystrom and Ohrling, 2004; Premberg et al., 2008) in order to provide parental groups adapted to father's needs.

Consistency was seen between the topics most desired and the topics most parents found were addressed in their parental groups, although some discrepancies where found. For example the parents wanted more focus on child-related community information such as social benefits, open preschool and kindergarten. They also wanted more time spent on existential questions, relationships with their own parents and parenting in general. Traditionally, medical topics are reported to be more frequently addressed in parental groups while more relationship-oriented issues, which may be perceived as more difficult to discuss, have been overlooked (Petersson et al., 2004). Community-related issues, a subject that parents want to spend more discussing (Petersson et al., 2004; Deave et al., 2008), are found by other studies to be less prioritised by nurses (Wallby, 2008; Lefèvre et al., 2013). This is important knowledge for CHC nurses who can adjust their agenda and spend more time and focus on those topics.

Strengths and limitations

The relatively low participation rate (53%) is a limitation and several nurses seem to have chosen not to inform the parents from their groups. To recruit respondents through caregivers is delicate as an involuntary selection could be made (Fenner et al., 2012; Fletcher et al., 2012). There could be a risk that only nurses with a high interest in parental groups have chosen to ask the parents in their parental groups to participate in the study which might have affected the result in a positive direction. Interviewing parents invited from a birth register may have provided a broader study population. The results are however consistent with earlier studies that have used alternative recruitment methods (Friberg, 2001). The under-representation of, for example, fathers, non-Swedish speaking parents, single or young parents and the study population being a rather homogeneous group is a limitation, although understandable as this reflects the parents who normally attend parental groups. It is a strength that parents from rural and urban areas, large and small towns have participated in the study. Some areas in the region are less well-represented which is consistent with areas with low frequency of parental groups (Centre of Excellence for CHS, 2013).

Satisfaction is difficult to measure and the results of such studies should be used with caution as they are criticised for all too often turning out more positive than is actually the case (Ortenstrand and Waldenstrom, 2005; Tiitinen et al., 2013; van Teijlingen et al., 2003). Another way to investigate satisfaction could be to use a more dissatisfaction-oriented approach in studies that reflects reality (Ortenstrand and Waldenstrom, 2005).

CONCLUSIONS

Parental groups seem to be a good way to break isolation and build new networks among new parents. Nurses' group leadership skills appear to be important to the outcome of parental groups, therefore education and training in group dynamics and group leadership for the CHC nurse could be of value. Parents want more focus on, for example, child related community information, existential questions and parenting in general and CHC nurses need to be informed about these opinions in order to adjust their agenda. More knowledge is needed about what would attract parents who do not currently participate in parental groups to contribute to the development of future parental groups.

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Appendix I

Fyll i ditt kodnummer här:
Ditt kodnr hittar du i ditt informationsbrev

Barnhälsovårdens föräldrastöd i Skåne

Du lämnar dina svar direkt på skärmen och avslutar med att klicka på "Skicka in" knappen i slutet av frågeformuläret.

Din BVC?

1. I vilken kommun ligger din BVC?

Definitioner för nedanstående fråga:

Hel-BVC: *Sjuksköterskan på BVC-enheten arbetar enbart med familjer med barn 0-6 år. Tid för verksamhetren klart avgränsad från annan verksamhet.*

Integrerad BVC: *Sjuksköterskan på BVC-enheten arbetar dels med barn på BVC och med vuxna på distriktssköterskemottagning eller vårdcentral.*

2. Vilken typ av BVC arbetar du på?

☐ Jag arbetar med hel-BVC

☐ Jag arbetar med integrerad BVC

Instruktioner för nedanstående fråga:

Om du ensam ansvarar för en grupp barn anger du det ungefärliga antalet nyfödda 2010.

Om du är en av flera sjuksköterskor som delar ansvaret för en grupp barn anger du din ungefärliga del av dessa barn födda 2010.

3. Ungefär hur många barn födda 2010 ansvarar du för? (ange närmast jämna 5-tal)

4. Hur många timmar per vecka ägnar du åt BVC arbete?

☐☐

Definitioner för nedanstående fråga:

Familjecentral: *Samverkan mellan och samlokalisering av de fyra basverksamheterna mödrahälsovård, barnhälsovård, öppen förskola och socialtjänst.*

Familjecentralsliknande verksamhet:
Barnhälsovård samlokaliserad med en annan kommunal verksamhet (öppen förskola eller socialtjänst).

5. Är din BVC samlokaliserad i en så kallad Familjecentral/Familjecentralsliknande verksamhet?

☐ Ja, med BVC och öppen förskola
☐ Ja, med BVC, MVC och öppen förskola
☐ Ja, med BVC och socialtjänst
☐ Ja, med BVC, MVC, och socialtjänst
☐ Ja, med BVC, öppen förskola och socialtjänst
☐ Ja, med BVC, MVC, öppen förskola och socialtjänst
☐ Nej, inte alls

Din bakgrund

6. Vilken utbildning har du?

☐ Barnsjuksköterska
☐ Distriktssköterska
☐ Både barnsjuksköterska och distriktssköterska
☐ Distriktssköterskebarnmorska
☐ Annan specialistutbildning
☐ Ingen specialistutbildning

7. Hur många hela år har du arbetat med barnhälsovård?
(ange 1 även om du arbetat mindre än 1 helt år).

☐ 1 år ☐ 2-3 år ☐ 4-5 år ☐ 6-10 år ☐ mer än 10 år

8. Vilka av nedanstående faktorer anser du bäst beskriver begreppet föräldrastöd inom barnhälsovården. Ange de 4 som bäst motsvarar din uppfattning.

- ☐ Tillgänglighet per telefon
- ☐ Personkännedom/Kontinuitet
- ☐ Kunna erbjuda kontakt med psykolog, logoped och barnläkare vid behov
- ☐ Regelbunden kontakt med socialtjänst
- ☐ Medicinsk hälsoövervakning
- ☐ Hembesök
- ☐ Vaccinationer
- ☐ Föräldragrupper
- ☐ Familjecentral
- ☐ Att kunna erbjuda konkreta metoder för föräldrastöd speciellt utvecklade för att lära
- ☐ Tillgänglighet för individuella besök
- ☐ Regelbunden kontakt med öppen förskola
- ☐ Annat

9. Inom vilka områden tycker du att det är mest angeläget att ta fram nya, verksamma metoder för BVC? Ange högst två.

- ☐ Sömn
- ☐ Mat
- ☐ Anknytning
- ☐ Kolik
- ☐ Barn med utagerande, aggressivt beteende
- ☐ Parrelation
- ☐ Barn med besvärligt temperament (kinkigt, gnälligt, svårt att tillfredställa)

Dina föräldragrupper

10. Erbjuder du föräldrar på din BVC att delta i föräldragrupper?

- ☐ Ja
- ☐ Nej

11. Om du svarat Nej på ovanstående fråga, vilken är orsaken? (Du kan ange flera orsaker)

- ☐ Bristande stöd från närmaste chef
- ☐ Saknar lämplig lokal
- ☐ Saknar teknisk utrustning
- ☐ Det är inget som efterfrågas av föräldrarna
- ☐ Föräldrarna anmäler sig men kommer inte på träffarna
- ☐ Jag har för litet barnunderlag
- ☐ Tidsbrist
- ☐ Jag anser att andra arbetsuppgifter är viktigare
- ☐ Jag saknar tillräcklig utbildning för uppgiften
- ☐ Jag får inte tillräcklig handledning/fortbildning
- ☐ Det känns inte meningsfullt
- ☐ Andra arbetsuppgifter prioriteras högre i organisationen
- ☐ Jag har svårt att få tag på tolk för att genomföra mina föräldragrupper
- ☐ Jag känner mig obekväm i rollen som gruppledare
- ☐ Jag erbjuder inte föräldragrupp just nu beroende på tillfälliga omständigheter

Informationspunkt

Om du normalt erbjuder föräldragrupper fortsätter du att fylla i frågeformuläret. Om du inte erbjuder föräldragrupper alls kan du hoppa över resterande frågor, gå längst ner i frågeformuläret och klicka på Skicka in-knappen.

Definition för nedanstående fråga:

Förstabarnssföräldrar: barnet är mammans första biologiska barn eller adoptivbarn.

12. Vilka föräldrar erbjuds att delta i föräldragrupp?

- ☐ Endast förstbarnsföräldrar
- ☐ Alla förstbarnsföräldrar, men även flerbarnsföräldrar i mån av plats eller behov
- ☐ Både förstbarnsföräldrar och flerbarnsföräldrar

13. Gäller samma förutsättningar om det är pappans första barn men inte mammans?

- ☐ Ja
- ☐ Nej

14. Vilka åldrar erbjuder du föräldragrupper för?

☐ Jag erbjuder föräldragrupper endast under spädbarnsåret

☐ Jag erbjuder föräldragrupper under spädbarnsåret men även föräldragrupper anpassade för föräldrar till barn över 1 års ålder

☐ Jag erbjuder endast föräldragrupper för föräldrar till barn över 1 års ålder

15. Har du vidtagit några särskilda åtgärder för att öka deltagandet av pappor i dina föräldra-grupper?

☐ Ja

☐ Nej

16. Om du svarat Ja, ange vilka åtgärder?

17. Uppskattningsvis, hur stor andel av barnens pappor deltar i dina grupper?

☐ 0 %

☐ 10 %

☐ 20 %

☐ 30 %

☐ 40 %

☐ 50%

☐ 60%

☐ 70%

☐ 80%

☐ 90%

☐ 100%

18. Erbjuder du föräldragrupper till speciella grupper av föräldrar, s.k. riktade grupper?

☐ Adoptivföräldrar

☐ Tvillingföräldrar

☐ Unga mammor

☐ Invandrarföräldrar

☐ Pappor

☐ Ensamföräldrar

☐ Erbjuder inga riktade grupper

☐ Annan riktad grupp:

19. Leder du själv alla grupptillfällen i de grupper du startar?

☐ Ja, alltid

☐ Nej, bara det/de första tillfället/tillfällena, sedan fortsätter gruppen självständigt

☐ Nej, jag delar ledarskapet med andra sjuksköterskor

☐ Nej, jag har kollegor som leder alla mina föräldragrupper

☐ Nej, jag delar ledarskapet med annan yrkeskategori, nämligen:

20. Tar du över grupper från MVC?

☐ Ja, alltid

☐ Ja, oftast

☐ Ja, någon gång

☐ Nej, aldrig

21. Hur många nya grupper startar du, eller tar över från MVC, i genomsnitt per år?

☐☐

22. Har du ett eget fast program som du följer i dina föräldragrupper?

☐ Ja, och jag följer detta program

☐ Ja, men jag ändrar det om föräldrarna har andra önskemål

☐ Ja, jag har en del fasta punkter men för övrigt avgör föräldrarnas önskemål

☐ Nej, föräldrarnas önskemål styr helt vad som diskuteras i gruppen

23. Vid hur många grupptillfällen träffas vanligen dina föräldragrupper? (Räkna tillfällen efter barnets födelse).

☐☐

24. Vilka ämnesområden tar du i regel upp i grupperna och på vilket sätt?

	Endast samtal	Samtal och något skriftligt material, broschyr, video, dvd, bildspel e.dyl
a) Graviditet och Förlossning	☐	☐
b) Amning	☐	☐
c) Familj och relationer	☐	☐
d) Sex och samlevnad	☐	☐
e) Samspel förälder-barn	☐	☐
f) Barn som skriker mycket	☐	☐
g) Kost	☐	☐
h) Sömn	☐	☐
i) Föräldraroll och gränssättning	☐	☐
j) Språk och tal	☐	☐
k) Barnsäkerhet	☐	☐
l) Egenvård	☐	☐
m) Vaccinationer	☐	☐
n) Tandhälsovård	☐	☐
o) Tobak	☐	☐
p) Alkohol	☐	☐
q) Samhällsinformation	☐	☐
r) Fritt enligt föräldrarnas önskemål	☐	☐

25. Vilka andra resurser tar du hjälp av i dina föräldragrupper? (Du kan ange flera alternativ)

- ☐ Psykolog
- ☐ Allmänläkare
- ☐ Barnläkare
- ☐ Logoped
- ☐ Tandhygienist
- ☐ Bibliotekarie
- ☐ Socialtjänst
- ☐ Familjerådgivning
- ☐ Försäkringskassan
- ☐ Barnmorska/MVC
- ☐ Dietist
- ☐ Öppen förskola (i kommunal, kyrklig eller annan regi)
- ☐ Inga andra resurser

26. Använder du boken "Leva med barn" i dina föräldragrupper?

- ☐ Ja
- ☐ Nej

27. Vilket/vilka av nedanstående strukturerade, manualbaserade program för föräldrastöd använder du regelbundet i din verksamhet, individuellt eller i grupp?

- ☐ PREP
- ☐ Vägledande samspel (ICDP)
- ☐ De otroliga åren
- ☐ Från första början
- ☐ COPE
- ☐ COPE for toddlers
- ☐ Föräldrakraft
- ☐ Marte Meo
- ☐ EPDS (Screening och uppföljande samtal vid behov)
- ☐ Mellow Parenting
- ☐ Använder ingen manualbaserad metod för föräldrastöd
- ☐ Annan...

28. Anser du att du idag har stöd och förutsättningar, som gynnar ditt arbete med föräldragrupper, i form av:

a) Stöd och godkännande från din närmaste chef?

- ☐ Stämmer mycket bra
- ☐ Stämmer bra
- ☐ Stämmer mindre bra
- ☐ Stämmer inte alls

b) Lämplig lokal?

- ☐ Stämmer mycket bra
- ☐ Stämmer bra
- ☐ Stämmer mindre bra
- ☐ Stämmer inte alls

c) Teknisk utrustning?

- ☐ Stämmer mycket bra
- ☐ Stämmer bra
- ☐ Stämmer mindre bra
- ☐ Stämmer inte alls

d) Regelbunden handledning?

- ☐ Stämmer mycket bra
- ☐ Stämmer bra
- ☐ Stämmer mindre bra
- ☐ Stämmer inte alls

29. Hur vill du rangordna de generella målen för föräldrautbildning. Ange 1 för det mål du anser är det viktigaste, 2 för det näst viktigaste och 3 för det minst viktiga?

Ge ökad kunskap	☐
Skapa möjlighet till kontakt och gemenskap	☐
Skapa medvetenhet om möjligheten att kunna påverka samhällsförhållanden	☐

Om utbildningen

30. Deltog du i utbildningsdagarna under 2010 alt 2011 om "Föräldrastöd i grupp i Region Skåne"?

☐ Ja, jag deltog båda dagarna

☐ Jag deltog en av dagarna

☐ Nej, jag deltog inte

31. Har du haft stöd av utbildningen?

☐ Ja

☐ Nej

Om ja, på vilket sätt?

Om manualen

32. Använder du dig av Föräldrastöd i grupp - manual för barnhälsovården i Region Skåne?

☐ Ja

☐ Nej

Om du svarat nej på ovanstående fråga , gå direkt till fråga 35

33. Hur använder du dig av manualen?

34. Har du haft stöd av manualen?

☐ Ja

☐ Nej

Om ja, på vilket sätt?

Om gruppledarrollen

35. Hur tycker du att det är att leda föräldragrupper?

☐ Lätt

☐ Svårt

Kommentar

36. Har du använt handledningsmaterialet "att växa som föräldragruppsledare" från statens folkhälsoinstitut 2009?

☐ Ja

☐ Nej

Om ja, har du varit hjälpt av det?

☐ Ja

☐ Nej

37. Du som använder dig av Föräldrastöd i grupp - manual för BVC; har manualen gjort det lättare för dig att leda föräldragrupper?

☐ Ja

☐ Nej

Om ja, på vilket sätt?

38. Har din roll som gruppledare påverkats?

☐ Ja, jag känner mig tryggare

☐ Nej, samma som tidigare

När du är nöjd med dina svar klickar du på knappen "Skicka in".

Tack för att du tog dig tid att svara på frågorna!

Grundenkäten är framtagen av Thomas Wallby mfl. Landstinget i Uppsala län.

Appendix II

Fyll i ditt kodnummer här:
Ditt kodnummer hittar du i ditt informationsbrev

Genom att kryssa i rutan för informerat samtycke ger du ditt medgivande till att delta i denna studie.

☐ Jag samtycker

Frågor om föräldragrupperna på barnavårdcentralen (BVC)

Detta frågeformulär skickas ut till alla föräldrar som deltagit i föräldragrupp i Region Skåne någon gång under perioden XXXX - XXXX.

Frågorna gäller endast föräldragrupper på barnavårdcentralen (BVC) och inte föräldragrupper på mödravårdscentralen (MVC).

Frågorna avser endast den föräldragrupp du deltog i under perioden XXXX - XXXX och inte eventuellt tidigare föräldragrupper som du deltagit i.

Frågeformuläret besvaras av den person som deltagit i föräldragruppen.
Om båda föräldrarna har deltagit fyller båda föräldrarna i vars ett formulär.

1. Har du svårt att förstå det svenska språket?

☐ Ja

☐ Nej

2. Önskar du bli kontaktad för att få hjälp med att besvara frågeformuläret?

☐ Ja

☐ Nej

Om du svarar ja på fråga 2 gå längst upp på sidan och klicka på "Skicka in".

3. Vem är du som besvarar frågeformuläret?

☐ Mamma

☐ Pappa

4. Vid barnets födelse var du

☐ Gift/sambo

☐ Ensamstående

5. Ditt födelseår

6. I vilket land är du född?

☐ Sverige

☐ Annat:

7. I vilket land är dina föräldrar födda?

Din pappa:

☐ Sverige

☐ Annat land, vilket:

Din mamma:

☐ Sverige

☐ Annat land, vilket:

8. Vilken utbildning har du?

Kryssa endast för det högsta alternativet. Du som har utländsk utbildning fyll i den ruta som bäst stämmer överens med din utbildning

☐ Högskola/universitet

☐ 3 årigt gymnasium

☐ 2-årigt gymnasium

☐ Grundskola/motsvarande

☐ Annan utbildning, vilken:

9. Vad är din sysselsättning när du inte är föräldraledig?

☐ Arbetar
☐ Studerar
☐ Arbetssökande
☐ Annat, ange vad:

Vid arbete, ange vad du arbetar som?

10. Är det barn som var anledning till att du gick i föräldragrupp nu, ditt första barn?

☐ Ja
☐ Nej

11. Vid vilken barnavårdcentral var ditt barn inskrivet när du gick i föräldragrupp 20XX?

12. Deltog du i föräldragrupp på BVC i Skåne någon gång under perioden XXXX - XXXX?

☐ Ja
☐ Nej

Du som svarat ja på denna fråga gå vidare till fråga 17

Frågorna 13 -16 besvaras av dig som inte deltagit i föräldragrupp på BVC i Skåne under perioden XXXX - XXXX.

13. Har barnets andra förälder (mamma/pappa) deltagit i föräldragrupp på BVC i Skåne någon gång under perioden XXXX - XXXX?

☐ Ja

☐ Nej

14. Har ditt barn tillhört någon annan BVC utanför Skåne under ovan nämnda tid?

☐ Ja

☐ Nej

15. Fick du eller barnets andra förälder någon inbjudan till föräldragrupp på BVC efter att Ditt barn fötts?

☐ Ja

☐ Nej

För dig som svarat nej på denna fråga avslutas frågeformuläret här. Gå längst upp på sidan och klicka på "Skicka in".

16. Du som blivit inbjuden men inte deltagit i någon föräldragrupp på BVC. Vad var skälen till att du inte deltog?

☐ Kunde inte få barnvakt till äldre barn
☐ Tidsbrist
☐ Tiden passade inte
☐ Inget behov av att delta i föräldragrupp
☐ Tycker inte om att vara med i grupp
☐ Deltog i annan liknande aktivitet
☐ Annat skäl

Vid annat skäl ange vad:

För dig som inte deltagit i föräldragrupp på barnavårdcentralen avslutas frågeformuläret här. Gå längst upp på sidan och klicka på "Skicka in".

Tack för din medverkan!

Frågorna 17 -33 besvaras av dig som deltagit i föräldragrupp på BVC i Skåne någon gång under perioden XXXX - XXXX.

17. Hur många träffar ingick i föräldragruppen på BVC?

Antal: ☐☐

☐ Vet inte/minns inte

18. Ange hur många träffar du deltog i

Antal: ☐☐

☐ Vet inte/minns inte

19. Deltog även barnets andra förälder i föräldragruppen på BVC?

☐ Nej, ingen gång
☐ Ja, någon gång
☐ Ja, flera gånger
☐ Ja, vid alla tillfällen

20. Framgick det av inbjudan att pappans deltagande i föräldragruppen på BVC var viktigt?

☐ Ja
☐ Nej
☐ Vet inte/Minns inte

21. Fick du någon information om innehållet i föräldragruppen på BVC innan den startade?

☐ Ja
☐ Nej
☐ Vet inte/Minns inte

22. Har innehållet i föräldragruppens diskussioner utgått från dina och övriga föräldrarnas önskemål och intressen?

☐ Ja, i hög grad
☐ Ja, i någon mån
☐ Nej, ganska lite
☐ Nej, inte alls
☐ Vet inte

23. Har du i föräldragruppen på BVC diskuterat följande:

Var vänlig och besvara alla alternativ:	**Ja**	**Nej**
a) Föräldraskapets glädje och svårigheter	☐	☐
b) Barns utveckling och behov	☐	☐
c) Barns hälsa och sjukdom	☐	☐
d) Relationer mellan barn och föräldrar	☐	☐
e) Syskonproblematik	☐	☐
f) Parrelationer	☐	☐
g) Relationer till egna föräldrar (barnets mor- eller farföräldrar)	☐	☐
h) Barnuppfostran	☐	☐
i) Barns uppväxtmiljö	☐	☐
j) Arbete och ekonomi	☐	☐
k) Samhällets stöd till barnfamiljer	☐	☐
l) Tobak, alkohol och droger	☐	☐
m) Vaccinationer	☐	☐
n) Barnolycksfall	☐	☐
o) Existentiella frågor (frågor om livets mening) tex. varför har man barn	☐	☐

24. Hur viktigt tycker du följande områden är att diskutera i föräldragrupp på BVC?

a) Föräldraskapets glädje och svårigheter

- ☐ Mycket viktigt
- ☐ Ganska viktigt
- ☐ Viktigt
- ☐ Ganska oviktigt
- ☐ Helt oviktigt
- ☐ Vet inte
- ☐ Ej aktuellt

b) Barns utveckling och behov

- ☐ Mycket viktigt
- ☐ Ganska viktigt
- ☐ Viktigt
- ☐ Ganska oviktigt
- ☐ Helt oviktigt
- ☐ Vet inte
- ☐ Ej aktuellt

c) Barns hälsa och sjukdom

- ☐ Mycket viktigt
- ☐ Ganska viktigt
- ☐ Viktigt
- ☐ Ganska oviktigt
- ☐ Helt oviktigt
- ☐ Vet inte
- ☐ Ej aktuellt

d) Relationer mellan barn och föräldrar

- ☐ Mycket viktigt
- ☐ Ganska viktigt
- ☐ Viktigt
- ☐ Ganska oviktigt
- ☐ Helt oviktigt
- ☐ Vet inte
- ☐ Ej aktuellt

e) Syskonproblematik

- ☐ Mycket viktigt
- ☐ Ganska viktigt
- ☐ Viktigt
- ☐ Ganska oviktigt
- ☐ Helt oviktigt
- ☐ Vet inte
- ☐ Ej aktuellt

f) Parrelationer

- ☐ Mycket viktigt
- ☐ Ganska viktigt
- ☐ Viktigt
- ☐ Ganska oviktigt
- ☐ Helt oviktigt
- ☐ Vet inte
- ☐ Ej aktuellt

g) Relationer till egna föräldrar (barnets mor- eller farföräldrar)

- ☐ Mycket viktigt
- ☐ Ganska viktigt
- ☐ Viktigt
- ☐ Ganska oviktigt
- ☐ Helt oviktigt
- ☐ Vet inte
- ☐ Ej aktuellt

h) Barnuppfostran

- ☐ Mycket viktigt
- ☐ Ganska viktigt
- ☐ Viktigt
- ☐ Ganska oviktigt
- ☐ Helt oviktigt
- ☐ Vet inte
- ☐ Ej aktuellt

i) Barns uppväxtmiljö

- ☐ Mycket viktigt
- ☐ Ganska viktigt
- ☐ Viktigt
- ☐ Ganska oviktigt
- ☐ Helt oviktigt
- ☐ Vet inte
- ☐ Ej aktuellt

j) Arbete och ekonomi

- ☐ Mycket viktigt
- ☐ Ganska viktigt
- ☐ Viktigt
- ☐ Ganska oviktigt
- ☐ Helt oviktigt
- ☐ Vet inte
- ☐ Ej aktuellt

k) Samhällets stöd till barnfamiljer

- ☐ Mycket viktigt
- ☐ Ganska viktigt
- ☐ Viktigt
- ☐ Ganska oviktigt
- ☐ Helt oviktigt
- ☐ Vet inte
- ☐ Ej aktuellt

l) Tobak, alkohol och droger

☐ Mycket viktigt
☐ Ganska viktigt
☐ Viktigt
☐ Ganska oviktigt
☐ Helt oviktigt
☐ Vet inte
☐ Ej aktuellt

m) Vaccinationer

☐ Mycket viktigt
☐ Ganska viktigt
☐ Viktigt
☐ Ganska oviktigt
☐ Helt oviktigt
☐ Vet inte
☐ Ej aktuellt

n) Barnolycksfall

☐ Mycket viktigt
☐ Ganska viktigt
☐ Viktigt
☐ Ganska oviktigt
☐ Helt oviktigt
☐ Vet inte
☐ Ej aktuellt

o) Existensiella frågor (frågor om livets mening) t e x varför har man barn

☐ Mycket viktigt
☐ Ganska viktigt
☐ Viktigt
☐ Ganska oviktigt
☐ Helt oviktigt
☐ Vet inte
☐ Ej aktuellt

p) Annat

25. Välj från föregående fråga ut de tre områden du tycker är viktigast att samtala kring i föräldragrupp på BVC.

Kryssa i <u>tre</u> alternativ

- ☐ Föräldraskapets glädje och svårigheter
- ☐ Barns utveckling och behov
- ☐ Barns hälsa och sjukdom
- ☐ Relationer mellan barn och föräldrar
- ☐ Syskonproblematik
- ☐ Parrelationer
- ☐ Relationer till egna föräldrar (barnets mor- eller farföräldrar)
- ☐ Barnuppfostran
- ☐ Barns uppväxtmiljö
- ☐ Arbete och ekonomi
- ☐ Samhällets stöd till barnfamiljer
- ☐ Tobak, alkohol och droger
- ☐ Vaccinationer
- ☐ Barnolycksfall
- ☐ Existentiella frågor (frågor om livets mening) tex. varför har man barn
- ☐ Annat

26. Hur har din roll som förälder påverkats av deltagandet i föräldragruppen på BVC?

- ☐ Blivit mer trygg/säker
- ☐ I någon mån blivit tryggare/säkrare
- ☐ Ingen skillnad
- ☐ Blivit mindre trygg/säker
- ☐ Blivit otrygg/osäker
- ☐ Vet inte

27. Hur många personer har du fått kontakt med genom föräldragruppen på BVC som du umgåtts med, gjort utflykt tillsammans med eller liknande.

- ☐ Ingen
- ☐ 1 person
- ☐ 2-3 personer
- ☐ Fler än 3 personer

28. Har du genom att delta i föräldragruppen på BVC fått kontakt med någon förälder som givit dig stöd känslomässigt? (t.ex. om du känt dig orolig för ditt barn eller osäker i din roll som förälder)?

- ☐ Ja, i hög grad
- ☐ Nej
- ☐ Vet inte

29. Har du genom att delta i föräldragrupp på BVC fått mer kunskaper om/förståelse för:

a) Barns utveckling och behov

- ☐ Ja, i hög grad
- ☐ Ja, i någon mån
- ☐ Nej, ganska lite
- ☐ Nej, inte alls
- ☐ Vet inte

b) Relationer

- ☐ Ja, i hög grad
- ☐ Ja, i någon mån
- ☐ Nej, ganska lite
- ☐ Nej, inte alls
- ☐ Vet inte

c) Samhällsförhållanden

- ☐ Ja, i hög grad
- ☐ Ja, i någon mån
- ☐ Nej, ganska lite
- ☐ Nej, inte alls
- ☐ Vet inte

d) Samhällets stöd till barnfamiljer

- ☐ Ja, i hög grad
- ☐ Ja, i någon mån
- ☐ Nej, ganska lite
- ☐ Nej, inte alls
- ☐ Vet inte

30. Vad tyckte du om sjuksköterskans medverkan i föräldragruppen på BVC?

a) Hon var kunnig

- ☐ Ja, i hög grad
- ☐ Ja, i någon mån
- ☐ Nej, ganska lite
- ☐ Nej, inte alls
- ☐ Vet inte

b) Hon var förberedd

- ☐ Ja, i hög grad
- ☐ Ja, i någon mån
- ☐ Nej, ganska lite
- ☐ Nej, inte alls
- ☐ Vet inte

c) Hon var engagerad

- ☐ Ja, i hög grad
- ☐ Ja, i någon mån
- ☐ Nej, ganska lite
- ☐ Nej, inte alls
- ☐ Vet inte

31. Har du i föräldragruppen på BVC haft möjlighet att diskutera med övriga föräldrar?

- ☐ Ja, i tillräcklig grad
- ☐ Ja, men inte tillräckligt mycket
- ☐ Nej inte alls
- ☐ Vet inte

32. Har du i föräldragruppen på BVC haft möjlighet att uttrycka dina åsikter?

- ☐ Ja, i tillräcklig grad
- ☐ Ja, men inte tillräckligt mycket
- ☐ Nej inte alls
- ☐ Vet inte

33. Vad anser du om föräldragruppen på BVC i sin helhet?

- ☐ Mycket meningsfull
- ☐ Ganska meningsfull
- ☐ En del meningsfullt, annat inte
- ☐ Ganska meningslös
- ☐ Mycket meningslös
- ☐ Vet inte

34. Övriga synpunkter på barnavårdcentralens föräldragrupper

När du är nöjd med dina svar klickar du på knappen "Skicka in".

Varmt tack för din medverkan!

Enkäten är framtagen av Malin Friberg 20010102

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