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Parental support in a changing society

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Abstract

In today's Swedish society there is increasing emphasis on health-promotive work among children, adolescents, and their parents. Knowledge is needed about why certain activities work better than others. It is important to study the parents' motives and experiences of participating in parental supporting programmes.

In child health care, mostly among the nurses, there is a contrast between what they wish to do and what they have to do according to policy guidelines. By revealing the main lines in the development of Swedish child health care (Paper I), we hoped to obtain a better understanding of this discrepancy between policy and practice. It is difficult to translate policy recommendation into practice. One reason is the increasing focus on psychosocial problems. Another reason is the transition from unambiguously described measures in terms of paternalistic regulation to a more participatory and expansive definition of roles and responsibilities.

In an interview study (Paper II), both parents and child health care staff emphasized support and medical check-ups as particularly important. There was a clash between the parents' need for support and their need for integrity. The parents viewed parental education as an opportunity to exchange experience with other adults, while the staff mainly regarded the education as a way to inform parents and strengthen them in their parental role.

Fathers participate to a lesser degree in parental supporting activities in Sweden today. To increase knowledge about fathers' perception of and involvement in their children's health, we interviewed 237 fathers of small children in Skåne by telephone (Paper III). The fathers were involved in their children to a large extent, and they performed just as many caring as playing activities. They had a good idea of the child's health and just over half of them had at some time contacted a doctor. Although 97% felt that they were good fathers, slightly more than half of them (54%) thought that they spent enough time with their children.

Most parental supporting programmes are initiated centrally. In Paper IV a process whereby parents of teenage children developed and implemented their own "parents' school" is described. Parents took part in planning meetings and lecture evenings including group discussions. The majority reported that they were satisfied with the activity and had acquired knowledge and insight about the teenage period. The parents' own ambitions for the activity seemed to be visionary and long-term.

This thesis indicates that it is not possible to propose one specific model for parental support. In future activities one should include the parents right from the planning and implementation stage. Long-term work is more important than many different short projects to obtain good evaluations. There is a need to clarify the conditions for developing methods of parental support in child health care. New forms of family support that includes the father on equal terms could be designed and researched.

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To my daughter Anna

List of publications

This thesis is based on the following publications, which will be referred to by their Roman numerals.

- I Hallberg A-C, Lindbladh E, Petersson K, Råstam L, Håkansson A. Swedish child health care in a changing society. *Scand J Caring Sci* 2005;19:196–203.
- II Hallberg A-C, Lindbladh E, Råstam L, Håkansson A. Parents: the best experts in child health care? Viewpoints from parents and staff concerning child health services. *Patient Educ Counselling* 2001; 44:151–9.
- III Hallberg A-C, Kristiansson R, Beckman A, Petersson K, Lindbladh E, Råstam L, Håkansson A. Fathers and their children's health: a telephone interview study. (*Submitted*).
- IV Hallberg A-C, Håkansson A. Training programme for parents of teenagers: active parental participation in development and implementation. *J Child Health Care* 2003;7:7–16.

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Introduction

Do we do the right things in our work of supporting parents? That question has followed me for the whole of my professional life in Swedish social services, school and child health care, and primary care since the 1970s until the present day. I have initiated and taken part in various supportive measures and health-promotive work to do with children and adolescents during a time of societal development and a changing health panorama. The question is still relevant.

In discussions with nurses in child health care it has become clear that there is sometimes an opposition between what one must do according to the instructions and what one wants to do. To achieve an understanding of this difference between policy and practice, a study was started to reveal the main lines in the development of Swedish child health care (Paper I).

During several years as a counsellor I have heard the question mainly from nurses in child health care, wondering whether they are doing the right things. What do the parents think, and what support do they want? This was the point of departure for the second study, where we sought to describe, through in-depth interviews with parents and child health care personnel, how parents and staff think about the work of child health care (Paper II).

During my work with supportive measures for parents of children and adolescents, it has struck me how few fathers take part, and how little we know about the fathers' perception of and involvement in their children's health. To achieve greater knowledge about this, a telephone interview study was conducted with fathers of infants in Skåne (Paper III).

A great deal of the support given to parents in Sweden is initiated and planned centrally in society. Little is known about parents' motives for participating and their perception of parental support measures. This experience led to the fourth study of a support programme in which parents of teenagers themselves took part in the development and implementation of a parental support activity (Paper IV).

Background

Today's society is increasingly focusing on the factors leading to improved health or the avoidance of illness, i.e. health factors. Since 1986, the Ottawa Charter for Health has been an important influence in the public health debate [1]. Prevention/health promotion work has been very much in focus.

The preamble to the UN Convention on the Rights of the Child points out the importance of the family situation for the child's development and how important it is for the child to receive the support it needs to further its positive development [2]. Article 24 of the Convention enshrines the need to provide parental support. The signatory states must take suitable measures such as:

To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents. ... To develop preventive health care, guidance for parents and family planning education and services (Article 24).

Sweden introduced a national public health policy in 2003. The eleven goals for public health work include factors such as participation and influence in society, improved health in working life, increased physical activity, sound nutritional habits, decreased use of alcohol and tobacco, and more health-oriented health and medical care [3]. Swedish public health care goals focus on health and health determinants rather than on illness [4].

Secure and sound childhood conditions are another goal stated in the Swedish public health care policy. A factor that is significant for a child's or young person's health is good parenting. Good parenthood depends on many different things. The parents' goals and values come into play, the children's characteristics, and the application of norms in different cultures. Early interaction between children and parents is important for a good relationship between children and parents. As shown below, the significance of parenthood for children's health has been demonstrated in several international and Swedish studies.

Parenthood and child health

The family is of great importance to the child, not least regarding lifestyle and healthy habits [5]. Children need security and opportunities to forge close relations in order to develop positively. In most cases the family has given the child these opportunities [6]. The early years in children's lives are the most significant, and it

is essential to offer parents support in this period. The early bond between children and parents is important. International research has shown that a secure bond serves as a foundation for a well-functioning relationship between children and parents, facilitating the growth and maintenance of close relations with adults and coevals in the pre-school years and later [7]. Individuals who establish a secure bond as infants retain this throughout their lives [8]. This in turn influences interaction with other adults during adolescence and in adult years [8–9].

It can happen that a child does not bond with its parents. An insecure bond can lead to mental ill health [10–11]. It has also been shown that an insecure bond is a risk factor for various forms of mental disturbance in pre-school and school years [10]. In cases where the interaction between parents and children been has been frightening for the child, this has been associated with a seriously elevated risk of developing aggression and other problems with acting out [12]. In Sweden about 40% of all children do not spontaneously develop a secure bond [13–14].

Several international studies have also emphasized the association between morbidity in childhood and in adult life [15], and an association between psychosocial problems in childhood and states such as depression [16], attention disorders and behavioural disorders [17–18], and personality disorders [19–20]. Also, smoking, which is one of the most expensive and pathogenic behaviours in the population, mostly has its roots in conditions during childhood and adolescence. The norms in the family play a major role in this, and the importance of parenthood can scarcely be exaggerated in this context [21].

Parental support

Many people manage their parenthood without outside help, and experience few conflicts or difficulties. Others feel insecure as parents and sometimes need support and help, knowledge and networks to be strengthened in their parental role. Salutogenic factors (health factors) strengthen the ability to resist mental and social stress [22]. Examples of such factors are creativity, good ability to create social relations, ability to have empathy, impulse control, problem-solving capacity and a feeling of being in control of one's own life. Many of these characteristics can be acquired through role-play training with adults. There are also salutogenic factors in families and the environment that are important to a child's or young person's health. An example is a trusting relationship with one or both parents or another adult, clear rules and boundaries, etc. It is thus important to provide parents with support so that the family can work with these salutogenic factors.

Parental support consists of organised work with parents to promote the child's well-being, or indirect work such as family law and various types of transfers. This dissertation focuses on examining the former – direct parental support – using international and Swedish research on the importance and effect of the different forms of such support.

Studies of parental support

Opinions have differed about the orientation of parental education programmes and the influence these can have on parents [23–24]. A comprehensive survey of published literature from 1997 notes that it is doubtful whether support for parents has any effects, that is, whether it influences children's development and welfare [25]. In contrast, a systematic research survey from 2003 on international parental support measures has shown many good examples of evaluation using scientific methods [26]. The evaluations revealed that the support led to distinct improvements in children's mental health [27–30]. Efforts in groups seem to give effects that are at least equally as good as individually directed measures.

Support for parents indirectly benefits the children. If the parents feel well, their children usually feel well too. International it has been shown that children manage better if their parents have good contacts with other adults [31]. Attempts to clarify how social contacts can promote health and well-being have highlighted different aspects of importance. For example, it is essential to be able to obtain information, to receive emotional support and opportunities for community [32]. It has also been found that social support is of particular value when parents encounter a problem or in some other way are exposed to strains [33].

Risk factors for ill health in adult age are partly grounded during childhood. There is a clear association between the use of alcohol, tobacco, and drugs on the one hand and mental ill health on the other. Efforts directed at parents offer the potential to prevent this type of problem. An American study showed that the occurrence of serious physical and mental morbidity in the 55–60 age group was three times lower if both parents had been warm and caring in the years when a person was growing up [34].

Effects of totally open discussion groups where the parents themselves decide the content have not been presented scientifically. Group activity designed by individual midwives has been investigated in controlled studies. It has been found that the work does not have any demonstrable effect [35]. It is uncertain whether open discussion groups geared to all parents have any effect. Research has shown, however, that such groups can have an effect when the parents have a shared problem [36–38]. This also applies to parents with children of younger school age [39].

Evidence for effects on children and parents of interaction programmes offered in the pre-school years can be found in studies, concerning both group programmes and programmes offered individually [40–50]. However, a review of five studies of parenting programmes aimed to improve the emotional and behavioural adjustment of children under the age of 3 concluded that there is insufficient evidence regarding the role such programmes might play in primary prevention. Nor is there enough data available concerning the long-term effectiveness [51]. For children of younger school age, interaction programmes have demonstrated effects

on children's mental health [52–54]. When it comes to the 10–15 age group, the effects here too have been shown to be greatest in structured parents' groups and in open discussion groups when the parents have a shared problem [39].

To sum up, a review of the international evidence regarding the effectiveness of parental support programmes indicates that there are many families in the community who could benefit from parenting support in one form or another [55].

Children's health

Child poverty has increased since 1990 in most of the world's developing countries, according to a Unicef report [56]. Between 40 and 50 million children in some of the world's richest countries are being raised in poverty. Child poverty differs between the rich countries and the poor ones, where e.g. half of all children do not have access to basic health care or schooling.

From an international perspective, the health of children and young people in Sweden is very good. In 2002, Sweden was one of the best nations in Europe according to a ranking by WHO of public health care of children aged 1–14 [57].

Sweden and Norway are outstanding as regards breast feeding. Swedish young people's use of cannabis, alcohol, and tobacco is below the European average. They are also happier in their relationships with their parents than the European average. Fewer children are bullied in Swedish schools, yet school is not popular amongst them. They show a rate of psychosomatic disorders that is higher than the European average [58].

In today's Swedish society, almost all children are well fed and have access to qualified health and medical care. However, the child's health remains influenced by factors such as the family's material situation, growing up with one or with two parents, dropping out of school or work, or growing up in a family of foreign origin. There are "social differences" in health in Sweden. A 2002 report shows that physical health problems are on average 60% more common in the less socially accepted children [59], and mental problems are 70% more usual. Sudden cot deaths are 3 to 4 times more common in more vulnerable social environments. Suicide and self-harm are more common amongst less socially accepted young people. Smoking, physical activity and alcohol are risk factors that are significantly influenced by the social environment.

Following the newborn period, the public health care problems of the growing years are mainly sudden infant death syndrome, mental problems, accidental injuries, infections, eating disorders, asthma, and allergies [60]. Asthma, allergies, obesity, and excess weight affect an increasing number of children. In the western world, the weight of children and young people in relation to their height has increased in the last twenty to thirty years. The proportion of overweight children in Sweden has doubled from the mid-1980s to 2000–2001 [61–62].

Mental illness is currently the greatest health problem during childhood and adolescence. However, complete information is not available on the extent. In 2004, 10–15% of all children sought the help of a child psychologist during their childhood/adolescence [62]. Every third 10–18-year-old had headaches, stomach aches or sleep problems in 2001 [63].

Many asylum-seeking children show signs of mental illness, particularly panic, fear, separation anxiety, and sleep disorders whilst asylum is being sought [64]. Every second child from a non-European country or from a non-EU country is in a vulnerable economic situation [65]. Such a situation is strongly linked to health risks such as psychosis, drug abuse, and excess weight [61].

Children and family in Sweden

The composition of the family has varied over time. In the early 1930s, Sweden had the lowest birth rate in Europe. In the 1930s and 1940s, to increase the birth rate, various economic reforms were carried out to reduce the difference between childless women and those who had children. Right up until the end of the 1950s, the father was usually the breadwinner and most mothers were housewives full-time, but the economic boom of the 1960s led to a higher frequency of gainful employment among women [66]. Family policy measures were now geared to support for low-income groups, single parents, and families with many children.

Large-scale structural rationalization took place, accentuating the demand for a mobile workforce in the 1970s and 1980s, and nativity fell once again. Family policy was chiefly geared to enabling both parents to work, for example, by expanding daycare for children and introducing parental insurance which gave parents the right to leave in connection with the child's birth. Despite higher material standards, shorter working hours, and expanded daycare, a weakening of the social ties between the generations was observed, and the isolated nuclear family became a familiar concept [67].

In the early 1990s, financial support for parents was subject to constant change [68]. Single parents or households where only one adult was gainfully employed found it increasingly difficult to manage economically. The fertility rate decreased again. There was also a decline as regards benefits and subsidy levels, exacerbating the already strained situation of poor families [69]. The number of children in low-income households rose in the 1990s, particularly those aged 0–6 years [63]. After 1998, the economic situation for families with children gradually improved. By raising child benefits and introducing a maximum fee for childcare, the government has tried to compensate these families for their adverse economic situation.

The situation today

In 2002, 17% of children aged 0–6 years lived in vulnerable economic conditions compared with 7% aged 7–17 years (65). Not all children have the good relations with their parents that are considered desirable. In the last twenty years, the number of children living with parents who are separated has increased. In 2001–2002, 85% of children aged 0–5 years lived with their biological parents; the equivalent figure is 73% for those aged 0–17 years [61].

The increased immigration that took place in the 1990s and the start of the 21st century has also contributed to the fragile social network of many parents. The occurrence of new marginalized groups living in poverty and unemployment has increased [59]. In 2002, over 100,000 children were born abroad, and a further 160,000 children had parents who were both born abroad [70]. The number of children of foreign extraction was around 15% in 2004 [62].

Parental support in Sweden

Several institutions in Swedish society emphasize the importance of support in parenthood [71–72]. It is essential that support is provided at an early stage and then follows the child during childhood and adolescence [73]. Examples of state authorities involved in work with parental support in Sweden are the National Board of Health and Welfare, the National Agency for Education, the National Institute of Public Health, the National Board of Institutional Care, and the Children's Ombudsman.

In the county councils, parental support is pursued in maternity care and child health care, and in the municipalities in individual and family care, child care, and schools. In addition, there are many interest groups and voluntary organizations performing active work, such as Save the Children, the Red Cross, the Home and School Association, church organizations, and immigrant organizations. Various adult education associations also hold study circles [73].

Child health care

Child health care in Sweden is the one institution that encompasses nearly all families with children and thus plays the most important role as far as public health care is concerned. Its task is to promote health and prevent ill-health. Parents' participation is required if children are to enjoy health care, and child health care has long been an important arena both for somatic check-ups of the child and for sup-

port to the parents. Several international surveys in recent years have highlighted the significance of child health care for children's health and well-being [21, 74] and its contribution to steadily improved physical health. As said above, the occurrence of behavioural and mental problems has increased [75]. Mental ill health is the largest health problem today [76]. As the health panorama has changed over the years, child health care has developed from having been a purely medical activity to acquire greater psychosocial ambitions. Changes in the range of childhood problems necessitate a way of working different from the prevailing and established way. Current problems, e.g. parental stress, postnatal depression and bonding difficulties, are being discussed within the child health care system today [77]. It has been pointed out that the focus on discovering deviations in children should be changed to a public health care perspective, i.e. mobilizing parental resources, confidence in parents' ability and competence, and concentrating on supporting children and families with special needs [60, 78–79]).

Thus, there has been a shift from a pure child perspective towards a more family-orientated outlook. Interaction between children, the family, and society has been increasingly emphasized [67, 80]. Child health care is supposed to help with adjustment to the parental role, to support the vulnerable family, and to assist in identifying children who are suffering. There is also a heavy emphasis on preventive work when children are exposed to smoking, and allergy prevention is an important task for child health care.

Since 1979 all new parents have been offered education and health information through organized parental education under the leadership of the nurse at the child health care centre [67]. A report from the National Board of Health and Welfare in 1992 showed that not all parents are reached by group parental education and that many who do not take part are in great need of psychosocial and other support [81].

The role of the father

The National Board of Health and Welfare emphasizes the child–parent relationship in its recommendations. If child health care is to work for the whole family, we must also involve the fathers in discussion and action. It is mostly mothers who visit child health care, and they constitute the majority in group activities [82]. Earlier research has lacked insight into fathers' role in their children's health [83].

At the same time, the demand for the fathers' active responsibility for their children has increased. It is important that activities for parental support in the future also satisfy the fathers' special needs for support and acknowledgement in their paternal role [30]. It is thus important to find out how fathers themselves appreciate such support. We also lack knowledge of how parents reason about their children's health and active participation in everyday life [84].

School children and teenagers

Since the 1970s there has been an idea that parents should be offered support even after the infancy period, when the responsibility for the children is often shared between parents and preschool/school [71, 85]. There have not been sufficient resources for this. The support that parents have received has often been geared to problems, and interventions have mostly taken the form of financial support or contact with, for example, child and adolescent psychiatry or the social services. But the field of parental support is under development and different types of parental support have gradually emerged [85]. Studies have shown that negative interaction causes and exacerbates behavioural problems in the child [86–87]. The various programmes after infancy are thus mainly aimed at developing positive interaction between children and parents. In the long term the aim is to reduce the risk of children developing behavioural problems.

In studies of programmes aimed solely at parents, effects have been demonstrated as regards children's behaviour [88], communication in the family [89], and the child's self-perception [90]. Support for parents with teenagers is usually geared to preventing problems to do with the use of drugs, tobacco, and alcohol. The programmes that dominate here are mainly intended to develop good communication between children and parents.

Studying parental support

Many health promotion activities as part of parental support have been initiated in Sweden. As stated above, there is evidence of their importance and effects both nationally and internationally. Many of the programmes initiated in Sweden have not been thoroughly evaluated both quantitatively and qualitatively. International studies show that it is important to do this, in order to see what works and why certain activities work better than others (55). For example, it is important to study parental motives for participation and their experience of the parental support programme in question. Do parents and professionals have differing views of parental support? Are we doing the right things? In the right place? What is behind the discrepancy between policy and practice as expressed by many of those in child health care? How do fathers regard their child's health, how involved are they and how can we get them to participate in health promotion activities? By means of the studies in this dissertation we would like to present parental support in Sweden from a staff and parental perspective, thus contributing certain aspects to the development of parental support work.

Design of the thesis

Paper I

Discourse analysis
Swedish child health care from 1930 to 2000
Selections of official documents

Paper II

Interview study
Parents and professionals in child health care
Practice

Paper III

Telephone interview study
Fathers of young children in southern Sweden
Perceptions of and involvement in child health

Paper IV

Process description
Evaluation of experiences of a parental programme
Intervention

Aims

The overall aim was to shed light on aspects of parental support in Sweden from the perspective of parents and staff in relation to societal development and a changed health panorama.

The studies making up the thesis had as their specific aim:

- To illustrate the main trends in the long-term development of Swedish child health care, in order to achieve a better understanding of current trends and problems (Paper I).
- To describe what parents and staff think about child health care; to identify agreements and differences in outlook as regards expectations of the individual consultation and the group-based parental education (Paper II).
- To find out more about fathers' perception of and involvement in their children's health, as part of the expansion of knowledge in child health care (Paper III).
- To describe the process whereby parents of teenage children develop and implement their own "parents' school" and to present their experience of participating in this (Paper IV).

Materials and methods

Swedish child health care in a changing society (Paper I)

The study was based on a selection of official documents concerning child health care in the period 1930 until today. In Sweden major changes in public activities are usually preceded by state inquiries, which review facts, analyse problems, and propose relevant measures [91]. On several occasions during the period in question, child health care had been the subject of state inquiries, and these documents were a significant part of our research material [67, 92–95].

Another type of document involved in the analysis was the instructions (policies and guidelines) issued by the National Board of Health and Welfare to make the overarching directives concrete [96–104]. In addition to this, our textual material included documentation from conferences [60], publications from ministries [66, 68], and scholarly articles [105–106] with the focus on child health care.

The method applied can be described as a form of discourse analysis [107]. The term discourse refers to a specific, coherent, and persuasive way of talking about and understanding a particular topic (such as child health care) [108]. A discourse analysis examines the construction of written (or verbal) accounts and the language/vocabulary employed. The rhetorical nature of texts is considered to be essential [109]. This means that emphasis is placed on statements, what is said about the phenomenon of investigation, while what actually happens in day-to-day work was outside the scope of our analysis.

In order to become familiar with our material, the selected texts were carefully read through. In the first analysis of the documents we concentrated on two general questions: What do the texts say about society/family/health, and how are aims/methods of child health care described? Passages dealing with these aspects were marked and a detailed coding of these segments identified central events and assumptions/statements, which were named and noted in the margin. Next we searched for patterns of differences and consistency in the data [108], and this resulted in the identification of four child health care discourses that corresponded to different periods.

When the material was examined once again, in the light of this classification, normality and control were recognized as central and continuous dimensions. We were then able to see how the meaning of these concepts changed in different discursive contexts. A shifting focus regarding level of responsibility (collective/individual) and orientation of measures (general/selective) was now observed as central themes in the public debate on child health care.

Parents: the best experts in child health care? (Paper II)

This study was conducted in a geographically delimited area in Malmö. The area reflects the socio-economic conditions in Malmö as a whole. There were four child health clinics, each of which was attached to a health centre.

In 1995 the staff at the four child health clinics were informed about the background, objective, and implementation of the study. The staff at the clinics – eleven doctors and fourteen nurses – had to write their names on a list if they were interested in taking part in the study, also suggesting the time and place for an interview. Six doctors and all the nurses expressed an interest in taking part.

Fifteen children aged 0–3 were selected at each of the four clinics. The age group 0–3 was selected because it is during this period that parents and children have the most frequent contact with child health care. A random selection was made from the list of registered children at each clinic [110]. The parents of the children were invited by letter to take part in our study. Ten families declined to participate. Parents of ten new randomly selected children were then invited to take part. A total of 58 mothers and 2 fathers were interviewed. One interview had to be excluded because the tape was damaged.

We wanted to describe the different ways in which parents and staff perceive and evaluate child health care. We chose to use semi-structured interviews to capture parents' and staff's values and viewpoints in their own words. The interview guide had a checklist to ensure that all relevant topics were discussed. The interviews took the form of conversations and were tape-recorded. The interviews were transcribed verbatim.

Data were analysed using a phenomenographic method [111–112]. A distinctive feature of this approach is the categorization of perceptions and the interpretive character of the analysis. Phenomenography aims to describe qualitatively how people see and experience things and phenomena around them, e.g. the health service they are offered.

To begin with, all the interviews were read through to obtain an overview of the material. In the interviews we looked for statements describing perceptions. Different statements which occurred on more than one occasion in the interviews were marked. Each individual statement was compared with statements in every other interview. On closer scrutiny of these, further statements were identified. The distinctive features of the statements were then analysed to find further dimensions that required new labels to describe perceptions. A varied and nuanced picture was obtained of the parents' and staff's view of the work of child health care.

Fathers and their children's health (Paper III)

As part of the expansion of knowledge in child health care, in this study we wanted to find out more about fathers' perception of and involvement in their children's health. We asked questions about the care and the upbringing of the child, the child's health and ill health, as well as about the role of the father.

We chose to conduct a telephone interview survey with fathers of small children. The study population comprised 300 randomly selected men living in the southernmost Swedish county of Skåne, with children of their own (biological or adopted) born in 1999, 2000, or 2001. A week or so before the interview, a letter was sent to the fathers about the study requesting their voluntary participation. We then telephoned the fathers, and if they agreed to take part the interview was held, either immediately or at some other agreed time.

We called 300 fathers. Out of those 21 could not be reached as there were no answers to repeated calls or they had moved without giving a new address, thus leaving 279 fathers in the study population. In 12 cases language difficulties were an obstacle to a good interview and 30 declined. Because of ethical considerations no further questioning was performed. A total of 237 fathers (85%; 237/279) were thus interviewed. Of those, 48 had a new child, born in 2002 (N=32) or 2003 (N=16). The interview focused on the youngest child in the family.

One hundred and sixteen interviews (42%) were conducted by the first author (ACH), while the remaining interviews were conducted by three other staff members at the department (N=81 interviews), one of the co-authors (KP; N=7), or by students under her supervision (N=33); a total of 7 people.

In the presentation of the results we primarily consider what all the 237 interviewed fathers answered. We applied logistic regression to investigate the role of father's age (above vs below the median), number of children in the family (more than one vs. only one). And father's occupation (white- vs. blue-collar). Finally, we did the same analyses of only those 189 fathers (80%) whose youngest child was born in 1999, 2000, or 2001, and the results remained almost the same.

Training programme for parents of teenagers (Paper IV)

In a neighbourhood of Malmö in southern Sweden an initiative was taken in 1995/96 to start activities for parents with teenagers.

In the summer of 1996, a telephone survey was conducted by an external consultant to ascertain the interest in a "parents' school", where the parents could meet and discuss the teenage phase and its problems. The questionnaire included

open questions about the parents' needs of more knowledge and contact with other parents. A total of 142 parents with children aged 10–16 years were interviewed. Forty-nine parents were interested in taking part in the planning of the school. A project leader (Ann-Christine Hallberg) was employed, and she invited the interested parents to the first planning meeting.

A total of 36 parents attended four planning meetings in the spring of 1997 (14–26 parents on each occasion), in order to plan the content and forms of parental training along with the project leader. At the beginning of August 1997, invitations were sent to all the households in Oxie with children aged 13–19 (approximately 1000). The parents were supposed to register their interest in taking part in four lecture evenings and follow-up evenings. A total of 105 parents (including those who took part in the planning meetings) registered, most of them with children under the age of 16.

A questionnaire was distributed in December 1997 to the 105 parents who had registered their interest in participating. The questionnaire included items with both fixed and open response alternatives. Those who had participated were asked to complete the whole questionnaire, including the questions concerning their experience of the actual activities. Those who did not participate were asked to answer the parts of the questionnaire dealing with their identity and their views on a continuation of the school. The questionnaire was completed by 66 parents (63%).

Results and comments

Swedish child health care in a changing society (Paper I)

Four discourses were identified, which served as a foundation for a periodization of the development of Swedish child health care. During the *first* period (1930s–1940s) the main task of child health care, alongside checking children’s development, was to inform and educate the mothers. The target group consisted of mothers who, for various reasons, were unable to look after their children. The measures of child health care are described as prophylactic work, mainly surveillance of nutrition and feeding and educating mothers on how to prevent disease by improving hygienic standards [93, 113].

In the *second* period (1950s–1960s) health supervision became the most important task, and child health care had to identify risks and discover abnormalities and disabilities. The main focus shifted from the social and nutritional perspective to medical examinations and immunizations. Preventive efforts related to physical health as well as mental health were started. New screening methods were introduced [100–104, 106].

The task of child health care was extended in the *third period* (1970s–1980s). The discussion increasingly focused on identifying health-related and social risk groups, and the work was more geared to monitoring how parents looked after their children. Duties now also included more supervision of the health of pre-school children. The importance of discovering child abuse and inadequate care was increasingly emphasized [96–97]. Parental education was introduced in child health care and a family-oriented strategy was described [67, 98–99].

In the *fourth* period (1990s to 2000s) the work of child health care concentrated more on the child’s environment and the family as a whole, and child health care is now defined as an institution which is supposed to strengthen the parents’ self-confidence and competence. In the discussion of child health care there is a greater focus on psychosocial problems [114]. The parents’ lifestyle is emphasized even more as being significant for the child’s health [69, 60]. Child health care has acquired a new expert role, expected to be available when the parents ask for advice [60, 71].

In the analysis of our material we found qualitative changes in views and attitudes in the development of Swedish child health care. *Normality and control* emerged as central and constantly present dimensions. We could see how the meaning of concepts changed during the studied period. This helped us to identify a basic change in the level of responsibility for children’s health and in the focus of measures in child health care.

During the two first periods a *collective level of responsibility* was predominant and children's health and well-being were in general perceived and talked about as a duty of society. A collectivistic orientation could also be noted in the discussion on child health care during the third period. Even though the advent of parental education – as a major theme in the policy debate – marked an important change in direction, the radical turn emerged in the 1990s, when the notion of *individual responsibility* was firmly established and consistently framed the discourse on child health care.

From the beginning, the target group of child health care was children and their mothers, but later the attention was directed at the family as a whole. *General measures* in the form of preventive work and vaccination programmes became the primary task of child health care in the 1950s and 1960s. During the 1970s and 1980s there were both general measures such as health promotion, pre-school health care, and parental education, and *selective measures* in the form of information campaigns targeting specific health-related and social risk groups. In the 1990s the question of cost-effectiveness affected the debate on whether or not child health care should concentrate its resources on vulnerable families and children with special needs, and as a result, selective measures were increasingly advocated.

Comments

Changes to society and to the area of health-related problems make great demands on child health care. In Sweden, as in many other countries, the importance of adjusting child health care to changed conditions is stressed [115–119].

The shifting focus from the child's physical health to "psychosocial" problems evidences the transition from descriptions of concrete and well-defined duties, which characterized policy outlines of child health care during the first two periods, to more abstract and general descriptions of tasks (characteristic of present policy documents) which are by definition more open to interpretation. Another reason for the difficulty of translating policy recommendations into practice is found in the transition from unambiguously described measures in terms of paternalistic regulations to more participatory and at the same time more expansive definitions of roles and responsibilities. The parent whose health awareness, competence and self-confidence should be increased, with assistance from nurses and doctors, represents a key figure in the contemporary discourse of Swedish child health care. As a result the burden of responsibility for both parents and staff tends to increase.

The method we used in this study was a form of discourse analysis. This examines the construction of written and verbal accounts and language/vocabulary employed. In this method the theoretical nature of the text is considered to be essential [109]. The method was thus suitable for our study. However, it should be

noted that our attempt to describe the transformation of the Swedish child health care agenda in a historical perspective has limitations in that the analysis is restricted to official policy documents, which means that debates among professionals as well as lay perspectives are not considered. However, the study offers a baseline for identifying essential trends and turning points. The historical approach should be seen as an analytical device that can assist the process of exploring the current gap between policy and practice.

Parents: the best experts in child health care? (Paper II)

The *parents* chiefly encountered child health care through individual visits. They either made contact on their own initiative or else they were invited to various medical check-ups for the children. They were also invited to take part in parent groups. The interview responses showed that there were significant differences in views between parents and staff, reflecting contradictions regarding both individual contacts and parent groups.

With regard to the individual contacts, parents and staff were unanimous in saying that the most important task of child health care is to give support. The *parents* came to the clinic to receive confirmation that they were making the right judgements in different situations. They came to have the child weighed and measured and in conjunction with this to get advice about food and breast-feeding. The parents also stressed the importance of being able to deal with questions about setting limits and insomnia in the children. It was felt important to receive a “professional judgement” from the staff. In several cases, child health care was also perceived as a support by virtue of the opportunity it gave to “get things off one’s chest” in order to reduce anxiety or to break a sense of isolation. The *staff* had a basically similar outlook. However, few parents thought that child health care should deal with private and family-related problems, preferring instead to look for help elsewhere in such situations. In contrast, the staff stressed the importance of working with the family as a whole.

The other task that both parents and staff highlighted as being important in child health care was the medical check-ups. Different attitudes could nevertheless be distinguished as regards the check-ups as well. The *parents* stressed the importance of knowing whether the child was healthy and developing normally, but the check-ups could also give parents feelings of guilt and anxiety, and in some cases they were perceived as surveillance. Whereas the parents emphasized the importance of checking physical health, the *nurses* in the main attached greater importance to checking up psychosocial health. They focused on the importance of checking the child’s mental development and the interaction between child and parents.

The interview responses also showed that the *nurses* felt torn between their own experience and knowledge and the duty imposed from above of pursuing all the points of the check-up at any price, even if this was often considered superfluous from a professional stance based on experience. This conflict could be a source of stress.

Twenty-nine of the interviewed parents had experience of participation in parental education, as had 12 nurses, but none of the doctors. Parents and staff had different views about this too. *Parents* saw the greatest benefit of parental education in the opportunity to meet other parents and exchange experiences. Just as with individual contacts with child health care, they emphasized the importance of support; being able to discuss one's insecurity with other parents, receiving confirmation and making contacts. The *nurses* primarily regarded parental education as an opportunity to inform the parents. The majority believed that they should work as they already worked, by assembling parents of children of different ages and informing them about concrete matters concerning the respective age group: diet, accidents, setting limits, and so on. Some nurses felt that they ought to work more with groups of parents who had special needs in common.

An important observation here was the stress caused by the demand to initiate parental education. The *nurses* felt that they were not regarded by their employer and colleagues as sufficiently efficient and competent in their work if they did not have ongoing group activities, while they also felt that they had inadequate time or knowledge to arrange and lead groups.

Comments

Both parents and staff emphasized two tasks as being of particular importance in the work of child health care: giving *support* and carrying out *medical check-ups*. Previous studies have presented similar results [120–123]. However, the results of our study showed various contradictions.

The *parents* came to the clinic when they were uncertain about matters concerning their children and sometimes also to get into contact with other adults. The *staff* spoke from their professional stance about the needs that child health care should satisfy according to central directives and stressed the importance of work with the whole. There was a tension between security and integrity.

As regards parental education, the *parents* saw this activity primarily as an opportunity to meet other adults and share experiences, while the *nurses* chiefly saw parental education as a pedagogical opportunity to give parents information.

Individual nurses experienced a conflict between what they wanted to do and what they felt that they had to do. Finally, there was also a hint of contradiction to do with how the nurse's professional role has changed from measures aimed at the child to inspecting the whole family and the child's environment.

The method we used is a well-documented scientific way of describing qualitatively how people perceive phenomena around them [111–112]. At the time when the study was conducted the selected area was representative of Malmö as a whole as regards people with foreign background, the proportion of people in gainful employment, the form of housing tenure, income distribution, the proportion of recipients of social assistance, etc. In the interviews we did not include questions about socio-economic factors, which could be a limitation. Our results are not necessarily representative of the situation in the country as a whole, or the situation today. The study does nevertheless provide a valuable basis for discussion and reflection about how the work of child health care can be designed in the future.

Fathers and their children's health (Paper III)

When it came to *the care and upbringing of the child*, three out of four fathers in the past two weeks had played with their child and also put it to bed and bathed it. Other activities occurred less frequently. Fathers with one child were “better carers” than fathers with more than one child. Otherwise, there were no statistically significant differences, in doing four and more caring activities or in doing three or more playing activities between younger and older fathers, those with one or more than one child, or between blue-collar and white-collar fathers.

When asked who gets up at night if the child wakes, the most common answer was the alternative “both” (48%), followed by the “mother” (30%) and “father” (16%). Others (6%) answered, among other things, that the child slept with the parents or that the child came to the parents by itself during the night. When we asked who had the greatest say concerning the child, fathers most frequently chose the alternative “both” (56%), followed by the “mother” (42%) and “father” (2%). The vast majority of fathers (90%), however, felt that usually there were no differences within the family when it came to child rearing.

When it came to *the child's health and ill health*, the majority of fathers (82%) answered that they could state their child's birth weight; white-collar workers more so than blue-collar workers (89% vs 75%). The majority also knew whether the child was vaccinated (87%).

Four out of five fathers (82%) thought that their child's health was good, while the other 43 mentioned some health problem, mostly relatively mild problems. More white-collar workers stated that the child's health was good. Just over half of the fathers (55%) had at some time contacted a doctor because of the child's illness. When asked who they turn to when the child became acutely ill (in this case an attack of diarrhoea), in both daytime and night time, the fathers would turn first to the child's mother, who was said relatively often (approx. 20%) to have already taken action. As regards professional help, in the daytime the fathers primarily consulted their general practitioner (31%), while at night they chiefly contacted

the emergency ward (39%) and the health information service (35%). There were no statistically significant differences in seeking professional help, neither daytime nor night time, between younger and older fathers, those with one child and those with more children, or between blue-collar and white-collar workers.

When it came to advice about how to prevent child accidents, as many as 135 (57%) fathers stated that they used their common sense, that they had experience of previous children, or that they had attended courses on child accidents and therefore did not need to turn to any outsider.

As regards the *role of father*, the most important things for the child's well-being were "security" (stated by 51% of the fathers), "love" (31%), and "commitment" (31%). The fathers believed that it was important for the children to feel secure in their home environment and their general surroundings, that the child had both parents present, and that there was harmony in the family. They mentioned the importance of parental commitment, and that the child received a lot of attention and felt needed.

The majority of the fathers had talked during the past year with one or more people about what it is like to be a father. Only 20 fathers (8%) answered "no", while 25 (11%) did not want to answer at all. There were no statistically significant differences, in either talking to the family or other relatives or to workmates or other friends, between younger and older fathers, between those with one child and those with more than one, or between blue-collar and white-collar workers.

Three of four fathers (72%) answered that they had read some book or magazine about children's health and upbringing. This was more common among fathers with only one child and among white-collar workers. Only slightly more than half of the fathers (54%) thought that they spent enough time with their children. Despite this, almost all the fathers (230/237; 97%) answered "yes" when asked if they were good fathers; six did not know and one father answered "No".

Finally, when we did the same analyses of only those fathers whose youngest child was born in 1999, 2000, or 2001 (189 fathers) three out of four statistically significant differences between white-collar and blue-collar workers disappeared. Otherwise the results remained the same.

Comments

Few studies have been conducted of fathers' views of their children's health. This study should be a useful addition to our knowledge of this. Our study examines 237 fathers' own involvement in, and attitudes to, their children's health and has revealed a number of new findings. The fathers state that they are involved to a large extent, and that they perform a lot of activities with their children.

It has previously been stated that fathers participate more in playing than in caring [124]. The child is felt to require more care than play during the first two

years, and the general perception has been that the mother is responsible for care, while the father is primarily the one who plays with the child. This become even more pronounced as the child grows older. In this study most of the children (80%) were aged 1–3.5 years which ought to have shifted the results more toward playing, but in our study an interesting finding is that the fathers state that they take at least the same part in caring activities as in playing activities. In line with earlier research [125], the fathers consider their own role important and manage it fairly well in the given circumstances of their economic responsibility for the family.

The strength of this study lies in the fact that it consisted of structured interviews conducted by jointly trained interviewers. The research leader performed almost half of the interviews. The participation rate is also relatively good, 237 out of 279 (85%).

Studies with the aim of investigating the involvement and participation of parents often attract those in good social circumstances. In this study we likewise have reason to assume that, among the 30 fathers who declined to take part and among the 12 who could not understand spoken Swedish, there were several with poor social circumstances. There were also more men living with the mother than the average for the entire population with children of this age (10% of the parents of 3-year-olds are divorced) [70]. Also, the 21 fathers who could not be reached might be different from the 237 that were interviewed.

Training programme for parents of teenagers (Paper IV)

The “parents’ school” in Oxie was planned by 36 parents and a project leader at four meetings. The parents were allowed to suggest conceivable lecturers and received a list of relevant literature. The parents decided that four lectures should be held during the autumn. Group discussions were to be held immediately after these lectures. The aims of the parents’ school were formulated by the parents:

- to reach parents who have or will soon have teenagers (the participation goal);
- to give them insight and knowledge about matters connected with the teenage phase (the knowledge goal);
- to work for strong and good relations between parents and teenagers (the relations goal);
- to create supportive environments and networks for parents in the neighbourhood (the contact and community goal).

Four lecture evenings on the following topics were arranged in autumn 1997:

- Why do some young people get into trouble while others do not?
- Teenagers and drugs – what can one do as a parent?
- With united forces – on attitudes to teenagers.
- What happens to a teenager? On teenage development and teenage identity.

Between 50 and 70 parents took part each evening. All the participants received a folder and a pen with “The Oxie Parents’ School” logotype. After the lecture, the project leader divided the parents into groups, and in each group one of the parents was appointed to lead the discussions. Literature about young adolescents and parenthood was available. In addition, the parents were asked to complete a small questionnaire about how the evening had been. The results were compiled by the project leader and reported to the parents at the next lecture.

The three follow-up evenings were not well attended. A total of 18 parents and two teenagers took part in the first two, while the third had to be cancelled because too few people had registered. Evidently, many parents felt that the discussions on the lecture evenings were sufficient.

A *questionnaire* was completed by 44 women and 22 men. Most of them had children aged between 11 and 15. The majority (41) of the 53 participating parents stated that they had acquired greater knowledge and insight about how parents can handle everyday conflicts with their children and about what it is like to be a teenager. Forty-eight parents thought that the parents’ school could help in the long term to strengthen relations between teenagers and parents. When it came to the opportunity to share other parents’ experiences, the majority (47) of the parents were favourable. Most of the parents, however, had not been in contact with other parents outside the parents’ school. Sixty-four parents thought that the parents’ school should be continued, and 51 parents wished to take part in a continuation.

Comments

Only about 10% of the families with teenagers participated, and the response frequency to the questionnaire was only 63%, although those who responded seemed to be fairly representative of the inhabitants of the neighbourhood. Despite the limited number of parents who took part in the study, the process description and the questionnaire responses give valuable knowledge about how one can proceed with work on various activities aimed at parents. It may be thought that the planning phase took a long time, but it was necessary to give the parents the opportunity to work on their own terms and to participate right from the start.

While earlier parental training programmes, in Sweden [67, 126], as well as internationally [23, 28, 127–137], have primarily focused on parents of young children, the Oxie parents’ school was aimed at parents of teenagers.

In health promotion work, such as ours, the research methods adopted must reflect the complexity of the work, and evidence of success must often be based on a much wider range of sources than the results of meta-analyses and systematic reviews of randomized controlled trials [138–139]. The research literature is lacking in evaluation of parenting classes as an intervention, and it is important that such research is done and reported [140]. It is not only important to establish evidence of what works in health promotion (i.e. outcome evaluation), but also to understand how and why these things have worked (i.e. process evaluation), so that success can be replicated [141]. Our study is a valuable contribution in this respect.

General discussion

Methodological considerations

Quantitative methods and qualitative methods complement each other. Although textual interpretation differs from statistical analysis, the underlying principles are much the same [142]. Qualitative methods are being used to an increasing extent in studies in family medicine and public health science. The reason for this is that these methods are suitable when the research questions concern phenomena such as experiences and values. They can be used, for example, to arrive at an understanding of self-perceived health and the encounter between people and professionals. Qualitative methods are descriptive, hypothesis-generating or interpretative [143–145].

The studies in this thesis have been performed using both qualitative and quantitative methods. The method in Paper I is a form of discourse analysis. This examines the construction of written and verbal accounts and language/vocabulary employed [108–109]. This method therefore suited the context well when we studied selected texts about the development and work of child health care. Alternating with different kinds of texts and different periods was toilsome but necessary for a reflexive interpretation. Our ambition was not to find a truth or any causal connections; instead we tried to gain an understanding of the development of work with child health care in Sweden.

In Paper II we used phenomenography, a well-documented scientific method for describing individuals' perceptions [111–112]. This qualitative method is particularly appropriate for describing subjective perceptions and values, and for complex situations where it is uncertain which aspects can be significant in the context [111–112, 146–147]. The method was highly time-consuming but it was chosen because we wanted an increased understanding of work with child health care. In our study we wanted more profound and nuanced knowledge of the experiences and perceptions of parents and staff, as regards both individual and group-based contact with child health care.

In paper III we used a structured telephone interview questionnaire which was analysed with quantitative methods. By putting questions directly to the fathers and not posting the questionnaire we were able to avoid having them ask the mothers; they themselves gave immediate answers to our questions. In our study the fathers said they do things with their children, but we have no evidence that they really do so. However, in view of the personal telephone contact with the fathers and the continuity with accustomed interviewers, the chances should be good

that they answered truthfully. But we are aware that the results could have been different if we had made observations of the fathers and their children in everyday life. In our subgroup analyses we found few statistically significant differences between younger and older fathers, between those with only one child and those with more than one or between white-collar and blue-collar workers. The reason for this may be that there are no large differences between these groups in Swedish society. But there may also be methodological explanations; our groupings of the fathers were quite crude, and our study population could have been larger. However, interviewing almost 250 fathers took quite a long time since we often had to ring repeatedly before we managed to contact a particular father. Nor was it easy to find a suitable time for the interview. Many interviews had to be held late in the evening when the children had gone to bed. Conducting in-depth interviews at times agreed in advance would have been one alternative, but it would have been much more time-consuming to travel round the whole of Skåne interviewing fathers. We did not have enough resources for that.

Studies have shown that programmes which, for example, take implementation factors into consideration work well in practice. So too do programmes in the form of short-level interventions for delivering factual information and fact-based advice to parents [55]. Paper IV describes a parental education programme for parents of teenagers, which can be regarded as a form of health-promotion work. In this work, the research methods adopted must reflect the complexity of the work. Evidence must often be based on a much wider range of sources. Knowing the parents' motives for participating and their perception of participation is important for future programme development [23, 55, 148–150]. It was quite easy to describe how planning and implementation were carried out ("process evaluation"). Otherwise, it was more difficult to measure whether the "parents' school" fulfilled the goals set up by the parents themselves. The work went on for a relatively short period of time, whereas the formulated goals were mainly long-term. Nevertheless an attempt at an analysis of the goals was made. Programmes are dynamic and context-bound [151–152]. The information one obtains through evaluation should be useful when it comes to understanding how programmes are designed, implemented, and modified, both local and generalizable knowledge. In this respect the method was appropriate for the purpose.

Responsibility for children's health and welfare

The influence of Swedish society on parenthood has taken different expressions in the course of history (Papers I–II). From 1930s to the end of 1960s children's health and well-being were considered to be the duty of society, to ensure that parents were influenced to give children good food and clothes and to bring them up in the "proper" way. Public authorities wanted to take more active responsibility

for children's health, upbringing, and development [153]. Parents were to be educated to become professional parents. Mothers above all were the target group of this parental education. But parental education was just a complement to the role of the state in children's development and upbringing. The greatest responsibility was expected to lie with professionals such as school and child health care [154]. This view of social responsibility also existed in the 1970s and the 80s, even if the individual responsibility was increasingly emphasized (Paper I). Through education one should strengthen the parents' competence regarding the child's health and care. A report on parental education was presented in 1978 [67] and later a final report [126].

Since the 1990s the individual responsibility for the child's health has been heavily emphasized (Paper I). In 1997 an inquiry on parental education published its report in which the term "parental education" was replaced by "support in parenthood" [71]. It was stressed there that society is responsible for giving parents support in parenthood, while responsibility for children's welfare is shared by everyone. When there are indications of deficiencies in the care of the child, it is wholly legitimate to act for the good of the child in accordance with the Social Services Act (SOL), the Care of Young Persons (Special Provisions) Act (LVU), the Code relating to Parents, Guardians and Children (FB), and the Convention on the Rights of the Child. The inquiry stresses the importance of new forms of networks and possibilities for meeting places for today's parents. It is the task of society to create forums for meetings between parents and experts for discussion of topics such as child rearing and norms and values associated with this. Society should also provide information about children's different phases and their need for care and love. There is special emphasis on strengthening parents and utilizing their own competence. It is clear, however, that the ultimate aim is also to prevent problems which could otherwise afflict children. If a child is to develop favourably, society has the responsibility to support parents and parents have an obligation to give children good conditions in which to grow up.

Direct support to parents of small children, expanded parental education, and specially directed preventive efforts in the pre-school years are held up in today's Sweden as being very important for children's health [3]. But at the same time as this social commitment is emphasized, parents are expected to obtain more and more knowledge on their own and get help when they need it. So the question whether who has the real responsibility for the child's health and welfare is still of immediate interest.

Present need of parental support in Sweden

During the last decade there has been increasing talk of the parents' living habits as being crucial for children's development and health [60, 68].

In Sweden the composition and living conditions of the family have changed in recent decades. Single parents find their economy increasingly strained. An increase in unemployment in recent years contributes to an even more distressing situation for many parents and children. While physical health has improved, mental ill health has increased. In other words, a diversity of factors both inside and outside the family determine how parents and children feel and what support they need [11]. Not all parents need special support in their parenthood. Many cope with their parental role without any problem, while others may feel insecure and bewildered as parents.

Who decides what needs the parents have and in what form support should be offered? If we look at the situation in Sweden, we see that the majority of the support offered to parents is initiated and planned by official institutions and authorities from a top-down perspective. In our second study (Paper II) this perspective was expressed in the form of a discrepancy between policy and practice. It was found that there are differences in the parents' and staff's perceptions and expectations of child health care. In addition, this perspective is also reflected in the individual nurse, in the sense that there are traces of a difference between what she feels she can and ought to do and what the instructions say that she should do. There is a natural contradiction in child health care between parents' individual needs and the public interest, ultimately represented by the care measures, the clinic, and the staff. It is as if they were "children of society", one parent said. The fact that the work of child health care increasingly tends to concern the psychosocial area and that roles and tasks have been expanded (cf. our Paper I) means that it has become increasingly important to reflect on how much one should intervene in the family's private sphere.

Not all parents are interested in support in groups, or they have a private situation which makes them unable to take part in the group activities offered. This must be respected. Individual supportive activities should therefore never cease (Paper II). It has happened that parents have felt pressed to take part in parental education in order not to be labelled as "bad parents". All interference in parenthood violates the parents' self-determination. It has been claimed that two requirements of parental support should be that there is agreement that the measure promotes children's health and welfare and that the measure is voluntary [39]. Although measures on behalf of parents show greater humility, it has been pointed out that interference occurs as soon as an expert or a public authority pronounces on how one should treat one's children [155–156]. The parents' school in Oxie (Paper IV) showed consideration for the parents' own perceived need of support and information regarding their teenagers.

Fathers too need support. This is shown in Paper III. The interviewed fathers stated that they sometimes spoke with other adults about what it is like to be a father. The profound involvement they displayed in the child's health and upbringing shows that the organizations that offer parental support today should ensure to

a greater extent that fathers are also able to take part in the activities initiated.

A recently presented report from the Institute of Public Health suggests new forms of parental support [39]. Today support is offered not only by county councils and municipalities but also by voluntary and private actors. As regards arenas for parental support, we consider it important to think from a parental perspective (Paper II). How do we create arenas which are also accessible for the fathers (Paper III) or for persons from unfavourable social backgrounds? The parent group activities of child health care involve far from all parents. In our experience, the older the children grow, the more parents need to meet, and therefore it is important to establish new arenas for this kind of support. In the project with the parents' school in Oxie (Paper IV) it was noted that many parents thought that there was greater need for support when the child started school. One may also ask whether parental support should really be arranged in the settings which simultaneously have a controlling function, and in the case of school also a grade-awarding function. It cannot be taken for granted that parents in need and in vulnerable situations find it easy or desirable to seek support in places like this.

General or directed parental support

Some parental support in Sweden is directed towards parents with children who have special needs, and some support is geared to parents in general [39]. It is important that both forms continue to exist in the future and can complement each other. A Swedish study from 2004 stresses the importance of designing parental support programmes for the future which are geared to socially disfavoured groups such as immigrants and single parents [82]. However, another study from 2005 provides some findings that contradict the well-known association between high socio-economic status and favourable outcome. There were no associations between high socio-economic status and high-quality interaction or low child difficulty. The few significant differences in fact favoured the low-status children [157].

Many parents who have difficulty for various reasons, in the family situation or in their parental role, prefer to seek and accept help of a general kind. We were able to see this clearly in the study of the parents' school in Oxie (Paper IV). Here the parents could assimilate what felt relevant to them at that moment, without their problems being stigmatized. Being able to come without any conditions and obtaining information in one's own way, and making new contacts on one's own, was perceived as very valuable by many parents.

When it comes to reaching broad groups of parents, it is important to take cultural aspects into consideration (Paper II). Through the years we have met many immigrant parents who do not feel at home in the parental support activities that are offered. Being a newcomer with different traditions of child rearing, and lack-

ing a firm social foundation in addition, makes it hard to feel at home in a parents' group. Alternatives must be created to involve these parents. When it comes to open pre-school, we see how many parents with a different cultural background take part in the supportive activities. A possible reason for this may be that many have no employment or occupation and in this case have a place to meet and exchange experience with other adults.

With regard to the fathers, one can discuss whether there should be groups purely for them. It was evident from Paper III that fathers stressed how important it was for both parents to be involved and participate in care and upbringing.

Design of parental support

People doing social and health-promotive work constantly have to grapple with the concept of "evidence-based" practice. But it is not always relevant to have control groups when evaluating programmes that take place in a broad social context, which are moreover perceived rather uniquely by each parent. Programmes of a health-promotive nature are often not designed as a response to a specific problem. They are defined instead as "a process for initiating, managing and implementing changes" [158]. There are things that can help parents in a troublesome situation, without having been scientifically proven. It is important to look at what the real purpose of the offered activity is and to decide on an evaluation method according to the type of intervention (Paper II).

Activity in certain programmes cannot be measured solely in objective and positivist terms. One must distinguish between programmes which seek specific effects, such as changed behaviour, and programmes which are intended more to function as supportive environments and for parents in general. In our experience, the latter type of programme is easier for parents to accept if they are in some kind of crisis and need support and opportunities to discuss with other adults/parents. The parents' school in Oxie (Paper IV) was an example of supportive activity which the parents found significant without having a strong scientific design. The process description we performed could be used to determine how the programme was implemented, what activities were offered, in what circumstances, to whom, and with what degree of exertion, and it contributed to both control and assurance of quality of practice [159].

Implications for clinical practice and future research

Our research shows that in future parental support activities one should include the parents right from the planning and implementation stage (Papers I, II, III, IV). Otherwise there is a risk of constructing programmes which the experts believe

in, while the parents feel uncertain about the purpose and may get the impression that they are being controlled.

There is a need to clarify the conditions for developing methods of parental support in child health care. There are differing expectations of the purpose and orientation of parental groups (Paper II). This also applies to parental support in general, and especially the fathers' needs should be highlighted and studied (Paper III). Individual parental support and group-based support complement each other.

It is not possible to propose one specific model of parental education. Alternatives should exist. It is important here to look at the purpose of the support; to teach skills in order to change behaviour or create understanding. It is essential to proceed from the parents' self-perceived needs (Papers II, III, IV).

In the development of future parental support, long-term work is more important than many different short projects if one wants a good evaluation (Paper IV). Our study of a "parents' school" showed that, just when the parents felt involved and interested in the activity, it was stopped.

More research is needed about immigrant parents' experience of participation in parental support measures (Paper II), and about the fathers' view of parenthood and their children's health, and their experiences of child health care. The results of our study of fathers (Paper III) yielded new knowledge about fathers' perceptions of their children's health which can be valuable for future planning of support for parents.

Conclusions

It is difficult to translate policy recommendations into practice. One reason is the shifting focus in child health care from the child's physical health to psychosocial problems, and another reason is the transition from unambiguously described measures in terms of paternalistic regulation to a more participatory and expansive definition of roles and responsibilities (Paper I).

There is a conflict between parents' need for security and their need for integrity. Individual nurses experience a conflict between what they want to do and what they feel they have to do. The parents view parental education as a chance to exchange experiences with other parents and receive support from other adults, while the nurses mainly see it as an opportunity to inform parents (Paper II).

Fathers are involved to a large extent in the care and upbringing of their children. They have a good picture of the child's health. The majority feel that they are "good fathers", although only just over half think that they have enough time for their children. New forms of family support including the fathers on equal terms can be designed and researched (Paper III).

It is possible to involve parents in both the planning and the implementation of parental support activities. The majority of the parents are content with their participation and want the activities to continue. The goals the parents set up are visionary and long-term, showing that this type of project must be given time to grow and that it is important that parents' wishes and opinions are considered right from the beginning (Paper IV).

Sammanfattning på svenska

I Sverige betonas idag alltmer det hälsofrämjande arbetet riktat mot barn, ungdomar och deras föräldrar. Olika föräldrastödsaktiviteter erbjuds. Det behövs ökad kunskap om varför vissa aktiviteter fungerar bättre än andra. Det är även viktigt att känna till föräldrarnas motiv för att delta och upplevelser av stödaktiviteten. Syftet med denna avhandling var att belysa aspekter på föräldrastöd i Sverige från ett föräldra- och personalperspektiv i förhållande till samhällsutveckling och ett förändrat hälsoproblempanorama.

I den första studien (I) ville vi synliggöra huvudlinjerna i den svenska barnhälsovårdens utveckling. Studien baserades på ett urval av texter/offentliga dokument rörande barnhälsovården från 1930-talet fram till idag och den tillämpade metoden var en form av diskursanalys.

Vid genomläsning av texterna identifierades fyra perioder i barnhälsovårdens utveckling. Under den första perioden (hygien och ordning – barnreformernas tid, 1930-tal och 40-tal) var barnhälsovårdens främsta uppgift, vid sidan om att kontrollera barnets utveckling, att informera och utbilda mödrarna medan insatserna under den andra perioden (profylax och optimism, 1950-tal och 60-tal) blev mera generella i form av förebyggande arbete och vaccinationsprogram. Hälsoövervakning för att identifiera risker och upptäcka avvikelser och handikapp blev det primära. Under den tredje perioden (sviktande nätverk och omsorg, 1970-tal och 80-tal) var insatserna såväl generella (hälsofrämjande arbete, hälsovård för förskolebarn, föräldrautbildning) som selektiva (identifikation av hälsorelaterade och sociala riskgrupper) och arbetet inriktades alltmer på att övervaka föräldrarnas skötsel av barnet. Föräldrarna skulle få stöd att hantera sina problem själva. Under perioden härefter (kostnadseffektivitet och nedrustning, 1990-tal och 2000-tal) inriktades arbetet alltmer mot barnets omgivning och familjen som helhet, och barnhälsovården definieras som en institution som skall stärka föräldrarnas självförtroende och kompetens.

Under de två första perioderna dominerade ett kollektivt ansvar för barns hälsa. Barns hälsa och välbefinnande ansågs vara en uppgift för samhället. Även under den tredje perioden noterades detta kollektiva ansvar även om införandet av en föräldrautbildning gjorde att ansvaret alltmer tillskrevs föräldrarna. Från och med period fyra ses hälsa som en individuell resurs som det är den enskilda individens ansvar att sköta, och barnhälsovårdens uppgift blir att påverka föräldrarna och stödja en hälsosam livsstil. Barnhälsovården får en expertroll och skall finnas till hands när föräldrarna själva söker stöd.

I den andra studien (II) ville vi beskriva hur föräldrar och personal tänker kring innehållet i barnhälsovårdens arbete, för att identifiera överensstämmelser och skillnader i synsätt. Data samlades in genom intervjuer och analyserades enligt fe-

nomenografisk metod. Vi studerade förväntningar på innehållet i den individuella konsultationen inom barnhälsovården, samt i den gruppbaseade föräldrautbildningen. Sextio föräldrar, fjorton sjuksköterskor och sex doktorer intervjuades.

Såväl föräldrarna som personalen betonade två uppgifter som särskilt viktiga inom barnhälsovårdens arbete: stöd och hälsokontroller. Det fanns en motsättning mellan föräldrarnas behov av stöd och deras behov av integritet. Den enskilda sjuksköterskan upplevde motsättning mellan vad hon ville göra och vad hon kände att hon måste göra. Föräldrarna såg föräldrautbildningen som en möjlighet att utbyta erfarenheter med och få stöd av andra vuxna, medan personalen huvudsakligen såg utbildningen som en möjlighet att informera föräldrar och stärka dem i deras föräldraroll. Studien visade således på en diskrepans mellan policy och praktik i barnhälsovården.

Det finns ingen rutin att ta med fäder i studier om tidig barndom trots att forskare upprepade gånger betonat vikten av deras engagemang för sina barn från barndomen till vuxen ålder. Fäderna deltar också i mindre omfattning i de föräldrastödjande aktiviteter som erbjuds föräldrar idag. För att öka kunskapen om fädernas uppfattning om och engagemang i sina barns hälsa genomfördes *den tredje studien (III)*. Per telefon intervjuades 237 småbarnsfäder i Skåne. Intervjuerna var strukturerade och berörde familjesituationen, deltagandet i barnets skötsel, uppfattningen om barnets hälsa samt rollen som pappa.

Fäderna angav att de i hög grad var involverade och engagerade i sina barn. Tre av fyra hade under de senaste två veckorna såväl lekt med barnet som nattat och badat sitt barn. Fyra av fem fäder (81 %) menade att deras barn hade god hälsa, medan övriga 43 tog upp något hälsoproblem. Här fanns mest relativt lindriga problem som infektionskänslighet och allergi, men också enstaka mera allvarliga åkommor. Drygt hälften av fäderna hade någon gång kontaktat läkare på grund av sjukdom hos barnet. Drygt hälften av fäderna (55 %) hade någon gång kontaktat läkare på grund av sjukdom hos barnet.

Det viktigaste för att barnet skall må bra är "trygghet" (angivet av 51 % av fäderna), "kärlek" (31 %) och "engagemang" (31 %). Tre av fyra fäder svarade att de läst någon bok eller tidskrift om barns hälsa och uppfostran. Endast drygt hälften av fäderna tyckte att de tillbringade tillräckligt med tid tillsammans med sitt barn. Trots detta svarade nästan alla (230/237) "ja" på frågan om de var en god pappa.

De flesta föräldrautbildningsprogram, såväl nationellt som internationellt, är riktade till småbarnsföräldrar och har initierats och planerats från centralt håll. I *den fjärde studien (IV)* beskriver vi den process varigenom föräldrar till tonårsbarn utvecklade och implementerade sin egen "föräldraskola". Vi presenterar även resultaten av den enkät, där föräldrarna fick ge sina synpunkter på utbildningsprogrammet.

En "Föräldraskola" planerades av 36 föräldrar och en projektledare. Mellan 14 och 26 föräldrar deltog i 4 planeringsmöten. Fyra föreläsningkvällar, inklusive gruppdiskussioner, arrangerades. Sammanlagt 105 föräldrar anmälde sitt intresse

för att delta i verksamheten och mellan 50 och 70 kom till varje föreläsningkväll.

Fyrtiofyra kvinnor och 22 män besvarade enkäten. Majoriteten av föräldrarna rapporterade att de varit nöjda med verksamheten och att de fått kunskap och insikt om tonårstiden. De ville även att "Föräldraskolan" skulle fortsätta. Föräldrarnas egna målsättningar med verksamheten föreföll visionära och långsiktiga.

Sammanfattningsvis visar avhandlingen att det inte är möjligt att föreslå en enda specifik modell för föräldrautbildning. Vid utformningen av framtida föräldrastöd bör man ta med föräldrarna i planering och implementering. Långsiktiga projekt är viktigare än många kortsiktiga för att kunna få fram bra utvärdering. Det är viktigt att klargöra förutsättningarna för att utveckla metoder för föräldrastöd i barnhälsovården. Särskilt bör fädernas behov synliggöras och studeras.

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