Constructed space and legitimacy for health work in the educational system: Perspectives of school nurses

SIV MORBERG, LOTTA DELLVE, BIRGITTA KARLSSON & MONICA LAGERSTRÖM

Department of Nursing, Karolinska Institute, Huddinge, Department of Public Health and Community Medicine, Sahlgrenska Academy, Göteborg University, Göteborg

Abstract
Increasing health problems among children place demands on school health care. It is unclear how contextual issues, e.g. reduced resources and low priority, impact the practising of health care work within the educational system. The aim was to gain a deeper understanding of school nurses’ perceptions of their opportunities for practising and handling health support work within the educational system. A qualitative study in line with constructivist grounded theory based on data from six focus group interviews with 24 school nurses. The results explain the conditions in which school nurses practise health support work within the educational system, as described in a conceptual model. The core category in the model was labelled construction of space and legitimacy for individual health support work within the educational setting. The model comprised four additional categories: experiencing restricted conditions for practising health support work; working alone and in isolation; retaining individual health support; and compromising and negotiating position and legitimacy. Interests and positions of political and organisational leaders, the school personnel and children/parents, as well as the school nurse’s own strategies, constructed a limited space and legitimacy for health support work.

Key words: School health care, health support, health work, school nurse, psychosocial work environment

Introduction
In recent years, there has been a significant increase in psychosocial problems among children and young people in Sweden (Danielsson, 2003; Bremberg, 2004; Swedish National Board of Health and Welfare, 2004). Schools health care is an important arena for promoting children’s health. It is unclear how changes in the welfare system, with decreased resources and increased demands, have altered the conditions for providing children’s health in schools.

The prevalence of psychosomatic complaints, especially headache and stomachache, has increased among children and young people in the Nordic countries (Berntsson, Köhler & Gustafsson, 2001; Berntsson & Köhler, 2001), and was found to be higher in low-income, low-educated, single-parent families (Berntsson et al., 2001). As the determinants of psychosocial complaints are multidimensional and related to social factors, e.g. it is children of families with low education, blue-collar work, low income, and unemployed parents who are most vulnerable (Berntsson & Köhler, 2001), children’s health strategies should be broad and easily accessible. Therefore, the school is one important arena for providing this.

However, public health work is designed on the basis of political, economic and discursive control factors (Gedda, 2001). Recently, low priority has been given to health care in schools (Iversen & Hags, 1994), and reduced economic resources and organizational changes have led to increased demands on school nurses (Swedish National Board of Health and Welfare, 2003).

Today, most of the health professionals within Swedish schools are school nurses. They were first employed at schools in Sweden a few decades into the 20th century (Hammarberg, 2001). The view at that time was that the school health care service...
should be part of the improvement of the population’s overall health, and this meant a new field of work for nurses. Nevertheless, the effectiveness of school nurses’ work has been poorly investigated, which has led to limited justification of their role (Wainwright, Thomas & Jones, 2000). Most of them are employed by schools, with a head teacher as their line manager. Their competence is based on training as a district or paediatric nurse. In schools they are often the only one of their profession, and responsible for school health care in more than one school (Swedish National Board of Health and Welfare, 1998). International studies show that cuts in economic resources have led to the function of school nurses being questioned. It seems that lack of information about the role of school nurses, and absence of research regarding the school nurses’ work, together with increasing demands for efficiency, has resulted in the need for school nurses being questioned (Wainwright et al., 2000; Maughan, 2003). Evidence of their effectiveness is also necessary in order to show the importance of the school nurses’ work to politicians and other decision-makers (Wainwright et al., 2000). In addition, the difficulty school nurses have in getting their work noticed as well as uncertainty concerning the role of the school nurse are further factors that contribute to their function being questioned (Maughan, 2003; Winland & Shannon, 2004).

The above difficulties experienced by school health personnel in making their work more noticeable, give rise to questions of how contextual issues impact on the practising of health care work within the educational system. In the present study, the aim was to gain a deeper understanding of school nurses’ perceptions of their opportunities for practising and handling health support work within the educational system.

**Method**

**Design.** The present qualitative study is based on data collected through focus group interviews (Krueger, 1994; Patton, 2002) with school health care professionals. Constructivist grounded theory was used as the qualitative approach, taking the perspective that people create social realities through their interpretation as well as through individual and collective actions (Charmaz, 2006).

**Sampling procedure and study participants.** In order to capture experiences of the everyday conditions for practising school health care we chose to select school nurses with more than two years of experience as participants. They were strategically selected from five areas of Sweden with different geographical locations, socioeconomic status and cultural background. The head school nurses provided a list of school nurses who met the inclusion criteria. The school nurses were contacted by telephone, informed about the study and asked whether they were willing to participate. Those who agreed were given further oral and written information about the purpose of the study. The participants were also informed that the interview would be tape-recorded and transcribed. The school’s head teacher and the head school nurses were contacted for information and for permission to carry out the study. No one objected to the study.

The participants were 24 school health nurses from 23 schools. They had between two and 30 years of experience of school health care (mean: 13 years). All were female, and their ages ranged from 30 to 60 years of age. Most of them were between 40 and 45 years old. Three of them were head school nurses, which meant that, apart from their work as a local school nurse, they also had the overall responsibility for school health care work within a defined area.

**Focus group interviews.** Qualitative focus group interviews were used in order to generate a deeper understanding of the school health professionals’ shared experiences of contextual conditions. The contextual strengths and obstacles, as well as conditions that may have meaning and utility for practising health care of children within the educational system, were in focus (Krueger, 1994; Patton, 2002).

Data collection was carried out during spring 2003. Six focus group interviews with four to five participants in each group were completed. The interviews took place in six different neutral locations, in rooms free from distractions, and they were held during the participants’ working hours. Each group lasted for one to one-and-a-half hours.

The role of the moderator (SM) was: to open the meeting; to stress the importance and confidentiality of the discussion between the participants; to introduce and get back to the focused themes; to listen and encourage but not interfere in the discussion between the participants; to create a relaxed climate and dialogue; to hold back participants who gave too personal information; to moderate participation in the discussion and to round off the discussion (Krueger, 1998a). The questions concerned the school nurses’ views of various aspects of their work situation. The questions used in the focus group interviews were open-ended and followed a question guide, with opening questions, introductory questions,
transition questions, key questions and concluding questions. Each interview ended with a short summary of key points as verification (Krueger, 1998b). The role of the assistant moderator (BK) was to observe and take notes on the interactions in the group.

**Data analysis.** The analysis of data can be described in two phases, and in line with a constructivist grounded theory approach (Charmaz, 2006). Systematic description was in focus in the first phase. All interviews were transcribed verbatim and read through several times to obtain a sense of the content and to reflect on the interviews. Then, line-by-line coding, close to existing data, was a process that led to a segmentation of data into smaller units, or codes. These codes were defined and labelled according to their content (initial coding). The initial codes were sorted into descriptive themes, which were systematically compared with the raw data (the transcribed interviews).

In the second phase, the development of conceptual theory was in focus, using theoretical notes and theoretical discussion within the research group to deepen the analysis. The interviews were coded on a more conceptual level (focused coding) in order to explore categories, along with their dimensions and properties. Theoretically, refined questions were asked concerning the raw data, as an alternative technique within “theoretical sampling” (Charmaz, 2006). Finally, the categories and the model were compared with the raw data, and were refined until no new properties of the pattern emerged (Glaser, 2001; Charmaz, 2006).

Throughout the analysis, the researcher referred back to the transcripts of the interviews to ensure that the resulting themes and categories kept close to the data, in order to ensure reliability (Polit & Beck, 2004). In the first and second phase of analysis, interactive processes within the focus groups were considered (Stevens, 1996), as well as extensiveness of comments, agreement and intensity of certain opinions (Krueger, 1998c). The first author conducted the first phase of analysis, but the initial codes, focused codes and themes were continuously discussed with the assistant moderator. In the second phase, the whole research group carried out the conceptual analysis and categorising. A core category, which was central to the data, the codes and the categories emerged as the conceptual framework, as described by Hallberg and Strandmark (2006).

**Ethical considerations.** Prior to each interview, the participants were informed about their right to terminate their participation in the interview. Confidentiality was assured. The study was approved by the Ethics Committee of Karolinska Institute (Dnr 02-240).

**Results**

The results explain the conditions for practising health support work within the educational system, described as a conceptual model (Figure 1). The core category in the model was labelled *construction of space and legitimacy for individual health support work within the educational setting*. The model was further composed of two categories related to working experiences, i.e. *experiencing restricted conditions for practising health support work*; *having autonomy but working in isolation*; and two categories related to

![Figure 1. Experienced space and legitimacy for individual health support work as constructed by interests of political and organisational leaders, the school personnel, children/parents and the school nurses’ own strategies.](image-url)
limited space and legitimacy, i.e. retaining individual health support, and compromising and negotiating position and legitimacy.

Construction of space and legitimacy for individual health support work within the educational setting

The school health professionals expressed concern about practising individual health support work due to poor legitimacy and space within the educational context. Interests and positions of political and organisational leaders, the school personnel and children/parents, as well as the school health professionals’ own strategies constructed the space and legitimacy for health support work. The political/organizational level constructed space and legitimacy for school health care by regulations and economic resources, as well as through the interests of political decision-makers and head teachers. The school personnel constructed space and legitimacy by restricting health education, disregarding school health care workers’ competence and by delegating complex psychosocial cases to school health care. The children and parents constructed space by demanding availability of school health nurses and through the increasing number of psychosocial problems. The restricted conditions experienced by the school nurses were described as low-priority work within the educational context; different perspectives and regulations; restricted participation in the dominant team; restricted opportunities for providing quality and the development of health issues; and being legitimated by children’s demands for availability. Working alone and in isolation from colleagues may create loneliness and powerlessness. In order to deal with their experienced limited space and legitimacy the school nurses used various strategies, conceptualised as retaining individual health care, compromising and negotiating to keep or strengthen their position and legitimacy. The categories, with their dimensions and properties, are described in the following text.

Experiencing restricted conditions for practising health support work

This category comprises five dimensions described as follows:

Having low-priority work within the educational context. School health care work was described as undervalued by head teachers and teachers in general. The head teachers did not know or were not interested in understanding the school nurses’ competencies, their work, the usefulness of their work or what policies governed their work. Political and school regulations also decreased the space for health care work within the educational setting:

The organisation is a problem. I think it’s a great problem and it’s difficult to get the head teachers to understand that our policies need to be followed. That we have to document our work and that this takes a lot of time . . . and other things . . . like the fact that we can’t just do what we feel like but have to follow the existing guidelines.

Having different perspectives and regulations. The school nurses described their own emphasis on the individual support perspective, in contrast to the group perspective that was experienced as more natural in the educational setting. Health work regulations provided legitimacy for the performance of health practices but at the same time constructed a division within the educational setting. However, laws and regulations were experienced as the guarantor for the school nurses’ existence in the organization.

Being restricted with regard to participation in the dominant team. The school nurses experienced that they were outside the dominant professional team. Their competence was acknowledged when there were complex and sensitive problems and cases. Problematic and complex cases of children or parents were redefined as health issues and delegated to the school nurse. Being the link between the school and the medical service in individual health-related cases, i.e. transferring the needs of these children from the medical to the school setting, provided a clearer position and legitimacy of school health personnel.

Having restricted opportunities for providing quality care and the development of health issues. It was felt that the responsibility for an increasing number of pupils, but with no more time to undertake this work imposed limitations on the quality of health care. The school nurses also experienced being restricted in terms of physical space due to demands that they should be available at their offices. Limited opportunities for further professional development were also described. The participants considered it difficult to maintain their professional knowledge when working in isolation.

Being legitimated by children’s demands for availability. Children and parents legitimated the school nurse by demanding that she should be constantly available for occasional individual meetings. In addition, the psychosocial problems among children increased demands for individual health care work. School nurses’ knowledge of individual children’s problems and professional confidentiality strengthened their position.
Having autonomy but working in isolation from colleagues

The participants experienced their work positively in relation to their autonomy, but negatively as regards their experienced isolation from colleagues. Autonomy referred partly to the ability to independently plan and organize their work, and autonomy regarding the content of their work, given some set frameworks. This provided opportunities for individual arrangements to match both the school’s needs and their own interests. Autonomy also meant working alone and in isolation. Lone working was expressed as missing having a colleague with whom they could discuss aspects of their work. Another aspect was that lone working could entail a sense of uncertainty and vulnerability when faced with difficult decisions or acute situations. The collegial conversations were seen as prerequisites for developing their work, their own personal development and their work identity.

Retaining individual health support

The strategy retaining individual support comprises four dimensions described as follows:

Claiming individual meetings with pupils to prevent and solve psychosocial problems at an early stage was one dimension of the strategy for retaining individual health support. The school health nurses’ broad competence in health issues, a holistic and individual approach, was described as necessary for a good meeting with children and the basis for health development:

We’re able to deal with depression, sleep disturbance, stress—all of which I think we’re very good at dealing with. They eat badly, or have lots of somatic problems, maybe they have allergies or other illnesses. Then there’s emotional well-being, friends and bullying. We know quite a lot about all these things that others don’t.

Maintaining availability for individual support was another dimension of the strategy. All participants viewed their availability, individual support and having time for pupils as one of the most important functions in practising school health care. They described an “open door policy”. Being available was considered a prerequisite for their supportive role. In most interviews, both the spontaneous and planned individual conversations with pupils were viewed as an important tool for the school nurse’s supportive role and a tool for their interaction with the pupils:

It’s in the one-to-one conversations…that’s where you find out about what they lack…and what they need.

Being an advocate for children and families was the third dimension of retaining individual support. This could involve speaking for individual pupils in their contact with counsellors, psychologists, teachers, and parents. Advocacy in relation to groups of pupils mainly concerned pupils’ work environment:

I think you’ve got to be a ‘work environment health officer’ because the children have a really bad working environment. Thirty pupils in each class, it’s noisy everywhere, with high decibels! They have no one who speaks up for them on this.

Seeking support/confirmation from children was the fourth dimension. School nurses emphasised the importance of their role and the appreciation they got from children and parents, while receiving little acknowledgement from teachers and head teachers. Sometimes they even described taking the role of mother for the students.

Compromising and negotiating position and legitimacy.

The strategy compromising and negotiating position and legitimacy comprises two dimensions, described as follows:

Having accessibility and flexibility. The clear and explicit need to be accessible and flexible was central in almost all interviews. Participants described how they were often asked to take care of situations that others felt unable to handle, and were needed to be available as a service function and organisational buffer in broader well-being issues. Being available and approachable in different situations and to different people could at times be experienced as a dilemma. In the interviews, this was expressed as: “I’m like a rubber band”, “I always give, give, give…to everyone and everywhere.”

Striving for increased role and profile. The participants discussed the dilemma of how to enhance the profile of school health work and thereby increase the understanding of their work within the educational setting. In the interviews, self-criticism occurred in that the school nurses viewed themselves as poor at promoting themselves. The school nurses tried to make their work more apparent in different ways, e.g. by keeping a record of the time they spent with each pupil. The individual conversation with the pupil was viewed as central to school nurses’ work but needed to be given a professional status:
We should be strong enough to state that we’re actually very good at what we do. We shouldn’t say ... oh, well ... he can come and chat with me if he wants to ... no, we should say: I’ve booked a meeting with John and it’s important that he attends.

It was considered important to make their work more evident and to present a clearer profile, in order to be able to argue for the importance of the school nurse’s profession in the future.

**Discussion**

The present study shows how political leadership and reduced economic resources, as well as the organisational context in schools, have an impact on school health care and result in a number of consequences. In the present study, the theoretical perspective has provided a conceptual model for understanding health care practices within the educational system. The school nurses in this study viewed the fact that they belonged to the educational system with a head teacher as their line manager as a significant problem and expressed their concern. They were concerned about the priorities set in the schools and the fact that the organisation often displayed a lack of support and understanding of the school nurse’s health work. This is in accordance with a study, which suggests that school nurses receive limited support and little understanding of their work (Croghan, Johnson & Aveyard, 2004). The study showed the unclear role of the school nurses. This was also found in a study of the complementary role of school staff and school nurses (Lightfoot & Bines, 2000) and found in our study of primary health care for district nurses (Karlsson, Morberg & Lagerström, 2006).

In the present study, availability can be seen as an example of the school nurses’ unclear role. Availability is viewed as a basic quality factor for school health work (Abrahamson & Hammarberg, 1996) and in the present study availability and time for pupils was seen as a prerequisite for the school nurse’s supportive role. The interviewed school nurses highlighted this supportive role from a holistic perspective, something that was viewed as a competency, but which was difficult to make apparent.

The school nurses in the present study found it difficult to argue for the importance of their work and to make their work apparent. The sense of professionalism they expressed was grounded in their competences and experiences, and they viewed their previous experience as an important knowledge base, and learnt as they carried out their work. This was related to their limited opportunities for professional development. As a lone worker within an educational system and not part of the dominating team there is a risk that the health work of the school nurse has limited legitimacy and space, but at the same time, the school nurse can be seen as a supporting factor as well as a buffer for the organisation (Winland & Shannon, 2004).

Young people’s health problems have changed in recent years, and in particular, there has been an increase in psychosocial problems (Swedish Ministry of Health and Social Affairs, 2001). Studies show increasing health problems among young people with decreasing social class (Borup & Holstein, 2004). Pupils from lower social classes and single-parent families frequently discuss various topics such as relationships, puberty, diseases and symptoms, as well as psychosocial issues, with the school nurse (Borup, 1998). Studies have also shown the importance of interaction in the meeting between the pupil and the school nurse, and that the most common reason for pupils to visit the school nurse’s office is to talk or to seek contact (Borup, 2002; Larsson & Zaluka, 2003).

Further research is needed in order to develop methods for working in structured ways with individual pupils who have different needs and problems, as pupils’ health issues have changed over the years (Danielsson, 2003). Examples of ways of developing instruments to identify students with health problems are the individual health dialogue with pupils (Borup, 2002) and the recent use of the ‘Sense of Coherence Scale’ (Myrin & Lagerström, 2006). In order to complement the experience school nurses already have, it would be important to have an overview of school nurses’ need to develop their own methods and tools further, as well as an ongoing structured plan of continued professional development, well anchored in recent research. In this way, the work of school nurses within child health care would be strengthened.

A theoretical perspective that relates to the present study is Bourdieu’s ideas of the system of dispositions: capital, habitus and field. These concepts have been used in nursing research when studying the school nurse’s teaching role and competency in developing the country’s general health care (Gedda, 2001) and Swedish healthcare organisations (Henriksen, 2002). Capital, habitus and field are key concepts and are used in relation to each other in Bourdieu’s theory. The concept of capital refers to resources of either a real character, i.e. finances, or a symbolic character. Symbolic capital can refer to knowledge or titles, and is grounded in attributes that are valuable to different groups (Broady, 1991), which is illustrated in the present study.
The concept of habitus is close to the theory of capital and refers to competencies gained from upbringing, experiences, and schooling (Broady, 1991; Bourdieu, 2000). The concept of field in Bourdieu’s research refers to the study of dominance differences between individuals or professional groups—in this study between school personnel and school health nurses. The concept of field is used to explain the situations in which groups with some autonomy have something in common or struggle for things that are viewed as important capital (Broady, 1991). A social field is defined by Bourdieu as, “a system of relations between positions of special agents and institutions who struggle for a common cause” (Broady, 1991, p. 266). The school environment is an example of a field and can be explained as a small community with hierarchies based on specific areas of knowledge and a historical culture. In this field, the school nurse exists as a lone worker with a different culture and capital. The way the school nurse is experienced within the school field depends on how the symbolic capital and habitat of the school nurse are valued and legitimized.

In the present study, different perspectives are evident, as teachers primarily have an educational perspective and school administrators mainly an administrative and organizational perspective of the school from an educational background. The breadth and multiplicity of the school nurse’s work requires knowledge from various areas of expertise, in which the science of caring is a large part. Moreover, the school health care service works primarily from an individual perspective, whereas school personnel traditionally work from a group perspective. As such, within any school, there are representatives with different backgrounds, knowledge, and ways of viewing situations, which can lead to the different groups failing to understand the school’s various activities. The contradictions in the educational field can be seen in the light of different schooling, culture and tradition, i.e. habitus. This was also described in the present study.

Health care work and supportive work are examples of the school nurse’s capital and habitus, which, according to Bourdieu (2000), can be given different values depending on the perspective of the individual. By linking the school nurses’ health work to the theoretical frame, there is a risk that the value and legitimacy of the school nurse’s capital and habitus—specific knowledge from experience and schooling—is reduced within the educational field. In turn, this situation can lead to limited space for school nurses’ health work.

Methodological discussion. Our methodological considerations are related to the small number of focus groups and the somewhat compromised theoretical sampling. However, the size of the sample is a tentative issue. Further, Charmaz (2006) also recognizes reanalysing existing data, with conceptually driven questions, as a possible way to conduct theoretical sampling.

The described theory is viewed as a substantive theory, i.e. a theoretical interpretation within a limited area related to time and place, of contextual conditions experienced by the school nurses for practising health support to children within the educational system. Here, focus groups may well capture and reflect the collectively experienced processes related to the contextual conditions. In the present interviews, the moderator and the assistant moderator were experienced in running groups, which was important for their ability to note the interaction within the groups. If group interaction is ignored, an important part of the analysis is missed (Reed & Payton, 1997), but in this study, the group size made interaction easy and enabled participants to express views that were either concurred or questioned by other group members.

The school nurses in the different interview groups knew each other because they worked in the same area. However, we reflected over the possible influence of these conditions after each interview, but concluded that this did not have a negative impact on the depth and richness of the data. At the same time, the attributes and principles of the school nurse’s work situation could be considered as typical for school nurses in general. The moderator/first author had professional experience in the research field through years of practice as a school nurse. Strauss and Corbin (1990) point out that personal knowledge and insight can help a researcher to see and understand events and actions more quickly. However, prior knowledge may also have an impact on the interpretation of the results. Therefore, the analysis in the initial phase was discussed with the assistant moderator, who had a different research background, throughout the analysis stage. The validity of the results was considered in all steps of the research process by constant comparison of raw data and codes, themes, categories and theoretical notes. These comparisons were made by the main part of the research group and discussed in theoretical seminaries.

Concluding remarks

In conclusion, the results of this study are shown as a conceptual model with a core category construction of space and legitimacy for individual health support work
within the educational setting for school nurses, taking the described individual, group and organizational aspects into account. Interests and positions of political and organizational leaders, the school personnel and children/parents, as well as the school nurse’s own strategies, constructed a limited space and legitimacy for health support work.

According to our findings, being a lone professional with an unclear professional role—at least in the other staff members’ view—and in a context in which school health work has low priority, meant that there were restricted opportunities for providing quality and for developing school health care work, as well as professional skills and methods for health work within schools. Thus, in order to strengthen the legitimacy of the school nurse, it is necessary to provide continuous professional development for the individual and develop methods for school health care work.

References

Abrahamsson, G., & Hammarberg, L. (1996). *Att utveckla skolhälsovården. En referensmaterial om kvalitetsåtgärder och kvalitetsutveckling.* (Developing the school health care system. Reference material regarding quality assurance and quality development). Stockholm: Liber Distribution.

Bermann, L. T., Köhler, L., & Gustfasson, J. E. (2001). Psychosomatic complaints in schoolchildren: a Nordic comparison. *Scandinavian Journal of Public Health, 29*(1), 44–54.

Bermann, L. T., & Köhler, L. (2001). Long-term illness and psychosomatic complaints in children aged 2–17 years in the five Nordic countries. Comparison between 1984 and 1996. *European Journal of Public Health, 11*(1), 35–42.

Borup, I. (2002). The school health nurse’s assessment of a successful health dialogue. *Health and Social Care in the Community, 10*(1), 10–16.

Borup, I. (1998). Pupils’ Experiences of the Annual Health Dialogue with the School Health Nurse. *Scandinavian Journal of Caring Sciences, 12*, 160–169.

Borup, I., & Holstein, B. E. (2004). Social class variations in school children’s self-reported outcome of the health dialogue with the school health nurse. *Scandinavian Journal of Caring Sciences, 18*, 343–350.

Bourdieu, P. (2000). *Outline of a Theory of Practice* (14th ed.). Cambridge: Cambridge University Press.

Bremberg, S. (2004). *Elevhälso—teori och praktik.* (Student health—theory and practice). Lund: Studentlitteratur.

Broady, D. (1991). *Sociologi och epistemologi. Om Pierre Bourdieus författarshopp och den historiska epistemologin.* (Sociology and epistemology. On Pierre Bourdieu’s authorship and historical epistemology). Stockholm: HLS Förlag.

Charmaz, K. (2006). *Constructing Grounded Theory. A Practical Guide Though Qualitative Analysis.* London: SAGE Publications.

Crogan, E., Johnson, C., & Aveyard, P. (2004). School nurses: policies, working practices, roles and value perceptions. *Journal of Advanced Nursing, 47*(4), 377–385.

Danielsson, M. (2003). *Svenska skolhälsovernor 2001/02.* Grundrapport. (Health Behaviour in School-Aged Children in Sweden—A WHO Collaborative Study). Stockholm: Statens folkhälsoinstitut. (Summary in Swedish).

Gedda, B. (2001). *Den offentliga helenheten. En studie om sjukhôltskans pedagogiska funktion och kompetens i folkhälsova˚rden.* (The official secret. A study of the school nurse’s educational function and competency in development of national health). PhD Thesis. University of Gothenburg.

Glaser, B. G. (2001). *The Grounded Theory Perspective; conceptualization contrasted with description.* California: Sociology Press.

Hallberg, L. R.-M., & Strandmark, M. (2006). Health consequences of workplace bullying: experiences from the perspective of employees in the public service sector. *International Journal of Qualitative Studies on Health and Well-being, 1*(2), 109–119.

Hammarberg, L. (2001). *En sund säl i en sund kropp. Hälsopolitik i Stockholms folkhållor 1880–1930.* (A Sound Mind in a Sound Body. Health Policy in Stockholm’s Elementary Schools 1880–1930). PhD Thesis. Stockholm: HLS Förlag.

Henningson, E. (2002). *Understanding in Healthcare Organisations—a Prerequisite for Development.* PhD Thesis. University of Uppsala.

Iversen, C. J., & Hags, B. J. (1994). School nursing in the 21st century; prediction and readiness. *Journal of School Nursing, 10*, 19–24.

Karlsson, B., Morberg, S., & Lagerström, M. (2006). Strong as individuals but weak as a group. Vård i Norden, 79(26), 36–41. (Abstract in English).

Krueger, R. A. (1994). *Focus Groups. A Practical Guide for Applied Research* (2nd ed). USA: SAGE Publications.

Krueger, R. A. (1998a). *Developing Questions for Focus Groups.* The Focus Group Kit no 3. USA: SAGE Publications.

Krueger, R. A. (1998b). *Moderating Focus Groups.* The Focus Group Kit no 4. USA: SAGE Publications.

Krueger, R. A. (1998c). *Analysing & Reporting Focus Group Results.* The Focus Group Kit no 6. USA: SAGE Publications.

Larsson, B., & Zaluka, M. (2003). Swedish school nurses views of school health care utilization, causes and management of recurrent headaches among school children. *Scandinavian Journal of Caring Science, 17*, 232–238.

Lightfoot, J., & Bines, W. (2000). Working to keep school children healthy: the complementary roles of school staff and school nurses. *Journal of Public Health Medicine, 22*(1), 74–80.

Maughan, E. (2003). The Impact of School Nursing on School Performance: A Research Synthesis. *Journal of School Nursing, 19*(3), 163–171.

Myrin, B., & Lagerström, M. (2006). Health Behaviour and Sense of Coherence among Pupils aged 14–15. *Scandinavian Journal of Caring Science,* in press.

Patton, M. Q. (2002). *Qualitative Research & Evaluation Methods* (3rd ed). London: SAGE Publications.

Pollit, D., & Beck, C. (2004). *Nursing research: Principles and Methods* (7th ed). Philadelphia: Lippincott Williams & Wilkins.

Reed, J., & Payton, V. R. (1997). Focus Groups: issues of analysis interpretation. *Journal of Advanced Nursing, 26*, 765–771.

Stevens, P. E. (1996). Focus groups: collecting aggregate-level data to understand community health phenomena. *Public Health Nursing, 13*, 170–176.

Strauss, A., & Corbin, J. (1990). *Basic of Qualitative Research. Grounded Theory Procedures and Techniques.* USA: SAGE Publications.

Swedish National Board of Health and Welfare (1998). *Skolhälsovården 1998.* (School health Service 1998). Stockholm: Socialstyrelsen. (In Swedish).

Swedish Ministry of Health and Social Affairs (2001). *Barns och ungdomens välfärd.* (Welfare among Children and Young People). SOU 2001:55. (In Swedish).
Swedish National Board of Health and Welfare (2003). *Hur bedrivs skolhälsovården i dag—förutsättningar och hinder. En studie omfattande nio kommuner 2003.* (How are School Health Services Managed Today—Conditions and Obstacles. A Study Covering Nine Municipalities in 2003). Stockholm: Socialstyrelsen. (In Swedish).

Swedish National Board of Health and Welfare (2004). *Socialstyrelsens riktlinjer för skolhälsovården.* (Swedish National Board of Health and Welfare’s guidelines for the School Health Service). Stockholm: Socialstyrelsen. (In Swedish).

Wainwright, P., Thomas, J., & Jones, M. (2000). Health promotion and the role of the school nurse: a systematic review. *Journal of Advanced Nursing, 32*(5), 1083–1091.

Winland, J., & Shannon, A. (2004). School staff’s satisfaction with school health services. *Journal of School Nursing, 20*(2), 101–106.