



**National guideline for health promotion and preventive work in the child
and youth health centres and school health service, 0 – 20 years**

About the guideline

The National guideline for health promotion and preventive work in the child and youth health centres and school health service (*Nasjonal faglig retningslinje for det helsefremmende og forebyggende arbeidet i helsestasjon, skolehelsetjeneste og helsestasjon for ungdom*) supersedes IS-1154 "Guide to the Regulation on the municipality's health promotion and preventive work in the health centres and school health service" (*Veileder til forskrift om kommunens helsefremmende og forebyggende arbeid i helsestasjons- og skolehelsetjenesten*).

The guideline is divided into four sections:

1. General sections concerning the enterprise's operation which cover all sub-services
2. Health centres 0–5 years
3. School health service 5–20 years
4. Youth health centres (YHC)

Sections 2, 3 and 4 contain specific recommendations for each sub-service.

The general sections, which concern all sub-services, must be viewed in the context of other recommendations in the health centre, school health service and youth health centre sections.

The municipal part of antenatal care is included in the health centre service and is covered by its own [National guideline for antenatal care](#).

Terms used in the guideline

- "Consultation" is used to refer to health checks
- "Parent" is used to refer to the mother, father, co-mother, co-father or other person with parental responsibility for the child or adolescent
- "The Regulation on the municipality's health promotion and preventive work in the health centres and school health service" (*Forskrift om kommunens helsefremmende og forebyggende arbeid i helsestasjons- og skolehelsetjenesten*) is also described by the abbreviated title "Regulation on health centres and the school health service".

Legal basis and guidelines for the work

Children have the right to essential medical care, including check-ups, in the municipality where they live or are staying temporarily. Parents are obligated to ensure that their children undergo health checks; see Section 6-1 of the Patient and Users' Rights Act (*pasient- og brukerrettighetsloven*). Children not permanently resident in Norway are also entitled to essential health and care services from the municipality, including health checks at health centres; see Section 4 of the Regulation on the right to health and care services for persons not permanently resident in Norway (*forskrift om rett til helse- og omsorgstjenester til personer uten fast opphold i riket*).

As part of the provision of essential health and care services, the municipality shall offer health promotion and preventive services, including health services in schools (the school health service) and health centres; see Section 3-2, first paragraph (1) of the Health and Care Services Act (*helse- og omsorgstjenesteloven*); see Section 3-1.

The scope of the health centres and school health service is regulated in more detail in the [Regulation on the municipality's health promotion and preventive work in the health centres and school health service](#) (*Forskrift om kommunens helsefremmende og forebyggende arbeid i helsestasjons- og skolehelsetjenesten*). The Regulation was used as a basis for the work on this guideline.

The purpose of the health centres and school health service is to promote mental and physical health, promote good social and environmental conditions and prevent illness and injury; see Section 1-1 of the Regulation. The service shall identify children and adolescents at risk as early as possible, offer them services and refer them to other services if necessary. The service shall be universal, and the approach shall be both individual and population-orientated. The services provided by health centres, the school health service and youth health centres shall be culturally sensitive and appropriate for the individual's needs and life situation.

The service shall also be interdisciplinary and be staffed by a public health nurse and doctor. The service should also offer physiotherapy. Team-based services covering a range of health professions ensure a holistic range of treatment, which means that other vocational groups such as psychologists, occupational therapists and personell with educational, social or multicultural skills can be included in the staff. Midwives shall be included in the staff providing antenatal care and postnatal care service. For more information about staffing, see [the General section: Management, control and user participation](#).

The municipality shall adapt its health and care services to ensure that the services offered or provided are conducted responsibly in pursuant of Section 4-1 of the Health and Care Services Act (*helse- og omsorgstjenesteloven*). This means, for example, that the services offered must be of good quality and be provided on time and to a sufficient scope. The obligation to ensure that the services offered or provided are conducted responsibly means that the organisation must plan and implement the measures necessary to ensure that the various services being provided at any time are appropriate. The obligation also means that organisational and systematic measures must be implemented to enable health professionals to fulfil their obligation to conduct their work in accordance with the requirements to professional responsibility and diligent care pursuant to Section 4 of the Health Personnel Act (*helsepersonelloven*) (Prop. 91 L (2010–2011)).

This guideline contains requirements regarding both what the service shall or must cover, as well as recommendations regarding what the scope of the service should be to ensure good practice and thereby also appropriateness. Considerations that have resulted in measures deviating from the prevailing guidelines shall be documented in the patient's medical records when such information is relevant and necessary; see Section 8, first paragraph (h) of the Medical Records Act (*journalforskriften*).

National focus areas of significance to the guideline:

1. Public health, environmental health protection and infection control (see the [Government's website on public health](#))
2. Prevention of cardiovascular diseases, diabetes, chronic lung diseases and cancer (Noncommunicable Diseases; see [NCD strategy 2013–2017](#))
3. Preventing, averting and identifying violence, abuse and neglect (see the [Escalation plan against violence and abuse 2017–2021 \(Opptrappingsplan mot vold og overgrep 2017-2021\)](#))
4. Equalisation of social inequality (see the [Government strategy – Children living in poverty 2015–2017 \(Regjeringens strategi Barn som lever i fattigdom 2015-2017\)](#))
5. Increased completion rates in upper secondary schools (see the [0-24 cooperation 2015–2020 \(0-24-samarbeidet 2015-2020\)](#))
6. Interdisciplinary cooperation to ensure the provision of holistic services for children and adolescents (see [Ministry of Health and Care Services. Report to the Storting no. 26 \(2014-2015\) Primary healthcare in the future – proximity and completeness \(St.meld. nr 26 \(2014-2015\) Fremtidens primærhelse - nærhet og helhet\), 2015](#))

Aim of the guideline

The guideline should clarify the authorities' requirements concerning the scope of the services and contribute to:

- good quality and professionally responsible operation
- holistic services
- proper prioritisation
- less unwanted variation
- equal services
- enable self-management and coping among parents, children and adolescents

Target groups

The target groups for the guideline are as follows:

- staff at health centres, school health service and youth health centres
- political and administrative officials in local government
- Educational institutions that train personnel for the services (colleges/universities),
- collaborating partners in local government, county councils and the specialist health service

- children, adolescents and their parents
- other relevant actors

The guideline is professionally normative

The national guideline is normative in that it presents recommended courses of action for the organisation. In conjunction with other relevant national professional guidelines, guides and circulars, this guideline will be a key tool in the operational planning of the services. If the organisation adopts a practice that deviates from the national professional guidelines, this shall be documented (see Section 8(h) of the Medical Records Act (*pasientjournalforskriften*)). The organisation should be prepared to justify its choices in the event of receiving any complaints or in connection with audits.

The recommendations in the guideline, together with the following national guidelines, circulars and guides, constitute the core scope of the service:

National guidelines

- [Nasjonal faglig retningslinje for oppfølging av for tidlig fødte barn, IS-1419](#)
- [Nasjonal faglig retningslinje for barselomsorgen. Nytt liv og trygg barseltid for familien, IS-2057](#)
- [Nasjonal faglig retningslinje for spedbarnsernæring](#)
- [Retningslinjer for undersøkelse av syn, hørsel og språk hos barn, IS-1235](#)
- [Nasjonale faglige retningslinjer for veiing og måling i helsestasjons- og skolehelsetjenesten, IS-1736](#)
- [Nasjonal faglig retningslinje for forebygging, utredning og behandling av overvekt og fedme hos barn og unge, IS-1734](#)
- [Nasjonal retningslinje for gravide i legemiddelassistert rehabilitering \(LAR\) og oppfølging av familiene frem til barnet når skolealder, IS-1876](#)
- [Nasjonal faglig retningslinje for tidlig oppdagelse, utredning og behandling av spiseforstyrrelser](#)

Key circulars and guides

- [Directive IS-6/2013 Health survey of adopted children from outside Western Europe \(*Rundskriv IS-6/2013 Helseundersøkelser av adopterte fra land utenfor Vest-Europa*\)](#)
- [Guide to the prevention of female genital mutilation \(FGM\) – offering consultation and voluntary gynaecological examination, IS-1746](#)
- [Guide to communication via an interpreter for managers and personnel in the health and care services, IS-1924](#)
- [Guide to children and adolescents with rehabilitation needs \(*Veileder om barn og unge med habiliteringsbehov*\), IS-2396](#)
- [Guide to health services for asylum seekers, refugees and reunited families \(*Veileder for helsetjenestetilbudet til asylsøkere, flyktninger og familiegjennforente*\), IS-1022](#)

The guideline provides a non-exhaustive description of acts, regulations, guides and guidelines that apply to the service, and it is expected that the service has routines in place in its management systems for familiarising itself with relevant regulations; see Section 6(c) of the Regulation on management and quality improvement in the health and care services (*forskrift om ledelse og kvalitetsforbedring i helse- og omsorgstjenesten*).

Knowledge basis and guideline methodology

The guide to the development of evidence-based guidelines (IS-1870) and method book for the preparation of national guidelines (IS-0267) has been influential in the process to develop the guideline. The recommendations have been developed using an evidence-based approach and the DECIDE framework (Developing and Evaluating Communication Strategies to Support Informed Decisions and Practice based on Evidence). The guideline is based on the best available knowledge wherever possible. This means that research-based knowledge, users' wishes and needs, and experience-based (clinical) knowledge have been assessed in relation to the desired and undesired consequences of the proposed measures. This knowledge is then assessed in the context of values, resource use, prioritisation criteria, laws and regulations. The guideline's recommendations are weighted considerations between these various sources of knowledge.

The Regulation on the municipality's health promotion and preventive work in the health centres and school health service with its objects clause, the specified areas of responsibility and services offered have been

influential and have provided the premises for the recommendations.

The research-based knowledge bases that form the framework and starting point for the recommendations are, in addition to the prevailing guideline methodology, founded on other relevant guidelines and systematic reviews of available knowledge. Selected literature searches have been conducted and, on behalf of the Norwegian Directorate of Health, the Knowledge Centre for the Health Services has prepared knowledge summaries based on both systematic reviews and primary literature. The quality of the research basis has been graded with the help of the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system. The grading ranges from very low to high quality. The research basis, including grading, is presented under the Research bases tab under relevant recommendations.

Preparation of recommendations

In the process from research basis to final recommendation, we have used the DECIDE methodology. DECIDE helps to structure discussions in the working group and to ensure that both the research basis, as well as experience from clinics and users, are assessed before the strength of the recommendation is approved (Vandvik et. al., 2013).

The strength of the recommendations depends on:

- the quality of documentation
- the degree of benefit from a recommended measure set against potential negative consequences
- if there is agreement on the values and preferences associated with the recommendations
- if any positive effect is worth the costs

Strong recommendations are phrased as “should” or “recommended”, while weaker recommendations are phrased as “may” or “proposed”.

A strong recommendation indicates that it is very likely that the advantages outweigh the disadvantages. This implies that users and health and care personnel in most situations will find the recommendation to be the correct cause of action.

A weak recommendation indicates that it is more uncertain whether the advantages outweigh the disadvantages. This implies that different choices may be correct for different users and that health and care personnel must assess what the correct procedure is depending on the individual situation.

The formulations “shall” or “must” shall be used in areas that are primarily based on prevailing acts, regulations and professional responsibility and diligence. These are not marked with “strong recommendation” or “weak recommendation”.

Considerations that result in applied measures deviating from the prevailing guidelines shall be documented in the medical records of the child/adolescent when the information is regarded as relevant and necessary; see Section 8, first paragraph (h) of the Medical Records Act (journalforskriften).

To emphasise the foundation of the individual recommendation, the recommendations are marked with:

- act,
- regulation,
- research basis,
- consensus in working group

Markings have been made in the introduction under “Rationale”. The purpose is to clarify the basis that influenced each individual recommendation.

When the research-based documentation is not directly transferable to the conditions the enterprise is working under and/or has not been based on a graded research basis, the recommendations will be marked with act, regulation and consensus in the working group.

Individual adaptation

National guidelines are normative documents, and health professionals must exercise professional discretion when evaluating each individual patient to take into consideration individual needs.

Economic assessments

Where we clarify or propose recommendations that could result in additional use of resources, economic calculations are performed.

Consultation, evaluation and revision

The guideline has been subject to internal and external consultations. Consultative input has been reviewed and incorporated into the final version of the guideline.

The Norwegian Directorate of Health is responsible for updating the guideline whenever new information indicates that it is necessary to amend one or more recommendations.

Work process

Through the Letter of Allocation 2012 from the Ministry of Health and Care Services, the Norwegian Directorate of Health has been commissioned to update the Guide to the Regulation on the municipality's health promotion and preventive work in the health centres and school health service (*Veileder til forskrift for kommunenes helsefremmende og forebyggende arbeid i helsestasjon og skolehelsetjenesten*, IS-1154, 2004). The Norwegian Directorate of Health decided in a management meeting in autumn 2012 that the guide should be replaced by a national professional guideline.

Working group

- Kvalnes, Astrid Hernes, senior adviser and project manager, Norwegian Directorate of Health
- Olsen, Susanne, adviser and legal practitioner, Norwegian Directorate of Health
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All working group members have signed an impartiality form in which they have given an account of possible professional and financial conflicts of interest associated with this work. The Norwegian Directorate of Health has assessed all participants in the working group regarding impartiality.

Steering group

The work has taken place in a project format, and the steering group comprised the following persons:

- Lie, Svein, divisional director for the primary health services division, Norwegian Directorate of Health
- Stigen, Ole Trygve, department director for the Public Health and Living Conditions department, Norwegian Directorate of Health (up to 1 July 2016)
- Granlund, Linda, divisional director for the public health division, Norwegian Directorate of Health (from 1 July 2016)
- Windspoll, Rolf J., acting department director for public health services, Norwegian Directorate of Health (up to 1 October 2016)
- Carlsen, Ellen Margrethe, department director for the child and youth health department, Norwegian Directorate of Health (from October 2016)
- Gamme, Anne, specialist manager, regulatory contact, Health and Welfare, Knowledge Centre for the Health Services

Reference group and particular stakeholders

The reference group has been broadly composed and comprised of representatives from patient advocacy groups and (non-governmental) organisations, the Knowledge Centre for the Health Services, relevant trade unions, ministries and directorates, the Norwegian Institute of Public Health, county governors and county councils, centres of excellence and the Ombudsman for Children. Invitations to two seminars about the guideline have been issued during the work. Prior to start-up, a dialogue meeting was held in November 2012 for relevant specialists and a separate meeting for users in March 2013. This was followed by a meeting in 2013 and a meeting in 2014.

Separate meetings have also been held with stakeholders such as the Knowledge Centre for the Health Services, the Norwegian Directorate for Education and Training, the Norwegian Directorate for Children, Youth and Family Affairs and the Norwegian Institute of Public Health.

RBUP Øst-Sør (Regional Centre for Children and Adolescent Mental Health), RKBV Vest (Regional knowledge Centre for Children and adolescents); KORUS (drug and alcohol competence centres) RVTS (Regional center on violence, traumatic stress and suicide prevention) have been commissioned by the Norwegian Directorate of Health to contribute to knowledge summaries in the fields of mental health, drugs and alcohol, violence and abuse. Several meetings have been held. The Norwegian Directorate of Health received two separate deliveries: one report for health centres 0–5 years coordinated by RBUP Øst-Sør and one for the school health service, including youth health centres, coordinated by RKBV Vest. KORUS and RVTS contributed to this work.

The reports form the basis of the recommendations laid down in these areas.

Methodological support

The guidelines secretariat and libraries at the Norwegian Directorate of Health and the Knowledge Centre for the Health Services provided methodological support. The communication department at the Norwegian Directorate of Health contributed guidance on communications.

Increased investment in research and method development

Health centres, the school health service and youth health centres are mandatory services. The services are core to municipal public health work and are the only primary health services that have a health promotion and preventive objects clause. Effective public health work comprises coordinated efforts directed towards both individuals and the social and physical environment in which they live. Further, the effect is influenced by the institutional and political frameworks.

In key areas, there is a lack of evidence-based knowledge about the natural progression of health conditions and perceived health complaints and factors linked to health and health disorders, as well as the positive and potentially adverse effects of interventions. Nearly all children and adolescents in Norway participate in the systematic follow-up provided by the health centres and school health service. The conditions are therefore optimal for obtaining such knowledge through research.

Research can be conducted in many ways and cover many aspects. For example, satisfaction amongst users of the services, relatives, practitioners and collaboration partners in kindergartens, schools and the Child Welfare Service; the prevalence of various health problems; and the effects of different measures and programmes. Research into factors linked to health, the occurrence of natural progression of health and perceived health issues, and the effects of specific measures, will be particularly valuable if the research is conducted based on how the service is performed over time through longitudinal and/or randomised controlled studies.

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1 General section: Management, control and user participation

1.1 Management system: Health centres, the school health service and youth health centres shall have a management system

Health centres, the school health service and youth health centres in the municipality shall have an internal control system (management system) for the systematic management of the enterprise's activities; see Section 3, first paragraph of the Health Supervision Act (*helsetilsynsloven*).

Internal controls are systematic measures that ensure that the organisation's activities are **planned, implemented, evaluated and corrected** in accordance with requirements stipulated in or pursuant to health and care legislation; see Section 4 of the Regulation on management and quality improvement in the health and care services (*forskrift om ledelse og kvalitetsforbedring i helse- og omsorgstjenesten*).

The purpose of the management system is to **contribute to professionally responsible health and care services, quality improvement and patient and user safety** and to ensure compliance with health and care legislation.

Rationale

The contents of this recommendation are based on legislation, regulations and the consensus of the working group.

Any enterprise which provides health and care services shall establish an internal control system for the enterprise and ensure that the enterprise and services are planned, carried out and maintained in accordance with the requirements stipulated in or pursuant to Acts and regulations; see Section 3 of the Health Supervision Act (*helsetilsynsloven*). [1] The County Governor has a supervisory role in ensuring that enterprises that perform health and care services have established internal control systems and that the enterprises conduct controls to prevent errors in the services.

The management system is crucial to ensure professional responsibility in the services. Inspections have indicated that some of the areas in the internal control system are particularly vulnerable in health centres, school health service and youth health centres [3]

It is up to the enterprise to determine how the requirements of the Regulation on management and quality improvement in the health and care services shall be fulfilled. Section 5 of the Regulation states that the management system **shall be adapted to the enterprise's size, nature, activities and risk factors and be of necessary scope** to comply with the requirements stipulated in or pursuant to health legislation. [4]

Practical information

The party with overall responsibility for the enterprise are responsible for ensuring that the requirements for the management system are fulfilled.

- **The municipality** has an overall responsibility for health centres, the school health service and youth health centres and is obligated to plan, implement and correct the enterprise; see Section 3-1, third paragraph of the Health and Care Services Act (*helse- og omsorgstjenesteloven*). [5] Responsibility rests with **the executive leader of the municipality**, in the final instance with **the municipal council**.
- **The manager of the health centres and school health service in the municipality** has in most cases been delegated this responsibility and is responsible for ensuring that the service fulfils the requirements of the management system.
- Even if responsibility has been delegated, **the municipality's executive management are responsible** for ensuring that the health centres and school health service fulfil the requirements of the management system.

Sections 6, 7, 8 and 9 of the Regulation on management and quality improvement in the health and care services (*forskrift om ledelse og kvalitetsforbedring i helse- og omsorgstjenesten*) describe in more detail

what the scope of the management system shall be.

In order to perform professionally responsible services, the enterprise shall have a management system that shall:

- Ensure **optimal and clear distribution of responsibilities and tasks** between employees.
- Ensure that employees have **correct and sufficient skills** to perform their tasks. The management shall ensure that employees have access to and an overview of the acts, regulations, guidelines and guides that are relevant to the service. See more in [the recommendation Competence](#).
- Ensure that **deviations** from professional responsible conduct and deviations from any requirements that the service imposes on itself are **registered and managed** and that measures are implemented to rectify errors and prevent vulnerabilities in the service.
- Ensure that **experiences** gained by employees and users are used actively to **improve the services**.

Further information about internal controls

- Regulation on management and quality improvement in the health and care services
- Norwegian Directorate of Health's guide [How to keep your own house in order – Internal controls in the social and health service \(Hvordan holde orden i eget hus - Internkontroll i sosial- og helsetjenesten\)](#)
- Norwegian Board of Health Supervision: [Manage to strengthen. Report from health centre service](#)
- Norwegian Board of Health Supervision: [Health centre – Help at the right time? Summary of national supervision of health centres 2013](#).

References

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- [5] Forskrift om kommunens helsefremmende og forebyggende arbeid i helsestasjons- og skolehelsetjenesten. FOR-2018-10-19-1584 Available from: <https://lovdata.no/dokument/SF/forskrift/2018-10-19-1584>

1.2 Delegation of responsibilities and tasks: The management shall ensure optimal and clear distribution of responsibilities and tasks in health centres, the school health service and youth health centres

The management shall ensure good and clear distribution of responsibilities and tasks in health centres, the school health service and youth health centres. The party or parties responsible for the enterprise shall describe the enterprise's goals, tasks, activities and organisation.

It shall be apparent how responsibilities, tasks and authority are distributed; see Section 6(a) of the Regulation on management and quality improvement in the health and care services (*forskrift om ledelse og kvalitetsforbedring i helse- og omsorgstjenesten*).

Rationale

The contents of this recommendation are based on legislation, regulations and the consensus of the working group.

Section 6(a) of the Regulation on management and quality improvement in the health and care services (*forskrift om ledelse og kvalitetsforbedring i helse- og omsorgstjenesten*) stipulates that the obligation to plan the enterprise's activities entail having an overview of and description of the enterprise's goals, tasks, activities and organisation. It shall be apparent how responsibilities, tasks and authority are distributed and how employees shall work systematically to improve quality and patient and user safety in the enterprise.

The management systems shall also ensure that the enterprise's tasks are carried out; see Section 7 of the Regulation, and evaluated; see Section 8 of the Regulation. [4]

Practical information

The management shall ensure that all employees are familiar with:

- their duties
- the scope of their responsibilities and those of the service
- the areas of responsibility of collaborating partners; see [the General section: Collaboration and co-operation](#)
- the enterprise's purpose
- who has authority to make professional and administrative decisions

In order to fulfil the requirements of the Regulation, the management at health centres, the school health service and youth health centres should ensure that:

- internal clarifications have been made regarding the tasks that the public health nurse is responsible for, the tasks that the GP is responsible for, and how they should collaborate; see the [recommendation Collaboration between the public health nurse and the doctor](#).
- as consistent information as possible is given about the various health information topics that appear in the health centre programme and topics in the school-entry health consultation in the 1st grade and the health consultation in the 8th grade; see the recommendations [Health centre programme](#) and [Topics in the school-entry health consultation and health consultation in the 8th grade \(not published\)](#).
- procedures are being drawn up for who shall refer to other collaborating partners.
- an overview is created of the areas in the health centres and school health service which are at risk of errors or where the enterprise is not fulfilling regulatory requirements.

The management shall be aware of, and ensure that, relevant acts and regulations, as well as relevant guidelines and guides, are available to the employees; see Section 7 of the regulations. [4]

For further information on the distribution of responsibilities and tasks; see the Norwegian Directorate of Health's guide [How to keep order in your own house – Internal controls in the social and health service \(Hvordan holde orden i eget hus - Internkontroll i helse- og sosialtjenesten\)](#). [2]

See also [the recommendation Competence](#).

References

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1.3 Competence: The management shall ensure sufficient specialist competence in health centres, the school health service and youth health centres

The municipality shall:

- Ensure that the service and personnel can fulfil their mandatory obligations, and to ensure sufficient specialist competence in the service; see Section 4-1, first paragraph, (c) and (d) of the Health and Care Services Act (*helse- og omsorgstjenesteloven*).
- Ensure access to the necessary personnel for the tasks the service shall perform and appropriate distribution of tasks between personnel; see Section 2-1 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*).
- Ensure that employees have sufficient knowledge and skills according to their profession; see Section 7 of the Regulation on management and quality improvement in the health and care services (*forskrift om ledelse og kvalitetsforbedring i helse- og omsorgstjenesten*).

Rationale

The contents of this recommendation are based on legislation, regulations and the consensus of the working group.

As part of its management system, the enterprise shall ensure that its employees have the necessary knowledge and expertise concerning the relevant specialist fields as well as the relevant regulations, guidelines, guides and of the management system; see Section 7 of the Regulation on management and quality improvement in the health and care services (*forskrift om ledelse og kvalitetsforbedring i helse- og omsorgstjenesten*). [4] The enterprise shall also have an overview of its employees' competence and needs for further training; see Section 6 of the Regulation.

The management system also requires the enterprise to evaluate and correct the service so that health and care legislation, including the requirement regarding professionally responsible conduct of services, is fulfilled; see Sections 8 and 9 of the Regulation. [5] The enterprise's skills requirements will be an important part of this review.

Staff in the services

In principle, it is up to the municipality to assess which skills the service requires in order to perform its tasks and services responsibly.

Section 3 of the Regulation on statutory nursing services in the municipality states that the municipality shall appoint public health nurses to meet the needs for special nursing functions in health promotion and preventive work. [6]

To perform the tasks that are stipulated in the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*) responsibly, a doctor must be included on the staff; see Section 4-1 of the Health and Care Services Act (*helse- og omsorgstjenesteloven*). [7]

To strengthen health promotion and preventive work, the municipality should strive to achieve a broad interdisciplinary range of skills in the service (Comments on Section 2.1 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*)). The staff in the services should therefore also include physiotherapists.

The service may also appoint other specialists, including:

- Psychologists
- Occupational therapists
- Other professional groups with educational, social work, interdisciplinary or cross-cultural skills

(Comments on Section 2-1 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*)).

The professional supervisor for the public health nurse service shall be the public health nurse; see

Section 3, fourth paragraph of the Regulation on statutory public health nurses in the municipality [6]. Administrative managers of health centres, the school health service and youth health centres need not be public health nurses.

Midwives shall be affiliated to the health centres to provide antenatal care and postnatal care; see [National guideline for antenatal care \(Nasjonalt faglig retningslinje for svangerskapsomsorgen\)](#) and [National guideline for postnatal care \(Nasjonalt faglig retningslinje for barselomsorgen\)](#). Midwifery skills can also be key in health centres 0–5 years, particularly for infants from 0 to 6 weeks of age, and in youth health centres.

Practical information

The management shall ensure that:

- Employees have sufficient knowledge and skills to be able to perform their duties.
- Employees have sufficient knowledge about the enterprise's internal controls to enable them to correct the enterprise, if necessary.
- There is a connection between required competence, service implementation and non-conformity management in order to reduce the risk of errors in the service.
- An ongoing assessment of competence requirements is conducted, now and in the future.

The staff in the services shall comprise:

- Public health nurse,
- Doctor

The services **should** also have:

- Physiotherapists

The services **may** also have:

- Psychologists,
- Occupational therapists
- Other occupational groups with educational, social work, interdisciplinary or cross-cultural skills

Staffing must always be assessed based on the competence required to run a professionally responsible service.

Midwives shall be affiliated to the health centres in connection with antenatal care and postnatal care; see [National guideline for antenatal care \(Nasjonalt faglig retningslinje for svangerskapsomsorgen\)](#) and [National guideline for postnatal care \(Nasjonalt faglig retningslinje for barselomsorgen\)](#). Midwifery skills can also be key in health centres 0–5 years, particularly for infants from 0 to 6 weeks of age, and in youth health centres.

Cooperation

Employees in health centres, the school health service and youth health centres must collaborate and cooperate to ensure high-quality and professionally responsible services.

In many instances, it will also be necessary for the service to draw on other competencies in addition to regular staff. For example, the service shall have procedures for cooperation with GPs, the dental service and other municipal services; see Section 2-1, third paragraph of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*). [5]

See recommendations in [the General section: Collaboration and co-operation](#).

How to ensure that the service have sufficient expertise?

It is the responsibility and obligation of the municipality to ensure that skilled personnel are employed to carry out the tasks of the service.

To ensure that the service has sufficient expertise, the management should:

- assess competence requirements based on the service's tasks and the local population health profile
- clarify resource requirements through training plans and a staff budget
- establish and maintain a strategic competence plan

References

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1.4 Quality and patient safety: Managers in health centres, the school health service and youth health centres should work systematically with quality and patient safety

The municipal management, which is responsible for the enterprise, must have sufficient insight into **what works well and what should be improved** in the service. To achieve this, a **collective understanding** must be established within the enterprise **concerning what the primary tasks and goals of the enterprise are**.

The goal of quality improvement work is to uncover, rectify and ensure that health centres, the school health service and youth health centres operate in accordance with laws and regulations. Significant elements of this will be to **develop, implement, control and improve** routines, instructions, procedures or other measures.

Rationale

The contents of this recommendation are based on legislation, regulations and the consensus of the working group.

Anyone who provides services under the Health and Care Services Act shall ensure that the enterprise works systematically for quality improvement and patient safety; see Section 4-2 of the Health and Care Services Act (*helse- og omsorgstjenesteloven*). [7] This is a responsibility of both managers and employees at all levels of the enterprise.

Sections 6 to 9 of the Regulation on management and quality improvement in the health and care services (*forskrift om ledelse og kvalitetsforbedring i helse- og omsorgstjenesten*) stipulate that the party or parties responsible for the enterprise shall:

- Draw on the experiences of children and adolescents/service users and next of kin to improve the enterprise.
- Gain an overview of areas in the enterprise in which there is a risk of errors or failure to fulfil regulatory requirements.
- Develop, implement, control, evaluate and improve procedures, instructions, routines or other measures to uncover, rectify and prevent any breach of health legislation.
- Carry out systematic monitoring and reviews of the management system annually, to ensure that it works as intended, and contribute to continuous improvement of the enterprise. [4]

Practical information

The management should seek to establish an overall system for conducting risk and vulnerability analyses. Such a system should show the basis for and consequences of any changes in the enterprise when new tasks are introduced.

Examples of risk areas are:

- lack of follow-up after a risk of developmental discrepancies has been uncovered in a child
- resources are not sufficient to conduct the recommended health consultations at fixed times or other tasks must be postponed
- non-conformities to routines and guides are not reported
- clarifications of which tasks the different personnel groups are responsible for has not been made

The management must be familiar with vulnerable areas and incidents in the enterprise. To safeguard such knowledge, routines must be established for **systematic monitoring and review of the management system** to ensure that it works and contributes to continuous improvement of the service.

Example of tools for systematic monitoring are:

- A working **non-conformity report system** that will allow for sufficient reporting of errors and incidents. For example, if a public health nurse is unable to offer a home visit within a stipulated deadline or if there is insufficient time to provide sex education in school, this is regarded as a non-conformity with respect to the recommended scope of the service. Such non-conformities shall be reported and registered.
- Regular self-monitoring and reporting on non-conformities with respect to plans.
- Internal audits.

Further information about user participation and quality improvement

User participation can improve the quality of services in that users genuinely influence the selection and design of the services. User participation is a statutory right for users and an obligation for the services. The management shall draw on the experiences of patients, users and relatives for planning, development and improvement of the enterprise; see Sections 6 to 9 of the Regulation on management and quality improvement in the health and care services (*forskrift om ledelse og kvalitetsforbedring i helse- og omsorgstjenesten*) and Section 3-10, second paragraph, of the Health and Care Services Act (*helse- og omsorgstjenesteloven*).

User participation can for example be ensured through

- a user committee
- user- and relative groups
- systematisation of feedback and the scope of complaints

In order for the right to participation to be genuine, it is crucial that the user receives sufficient and tailored information. It is important that the party concerned, as far as possible, is familiarised with the scope of the service and their rights. Service providers shall strive to achieve good dialogue with the user so that he/she feels security, understanding and equality.

See more about user participation in [the recommendation User participation](#).

References

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1.5 Low-threshold programme: Children and adolescents shall have an readily available and accessible low-threshold programme in health centres, the school health service and youth health centres

The services in health centres, the school health service and youth health centres shall be **free of charge**.

Children, adolescents and their parents shall be able to **attend without an appointment or referral** (drop-in).

Rationale

The contents of this recommendation are based on legislation, regulations and the consensus of the working group.

The municipality shall offer health promotion and preventive services, including health services in schools (school health service) and health centres; see Section 3-2, first paragraph (1) of the Health and Care Services Act (*helse- og omsorgstjenesteloven*). [7] The services' tasks are described in more detail in the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*), especially in Section 2-3. [5]

To fulfil the purpose of the service and ensure that the services perform their tasks professionally responsible, the services must be available as a low-threshold service for children, adolescents and their parents.

The availability of the health centre and school health service to children, adolescents and their parents provides a potential to reach everyone, regardless of their social status. Universal measures and early intervention in health centres, the school health service and youth health centres are important principles for eliminating social inequality in health. [8]

One prerequisite for reaching parents, children and adolescents is that they are familiar with the scope of the service and that they perceive it as being available and accessible.

All children, adolescents and their parents have the right to information that is necessary to gain sufficient insight into the services. If required, they should also receive information about other municipal services; see Sections 3-2 and 3-4 of the Patient and Users' Rights Act (*pasient og brukerrettighetsloven*). [9]

See more in [the recommendation User participation](#).

The Ombudsman for Children's report based on expert meetings with children and adolescents highlights that pupils wish to receive more information about health centres, the school health service and youth health centres (Ombudsman for Children, 2013). Children and adolescents have stated that the services should provide them with more information about what the services can be used for and help them further to find other kinds of help.

As for lower and upper secondary schools, surveys from Sintef show that where the school health service is regularly present over time, it is used by 50% of pupils for drop-in consultations, as well as the ordinary consultations offered to everyone. [10]

Practical information

To ensure that low-threshold services are readily available and accessible, the services shall ensure:

- Opening hours that are suitable for the target group and the objective of the service.
- That the services are free.
- Universal design to accommodate for pushchairs and wheelchairs and such.
- Appropriate competence among employees.
- That children, adolescents and parents can make contact without an appointment or referral, either via attendance in person (drop-in), by phone/SMS and/or through other digital solutions

Information

The service should actively provide information about services via channels that are readily available to children, adolescents and parents, via social media such as Facebook, for example.

The services' websites should provide information about the services, availability, which professions or specialists the service provide, and the professionals' obligation to maintain confidentiality. An assessment should be undertaken as to whether information should also be translated into other languages.

The service should involve users to ensure that information about the services is available in the arenas in which children, adolescents and parents participate. See [the recommendation User participation](#).

When dealing with individual users, the service shall notify them of its obligation to maintain confidentiality and of the limitations that apply. Following consultations that require follow-up, the service shall inform the users about who they will make contact with and involve the users in how this shall proceed; see Sections 3-1 and 3-2 of the Patient and Users' Rights Act (*brukerrettighetsloven*).[9]

Location

To ensure availability, the location of the service should be appropriate for users. This applies to all sub-services.

Important prerequisites for availability include:

- Proximity to public transport,
- Car parking

A key point of the **school health service** is that it is located where children and adolescents are at school and works as a drop-in service. [11] For school children and adolescents, it is important that employees in the school health service are available at school. Pupils must know when, where and how they can contact the school health service.

By being present in the school environment, the school health service will ensure that pupils have the option to contact the service, address the interdisciplinary cooperation and the environmentally-orientated work at school.

For adolescents, it is important to have a point of contact for both minor and major problems without having to make an appointment or involve their parents. Adolescents are often spontaneous, and those who need help, often want help immediately.

Youth health centres should be located in places that are easy for adolescents to visit, and the opening hours should suit adolescents' needs. Section 3-2(1) (a) first paragraph of the Health and Care Services Act (*helse- og omsorgstjenesteloven*) stipulates that the municipality shall offer a health service at school, but it is also important that adolescents who for various reasons do not attend school have an readily available and accessible service which they can contact. Youth health centres shall be a supplement to, and not a replacement for, the school health service. Youth health centres shall be perceived as relevant to all regardless of ethnicity, disability, sexual minority status, etc.

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1.6 User participation: Health centres, the school health service and youth health centres shall ensure user participation

Health centres, the school health service and youth health centres shall ensure that children and adolescents are **heard, get involved and enabled to exert influence** in their dealings with the services, at individual and system level.

The services shall work to ensure that children and adolescents feel that their experiences and input are regarded as valid when decisions are to be made and new measures designed.

At **individual level**, user participation means listening to what children and adolescents say and asking for their input in matters that concern them.

At **system level**, user participation can mean that representatives of children and adolescents are involved in the design of the service.

Rationale

The contents of this recommendation are based on the law and the consensus of the working group.

The right of children and adolescents to be heard and express their opinion is in compliance with Article 12 of the UN Convention on the Rights of the Child, which states the following: “Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child”. [13] The Convention has not set any age limit for this right, but emphasises that the child's view shall be given due weight in accordance with the age and maturity of the child.

Article 104 of the Norwegian Constitution states that children have the right to respect for their human dignity. The provision also states that children have the right to be heard in matters that concern them and that their opinions shall be given due weight in accordance with their age and level of development.

The municipality shall ensure that representatives of patients and users are heard during the development of the municipality's health and care service and that enterprises offering health and care services covered by the Health and Care Services Act establish systems for the procurement of patients' and users' experiences and views, see Section 3-10, first and second paragraph of the Health and Care Services Act. [7]

Children and adolescents and their parents have the right to receive information about their state of health and the content of the care that is provided; see Sections 3-4 and 3-2 of the Patient and Users' Rights Act (*pasient- og brukerrettighetsloven*). As far as possible, the services shall be designed in collaboration with the user; see Section 3-1 of the Patient and Users' Rights Act (*pasient- og brukerrettighetsloven*).

Health professionals shall provide information in a way that is suitable to the recipient's individual circumstances, such as age, maturity, experience and cultural and linguistic background; see Section 3-5 of the Patient and Users' Rights Act (*pasient- og brukerrettighetsloven*) and Section 10 of the Health Personnel Act (*helsepersonelloven*). [14] This entails professionals in the service having to use a language and mode of expression that children/adolescents understand. It may be relevant to use characters or drawings to show what must be done and why it is important that this is done.

Consent and co-determination

- **Children under 12 years of age:** Parents have competence to consent on behalf of the child; see Section 4-4 first paragraph of the Patient and Users' Rights Act (*pasient- og brukerrettighetsloven*).
- **Children between 12 and 16 years of age:** The opinions of children and adolescents shall be given due weight. Children/adolescents may wish that information about specific issues is not disclosed to their parents. Health professionals must consider to oblige this; see Section 4-4, fifth paragraph of the Patient and Users' Rights Act (*pasient- og brukerrettighetsloven*).
- **Adolescents between 16 and 18 years of age:** Adolescents have the right to consent themselves; see Section 4-3, first paragraph (b) of the Patient and Users' Rights Act (*pasient- og brukerrettighetsloven*).

See the [Norwegian Directorate of Health's directive I-8/2015](#) for further information regarding the regulations of the Patient and Users' Rights Act (*pasient- og brukerrettighetsloven*) concerning the child's right to be heard, the child's right to co-determination and the right to information.

Practical information

The services shall **involve the child in conversation according to the child's age, maturity and form of expression**. In connection with involvement among younger children, the services should be aware of the forms of expression of such children to be able to ensure that they are addressed during consultations.

Important clarifications in the involvement process should be:

- What shall be included in the involvement process?
- Who shall we ask?
- Who shall ask?
- Where and how should involvement be conducted? [15]

User participation at individual level

User participation at individual level shall be addressed in consultations and in the service's other meetings with children, e.g. during drop-in visits, when the service participates in education or in group

conversations.

Health centres, the school health service and youth health centres shall ensure that children, adolescents and their parents feel they are being listened to and heard. The services shall make provision for ensuring that children's and adolescents' influence is genuine. The services should conduct user surveys on a regular basis.

User participation at individual level must suit the individual's needs; see [the recommendation Adapted service. The Ombudsman for Children's website](#) contains information suitable for children about their right to express their opinion and be heard.

User participation at system level

User participation at system level can be addressed through fora such as:

- the adolescents' municipal councils,
- Children and Youth councils
- student councils
- contact groups
- The Sami Parliament's Youth Policy Committee (SUPU)
- user councils
- parents' committees in schools and kindergartens

When children and adolescents are to be involved at system level, the service should consider **who is representative** and can speak on behalf of an entire group.

User organisations such as Voksne for Barn (Adults for Children) and Save the Children can be important partners in allowing children to be heard and can be a vital connection between individual users/groups and specialist environments. They are focused on communicating young users' messages. See also Theoretical perspectives on adolescents' participation [16]

The Ombudsman for Children focuses on listening to children and communicating the views of children and adolescents. See the [Ombudsman for Children's website](#) on how they use children and adolescents as experts.

The Ombudsman for Children has also developed an [expert handbook](#) that provides a brief introduction into how to conduct expert meetings and establish expert groups.

References

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1.7 Adapted services: Health centres, the school health service and youth health centres should provide a service that is suited to the users' circumstances and needs.

Health centres, the school health service and youth health centres shall provide an equal service to the entire population. The service to children, adolescents and their parents should be **suited to the individual's circumstances and needs** to ensure an equal service. This entails:

- Taking into account linguistic and cultural differences in the indigenous Sami population.
- Taking into account linguistic and cultural differences in the immigrant population.
- Taking into consideration social differences in health and users' needs regardless of educational background, financial situation and class affiliation.
- That the service is suited to children and adolescents with physical and/or mental disabilities.
- That children, adolescents and parents with particular needs receive the follow-up they require; see [the recommendation Follow-up groups](#).
- That the service is available and accessible; see [the recommendation Low threshold services](#).
- That the service adjusts time spent in consultations based on individual needs. Particularly, consideration must be given to spend extra time when using a qualified interpreter.

Mutual dialogue, knowledge and expertise, trust and time are prerequisites for an equal service, and it is the responsibility of management to ensure that this is achieved (the Equality and anti-discrimination ombudsman).

Rationale

The contents of this recommendation are based on the law and the consensus of the working group.

It is an overall political goal that everyone shall receive **equal health and care services** regardless of their diagnosis, residence, gender, country of birth, ethnicity and life circumstances. One of the aims of the Health and Care Services Act is to ensure the quality of the services and an equal service; see Section 1-1 of the Act [7].

Universal measures and early intervention in health centres, the school health service and youth health centres are important principles for levelling the social gradient in health [8]. The services must be adapted to the individual's circumstances and offer follow-up of the individual based on their needs.

In accordance with the [National strategy concerning immigrants' health \(2013–2017\)](#), services to persons from an immigrant background shall be developed as an integrated part of the overall health and care service and be designed based on local conditions and in close proximity to users.[22] It is primarily the ordinary municipal services that shall make provision for users from an immigrant background, both professionally and organisationally. Further, it is important to select relevant tools based on the user group and their needs, and to implement measures for dealing with the particular challenges of these user groups.

Practical information

Users with different linguistic or cultural backgrounds

It is the responsibility of management to ensure a proper and sufficient level of competence in the services in accordance with demographic changes; see [the recommendation Competence](#).

Services must be adapted to ensure that the Sami language and cultural background are addressed and

that professionally responsible services are offered; see Section 3-10, fourth paragraph of the Health and Care Services Act and Section 3-5 of the Act Concerning the Sami Parliament and other Sami legal matters [17].

The services provided by health centres, the school health service and youth health centres shall be culturally sensitive and adapted to the needs of children, adolescents and families with migrant background. For more information, see the Centre for Migration and Minority Health (NAKMI) and the Government's national strategy concerning immigrants' health 2013-2017.

Children and adolescents and their parents have the right to receive information about their state of health and the care that will be provided, and the information **shall be suited to the recipient's individual circumstances**, such as age, maturity, experience and cultural and linguistic background; see Section 3-2 and 3-5 of the Patient and Users' Rights Act (*pasient- og brukerrettighetsloven*) [9].

Health professionals in the services **shall ensure that a qualified interpreter is used when required, see Section 10 of the Health Personnel Act** (*helsepersonelloven*). [14] When using an interpreter, it may be necessary to extend the consultation time. Further information may be found in the Norwegian Directorate of Health's guide [Good communication via an interpreter](#).

Users with special needs

The services should provide tailored services to various groups of children and adolescents with special needs. As an example, this could apply to children and adolescents with:

- disabilities
- chronic illness
- psycho-social challenges

The services should set aside a sufficient amount of time for consultations and follow-up of children and adolescents with special needs.

The services shall collaborate with relevant actors to address the needs of these children/adolescents in the most optimal way; see Section 3-4 of the Health and Care Services Act and Section 2-1 Regulation on health centres and the school health service. [7] [5] See also the General section: Collaboration and co-operation.

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2 General section: Collaboration and co-operation

2.1 Coordinating unit: Health centres, the school health service and youth health centres shall collaborate with the coordinating unit for habilitation and rehabilitation

The municipal coordinating unit is a key collaboration partner for health centres, the school health service and youth health centres to ensure holistic and coordinated services.

Written co-operation procedures shall be established for assessment and follow-up of children who require an individual plan or long-term services.

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

Health centres, the school health service and youth health centres shall collaborate with “other municipal services”; see Section 2-1 of the Regulation on health centres and the school health service. [5]

Health centres, the school health service and youth health centres encounter virtually all babies and infants, many children, adolescents and their parents and therefore has a vital role in detecting the need for long-term and coordinated services at an early stage.

The coordinating unit shall contribute to ensure holistic and coordinated services to patients and users who require services from multiple sectors and levels. Detecting and reviewing the need for services and coordinating measures at an early stage is important to ensure early intervention.

Children and adolescents who need habilitation are a diverse group. Some of the children are born with disabilities, others have been injured or been diagnosed with chronic illnesses during their childhood and teenage years. Coordination across disciplines, levels and sectors is vital to ensure holistic services to children and adolescents with disabilities.

Individual plan

Patients and users who require long-term and coordinated services have the right to an individual plan; see Section 2-5 of the Patient and Users' Rights Act (*pasient- og brukerrettighetsloven*). [9] If they do not wish to have such a plan, they shall still be offered a coordinator. A notification of needs shall be submitted to the coordinating unit for habilitation and rehabilitation. Health professionals working in health centres, the school health service and youth health centres, may, like other health professionals, assume the role of coordinator. The coordinator shall ensure that an individual plan is prepared if the child, adolescent and/or their parents require it. For children or adolescents who have disabilities or who for other reasons require long-term, coordinated services, it is recommended that an individual plan be drawn up as soon as possible

Practical information

Health centres, the school health service and youth health centres should collaborate with the coordinating unit on:

- Procedures for notifying the coordinating unit of children who require follow-up and an individual plan.
- Clarification regards to the health centre, school health service and youth health centre's role in the work with individual plans in the municipality.
- Procedures for appointing a coordinator employed at health centres, the school health service and youth health centres, and procedures for replacing a coordinator.

The coordinating unit can assist health centres, the school health service and youth health centres by offering guidance and training concerning individual plans and the coordinator role.

Relevant links

- [The Norwegian Directorate of Health's guide to rehabilitation, habilitation, individual plans and coordinators.](#) [The Norwegian Directorate of Health's guide to children and adolescents with](#)

[habilitation needs](#)

- See also [the recommendation Follow-up groups](#).

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2.2 The Child Welfare Service: Health centres, the school health service and youth health centres shall systematically collaborate with the Child Welfare Service

Health centres, the school health service and youth health centres shall collaborate with the municipal Child Welfare Service. When necessary, the services should also collaborate with the Norwegian Directorate for Children, Youth and Family Affairs.

Managers of enterprises should ensure that procedures and regular collaboration meetings are established, both on a system and an individual level, which ensure that children and adolescents are identified as early as possible and receive the necessary follow-up.

See also [the General section: Duty of disclosure](#).

Rationale

The contents of this recommendation are based on legislation, regulations and the consensus of the working group.

Health centres, the school health service and youth health centres shall collaborate with “other municipal services”; see Section 2-1 of the Regulation on health centres and the school health service. [5] *Health professionals have an obligation to notify the Child Welfare Service* if there are any serious concerns regarding children/adolescents; see the General section: Duty of disclosure.

Through regular consultations, personnel in health centres, the school health service and youth health centres will gain knowledge about children, adolescents and their families and can help to identify children and adolescents at risk. A collaboration with the Child Welfare Service will help children and adolescents, whom the enterprise is concerned about or who live under conditions that could be harmful to their health and development, to receive help and care at the right time.

Children and adolescents under the care of the Child Welfare Service may have special challenges that require the services to collaborate with GPs, municipal psychologists, coordinating units, other health services, staff at schools with particular responsibility for following up pupils, and the Educational and Psychological Counselling Service (PPT) etc.

The Child Welfare Service and health centres, the school health service and youth health centres must be aware of each other's roles and responsibilities. Collaboration with the Child Welfare Service at a system-wide and individual level is important to ensure overall health and development among children and adolescents.

Practical information

Examples of areas in which the Child Welfare Service and health centres, the school health service and

youth health centres should collaborate:

- Procedures to ensure that health centres, the school health service and youth health centres can discuss children/adolecents/families anonymously and receive guidance from the Child Welfare Service in the municipality when required.
- Procedures to ensure that children and adolescents in need are identified at an early stage and receive the necessary help from the Child Welfare Service.
- Risk assessments and evaluations of unwanted incidents (self-monitoring).
- Joint competence planning regarding topics that are relevant to both agencies.
- Ensuring joint understanding of each other's social mission and roles.

Collaboration procedures should be in writing.

Improved Collaborative Efforts (BTI)

[Improved Collaborative Efforts](#), the "BTI" model, is a collaboration model that ensures holistic coordinated interventions for children, adolescents and families whom the services are concerned about, without there being a breach in follow-up.

Experience shows that actors gain a better and mutual understanding and overview of each other's duties and become better at coordinating measures and responsibilities. This results in a more continuous and holistic follow-up. BTI also ensures that the intervention is documented and facilitates smooth transition between different services. The model contains a fixed collaboration structure that means that there is always an employee who has responsibility for coordinating the interdisciplinary collaboration and documenting this in a "relay log".

Relevant links

- [Information concerning the Child Welfare Service's duties and organisation \(Norwegian Directorate for Children, Youth and Family Affairs\)](#)
- [Directive I-11/2015 concerning collaboration between mental health services and the Child Welfare Service](#)
- Improved Collaborative Efforts (tidligintervensjon.no)
- [Familiens](#) hus (family-centred services)

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2.3 Public health work: Health centres, the school health service and youth health centres shall collaborate with the party responsible for municipal public health work

Health centres, the school health service and youth health centres shall have a systematic partnership with the party who is responsible for municipal public health work in order to contribute to the overview the municipality shall have in accordance with Section 5 of the Public Health Act.

It is the manager's responsibility to ensure that the services have procedures for collaboration in place.

Rationale

The contents of this recommendation are based on legislation, regulations and the consensus of the working group.

The municipality is responsible for public health work in the municipality and shall have a continuous overview of public health; see Sections 4 and 5 of the Public Health Act and Section 4 of the Regulation on overview of public health [26] [27] The overview work, which is part of the municipality's public health work, can be delegated and resolved in whatever way the municipality regards as the most appropriate. Public health work must be sufficiently rooted in central management and the agencies that work with planning in the municipality. [28]

Health centres, the school health service and youth health centres shall contribute to the municipality's overview of the state of health and the factors that could influence the health of children and adolescents, as well as pregnant women who attend check-ups at health centres; see Section 2 of the Regulation on health centres and the school health service. [5]

Through their meetings and regular consultations with children and adolescents, health centres, the school health service and youth health centres are well-equipped to gain an overview of factors that could promote or hamper the health of this demographic group.

Knowledge from the school health service could be necessary in understanding special challenges that may be associated with the circumstances at an individual school, or that could be related to living conditions or social conditions outside the school. Work at health centres can contribute to identifying special challenges in areas associated with individual groups. [29]

Practical information

Managers of health centres, the school health service and youth health centres should take the initiative to collaborate on how the services contribute with knowledge regarding determinants of health (both negative and positive) and an overview of the state of health of children and adolescents if a collaboration of this nature has not been already established.

The content of the municipality's overview

According to Section 5 of the Public Health act, the municipality shall have an overview at population level. The overview document must not contain information identifiable to individuals.

The municipalities' overview shall cover information about and assessments of, see Section 3 of the Regulation on overviews of public health:

- composition of the population
- childhood conditions and living conditions
- physical, biological, chemical and social environment
- injuries and accidents
- health-related behaviour
- the population's state of health

Examples of indicators:

- vaccination coverage
- breastfeeding frequency
- weighing and measuring
- sexually transmitted infections
- use of contraception
- teenage pregnancies
- abortions

Examples of illnesses or conditions that can be prevented from childhood and teenage years:

- mental disorders
- non-communicable diseases (NCDs, e.g. cardiovascular diseases, diabetes, chronic lung diseases and cancer)
- overweight and underweight

The services should collaborate with Healthy life centres for children and adolescents where these exist.

Relevant links

- [The guide Overview of state of health and influencing factors, the Norwegian Directorate of Health 2013](#)
- [Guides to local public health work, the Norwegian Directorate of Health](#)
- [Public health profiles \(fhi.no\)](#)
- [Ungdata.no](#)

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2.4 GPs: Health centres, the school health service and youth health centres shall collaborate with General Practitioners (GP) of children/adolescents

Health centres, the school health service and youth health centres shall have procedures in place for collaboration with GPs of children and adolescents to ensure transparent distribution of responsibilities and tasks and good understanding of role. It is the municipality's responsibility to ensure that the services are able to collaborate; see [the recommendation District medical officer](#).

Collaboration with individual GPs must be based on consent of the child/adolescent and/or their parents. See [the recommendation User participation](#).

The name of the GP of the child/adolescent shall be specified in the patient's medical records; see

Section 8(letter m) of the Medical Records Act, and procedures should be in place to register a change of GP.

Rationale

The contents of this recommendation are based on legislation, regulations and the consensus of the working group.

Health centres, the school health service and youth health centres shall collaborate with GPs, see Section 2-1, third paragraph of the Regulation on health centres and the school health service. [5]

It is the responsibility of municipalities to facilitate collaboration with GPs; see Sections 3-3 and 4-1 of the Health and Care Services Act and Section 8 of the general practitioner regulations. [7] [32] The municipality must ensure necessary collaboration procedures that are complied with by both GPs and health centres, the school health service and youth health centres.

If GPs and health centres, the school health service and youth health centres collaborate, the likelihood of identifying children and adolescents who need additional follow-up will increase. GPs are, in principle, responsible for all general practitioner tasks within somatic, mental health and drug/alcohol abuse for citizens on their list; see Section 10 of the general practitioner regulations. It is GPs who should arrange for medical investigations and other types of follow-up where this is required. If there is a need for medical investigation, health centres, the school health service and youth health centres shall refer the child/adolescent to a GP.

GPs, health centres, the school health service and youth health centres have important information about their users. By coordinating their care, health centres will be able to provide an efficient, targeted and holistic service to children and adolescents. This will also increase the likelihood of detecting health risks among children and adolescents.

Practical information

Written collaboration agreements should exist between GPs and health centres, the school health service and youth health centres.

Collaboration between GPs and health centres, the school health service and youth health centres should include:

- Roles, tasks and distribution of responsibility between GPs and the medical service at health centres, the school health service and youth health centres.
- Procedures regarding who at the health centres, the school health service and youth health centres is responsible for making contact with the child/adolescent's GP.
- Procedures to ensure that health centres, the school health service and youth health centres contact the GP when evidence of illness or a risk of illness is uncovered during consultations at the health centre or in the school health service.
- Procedures to ensure that GPs receive information if the health centre doctor, school doctor or municipal psychologist refers directly to the specialist health service.
- Procedures for collaboration concerning follow-up of chronically ill children/adolescents, and others who require additional medical follow-up.

Consent and co-determination

- **Children under 12 years of age:** Parents have competence to consent on behalf of the child; see Section 4-4 first paragraph of the Patient and Users' Rights Act (*pasient- og brukerrettighetsloven*).
- **Children/adolescents between 12 and 16 years of age:** The opinions of children and adolescents shall be taken into account. Children/adolescents may wish that information about specific issues is not disclosed to their parents. Health professionals must consider to oblige this; see Section 4-4, fifth paragraph of the Patient and Users' Rights Act (*pasient- og brukerrettighetsloven*).
- **Children between 16 and 18 years of age:** Adolescents generally have the right to consent themselves; see Section 4-3, first paragraph (b) of the Patient and Users' Rights Act (*pasient- og brukerrettighetsloven*). [9]

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2.5 District medical officer: Health centres, the school health service and youth health centres shall establish a collaboration with the district medical officer

The district medical officer shall function as medical adviser to the municipality.

Managers of health centres, the school health service and youth health centres should take the initiative to involve the district medical officer in the development of the services' planning work and prioritisation.

Rationale

The contents of this recommendation are based on the law and the consensus of the working group.

The district medical officer acts as a medical adviser to health centres, the school health service and youth health centres; see Section 5-5 of the Health and Care Services Act and Section 7-2 of the Act Relating to the Control of Communicable Diseases[7] [33] The district medical officer's tasks include providing guidance on the planning and control of the municipality's combined medical resources, and on municipal planning, management and evaluation of the health and care services in the municipality, as well as municipal administration in general. Further, the district medical officer can contribute to the development of systems and procedures for collaboration and co-operation between the municipality and the specialist health service. [11]

The district medical officer's tasks may vary from municipality to municipality. It is important that the services are familiar with which tasks relevant to the services that are assigned to the district medical officer in their municipality.

The district medical officer has community medicine competence, which is important in the health promoting and preventive work that takes place in the services. Community medicine can be defined as group-orientated medical work to:

- Map illness and health in a population as well as social health determinants.
- Recommend, implement and manage health measures and health services.
- Recommend the distribution of health resources. [34]

The district medical officer should be involved in planning to ensure the quality of the medical work in all sub services as well as providing guidance to health professionals who have tasks relating to vaccinations and protection against infectious diseases. The enterprise's manager is responsible for involving the district medical officer in the services' planning work, prioritisation and reports.

Practical information

To ensure a solid foundation and interaction, the district medical officer should be involved in work with collaboration agreements between health centres, GPs, any doctors responsible for infection control, the coordinating unit and the special health service.

The services should collaborate with the district medical officer on:

- public health, including environmental health protection
- competence plans regarding infection control
- Childhood Immunisation Programme
- health-related emergency response

Health centres, the school health service and youth health centres should prepare written collaboration procedures with the district medical officer to ensure quality and internal control.

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2.6 Psychologist: Health centres, the school health service and youth health centres shall collaborate with psychologists in the municipalities' other mental health services

Where the municipality has appointed a psychologist, health centres, the school health service and youth health centres shall cooperate with the psychologist. If the municipality does not have a psychologist, the services should have a systematic collaboration with the specialist health service for guidance purposes.

It is the manager's responsibility to ensure collaboration procedures; see [the General section: Management, control and user participation](#).

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

Health centres, the school health service and youth health centres shall collaborate with "other municipal services"; see Section 2-1 of the Regulation on health centres and the school health service. [5] If the municipality has appointed a psychologist or provides other mental health services, health centres, the school health service and youth health centres shall collaborate with these services.

Mental afflictions are often temporary. However, at any one time, 15–20% of children and adolescents

between the ages of 3 and 18 have impaired function due to mental afflictions such as anxiety, depression and behavioural problems. Around 8% of them have such serious problems that they fulfil the criteria for a mental disorder. [42]

Mental health work with children and adolescents entails directing focus at the factors that influence mental health – both factors that influence health promotion and factors that hinder health promotion. Many municipalities have appointed a psychologist, and many municipalities have a low-threshold programme for mental health work which offers help and follow-up to children and adolescents and families experiencing mental health problems. [39]

A key tool for dealing with the challenges within mental health and drug/alcohol abuse, as well as the field of violence and trauma, is to strengthen the quality and competence in municipalities. [38] [39] [40] [36] One of several measures to achieve this has been to stimulate the employment of more psychologists in the municipal health and care services. There has been a marked increase in the number of psychologist positions over the last three years. However, many municipalities still report that they do not have the necessary psychological expertise. In recent years, municipalities have increased the number of psychologists employed at health centres, the school health service, family centres and in the municipality's other mental health and drug/alcohol abuse services. Psychologists shall contribute to strengthening the municipalities' overall work within mental health, drug/abuse and in the field of violence and trauma, and psychologists can also contribute with competence development and guidance. [39]

Guidance from the specialist health service

If the municipality has not appointed a psychologist, health centres, the school health service and youth health centres should have a systematic collaboration with the specialist health service, especially the Child and Adolescent Psychiatric Outpatient Services (BUP). The specialist health service is obligated to provide the municipal health and care services with professional guidance; see Section 6-2 of the Specialist Health Service Act. [37] Further information may be found in Directive I-3/2013 The specialist health service's obligation to provide guidance to the municipal health and care service.

Practical information

Municipalities that have psychologists should prepare procedures for collaboration between health centres, the school health service and youth health centres and psychologists as well as the municipality's other mental health services.

In accordance with the initiative for psychologists in municipalities, the psychologists shall:

- participate in health promoting and preventive work
- enter into interdisciplinary and multi-sector collaboration within the work with mental health and drug/alcohol abuse
- focus on outreaching measures
- make access to mental health help easier for children and adolescents

Relevant documents:

- [Circular I-3/2013 concerning the specialist health service's obligation to provide guidance to the municipal health and care service](#)
- [The Norwegian Directorate of Health's guide to mental health work for children and adolescents in municipalities](#)

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2.7 Norwegian Labour and Welfare Administration (NAV): Health centres, the school health service and youth health centres should collaborate with NAV.

Health centres, the school health service and youth health centres should establish procedures **at system level** for collaboration with NAV in the municipality. The goal of the collaboration should be to ensure that children and adolescents are identified at an early stage and receive the necessary follow-up.

Health centres, the school health service and youth health centres can collaborate with NAV **at individual level** regarding children with a need for additional follow-up. It is up to the individual municipality to assess the need for collaboration on an individual level.

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

Health centres and the school health service shall have procedures for cooperation with “other municipal services”; see Section 2-1 of the Regulation on health centres and the school health service. [5] It is recommended that health centres collaborate with NAV in the municipality at system level or at individual level in the case of special needs. The municipality is responsible for making provision for the implementation of such a collaboration; see the General section: Management, control and user participation.

The interaction of health centres, the school health service and youth health centres with NAV should be strengthened, particularly at system level, but also at individual level where this is appropriate. Procedures that ensure a holistic service to children and adolescents should be emphasised.

Childhood poverty and social inequalities

Childhood poverty in Norway is on the increase. According to Statistics Norway, the proportion of children who grew up in families with persistent poverty was 8.6% in 2013. [44] These children and their parents are users of health centres, the school health service and youth health centres. We are aware that poor children are more vulnerable to health problems than other children. [46]

Children and adolescents shall have a living standard that is sufficient for good physical, mental and social development. Children and adolescents are particularly vulnerable when the family is facing a difficult financial situation. The municipality shall ensure that children with special needs are assessed when considering applications for financial support.

Early intervention is crucial for the prevention of social and health problems. This particularly applies to children and adolescents in disadvantaged families. Health centres, the school health service and youth health centres could have vital knowledge about health issues among children and adolescents of whom NAV does not necessarily have an overview. [43]

Drop-out rates in upper secondary school

The proportion of pupils who complete upper secondary school with a university and college admissions certification or vocational qualification within five years has in recent years remained stable at around 70%. [45] During the five-year period 2010–2015 only 59% of pupils completed upper secondary school in the nominal time frame (three years for academic study programmes, four years for vocational study programmes). In recent years there has been a major political initiative to increase completion rates in upper secondary schools, and a collaboration between four ministries and five directorates regarding the issue has been implemented (0-24 samarbeidet).

To increase upper secondary completion rates, an overall perspective, systematic efforts and early intervention are required. Health centres, the school health service and youth health centres are important actors in the efforts to increase completion rates.

A literature review from OECD shows that successful measures for increasing completion rates considers several risk factors at a time and involves the implementation of measures within schools, outside schools and at a system level. [47] The review also shows measures outside schools are more successful than measures within schools. Research shows that cross-sector collaboration is important to increase completion rates. Health centres, the school health service and youth health centres and NAV could be key actors in such a collaboration.

Practical information

Collaboration procedures should be in writing.

Collaboration at system level

Health centres, the school health service and youth health centres should collaborate with NAV in the municipality at system level where appropriate.

The collaboration should particularly focus on:

- Child poverty
- Transfer of knowledge regarding normal development and child health from health centres, the school health service and youth health centres to NAV
- Drop-out rates in upper secondary school
- Social inequalities

Collaboration at system level could include joint themed days about children and adolescents in the municipality.

Relevant themes could be:

- To become familiar with each other's social mission and tasks, including the purpose of the services and what the services work with.
- Local challenges in the municipality, including poverty and school completion rates and social inequalities.
- Key public health topics that are important to children and adolescents, for example sleep, nutrition, physical activity, sexual health, infection control and asthma and allergies.
- Knowledge exchange regarding violence, abuse and neglect and violence in close relationships.

It may be relevant to involve other services on such themed days, for example, the school and Child Welfare Service; see [the recommendation Child Welfare Service](#).

Several upper secondary schools have NAV advisors present several days per week. The school health service and youth health centres should collaborate with NAV advisers in upper secondary schools, where they are present, to prevent absence from school and promote good future integration in working life.

Individually-orientated collaboration

To the extent that it is desirable, health centres and the school health service can collaborate on the follow-up of children or adolescents with chronic illness, or who require additional follow-up.

Collaboration regarding individuals can only take place with the consent of the child/adolescent or their parents. Such consent should be entered in the child's medical records; see Section 8 of the Medical Records Act.

If possible, health centres, the school health service and youth health centres should get designated a contact person at NAV.

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2.8 Dental health service: Health centres, the school health service and youth health centres shall collaborate with the public dental health service.

Health centres, the school health service and youth health centres shall have a systematic collaboration with the public dental health service. A systematic collaboration with the public dental health service will help ensure that children and adolescents receive good quality in the overall health service, will be correctly prioritised and receive continuity of care.

The collaboration should:

- Ensure that health centres perform oral cavity examinations on children from 0 to 3 years of age professionally responsible and safely; see [the recommendation Oral cavity examinations](#).
- Make provision for procedures that ensure that the school health service and youth health centres can refer children and adolescents to the public dental health service when required.

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

Health centres and the school health service shall have procedures for cooperation with the public dental health service, for example, see Section 2-1 of the Regulation on health centres and the school health service. [5]

To strengthen health promotion and preventive work, the municipality should seek to achieve a broad interdisciplinary basis for the total range of competence in the service (Comments on Section 2.1 of the Regulation on health centres and the school health service).

Effective and structured collaboration between the public dental health service and health centres is a prerequisite for ensuring that health centres can perform oral cavity examinations on children at six weeks, six months, one year and two years of age. See [the recommendation Oral cavity examinations](#).

Practical information

Health centres and the school health service should contribute to the follow-up of children's dental health and to establishing proper dental health behaviour (brushing teeth, diet) from an early age.

A written collaboration agreement should be established between health centres, the school health service and youth health centres and the public dental health service. The agreement should be sanctioned at a management level. The agreement can also be sanctioned in a general collaboration agreement between municipalities and county councils (chief municipal executive and county dental officer).

The collaboration agreement should contain the following:

- purpose of the agreement
- responsibilities and obligations of the respective parties
- procedures for collaboration regarding oral cavity examinations at health centres from 0–5 years of age
- procedures for referring children and adolescents to the dental health service
- a systematic plan for joint training, guidance and professional support, including criteria for referral
- a description of which quality data shall be logged and evaluated

References

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3 General section: Duty of disclosure

3.1 Health professionals are obligated to notify the Child Welfare Service

Health professionals shall, without being hampered by any obligation to maintain confidentiality, and at their own initiative, immediately notify the Child Welfare Service:

- When there is reason to believe that a child is being abused at home or that a child is suffering other forms of neglect.
- When a child has displayed persistent and serious behavioural difficulties.

If one of these criteria is fulfilled, health professionals shall immediately notify the municipal Child Welfare Service; see Section 33 of the Health Personnel Act (*helsepersonelloven*).

The obligation to notify the Child Welfare Service takes precedence over the obligation to maintain confidentiality

When undertaking an assessment as to whether information should be disclosed to the Child Welfare Service, the circumstances of the child or adolescent shall weigh more heavily than the right to maintain confidentiality regarding circumstances that affect the patient or user.

Personal obligation to notify

The duty of disclosure is an independent obligation for all health professionals. In situations in which several persons receive the same or different knowledge about serious circumstances that suggest that the Child Welfare Service should be notified, each party has an independent obligation to notify the Child Welfare Service.

The aim of the duty of disclosure is to ensure that children and adolescents receive the necessary follow-up and care from the Child Welfare Service, and to protect children and adolescents from further mistreatment and serious neglect by letting the Child Welfare Service implement the necessary measures.

More about the duty of disclosure

- Health professionals **cannot independently choose** between disclosing and not disclosing information if the criteria for the duty of disclosure have been fulfilled.
- **The threshold for notifying the Child Welfare Service** must be low. Health professionals are not required to have irrefutable knowledge about the circumstances that trigger the concern, but it must be based on more than just vague suspicion.
- Health professionals should **not investigate** the home situation or other aspects more closely before they notify the Child Welfare Service. Health professionals should not conduct a child welfare assessment of the situation. These are the responsibilities of the Child Welfare Service.

Health professionals shall submit a letter of concern based on a total assessment

Relevant aspects of such an assessment should be:

- the behaviour of the child and its parents

- communication and interaction between the child and its parents,
- physical and/or mental signs
- other aspects that you would usually not see

Situations in which health professionals must notify the Child Welfare Service

No specific knowledge of the situation is required, but there must be grounds for suspecting that a child has been subject to mistreatment or other forms of serious neglect.

Health professionals must notify the Child Welfare Service of:

- Situations in which the parents do not ensure the necessary medical care for a child in the case of a life-threatening or serious illness or injury.
- Situations in which the parents do not ensure that disabled or children with particular needs receive the necessary treatment and training.
- Situations where there is evidence of a serious lack of daily care, mistreatment or abuse.
- Situations in which a child has displayed persistent and serious behavioural difficulties.

The fact that a child does not live under optimal conditions does not in itself trigger a duty of disclosure.

Examples of situations in which health professionals must notify the Child Welfare Service:

- Where a child is subject to violence in the family.
- In cases where a child witnesses violence, the child can be subject to neglect. The extent to which any suspicion of such circumstances is covered by the duty of disclosure will depend on an overall assessment.
- Neglect can also occur where children or adolescents are subject to violence or abuse from persons other than their closest carers.
- In situations where parents are unaware that a child is being abused, neglect can occur if the parents are regarded as not being capable of protecting the child from continued abuses or ensuring that the child or adolescent receives the necessary help.
- Where drug/alcohol abuse is suspected in combination with other observations in a treatment situation that cause concern.
- When there are suspicions that a child/adolescent has been or could be subject to female genital mutilation; see [Guide to the prevention of female genital mutilation: Offer of consultation and voluntary gynaecological examination \(IS-1746\)](#).
- Situations in which there is a suspicion that a child/adolescent has been or could be forced to marry against their will (forced marriage).

Read more about the signs that could cause concern in the recommendations:

- [Interaction](#) in health centres, 0–5 years of age
- [Violence, abuse and serious neglect](#) in Health centres, 0–5 years of age
- [Lightly clothed](#) in the school health service
- [Violence, abuse and neglect, 1st grade](#) in the school health service
- [Violence, abuse and neglect, 8th grade](#) in the school health service

Contents of a letter of concern to the Child Welfare Service

Health professionals are responsible for assessing which information it is relevant to provide for the Child Welfare Service to perform its responsibilities.

Aspects that should be included in a letter of concern:

- The basis of your knowledge of the family.
- The type of contact you have had with the family.
- Description of what it is that you are concerned about, as concrete and descriptive as possible.
- What other agencies has the family been in contact with?
- Whether you have attempted to give/offered guidance/help, whether the family has requested

this and how they have benefited from the help, where applicable.

Information to the Child Welfare Service should generally be submitted in writing. The exception is when a child's life and health are in urgent danger.

Checklist when writing a letter of concern.

- The note of concern shall be sent as soon as there are verified findings that give cause for concern.
- All health professionals are obligated to report even if other professionals have the same knowledge or if letters of concern have been submitted previously. The duty to report is an individual responsibility.
- In the event of any uncertainty, you can discuss the case with the Child Welfare Service in your municipality without divulging the name of the child/adolescent.
- Parents must not be notified if this could result in risk or disadvantages to the child/adolescent (see below for further information).
- It may be a good idea to call the Child Welfare Service and notify them that you are submitting a letter of concern. Several municipalities have produced dedicated letter of concern templates. See the website of the Norwegian Directorate for Children, Youth and Family Affairs for further information, and see [the recommendation Child Welfare Service](#).

When should the child/adolescent and parents be notified?

When there is a duty of disclosure, the information shall be submitted to the Child Welfare Service regardless of the will of the child/adolescent/parents/other next of kin. As far as is possible (and not contrary to the purpose of the provision: to address a situation that could result in harm to the child), health professionals should notify the child/adolescent and/or the person/persons with parental responsibility before the information is passed on.

In serious situations or in situations in which health professionals are uncertain, it shall be left to the Child Welfare Service to assess when and in which way the parents shall be notified. The case shall then be discussed with the Child Welfare Service and the police to ensure well-planned and coordinated management of the situation.

Examples of situations in which the Child Welfare Service should assess how parents shall be notified:

- When there is suspicion that a child/adolescent has been subject to sexual abuse
- When there is suspicion that a child/adolescent or someone close to a child/adolescent has been subject to violence or abuse
- If notifying the parents could put someone's life or health at risk.
- In the case of concern regarding forced marriage
- In the case of concern regarding female genital mutilation

In such cases, information to parents could mean that the Child Welfare Service or the police are unable to provide the child or others adequate protection or that vital evidence is lost.

Documentation and medical record keeping

Letters of concern shall be documented and entered in medical records, see Section 8 of the Medical Records Act.

- Findings must be entered in medical records
- If possible, photos may be taken (showing the scale, if applicable) of any injuries/traumas. These can also be illustrated on a separate sheet attached to the medical records.
- A copy of the letter of concern shall be attached to the medical records.
- If the police have also been notified, this shall be recorded in the medical records.
- Parents must not be notified if this could result in risk or disadvantages to the child/adolescent (see above for further information).
- The medical records shall state whether the parents have been notified about the letter of

concern.

Statens barnehus (interministerial multidisciplinary competence centres for child protection) recommends the following method for the documentation of findings (Statens barnehus, 2016):

- Keep a log and take notes. Continue to take notes as you observe or talk with the child/adolescent. Notes can be vital in any report, letter of concern to the Child Welfare Service or legal proceedings.
- If the child/adolescent provides a personal testimony, it is important that the child/adolescent can talk freely and that you ask open and non-leading questions. Write down statements and details as verbatim as possible. Describe the situation in which the child/adolescent is talking and describe their state of mind.

The Child Welfare Service's handling and follow-up of a letter of concern

The Child Welfare Service shall provide feedback regarding what it has done in the case after it has received a letter of concern. The feedback will depend on whether the letter of concern is dismissed or whether the Child Welfare Service concludes that further investigation shall be carried out; see Section 6-7a, first paragraph of the Child Welfare Act.

The Child Welfare Service is dependent on the parents' consent for it to be able to notify the health centre, the school health service and youth centres of which measures have been implemented at home, unless the health centre, school health service and youth health centre are included as part of the measures.

Help for families when the criteria for the duty of disclosure have not been fulfilled

All families can enter difficult life situations in which they require help and support from the Child Welfare Service to address their children's care needs.

All personnel in health centres, the school health service and youth health centres should encourage families to get in touch with the Child Welfare Service if they see that a family has or may have a need for help and support to address the children's care needs.

If the family so desires, personnel in the services should assist the family in contacting the Child Welfare Service.

The Child Welfare Service offers a range of consent-based measures in the home to help families, including enhancing parenting skills, compensating for shortcomings in care or offering relief to the parents. The aim of relief measures is to contribute to positive change in the child or in the family. For more information about such measures; see the website of the Norwegian Directorate for Children, Youth and Family Affairs.

3.2 Duty of disclosure when instructed by the Child Welfare Service

Health professionals may be instructed to provide necessary information to the Child Welfare Service; see Section 33, third paragraph of the Health Personnel Act (*helsepersonelloven*).

Upon instruction from the Child Welfare Service to disclose information, it is the Child Welfare Service, not health professionals, who shall assess whether criteria for the duty of disclosure exist.

It is also the Child Welfare Service which assesses what information is relevant. The Child Welfare Service must specify what type of information must be provided. It cannot, for example, demand the disclosure of a complete medical record.

Based on information from the Child Welfare Service, health professionals shall decide which information shall be disclosed. An instruction to disclose information can be appealed to the County Governor in accordance with Section 14 of the Administration Act.

Health professionals should, as far as possible and appropriate, notify the patient before information is submitted to the Child Welfare Service.

In accordance with the other provisions concerning exemption from an obligation to maintain confidentiality, health professionals should normally attempt to request consent. This applies when such an attempt does not conflict with the purpose of the provision, which is to address a situation that could result in harm to the child.

In situations where no duty of disclosure or right to information exist, information shall only be divulged to the Child Welfare Service upon consent. For further information, [see Directive IS-17/2006: The obligation and right of health professionals to give information to the Child Welfare Service, the police and social services in the event of suspected mistreatment of children in the home, other forms of serious abuse of children or misuse of drugs/alcohol during pregnancy.](#)

Further information

Learn more about the duty of disclosure to the Child Welfare Service in:

- [Directive IS-8/2012 Health Personnel Act \(*helsepersonelloven*\) and comments](#), p. 84

3.3 Duty of disclosure to the emergency services and duty of prevention

Duty of disclosure to the police and fire service

Health professionals shall notify the police and fire service if it is necessary to prevent serious injury to persons or property; see Section 31 of the Health Personnel Act (*helsepersonelloven*).

Learn more about this obligation in [Directive IS-9/2015 Obligation and right of health professionals to give patient information to the police.](#)

Duty of prevention in accordance with the penal code

- Health professionals are obligated to prevent criminal offences from being committed; see Section 196 of the penal code.
- To prevent a criminal offence from taking place, health professionals can report the relevant circumstances to the police or, in some other way, attempt to prevent the action from being committed.
- This obligation applies for as long as it remains possible to prevent the criminal offence from being committed, and when it appears certain or most probable that the criminal offence will be committed.

The duty of prevention applies, for example, to the following punishable circumstances, which may also bear a relationship to the duty of disclosure to the Child Welfare Service:

- Section 274 of the penal code – Gross bodily harm
- Section 274 of the penal code – Mistreatment in close relationships
- Section 283 of the penal code – Gross mistreatment in close relationships
- Section 312 of the penal code – Incest
- Section 314 of the penal code – Sexual contact with other closely related persons

Other breaches of law that are listed in Section 196 of the penal code may also be relevant.

Duty of prevention in the case of female genital mutilation

Employees in the health and care service shall prevent female genital mutilation, see Section 284 of the penal code. The duty of prevention applies without regard to the obligation to maintain confidentiality.

See also the Norwegian Directorate of Health's guide to [Prevention of female genital mutilation – Offer of consultation and voluntary gynaecological examination.](#)

3.4 The municipality shall have a management system that addresses the duty of disclosure

The municipality's management system shall **ensure that health professionals comply with the duty of disclosure** and notify the Child Welfare Service when there are grounds for doing so.

The management system must, for example, demonstrate where responsibility has been placed, ensure that there is sufficient expertise and that circumstances that could provide the basis for notifying the Child Welfare Service are identified, assessed, documented and executed when disclosure is relevant. The management system must establish procedures/routines necessary to ensuring compliance with the duty of disclosure.

Section 4-1 of the Health and Care Services Act stipulates that the municipality shall adapt services so that the personnel can maintain their statutory obligations. This entails the implementation of necessary organisational and systematic measures that enable health professionals to fulfil their duty of disclosure to the Child Welfare Service.

The municipality should have procedures in place to ensure that health professionals are familiar with and comply with the following obligations:

- Duty of attention towards children and adolescents in general and towards siblings and disabled children; see Section 33 of the Health Personnel Act (*helsepersonelloven*).
- Duty of disclosure to the Child Welfare Service – on own initiative and when instructed; see Section 33 of the Health Personnel Act (*helsepersonelloven*).
- Duty of disclosure to the police and fire service see Section 31 of the Health Personnel Act (*helsepersonelloven*).
- Personal responsibility for notifying.

The municipality should have procedures in place for:

- When parents shall and shall not be notified.
- Documentation and keeping a record of letters of concern to the Child Welfare Service.
- The procedure when submitting a letter of concern to the Child Welfare Service.
- Mutual and binding collaboration between health centres, the school health service and youth health centres and the Child Welfare Service; see [the recommendation Child Welfare Service](#).
- Training and maintenance of expertise.
- Reporting.

The municipality should ensure that health professionals have knowledge of:

- Which findings could provide the basis for suspicion concerning mistreatment or other forms of serious neglect.
- Which feedback can be expected from the Child Welfare Service; see Section 6-7a of the Child Welfare Act.

See [the General section: Management, control and user participation](#) for further information about the management system.

4 Health centres 0–5 years

4.1 The health centre programme: All children from 0–5 years of age should be offered regular consultations at health centres

All children from 0–5 years of age should be offered regular consultations at health centres. Health centres for children from 0 to 5 years of age should follow a standardised programme of **14 consultations, including a home visit to new-born babies** (health centre programme).

The objective of the health centre programme is:

- to ensure that parents can cope with and master their roles as parents to ensure good interaction between parent and child
- to promote physical, mental and social development in babies and infants
- to prevent and detect violence, abuse, and neglect
- to detect physical and mental developmental anomalies at an early stage
- to help the child receive necessary follow-up and instigate referrals when required

In addition to the 14 consultations in the health centre programme, [the National guideline for postnatal care](#) recommends home visits by a midwife.

Rationale

The contents of this recommendation are based on legislation, regulations and the consensus of the working group.

To fulfil the responsibility of offering necessary health and care services to everyone living in the municipality, the municipality shall offer health promoting and preventive services in the form of health centre services; see Sections 3-1 and 3-2, first paragraph no. 1 of the Health and Care Services Act [7]

Children have the right to health checks in the municipality in which they live or temporarily reside as a part of their right to necessary health care; see Section 6-1 of the Patient and Users' Rights Act (*pasient-og brukerrettighetsloven*). [9] The right to health checks for children has been particularly designed to ensure that the children will be receiving health checks (consultations) in health centres and the school health service.

In accordance with Chapter 2 of the Public Health Act, the municipality is also responsible for promoting public health and preventing illness and, pursuant to Section 5 of the act, shall have an overview of the state of health in the population as well as health determinants.[27] The Regulation on health centres and the school health service stipulates in Section 2-2 that health centres are obligated to contribute to such an overview when it concerns children and adolescents from 0 to 20 years of age, as well as pregnant women who attend check-ups at health centres.[5]

To fulfil the obligations specified above in accordance with acts and regulations, it is recommended that all children are offered a standardised programme with 14 consultations under the auspices of health centres in the period from birth and up to the time they start school. This will help the municipality provide an professionally responsible health-promoting and preventive service that promotes physical and mental health, good social and environmental conditions and prevents illnesses and injuries; see Section 1-1 of the Regulation on health centres and the school health service and Section 4-1 of the Health and Care Services Act. Health centre provision for children aged 0–5 years shall include health checks and guidance with follow-up, referrals when required, information activities, individual guidance and guidance in groups and home visits/outreach work; see Section 2-3 of the Regulation on health centres and the school health service.

The following aspects have been key in the choice of recommended timing and number of consultations in the health centre programme:

- In most cases, health centres are the only public institutions that see children and families on a regular basis before children start kindergarten. They therefore play an important role in

strengthening parenting skills, detecting any developmental anomalies and preventing and detecting violence, abuse and neglect among young children.

- After children have started kindergarten there is also a need for regular consultations at health centres to ensure continuity in the medical follow-up of children.
- Consultations in the health centre programme should follow the normal attainment of milestones in the child's development, so that any anomalies can be detected, and parents can receive information adapted to the child's age and level of development. As children develop at individual paces, frequent consultations are important to ensure that the service follows the development of each child.
- Support from health centres is important to help reduce social inequalities in health. Guidance based on the parents' knowledge and needs, about topics such as breastfeeding/nutrition, interaction and bonding is particularly relevant.
- In the interest of efficiency, consultations should take place simultaneously with vaccinations in the Childhood Immunisation Programme. Likewise, consultations should take place simultaneously with weighing and measuring stipulated in the [National guideline for weighing and measuring](#) and with dates for checking vision, hearing and language stipulated in the [National guideline for screening vision, hearing and language in children](#).
- Reference is also made to corresponding guidelines from other countries, especially Sweden's [Guidelines for Child Health Care 2014](#) in the National Guide for Child Health Care, from the National Board of Health and Welfare, which also recommends 14 consultations. [51]

Children's health in Norway

Each year, approx. 60,000 children are born, and the health of Norwegian children from a global perspective is very good. Infant mortality is low, and there is a high rate of survival for premature babies. Good dietary habits are formed in childhood. [41] Around 80% of all Norwegian mothers breastfeed their infants up to 6 months of age. Accidental deaths have been reduced considerably. Nonetheless, accidents continue to be a significant cause of death among children and adolescents. The majority of these fatalities could be prevented.

Through the health centre programme, parents receive systematic guidance about diet, breastfeeding, interaction, child accidents and injuries, for example. This helps to boost children's health, prevent and detect atypical development and provide an opportunity to identify children who are subject to violence, abuse and neglect.

Health centres and local public health work

According to Statistics Norway, approx. 98% of all children in Norway are in contact with health centres in their early years and regularly up to the start of school. For the vast majority of children, health centres are the only public institutions that regularly make contact with children and families, during the child's first year. Health centres and the school health service therefore have an opportunity to reach all population groups in society with health-promoting and preventive information.

There are many milestones in a child's development during the first year, and most children acquire mental and physical skills in the same order. However, normal variations are significant, and children develop and mature at individual paces. Frequent consultations are therefore necessary to follow the individual child's psychomotor development, bonding and regulation. If the child is unable to master skills at the respective milestones, personnel at health centres will be able to offer the necessary guidance and advice, assess additional follow-up and refer the child to, for example, a GP if there is a need for further treatment or examination. The public health nurse will be able to provide support and confirmation to the parents with regard to issues related to the child's growth, breastfeeding and diet, sleep habits and psychomotor development.

Local municipalities are responsible for monitoring children's health situation in their own municipality, and shall plan and implement measures that promote the most optimal physical and mental health in pregnant women, children and adolescents; see Sections 2-1 and 2-2 of the Regulation on health centres and the school health service. This provides the local services with an opportunity to contribute to political decision-making adapted to local conditions and local challenges. Regular consultations at health centres provide the municipality with a good basis for collecting data in order to obtain the required overview of the state of health of the population; see Section 5 of the Public Health Act, as health centres have high attendance rates among all population groups. KOSTRA (Municipality-State-Reporting) is an

important source of statistics and provides a basis for comparison and decision-making for both municipalities and the government. Through KOSTRA, municipalities document their effort in the health-promoting and preventive work among children and adolescents.

Reducing of social inequalities in health

Children have few opportunities to influence their framework and social conditions, and the number of children living in poverty is increasing. In the period 2011–2013 there were 84,000 children in families living on persistently low incomes. By 2012–2014 this number had risen to 92,000. [44] The increase primarily comprises families from an immigrant background. In some families, both children and parents face challenges as a consequence of circumstances relating to the child, the parents or due to difficult life events. These challenges are generally such in nature that multiple measures need to be implemented, including parental respite, help in the home, financial assistance and health care.

Health centres have a unique opportunity to observe, provide guidance and advice, as well as follow-up of vulnerable children and adolescents. Health centres shall have a close interdisciplinary collaboration with other municipal services and the specialist health service, and shall provide referral to other services where required; see [the General section: Collaboration and co-operation](#).

Children living in poverty are at greater risk of developing health complaints, the effect of which can last their entire lifetime. The standardised health centre programme constitutes a universal option for all families. Historical data shows that a low-threshold programme like this reduces health risks during the infant years, that the effect is stronger for children from low socio-economic backgrounds and that the effect can last until adulthood. [56] Health centres have witnessed a great increase in the number of families from an immigrant background, for whom language and culture can hamper communication with the service. This results in a need for close contact and special adaptation of the services. When necessary, an interpreter shall be used. See [the recommendation Low-threshold services](#).

Preventing, averting and detecting violence and neglect

Young children and children with disabilities are particularly vulnerable to violence, abuse and neglect. [55] Health centres are the public institutions that systematically and regularly observe a child's health and development and are in frequent contact with the child's carers in the period before the child starts kindergarten. This provides both an opportunity and a responsibility for preventing, averting and detecting violence, abuse and neglect amongst the very youngest children. In this regard, health centres constitute a vital safety net for children.

Reports suggest that the greater the resources a municipality spends on public health nurses/health centres in relation to the number of children in the municipality, the smaller are the unaddressed needs for Child Welfare Service measures in the home. [57] This could indicate that good preventive work in municipalities has significance for the use of such measures.

It is recommended that children undress during all health checks and during weighing and measuring, so that health professionals can observe skin, motor skills, well-being, interaction and any signs of violence and abuse. See also [the recommendation Violence, abuse and neglect](#).

It is estimated that each year 5–15 infants in Norway are seriously injured by being shaken (Shaken Baby Syndrome/Abusive Head Trauma (AHT)) and that around 5 children die from such injuries. [50] Close follow-up at health centres can help provide parents with guidance in the interaction and management of children in order to prevent severe injury from AHT.

Infection control and the Childhood Immunisation Programme

Health centres and the school health service are also subject to Section 3-8 of the Act relating to the control of communicable diseases concerning vaccination and immunisation of the population. [33] Municipalities are obligated to have separate plans for infection control work, and tasks that are often conducted in health centres and school health service are:

- prevention and control of tuberculosis
- implementation of the Childhood Immunisation Programme
- follow-up, guidance and vaccination in connection with infectious diseases/epidemics

Vaccinations prevent diseases by stimulating immunity that can prevent illness. The number of new

occurrences of infectious diseases is lower in Norway than in other European countries. [41] The Childhood Immunisation Programme is offered to all children of preschool and primary school age and shall be carried out at health centres and the school health service; see Section 4 of the Regulation on the national Childhood Immunisation Programme (*forskrift om nasjonalt vaksinasjonsprogram*). [53] The recommended programme currently comprises vaccines against 12 diseases. A review of national vaccination coverage in 2015 shows that increasingly more children are being vaccinated and that the vast majority of children and adolescents in Norway complete the recommended immunisation programme. Compared to other countries, Norway has very high vaccination coverage. [49] It is crucial to maintain the immunisation programme and high vaccination coverage in order to keep the presence of infectious diseases at a minimal level in the future.

Prevention of non-communicable diseases

Preventive measures at a population level are largely the same for all NCDs (non-communicable diseases) and entail the prevention of alcohol and tobacco use and the promotion of healthy diets and increased physical activity. [54] Health centres have an obligation to, and play a vital role in, contributing to the prevention of non-communicable diseases. For example, through advice about diet, tobacco, drugs/alcohol habits in parents, as well as physical activity. The recommended health centre programme raises these topics regularly with parents and children so that they can form a positive basis for the development of good habits for the family.

Practical information

The recommendations in the general section and section concerning health centres for children from 0 to 5 years must be seen in context to ensure consistency.

During all consultations at health centres:

- Review medical records and describe findings that provide a basis for follow-up; see also, [the recommendation Follow-up groups](#).
- Ensure adequate user participation; see the [recommendation User participation](#).
- An interpreter shall be used when necessary; see the [Norwegian Directorate of Health's guide to communication via an interpreter](#).
- Children should be naked when they are examined, but take into consideration the child's modesty and consider letting it keep its underpants and/or top on.
- Ensure the necessary collaboration between the GP and public health nurse; see [the recommendation Collaboration between the public health nurse and the doctor](#).
- Based on the needs, an assessment must be made as to whether other specialists should participate in the consultations; see [the General section: Collaboration and co-operation](#) and [the recommendation Physiotherapist](#).
- Assess other kinds of interdisciplinary collaboration with, for example, the mental health services in the municipality, Family Counselling Service, Child Welfare Service and the specialist health service, based on requirements. See [the General section: Collaboration and co-operation](#) and [the General section Duty of disclosure](#).

Health centres should also, when necessary, provide parents with information about:

- Dressing according to the weather and time of year.
- Sun protection; see [the Norwegian Radiation Protection Authority's website on sun protection, recommendations and advice](#).

If there is a need for additional follow-up

In addition to the recommended consultations in the health centre programme, the family should be offered additional follow-up when this is necessary.

Examples of situations in which there could be a need for additional consultations:

- When the mother and/or father shows signs of mild depression or other mental illness or conditions.

- In the case of concerns/challenges associated with, for example, breastfeeding, diet, sleep, weight, well-being and interaction.
- For families who for various reasons require additional support or guidance.
- If a child does not attend kindergarten.

See also [the recommendation Follow-up home visits](#).

Relevant documents for the health centre programme:

See other national professional guidelines for recommendations associated with specific topics in the health centre programme:

- [National guideline for infant nutrition](#)
- [Weighing and measuring at health centres and in the school health service, IS-1736](#)
- [Screening of vision, hearing and language IS-1235](#)

Other relevant national guidelines:

- Postnatal care, new life and safe postnatal periode for the family, IS-2057
- Follow-up of premature babies, IS-1419
- Prevention, investigation and treatment of overweight and obesity in children and adolescents, IS-1734
- Pregnant women undergoing Medication Assisted Rehabilitation (MAR) and follow-up of the families until the child reaches school age, IS-1876

[Health centre programme for children aged 0–5 years: Summary of recommended consultations and topics \(PDF\)](#)

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4.2 Doctor: Health centres shall offer children health checks performed by a doctor

Health centres shall offer health checks performed by a doctor. These health checks should be performed as part of the health centre programme at the consultations when the child is **six weeks, six months, one year and two years old**.

Routine health checks shall help to prevent development of physical and mental problems and identify associated risk factors.

Collaboration concerning the health checks by health professionals with various expertise, experience and responsibilities will help improve the professional quality and interdisciplinary discussions, consideration of the child, and ongoing assessment. See [the recommendation Collaboration between the public health nurse and the doctor](#).

Rationale

The scope of this recommendation is based on legislation, regulations and the consensus of the working group.

The health centre service shall include health checks and advice with follow-up/referral as required; see Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*).[5] The health checks that are to be performed are such that a doctor's competence is necessary to ensure that services provided are conducted responsibly ; see Section 4 of the Health Personnel Act (*helsepersonelloven*) and Section 4-1 of the Health and Care Services Act (*helse- og omsorgstjenesteloven*).[14] [7]

The recommendations concerning the scope of the health checks is based on experience gained from the practice of health centres. Current practice has been evaluated and developed from the previous Guide to the Regulation on the health promotion and preventive work on health centres and the school health service (*Veileder til Forskrift om kommunens helsefremmende og forebyggende arbeid i helsestasjons- og skolehelsetjenesten*). [58]

The purpose of the medical examination is to prevent and identify risk factors for disease, and atypical or delayed physical, mental and behavioural development at an appropriate time.

Children mature and develop at different paces. Nevertheless, it is important that children who do not follow normal development are identified and secured regular follow-up, with the involvement of other professions when necessary.

Early childhood experiences have a significant impact on the child, both physically and mentally. When life is not perceived to be safe and meaningful, long-term physical and psychological stress can predispose the individual to physical and mental illness. Children have an innate capacity to retrieve health and rectify developmental problems if they receive adequate follow-up at the correct time.

In general, Norwegian children have good health; however, depending on the parents' socioeconomic status, differences become apparent as early as 0-5 years of age (Ministry of Health and Care Services, 2006). It has been shown that children whose parents have lower educational attainment more often are premature or have low birth weight. Incidences of caries, overweight, mental health problems, behavioural problems, asthma, pain disorder and serious accidents are also higher in this group.

There is a tendency towards a higher incidence of health problems among adult immigrants than for the population in general. There is relatively little documentation available concerning the health status of children of immigrants. [59]

See in addition other National guidelines:

- [Follow-up of premature babies, IS-1419](#)
- [Postnatal care, new life and safe postnatal period for the family, IS-2057](#)
- [Screening of vision, hearing and language, IS-1235](#)
- [Weighing and measuring in the health centre and school health service, IS-1736](#)
- [Prevention, investigation and treatment of overweight and obesity in children and adolescents, IS-1734](#)
- [Pregnant women undergoing Medication Assisted Rehabilitation \(MAR\) and follow-up of the](#)

[families until the child reaches school age, IS-1876](#)

Height and weight development

- A child normally attains his or her growth pattern (percentile channel) for head circumference, length and weight during the first six to twelve months. The parents' heights and head circumferences must be considered when assessing the child's growth pattern. Atypical growth patterns during this period or later could be due to nutritional problems or deficient nutrition, several developmental anomalies, or disease. Possible causes must be mapped using the medical history and clinical examination.
- Underweight or overweight in childhood could be caused by illness, nutritional problems or an unhealthy lifestyle. Risk factors for developing overweight include overweight in parents and/or siblings combined with unfavourable weight gain in the child, particularly after the first year of life.

Congenital developmental anomalies and disease

There are a number of potential developmental anomalies or conditions, and the doctor should therefore perform a general clinical examination at every health check. Attention should be focused in particular on the possibility of:

- **Congenital heart disease** About 8 in 1,000 children have a congenital heart disease. Most are detected before the child leaves the maternity ward, but still many are detected at various times during infancy and childhood. This applies in particular to ventricular septal and atrial septal defects, patent ductus arteriosus, constriction of the aorta (coarctation of the aorta) and rarer conditions. At every health check performed by a doctor, the heart should be examined by auscultation. Innocent murmurs are common. If murmurs or other symptoms or findings that could be ascribed to a heart condition are found, a more thorough investigation must be made including assessment of colour, respiratory pattern, peripheral pulses, the size of the liver, and growth pattern.
- **Developmental dysplasia of the hip/hip luxation.** This condition is most often detected by examination by the specialist health service postnatally, but progression to luxation can occur later. Clinical examination of the hips should be performed by a doctor at six weeks, six months and one year by investigating difference in leg lengths, and abduction of the hips. In addition, the Ortolani test and Barlow manoeuvre should be performed at six weeks of age, and assessment of gait at two years of age. Asymmetrical skin folds on the thighs and bottom are common and are not normally a symptom of developmental dysplasia of the hip/hip luxation if investigations are otherwise normal.

Retinoblastoma and cataract can be detected by examining the red reflex at six weeks of age. Later, a persistent squint should result in examination of the retina, partly with retinoblastoma in mind. See the [National guideline for screening vision, hearing and language in children \(Nasjonal faqlig retningslinje for undersøkelse av syn, hørsel og språk hos barn\)](#).

Psychomotor development

Delayed or atypical motor, psychological, behavioural, linguistic or other development could be caused by congenital developmental anomalies, genetic factors, disease or inadequate care. In addition to checking whether the developmental milestones have been attained, it is important to evaluate the developmental rate and whether there is loss of skills.

Motor development

Motor development is evaluated based on movement patterns, including symmetry, tone, attained skills and the quality of those skills. Delayed or atypical motor development can be due to:

- Congenital developmental anomaly, e.g. malformation of the brain and hydrocephaly or genetically related neurologic, neuromuscular and muscular disease.
- Neurological injury related to the pregnancy or birth e.g. premature birth, brain haemorrhage, circulatory disorders in the brain, birth asphyxia, hydrocephaly or microcephaly (head circumference) and injury to the brachial plexus (asymmetric Moro reflex and difference in tone) or facial nerve (asymmetry when using facial muscles). The outcome can be delayed skills development, local pareses and cerebral paresis.

- Diseases associated with the neuromuscular system, or chronic conditions that restrict the child such as cardiac or pulmonary conditions.
- Violence, abuse or neglect.

Psychological and behavioural development

Psychological and behavioural development are evaluated based on social contact, temperament, and affect regulation difficulties at an early age; as the child gets older, evaluation is based on social skills, language development, ability to concentrate and impulsivity.

- Developmental disability manifests as significant developmental delay, both mental and motor, in most areas.
- Autism spectrum disorders can manifest as a lack of language (no babbling, pointing or other communication around one year of age, lack of language and ability to communicate by two years of age and, later, ritualistic and obsessive behaviour characteristics).
- Hyperkinetic disorders (ADHD) manifest as problems concentrating and difficulty maintaining attention, lack of impulse control and motor restlessness.

Long-term or chronic conditions

Long-term or chronic conditions can result in nutritional problems, failure to thrive, developmental delay, and other expressions of reduced well-being. The doctor should ask about such conditions at each health check, in particular if there is atypical growth, development, well-being and persistence, but also more generally. Suspicion of such conditions is based on the medical history and targeted clinical examinations.

Particular attention should be paid to:

- Respiratory tract diseases such as chronic cough, laboured/audible breathing and fatigue. Possible causes include congenital anomalies in the airways, infection-triggered airway obstruction or asthma, poor indoor climate, for example due to smoking in the home, enlarged adenoids or rare diseases such as cystic fibrosis.
- Cardiac disease such as congenital heart conditions give symptoms such as problems breathing, nutritional problems, lack of weight gain, fatigue, sweating, cyanosis or paleness.
- Endocrine conditions which can cause growth changes (reduced or abnormally increased height, underweight or overweight), delayed psychomotor development and various symptoms of disease.
- Anaemia, in particular due to iron deficiency. Iron deficiency can also give symptoms of impaired attention and cognitive development without concomitant anaemia.
- Skin diseases which produce a rash. Atopic eczema is characterised by typical localisation, dry skin and itching.

Violence, abuse and neglect

Child neglect and abuse can produce the same general symptoms and findings as chronic somatic diseases. Child neglect should be suspected if a chronic disease cannot be identified as the cause of the symptoms, if the child has or has had wounds, bruises or fractures, or injury to the genitals and oral cavity, that otherwise cannot be satisfactorily explained, and if extensive caries is present. See the separate [recommendation Violence, abuse and neglect](#).

Iron deficiency

Iron deficiency (ID) is the most common nutritional deficiency in children throughout the world. WHO has estimated that a quarter of the world's population has iron deficiency anaemia (IDA), and that it primarily affects pre-school children and women. Several studies have demonstrated impaired psychomotor development in infants with iron deficiency, even in the absence of anaemia. Prevention and early treatment of iron deficiency are therefore imperative. The first year of life sees major changes in diet. Children transition from taking only breast milk to consuming almost normal food. Due to their rapid growth, infants are particularly prone to developing iron deficiency during this phase.

In recent decades, Norway has seen high immigration of ethnic groups from non-European countries with

different social and nutritional backgrounds. This increasing non-western immigration to Norway makes it important to consider that children with low Hb, MCV, and MCH, and high TfR, do not necessarily have iron deficiency or iron deficiency anaemia. These children could have haemoglobinopathies and will not benefit from iron supplements. This should be investigated in more detail and the child referred to the GP if necessary (Baker & Greer, 2010, Saunders et al., 2016).

Practical information

At routine health checks, the doctor should use the medical history and clinical examinations to identify risk factors for developing physical and mental health problems and unfavourable development. These could be factors linked to family, social conditions or the child. The doctor should be particularly aware of conditions for which prevention and early intervention have a documented positive effect.

Parents must have the opportunity to ask questions about the child's health and development.

Scope of the doctor's examinations:

Advice and guidance to promote physical and mental health

General clinical examinations

- Particular attention should be paid to the possibility of congenital heart disease, developmental dysplasia of the hip/hip luxation and eye/vision problems (red reflex at 6 weeks of age and red reflex/retina examinations if a squint is present).

Assessment of psychomotor development

- Developmental rate and loss of skills. Endeavour to identify delayed or atypical motor, psychological, behavioural, linguistic or other development that could be caused by congenital developmental anomalies, genetic factors, disease or inadequate care.

Assessment of motor development

- Assess the movement pattern (symmetry, tone, attained skills and the quality of the skills).

Assessment of psychological and behavioural development

- Assess social contact, temperament, and any self-regulating problems at an early age, and social skills, language development, capacity to concentrate and impulsivity.

Assessment of growth and weight development

- Assess growth patterns (head circumference, length/height and weight) based on what is expected from the percentile curves and the parents' measurements. Special attention should be paid to identifying risk factors for the early development of overweight, particularly an early tendency to overweight when the parents or siblings are overweight; [see the National guideline for weighing and measuring in the health centre and school health service \(Nasjonal faglig retningslinje for veiing og måling i helsestasjons og skolehelsetjenesten\)](#) and the [National guideline for the prevention, investigation and treatment of overweight and obesity in children and adolescents \(Nasjonal faglig retningslinje for forebygging, utredning og behandling av overvekt og fedme hos barn og unge\)](#).

Assessment of long-term or chronic diseases

- In the case of long-term or chronic disease, the doctor should ask the parents at every health check about nutritional problems, slow growth, late development and other indicators of impaired well-being of the child.

Assessment of child neglect and abuse

- At all consultations, the doctor should be alert to the possible presence of child neglect and abuse which can produce the same general symptoms and findings as chronic somatic diseases.
- In particular, the doctor should suspect neglect if a chronic disease has not been identified as the cause of the symptoms, if the child has or has had wounds, bruises or fractures, or injury to the genitals and oral cavity that otherwise cannot be satisfactorily explained or extensive caries. See also the recommendation on Violence, abuse and neglect.

Assessment of children with non-western background and low Hb

- Children with a non-western background can have low Hb without necessarily having iron deficiency or iron deficiency anaemia. These children could have **haemoglobinopathies** and will not benefit from iron supplements. If anaemia is suspected, the child should be referred to the GP for further investigations.

See also [the recommendation Collaboration between the public health nurse and the doctor](#).

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4.3 Home visits: A home visit by the public health nurse should be the first consultation in the health centre programme

Services offered by the health centre shall include home visits; see Section 2-3 of the Regulation on health centres and the school health service. Home visits to newborn children should be the first of a total of 14 consultations in the health centre programme for health centres 0-5 years.

The public health nurse should visit the home 7-10 days **postpartum**.

The objectives of home visits are:

- to provide parents with individual and necessary information, support and guidance based on need
- to establish early contact, preferably with both parents present
- provide the basis for further follow-up of the child and co-operation with the family

Rationale

Population

Populations with low socioeconomic status

Intervention

Home visit

Comparator

Standard service

Outcome

General safety and health

Evidence profile

Outcome	Confidence in estimates	Relative effect	Standard service	Home visit	Absolute difference	Participants (studies), follow-up
General safety and health		0 (CI 0 - 0)	0 per 1000	0 per 1000	0 fewer per 1000 (CI 0 - 0)	

Summary

The Norwegian Knowledge Centre for the Health Services searched for, critically evaluated, and graded available systematic high-quality reviews on the effect of interventions to adapt the health centre service or equivalent health services, for families with low socioeconomic status, ethnic minority families or teenage mothers, as well as reviews on the effects of measures to promote interaction with their child on mothers with postnatal depression (Mosdøl et al., 2014). Two systematic high-quality reviews, which reported the effects of the home visit programme on vulnerable groups, were identified in the report [The effect of adapted interventions for the health centre service \(Effekt av tilpassede tiltak for helsestasjonstjenesten\)](#) published by the Norwegian Knowledge Centre for the Health Services. One of the systematic reviews studied the effect on the incidence of injury and accidents, and the home environment (Kendrick et al., 2013), whilst the other reported the effect on uptake of childhood immunisation (Kendrick et al., 2000). No systematic reviews were found on home visits to vulnerable groups with other relevant outcomes. The systematic reviews included a total of 33 studies from USA, Australia, Canada, United Kingdom, Ireland, New Zealand and Turkey. In summary, the studies showed a reduction in the incidence of childhood accidents, but the effect on compliance with childhood immunisation was uncertain.

For a more detailed report on the effect estimates and grading of the quality of the documentation; see the report [The effect of adapted interventions for the health centre service](#) pp. 34-35, Tables 4 and 5.

Improving the quality of the home visit service

Quality criteria for increasing home visit coverage and scope could include strengthening professional reflection through evidence-based internal education. Other options include preparing

checklists/procedures for conducting home visits, reporting deviations, clarification of goals set by the societal remit on provision of equal services, as well as endeavours to achieve the goal of certification as a breastfeeding centre of excellence and to maintain certification requirements in the future.

The manner in which the public health nurse/midwife informs the parents about the home visit can influence whether or not they agree to a home visit. It is important to ask both parents to be present during the home visit. The role of Norwegian fathers as carers from immediately after the birth is one of the prerequisites for an equal society (Norwegian Ministry of Children, Equality and Social Inclusion 2008).

Home visit versus consultation at the health centre

To ensure early contact with families with newborns, some local authorities have placed a consultation at the health centre on a par with a home visit. A home visit and first contact at the health centre have been documented as the same type of contact in the records and have been reported to KOSTRA (Municipality-State-Reporting). Such a combination leads to inaccurate reports and an excessively high home visit cover. The definition of a home visit is that the visit actually takes place in the family home.

Rationale

The scope of this recommendation is based on regulations, research basis and the consensus of the working group.

The services provided by the health centre shall include home visits; see Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*). This mandatory home visit is recommended 7-10 days postpartum, and after the mother and child have returned home from the hospital. The health centre service shall offer information, advice and guidance, and this should be provided at the home visit; see Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*). [5]

In recent years, the length of the hospital stay has been reduced from about 5 days to between 8 and 48 hours postpartum for healthy mothers and their newborn babies. Early discharge from the maternity ward coincides with the normal period of uncertainty experienced by the parents in their new role as carers. More women are discharged before the production of breast milk has been established and before the baby is suckling satisfactorily. [60] During a home visit, the public health nurse will be able to get a more comprehensive view of the family's needs and challenges, and offer guidance based on the parent's actual everyday situation and the needs of the child.

The home visit is an offer to the family on their home ground. Shortly after the birth, a home visit is easier for the parents. They avoid the stress of getting to the health centre before they have become used to breastfeeding and taking care of the child. Home visits to all families can help avoid stigmatisation of certain groups.

Home visits to newborn babies can help strengthen bonding with the child and support parenting skills. For the majority of infants and their parents, bonding takes place intuitively, but some parents may need more advice and guidance to help establish bonds. A sound start can prevent abnormal development and neglect.

Home visits in an environment in which the family feels secure provides a particularly good opportunity for the early detection and identification of any need for support in addition to that contributed by family and social networks. During a home visit, the parents can bring up specific problems and receive guidance adapted for the actual situation.

The guideline's recommended topics for home visits are based on knowledge and experience of parents' wishes and needs.

See also the recommendations:

- [Parental mental health](#)
- [Parent education programmes](#)
- [Psychomotor development](#)
- [A tobacco-free environment](#)

- [Interaction](#)
- [Violence, abuse and neglect](#)

Home visits by the midwife

[The National guideline for postnatal care, New life and safe postnatal period for the family \(Nasjonalt faglig retningslinje for barselomsorgen, Nytt liv og trygg barseltid for familien, IS-2057\)](#), section 5.6 Home visits, states: “For women and their newborn babies for whom follow-up is considered to be as safe at home/locally as in the maternity ward, a home visit by the midwife is recommended within the first to second day after returning home. Women with positive experience from previous births, breastfeeding and the postnatal period will be offered a visit by a midwife on one of the first three days after returning home”.

This will primarily apply to postnatal women who return home shortly after the birth, and where there is considered to be a need for follow-up by a midwife in the days following. In municipalities that do not have an established service, follow-up in the home will not be considered equally safe. These women must be followed up at the hospital. A collaboration between the public health nurse and midwife is key to ensuring a good transition from the pregnancy and postnatal period to the newborn period. See the [National guideline for postnatal care \(Nasjonalt faglig retningslinje for barselomsorgen\)](#).

Practical information

The home visit to the newborn is a service offered to the family on their home ground and, whenever possible, should be made no later than 7-10 days postpartum. The home visit should be made regardless of how many previous children the family has.

- A time should be agreed with the parents, and they should be informed of the health centre’s service prior to the visit.
- It is preferable that both parents are present at the home visit.
- If the parents do not want a home visit, this must be documented in the child’s records.

The home visit should primarily offer the advice and guidance that is needed by the family, and on topics that the parents themselves wish to raise.

Collaboration with the midwife

The public health nurse should ensure a smooth transition from the antenatal and postnatal period to the newborn period and follow-up at the health centre, by exchanging information with the midwife as necessary. See [the National guideline for postnatal care \(Nasjonalt faglig retningslinje for barselomsorgen\)](#) for further information on home visits by the midwife and collaboration.

Scope of the home visit

The home visit should include discussion of at least the following topics:

- The parents’ physical and mental health – experiences of the birth, social network, parenting, their relationship, siblings, etc.; see [the recommendation Parental mental health](#)
- The transition from a couple to a family, concerns and joys surrounding parenting and division of tasks between the parents
- Breastfeeding or other infant nutrition
- The child’s sleep pattern
- Stimulating the child
- Interaction and the child’s need for affect-regulating support and care

- The parents' importance in development and interaction with the child
- Child accidents/injuries (hand out [brochures](#))
- A tobacco-free environment
- Alcohol and drugs

The following should be performed during the home visit:

- Observation of the child's well-being and weight gain.
- Weighing and measuring of the child's head circumference (in compliance with the [National guideline for weighing and measuring by the health centre and school health service \(Nasjonale faglige retningslinjer for veiing og måling i helsestasjons- og skolehelsetjenesten\)](#)).
- Observe and talk about the parents' sensitivity to and interaction with the child.
- Observation of the child's motor skills.
- Examination of the child's skin and umbilical cord stump.

The child should be completely undressed during examination and observation.

The public health nurse should be particularly aware of the following during the home visit:

- If the child is markedly yellow in colour, the public health nurse should immediately call the maternity ward so that the child can be taken either there or to their GP to have their bilirubin level measured.
- Children with chronic conditions may have the right to an individual plan. The public health nurse must contact the coordinating unit in the municipality; see the [General section: Management, steering and user participation](#) and [the recommendation Coordinating unit](#).
- The public health nurse must be aware of conditions that could necessitate a duty to report a concern to the Child Welfare Service; see the [General section: Duty of disclosure](#).

See also the recommendations [Interaction](#) and [Violence, abuse and neglect](#)

An interpreter must be used if necessary.

Breastfeeding

[The Norwegian National Advisory Unit on Breastfeeding](#) (*Nasjonal kompetansetjeneste for amming og NKA*) shall develop and disseminate knowledge on breast milk and breastfeeding. NKA's core work includes knowledge dissemination, follow-up of the Mother-Baby Friendly initiative in the primary and specialist health services, investigation of clinical problems, research and contributing to professional guidelines. Health professionals can contact NKA with questions for advice and guidance relating to breastfeeding.

If the mother wants or needs more guidance on breastfeeding, the public health nurse can also recommend that she contacts the [Breastfeeding helpline](#).

If there are problems breastfeeding, the tongue and lip frenula and the palate must be examined and, if necessary, assessed to determine whether follow-up by a GP is required.

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4.4 Oral cavity examinations: The health centre should examine the child's oral cavity

- Examination of the oral cavity should be carried out during the consultations at six weeks, six months, one year and two years.
- Examination of the oral cavity can be performed by the public health nurse or doctor.
- The health centre should ensure that the child is **referred** to the public dental health services if necessary.
- Motivation for and learning how to clean teeth and good dental health should be a central aspect of the examination.
- Oral cavity examinations require a **good and structured collaboration** between the public dental health services and the health centre. See [the recommendation The dental health service](#).

Key information

Advantages and disadvantages

Advantages:

The public health nurse has a good local knowledge, knows the family and, using this background, can adopt a preventive approach. Examination at the health centre will likely reduce social inequality in dental health.

The fact that the public health nurse performs the examinations and refers children to the public dental service can strengthen the collaboration between the two services.

It is natural for the public health nurse to provide information on dental health as part of the general health information provided to parents. Thus, parents avoid having to go with an infant to both the health centre and the dental clinic.

Disadvantages:

The quality of the examinations at the health centre may not be as high if there is poor collaboration with the dental health service. This necessitates that the public health nurse is competent in oral health.

The advantages are considered to outweigh the disadvantages.

Quality of the documentation

Low

Values and preferences

There is probably no uncertainty or variation regarding how people appreciate the most important outcomes. No important negative outcomes have been found.

Resource considerations

This initiative is in effect today. Better examinations at the health centre will require a little more time, but it is assumed these will help improve dental health, particularly among children who are at risk of developing caries.

The initiative is considered cost-effective.

Rationale

Population

Children 0-3 years

Intervention

Dental and oral cavity examinations by the public health nurse/doctor at the health centre

Comparator

Dental and oral cavity examinations by dental health professional

Outcome

Caries, oral disease, oral function

Evidence profile

Outcome	Confidence in estimates	Relative effect	Dental and oral cavity examinations by dental health professional	Dental and oral cavity examinations by the public health nurse/doctor at the health centre	Absolute difference
Caries, oral disease, oral function		0 (CI 0 - 0)	0 per 1000	0 per 1000	0 per 1000 (0 - 0)

Summary

The underlying knowledge is based on the guideline "Strategies to prevent dental caries in children and adolescents", pp 28-29, prepared by the Irish Oral Health Services Guideline Initiative in 2009, and a systematic review "The importance of preventive dental visits from a young age: systematic review and current perspectives" (Bhaskar et al, 2014).

Other health professionals' assessment of the caries risk

The research-based evidence for involvement of health professionals other than dental health professionals in caries risk assessment is limited. A systematic review which included two studies found that trained health professionals could identify infants with caries with almost the same accuracy as dental health professionals (Bader et al, 2004).

One systematic review (Bhaskar et al., 2014) included four studies from the USA. All studies used data from Medicaid to investigate whether early preventive dental visits resulted in fewer restorative treatments later. Only one of the studies had dental health (caries) as an outcome goal. The results from the four studies were inconsistent. One of the studies found that early preventive treatment resulted in fewer restorative visits; another found that children who received early preventive treatment had more restorative visits. One study found no difference in the number of later restorative visits between those who had early preventive visits and those who did not. The study that had caries as the outcome measures found no difference in the incidence of caries in the groups. Research-based evidence which supports that early preventive visits give fewer restorative treatments later, is limited.

[Documentation of search – Oral cavity examinations in infants 0-2 years \(PDF\)](#)

[Documentation of search for guidelines \(PDF\)](#)

Rationale

The scope of this recommendation is based on legislation, regulations, evidence-based research and the consensus of the working group.

The county authorities are responsible for the public dental health service which provides regular and outreaching services to children and adolescents from birth until 18 years of age; see Section 1-1 and Section 1-3(1)(a) of the Dental Health Services Act (*tannhelsetjenesteloven*). (48) In practice, the child's right to dental health help is attended to by the health centre until the child is three years old. If the health centre is to attend to the child's right to dental healthcare, it is recommended that the health centre performs four oral cavity examinations on children at six weeks, six months, one year and two years of age.

The public dental health service continues to have overall responsibility for provision of dental health services to children aged 0-3 years. If the health centre is to attend to the children's dental health in a satisfactory manner, the public dental health service and the health centre should collaborate to ensure that personnel at the health centre receive training and information sufficient to perform the recommended oral cavity examinations.

The health centre shall collaborate with the public dental health service; see Section 2-1 third paragraph of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*).[5] See [the recommendation The dental health service](#).

In accordance with the Dental Health Service Act (*tannhelsetjenesteloven*) requirement for regular and outreaching activities for children under three years of age, the public dental health service must work with the health centre to ensure that public health nurses and other personnel at the health centre receive guidance and education on dental health, and that parents receive information about the services to which children are entitled. See [the recommendation on collaboration with the health centre in the National guideline for the dental health service for children and adolescents 0-20 years \(Nasjonal faqlig retningslinje for tannhelsetjenester til barn og unge 0-20 år\) \(unpublished\)](#).

It is natural that dental health is integrated in the consultations in the health centre programme. Teeth are part of the body, and dental health must therefore be an integral part of health.

There is some evidence that health professionals with training can identify caries in infants with almost the same accuracy as dental health professionals (see Research basis). Personnel at the health centre have competence in health promotion and preventive work and often have a relationship with the child and family that is useful when evaluating measures.

Children start to get teeth from six to eight months of age and have all their milk teeth by about three years of age. It is important that twice-daily brushing of teeth with fluoride toothpaste is established from the time the first teeth erupt to stimulate good dental health habits.

Children and families with health problems or other challenges are often prone to dental diseases. The risk factors for developing caries and other diseases often coincide. It is important to ensure that these are identified at an early stage and referred to the dental health service as necessary.

Practical information

Oral cavity examination

Examination of the oral cavity can be performed by the doctor or public health nurse. Which person is to perform the examination at each of the four consultations should be decided in advance; see [the recommendation Collaboration between the public health nurse and doctor](#).

The public dental health service is responsible for providing professional support, training and guidance to personnel at the health centre. The public health nurse and doctor should contact the dental clinic if they have any questions.

The oral cavity examination should be performed in accordance with a dedicated procedure for dental and oral cavity examinations at the health centre:

At the 6week consultation:

Examine the mouth for fungal infection (thrush) and malformations.

If there are problems breastfeeding, the tongue and lip frenula and the palate should also be examined, and the need for follow-up by a GP should be considered.

At the 6month consultation:

Generally, at this age, the first teeth appear at the front in the lower jaw. The most important goal of this examination is to check whether any teeth have erupted and to show the parents how to clean them. The goal is to establish the habit of twice-daily tooth brushing with a barely visible amount of fluoride toothpaste.

At the 1year consultation:

By the age of one, all four front teeth have generally appeared, both top and bottom. The molars have generally not erupted. Examine whether there is visible plaque on the front of the front teeth in the upper jaw by lifting the child's upper lip. If necessary, use the non-pointed end of a toothpick and move it along the gum to look for plaque. Repeat on the lower jaw. Instruct the parents to brush the teeth twice daily with an amount of fluoride toothpaste corresponding to the child's little fingernail. If there are problems with tooth brushing and large amounts of plaque are visible, the child should be referred to the dental clinic. Also consider referring the child if the parents say there are any types of oral problems.

At the 2year consultation:

By two years of age, the canines and the first molars have normally erupted. Start the examination by lifting the child's upper lip to see whether there is visible plaque on the front side of the front teeth in the upper jaw. If necessary, use the non-pointed end of a toothpick and move it along the gum to look for plaque. Look at the molars and the mucous membranes. Refer the child to the dental clinic if you see caries or discolouration, or if there are any problems with brushing of the teeth and visible plaque. Instruct the parents to brush the teeth twice daily with an amount of fluoride toothpaste corresponding to the child's little fingernail.

Dental health information

The public health nurse or doctor should emphasise the importance of establishing good habits and twice-daily tooth brushing from eruption of the very first tooth. Teeth and dental health should also be discussed in conjunction with topics such as hygiene, eating habits and nutrition.

5 months – Diet and tooth brushing

- Dietary recommendations in accordance with national guidelines. Focus on limited sugar intake, amount and frequency. Water as a thirst-quencher.
- Brush teeth with fluoride toothpaste morning and evening after the first tooth has erupted. Use a barely visible amount of toothpaste on the brush. Focus on good dental health habits from an early age. See [the recommendation Diet](#).

6 months – Diet and tooth brushing as at five months

- Examination of the oral cavity and teeth.

8 months – Diet and tooth brushing

- Dietary recommendations in accordance with national guidelines. Focus on limited sugar intake, amount and frequency. Water as a thirst-quencher. See [the recommendation Diet](#).
- Brush teeth with fluoride toothpaste morning and evening after the first tooth has erupted. Use a barely visible amount of toothpaste on the brush. Challenges of tooth brushing in small children. Instruction in brushing technique. The dental clinic can give guidance.

10 months – Diet and tooth brushing

- Follow-up of information given at 8 months. Ask whether tooth brushing is going well.

12 months – Diet and tooth brushing Oral cavity examination

- Diet and *tooth brushing* as for 8 and 10 months. Amount of toothpaste corresponding to the child's little fingernail.

15 months – Diet and tooth brushing

- Follow-up of information given at 8 and 10 months.
- Eruption of the first milk molars is imminent. Talk about the importance of brushing the molars. Give instruction in brushing technique as necessary.

2 years – Diet and tooth brushing Oral cavity examination

- Follow-up of information given at 8 and 10 months.
- Eruption of the rear milk molars is imminent. Talk about the importance of brushing the molars. Give instruction in brushing technique as necessary.
- Examination of the oral cavity and teeth. Is there a need to refer the child to the dental health service?

Breastfeeding

There is no evidence that breastfeeding causes caries. Breast milk has a somewhat higher lactose content than cow milk, but lactose is less cariogenic than sucrose, glucose, fructose and inverted sugars. Saliva production decreases at night, which increases the risk of caries if sugars are ingested. Frequent breastfeeding or milk from a bottle at night should therefore be avoided once teeth have come through.

Dummy and sucking fingers

Children are born with a need to suck. If the child is weaned off the dummy too early, they may start to suck their fingers. This is not desirable, as it can be more difficult to wean finger-sucking.

The health centre should assess the child's maturity and the parents' motivation to support the child when weaning them off their dummy before the parents are encouraged to wean the child off their dummy.

When the child is three to four years old, the health centre should inform the parent's that sucking a dummy and fingers can cause an incorrect bite. How often and how long a dummy or finger is used greatly affects the extent of the incorrect bite. Use of a dummy or finger should be limited to bedtime.

From five years of age, the health centre should encourage weaning both dummy and finger-sucking.

Referral to the dental clinic

Children who need a consultation with a dentist or dental hygienist should be referred to the dental health service. There should be a low threshold for referral. All referrals should be followed up with a discharge summary sent by the dental health service.

The health centre should have a low threshold for referring the child to the dental clinic. The health centre should collaborate with the public dental service in the same county to ensure good referral routines; see [the recommendation The dental health service](#).

The health centre should refer the child to the dental clinic for cases of:

- pain from teeth or gums
- poor tooth brushing habits that the health centre has been unable to change,
- sugary drinks habit that the health centre has not managed to change,
- Visible plaque, discolouration or caries
- chronic diseases that could affect future dental health
- use of medications that contain sugar or result in a dry mouth

The health centre should also be aware of and consider referral for:

- children of parents with a serious somatic disease, drug addiction or mental illness; see the recommendation Children of parents with mental illness, drug addiction or serious somatic disease should be the focus of considerable attention in the National guideline for dental health services for children and adolescents (*Nasjonal faglig retningslinje for tannhelsetjenester til barn og unge*) (unpublished)
- children from families with known risk
- children from families with immigrant background; see the recommendation Children with immigrant background should be the focus of considerable attention in the National guideline for dental health services for children and adolescents (*Nasjonal faglig retningslinje for tannhelsetjenester til barn og unge*) (unpublished)

For more information on referral criteria; see [Criteria for referral from the health centre to the dental health service](#).

A referral form has been prepared for use when referring children to a dental clinic:

- [Proposed form for referral from the health centre to the dental health service \(DOC\)](#)

The number of two-year old children who are referred to the dental health service from the health centre must be reported in KOSTRA.

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4.5 Group consultations: The health centre should offer all parents the opportunity to take part in group consultations

The health centre should offer all parents the opportunity to take part in group consultations in addition to individual consultations.

Parents who decline to take part in group consultations should be offered individual consultations instead.

Wherever possible, parents should be offered the opportunity to take part in group consultations at **4 weeks, 4 months and 17-18 months**. In addition, the health centre can offer group consultations **at 5 months and either 8 or 10 months**, instead of individual consultations.

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

The services for children and families provided by the health centre shall include the provision of information and guidance, individually and in groups; see Section 2-3 of the Regulation on the health centre and school health service (*forskrift om helsestasjon- og skolehelsetjenesten*). [5]

Group consultations give parents the opportunity to support each other and learn from each other's experiences. This can help create a social network. The purpose of a group-oriented service in the health centre is to enable parents who are in the same situation to acquire insight, understanding and parental skills. Groups can thereby provide increased scope for user participation and peer initiatives.

The parents themselves should be the most important resource in the group, both in regard to knowledge on own children and practical knowledge about caring for a baby. Parents often have a strong need to exchange experiences and knowledge concerning children. Together with other parents, they can find solutions that can be useful. [67]

Some parents can have a greater benefit from this type of service, for example first-time mothers, single parents and families who have recently moved into the area.

It is important that there are regular and systematic individual health checks, both physical and psychological, to enable follow-up of the child. Some situations can be difficult to manage in groups, not only for the parents but also for the health professionals. This applies to issues that the parents do not wish to share with others, such as concerns about the parents' health, life situation, observed interaction problems or indications that the child is developing atypically. [66] If there is a need for individual consultations in addition to group consultations, the parents should be offered this.

Parent education programmes can be used in groups; see [the recommendation Parent education programmes](#).

Practical information

The health centre must consider offering group consultations versus individual consultations based on **the users' needs, number of births followed by the centre and language barriers**.

Groups should be run systematically and with clear goals. The health information and choice of topics should consider needs, the wishes of the parents, and local circumstances.

Health professionals at the health centre shall inform parents that group consultations are voluntary and that parents can be offered individual consultations instead. If health professionals consider that there is a need for an individual consultation in addition to participation in group consultations, parents must be informed of this prior to the group consultation.

Some groups meet in private homes and have good experiences with this. For each group, the health centre should consider whether the group should be encouraged to meet in addition to the scheduled group consultations.

The health centre may also facilitate the establishment of, for example:

- postnatal groups
- father groups
- networking under the auspices of voluntary organisations

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4.6 Diet: The health centre should provide guidance on diet adjusted for each child and family

The health centre should assess the child's diet and provide advice that is appropriate for each child and each family.

The health centre should **assess and provide advice** on the child's diet from the time the child is born. What the child eats and drinks during a typical day should be assessed through talking with the parents.

Such an assessment will provide the health centre with the best foundation for providing **individualised advice** based on [the National guideline for infant nutrition](#) and [The Directorate of Health's Dietary recommendations](#).

The assessment will facilitate the detection of any challenges associated with food and mealtimes.

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

The purpose of the health centre service includes promoting mental and physical health and preventing disease and injury; see Section 1-1 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*). [5] Furthermore, the health centre shall contribute to the creation of a good environment in which the child can grow up, in part through measures to strengthen the parents' parenting skills (Comments on Section 1-1 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*)). Diet and meal habits are important elements in a healthy and safe childhood, and the health centre should therefore provide

parents with the information they need to make good choices regarding food and diet for their children.

Children are dependent on a regular supply of energy and nutrients to grow and develop. They need a lot of nutrients relative to their weight, and therefore need frequent meals.

Children who have a nutritionally poor diet with high sugar intake over longer periods of time have a poorer basis for good health and development. In the short term, this can result in poor functioning in daily life. In the longer term, it can result in poor dental health and overweight. Advice on the need to restrict sugar intake is therefore important in the early establishment of healthy eating habits.

Routine weighing and measuring of the child from birth until the consultation at four years of age shall be performed at the health centre. To prevent serious atypical development, it is important to detect difficulties and symptoms at an early stage to prevent overweight, malnutrition and incorrect nutrition; see [the National guideline for prevention and treatment of overweight children \(Nasjonal faglig retningslinje for forebygging og behandling av overvekt barn\).](#)[70]

The authority's dietary recommendations are based on the Nordic Nutrient Recommendations (NNR 2012): The following Norwegian recommendations have been drawn up based on NNR 2012:

- [The Directorate of Health's dietary recommendations \(Helsedirektoratets kostråd\) \[71\]](#)
- [The Directorate of Health's Recommendations on diet, nutrition and physical activity \(Helsedirektoratets anbefalinger om kosthold, ernæring og fysisk aktivitet\) \[72\]](#)

In addition, the Dietary recommendations for the promotion of public health and prevention of chronic disease – Methodology and scientific knowledge basis (*Kostråd for å fremme folkehelsen og forebygge kroniske sykdommer – Metodologi og vitenskapelig kunnskapsgrunnlag*) is also used as a basis for the Directorate of Health's dietary recommendations.

Practical information

Conducting the diet consultation

Food intake should be assessed by asking questions about what the child eats and drinks during a normal day/24 hour.

The consultation should cover the following topics:

- breastfeeding, breast milk substitutes and introduction of solid food (see the [National guideline for infant nutrition \(Nasjonal faglig retningslinje for spedbarnsernæring\)](#))
- choosing foods (including product types and food preparation),
- amount of food and portion sizes
- mealtime rhythm
- meal timing
- mealtime setting (the meal's social function)
- challenges associated with eating

Open questions should be used when establishing the child's dietary history to obtain the best possible overview of the family and child's eating habits. More information on assessing food habits and mealtimes can be found in *The Diet Handbook (Kosthåndboken)* [68]:

- Assessment of energy, protein and fluid needs as well as taking the diet history; see [Chapter 9 of The Diet Handbook \(Kosthåndboken\)](#)
- More about diet for premature babies, infants and children in [Chapter 4 of The Diet Handbook](#)
- More about nutrition work in the health centre and school health service in [Chapter 6 of The Diet Handbook](#)

Suspected eating disorders/poor nutrition

If eating disorders and/or poor nutrition are suspected, possible underlying factors should be assessed in addition to establishing the dietary history, e.g.:

- gastrointestinal problems (diarrhoea/constipation)
- ongoing medical investigations and treatment
- poor oral and dental status,
- swallowing problems, eating difficulties,
- social and cultural factors
- food sensitivity and allergies

This list is not exhaustive; see also overview of factors that can affect food intake in [The Diet Handbook, p. 277](#)

If the assessment detects conditions that should be investigated further and/or treated, the child should be referred to the GP; see [the recommendation GPs](#).

A clinical nutritionist in the specialist health service may also be contacted. The specialist health service has a duty to provide guidance for health professionals in the municipality; see Section 6-3 of the Specialist Health Service Act (*spesialisthelsetjenesteloven*). [37]

If the municipality employs a clinical nutritionist, the public health nurse can work with them.

If possible, a clinical nutritionist should be involved in individual approaches to the child in cases of selective eating, lack of growth, overweight, allergy, intolerance, reflux or nutrient deficiency. If necessary, the child should also be referred to the GP.

In the interdisciplinary team, clinical nutritionists can be important contributors within training and as a resource for other health professionals.

Advice on diet and mealtime habits

0-1 years of age: See the [National guideline for infant nutrition \(Nasjonalt faglig retningslinje for spedbarnsernæring\)](#)

From 1 year of age, the child can eat the same as the rest of the family. [The Directorate of Health's recommendations for a good and varied diet is recommended](#). The child can continue to receive breast milk after 1 year of age

The mealtime as a social arena

Taking part in shared meals with good role models promotes good eating habits. Attitude to food and meals is influenced by the experiences a child has at mealtimes. Children aged 1.5 - 5 years are interested in what other people eat. Thus, shared meals and the people who dine with the children are important in helping the child to learn how to eat and in establishing good dietary habits. Meals are an important learning arena for developing social competence and cultural understanding. Children need pleasant surroundings and structure around meals not only in order to consume the food and drink they need, but also so that they learn to take the time to eat properly and appreciate meals as a social event.

Taste development

The introduction of foods to infants can influence taste preferences and diet as an adult. From 1.5 to 5 years of age, children establish their own personal taste preferences.

Dietary recommendations

The diet should be varied and composed of wholemeal products, lean dairy products, fish, beans, linseed and peas, vegetables, fruit and berries and limited amounts of processed meat, red meat, salt and sugar. Choose water as a thirst quencher and keep sugary drinks for special occasions.

The Keyhole label makes it easier to choose healthy alternatives when shopping. [The recommendations and the brochure entitled Small steps, big difference - advice for a healthier diet \(Små grep, stor forskjell – råd for et sunnere kosthold\)](#) present all the dietary recommendations.

Cow's milk

Children younger than 1 year old should not drink cow's milk. Cow's milk and cow milk products are an

important source of energy, protein, calcium and other nutrients in the Norwegian diet. However, cow's milk contains little iron, and use of cow's milk in infants can increase the risk of iron deficiency by displacing more iron-rich food from the diet. See the section below on iron.

It is recommended that the introduction of cow's milk as a drink and in porridge be postponed until 12 months of age. Small amounts of cow's milk may be used in cooking towards the end of the first year - from about 10 months of age. Children may be offered yoghurt and soured milk, preferably the type without addition of sugar, together with corn products or as a dessert.

From one year of age, semi-skimmed milk with varying fat content or skimmed milk is recommended if the child is growing normally. Low-fat milks rather than whole milk are recommended to reduce the amount of saturated fat, and to imprint healthy food habits at an early age. Young children should consume limited amounts of cow's milk and cow milk products to avoid displacing iron-rich foods from their diet. Children should be offered a maximum of 5-6 dl per day, including yoghurt.

Iron-rich diet

It is very important that supplementary feeding contains sufficient iron with good bioavailability to ensure an adequate intake of iron from age six months to one year. In addition to iron-fortified porridge, meat (including offal), wholemeal bread and corn products are good sources of iron. Iron in meat and fish (haeme iron) is taken up more efficiently by the body than iron in corn products and other plant foods (non-haeme iron). The uptake of non-haeme iron is promoted by vitamin C and a factor in meat, fish, and seafood when this is consumed in the same meal. Intake of meat has been shown to have a positive effect on the iron status of infants.

In Norway, we have a long tradition of recommending the use of iron-fortified porridge for infants. Studies have shown that iron-fortified children's porridge can prevent development of iron deficiency in children.

Vitamin D

Vitamin D is recommended as a supplement from four weeks of age, in the form of either cod liver oil or vitamin D drops.

Relevant links

- [Nasjonal faglig retningslinje for spedbarnsernæring \(National guideline for infant nutrition\)](#)
- [Nasjonal faglig retningslinje for barselsomsorgen \(National guideline for postnatal care\)](#)
- [Nasjonal faglig retningslinje for veiing og måling i helsestasjon og skolehelsetjeneste \(National guideline for weighing and measuring in the health centre and school health service\)](#)
- [Nasjonal faglig retningslinje for mat og måltider i barnehage \(National guideline for food and meals in kindergartens\)](#)
- [Bra mat i barnehagen \(Good food in kindergartens\)](#)
- [Nasjonal faglig retningslinje for forebygging, utredning, og behandling av overvekt og fedme hos barn og unge \(National guideline for prevention, investigation and treatment of overweight and obesity in children and adolescents\)](#)
- [Kosthåndboken \(The Diet Handbook\)](#)

Examples of tools that can be used:

- The Norwegian Cancer Society's guides [Gode vaner for god helse – barn, kosthold og fysisk aktivitet \(Good habits for good health – children, diet and physical activity\)](#)
- [Kostholdsplanleggeren – et kostholdsverktøy fra Mattilsynet og Helsedirektoratet](#) (The Diet Planner – a dietary tool from the Norwegian Food Safety Authority and the Directorate of Health)
- In cases of overweight and/or obesity, the [Diet Tool](#) can be used

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4.7 Psychomotor development: Parents should receive information and guidance on their child's psychomotor development and physical activity

The public health nurse should give parents information and guidance on normal child psychomotor development. In addition, the public health nurse should give advice on activities that promote the child's psychomotor development, and on the importance of the child being physically active.

The topics **should be addressed regularly** both at individual consultations and at group consultations.

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

The purpose of the health centre service is to promote mental and physical health and to prevent disease and injury; see Section 1-1 of the Regulation on health centres and the school health service. [5] Advising parents on normal psychomotor development and the importance of physical activity in promoting psychomotor development is central in the health promotion and preventive work of health centres.

Psychomotor development

A child's development is often described using a number of factors such as language, social and emotional competence, and cognitive and motor skills. This is acceptable in theory but, in practice, all these factors are mutually dependent if the child is to develop age-appropriate skills. A child's psychomotor development is closely interwoven with the feeling of being a separate person – the experience of "the self". This development occurs in close interaction with the parents. The younger the child, the more closely all development processes are interlinked. Studies show a clear relationship between motor development, cognitive development, social development and language development. Providing information on the importance of movement and psychomotor development at consultations at the health centre is therefore important to strengthen the parents' parenting skills, and thereby contribute to a good environment in which the child can grow up (Comments on Section 1-1 of the Regulation on health centres and the school health service).

Psychomotor development involves changes that occur over time. Development of psychomotor skills throughout infancy and childhood are interlinked and are affected by several factors, from the characteristics of the child to the child's social context. Psychomotor skills are important enabling the

child to participate and function in social situations, play, learning and development, and they help to reduce overweight in children. To promote optimal motor and cognitive development, it is important that various types of atypical development are detected as early as possible. [74]

Physical activity

Regular physical activity is necessary for normal growth and development in children and adolescents (Meen, 2000). [75] Through experiencing its body in various activities, the child investigates details and qualities of movement such as speed, strength, endurance and moveability. [76] Being sufficiently physically active during childhood prevents diseases and problems during childhood and later in life.

Practical information

Public health nurses shall have knowledge on psychomotor development, including:

- age-appropriate gross and fine motor development, including motor development in relation to cognitive and social development
- signs of atypical development
- measures to promote activity and psychomotor development in the child

If it is discovered that the child's psychomotor development deviates from normal, the child should be examined by a doctor and/or physiotherapist at the health centre. Whether the child should be referred for further investigations should also be assessed.

Physical activity in the child

The public health nurses should provide information on how parents can promote the psychomotor development of their child through physical activity.

Physical activity for children from 0 to 2 years:

The parents should be given information on the importance of providing the child with challenges that stimulate learning and psychomotor development.

The parents should be encouraged to let the child:

- Have freedom to move.
- Lie on their stomach, lift their head, roll from their stomach to their back, and vice versa.
- Move around on the floor, roll, pull along, crawl, climb and jump.
- Stand and walk - from stumpy toddling to free diagonal gait.
- Try to throw and catch objects.
- Run, try to hop, practice basic types of movement.
- Explore the surroundings helped by an adult.
- Go for walks close to home, in the woods, outdoors and indoors bathing, explore the terrain and ground in different seasons – snow, ice, moss, roots, grass, asphalt, beach.
- Play with a ball, climb up, jump down, slide.

Physical activity for children from 2 to 5 years:

From 2 to 5 years of age, children develop greater control of their bodies. Public health nurses should encourage the parents to be active with their child.

Together, children and parents should:

- Train carrying things, running, jumping with legs together, hopping and rolling.
- Train balance, rotation, throwing and catching objects to acquire control of their movements.
- Provide movement experiences in a varied physical environment, outdoors and indoors.
- Be involved in play and varied physical activity.
- Go for walks close to home, in the woods, outdoors and indoors bathing, explore the terrain and ground in different seasons.

(Norwegian Directorate of Health, 2014)

See the Directorate of Health's [National recommendations on physical activity for children 0-5 years of age \(Nasjonale anbefalinger om fysisk aktivitet for barn 0-5 år\)](#).^[73]

The role of the physiotherapist

Physiotherapists have specific competence on the importance of psychomotor development/physical activity in infants and toddlers. Physiotherapists should take part in the health promoting and preventive work at the health centre; for example, in group consultations at 4 months of age, and in the system-focused collaboration with personnel at the health centre to quality assure various topic areas and advice for the different age groups. Collective educational seminars on physical health can be organised for all personnel who work at the health centre.

See also [the recommendations Group consultations](#) and the recommendation [Physiotherapist](#).

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4.8 Physiotherapist: The public health nurse and doctor should collaborate with the physiotherapist

The public health nurse and doctor should collaborate with the physiotherapist in particular on the child's motor development, and on identifying and following-up a child with atypical movement development. See [the recommendation Psychomotor development](#).

A formalised collaboration between the professional groups in the health centre service can strengthen the health-promoting and preventive work, both at the individual and system level, and contribute to identifying delayed and atypical movement development.

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

Physiotherapists are recommended as a part of the personnel at health centres, in the school health service and youth health centres; see [the recommendation Psychomotor development](#) (Comments on Section 2-1 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*)).

The health centre service shall among other things offer information, guidance and advisory services; see Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*). [5] Central topics include physical and mental development, play and movement development and physical activity (Comments on Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*)). Physiotherapists have specialist expertise in these areas and can ensure that the health centre provides good advice to parents.

Assessment of age-appropriate motor development necessitates sufficient competence in this subject, as

well as a close partnership between the professional staff affiliated with the health centre. Physiotherapists have the competence necessary to assess the locomotor organs, motor development and physical expressions of mental problems.

A formalised collaboration between professional groups can strengthen the health promoting and preventive work, at both individual and system level. Furthermore, this could be one of several measures to ensure early intervention. Early intervention is comprised of multidisciplinary measures to promote health and well-being in the child, limitation of developmental delay and function impairment, prevention of loss of functionality, promotion of the parent function and general family interaction. [79]

Delayed development or atypical development will be identified in about 5% of all children under 5 years of age. Children do not grow out of these problems, although the symptoms may become milder as they get older. Studies have shown that, without intervention, a child will continue to experience problems ten years after their initial assessment/testing. [80] [81]

Several studies show a clear relationship between motor development, cognitive development, social development and language development in children (Carlberg 2002 in Bechung p. 56).

There may be many reasons why overweight children can experience problems developing motor skills. Health professionals should intervene at an early stage with dietary advice and measures that promote the child's opportunities for motor development and activity in daily life. Guidance on recommended diet and measures that promote motor development and activity can be provided in the home. See the recommendations [Psychomotor development](#), [Diet](#) and [Kindergartens](#).

Practical information

Examples of areas in which collaboration should be considered:

- Physiotherapists can participate together with the public health nurse in **the recommended group consultations**, for example the group consultation at four months, so that they can help strengthen the parents' skills with simple measures that promote motor development and physical activity. See [the recommendation Group consultations](#).
- **Planning and conducting consultations** in groups or individually can take place as a collaboration between the public health nurse and physiotherapist and doctor, if necessary.
- Physiotherapists should participate in the **process of assuring quality standards in areas** in the health centre programme where the physiotherapist's skills are pivotal, e.g. in the areas of psychomotor development and physical activity. See [the recommendation Psychomotor development](#).
- **Collective competence seminars** on physical health can be organised for all staff who work at the health centre.
- If a public health nurse or doctor identifies **atypical motor development** or other challenges in the child, they should involve the physiotherapist at the health centre.

The management at the health centre should ensure that the physiotherapist is included as part of the team in the service (see [the recommendation Competence](#)) and ensure that the service enables the public health nurse, doctor and physiotherapist to work together.

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4.9 Sexual development: Parents should be given guidance on children's natural sexual development

The health centres should provide guidance so that parents are sufficiently well-informed to be able to talk to their children about bodies, gender and sexuality, safety and boundaries.

Guidance on sexual development **should be provided at the 2- and 4-year consultations.**

The guidance should serve to:

- **Boost the child's conceptual apparatus, self-awareness, self-esteem and respect for identity, body and boundaries.** This enables the child to distinguish between positive and inappropriate touching. The confidence to confide in a trusted adult is important in preventing child abuse.
- **Boost parental knowledge and awareness of children's natural sexual development and how this is expressed in play and general behaviour.** This enables parents to distinguish between natural sexual development and sexual behaviour that may be cause for concern.

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

Health centre services shall provide advice, information and guidance; see Section 2-3 of the Regulation on health centres and the school health service) [5]. Sexuality, play, motor development and social skills are some of the key topics to be covered by the information, advisory, and guidance services (Comments on Section 2-3 of the Regulation on health centres and the school health service). Counselling parents on the child's sexual development will boost parenting skills and help to create a safe and nurturing environment for childhood development (Comments on Section 1-1 of the Regulation on health centres and the school health service).

The basis for sexual health is established in early infancy. Young children discover and explore their own sexuality, gender identity and sexual identity, and ask questions about bodies, gender and reproduction from the age of three to four. An understanding of bodies, emotions and relationships is important for the child's self-management and self-efficacy related to their own personal health and builds a foundation for a healthy lifestyle and healthier life.

Parents are important in fostering a healthy and secure sexuality in the child. [84] They should be encouraged to talk to their child about bodies, identity and sexual development in every phase of childhood and adolescence. Confident and knowledgeable parents will mirror and regulate all feelings, including sexual feelings, making them comprehensible, manageable and real to the child. [85]

A positive attitude towards, and respect for, one's own body, makes it easier for a child to distinguish between positive and inappropriate touching and can lower the threshold for confiding in a trusted adult about offence or abuse. [83] Adults should give children positive messages, but also teach them to speak out if they are at risk of abuse and exploitation.

Article 12 of the UN Convention on the Rights of the Child affirms the right of the child to be heard. [13] In order to exercise this right, it is important that children are able to talk about complex issues, including sexuality, boundaries and gender identity. It is thus important for the child to learn from an early age to name parts of the body and know the basics of sexuality and reproduction. Children must have the ability to signal their own boundaries and to respect those of others.

A secure and well-adapted child will be curious about his or her surroundings and keen to explore them.

This exploration also includes other children's bodily sensations. Learning to respect other people's bodies and boundaries is crucial in preventing abuse. A knowledge of the human body, a positive body-image and a positive attitude to sexuality are key factors in the development of a secure sexual identity and more confident and secure sexual behaviour in adulthood.

Practical information

- Key milestones in childhood sexual development are the child's own perceptions, experiences and awareness of his or her own body, boundaries and attachment.
- Guidance should **focus on sexual and relational development** at both the 2- and 4-year consultations.
- This guidance entails familiarity with the child's development.

2year consultation

- The session with the parents should cover topics relating to **natural sexual development** and the child's **exploration** and experience of his or her own body and bodily functions as well as the parents' responsibility for teaching the child about **intimate boundaries**.
- The parents should be made aware of the importance of the child acquiring early conceptual apparatus and **learning to name the parts of the body**.
- Nappy changing and potty/toilet training are good settings for observation and conversation.

4year consultation

- The session with the parents should cover topics concerning **sexual play**. Children use play to explore their own and other children's bodies, including their genitals, as a natural part of their development from infancy. They should have the opportunity to experiment, explore and be themselves without feeling stigmatised.
- The guidance should also encourage parents to **teach children to set boundaries** for their own body, and about the difference between positive and inappropriate touching.
- From age 4, topics relating to **gender identity and sexual orientation** can also be included.
- From age 3 to 4, children begin increasingly to make their own circle of friends and acquaintances. Sexual curiosity and curiosity about other children's bodies may arise when playing with friends. Discussions concerning friendship and emotional well-being may be a good context for raising the topic of sexual development.

Relevant documents

- [Snakk om det! Strategi for seksuell helse 2017-2022 \(Strategy for sexual health 2017-2022\)](#)
- [Trygghet, mangfold, åpenhet - Regjeringens handlingsplan mot diskriminering på grunn av seksuell orientering, kjønnsidentitet og kjønnsuttrykk 2017 – 2020 \(Safety, diversity, openness. The Norwegian Government's action plan against discrimination based on sexual orientation, gender identity and gender expression 2017–2020\)](#)

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4.10 A tobacco-free environment: The health centres should provide parents with information and guidance on the child's right to a tobacco-free environment

- Parents should be given information about the child's right to a tobacco-free environment, and on help to quit tobacco-use/smoking.
- The topic of tobacco-use should be raised **at the first consultation**; see [the recommendation Home visits](#). Based on this, health professionals should **assess** at which subsequent consultations this topic should be addressed.
- Health professionals at the health centres can raise the topic of tobacco-use both in individual and group consultations; see [the recommendation Group consultations](#).

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

The objective of the health centres and school health service is to promote physical and mental health, promote good social and environmental conditions and prevent illness and harm; see Section 1-1 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*). [5] Informing parents about aids for quitting tobacco-use, and providing parents with information to ensure that children are not adversely affected by parental tobacco-use is thus a primary task for the health centres.

Children also have a statutory right to a smoke-free environment, and those who have children in their care have a duty to ensure that this right is respected; see Section 28 of the Act relating to prevention of the harmful effects of tobacco (*tobakksskadeloven*). [88] One of the main goals of the National strategy for tobacco control 2013-2016 (*Nasjonal strategi for arbeidet mot tobakkskader 2013-2016*) is to prevent young persons from starting to use tobacco products.

Tobacco products are defined as products that can be smoked, sniffed, sucked or chewed, provided that they consist entirely or partially of tobacco.

On average, the children of mothers who smoke have a lower birth weight and are at greater risk of SIDS and developing asthma. Infants exposed to passive smoking are at greater risk of SIDS, regardless of whether the mother smoked during pregnancy. [89]

Being exposed to passive smoking means that a person breathes in air contaminated by tobacco smoke. Passive smoking results in inhalation of the same substances that are present in active smoking. Tobacco smoke consists of a complex mixture of between 4,000-7,000 different chemical substances, 50-70 of which are potential carcinogens. At least 80 per cent of the harmful tobacco smoke is invisible. [86]

Passive smoking is especially harmful for young children. Tobacco smoke impairs lung function and makes the mucous membranes in the airways more susceptible to infection. Children who do not grow up in a smoke-free indoor environment consequently suffer more frequent airway infections such as bronchiolitis, bronchitis and pneumonia, and recurrent ear infections. [87]

Passive smoking can have both short-term and long-term adverse health impacts on children. Some of the commonest short-term impacts are less severe symptoms such as persistent cough, eye irritation and shortness of breath.

Practical information

Parents should receive information on:

- The right of the child to a smoke-free environment
- The harmful effects of passive smoking
- The need for any smoking to take place outdoors, and not indoors by an open window or under an extractor fan
- Parental responsibility for keeping oral tobacco pouches out of reach of the child if the parents use oral tobacco

The public health nurse and doctor should provide information about **where the parents can get help to quit smoking/taking oral tobacco**, including:

- The collection of information on how to stop smoking and oral tobacco use at [Helsenorge.no](https://helsenorge.no)
- The Directorate of Health's *Slutta* (Quit) app
- Local courses on stopping smoking and oral tobacco use, e.g. as provided by the municipal healthy lifestyle centres

Relevant links

- [The Directorate of Health's site on tobacco, including smoking and oral tobacco](#)
- [Helsenorge.no on the benefits of stopping smoking](#)
- The Directorate of Health's stop smoking campaign publications can be posted in waiting rooms:
- [Hva skjer i kroppen når du kutter røyken? \("What happens to your body when you quit smoking?"\)](#)
- [Det du ikke ser – om barn og passiv røyking \(What you don't see - about children and passive smoking\)](#)
- [Nasjonal faglig retningslinje for røykeavvenning \(the National guideline for stopping smoking\)](#)

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4.11 Follow-up home visits: Health centres should consider home visits as follow-up measures for families with extra needs

- Health centres should consider home visits **as part of an extended follow-up service** for families with extra needs.
- A home visit may encourage more contact and trust, and is an opportunity to observe skills and interactions between the child, siblings and parents in their normal setting.

Rationale

Population

Mothers and children in the postnatal period

Intervention

4-6 home visits

Comparator

1 home visit

Outcome

Children's mental and/or physical health, parental satisfaction

Evidence profile

Outcome	Confidence in estimates	Relative effect	1 home visit	4-6 home visits	Absolute difference
Children's mental and/or physical health, parental satisfaction		0 (CI 0 - 0)	0 per 1000	0 per 1000	0 per 1000 (CI 0 - 0)

Summary

The Knowledge Centre for the Health Services searched for, critically assessed and graded the high-quality systematic reviews that exist on home visits and parent education programmes which are assessed as relevant for Norway's health centres (Vist et al., 2015). One systematic review (Yonemoto et al., 2013) summarised the effects of various home visit schedules during the early postnatal period ([Background documentation for the 2015 National guideline for health centres](#)). This systematic review included multiple comparisons, where comparisons of several versus only one home visit for mothers and children in the early postnatal period were relevant to the problems addressed by the PICO process. The problems were elucidated by three randomised controlled primary studies from Syria, Zambia and Northern Ireland. The population was limited to normal, healthy children. The studies from Northern Ireland additionally excluded high-risk mothers (with a family background of domestic violence, substance abuse, mental health issues). In the studies from Syria and Zambia, the women had limited access to health care other than the home visits they received through the studies.

The effects were reported in terms of several outcome measures. The documentation compares multiple home visits with a single home visit. It indicates that:

Multiple home visits have a slight effect on:

- Increased average score for maternal satisfaction with postnatal care and services (GRADE: low quality).
- Reduced use of other child health services (GRADE: low quality).
- Increased proportion of children exclusively breastfed at age six months (GRADE: low quality)

Multiple home visits have negligible or no effect on:

- Severe maternal health problems (GRADE: moderate quality)
- The proportion of mothers who were satisfied with postnatal care and services (GRADE: low quality)
- Frequency of airways infections in the child (GRADE: low quality)
- Neonatal mortality (GRADE: Low quality)

We have insufficient evidence as to whether multiple home visits have an effect on:

- Maternal mortality up to 42 days postpartum (GRADE: very low quality)

For more detailed reporting on estimated effects and the grading of the quality of the evidence; see pp. 19-20, Table 3 of the report.

Rationale

The scope of this recommendation is based on regulations, research basis and the consensus of the working group.

The services of the health centre should include home visits; see Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*). [5] In addition to the home visit 7-10 days postpartum, home visits should be granted to families with special needs.

Summarised international research

Systematic reviews of international research indicate that multiple home visits undertaken as a universal service may have some beneficial effects, compared with a single home visit for individual outcomes; see more under Research basis. [90] However, the systematic review relied on in the report includes no studies of Norwegian health centre services. The studies included originate from countries in which both the health service and the population are not regarded as being directly comparable with the Norwegian population. [63]

In addition, the Norwegian Knowledge Centre for the Health Services' report, which is based on a summary of international research on home visit schedules for at-risk groups, points to an effect on the reduced incidence of accidents affecting children; see Research basis. [59] Home visits may thus be a measure for providing equitable healthcare services. The effect on completing the child vaccination schedule is uncertain, and reports on other relevant outcome measures are lacking. [59] The systematic review that reports on the effect of the child vaccination schedule includes studies from countries with populations that are not directly comparable with the Norwegian population. [62] In addition, the scope of the home visits in the interventions tested in the studies is both more comprehensive and involves more complex interventions. The standard health care service that serves as the comparator is judged to be relatively dissimilar to the Norwegian service.

The findings on outcomes are thus not directly applicable to the home visit schedules employed by Norwegian health centres.

The available evidence from the summarised research above points to some possible beneficial outcomes, but confidence in the results is uncertain, including their applicability to Norwegian circumstances (GRADE: low), and the documentation does not include all the relevant outcome measures. This emphasises the need for research on Norwegian health centre services comprising home visits as both a universal service and as an extended service to at-risk groups.

Practice-based knowledge

Practice-based evidence indicates that service users/families with extra needs may benefit from home visits.

Through regular contact with families, the public health nurse is in a unique position to undertake preventive intervention at an early stage. A home visit provides a better setting for achieving contact and trust with the family and the child than normal consultations, and is also an opportunity to observe skills and interactions between the child, siblings and parents in their normal setting. For the family, a consultation with a health professional in their own home may be more reassuring and less stressful than an appointment at the health centre.

Follow-up home visits in addition to the recommended visit 7-10 days postpartum should be considered if the health centre judges that the child/family has a special need for help and parenting support measures.

Home visits should also be considered as an intervention if parents fail to attend appointments with their child at the health centre, as non-attendance is a common reason for a letter of concern being sent to the Child Welfare Service.

Practical information

The health centre should assess home visits as part of an extended follow-up service for families with extra needs.

Examples of situations where the health centre should assess the need for home visits (not an

exhaustive list):

- Where the mother has breastfeeding problems
- For families who have just moved to the municipality
- For minority-language families/families who have just arrived in Norway
- If the child is adopted
- In the event of serious crises, including severe illness or death
- In case of non-attendance by a child and its parents
- At the parents' request

The family must receive advance notification of the home visit and the public health nurse should involve the family in her assessment of whether they are to be offered extra home visits. The public health nurse should plan the home visit carefully in terms of topics, observation and screening following a professional assessment.

The duty of disclosure to the Child Welfare Service arises if there is concern about a child's care situation or violence in the family. See [the General section: Duty of disclosure](#).

The public health nurse should also consider whether home visits should be undertaken jointly with other professionals, such as a physiotherapist or psychologist; see [the recommendation Physiotherapist](#) and the General section: [Collaboration and co-operation](#).

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4.12 Interaction: Parents should be given guidance on interaction at all consultations in the health centre programme

Interaction is used here to refer to communication between the child and his or her parents. Sensitive interaction fosters **secure attachment** whereby the child feels understood and is helped to acquire the ability to **regulate its emotions**. Parent-child interactions are crucial for the child's physical, mental, intellectual and psychosocial development.

Through guidance on interaction, the health centre should:

- Assist in promoting and supporting adequate interaction and secure child-parent attachment
- Promote parenting skills
- Correct undesirable or deficient interaction
- Prevent, avert and detect violence, abuse and neglect

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

The health centre service shall offer information, advice and guidance; see Section 2-3 of the Regulation on health centres and the school health service. [5] Family interaction and attachment are core themes of these activities (Comments on Section 2-3 of the Regulation on health centres and the school health service).

The purpose of the health centre service is to promote mental and physical health, good social and environmental conditions and prevent illness and harm; see Section 1-1 of the Regulation on health centres and the school health service).

In addition, the health centres shall contribute to creating a nurturing childhood environment, through measures to build parenting skills for example (Comments on Section 1-1 of the Regulation on health centres and the school health service). Regular guidance on parent-child interaction, and a focus on what parents can do to encourage secure attachment and instill self-regulation in their child will contribute to a nurturing environment. Guidance is also a crucial factor in preventing violence, abuse and neglect by making parents become aware of their own thought and reaction patterns and provide them with tools to make them more resourceful in tackling parenting challenges.

Recognition of the child's feelings promotes secure attachment, which is essential for sound mental health in the developing child. [96] [100] One of the crucial factors in early childhood development is the quality of the interaction between the child and its parents. Secure attachment to the parents protects, while insecure attachment inhibits, and promotes risk factors. [103]

Good parenting means being accepting, loving, available and showing balanced responsiveness. This encourages children to develop a secure attachment to their close family. The parents of secure children have a keen focus on the child's inner emotional state. The strategies used by parents for comforting and protecting their child when it is upset or distressed are internalised in the child. This enables the child to show flexibility in relationships. [95] Secure attachment promotes the child's capacity to understand itself and the people around it. It also helps the child to regulate and differentiate emotions. [106] One precondition for self-regulation is that the parents 'carry' the child's emotions until the child is more capable of dealing with them independently. [105]

Children who grow up in families where caregiving is satisfactory, in that the closest relations are loving, responsive, adaptive, stable, available and accepting, will usually develop a secure attachment.

Attachment bonds are formed gradually through interaction, and means that at an early stage, the child prefers its primary cares over others. Attachment behaviour will not necessarily be observable in every given situation. Attachment behaviour is triggered and typically manifested when a child feels insecure. It is observable in separation and reunion situations.

The manner in which the child is responded to emotionally is understood to be the 'driver' of child-parent attachment. Children who develop secure attachment become resilient to challenges, crises and adversity in later life. Research indicates that children characterised by secure attachment tend to be more optimistic and achieve greater contentment and self-esteem. They are more tolerant of differences between people and are more charitable towards others than children with varying degrees of insecure attachment. [105] Emotional development deficits are focal in mental health problems. A number of developmental areas may be adversely affected by emotional development deficits in childhood. [101]

At birth, the infant brain is not fully developed, and early infancy is a significant determinant of cerebral development in later life. [108] Many early infancy researchers address the possible consequences of social environment and early affective interaction on cerebral development and the 'wiring' of the nervous system. [98] In terms of both risk and protective factors, children's receptiveness to their environment and level of caregiving varies from one child to the next. This is to some extent determined by hereditary factors. [97]

Attachment is a determinant of mental health in early and later infancy and should therefore be addressed in all consultations in the health centre programme. Individual parents need to have or acquire the ability to distinguish between adequate and deficient sensitivity to, or protectiveness of, their children. The regular consultations provide an opportunity to focus on the child's need for support in exploring its world and its need for comfort, contact and closeness.

Interaction in breastfeeding and bottle-feeding sessions

Much of the interaction between the mother/parents and infant takes place during feeding sessions.

Health centres should provide advice in line with [the National guideline for infant nutrition \(Nasjonal faglig retningslinje for spedbarnsernæring\)](#) and [the National guideline for postnatal care \(Nasjonal faglig retningslinje for barselsomsorgen\)](#) in order to ensure correct infant nutrition while promoting good parent-child interaction in feeding sessions. The mother should receive advice on early signs of hunger in the infant (Danish Health Authority, 2016). Mothers who wish to breastfeed their baby should be given expert guidance until breastfeeding has been established. Health professionals can obtain advice concerning breastfeeding guidance from [the Norwegian National Advisory Unit on Breastfeeding at Oslo University Hospital](#).

Successful breastfeeding fosters good interaction [107] (Dennis & McQueen 2009; Haga SM 2012), while a stressful breastfeeding experience may inhibit interaction. [102] [99]

Maternal mental health in the postnatal period and breastfeeding are closely linked. A successful breastfeeding experience is conducive to sound mental health in the mother and prevention of postnatal depression (Dennis & McQueen 2009; Haga 2012). Conversely, problems with breastfeeding may adversely affect postnatal maternal mental health and exacerbate postnatal depressive symptoms (Dennis & McQueen 2009).

Abusive Head Trauma (Shaken Baby Syndrome)

Abusive Head Trauma (AHT), formerly known as Shaken Baby Syndrome, is the most severe form of physical abuse affecting infants under 12 months. The incidence globally is cited as approx. 2-2.5 in 10,000 infants. A third of the infants die from their injuries, while a further third survive with severe injury and may be dependent on care for the rest of their lives. The final third survive without lasting injury. The cause of this form of physical abuse may be fatigue and frustration in relatives, who lose control and subject their child to physical abuse after a sustained period of stress and problems. Studies in the USA have demonstrated that the risk of physical abuse of infants can be reduced by informing parents during the early infancy period of the risks of shaking a child. [91]

Practical information

Guidance should focus on the child's attachment and the parents' emotion regulation of the child, and should be a consistent focus in all consultations depending on the age of the child.

Through guidance on interaction, the public health nurse should inform the parents of the importance of the

- child's well-being in order to promote healthy childhood development
- the need to establish satisfactory interaction with the child in early infancy
- sensitivity towards and regulation of the child's physical and emotional needs so that the child feels secure, is met with empathy, and emotions are regulated appropriately for age and developmental stage
- having realistic expectations of what a child is capable of and the importance of the parents seeing and accepting their child for who she/he is
- the importance of interaction for cerebral development
- interaction and attachment to promote mental health, self-esteem, self-confidence and self-awareness in the child
- a successful breastfeeding/bottle-feeding experience for secure child-parent attachment

A number of constructive and evidence-based measures can be employed to strengthen child-parent interaction and attachment; see [the recommendation Parent education programmes](#) for more information.

Interaction during breastfeeding and bottle-feeding sessions

The health centres should provide advice in line with [the National guideline for infant nutrition \(Nasjonal faglig retningslinje for spedbarnsernæring\)](#) and [the National guideline for postnatal care \(Nasjonal faglig retningslinje for barselsomsorgen\)](#) in order to promote good parent-child interaction in breastfeeding or

bottle-feeding sessions. Mothers who wish to breastfeed their child should be given expert guidance until breastfeeding has been established. Health professionals can obtain advice on breastfeeding guidance from [the Norwegian National Advisory Unit on Breastfeeding at Oslo University Hospital](#).

Most women experience challenges with breastfeeding (Section 6.3 of the National guideline for postnatal care (*Nasjonalt faglig retningslinje for barselsomsorgen*)). Women who suffer symptoms of depression or experience breastfeeding challenges should receive additional follow-up as part of the standard breastfeeding guidance (Sections 6.3 and 6.7 of the National guideline for postnatal care (*Nasjonalt faglig retningslinje for barselsomsorgen*)).

In some cases, the woman may need help to stop breastfeeding without feelings of defeat and failure. Parents who bottle-feed their infant should be given guidance on the significance of eye and skin/body contact for early attachment during feeding sessions. Parents should also be advised that the attachment-promoting hormone oxytocin, which is present in breast milk, is also produced in response to the sensory stimuli of skin contact, smell, taste, sound and sight. [107]

Preventing violence, abuse and neglect

Emotional attachment between parents and children is a key determinant of early psychological development. A lack of attachment can cause apathy and infantile anorexia. [92] [93] [94]

Through guidance and observation, the health centres should seek to **detect parent-child interactions that might be a risk factor concerning insecure attachment, attachment disorder and/or neglect**.

If the parents show a lack of emotional commitment to the child, appear to be highly unpredictable in their personality or lifestyle or limit the child's scope for development in relation to the child's innate resources and abilities, this may be cause for concern about child neglect.

By observing the child and the parents, it may be possible to help to correct undesirable or weak interaction or detect behaviours that could give rise to suspicion that the child is being subjected to violence, abuse and neglect. Weak interaction, responsiveness and contact between the parents and the child may give rise to suspicions of violence, abuse or neglect, and health centres should direct particular attention at detecting such harm; see [the recommendation Violence, abuse and neglect](#) and [the section on Duty of disclosure](#).

Rocking versus shaking infants

The public health nurse should inform the family of the risk associated with shaking infants, and particularly the risk of causing severe brain injury (Abusive Head Trauma (AHT), formerly known as Shaken Baby Syndrome). The information should be given at the first consultation in the health centre programme; see [the recommendation Home visits](#). Parents should be given advice on tackling challenging situations, and the importance of remaining calm if they become frustrated.

Follow-up

- Where necessary, families should be offered additional consultations to ensure good parent-child interaction.
- The public health nurse should assess the need to discuss any interaction concerns with other health centre staff such as a psychologist and doctor.
- If the family needs follow-up services, the health centre should consider referring the family to a psychologist, GP or other relevant primary care professionals; see [the General section: Integration and coordination](#).

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4.13 Parental mental health: Parents should be asked about their own mental health and well-being

Parental mental health and well-being should be addressed in consultations in the health centre programme.

Growing up in a nurturing family environment with caring and competent parents promotes the mental health of the child.

Parental mental health and well-being should be addressed at the **home visit 7-10 days postpartum** and should be a **recurrent topic** in all consultations to ensure that the child is being raised in a nurturing and secure environment. See [the recommendation Home visits](#).

In addition, during the postnatal home visit, the parents should be asked about any physical ailments/medical condition they might have that could affect the child.

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

The purpose of health centres is to promote mental and physical health, good social and environmental conditions and prevent illness and harm; see Section 1-1 of the Regulation on health centres and the school health service. [5] The health centres shall contribute to creating a nurturing environment in which children and adolescents can develop through measures to boost parenting skills, for example (Comments on Section 1-1 of the Regulation on health centres and the school health service).

Parental mental health, well-being, physical ailments and/or medical conditions, and daily coping ability influence the childhood environment.

Child-parent interaction is determined by the predictability and sensitivity of the parents/carers. Both the mother and father/partner play a key role in positive family interaction. See also [the recommendation Interaction](#).

Some first-time parents may feel insecure, while others assume that life with a new baby will be smooth and carefree. It is important that health professionals do not raise problems, but rather ensure that those who need extra support and help receive this.

If parents have past issues they need to address, such as violence, abuse or neglect in their own childhood, they should be advised to consult their GP, psychologist or the mental health service in the municipality.

The family should be regarded as a unit, and if the parents, siblings or child need additional follow-up because of stress factors that are causing mental health problems or disorders, they should be advised to contact their GP, a psychologist or the mental health service under their local authority, or the specialist health service.

Postnatal depression

Every year, an estimated 3,000-9,000 women in Norway are affected by postnatal depression. [42] Maternal postnatal depression is a risk factor for mental health problems and developmental disorders in offspring, as it may impair parental sensitivity and ability to protect the infant. There is a risk of the infant receiving marginal care in the phase of life when its development is most intense and parental influence is at its greatest. [117]

Fathers can also suffer from postnatal depression. A Danish study revealed that approx. 7% of fathers develop postnatal depression. [112] Other studies demonstrate that fathers living with mothers suffering from postnatal depression are at greater risk of the same. [111] One study correlates paternal childhood adversity with an increased risk of paternal antenatal depression and anxiety. [116] To ensure proper developmental support for both the unborn baby and infant, it is therefore important for health professionals to be vigilant about both parents' emotional/mental state and reactions.

Infants with depressed mothers may have regulation problems in behavioural, physiological and biochemical areas from birth. [118] Studies in this field indicate that such infants may show elevated levels of stress and negativity towards and rejection of the mother in the first year of life. They may show little positive emotion and high negative emotion, and give the impression of being depressed. [97] In infants aged one to two years, maternal depression may be associated with socioemotional and cognitive developmental disorder in the infant. [115]

For more information about diagnosing and treating postnatal depression, see [the National guideline for diagnosing and treating adult depression within the primary and specialist health services \(Nasjonalt faglig retningslinje for diagnostisering og behandling av voksne med depresjon i primær- og spesialisthelsetjenesten\)](#).

Screening methods

The Edinburgh Postnatal Depression Scale (EPDS) is not recommended for universal screening in Norway, but may be employed as one method of detecting antenatal and postnatal depression combined with supportive counselling. [Tidlig Inn](#) provides training in the use of EPDS and is provided at the initiative of the local authority.

Social inequality

The family unit is a significant factor for mental health and well-being in both children and adults. Infants have less scope for influencing their childhood conditions than the adults in the family. Childhood is influenced by the parents' socioeconomic status, social and emotional resources and lifestyle choices. Much of the influence of societal factors and living conditions on children's mental health stems from the influence of the same factors on the parents. [113]

Parental educational attainment and income may have direct impact on children and adolescents. Low education and limited financial resources can impair parental coping skills, which in turn affects parenting. Negative parenting strategies appear to be important mechanisms for understanding the correlation between the family's socioeconomic status and the child's mental health [110]

The level of social support also plays a role, since it affects how parents deal with everyday tasks and challenges. In families affected by many stress factors, social support has a protective function, while social support perceived as lacking is a risk factor for children's mental health. Unemployment is a significant risk factor for mental health problems. [113]

A lack of parenting skills and especially challenging parental responsibilities are risk factors for subsequent mental health problems in the child. By providing information, and coaching in skills for dealing with negative feedback and stress, parents can improve their skills for dealing with situations as they arise. [109]

Practical information

Transition from postnatal care to the health centre programme

In advance of the home visit 7-10 days postpartum, the public health nurse should confer with the midwife to facilitate a smooth transition from perinatal care to health centre follow-up services. This will be an opportunity for providing additional supportive counselling and offering follow-up, guidance and early-referral for parents/families when needed.

The midwife-public health nurse conference can be carried out without the parents' consent, provided that the two health professionals have no reason to believe that the parents would object to them exchanging personal data; see Section 25 of the Health Personnel Act.

However, the mother/father/partner should always be made aware that their personal data is being exchanged in the interests of continuity of care.

See also [the National guideline for postnatal care \(Nasjonal faglig retningslinje for barselomsorgen\)](#).

Consultation concerning parental mental health and well-being

During home visits, the public health nurse should ask the parents open questions to enable them to discuss their own thoughts and concerns about their child and parenting.

The public health nurse should raise the following topics with the parents:

- The parents' experience of becoming parents, emotional well-being and adjustment to their new role, including information about the normal emotions, challenges, experiences and ideas involved in becoming parents.
- The mother's/father's/partner's mental health, including any prior problem or disorder.
- Postnatal depression.
- Interaction with the infant, including how the parents tackle feelings of anger and frustration when the infant is perceived as challenging; see also [the recommendation Interaction](#).
- Parental interaction and relationship.
- Experiences from the parents' own childhood; positive aspects they want to draw on in their own parenting, and what they aim to do differently.
- Social networks and family networks.
- Alcohol and drug habits.
- The parents' state of physical health or any medical condition that might affect their parenting.

Health centres should pay particular attention to:

- Signs of insecure parenting; lack of confidence in the parents.
- Parents with symptoms of depression, anxiety, trauma or other risk-prone emotional stress.
- Families adversely affected by many stress factors.
- Families with children who have physical or mental disabilities.
- Signs of alcohol or drug abuse/domestic violence.

Follow-up as necessary

- The public health nurse should offer individual supportive counselling sessions and additional consultations and guidance for parents who for whatever reason need extra follow-up.
- The public health nurse should assess the need for interdisciplinary care in conjunction with a GP, midwife or psychologist for example.
- The mother/father/partner should be encouraged to consult a psychologist or GP or other relevant professional or service as necessary; see [the recommendation GPs](#) and [the recommendation Psychologist](#).
- Parents with a limited social network should be recommended to attend group consultations, where these are available; see [the recommendation Group consultations](#).

Health centres should keep a list of municipal respite care and supportive care services, such as:

- The Family Counselling Service (*Familieverntjenesten*), which is a free, low-threshold county service for families dealing with conflicts or crises in the family, and for parents who are required to attend mandatory dispute resolution or mediation in connection with divorce/break-ups.
- HSF (Home start Family Contact; non-profit, volunteer-run service for families with preschool-age children) may be an important partner.
- Mental health services, low-threshold programmes.
- Services provided by the Child and Adolescent Psychiatric Outpatient Services (BUP) (for example, the infant psychiatric care team).

Postnatal depression

The public health nurse should maintain particular focus on detecting symptoms of postnatal depression in the mother/father/partner at consultations in the postnatal period; at the home visit 7-10 days postpartum; at the 4-week check-up and at the 6-week checkup.

The Edinburgh Postnatal Depression Scale (EPDS) may be used for individualised screening for depression in mothers as an adjunct to a clinical interview. [Tidlig Inn](#) offers training concerning early intervention tools and methods. EPDS is included in this programme.

Keeping health records on the parents

Health centre staff are required by law to maintain a medical record for each patient; see Section 39 of the Health Personnel Act (*helsepersonelloven*). Relevant and essential data on the mother's/father's/partner's physical and mental health must in principle only be recorded in the mother's/fathers'/partner's respective medical record. Data on other family members may only be recorded in the child's own medical record if the data are relevant to conduct professionally responsible follow-up of the child's development and health. With respect for the child's future right of access to its own medical record, health professionals should exercise discretion concerning the nature of data on family members that should be recorded, and in what manner.

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4.14 Parent education programmes: The Health Centre can offer universal, primary preventive parent education programmes

The Health Centre can offer universal, primary preventive parent education programmes to groups and/or individually to parents.

The purpose is to promote the child's development and prevent mental problems in the child by strengthening the parents' parenting skills.

Rationale

Population

Children aged 0-5 years

Intervention

Individual or group-based prevention interventions adjusted for the child and/or carers and/or preschool teachers

Comparator

Other measures, waiting list or no measures

Outcome

Outcome general mental health, externalising and internalising symptoms

Evidence profile

Outcome	Confidence in estimates	Relative effect	Other measures, waiting list or no action	Individual or group-based prevention interventions adjusted for the child and/or carers and/or preschool teachers	Absolute difference
Outcome general mental health, externalising and internalising symptoms		0 (CI 0 - 0)	0 per 1000	0 per 1000	0 per 100 0 - 0

Summary

To address the PICO process, RBUP South East was given the remit of updating a Cochrane review as part of the guideline work.

The Cochrane review has now been published and summarises international research on the effect of group-based parent education programmes targeting infants and young children. It includes randomised or quasi-randomised studies.

The results provide some support for using group-based parent education programmes to improve the emotional and behavioural regulation of infants and small children. However, the limited documentation showed that the effect of the programme did not persist over time.

Documentation on the impact of parent education programmes in the primary prevention of mental health problems in infants and young children is not sufficiently robust to draw any clear conclusions. For reports and a more detailed overview of the effect estimates and grading of the results; see [The Norwegian Knowledge Centre for the Health Services' review of the Cochrane review with the Summary of Findings \(SOF\) tables.](#)

The conclusion emphasises that more research in this area is important and essential.

Rationale

The scope of this recommendation is based on regulations, research basis and the consensus of the working group.

The purpose of health centres is to promote mental and physical health, to promote good social and environmental conditions and to prevent illness and injury; see Section 1-1 Regulation on health centres and the school health service (forskrift om helsestasjons- og skolehelsetj.).[5] The health centres shall, through interdisciplinary collaboration, contribute to creating a sound environment in which children and adolescents can develop through measures to strengthen the parents' parenting skills (Comments to Section 1-1 of the Regulation on health centres and the school health service (forskrift om helsestasjons- og skolehelsetj.)). The health centre service shall also offer information, guidance and counselling on topics such as interaction, social competence, bonding within the family, etc.; see Section 2-3 Regulation on health centres and the school health service (forskrift om helsestasjons- og skolehelsetj.). Universal, primary preventive parent education programmes can be constructive tools for realising this purpose.

Several parent education programmes are available in Norway, but only a few of these are universal, primary prevention programmes.

The purpose of the primary prevention programmes is to contribute to promoting the child's development and to preventing mental problems through strengthening the carers' parenting skills; by increasing their sensitivity and awareness of the child's signals; and by enabling them to meet these needs. [119]

Evaluations that have been performed on the advantages and disadvantages of implementing universal primary preventive parent education programmes in Norway:

Summarised, international research (see more under Research basis)

There is some support from international summarised research on the benefit for the child of similar universal, primary prevention programmes to those used in Norway, both in the short and long term. All the included studies tested parent education programmes based on behavioural theory, cognitive behavioural theory or model learning. The results can therefore not be extrapolated or generalised to other types of parent education programmes. It is emphasised that there is a need for further research in this area.

On parent education programmes in Norway and research evidence

There is a lack of high-quality research evidence for several the parent education programmes that are currently used in Norway. The research on Norwegian programmes has primarily been conducted on parent education programmes that focus on the parents of children and adolescents with behavioural problems. [119]

In Norway, the introduction of the parent support measures was the result of conscious and strategic political decisions at government level. Both the implementation (including education of therapists/specialists) and the research on these measures have been financed and implemented under the auspices of the government. [119]

[Ungsinn.no](#) is an online scientific journal with measures and programmes on mental health for children and adolescents. Here you can find information on programmes that are available and in use in Norway.

ICDP is a universal health promoting and prevention programme directed at carers, generally the parents. The programme is currently offered in almost 200 municipalities through the Ministry of Children and Equality. ICDP aims at strengthening the environmental conditions in which children and adolescents

grow up through education of parents and other carers.

The Norwegian Institute of Public Health has been given the remit by the Ministry of Children and Equality to conduct a randomised controlled trial (RCT) of ICDP, but the results of this study are not yet available.

Based on an evaluation of current research and the status of programmes in Norway, as well as the experiences acquired by many health centres after using the programmes, universal, primary preventive parent education programmes have now been proposed for general implementation by health centres for children 0-5 years. However, both international summarised research and the available Norwegian studies indicate that there is a need for additional high-quality studies to document the effects of universal, primary preventive parent education programmes (both desirable and undesirable effects). When this becomes available it will provide a better foundation from which a more robust recommendation on the use or non-use of such programmes in Norway can be recommended.

Further, we do not know enough about the effect of the Norwegian programmes from a more comprehensive perspective, as part of an extensive long-term health centre service, and in conjunction with other services/consultations offered by the health centre.

It is also desirable to acquire more knowledge on the possible causes of any effects/absence of effects, i.e. any intermediate factors and mechanisms that potentially contribute to change.

Practical information

Use of parent education programmes requires training to ensure that the programmes are implemented as intended. Manuals and material necessary for implementation of the programmes should be available in Norwegian.

ICDP

The International Child Development Programme (ICDP) can be used for systematic parent education. ICDP is a universal health promoting and prevention programme directed at carers, generally the parents.

The Norwegian Directorate for Children, Youth and Family Affairs (Bufdir) has the rights to use and further develop the programme, and offers certification courses for public health nurses. See [Bufdir's website](#) for more information.

Bufdir has also compiled a leaflet for parents, "Sammen foreldre og barn" (Together as parents and children), for use in consultations at the health centre. The leaflet is intended as an aid for the public health nurse when talking with the parents and for making them aware of the importance of interacting with the child. The material is free. It has not been translated into other languages. To use and order this material, at least half of the public health nurses at the health centre must have completed a one-day course in use of the leaflet or be certified ICDP facilitators. The material can be ordered on [Bufdir's website](#).

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4.15 Violence, abuse and neglect: The health centre shall contribute to averting and identifying violence, abuse and neglect

The health centre shall, through the health centre programme, **contribute to averting and identifying** violence, abuse and neglect

Public health nurses, doctors, physiotherapists, midwives and other personnel at the health centre must **be aware** of factors that could indicate that the child is suffering violence, abuse or neglect and shall, at the consultations in the health centre programme, **observe the child and family to avert and identify** such conditions.

When there is reason to believe that a child is being abused in the home or subjected to other forms of serious neglect, or when the child displays persistent and serious behavioural problems, the personnel at the health centre must **report it to the Child Welfare Services**. See more in [the General section: Duty of disclosure](#).

Rationale

The contents of this recommendation are based on the law and the consensus of the working group.

Anyone who provides health help shall be aware in their work of conditions that could result in actions by the Child Welfare Service; see Section 33 of The Health Personnel Act. [14] Personnel at health centres shall therefore be aware of conditions that could indicate that the child is suffering violence, abuse or neglect and, at the consultations in the health centre programme, shall observe the child and family to avert and identify such conditions.

Neglect is defined as a lack of ability by the carers to meet the child's basic physical, emotional, mental and/or medical needs.

Violence is here defined as physical, mental and sexual violence. Being a victim of violence or witnessing violence in the home is an immense stress factor and affects the health and quality of life of children as well as adults. Persons who experience physical, mental and/or sexual violence in the home or witness violent incidents have an increased risk of lowered quality of life, mental and somatic health problems, injury and death. [125] [131] [126] [132] [124] [127]

There is increasing evidence that experiencing violence or emotional trauma in childhood has deep and permanent effects on the development of the brain. The emotions that are immediately triggered by abuse such as fear, anger and sadness can become the breeding ground for lifelong problems with emotional regulation, self-image and stress activation. Moreover, child abuse can disturb the normal attachment dynamics between parent and child and affect social relationships throughout the child's life. Body and mind affect each other continuously. Major prospective studies have repeatedly demonstrated that children who are subjected to violence and neglect have a significantly increased risk of developing mental illness, cognitive impairment, drug abuse, criminal behaviour, failing physical health and early death compared with children who are not abused. [125] [131] [126] [132] [124] [127] The broad spectrum of negative consequences that have been reported in clinical and epidemiological studies have been reinforced by epigenetic, neuroendocrine, immunologic and structural neurobiological changes linked to abuse in childhood. [128] [129]

Prevention and intervention to safeguard children against suffering violence, abuse and neglect must therefore be essential aspects of the health centre services if they are to meet the aim of promoting mental and physical health, good social and environment conditions, and preventing illness and injury; see Section 1-1 of the Regulation on health centres and the school health service (forskrift om helsestasjons- og skolehelsetj.). [5]

Violence against a mother or father, or between parents, is also violence against the child. [123] Research has shown that being a witness to violence or being exposed to violence can be just as harmful as being subjected to violence oneself. Violence in close relationships means that the person or persons who are supposed to protect the child are themselves so frightened or frightening, that the protection of the child ceases. Research shows that the quality of care from a vulnerable parent/carer is affected as a result of the dynamics of the violence. When there is no safe haven in which the child can seek comfort, the child can develop severe insecure attachment to its parents. [121] [95] This can, in turn, negatively affect the child's development; see [the recommendation Interaction](#).

The majority of children in Norway take advantage of the standard health centre services in the municipalities. Children younger than one year of age are most frequently the subject of violence and abuse. During the child's first year, the health centre is the only public body, and the public health nurse the only medical professional, which systematically and regularly observes the child's health and development, and which has regular contact with the child's carers. This provides a unique opportunity, and a particular responsibility, for averting and identifying violence to and neglect of the very youngest children. The report, *Den Vanskelige samhandlingen* (The difficult interaction), states: "The greater the resources the municipality allocates to public health nurses/ health centres compared to the number of children in the municipality, the smaller the unmet need for various types of Child Welfare Services interventions in the home". ([57] This can indicate that good preventive work in the municipality is important for the use of these measures. The health centre therefore constitutes a very important safety net for the child.

The early intervention education programme *Tidlig inn* is an offer to health professionals for training in the use of tools and discussion methods for identifying mental problems and disorders, violence, and drug abuse in parents of young children. Through this programme, the participants shall feel secure when asking about violence in close relationships, as well as when following-up cases that have involved violence.

Practical information

Health professionals must be alert to symptoms and have the confidence to think that a child could be exposed to mistreatment, neglect or abuse. In practice, it is useful to think of this condition as a 'syndrome' and, as with other syndromes, it is the combination of various symptoms and findings that determine the diagnosis.

To avert and identify violence, abuse and neglect, the health centre should:

Listen and observe:

- At all consultations, undress the child completely and look for bruises and other signs of injury. Shyness should be taken into consideration as the child gets older; older children may therefore keep their underwear and top on.
- Observe the interaction between the parents and child, including whether the parents display animosity or have a negative attitude or unrealistic expectations of the child. Psychological violence leaves no visible marks on the body, but children that live in fear and stress acquire changes in their brain which can cause self-regulation problems such as crying a lot and irritability, attachment problems and poor growth and well-being; see [the recommendation Interaction](#).
- Have an updated overview of who the child lives with, and routinely ask the parents about stress in the environment.
- Complete recommended home visits; see [the recommendation Home visits](#) and [the recommendation Follow-up home visits](#).

The health centre should be particularly aware of conditions such as:

- Bruises and other skin injury in infants.
- Bruises and other skin injury on protected areas (including the genitals/nappy area).
- Marks or patterns which could indicate injury caused by an object.
- Children who have been treated for injury, the cause of which is unclear. Injury in children can also be due to a lack of supervision and safety in the home, in which case neglect must be considered.
- Concerns about behaviour, growth and/or development for which there is no other explanation. One should pay particular attention if the child's behaviour changes or if there is a loss of skills.
- Children who display signs of attachment disorder (reactive or non-discriminatory attachment).
- Mother or father talks about violence by their partner.
- The child or others make comments that cause you to suspect violence.

In cases of concern, the health centre should:

Try to find an explanation:

- Ask what happened if you see bruises or other marks on the child's body.
- Ask about parenting strategies and what the parents do if they get frustrated.
- Talk with the parents about your concern or parts of it. Be as precise as possible about why you are concerned, but without discussing the cause in the first instance.
- Ask for permission to collect information from and discuss with the GP, the local children's ward or the kindergarten, for example. If the child has moved into your area, ask for permission to collect information from the last health centre, GP or hospital. A duty of confidentiality is not an obstacle to divulging the information to others if the person who is entitled to confidentiality consents; see Section 22 of the Health Personnel Act.

Document:

- All findings shall be documented in the child's records.
- Photos should be taken of bruises and/or other signs of inflicted injury, if discovered. Photos should be taken so that it is possible to see the location of the mark on the body.

Evaluate, suspect or exclude violence, abuse or neglect:

- Analyse and describe for yourself what causes you concern.
- Additional consultations either at the health centre or a home visit, preferably in an interdisciplinary collaboration, can be used to investigate a vague suspicion in more detail.
- Concern about the child can be discussed anonymously with colleagues, collaboration partners or managers.
- If there is reason to believe that the child has been, or is, the victim of violence, abuse or neglect, the health professionals shall on their own initiative send a letter of concern to the Child Welfare Services. Read more in the [General section: Duty of disclosure](#)
- Health professionals must also evaluate whether there is a basis for reporting to other emergency services, including the police. Read more in the [General section: Duty of disclosure](#)

(NKVTS, 2016, NICE, 2009) (122) (130)

Families in a **vulnerable and exposed life situation should be followed more closely**; the involvement of other professionals and/or support bodies should be considered such as municipal mental health services, psychologist, doctor, the Family Counselling Service or the Child Welfare Services; see also the General section: Collaboration and co-operation and [the recommendation Parental mental health](#).

It is particularly important that the health centre has **good routines for following up parents and children who do not attend appointments**. Section 6-1 of the Patient and Users' Rights Act (pasient- og brukerrettighetsloven) states that children have the right to health checks and that parents are obligated to ensure that their child attends the health checks. See [the recommendation Children who do not attend](#).

[The education programme Tidlig inn](#) is an offer to health professionals for training in the use of tools and dialogue methods for identifying mental problems and disorders, violence and drug abuse in parents of young children.

Abusive Head Trauma

The public health nurse or other professional at the health centre should inform the family of the risk associated with shaking infants, and particularly the risk of causing severe brain injury (Abusive Head Trauma, formerly known as Shaken Baby Syndrome). The information should be given at the first consultation in the health centre programme; see [the recommendation Home visits](#). Parents should be given advice on how they can tackle challenging situations, and how important it is to remain calm when they get frustrated.

Organisational aspects

Management has the responsibility to ensure that the health centre, school health service and youth health centre has a system and measures to prevent, avert, and identify violence and abuse. Managers at all levels shall ensure that employees in the services have the necessary competence on violence and abuse.

The services should be familiar with the municipal action plans against violence in close relationships.

Other guidance material

- The Norwegian Centre for Violence and Traumatic Stress Studies (NKVTS) has published a handbook on [suspected child abuse for health and care personnel](#).
- The health centre shall be aware of children who could have suffered **female genital mutilation**. See the guide to [Prevention of female genital mutilation](#)
- See also [Guide to female genital mutilation](#) from NKVTS.
- [The National guideline for antenatal care](#) contains useful information that can be utilised when posing questions about violence.
- [The Regional Resource Centre for Violence, Traumatic Stress and Suicide Prevention \(RVTS\)](#) can also be contacted.

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4.16 Kindergartens: The health centre shall have a systematic collaboration with kindergartens in the municipality

Combined, the health centres and kindergartens have detailed knowledge of the child population and are familiar with children in the municipality. The health centre should therefore collaborate with the kindergartens in the municipality at a organisational level.

The health centre can collaborate with the kindergartens at individual level for children who require additional follow-up. It is the responsibility of each municipality to evaluate the need for collaboration at individual level.

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

The health centre shall have procedures for collaboration with “other municipal services”; see Section 2-1 of the Regulation on health centres and the school health service (forskrift om helsestasjons- og skolehelsetj.). [5] It is recommended that the health centre collaborates with the kindergartens in the municipality at an organisational level, and at the individual level in cases of special need. It is the responsibility of the municipality to facilitate implementation of such a collaboration; [see the General section: Management, steering and user participation.](#)

As many as 90.4% of children attend kindergarten in Norway. [135] The health centre service and the kindergartens relate to, and see, the same children regularly. They can reap major benefits from sharing experiences and knowledge on the child population in the municipality through systematic partnership.

The collaboration between the health centre and the kindergartens can also be useful in the municipal public health work; see Section 5 of the Public Health Act. [27]

A physical and psychosocial environment of good quality in the kindergarten is important for the child’s health, well-being and learning. Mapping undertaken by the Norwegian Directorate of Health in 2013 and 2015, revealed that many schools and kindergarten in the municipalities were not approved in accordance with the Regulation on environmental health protection in kindergarten and schools (forskrift om miljørettet helsevern i barnehager og skoler).[134] Therefore, personnel associated with the health centre should contribute to the environmental work in the kindergartens, for further details see the Guide to environmental health protection in kindergartens and schools and the recommendation The District Medical Officer.

Collaboration at the individual level

At the individual level, collaboration can be advantageous for providing good support for children who need additional follow-up. The health centre can, by applying its professional competence, contribute at an early stage with identifying unfavourable conditions and, if necessary, initiate measures. The kindergarten, for their part, can contribute to providing a basis from which to make an appropriate assessment because they know the child, and they hold kindergarten-specific competence. Families who need enhanced services from the health centre will often require additional follow-up in the kindergarten.

For municipalities and city areas with a high number of kindergarten and/or long distances, it will be resource intensive and logistically challenging to collaborate at the individual level. It is therefore the responsibility of each municipality to evaluate whether, and how, collaboration at the individual level is to be implemented.

Collaboration at the individual level must be based on consent from the child's parents, because collaboration on an individual means that health professionals at the health centre exchange information on the child's physical health or illness status, or other personal conditions; see Sections 21 and 22 of the Health Personnel Act. [14]

Family Centres (Familiens hus)

Several municipalities have established family centres. Services often include the local health centre, including maternity care, "drop-in play group", the preventive educational and psychological counselling service and, ideally, the municipal Child Welfare Services. The model is based on the principles of early intervention and "one door access" for coordinated help and is well-suited to capturing children and families with special needs for support and follow-up. The purpose of the collaboration is that families are met by a well-integrated chain of measures.

Educational and Psychological Counselling Service (PPT)

PPT is the municipality's advisory and expertise centre for issues relating to children and upbringing. PPT provides advice on well-being, the learning environment and adapted education. Health centres can refer a child directly to PPT after the parents have given their consent.

Practical information

The health centres and kindergartens should have written collaboration agreements. The services should ensure mutual knowledge on and clarification of roles in the collaboration.

The collaboration can be organised through the family centres, which have been established in many municipalities.

Systematic partnership

The systematic collaboration can include joint theme days on children in the municipality, at which the health centre and the kindergarten participate and discuss topics that are of interest for both services and common challenges identified by the services during their work.

Relevant topics on theme days could be:

- Preventing, averting and identifying violence and abuse to children; see [the recommendation Violence, abuse and neglect](#).
- Injuries and accidents
- Nutrition
- Sleep
- Bullying

Medication management

The health centre shall contribute to establishing routines for managing medications in kindergartens, schools and after-school programmes; see Section 2-4 of the Regulation on health centres and the school health service (forskrift om helsestasjons- og skolehelsetj.). [5]

This means that the health centre shall contribute to compiling routines on safe storage, administration and handout of medications in kindergartens, including routines for training personnel in kindergartens who assist children who require medication.

The health centre's responsibility presupposes that the management in the kindergarten contacts the health centre for assistance.

For information on medication management in schools; see the [recommendation on Collaboration with schools in the Guideline for the school health services \(not published\)](#).

Environmental health protection

The health centre should assist kindergartens in complying with the requirements in the Regulation on environmental health protection in kindergartens and schools (forskrift om miljørettet helsevern barnehager og skoler. For more information; see [Environment and health in the kindergarten - Guide to the Regulation on environmental health protection in kindergartens and schools](#).

Collaboration on individual children

The health centre and the kindergartens can, to the extent necessary, collaborate on vulnerable children who need additional follow-up. This could for example apply to:

- children who have problems related to language development,
- chronically ill children
- other concerns for children

Collaboration on individual children is only permitted after the parents have given their consent. The obtained consent should be documented in the child's records at the health centre; see Section 8 of the Medical Records Act (Journalforskriften). [31]

As necessary, the health centre can also contact and collaborate with PPT. See also [the Collaboration guide to children and adolescents with habilitation needs](#).

Information on kindergarten services

The health centre should inform parents about the kindergarten services in the municipality and the options for applying for a kindergarten place. See the web page [Kindergarten facts](#).

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4.17 Childhood vaccinations: The health centre shall provide vaccination in accordance with the Childhood Immunisation Programme

The health centre shall provide vaccination for all children resident in Norway in accordance with the Childhood Immunisation Programme.

Protection against communicable infections and vaccination are important tasks of the health centre. High vaccine cover helps prevent serious infectious diseases.

For more information see the [Norwegian Institute of Public Health's web pages on the Childhood Immunisation Programme](#).

Rationale

The contents of this recommendation are based on regulations.

The Childhood Immunisation Programme shall be offered to all children of preschool and primary school age and the vaccination schedule will be implemented through the health centre and school health service; see Section 4 of the Regulation on the national Childhood Immunisation Programme (*forskrift om nasjonalt vaksinasjonsprogram*). [53] The vaccinations shall be provided cost free. The health centre shall provide information and offer the Childhood Immunisation Programme; see Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetj.*). [5]

The recommended Childhood Immunisation Programme is set by the Ministry of Health and Care Services.

The Norwegian Institute of Public Health provides guidelines for implementation of the Childhood Immunisation Programme, including target groups, frequency and the technical composition of the vaccines. The Norwegian Institute of Public Health procures and distributes the vaccines for the programme.

The vaccines offered in the Childhood Immunisation Programme at the present time provide good protection for each person vaccinated. Vaccinating the majority of a population against a disease means there will be few people who can become infected and pass the disease on to others. This is called “herd immunity” and makes it possible to keep the disease in check on a population level. This also protects people who are not vaccinated.

Practical information

The Childhood Immunisation Programme shall be offered to all children, and the individual vaccines shall be offered at the recommended age. It may be necessary for a variety of reasons to adjust the immunisation programme.

All parents should receive information on vaccines at the home visit 7-10 days after the birth; see [the recommendation Home visits](#).

More information

- For an overview of the time points for vaccinations and other information on the programme; see [the Norwegian Institute of Public Health web pages on the Childhood Immunisation Programme](#)
- For more information on routines at vaccination and reactions after vaccination; see the [Norwegian Institute of Public Health Guide to Vaccination \(Vaccination Book\)](#)
- [Contact information for the Norwegian Institute of Public Health regarding the Childhood Immunisation Programme](#)

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4.18 Follow-up groups: The health centre and school health service should register children in follow-up groups

Follow-up groups are a tool that can help identify and categorise a child's need for follow-up.

At each consultation, health professionals should assess the child's need for measures and follow-up and categorise as group 0, 1, 2, 3 or 4.

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

Registration in follow-up groups that are documented in the child's record will help create an overview of the number of children who are offered assistance by the health centre and the extent to which they need various help and support measures.

In line with Section 5 of the Public Health Act (Folkehelseloven) and Section 3(a) of the Regulation on overview of public health (forskrift om oversikt over folkehelsen), registration in follow-up groups will contribute to the municipality's overview of the health of the children and adolescents in the population, to which the health centres, school health service and the youth health centres shall contribute; see Section 2-2 of the Regulation on health centres and the school health service (forskrift om helsestasjons- og skolehelsetj.). [27] [5]

Practical information

For more information; see [the Directorate of Health's Guide to record keeping in the health centre and school health services \(IS-2700\)](#) p. 29

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4.19 Children who do not attend: The health centre should have routines to follow up parents and children who do not attend appointments

The health centre should **have routines to follow up** parents and children who:

- do not attend agreed health consultations
- repeatedly cancel or change agreed appointments

Rationale

The contents of this recommendation are based on the law and the consensus of the working group.

Children have the right to health checks and parents are obligated to ensure that the child attends the health checks; see Section 6-1 of the Patient and Users' Rights Act (pasient- og brukerrettighetsloven).[9]

This provision in the Patient and Users' Rights Act (pasient- og brukerrettighetsloven) shall protect children and adolescentadolescents and secure access to all necessary health services. This means that the health centre can order parents to ensure that the child/adolescent attends health consultations. Such an order would be an individual decision that can be appealed. When an individual decision is taken, the rules on individual decision in the Public Administration Act (Forvaltningsloven) must be followed.

Even though the child has the right to health checks, and parents have a duty to ensure attendance, all consultations in the health centre programme and any additional consultations are based on voluntary participation.

The services shall work to ensure that the child's right to health checks is met.

Non-attendance at health consultations could necessitate a letter of concern to the Child Welfare Service; see Section 33 of the Health Personnel Act .[14] See the [General section: Duty of disclosure](#).

Practical information

There can be a variety of reasons why children and parents do not attend, from moving, illness and holiday to varying degrees of neglect.

The health centre **should have routines** to:

- ensure that the child has **health consultations**
- **follow up children that do not attend** as agreed, or when they repeatedly change appointments

Examples of measures to ensure the child's right to health consultations:

- send an individual letter of appointment with a clear description of the health centre and the school health service's roles and responsibilities
- use SMS to remind parents of agreed appointments

Examples of follow-up measures when the child does not attend:

- check that the address in the National Registry is correct
- make a phonecall to the parents
- consider a home visit
- discuss the case with colleagues, the multidisciplinary team or immediate superior

Relevant and necessary information on follow-up measures shall be documented in the child's records; see Section 8 of the Medical Records Act (Journalforskriften). [31] If a child attends health consultations at the GP's office instead of the health centre, this must always be documented in the records; see [the recommendation GPs](#).

A letter of concern because of non-attendance

After individual assessment, health professionals can inform the parents that it may be necessary to send a letter of concern to the Child Welfare Services if they do not ensure that the child attends consultations. It is important that the Child Welfare Services are not presented as a threat, but as a supporting organisation.

Before the health centre sends a letter of concern, a proper assessment of the situation must be conducted. In some cases, it may be sufficient that the child misses one consultation; for example, if there are pre-existing conditions that generate suspicion and trigger the duty of disclosure. In other cases, the parents and child may miss several appointments before it is considered correct to report a concern. See [the General section: Duty of disclosure](#).

References

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4.20 Collaboration between the public health nurse and the doctor: The public health nurse and doctor should collaborate on preparations and follow-up of all health checks at which a doctor is present

The public health nurse and doctor should **collaborate on preparations and follow-up** of all health checks at which a doctor is present. This applies to the consultations at:

- 6 weeks
- 6 months
- 1 year
- 2 years

The public health nurse and doctor should **set aside time to prepare the health checks together**, and assess the need for any follow-up consultations.

If necessary, other health professionals should be involved in the collaboration, such as midwife, physiotherapist or psychologist.

Rationale

The scope of this recommendation is based on the consensus of the working group.

Collaboration on health checks at which a doctor performs somatic examinations contributes through the various competences and experience to increase the professional quality, interdisciplinary discussions and reflection around the child. A systematic collaboration around each child will contribute to a coordinated and holistic assessment of the child. The results of examinations, observations and assessments should be discussed and quality assured. [138]

The health centre doctor is responsible for performing the health checks, for identifying conditions that require investigation and follow-up, and for contributing public health information. If there is a need for further investigation and treatment, the health centre doctor refers the child to the general practitioner. If appropriate, the child can be referred directly to the specialist health services, and in this case the GP should be notified. See [the recommendation GPs](#).

In cases where other health professionals are involved in the health consultation (for example midwife, physiotherapist or psychologist), it is important that they are also involved in the preparations and review of the investigation.

Health professionals can collaborate without being bound by the duty of confidentiality if the user does not object to the collaboration; see Section 25 of the Health Personnel Act. [14]

Practical information

Collaboration routines should be in writing to ensure quality and continuity, for example when personnel move. Collaboration routines should clarify roles and responsibilities.

Regular evaluations should be performed using collaboration meetings at the health centre.

Physiotherapists and, if necessary, psychologists or other health professionals should be involved in the preparations of the investigations as required.

See also the recommendations:

- [GP](#)
- [Psychologist](#)
- [Responsibility and task distribution](#)
- [Doctor](#)

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5 School health service, 5-20 years

5.1 Collaboration with schools

5.1.1 Systematic partnership: The school health service should have a systematic partnership with schools

The school health service should work in systematic partnership with schools to facilitate a sound physical and psychosocial environment for pupils.

If no partnership with the school is in place, the school health service should take the initiative for establishing one.

The school health service should be involved in efforts by schools to plan school-wide, group-based and individualised interventions.

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

The school shall facilitate a sound physical and psychosocial environment on its premises; see Sections 9a-2 and 9a-3 of the Education Act. [141]

School health service programmes for children and adolescents shall include partnering with schools on measures to promote a sound psychosocial and physical learning environment for pupils, and assistance and education in groups/forms/parent meetings at the school's discretion; see Section 2-3 of the Regulation on health centres and the school health service. [5]

In partnership with school staff, pupils and parents, the school health services are required to facilitate healthy schools by promoting a sound learning and working environment with respect to health, well-being and safety. School health service interventions comprises the entire school environment, both physical and psychosocial, indoors and outdoors (Comments on Section 2-3 of the Regulation on health centres and the school health service).

The school health service shall assist in establishing procedures for managing medications in kindergartens, schools and after-school programmes; see Section 2-4 of the Regulation on health centres and the school health service.

The school health service must be familiar with Chapter 9a of the Education Act concerning pupils in their school setting, and with the requirements of the Regulation on environmental health protection in kindergartens and schools (*forskrift 1. desember 1995 nr.928 om miljørettet helsevern i barnehager og skoler m.v.*). [141] [142]

In collaboration with pupils, parents, school staff and other partners, the school health service shall work to identify pupils with health problems linked to the school setting (Comments on Section 2-3 of the Regulation on health centres and the school health service).

In order to fulfil its obligations for partnering with schools and other obligations for the school health service pursuant to the Regulation on health centres and the school health service, the school health service should establish a systematic partnership with schools and lay down joint procedures and plans.

Why should the school health service have a systematic partnership with schools?

A partnership based on a structured model, clear-cut division of responsibilities and reliable procedures with well-defined roles has greater potential for achieving lasting results than where the joint arrangement is arbitrary and lodged with individuals. [144] [147] [139]

The purpose of a partnership arrangement is to achieve synergies and enhanced quality in the interventions and actions undertaken by the partners to ensure a good school and formative environment for children and adolescents. [150]

The school health service should be an important partner for schools. [150] It should be a key driver of health promotion and preventive work to ensure a sound psychosocial school environment for all pupils, and shall operate with a holistic approach to expertise on health, formative years and quality of life. Further, it shall support children and adolescents in a vulnerable phase of life, and shall contribute in preventing pupils from dropping out of upper secondary education. Where the school health service is readily available and accessible at schools, it will be in a better position to detect problems at an early stage and achieve better pupil reach regardless of their social background. The school health service can deal with health-related problems that present a barrier for learning. [148] [146] [143] Studies indicate that school staff working with the school health service would like a public health nurse to be more available at the school and in classroom teaching. [149]

At schools where the school health service is available on site, the proactive and school-wide efforts for all pupils are increased. The partnership with a given school improves and also provides greater scope for school health service involvement in school planning. [145] See [the recommendation Low-threshold services](#).

Practical information

Systematic partnering between the school health service and schools is **imperative and essential** in order for the school health service to fulfil its statutory obligations and follow the recommendations of this Guideline.

A well-organised systematic partnership is a particularly important criterion for school-wide or group-based health promotion work. This applies in particular to the following recommendations:

- [Overview](#)
- [Education](#)
- [Visits to youth health centres](#)
- [Parent meetings](#)
- [Psychosocial environment](#)
- [Food and meals](#)
- [Physical activity](#)
- [Tobacco, alcohol and drugs](#)
- [Divorce/break-ups](#)
- [Absence giving reason for concern](#)
- School-entry health [consultation](#)
- [Health consultation, 8th grade](#)
- Follow-up counselling

The systematic partnership between the school health service and schools should aim to achieve [150] [139]:

- Shared values
- A shared understanding of concepts
- Clear-cut division of roles and responsibilities
- Familiarity with each other's rules and regulations

The partnership should entail that the **school health service participates in relevant forums** in schools, such as:

- Meetings with school principals and teaching staff
- School planning days
- The school resource team, multidisciplinary team and meetings with advisers, school counsellors, and teaching staff
- Student council meetings, parent meetings, Parents' Council Working Committee (FAU), liaison committee, school environment committee and after-school programmes as relevant
- Forums on reducing the upper-secondary school dropout rate and measures to prevent dropouts from school generally

Environmental health protection

Through systematic partnerships with schools, the school health service should contribute in ensuring that schools fulfil the requirements of the Regulation on environmental health protection in kindergartens and schools etc. (*Forskrift om miljørettet helsevern i barnehager og skoler mv.*). [142]

For the specifics of these requirements; see [the Guide to the Regulation on environmental health protection in kindergartens and schools etc.](#) (*Veileder til forskrift om miljørettet helsevern i barnehager og skoler mv.*).

Medication management

The health centres and school health service shall be instrumental in establishing routines for managing medication in kindergartens, schools and after-school programmes; see Section 2-4 of the Regulation on health centres and the school health service. [5]

This means that the school health service shall be instrumental in establishing procedures for safe storage, administration and dispensing of medication at schools, including procedures for training staff who assist children with medication.

The regulation does not impose any obligation on the school health service staff to perform day-to-day management of medicines.

The school health service's responsibility presupposes that the school principals contacts the school health service if assistance is required.

More information

- [Education Act](#)
- [The Directorate of Health's website on mental health in schools](#)

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5.1.2 Overview: The school health service should maintain an overview of pupil health status

The school health service should obtain an overview of the state of the pupil population's health through:

- Performance of its service obligations
- Contact with the pupils, parents and school
- Use of available sources and tools for information

The overview of the health status of the pupil population and factors impacting the health of children and adolescents should be used in work on:

- Systematic plans and interventions to promote pupil well-being, learning and health in partnership with the school
- Interventions at group and individual level as required
- The service's contribution to the municipalities overview of the general status of public health and health determinants. See [the recommendation Public health work](#).

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

Several of the tasks lodged with the school health service pursuant to Section 2-3 of the Regulation on health centres and the school health service require that the service maintains an overview of the status of the pupil population's health and determinants of child and adolescent health. [5] Performance of these tasks will serve to give the school health service an overview of the health status and challenges in the child and adolescent population. In addition, the school health service should be familiar with, and in a position to use, different existing sources to gain an overview of the population at school and local-authority level.

The school health service programme shall include partnering with schools on measures to promote a sound psychosocial and physical learning and working environment for pupils; see Section 2-3 of the Regulation on health centres and the school health service. In drawing up plans and measures to promote pupil well-being, learning and health, the school health service shall work in partnership with schools; see [the recommendation Systematic partnership](#). Obtaining a joint overview of the status of the pupil population's health and factors impacting it, should be an integral component of the school health service's partnership with the school.

An overview will enable the school health service to perform its tasks efficiently and expediently. The object is to obtain a joint understanding with the school of any challenges and opportunities regarding the pupil population as a whole, as well as regarding individual pupils. This facilitates planning and implementation of universal, group-based and individualised targeted health promotion and preventive work. For the purpose of preventive healthcare, the school health service interfaces with children and adolescents on a wide front, which provides unique insights into their situation. This applies not only to health status directly, but also more generally to living conditions, social networks and the physical and mental environment, school factors etc.

The overview will also enable the school health service to measure trends over time, set goals for planned interventions and measure their effects. [29]

In partnership with the other municipal health and care services, the school health service shall be instrumental in obtaining an overview of the state of health of the general population, and the positive and negative factors affecting it, which the local authority is required to monitor under Section 5 of the Public Health Act; see Section 2-2 of the Regulation on health centres and the school health service, and Section 3-3 of the Health and Care Services Act; see [the recommendation Public health work](#). [27][5][7]

Practical information

Obtaining a joint overview of the status of the pupil population's health and factors impacting it should be an integral component of the school health service's partnership with the school. See [the recommendation Systematic partnership](#).

Overview through performance of school health service tasks

The school health service's tasks, pursuant to the Regulation on health centres and the school health service and the present Guideline, will be instrumental in providing the service with an overview of status and challenges in the child and adolescent population.

This applies, for example, to tasks such as:

- Carrying out the school-entry health consultation; see the recommendation School-entry health consultation and the 8th-grade health consultation; see [the recommendation Health consultation, 8th grade](#)
- Attendance at parent meetings and meetings with the school. See, for instance: [the recommendation Parent meetings](#)
- Assistance and education in groups/forms. See [the recommendation Education](#)
- Through other contact with pupils, such as in drop-in consultations. See [the recommendation Low-threshold services](#)
- By performing health assessments such as weighing and measuring pupils, testing vision, hearing and language

Overview through contact with pupils, parents and schools

Consultations with pupils and their parents, both individually and in groups, can help to provide an overview of trends in the population and a picture of the challenges that exist in the local community. The insights gained can help to enable the school health service, in conjunction with the school, to plan and implement targeted school-wide, group-based or individual interventions.

The school health service can, if necessary, collaborate with relevant stakeholders in order to obtain an overview of trends in the population and challenges in the local community. Such stakeholders might be:

- The school's student council

- Teaching staff at the school
- School social workers/ staff working for a good school environment (miljøarbeider)
- Parents' Council Working Committee
- Child Welfare Service
- The police

It must be taken into account the fact that children, adolescents and families with an ethnic-minority background, and indigenous populations may face special challenges. These challenges must be identified in order to understand and overcome them satisfactorily. See [the recommendation Targeted services](#).

Tools and sources which provide a review

The school health service should be familiar with, and able to use, relevant sources and tools which provide an overview of the health status of pupils, including:

- Directorate for Education and Training: [Annual pupils' survey of learning and well-being \(years 5-13\)](#)
- Directorate for Education and Training: [Annual teachers' survey on pupil learning and well-being](#)
- Directorate for Education and Training: [Annual parents' survey on pupil learning and well-being](#)
- [Ungdata](#)
- Norwegian Institute of Public Health: [Municipal public health profiles](#)
- [Directorate for Education and Training: situational analysis resource for schools](#)
- [Statistics Norway, KOSTRA - Municipality-State-Reporting](#)
- [Surveys of quality in local-authority services, the school health service](#)
- The Norwegian Institute of Public Health: [Municipal Public Health Statistics Bank](#)

The school health service can collaborate with expert personnel to interpret different data sources. See [the recommendation Public health work](#).

For more information on public health status and health determinants; see [the Directorate of Health's online articles](#).

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5.1.3 Education: The school health service shall contribute to education in groups or forms at the discretion of the individual school

In order to fulfil its obligation to assist in school education, the school health service should offer schools:

- Assistance in providing education on topics in the school curricula and education linked to specific challenges at the school or in the local community
- Discussions, health information and counselling in groups for pupils with specific needs

Assistance in the school's education should be clarified through the systematic partnership with the school; see [the recommendation Systematic partnership](#).

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

Children and adolescents have the right and the duty to receive lower secondary education and the right to upper secondary education; see Sections 2-1 and 3-1 of the Education Act. [141] The school has the principal responsibility for education of its pupils.

Services for children and adolescents within the school health service shall comprise assistance and education in groups/forms/parent meetings at the school's discretion; see Section 2-3 of the Regulation on health centres and the school health service). [5] In order to meet the requirements of the regulation on assistance in education, the school health service should offer such assistance in line with school curricula for relevant subjects, and offer discussions and guidance for groups of pupils with specific needs, in partnership with the school.

The school health service's obligation to assist in providing education is limited to the extent that a given school requires such assistance. Because each school has the principal responsibility for education, the education that is to be provided by the school health service must be coordinated with the school's curricula. This is best achieved through a close partnership between the school and the school health service, and should form part of the systematic partnership between the school health service and the school; see [the recommendation Systematic partnership](#).

The school health service should assist in health-promotion efforts in such a way that the education is a process that enables children and adolescents to gain greater control over and improve and maintain their health, thereby facilitating healthy choices. [155]

A combination of health education, prevention and health promotion efforts will encourage adolescents to make healthy choices. Educating pupils on health challenges and health awareness in forms can be combined with more in-depth education through group-based discussions and guidance. For group-based sessions, the focus should be on the pupils exchanging ideas and opinions between them in order to foster personal initiative, involvement, engagement and learning.

To make informed choices, children and adolescents need compelling and accurate information about the various health determinants. Health education and information aim to make children and adolescents knowledgeable, and to instil positive attitudes and improve skills. Health information and education is also instrumental in instilling positive social norms related to health behaviours in a population. [156]

A close partnership between schools and the school health service is essential for health promotion and preventive efforts at an early stage in the interests of improving the pupils' school and home environment. In that the school health service with its health promotion and preventive perspective collaborates with teaching staff on health-related education, the two will be mutually complementary. [139]

The users of the school health service indicate that adolescents want to know more about determinants of their physical and mental health and how the two are linked. [140]

When the school health service contributes to school education, experience suggests that pupils find it easier to visit the school health service afterwards.

Practical information

Through the systematic partnership with the school, the school health service should ascertain and plan the service's contribution to school-based health education; see [the recommendation Systematic partnership](#).

Relevant topics for school-based health education, include:

- Mental health
- Sleep
- Diet; see [the recommendation Food and meals](#)
- Physical activity; see [the recommendation Physical activity](#)
- Puberty, the body, and sexual health; see [the recommendation Sexual health education](#)
- Tobacco, alcohol and drugs; see [the recommendation Tobacco, alcohol and drugs](#)
- Violence and abuse; see the chapter on [Violence, abuse and neglect](#)

See the [Directorate for Education and Training's website](#) for a list of curricula.

The education should also be seen in the context of topics raised in the school-entry health consultation and in the health consultation in the 8th grade; see [the recommendation Topics during health consultation](#).

The education must be culturally sensitive and with consideration to children and adolescents with specific needs and challenges; see [the recommendation User participation](#) and [the recommendation Targeted services](#).

Group-based guidance

Extra-curricular group interventions should be based on a knowledge of the challenges faced by children and adolescents at individual schools and in the local community; see [the recommendation Overview](#).

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5.1.4 Sexual health education: The school health service shall offer to assist with school sexual health education

The school health service should **assist in the school's sex education, especially on the topic of sexual health**. The school health service should also consider **offering group-based education** as needed.

The education should ensure that all children and adolescents are empowered with sufficient knowledge and competence concerning sexual health, and should contribute in preventing sexual abuse.

The education should be age-adapted and coordinated with school curricula.

Rationale

Population

Adolecents 12-20 years

Intervention

Interventions including education, information and counselling within the primary health service, school-based intervention or a combination of the two

Comparator

No intervention or standard service

Outcome

Contraceptive use, sexually transmitted disease, unintended pregnancy

Evidence profile

Outcome	Confidence in estimates	Relative effect	No intervention or standard service	Interventions including education, information and counselling within the primary health service, school-based intervention or a combination	Absol. diff.
Contraceptive use, sexually transmitted disease, unintended pregnancy		0 (CI 0 - 0)	0 per 1000	0 per 1000	0 per 1000 (0 - 0)

Summary

Outcome: For a detailed report on the outcomes and grading of the quality of the studies; see the Summary of findings table on page 4 [here](#).

[A Cochrane targeted update](#) summarised research on the effect of multiple interventions to prevented unintended pregnancies with respect to several outcomes: unintended pregnancy, sexual debut, use of condoms, hormonal contraceptives and the incidence of sexually transmitted diseases.

The interventions included a combination of health education/information, skills-building and motivating the use of contraceptives. This form of education/intervention is judged as relevant and feasible for implementation in a partnership between the school health service and schools in Norway. The update included 35 studies representing 67,743 adolescents aged 12-21. The majority of the included studies were conducted in the USA. None of the studies were conducted in Norway.

The interventions were of varying duration and scope. The quality of the evidence was graded from “very low” to “moderate” certainty for different outcome measures; for a detailed explanation of GRADE; see under the About this Guideline tab.

The findings indicate that interventions to prevent unintended pregnancy:

- Probably reduce unintended pregnancies
- Probably increase condom use at last sex, and may increase consistent condom use
- Probably make little or no difference to initiation of sexual debut
- No effect on use of hormonal contraceptives (but confidence in the estimates was assigned the GRADE very low).
- May make little or no difference to sexually transmitted diseases

Population

Children and adolescents 5-13 years

Intervention

Intervention, including education on sexual abuse

Comparator

No education on sexual abuse

Outcome

Skills (protective behaviours, disclosure), knowledge of sexual abuse concepts

Evidence profile

Outcome	Confidence in estimates	Relative effect	No education on sexual abuse	Intervention, including education on sexual abuse	Absolute difference
Skills (protective behaviours, disclosure), knowledge of sexual abuse concepts		0 (CI 0 - 0)	0 per 1000	0 per 1000	0 per 1000 (CI 0 - 0)

Summary

Outcome: For a detailed report on the outcomes and grading of the quality of the evidence; see [Summary of Findings tables in the Norwegian Knowledge Centre for the Health Service's conclusion on this systematic review](#).

One systematic review in particular was highlighted. It included 24 studies representing a total of 5802 schoolchildren and adolescents aged 5-18, and assessed the effectiveness of school-based education programmes for the prevention of child sexual abuse (Walsh et al., 2015). The purpose of the education programmes was to increase knowledge of and skills in a) protective behaviours and b) ability to disclose sexual abuse if it occurred. The education was compared with letting the children/adolescents watch animations versus being wait-listed for education in sexual abuse. This form of education programme is judged as relevant and viable for implementation in a partnership between the school health service and schools in Norway.

The follow-up time in the included studies was generally short, the outcomes were measured immediately post-intervention, but some of the studies obtained follow-up measurements up to six months later. The majority of the included studies were conducted in the USA and Canada, but the remainder were from Asia and Europe. No Norwegian studies were included in this systematic review.

The findings indicate that school-based sexual abuse prevention programmes:

- Probably increase child protective behaviours
- Probably result in more disclosures of past or current sexual abuse
- Probably increase children's knowledge of sexual abuse concepts
- Probably result in little or no difference in children's fear or anxiety of being subjected to sexual abuse

Population

Children and adolescents, 10-20 years

Intervention

The intervention included education, counselling or the like on dating, party and drug-related sexual harassment, assault and sexual abuse

Comparator

No intervention

Outcome

The incidence of sexual harassment, assault and sexual abuse

Evidence profile

Outcome	Confidence in estimates	Relative effect	No intervention	The intervention included education, counselling or the like on dating, party and drug-related sexual harassment, assault and sexual abuse	Absolute difference	Participants (studies), follow-up
The incidence of sexual harassment, assault and sexual abuse		0 (CI 0 - 0)	0 per 1000	0 per 1000	0 per 1000 (CI 0 - 0)	

Summary

Outcome: For a detailed review of the effectiveness estimates and grading of the quality of the evidence, see [the Summary of Findings \(SOF\) – tables on page 3 of the systematic review](#).

A literature search identified 3 high-quality systematic reviews of studies on the effectiveness of interventions to reduce intimate partner violence among young persons aged 12 to 25 (in the context of dating and romantic relationships etc.) (Fellmeth et al., 2013, De Koker et al., 2014, Langford et al., 2014). The summary article by Langford et al. (2014) is based on such a large number of interventions that it was judged as non-viable for a PICO process. The two others summarise interventions (education including health information and skills training), which are judged as being viable for implementation in a partnership between schools and the school health service in Norway.

The systematic review by Fellmeth et al. (2013) reported on the effect of interventions for preventing relationship and dating violence in adolescents and young persons aged between 12 and 25 years. Relationship and dating violence were defined as ranging from verbal abuse, physical and sexual harassment, and threats, to rape and murder. The interventions comprised a combination of education/health information elements and skills training and targeted both young persons who may have never experienced or perpetrated relationship violence/harassment and young persons who had experienced or perpetrated relationship violence/harassment in the past (primary and secondary prevention).

Thirty-three studies, both randomised controlled studies and quasi-randomised studies were included in the meta-analyses. All the studies were from the USA. The majority of interventions were implemented in educational institutions (25 at universities and 10 at upper-secondary schools), while three were in community settings.

The review reports on 4 outcome measures: 1) episodes of relationship and dating violence, 2) attitudes towards relationship and dating violence, 3) behaviour related to relationship and dating violence, 4) knowledge and skills related to relationship and dating violence.

For the outcome measures “episodes” and “attitudes”, there was a near-significant effect from interventions, and for “knowledge” related to relationship violence, the effect was significant (measured in scales). None of the other measures were demonstrated to have an effect or any effect trend; for details see below. The quality according to the GRADE methodology for reported outcome measures was moderate (for details of GRADE, see under the About the Guideline tab). None of the included studies reported effects on physical or psychosocial health targets, or undesirable effects.

Eight of the included studies, representing a total of 3405 individuals, reported on the **effect on episodes** of relationship violence, but the findings across the studies showed no clear effect. The near-significant effect showed a trend from relatively great effect to negligible or harmful effect [RR 0.81 (95 CI: 0.64 to 1.02)]. This means that in the best case interventions can achieve a 46% reduction in episodes of relationship violence with a variation towards no or negligible harmful effect. Further, this means that had the intervention been carried out for the population that received no intervention (control groups), in absolute terms, this would result in 59 fewer to 0 or 3 more episodes from implementing interventions.

22 of the included studies representing a total of 5256 individuals reported an **effect on attitudes to relationship** violence. The results of the pooled studies showed a near-significant effect, but on average a 0.12 higher score in favour of the intervention group (95% CI: -0.02 to 0.27), which points to somewhat less acceptance of relationship violence than in the control group. This implies that, in the best case, a beneficial change in attitudes toward relationship violence may be achieved from interventions of 0.27 to no improvement or a negative trend of -0.02.

Ten of the included studies representing a total of 6206 individuals reported an effect on **knowledge** related to relationship violence (measured with reference to different types of scales). The results of the pooled studies pointed to a small, significant average increase (improvement) in knowledge in favour of the intervention group of 0.43 (95% CI: 0.25 to 0.61). This implies that, in the best case, a beneficial change in knowledge related to relationship and dating violence may be achieved from interventions of 0.61 as the best effect to the lowest of 0.25.

Rationale

The scope of this recommendation is based on regulations, research basis and the consensus of the working group.

The school health service shall comprise education in groups, forms and parent meetings at the school's discretion; see Section 2-3 of the Regulation on health centres and the school health service. [5] Assistance in classroom-based and group-based sexual health education should be offered from primary school to upper-secondary level. See the [recommendation Education](#) and [the recommendation Parent meetings](#).

Public health and life-skills are key topics in schools. The ability to make healthy choices is an important life skill, and knowledge of physical, mental and sexual health, and lifestyle consequences are significant health determinants. [154] School-based sexuality education programmes are instrumental in ensuring that children and adolescents acquire the necessary knowledge, skills and attitudes concerning sexual health, factors that promote lifelong quality of life, coping and self-esteem.

Empirically, sexual health is one of the areas in which the school health service can contribute valuable expertise in supplement to school expertise. The universal approach to education programmes can be supplemented and boosted by the school health service's scope for providing individualised guidance. Where the school health service is visible to everyone in group-based education, it will be easier for individual pupils to contact the service for personal advice if needed. For details, see [the recommendation Health consultation, 8th grade](#) and [the recommendation Visits to YHCs](#)

Specific education on physiology and anatomy, contraception and sexually transmitted diseases is a field of sex education that makes high demands on up-to-date and comprehensive knowledge. Thus, the school health service should strive to offer its expertise in this element of school-based sexuality education programmes.

Rationale and principles for education

- **Promotion of sexual health:** openness, respect for diversity and positive attitudes to sexuality are societal factors that promote sexual health. WHO and other international institutions emphasise that the best strategy for addressing challenges and problems related to sexual health, abuse, illegal sexual practices, unintended pregnancies and sexually transmitted diseases is to promote, and focus on, the positive aspects of sexuality. [165]
- **Age-appropriate approach:** The foundation for sexual pleasure, coping and a secure identity is established in childhood, and age-appropriate education on body, identity and coping are crucial for later development. [162]
- **Education before the need arises:** Pupils should receive sexuality education before they need to know. [162] Education on condom-use and other methods of birth control, and challenges related to sexuality and alcohol and drugs, should be provided before the pupils are confronted with situations where they need to put knowledge of these aspects to use. This encourages adolescents to have their sexual debut later, more readily use a condom and other contraceptives and develop a positive attitude towards their own sexuality and to sexual intimacy.
- **Information and knowledge in a secure setting:** The internet is an important source of information about the body, boundaries and sexuality (WHO, 2010), but online information may be inaccurate or provide a distorted idea of reality. Sexuality education from trusted adults with appropriate expertise is consequently an important rectifier and input.
- **Empowerment:** Access to knowledge, information and education on sexuality, sexual health and interpersonal relations are fundamental for empowerment and control in relation to the individual's personal health.
- **Universal and individual interventions and scope for reflection:** Assistance in teaching situations will reach all the pupils. The pupils should have the opportunity to reflect on relationships, feelings, values, attitudes and in that way acquire fundamental communication skills.
- **The norm-critical approach** involves challenging preconceptions of roles and norms in society, of considering whether practice and values are aligned, and challenges prevailing practices. The value of the norm-critical approach in, for example, sexuality education is that it facilitates discussion of the nature of sexual health in the light of existing and accepted diversity in society.
- **Detecting and preventing sexual abuse:** The general consensus in expert environments is that a sound conceptual apparatus, body confidence and autonomy are key protective factors against sexual abuse of children. A positive and confident attitude to their body enables children to distinguish between positive and inappropriate touching. The confidence to confide in a trusted adult is also important in preventing child abuse.
- **Groups with specific needs:** Certain groups have specific needs which the general sexuality education may not address. In order to fulfil the right to equitable services, the school health service should consider providing targeted education in groups or individually outside the classroom.

Research evidence concerning the effect of interventions to reduce the number of unintended pregnancies

Summarised international research indicates that a combination of education, health information, skills training and motivation for the use of contraception:

- Probably reduce the number of unintended pregnancies
- Probably result in a higher proportion using a condom at last sex, and may increase consistent condom use
- The effect of other outcome measures shows no effect and/or the quality of the evidence (GRADE) is so low that it is difficult to draw any conclusions concerning the effect.

For details, see Research basis. [163]

Research evidence concerning the effect of education on concepts of sexual abuse perpetrated against children and adolescents

Systematic reviews of international studies indicate that education programmes for children concerning sexual abuse concepts may have an effect on several outcomes, and suggest that such education does not instil more anxiety and fear. For details, see Research basis. [163]

The main goal of school-based education to prevent sexual abuse should be for children and adolescents to gain:

- Knowledge of concepts of sexual abuse
- Relevant skills for preventing sexual abuse
- Knowledge of who to tell if they or others experience sexual abuse

Research evidence concerning the effect of interventions to reduce relationship and dating violence amongst adolescents

Systematic international research demonstrates that interventions in schools and communities (mix of primary and secondary prevention) to reduce the incidence of relationship and dating violence amongst adolescents, which includes a combination of education and health information and skills building, probably:

- Have effect on knowledge of concepts
- At best result in fewer episodes of relationship violence and harassment
- Foster better attitudes among adolescents

Evaluations

Although knowledge in itself is not usually sufficient to influence behaviour, it can be instrumental in fostering positive social norms relating to health behaviour within a population. [156]
Increased knowledge serves as an element in long-term efforts to influence behavioural change.

The variation in estimated effect for the outcomes 'behaviour' (episodes of relationship violence/harassment) and 'attitudes' was so great that it is uncertain whether unwanted effects can be avoided for these outcomes. Further studies are therefore needed in this area, and for the school health service's focus and objectives, it would be desirable to study the effect of primary and secondary preventive interventions separately. For details, see Research basis. [161] [160]

Further research is needed regarding the design and evaluation of effective interventions in order to reduce relationship violence/harassment amongst adolescents before specific programmes can be recommended.

About violence and sexual abuse

Children must be protected against all forms of sexual abuse. A sound conceptual apparatus and confidence in their own body are key protective factors in countering sexual abuse.

School-based interventions and education programmes to prevent sexual abuse are in line with the action plan [En god barndom varer livet ut \(a good childhood lasts a lifetime\)](#) on preventing violence and abuse of children and adolescents in and outside the home.

Children's feedback must be used proactively to improve interventions for those who have experienced violence or sexual abuse.

Practical information

The school health service should in particular offer its expertise in education on identity, romantic relationships and dating, boundaries, physiology and anatomy (erogenous zones etc.), contraceptives and sexually transmitted diseases.

Openness, respect for diversity and positive attitudes to sexuality are key topics for the education programme.

In all education, the service should:

- Use gender- and sexual orientation-neutral language. See [the recommendation Gender- and sexual orientation-neutral language](#)
- Be culturally sensitive. Interventions should be sensitive to the target groups they aim to benefit. Information, education and interventions should be designed interactively with pupils. See [the recommendation User participation and the recommendation Targeted services](#)
- Take account of links between ethnicity, tradition, gender, age, disability and sexual orientation (intersectionality)

Assisting in school-based education

The education should be integrated with the school's life-skills teaching, where topics such as self-respect, interpersonal relationships and sexuality are topical. Sexuality education serves to improve school-wide unity, the pupils' psychosocial environment and boosts anti-bullying efforts. [154]

Sexuality education should be integrated with the school curriculum. For more information about curricula, see the website of the Ministry of Education and Training: <https://www.udir.no/laring-og-trivsel/lareplanverk...>

The pupils should have the opportunity to reflect on relationships, feelings, values, attitudes, identity, alcohol and boundaries and thus acquire fundamental skills. Group-based education offers extended scope for exchanging ideas and opinions, for reflection and for concentrating on more intensive skills building than the curriculum permits.

The education should be adapted to the children's age and maturity and may vary in form and content. Educational aids such as drama, animations, puppet shows, films and interaction through role play and scenarios may be suitable.

Topics that the school health service should contribute to in the school-based education break down as follows:

Primary school

- Sexual rights – self-respect, interpersonal relationships, sexuality and identity
- Physical development – puberty, fertility, reproduction
- Sexuality in society – attitudes, values and diversity
- Bodily integrity and boundaries
- Violence and sexual abuse; see [the chapter Violence, abuse and neglect](#)

Lower secondary school

- Physical development – puberty, fertility, reproduction
- Sexuality in society – attitudes, values and diversity
- Sexual rights and bodily integrity and boundaries
- Self-respect, interpersonal relationships, sexuality and identity
- Violence and sexual abuse; see [the chapter Violence, abuse and neglect](#)
- Contraception, preventing unintended pregnancy and abortion

- Sexually transmitted infections (STIs) and condom use
- Sexuality, alcohol, drugs and sexual abuse; see [the recommendation Tobacco, alcohol and drugs](#)

Upper secondary school

- Sexuality in society – attitudes, values and diversity
- Sexual rights and bodily integrity and boundaries
- Self-respect, interpersonal relationships, sexuality and identity
- Violence and sexual abuse; see [the chapter Violence, abuse and neglect](#)
- Contraception, preventing unintended pregnancy and abortion
- Sexually transmitted infections (STIs) and condom use
- Sexuality, alcohol, drugs and sexual abuse; see [the recommendation Tobacco, alcohol and drugs](#)

Group-based and targeted sex education

As needed, and in partnership with schools, the school health service should offer group-based sexual health education. Education about puberty at primary school level may be suitable for group-based sessions.

To respect the right of children and adolescents with specific needs to equitable services, the school health service should consider providing individualised education outside the classroom. Interventions and services should be sensitive to their target groups.

Guidelines for the content of education to prevent sexual abuse

Children and adolescents should learn about personal boundaries and concepts of sexual abuse, and be taught skills to prevent sexual abuse. This includes knowledge and skills concerning:

- Identifying problem situations
- How to avoid exposure to risk situations, and awareness of what is appropriate in contact with strangers
- That children and adolescents decide over their own bodies
- Setting boundaries, including the ability to tell the difference between positive and inappropriate touching
- Knowing who children and adolescents can tell if they or others suffer sexual abuse

Children and adolescents report that

Children who have themselves been victim of violence and abuse want public health nurses to [164]:

- Visit them in classrooms and otherwise be more visible amongst the pupils
- Explain what the public health nurse can help with and what children can talk to her about
- Explain confidentiality and its limitations
- Follow up from the 1st grade onwards
- Use child-friendly language without any difficult words

More information

- [Uke 6](#) is a free sex education resource for working with skills targets in several subjects
- [The Directorate of Health's online articles on sexual health](#) contain additional information on the topic of sexual health
- [Ung.no](#) is the public sector youth information channel, where adolescents can look up answers to their questions

- Sjekkdeg.no can be used for learning about contraception and sexually transmitted infections
- The Norwegian Directorate for Children, Youth and Family affairs publishes [Sexuality and gender - educational resources on sexuality and gender for secondary school teachers](#) to address topics such as sexual harassment and gender-based bullying
- The [Sex og samfunn](#) website provides comprehensive information on sexuality, contraception and sexually transmitted diseases. *Sex og samfunn* has also produced a [Sexual health methodology book](#) for use by health professionals

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5.1.5 Visits to YHCs: The school health service should offer all lower secondary school pupils a visit to a youth health centre (YHC)

The visit to the YHCs should serve as a supplement to the education provided by the school and the school health service concerning sexual health, by:

- Making adolescents specifically aware of the health centre's location, opening hours and the services that are provided there and elsewhere within the health service relating to physical and mental health
- Supplementing other education concerning sexually transmitted infections (STIs) and the availability and use of contraceptives
- Supplementing other education concerning how tests, physical examinations and other procedures are carried out in a specific setting

Rationale

Population

Adolescents 12-20 years

Intervention

Intervention including education, information and counselling within the primary health service, in school-based programmes or a combination of the two

Comparator

No intervention or standard service

Outcome

Contraceptive use, sexually transmitted disease, unintended pregnancy

Evidence profile

Outcome	Confidence in estimates	Relative effect	No intervention or standard service	Intervention including education, information and counselling within the primary health service, in school-based programmes or a combination of the two	Absol. diff.
Contraceptive use, sexually transmitted disease, unintended pregnancy		0 (CI 0 - 0)	0 per 1000	0 per 1000	0 per 1000 (0 - 0)

Summary

Outcome: For a detailed report on the outcomes and grading of the quality of the studies; see [Summary of Findings tables in the Norwegian Knowledge Centre for the Health Service's conclusion on this systematic review](#).

One systematic review in particular was highlighted. It included 24 studies representing a total of 5802 schoolchildren and adolescents aged 5-18, and assessed the effectiveness of school-based education programmes for the prevention of child sexual abuse (Walsh et al., 2015). The purpose of the education programmes was to increase knowledge of and skills in a) protective behaviours and b) ability to disclose sexual abuse if it occurred. The education was compared with letting the children/adolescents watch animations or being wait-listed for education in sexual abuse. This form of education programme is judged as relevant and feasible for implementation in a partnership between the school health service and schools in Norway.

The follow-up time in the included studies was generally short, the outcomes were measured immediately post-intervention, but some of the studies obtained follow-up measurements up to six months later. The majority of the included studies were conducted in the USA and Canada, but the remainder were from Asia and Europe. No Norwegian studies were included in this systematic review.

The findings indicate that school-based sexual abuse prevention programmes:

- Probably increase child protective behaviours
- Probably result in more disclosures of past or current sexual abuse
- Probably increase children's knowledge of sexual abuse concepts
- Probably result in little or no difference in children's fear or anxiety of being subjected to sexual abuse

Population

Children and adolescents 5-13 years

Intervention

Intervention, including education on sexual abuse

Comparator

No education on sexual abuse

Outcome

Skills (protective behaviours, disclosure), knowledge of sexual abuse concepts

Evidence profile

Outcome	Confidence in estimates	Relative effect	No education on sexual abuse	Intervention, including education on sexual abuse	Absolute difference
Skills (protective behaviours, disclosure), knowledge of sexual abuse concepts		0 (CI 0 - 0)	0 per 1000	0 per 1000	0 per 1000 (CI 0 - 0)

Summary

Outcome: For a detailed report on the outcomes and grading of the quality of the evidence; see [Summary of Findings tables in the Norwegian Knowledge Centre for the Health Service's conclusion on this systematic review](#).

One systematic review in particular was highlighted. It included 24 studies representing a total of 5802 schoolchildren and adolescents aged 5-18, and assessed the effectiveness of school-based education programmes for the prevention of child sexual abuse (Walsh et al., 2015). The purpose of the education programmes was to increase knowledge of and skills in a) protective behaviours and b) ability to disclose sexual abuse if it occurred. The education was compared with letting the children/adolescents watch animations or being wait-listed for education in sexual abuse. This form of education programme is judged as relevant and feasible for implementation in a partnership between the school health service and schools in Norway.

The follow-up time in the included studies was generally short, the outcomes were measured immediately post-intervention, but some of the studies obtained follow-up measurements up to six months later. The majority of the included studies were conducted in the USA and Canada, but the remainder were from Asia and Europe. No Norwegian studies were included in this systematic review.

The findings indicate that school-based sexual abuse prevention programmes:

- Probably increase child protective behaviours
- Probably result in more disclosures of past or current sexual abuse
- Probably increase children's knowledge of sexual abuse concepts
- Probably result in little or no difference in children's fear or anxiety of being subjected to sexual abuse

Population

Children and adolescents, 10-20 years

Intervention

The intervention included education, counselling or the like on dating, party and alcohol/drug-related sexual harassment, assault and sexual abuse

Comparator

No intervention

Outcome

Skills (protective behaviours, disclosure), knowledge of sexual abuse concepts

Evidence profile

Outcome	Confidence in estimates	Relative effect	No intervention	The intervention included education, counselling or the like on dating, party and alcohol/drug-related sexual harassment, assault and sexual abuse	Absolute difference	Part (st. info)
Skills (protective behaviours, disclosure), knowledge of sexual abuse concepts		0 (CI 0 - 0)	0 per 1000	0 per 1000	0 per 1000 (CI 0 - 0)	

Summary

Outcome: For a detailed review of the effectiveness estimates and grading of the quality of the evidence, see [the Summary of Findings \(SOF\) tables on page 3 of the systematic review](#).

A literature search identified 3 high-quality systematic reviews of studies on the effectiveness of interventions to reduce intimate partner violence among young persons aged 12 to 25 (in the context of dating and romantic relationships etc.) (Fellmeth et al., 2013, De Koker et al., 2014, Langford et al., 2014). The summary article by Langford et al. (2014) is based on such a large number of interventions that it was judged as non-viable for a PICO process. The two others summarise interventions (education including health information and skills training), which are judged as being feasible for implementation in a partnership between schools and the school health service in Norway.

The systematic review by Fellmeth et al. (2013) reported on the effect of interventions for reducing relationship and dating violence in adolescents and young persons aged between 12 and 25 years. Relationship and dating violence were defined as ranging from verbal abuse, physical and sexual harassment, and threats to rape and murder. The interventions comprised a combination of education/health information elements and skills training and targeted both young persons who have never experienced or perpetrated relationship violence/harassment and young persons who had experienced or perpetrated relationship violence/harassment in the past (primary and secondary prevention).

Thirty-three studies, both randomised controlled studies and quasi-randomised studies were included in the meta-analyses. All the studies were from the USA. The majority of interventions were implemented in educational institutions (25 at universities and 10 at lower-secondary schools), while three were in community settings.

The review reports on 4 outcome measures: 1) episodes of relationship and dating violence, 2) attitudes towards relationship and dating violence, 3) behaviour related to relationship and dating violence, 4) knowledge and skills related to relationship and dating violence.

For the outcome measures “episodes” and “attitudes”, there was a near-significant effect from

interventions, and for “knowledge” related to relationship violence, the effect was significant (measured in scales). None of the other measures were demonstrated to have an effect or any effect trend; for details see below. The quality according to the GRADE methodology for reported outcome measures was moderate (for details of GRADE, see under the About the Guideline tab). None of the included studies reported effects on physical or psychosocial health targets, or undesirable effects.

Eight of the included studies, representing a total of 3405 individuals, reported on the **effect on episodes** of relationship violence, but the findings across the studies showed no clear effect. The near-significant effect showed a trend from relatively great effect to negligible or harmful effect [RR 0.81 (95 CI:

0.64 to 1.02)]. This means that in the best case interventions can achieve a 46% reduction in episodes of relationship violence with a variation towards no or minor harmful effect. Further, this means that had the intervention been carried out for the population that received no intervention (control groups), in absolute terms, this would result in 59 fewer to 0 or 3 more episodes from implementing interventions.

22 of the included studies representing a total of 5256 individuals reported an **effect on attitudes to relationship violence**. The results of the pooled studies showed a near-significant effect, but on average a 0.12 higher score in favour of the intervention group (95% CI: -0.02 to 0.27), which points to somewhat less acceptance of relationship violence than in the control group. This implies that, in the best case, a beneficial change in attitudes toward relationship violence may be achieved from interventions of 0.27 to no improvement or a negative trend of -0.02.

Ten of the included studies representing a total of 6206 individuals reported an effect on **knowledge** related to relationship violence (measured with reference to different types of scales). The results of the pooled studies pointed to a small, significant average increase (improvement) in knowledge in favour of the intervention group of 0.43 (95% CI: 0.25 to 0.61). This implies that, in the best case, a beneficial change in knowledge related to relationship and dating violence may be achieved from interventions of 0.61 as the best effect to the lowest of 0.25.

Rationale

The scope of this recommendation is based on regulations, research basis and the consensus of the working group.

The school health service programme is required to comprise information, guidance and counselling to individuals and groups, as well as assistance and education in groups, forms and parents' meetings at the schools' discretion; see Section 2-3 of the Regulation on health centres and the school health service. [5] The recommendation is for a proportion of these statutory tasks to consist of inviting lower secondary school pupils to visit their local youth health centre (YHC).

Visits to a YHC can be conducted at an early stage at lower secondary school, but should be timed so as to be relevant to the majority of the pupils. By conducting visits to YHCs, adolescents will gain information about the scope of the service, which health issues they can raise, the format of consultations and what is involved in being tested for a sexually transmitted disease for example.

One aim of the visit is to ensure that adolescents become aware of:

- the health centre's location
- that the service is free of charge
- opening hours
- the nature of services provided at the YHC and elsewhere within the health service

Awareness of the services offered by a YHC will help to increase usage, and represent an important initiative for pupils who drop out of upper secondary school, adolescents who have a high threshold for contacting the health service and boys who are reluctant to seek out the health service; see [the recommendation measures to reach boys](#). The feedback received from the service is that many adolescents contact a YHC to talk about contraception, pregnancy, abortion, eating disorders, depression, grief, loneliness, difficult family relationships, drugs/alcohol, violence, abuse and bullying.

There is little evidence as to whether educational visits for pupils increase the use of YHCs. However, the Action plan for preventing unintended pregnancy and abortion 1999 – 2003 (Handlingsplan for forebygging av uønsket svangerskap og abort 1999 – 2003) refers to a rise in the number of visits made to

the youth health centre where the pupils among other measures had a visit to the youth health centres. [158]

The service will supplement school-based sexuality education and the school health services guidance for adolescents concerning sexuality, contraception and sexual health. Experiences from school-based education indicate that pupils are more likely to contact the service afterwards.

Sexual health

Having the necessary resources to act and a positive attitude to one's own body is crucial for sexual pleasure and for the development of a secure sexual identity and more confident sexual behaviour.

Adolescents who receive sexuality education before they need to know have their sexual debut later, more readily use a condom and other contraceptives, and develop a positive attitude to their own sexuality and to sexual intimacy. These are factors which can prevent sexually transmitted infections (STIs) and unintended pregnancy. WHO recommends that sexuality education programmes should be relevant to the stage of adolescent sexual development.[162] See [the recommendation Sexual health education](#).

The proportion of adolescents who state that they have had sex increases for each year group through the teenage years. Seven per cent had had sex in the 8th grade, 14 per cent in the 9th grade and 24 per cent when leaving lower secondary school. [159] Adolescents who have a low socioeconomic status or other vulnerability factors tend to have their sexual debut earlier, have more partners and become parents in their teens more often than the majority of adolescents.

Research evidence concerning the effect of measures to reduce unintended pregnancy

Summarised international research indicates that teaching based on a combination of teaching health information, skills training and motivation for the use of contraception:

- Probably reduce the number of unintended pregnancies
- Probably increase condom use at last sex, and may increase consistent condom use

See Research basis. [157]

The effect of other outcome measures shows no effect and/or the quality of the evidence (GRADE) is so low that it is difficult to draw any conclusions concerning the effect.

Research evidence concerning the effect of education on concepts of sexual abuse perpetrated against children and adolescents

Summarized international reviews indicate that educating children and adolescents about sexual abuse concepts probably have a beneficial effect on numerous outcomes (self-protective skills, proportion who are willing to disclose that they have experienced sexual abuse, and knowledge of concepts of sexual abuse). Such education does not appear to cause any increase in anxiety or fear of being subjected to sexual abuse; see Research basis. [163]

Research evidence concerning the effect of measures to reduce relationship and dating violence amongst adolescents

Systematic reviews indicate that programmes and interventions in schools and communities (mix of primary and secondary prevention) to reduce the incidence of relationship and dating violence amongst adolescents, which includes a combination of education and health information and skills training, probably:

a) have an effect on knowledge, b) at best may result in fewer episodes of relationship violence/harassment and c) improve attitudes among adolescents; see Research basis. [161] [160]

The reviews showed that the variation in estimated effect for the outcomes 'behaviour' (episodes of relationship violence/harassment) and 'attitudes' was so great that it is uncertain whether unwanted effects can be avoided for these outcomes. Further research is needed regarding the development and evaluation of effective measures (both primary and secondary preventive measures) in order to reduce relationship violence/harassment amongst adolescents.

Evaluations

Although knowledge in itself is not usually sufficient to influence behaviour, it can be instrumental in fostering positive social norms relating to health behaviour within a population. [156]
Increased knowledge of concepts serves as an element in long-term efforts to influence behavioural change.

Practical information

The school health service and youth health centres (YHC) should work in partnership to offer lower secondary school pupils visits to YHCs.

Youth sexual development and experimentation varies from one individual to the next. The visit to the YHC should happen at a time when it is relevant to the majority of the pupils.

Where geographic distances make it difficult to conduct a visit to a YHC, other measures should be considered, e.g. a member of staff from a YHC could visit the school or an information video could be produced about the services provided by the YHC.

Planning visits to YHCs

The school health service should ensure that the school principal and relevant contact teachers receive an invitation to the YHC visit, with information about the date/time, content and duration.

- Teachers should be invited to participate with the pupils
- The date/time of the visit to the YHC should be integrated in the pupils' timetable, and ideally with an outline programme for the visit
- The visit should take account of the pupils' knowledge of the topics to be addressed
- Pupils with specific needs for adapted teaching and the teachers' role during the visit should be clarified in advance

The visit should include a tour of the premises and information concerning:

- Services available
- The fact that adolescents can obtain guidance regarding sexual health
- The fact that adolescents can get help and guidance concerning questions and challenges linked to physical and mental health, e.g. diet, eating disorders, sleep, tobacco, alcohol, other drugs and medication use, violence, sexual abuse and neglect
- The staff and their professional background
- Confidentiality and its limitations
- That the services are free
- Opening hours and how to contact the centre, including the drop-in service

The visit should supplement other education concerning sexually transmitted infections (STIs) and the availability and use of contraceptives. The pupils should be informed about how tests, physical examinations and other procedures are carried out in a specific setting such as a youth health centre. See [the recommendation Sexual health education](#).

The school health services should request feedback from YHCs concerning experiences after the visit

- It is important to obtain information concerning specific observations and other aspects which could be of importance for further collaboration and follow-up of pupil groups or forms
- The school health service or YHC should also give the school feedback concerning experiences from the visit. In this context, health professionals must observe confidentiality

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5.1.6 Psychosocial environment: The school health service should contribute to the schools' work relating to measures which promote a good psychosocial environment

In partnership with the school, the school health service should particularly focus on:

- Promoting a good psychosocial environment at the school
- Prevent **unhappiness, bullying and mental health problems** amongst children and adolescents through universal, group and individually oriented measures

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

The school shall work actively and systematically to promote a good psychosocial environment in which every pupil can experience security and social affinity; see Section 9a-3 of the Education Act (*opplæringsloven*).[141] The services offered to children and adolescents by the school health service should include preventive psychosocial work and collaboration with schools concerning measures to promote good psychosocial and physical learning and working environments for pupils; see Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*).[5] The school health service should therefore work closely with the school in order to implement measures which promote a good psychosocial environment.

The school health service should look as much at the strengths of pupils as at risk factors, problems and illnesses. Well-being and good mental health are important in themselves, and protect children and adolescents from emotional and behavioural problems, violence and crime, teenage pregnancy, drug and alcohol abuse and drop-out. Structural factors are vital for creating healthy environments which promote well-being. A good psychosocial environment and a good learning environment promote well-being and prevent bullying, and it is therefore important that the school health service contributes to the primary preventive work that is carried out at the school.

The mental health of children and adolescents is of particular importance for well-being, academic performance and the ability to function in the school environment. At the same time, the academic performance of children and adolescents is vital for mental health (Gustafsson et al, 2010). At school, bullying and a lack of coping resources are amongst the most serious risk factors regarding poor mental health, and the Norwegian Institute of Public Health recommends that programmes be implemented to prevent bullying (Norwegian Institute of Public Health, 2011). [113]

Both Norwegian and international research shows a link between mental health and drop-out at upper secondary schools. [166] [168] Measures which help children and adolescents who are struggling with academic and social difficulties can be effective in helping to prevent absence and drop-out. The preventive work should start at an early stage and cover all phases of education. The transitions between primary school and lower secondary school and between lower secondary school and upper secondary school are particularly vulnerable phases. [153]

Other guidelines and evidence-based knowledge of the effects of measures

Guidelines published by the National Institute for Health and Care Excellence (NICE) recommend that schools establish holistic programmes which promote the social and emotional abilities and well-being of children in the age range 4 to 19, and that schools have access to competence, advice and support so that they can implement effective measures. [169] [170]

The National Institute of Public Health has recommended that programmes to combat bullying and behavioural problems with documented effects be carried out in primary and lower secondary schools in Norway. [113] Numerous programmes aimed at combating bullying and behavioural problems are in use and have been assessed in Norway; see [Ungsinn.no](https://ungsin.no). It is up to the school to decide if programmes should be used.

It has been noted that many measures aimed at combating bullying do not take account of the special characteristics of digital bullying. [171] The National Institute of Public Health's systematic review of digital bullying concludes that there is a lack of knowledge in this field, particularly high-quality research documentation. No Norwegian studies of measures to combat digital bullying have been carried out.

Background

Environmental factors which are key to boosting the health of children and adolescents coincide with fundamental conditions that contribute to a positive learning environment. A healthy school environment consists of a school which:

- Offers pupils opportunities to actively participate and develop
- Offers pupils opportunities to develop coping resources
- Is characterised by positive relationships between the pupils, and between the pupils and the school's staff
- Is free from bullying

School is important for the development and maintenance of social networks. A good learning environment can provide many good experiences of community and help pupils to develop coping resources. These are factors which can boost and protect the mental health of children. A child's well-being at school correlates with their reported mental health and well-being later in life.

Practical information

Through the systematic partnership with the school, the school health service should ascertain and plan the service's contribution to the work relating to the psychosocial environment at the school; [see the recommendation Systematic partnership](#).

The school health service should also have an overview of trends and developments in the environment at the school and in the local community in order to be able to implement secondary preventive measures as and when necessary; see [the recommendation Overview](#).

Promote a good psychosocial environment at the school

A positive psychosocial environment and a good learning environment promotes well-being and prevents bullying.

The school health service should be familiar with the school's plans for a good school environment and help to ensure that children and adolescents develop coping resources as well as a sense of affinity.

The partnership with the school should revolve around the creation of a secure and inclusive community around the children, where all the pupils take responsibility for a secure and good psychosocial environment both in class and at the school generally.

Among other things, the school health service should help to:

- Normalise diversity within the pupil group. See [the recommendation Gender- and sexual orientation-neutral language](#)
- Adapt the outdoor areas of schools to meet the needs of pupils, e.g. in order to facilitate physical activity and play. See [the recommendation Physical activity](#)
- Facilitate a good framework around school meals. See [the recommendations Food and meals](#)
- Follow up children and adolescents who are experiencing difficulties. See [the recommendation Follow-up of mental health](#)
- Ensure the participation and involvement of children and parents in the work. See [the recommendation User participation](#) and [the recommendation Parent meetings](#)
- Contribute to teaching concerning topics such as mental health, violence, abuse and neglect, nutrition and physical activity. See [the recommendation Education](#)
- Ensure that pupils are familiar with the services offered by the school health service. See [the recommendation Low-threshold services](#)

More information on psychosocial environment and the prevention of bullying

- [The Directorate of Health's website on Mental health in schools](#)
- [The Directorate of Education's pages on bullying](#)

Group- and individual-based measures to prevent bullying, unhappiness and mental problems

The school health service should contribute to:

- Early interventions through extra follow-up and support in classes, groups and at individual level as and when necessary
- The follow-up of pupils at individual level as and when necessary, e.g. children or adolescents who are being bullied or are bullying others

Bullying and well-being should be brought up in a meeting with the individual pupil. See the recommendation Topics during health consultations and [the recommendation Underlying causes](#).

Follow-up when necessary

The school health service should offer children and adolescents follow-up consultations, and refer them to a GP or psychologist as and when necessary.

Digital bullying

Bullying via mobile phone and online mostly takes place outside school, but most people who are bullied online are also bullied in the traditional manner. As regards digital bullying which takes place outside school, it may be necessary for the school health service and the school to work with the parents, police or others to resolve issues.

For more information on digital bullying; see [the Directorate of Education's website](#)

Relevant reports and background information:

- [Ungdata - Nasjonale resultater 2014, NOVA Rapport nr 7/15 \(Ungdata - National results 2014, NOVA Report no. 7/15\)](#)
- [En studie av skolemiljøprogrammet i norsk skole. NOVA Rapport nr 15/14 \(A study of the school](#)

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- [Skolers arbeid med elevenes psykososiale miljø, NOVA Rapport nr 14/15 \(The work of schools relating to the psychosocial environment of pupils, NOVA Report no. 14/15\)](#)
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5.1.7 Tobacco, alcohol and drugs: The school health service should contribute to the work of schools relating to universal measures to prevent the use of tobacco, alcohol and drugs

The school health service should work with schools regarding plans and measures to **prevent the use of tobacco, alcohol and drugs** amongst pupils.

The school health service should:

- Have an overview of support material and drug prevention work in schools
- Work with schools concerning the implementation of learning activities linked to competence targets relating to alcohol and drugs in study plans
- Work with schools concerning measures to prevent the use of tobacco amongst pupils

The work of the school health service to prevent the use of tobacco, alcohol and drugs should be based on local circumstances and challenges; see [the recommendation Overview](#).

Rationale

The scope of this recommendation is based on regulations, research basis and the consensus of the working group.

The services offered to children and adolescents by the school health service should include preventive psychosocial work and assistance and teaching in groups, classes and at parent meetings in accordance with the wishes of the school; see Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*). [5] In these tasks, the school health service should work on universal measures to prevent the use of tobacco, alcohol and drugs. This work should be carried out in collaboration with schools.

Tobacco and alcohol prevention measures carried out by the school health service support the 2013-2017 NCD strategy for the prevention of four non-communicable common diseases; cardiovascular diseases, diabetes, COPD and cancer. [54] Common underlying risk factors for the non-communicable diseases are poor diet, physical inactivity, tobacco use and harmful use of alcohol.

Two key targets in the NCD strategy are to:

- Prevent adolescents from starting to smoke or take oral tobacco (snus)
- Slow down the increase in alcohol consumption, raise awareness of the links between alcohol and health and reduce the occurrence of alcohol-related diseases.

Research-based knowledge concerning the effect of school-based measures to combat the use of tobacco, alcohol and drugs

The Norwegian Knowledge Centre for the Health Services' report from 2012 concerning [“The effect of primary preventive measures to combat the use of tobacco, alcohol and drugs by children and adolescent”](#) (*Effekten av primærforebyggende tiltak mot bruk av tobakk, alkohol og andre rusmidler hos barn og unge*) summarises ten high-quality systematic reviews based on international research, where the documentation is graded. The report's conclusions include:

- Extensive school-based measures to combat the use of alcohol and marijuana are effective in preventing the use of both alcohol and marijuana amongst 10-15-year olds.
- School-based measures to combat illegal drugs which place emphasis on skills are probably effective in preventing the use of hard drugs amongst children and adolescents.
- School-based preventive measures to combat smoking which emphasise social skills amongst children and adolescents may be effective.
- School-based measures aimed at combating illegal drugs (emphasis on knowledge) and multi-component measures to prevent the use of alcohol amongst children and adolescents may be effective.

- School-based measures to combat the use of alcohol and marijuana which only emphasise knowledge are probably not effective in preventing alcohol consumption amongst 10-15-year olds.

The report stresses that there is insufficient high-quality documentation, but preventive school-based measures are important in order to reach all adolescents and measures should be theoretically based and last over time.

Norwegian alcohol and drug prevention programmes have been assessed in the report entitled Preventive measures in schools (Forebyggende innsatser i skolen). [174] It is noted that there is evidence to suggest that the alcohol and drug prevention work being carried out at lower and upper secondary schools should be intensified. [175]

Deliberations concerning the use of school-based tobacco prevention programmes:

The low and declining proportion of Norwegian young smokers and the trend which indicates that smoking amongst adolescents has become a marginalised behaviour [172] may indicate that the need for preventive programmes has diminished correspondingly.

However, tobacco is highly addictive and is one of the key risk factors behind cardiovascular diseases, lung and respiratory diseases and various forms of cancer, and the marked social gradient regarding daily smoking is contributing to social health differences. [177] The use of oral tobacco amongst young people also gives cause for concern and indicates that further measures in the preventive work aimed at children and adolescents are important.

The effects of school-based programmes to prevent the use of tobacco, alcohol and drugs are generally small, but when school-based programmes are included as one of a number of measures in a broader approach to public health, they can help to achieve bigger, lasting effects at population level. [176]

The tobacco prevention programme (FRI)

The “Be smoke-free” (*Vær røykfri*) programme which is partly based on the principles of recognising social influences in people starting smoking and enhancing social skills in remaining tobacco-free has been shown to have an effect on the prevention of smoking and the use of oral tobacco, and an even stronger effect on experimentation with cannabis.

The programme was revitalised in 2006 and renamed FRI. Changes were made in order to make the programme easier to implement. The theoretical basis and scope of the programme are continued, but the training of teachers was replaced by a DVD and an online guide. Changes were also made to update the programme to bring it more into line with today’s society and changes in curricular. The main changes were related to the framework surrounding the programme, not to academic elements which are important for the effects.

FRI is based on *VÆR røykfri*, which has been evaluated twice. To find out more about FRI, visit www.FRIstedet.no

Graduation celebrations

Graduation celebrations have a long tradition in Norway, and many people are concerned about the consequences of drug and alcohol use during these celebrations. Little research has so far been carried out concerning this field. Negative consequences of the graduation celebrations are only considered directly in a limited number of studies, none of which provide a sound basis for assessing graduation celebrations as a cause of poor academic performance or poor health. However, two studies suggest that such links may exist. For more information, visit [the National Institute of Public Health’s website](http://the.NationalInstituteofPublicHealth.s website).

Drugs and sexuality

The school health service should view teaching concerning sexuality and tobacco, alcohol and drugs in context.

Amongst girls who had experienced one or more unwanted sexual contacts who took part in a survey, 44% said that alcohol had been involved the first time they experienced an unwanted sexual contact. Amongst the boys, 53% reported that alcohol was involved in their first unwanted sexual contact. If

alcohol was involved at the time the assault occurred, it was most common for both parties to be intoxicated. A survey conducted by NOVA shows that the effects of the preventive work linked to unwanted sexual contacts have been limited and that there is a need for more research concerning the area. However, the survey stresses the importance of targeted preventive measures and that long-term and planned measures are important in bringing about change. Such measures could include talking about attitudes at school over several years. [159].

Practical information

Preventive work linked to tobacco

FRI

FRI is a tobacco prevention programme for lower secondary school pupils which is adapted to the curricular of lower secondary schools. The school health service should be familiar with FRI. For more information, visit www.FRIstedet.no

The school health service should:

- Inform schools/teachers about the programme and be a driving force in teachers (the school) signing up the grade
- Tell parents about FRI at parent meetings
- Inform classes and student councils about FRI

Preventive work linked to alcohol and drugs

[The Norwegian Directorate of Health and the Norwegian Directorate for Education](#) and training have developed support material for drug prevention work at schools. This support material is primarily intended as a source of support for the teaching about drugs, adapted to relevant competence targets in the various curricula. The school health service should be familiar with the scope of the support material.

The school health service should work with schools concerning drug prevention work at schools, partly through:

- Planning and execution of teaching in classes or groups; see [the recommendation Education](#)
- Participation with information in parent meetings; see [the recommendation Parent meetings](#)
- Participation in multidisciplinary planning meetings; see [the recommendation Systematic partnership](#)
- Work relating to the psychosocial environment at schools; see [the recommendation Psychosocial environment](#)

There are a number of Norwegian programmes which can be used in the preventive work linked to alcohol and drugs. However, it is up to the individual school/school administration to implement these programmes.

In addition to working with the school's teachers, the school health service should consider working with school social workers, the Child Welfare Service, the police, coordination of local drug and crime prevention measures (SLT), youth support teams and drug consultants in the municipality and any drug polyclinics in the specialist health service, in the preventive work linked to alcohol and drugs.

The graduation celebrations ("Russetiden") is a time when adolescents tend to consume more alcohol and drugs. To promote good health and prevent unwanted events linked to injury, accidents, unwanted sexual behaviour, communicable diseases (such as SOI and meningococcal infection), etc., the school health service should:

- Ensure that adolescents are given the necessary knowledge and information
- Facilitate reflection on the use of alcohol and drugs and unwanted events
- Establish a partnership with the school, the graduation celebrations board, student council, police and any other relevant collaboration partners ahead of the graduation celebrations

Early alcohol consumption is associated with early sexual debut, among other things. The school health service's teaching concerning alcohol and drugs should therefore be viewed in context with the teaching relating to sexuality; see [the recommendation Sexual health education](#).

Follow-up of pupils when necessary

See the recommendation Topics during health consultations regarding the use of minimal intervention regarding the consumption of tobacco during health consultations in the 8th grade.

When necessary, the school health service should offer follow-up consultations to pupils. The school health service should refer pupils to other relevant bodies when necessary. Such bodies could for example include:

- Drug and alcohol consultants in the municipality
- GPs
- Psychologists or low-threshold mental health services in the municipality

See also [the Directorate of Health's guidance entitled "From concern to action" \(Fra bekymring til handling\) \(IS-1742\)](#) concerning early intervention within the field of drugs and alcohol.

More information

- [Kunnskapssenterets rapport nr. 7 2012 Effekten av primærforebyggende tiltak mot bruk av tobakk, alkohol og andre rusmidler hos barn og unge \(The Norwegian Knowledge Centre for the Health Services' report no. 7 2012 "The effects of primary preventive measures to combat the use of tobacco, alcohol and drugs amongst children and adolescent"\)](#)
- [Veivisere i lokalt folkehelsearbeid](#) (Guide to local public health work)

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5.1.8 Food and meals: The school health service should contribute to the creation of a good framework relating to school meals and food in schools

The school health service should be a driving force to ensure that the National guideline for food and meals in schools ([Nasjonal faglig retningslinje for mat og måltider i skolen](#)):

- Is implemented and followed
- Is incorporated into the school's own governing documents

In order to achieve this, the school health service should participate in the work relating to plans and measures at schools; see [the recommendation Systematic partnership](#).

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

The school health service's services should include the provision of information and guidance both individually and in groups and collaboration with the school concerning measures which promote a positive psychosocial and physical learning and working environment for pupils; see Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*). [5]

An appropriate framework relating to school meals and good food and beverages with healthy nutritional content is an integral part of a strong learning and working environment. The school health service should therefore contribute to this.

It follows from Section 7 of the Regulation on environmental health protection in kindergartens and schools (*forskrift om miljørettet helsevern i barnehager og skoler*) that schools must be satisfactory from a health perspective. This includes safeguarding the nutritional and social value of meals; see Section 11. Among other things, schools must ensure that the social functions of meals are addressed. [136]

To ensure that meals are of good nutritional value, [the Directorate of Health's guideline for food and meals in schools](#) should be used as a basis in connection with catering. To safeguard the social functions of meals, schools should physically facilitate dining and ensure that sufficient time is set aside to safeguard the well-being of pupils.

The school health service should work with schools to ensure compliance with the provisions of the Regulation.

Promote and facilitate a healthy diet

A healthy diet will boost academic performance and improve both physical and mental health. [181] Sufficient sleep, physical activity and a good diet will give pupils energy and protect their health. Facilitating good habits for physical activity, diet and sleep is important in order to promote healthy weight development, prevent illness and ailments in both the short and the long term, and promote well-being and learning.

[The National guideline for food and meals in schools](#) (Nasjonal faglig retningslinje for mat og måltider i skolen) is based on recommendations concerning diet, nutrition and physical activity.[180] [The Directorate of Health's dietary recommendations](#) are one of the competence goals in the national curriculum subject 'Food and health' in schools. One of the key goals in [the Norwegian strategy for the prevention of non-communicable diseases](#) is to increase the proportion of people who are aware of and follow the national dietary recommendations, help children and young people to establish good dietary habits and make it easier for everyone to adopt healthy food habits.

Meals are a fundamental factor in promoting concentration and learning at school. An appropriate setting for a meal that offers peace and enough time to enjoy the meal is conducive to positive dining experiences and well-being. For many children and adolescents, meals at school represent an important part of their energy intake. Meals at school influence diet, habits and health, regardless of whether the pupils bring their food with them or the meals are served. The guideline for food and meals in schools recommends greater collaboration both nationally and locally in order to promote good meal arrangements which reach everyone, regardless of socioeconomic status.

The school health service should help to ensure that the recommendations in the National guideline for food and meals in schools are implemented by schools.

Ensuring that pupils have enough time to eat is a prerequisite for them to be able to consume enough food during their school day. The Directorate of Health recommends a minimum of 20 minutes for eating. Handwashing, queueing, tidying up, etc. should not be included in these 20 minutes.

Meals at school and after-school programmes offer many opportunities for educational activities to improve the pupils' general knowledge concerning food. Such activities can support learning in both the national curriculum subject 'Food and Health' and other subjects such as science and social studies. The school health service can contribute to a holistic approach to the work relating to food and meals by helping to ensure that the guideline for food and meals is incorporated into the governing documents of schools.

Pupil involvement is important in facilitating positive and enjoyable meals based on healthy food and beverages. One aspect is to accommodate the needs of pupils who for religious or cultural reasons are restricted in what they are permitted to eat and drink.

In a dialogue with pupils, eating habits can be identified, and pupils can contribute suggestions regarding the type of healthy products they could eat, for example. This could represent an excellent opportunity to demonstrate the link between sufficient and nutritious food and vitality and energy to cope with the school day.

Learning about food and nutrition at school has the potential to influence dietary choices made at home. A common understanding of the importance and place of food and meals in school is vital for consistent communication to pupils and homes alike.

Background

The National Institute of Public Health's Child growth study shows that on average one in six (16%) of 3rd grade pupils were overweight (including overweight defined as obesity) during the period 2008-2012. [182] The survey entitled "Health habits amongst school pupils" (*Helsevaner blant skoleelever*) conducted in 2012 shows that 12% of boys and 15% of girls in the 6th grade are trying to lose weight. [183] An awareness of such challenges is essential in the work relating to health promotion and preventive work that is carried out linked to meals in schools.

Data from the school meal study [178]:

- Around half of heads of lower and upper secondary schools are aware of the Directorate of Health's National guideline for food and meals in schools.
- Just 40% of schools with pupils in junior school (5th - 7th grades) had set aside at least 20 minutes for eating. In the case of primary school pupils, the corresponding figure was 55%.
- A little over 30% of before- and after-school programmes for children prepare a daily meal for pupils after school.
- Around 80% of lower secondary-only schools had a canteen or tuck shop and the majority of upper secondary schools had one.
- Around 60% of the upper secondary schools which took part in the study offered sugary soft drinks and many offered cakes, waffles and buns on a daily basis.

Concerning the evidence and research in the guideline for food and meals in schools

[The National guideline for food and meals in schools](#) applies to any foods and beverages provided during the school day, including school trips, during before- and after-school programmes, and from food and beverage vending machines on school grounds. The recommendations in the guideline are divided into three sections: primary schools including before- and after-school programmes, lower secondary schools and upper secondary schools.

For a more detailed account of the evidence and research on which the guideline for food and meals is based; see the chapters on background and method in the three parts.

Practical information

Healthy food and good mealtimes are an important aspect of a positive school environment, which should ideally be included in the municipalities and county authorities' overview documents. For a more detailed explanation of the requirements concerning overview; see [the recommendation Overview](#).

The guideline for food and meals in schools consists of three parts:

- Overview of the recommendations concerning food and meals in **primary schools and before- and after-school programmes**, [part 1](#):
- Overview of the recommendations concerning food and meals in **lower secondary schools**, [part 2](#):
- Overview of the recommendations concerning food and meals in **upper secondary schools**, [part 3](#):

Two short videos have been produced to illustrate the importance of food in a typical school day. These videos are available via the [Directorate of Health's Youtube channel](#).

On the [Directorate of Health's website](#), you will also find supporting material for the videos for use in with children and adolescents, school staff and parents.

Partnerships with schools and before- and after-school programmes

The school health service can encourage schools and before- and after-school programmes to run activities and measures to stimulate pupils' curiosity about, and interest in, foods, cookery and culinary culture. A range of inspirational courses for healthy and safe catering in lower secondary schools has been developed which the school health service can disseminate.

The school health service should help to ensure that pupils have at least 20 minutes to eat their meal. Handwashing, queueing, tidying up, etc. should be in addition to these 20 minutes.

Teaching and information provision

The school health service should:

- Provide information concerning food, diet, packed lunches and special provision due to food allergies at **parent meetings**; [see the recommendation Parent meetings and Information to parents and pupils concerning school food at Helsenorge.no](#).
- Contribute to **teaching** in classes or groups concerning food and meals in order to boost the competence of pupils concerning nutrition and the function of food with regard to the body.
- Bring up the topic of food and diet in **health consultations during the 1st and 8th grades**; see the recommendation [Topics during health consultations](#)
- Pupil **involvement** is important in facilitating positive and enjoyable meals based on healthy food and beverages

Other relevant links

- [NCD-strategi 2013-2017](#)
- [Veileder til forskrift om miljørettet helsevern i barnehager og skoler \(IS-2013-2017\); 2014 \(NCD Strategy 2013-2017 Guide to the Regulation on environmental health protection in kindergartens and schools etc.\)](#).
- [Nasjonale anbefalinger for kost og fysisk aktivitet \(National recommendations concerning diet and physical activity\)](#)
- [Veileder God oversikt – en forutsetning for god folkehelse \(Guide Good overview - a prerequisite for good public health\)](#)
- [Helsedirektoratets rapport om trivsel i skolen \(Directorate of Health's report on well-being in schools\)](#)
- [Nasjonal senter for mat, helse og fysisk aktivitet \(National Centre for Food, Health and Physical Activity\)](#)
- [Matportalen \(The Food Portal\)](#)

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5.1.9 Physical activity: The school health service should contribute in facilitating physical activity amongst children and adolescents

The school health service should:

- Help to ensure that children and adolescents have **good and safe opportunities to be physically active** in school, in the local community and on their way to and from school
- Initiate a partnership with schools to promote and facilitate physical activity and prepare written governing documents and action plans within this area
- Bring up physical activity and inactivity in meetings with pupils and parents

It is essential that the school health service has a systematic partnership with schools and that the service is involved in the preparation of plans and measures in schools. See [the recommendation Systematic partnership](#).

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

The school is responsible for providing an environment which promotes health, well-being and learning; see Section 9a-1 of the Education Act (*opplæringsloven*). [141]

One of the purposes of the school health service is to promote a healthier lifestyle amongst its target population (Comments on Section 1-1 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*)). By promoting physical activity and contributing so that children and adolescents can be physically active on a daily basis both in school and in the local

community, the school health service will contribute to an environment which promotes health, well-being and learning.

In partnership with school staff, pupils and parents, the school health service will create a school which promotes healthy lifestyles. The measures concern the entire school environment, both physical and psychosocial, indoors and outdoors (Comments on Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*)). [5]

The school health service shall be familiar with the Regulation on environmental health protection in kindergartens and schools etc. (*forskrift om miljørettet helsevern i barnehager og skoler m.v.*). This Regulation has the overall aim of contributing to a better childhood and learning environment for pupils in schools (Comments on Section 2-3 of the Regulation on health centres and the school health service and the Guide to the Regulation on environmental health protection in kindergartens and schools etc.). [142]

The national recommendations concerning diet, nutrition and physical activity and the Directorate of Health's Guide to the Regulation on environmental health protection in kindergartens and schools etc. should be used as a basis in the work to promote active learning, increased physical activity and reduced inactivity in schools.

Promote and facilitate physical activity

Sufficient sleep, physical activity and a healthy diet all help to boost energy levels and promote physical and mental health, well-being and learning.

Research shows that physical activity, good motor skills and good physique are important for pupils' cognitive function [205], and that daily physical exercise has a positive effect on learning and academic performance. [186] [203]

There is a positive link between the physical activity and mental health of children and adolescents [191], and the amount of physical activity that children get during their teenage years has a clear link to their mental well-being in adulthood. [201] Physical activity and a healthy diet are important for promoting healthy weight development and preventing obesity. [192]

Some of the key goals in the Norwegian strategy to prevent non-communicable diseases are to:

- Raise awareness amongst the population concerning physical activity to improve quality of life and health, and prevent disease
- Increase the proportion of people who are aware of and follow the national recommendations for physical activity
- Facilitate physical activity and an active lifestyle [54]

Schools and the local community - can offer good opportunities for physical activity for everyone

Children and adolescents spend much of their day at school. Both the indoor environment and the outdoor environment at school are important for the opportunities of pupils to be physically active. A school's interior, premises, indoor air quality, rules concerning being outside during breaks, the school playground's area and quality and school roads can all promote physical activity. In addition, a school's management and teaching and other staff are important agents in facilitating regular physical activity and encouraging pupils to develop a lifelong passion for physical activity.

Pupils at schools which have a clearly established strategy or action plan for physical activity are more active. [197]

The outdoor environment and the design of school playgrounds are important for physical activity. [198] Children and adolescents who have attractive places with varied design and surfaces where they can spend time and play are more physically active. [202] [204] [207] [196] At the same time, studies have shown that there is enormous variation in the size and quality of outdoor area of schools. [179]

Sufficient exercise equipment, e.g. skipping ropes, toboggans, frisbees, various types of balls and simple measures such as the marking out and painting of hopscotch markings, mazes and the like in school playgrounds, and the organisation of activities during breaks can help to boost levels of physical activity

amongst pupils. [207] [204] [196] There is a marked reduction in activity levels amongst pupils from primary school to lower secondary school (Directorate of Health, 2012), and provision for outdoor activities is generally better at primary schools than it is at lower secondary schools.

School-based interventions which focus on structural measures to improve the environment and conditions for physical activity have effect on all pupils, regardless of their socioeconomic background. [193] In this way, such measures help to reduce social inequalities.

Environmental health protection in kindergartens and schools

The school health service shall be familiar with the Regulation on environmental health protection in kindergartens and schools etc. (*forskrift om miljørettet helsevern i barnehager og skoler*), which has the overall aim of promoting a better childhood and learning environment for pupils in schools. [5] [142]

It follows from Section 7 of the Regulation that schools must be satisfactory from a health perspective. Among other things, this entails considering:

- Locations for new activities (Section 8)
- Design and interior fittings/furnishings (Section 9)
- Opportunities for activity and rest (Section 10)
- Meals (Section 11)
- Psychosocial conditions (Section 12)

Cooperation with healthy life centres

Many healthy life centres offer activities to children and adolescents and their parents. [187] They offer activities and courses which are designed to meet the needs of children and adolescents who are in need of follow-up after weighing and measuring, or who do not take part in organised activities for various reasons.

The activities and courses are suitable for children and adolescents who have no social network or who have parents who are unable to pay for leisure activities. The healthy life centres cooperate with other public sector, private sector and voluntary bodies. They have a good overview of and can introduce participants to relevant activities and courses after the follow-up period.

The school health service should establish a partnership with healthy life centres where they have been established.

Voluntary groups and organisations

Voluntary groups and organisations are an important contributor in the work of municipalities relating to public health and prevention. A partnership with local sports groups and schools can help to include children and adolescents in organised activities with their peers; see [Security, participation and engagement - the government's work for children and adolescents \(Trygghet, deltakelse og engasjement - regjeringens arbeid for barn og ungdom\)](#).

Practical information

In the municipality

Through the planning and building agency, the school health service may influence developments in the local community in order to promote good opportunities for physical activity for children and adolescents.

For example, the school health service may put forward proposals concerning:

- Safe walking and cycling routes, so that all pupils can walk or cycle to and from school. [See the National walking strategy and the National cycling strategy.](#)
- Schools and playgrounds with grounds, designs and equipment which promote physical activity during lessons and breaks, both outdoors and indoors.

The advice service for schools and kindergarten ([Rådgivningstjenesten for skole og barnehageanlegg](#)) facilities can provide advice concerning the refurbishment and new-build of school buildings and school facilities. The service disseminates research-based knowledge concerning architecture and educational

principles, universal design and provision for daily physical activity.

The school health service should be aware of local activities from different groups and associations and may refer pupils and parents to these as and when necessary.

Systematic partnership with schools

The school health service's partnership with schools should include a dialogue concerning the importance of a safe and activity-friendly local environment in and around the school.

The school health service should work with schools concerning organisation of the school day and establish routines which give pupils an hour of daily physical activity in total and help to reduce inactivity. Examples of these include:

- Use learning strategies and teaching methods which include physical activity in all subjects
- Have breaks with physical activity during teaching
- Introduce measures to include all pupils and prevent drop-out from physical education lessons
- Introduce measures to increase the amount of physical activity during physical education lessons
- Purchase equipment for loan
- Facilitate physical activity during breaks in which all pupils can take part
- Work with parents so that all pupils can walk or cycle to and from school. For example:
 - Encourage parents not to drive their children to school
 - Limit parking opportunities around the school
 - Facilitate walking groups to and from school
 - Introduce a school patrol

Physiotherapists have specific competence concerning the importance of physical activity amongst children and adolescents. Together with public health nurses, physiotherapists can contribute to the system-focused collaboration with schools concerning physical activity.

Teaching and information provision

The school health service should:

- Inform parents at parent meetings of the importance of physical activity, how children and adolescents can be physically active and measures for reducing inactivity. See [the recommendation Parent meetings](#)
- Contribute to teaching concerning physical activity in classes or groups. See [the recommendation Education](#)
- Bring up physical activity during health consultations in 1st and 8th grades. See the recommendation Topics during health consultations
- Ensure pupil participation in order to promote physical activity at schools, in the local community and on the way to and from school; see [the recommendation User participation](#)
- Contribute to environmental work; see [the recommendation Psychosocial environment](#)

Follow-up of individual pupils

Public health nurses and physiotherapists should work together concerning individual pupils with special needs linked to physical activity and inactivity and give them support as and when necessary.

Follow-up could for example include:

- Adapted follow-up in physical exercise and encouragement to take part in physical exercise during breaks and other lessons
- Guidance of the child/adolescent and their family
- Referral to the GP, healthy life centre, occupational therapist or other relevant bodies

Regarding children and adolescents who are overweight or obese; see [the National guideline for the prevention, investigation and treatment of overweight and obesity in children and adolescents \(Nasjonal faglig retningslinje for forebygging, utredning og behandling av overvekt og fedme hos barn og unge\)](#).

More information

- [Nasjonalt senter for mat, helse og fysisk aktivitet \(Norwegian National Centre for Food, Health and Physical Activity\)](#)
- [Helsedirektoratets rapport om skolens utearealer \(Directorate of Health's report on school outdoor areas\)](#)
- [Helsedirektoratets anbefalinger om fysisk aktivitet for barn og unge 6-12 år og 13-17 år \(Directorate of Health's recommendations concerning physical activity for children and adolescent aged 6-12 and 13-17\)](#)
- [Helsedirektoratets anbefalinger om kost, ernæring og fysisk aktivitet \(Directorate of Health's recommendations concerning diet, nutrition and physical activity\)](#)
- [Den fysiske skolesekken \(The physical schoolbag\)](#)
- [Aktivitetskassen \(The activity toolbox\)](#)
- [Veileder til forskrift om miljørettet helsevern i barnehager og skoler \(Guide to the Regulation on environmental health protection in kindergartens and schools etc.\)](#)
- [Trygghet, deltagelse og engasjement - regjeringens arbeid for barn og ungdom \(Security, participation and engagement - the government's work for children and adolescents\)](#)

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5.1.10 Parent meetings: The school health service shall help to disseminate health information at school parent meetings

The school health service shall help to disseminate health information at school parent meetings in accordance with the wishes of the school. The aim is to promote health, well-being and learning amongst children and adolescents.

The school health service should specifically offer to contribute to school parent meetings:

- Upon starting school (1st grade)
- During the first year at lower secondary school (8th grade)
- During the first year at upper secondary school (Vg1)
- Otherwise as and when necessary

If the school so wishes, the school health service shall participate in the school's parent meetings in order to provide:

- Health information with a focus on health promotion and prevention topics
- Health information which can support the work of the school
- Information linked to special challenges amongst all pupils, groups or individual pupils
- Information on the services offered by the school health service and the collaboration between the school and the school health service

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

The services offered to children and adolescents by the school health service should include assistance and teaching in parent meetings in accordance with the wishes of the school, and the provision of information and guidance, both individually and in groups; see Section 2-3 of the Regulation of health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*). [5]

It is important that health professionals participate in parent meetings to:

- Disseminate health information
- Provide information on the services offered by the school health service
- Raise awareness of the service and make it easier for parents to make contact

Health information to parents

The school health service should contribute making parents aware of the importance of healthy habits and how they can encourage habits which promote health, well-being, concentration and learning both at home and at school.

Initiating discussions within parent groups can encourage reflection on shared challenges. Through reflection, parents can also understand how they can encourage healthy habits and support and motivate children and adolescents.

Practical information

In partnership with the school, the school health service should consider what topics would be most appropriate to focus on during the various parent meetings; see also [the recommendation Overview](#).

Topics which can be brought up at parent meetings:

- Coping resources, well-being, relationships and bullying
- Sleep and sleep habits
- Diet and mealtime habits
- Physical activity and inactivity
- Violence and abuse

In addition, **tobacco, alcohol and drugs, sexual health and contraception** may be relevant topics to bring up in parent meetings at lower and upper secondary schools.

It may be useful for the school health service to initiate discussions concerning shared challenges and how parents can help to promote health and well-being amongst children.

At parent meetings, the parents should be given information about:

- The topics that will be covered during the school-entry health consultations and the health consultations in the 8th grade; see the recommendation Topics during health consultations
- Information concerning special health challenges for children and adolescents. For example, acute crises, health during graduation celebrations and health-threatening norms and conduct which can arise within all or part of the pupil population.

More information

- [The Directorate of Health's guide concerning psychosocial measures in the event of crises, accidents and disasters](#)

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5.1.11 Divorce groups: The school health service can offer group counselling to support children and adolescents who experience divorce/break-ups between their parents

The school health service can offer group discussions/ counselling for children and adolescents who experience divorce/break-ups between their parents.

The purpose of group measures should be to enhance the ability of group members to cope with the strains of everyday life and reduce negative consequences in the long term.

Rationale

Population

Children and adolescents aged 5-20 who have been affected by divorce/break-ups between their parents/guardians

Intervention

Group measures where the aim is to promote psychosocial health amongst those who have experienced divorce/break-ups

Comparator

No measures or other types of programmes/initiatives with the same purpose

Outcome

Primary: psychosocial e.g. coping resources, well-being, quality of life. Secondary: physiological/biological

Evidence profile

Outcome	Confidence in estimates	Relative effect	No measures or other types of programmes/initiatives with the same purpose	Group measures where the aim is to promote psychosocial health amongst those who have experienced divorce/break-ups
Primary: psychosocial e.g. coping resources, well-being, quality of life. Secondary: physiological/biological		0(CI 0 - 0)	0 per 1000	0 per 1000

Summary

Outcome: For a more detailed account of the results and the quality of the documentation (GRADE); see the SOF tables (p.17 of the [Norwegian Knowledge Centre for the Health Services' report](#))

Initially, efforts were made to identify high-quality reviews, but no recent reviews were found concerning the effects of group measures aimed at children/adolescents who either are experiencing or have experienced divorce/break-ups within their family.

The Norwegian Knowledge Centre for the Health Services was therefore commissioned to prepare a review of the effects of such group initiatives on psychosocial outcome, including behavioural outcomes and any physiological outcomes. One prerequisite was that the measures were such that they can be carried out by the school health service in partnership with a school or in conjunction with a youth health centre, for example.

Twenty-one primary studies (observation studies and randomised controlled studies) are included in the review. Most studies were carried out in the USA, three in Canada and one study each in South Africa, Iran and the Netherlands. One of the studies described the population as coming from affluent families; the other studies which described this aspect had a population from lower or middle-income groups. Some of the studies cited mixed ethnicity, but most did not refer to this. The interventions, the group measures, had a duration of between 6 and 16 weeks with one meeting per week. The studies primarily included children of primary/lower secondary school age, but two studies also included kindergarten children. They were carried out by group leaders with different professional backgrounds.

The interviews were based on a similar underlying understanding: Divorce/break-ups leads to stress, confusion and feelings of loss and grief in children. The school-based measures seek to reduce any harmful effects by giving the children a better understanding of the situation and providing guidance concerning strategies for accepting, coping with and adjusting to the change.

Common aspects of the group initiatives were:

- Regular meetings, a "get to know each other phase", information and guidance concerning the topic of divorce/break-ups, clarification of any misunderstandings, opportunity to discuss emotional reactions, supportive social environment with room to exchange experiences, skills training in coping and problem-solving strategies.

The collective documentation is characterised by considerable variation in the outcomes which were measured and in the selected measuring tools. The quality of the documentation is classified as being "low" or "very low". The level of confidence in the effects was generally downgraded because the documentation is characterised by studies with unclear or a high risk of systematic distortions in the results, few participants and variable findings between the studies.

The results show that:

- Children who have taken part in group measures may experience less anxiety and be better prepared to adapt to the situation they face regarding divorce/break-ups compared with those who have not taken part. However, there is some uncertainty over whether group measures impact on a child's self-esteem and perception of depression or whether the children change their opinions and attitudes towards divorce/break-ups.
- Group measures may lead to the parents perceiving improvements in their children's emotions in connection with divorce/break-ups and their social behaviour and problem-solving skills. However, there is some uncertainty over whether group measures result in parents identifying improvements in their children's behavioural problems and emotional well-being.
- Group measures may lead to teachers seeing improvements in the functioning of children in some areas in a school context. However, it is not certain whether group measures lead to teachers seeing improvements in the problematic behaviour, school absenteeism and academic performance of the children.

Rationale

The scope of this recommendation is based on regulations, research basis and the consensus of the working group.

The services offered to children and adolescents by the school health service should include consultation with follow-up/referral as necessary, the dissemination of information and the provision of guidance both individually and in groups; see Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*).^[5] The service should particularly focus on children and adolescents with special needs (Comments on Section 2-3 of the Regulation on health centres and the school health service). As part of this, the service could offer discussion groups to children and adolescents who experience divorce/break-ups between their parents.

Every year, many children and adolescents experience divorce/break-ups within their family. For some, divorce/break-ups can increase the risk of emotional and behavioural problems in adjusting to the new situation.

Children and adolescents who have experienced divorce/break-ups between their parents may be a group with special needs, which may face challenges in getting through the school day. These children can benefit from group discussions, and the school health service can work with the school to offer such group discussions to this group.

Summarised research concerning the effect of group measures aimed at children and adolescents who experience divorce/break-ups between their parents shows that such measures may lead to:

- The children experiencing less anxiety and being better adapted to the situation surrounding the divorce/break-up
- The parents identifying improvements in their children's social behaviour, problem-solving skills and the emotions they are experiencing in connection with divorce/break-ups
- Teachers perceiving improvements in the functioning of children in some areas in the context of school

There is some uncertainty over the extent to which group measures have an effect on a number of other reported outcome measures relating to the experiences and perceptions of children, parents and teachers. For more information, see the Research basis from the [Norwegian Knowledge Centre for the Health Services, 2016](#).^[211]

The measures that are evaluated in the Knowledge Centre for the Health Services' report are based on an understanding that divorce/break-ups lead to stress, confusion and feelings of loss and grief in children. Divorce/break-ups can have adverse effects on the normal development of a child and temporarily reduce the ability of the parents to be there and support their child. The situation requires the child to acquire skills that they would not normally have. During the period of familiarisation with the breakdown in family life, two processes must be gone through: acceptance and adaptation. ^[211]

It is essential that the school health service has a systematic partnership with schools and that the school health service is involved in the preparation of plans and measures in schools. See [the recommendation Systematic partnership](#).

Evaluation of available programmes

In a Norwegian context, although no experimental evaluations have been carried out on the effects of groups for pupils who have experienced divorce/break-ups, other types of evaluations have been conducted. On the basis of questionnaires from pupils, parents, teachers and group leaders, the evaluation of the Plan for implementation of discussion groups for divorce children in schools (*Plan for Implementering av Samtalegrupper for skilsmissebarn i skolen* or PIS) concluded that “the pupils become more open, expand their social network, gain greater self-esteem, worry less, become less involved in conflict, become happier and can see that they can help others in the same situation” (www.forebygging.no, 2015). Findings from a Norwegian qualitative study which interviewed 28 children and adolescents who had taken part in one of the two programmes referred to above supports the view that the target group consider discussion groups to be very positive. [210] However, it is less clear whether such programmes also impact on behavioural outcomes such as academic performance and aggressive and uncontrolled behaviour.

Background

Every year, many children and adolescents experience divorce/break-ups within their family. In recent years, divorce have affected between 8,000 and 10,000 children under 18 with parents who have been married (see Statistics Norway’s table calculator). There are no statistics concerning break-ups experienced by children with parents who have been cohabiting partners, but not married.

In most cases, divorce/break-ups lead to major changes in everyday life; changes in household finances, maybe a change in home, less time spent with one of the parents, or moving between them. For some children and adolescents, divorce/break-ups can, when combined with other factors, lead to an increased risk of emotional and behavioural adaptation problems. [213] [208] This means that the increased vulnerability can probably partly be attributed to both the actual divorce/break-up and the circumstances and interaction which prevailed within the family before the break-up. [212] In general, the difference in risk is not great compared with the risk for children from intact families, but there is considerable variation in responses at individual level. [209] It must therefore be assumed that some children who experience divorce/break-ups in their family may be in need of extra follow-up and support. In the literature, this group is estimated to amount to around 20 - 25%. [214]

Practical information

Partnerships with schools

Through systematic partnerships with schools, the school health service should plan the organisation of group discussions, etc. for pupils who have experienced divorce/break-ups; see [the recommendation Systematic partnership](#).

Composition of groups

Groups for children and adolescents who experience divorce/break-ups can be organised for children at primary school, lower secondary school and upper secondary school. These groups must be adapted so that they are appropriate for the age and needs of the pupils concerned.

The instigation of group measures should be based on a knowledge of the challenges being faced by children and adolescents at the individual schools and in their local community; see [the recommendation Overview](#).

In the groups, the school health service should provide guidance concerning strategies in accepting, coping with and adjusting to the changes. The groups should meet regularly.

Group measures should encompass elements which offer opportunities to [211]:

- Clear up any misunderstandings
- Discuss emotional responses
- Create a supportive social environment with room to exchange experiences
- Develop coping and problem-solving strategies

Use of available programmes

The school health service may use available Norwegian programmes to carry out group measures aimed at children and adolescents who experience divorce/break-ups.

In Norway, PIS (a Norwegian abbreviation of “Plan for implementation of discussion groups for divorce children in school”) is the most frequently used initiative; for more information; see [Forebygging.no](https://forebygging.no). PIS involves targeted programmes for the various age groups at primary and lower and upper secondary school. In the Kristiansand area, a similar programme, called “Vanlig, men vondt” (Common, but painful) is used; see [Kristiansand municipality’s website](https://www.kristiansand.kommune.no) for more information.[210]

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5.1.12 Absence giving reason for concern: In partnership with the school, the school health service should be involved in the follow-up of pupils with absence rates giving reason for concern

It is the school that is responsible for implementing the necessary measures to reduce absence rates. The school health service should work with the school to follow up absence giving reason for concern.

Absence giving reason for concern can cover both documented and undocumented absence from school.

Rationale

Population

Pupils 5-20 years

Intervention

Various measures for preventing drop-out from school

Comparator

Nothing or common practice

Outcome

Drop-out

Evidence profile

Outcome	Confidence in estimates	Relative effect	Nothing or common practice	Various initiatives for preventing drop-out from school	Absolute difference	Participants (studies), follow-up
Drop-out		0 (CI 0 - 0)	0 per 1000	0 per 1000	0 per 1000 (CI 0 - 0)	

Summary

Outcome: see the [Summary of Findings table \(PDF\)](#)

Efforts were made to identify high-quality systematic reviews, and one systematic review was found which covered 152 studies. This was assessed using the GRADE method, including DECIDE. We have a medium level of trust (GRADE) in this documentation concerning the effect of drop-out; see the explanation under the tab About the guideline.

Rationale

The scope of this recommendation is based on regulations, research basis and the consensus of the working group.

The services offered by the school health service should include partnerships with schools concerning initiatives which promote a good psychosocial and physical learning and work environment for pupils; see Section 2-3 of the Regulation on the health centre and school health service (*forskrift for helsestasjons- og skolehelsetjenesten*).[5] Absence can be prevented and reduced through a good psychosocial and physical learning and working environment; see [the recommendation Psychosocial environment](#).

The school health service should also contribute to the follow-up of individual pupils with levels of absence giving reason for concern, as it may for example be useful for the pupil to speak to someone who is not as closely linked to the school as the teacher. The school health service also has the competence to clarify any health-related causes of absence and can offer home visits where appropriate; see [the recommendation Home visits](#).

Frequent systematic absence, including undocumented absence, documented absence and absence from individual lessons, as well as weak or declining school performance, are important signals (amongst many others) which may indicate a risk of drop-out, even when these signals become apparent at an early stage at primary school. The risk factors may become apparent at an early stage, even before a child starts school.

Drop-out from upper secondary school education increases the risk of low labour market participation, health problems, dependency on social benefits and crime. [217] In Norway, around 30% of pupils do not complete upper secondary school during the five-year period after lower secondary school. The drop-out rate is highest for vocational educations and amongst boys. Drop-out is normally the final step in a long and complex demotivation process which starts at an early age. [218] The causes of drop-out are complex and cover factors at numerous levels: societal, institutional and individual.

Amongst individuals, health problems, including mental health problems, difficult social circumstances, parents with low educational attainment and low participation in the labour market and society in general, poor Norwegian skills, lack of elementary literacy and numeracy skills and poor academic performance are important explanatory factors for drop-out.[217] The government has instigated numerous initiatives to reduce drop-out rates[218], including the 0-24 collaboration (*0-24 samarbeidet*).

What does summarised research show?

A systematic Campbell review based on 152 studies shows that many types of programme and

intervention can help to reduce drop-out. [219] This review has been assessed and graded. For the programmes as a whole, it was calculated that they increase the probability of preventing drop-out. In absolute terms, such programmes and interventions reduced average drop-out from 21% to 13%. For more details concerning the effect estimates and grading, see the table in the Research basis.

In addition to the systematic review by Wilson et al, the Knowledge Centre for Education has published a report on “Drop-out from upper secondary education” (*Frafall i videregående opplæring*). [218] This report describes 26 studies which were published following the search by Wilson et al. [219] The effect results from the more recent studies are presented as “positive” or “zero” and there is no presentation of how the results from these 26 new studies correspond to or impact on the overall effect of the previous 152 studies. Both reviews conclude that interventions to prevent drop-out from school have a positive effect.

Assessment of the research basis

Most evaluated interventions described by Wilson et. al. are carried out in the classroom, while others are school-based initiatives outside the classroom or community-based programmes in the form of guidance and practical initiatives adapted to the individual. A more detailed description of the initiatives is presented in the systematic review. [219] The intervention programmes which had an effect lasted two years on average, and most included daily contact with the individual pupil. Many of the programmes have therefore been challenging both organisationally and in terms of resources for both finances and personnel. Of the effective interventions, follow-up in connection with absence registration was amongst the simplest to carry out. The school health service should therefore offer to contribute to the school’s follow-up of pupils who are at risk.

Associated assessments

Teachers have extensive experience of assessing changes in the functional ability of pupils. Systematic follow-up of changes can identify pupils who are experiencing difficulties at an early stage. In some cases, a school can instigate initiatives within its own framework, while in others, it may be more appropriate to work with the health service or other bodies. Through initiatives aimed at the children or adolescents themselves and the school’s staff, the school health service can contribute to an inclusive school environment, alongside the initiative in the workplace and NAV for adult employees.[215] [See the recommendation Psychosocial environment.](#)

Amongst the professionally active population, a systematic assessment was made of health status in connection with absence from work. There are also comprehensive regulations linked to certified absence, with a focus on collaboration between the employer, GP, occupational health service and NAV. Amongst children and adolescents, as regards school absenteeism, there are no national guidelines for collaboration between the school, the school health service or other services.

An important initiative is to ensure that good routines are established to follow up pupils with systematic and/or high levels of absence, e.g. through routine referral to the school health service or GP. Results from a major study of upper secondary schools in Hordaland found that 40% of pupils with a high absence rate (15% absence or more during the most recent term) had no contact with any of the health services which were included during the period concerned (school health service, GP, youth health centre, the specialist health service, including mental health care). [216]

Practical information

The school health service should work with schools to plan and carry out universal programmes which promote well-being and health for all; see [the recommendation Psychosocial environment.](#)

Through the systematic partnership with the school, the school health service should ascertain and plan the service’s role in the follow-up of absence rates giving reason to concern amongst pupils; see [the recommendation Systematic partnership.](#)

Absence giving reason for concern

The school health service and the school should ensure that they have a common understanding of what constitutes absence giving reason for concern. Absence giving reason for concern could for example be:

- Frequent absence
- Increasing absence
- Absence linked to a particular day of the week
- High rate of absence from certain subjects, e.g. physical education

Absence may give reason for concern even if notice of absence is given.

Absence giving reason for concern is one of many factors which could result in an increased risk of drop-out. Other risk factors include declining performance at school, academic weaknesses, mental and physical health problems and poor social network.

Follow-up of pupils with absence giving reason for concern

Early intervention is important in preventing absence from becoming a pattern and the cause of additional problems.

The school health service should support the school in the follow-up of pupils at risk and pupils with absence giving reasons for concern by:

- Ensuring that the service becomes involved at an early stage in the follow-up of individual pupils and groups with absence rates giving reason for concern.
- Reaching agreement with the school concerning the initiatives that the school health service can offer. The school health service could for example follow up relevant pupils with consultations, either individually or in groups, and offer home visits to pupils at risk; see [the recommendation Home visits](#)
- Discuss problems/cases anonymously with the school. The school health service shall obtain the consent of the pupil and/or their parents before the school health service contacts the school regarding named pupils or pupils who can be identified individually
- Consider referring pupils to a GP, the specialist health service or other institutions
- Consider collaboration with physiotherapists, e.g. in connection with the follow-up of pupils with a high absence rate in physical education
- Consider multidisciplinary collaboration with bodies such as NAV, the Child Welfare Service, the Educational and Psychological Counselling Service (PPT), the Child and Adolescent Psychiatric Outpatient Services (BUP) and low-threshold services for mental health. See the General section: Collaboration and co-operation

The rules concerning absence from upper secondary school

Absence due to an appointment with a GP, dentist, BUP, the school health service, etc. should not be included in the calculation of overall absence. See the [Circular on the absence threshold \(Rundskriv om fraværsgrensen\) from the Directorate for Education and Training](#).

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5.2 Health examination and health consultation

5.2.1 The school-entry health consultation: All children should be offered a health consultation and a somatic examination in the 1st grade

All children should be offered an examination by the school health service upon starting school. This examination should include:

- **Health consultation by a public health nurse**
- **Somatic examination by a doctor**

The school-entry health consultation should be carried out after the child has started school in the 1st grade in order to:

- Establish contact with the children who go to school and their parents
- Create a good starting point for collaboration between the school health service and the school concerning the needs of the child
- Identify children who have moved to the municipality between their previous consultation at the health centre and starting school

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

Services offered to children and adolescents by the school health service should include health examinations and advice with follow-up/referral as necessary; see Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*). [5] One of these obligatory examinations should be carried out when the child starts school.

The school-entry health consultation consists of a medical examination and a health assessment, and is carried out in order to:

- Give the child and parent the opportunity to bring up health-related matters which the parents or child are concerned about
- Promote physical and mental health through the provision of advice and guidance
- Prevent negative developments in health
- Identify diseases
- Assess the significance of illnesses and other health problems
- Identify factors and adaptations at school for children with illnesses or disabilities
- Facilitate the assessment of whether the child has severe difficulties in the home or is showing signs of neglect, violence or abuse

Medical examination

Some children face health challenges when they start school or experience such challenges during the first years of school. [41] Common illnesses and health problems when children start school are:

- **Asthma:** At 10 years of age, 15-20% have had asthma and around 10% still face problems associated with asthma. At school age, half of the cases of asthma is linked to allergies. In other cases, the cause is triggered by physical exertion or infection. More rarely, asthma can be a consequence of premature birth.
- **Atopic eczema:** Around 20% of school children have had or still have atopic eczema.

- **Allergic rhinoconjunctivitis:** Around 25% will develop allergic rhinoconjunctivitis.
- **Overweight and obesity:** 15-20% of school children are overweight or morbidly obese.
- **Pain conditions:** 15-20% of school children have persistent pain in their head, stomach or musculoskeletal system. During the teenage years, more than 40% report that they often experience pain. [221]

Many of the health problems are already known when the child starts school, but a lot may also be unknown. Examples of relatively rare conditions which may be important to detect include congenital heart disease where around 6% of heart defects which require treatment are discovered after the age of two [223], and undescended testicles which may have arisen because the testicles have moved up from a previous position in the scrotum. [224] [222] Relatively common diseases may also remain undiscovered or under-treated, and correct treatment can improve health, well-being and functional level.

Our health is affected by physical, mental and social factors and according to the WHO “health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. This definition is based on a holistic view of humans. The health consultation and medical examination must therefore be viewed in context.

Practical information

The school-entry health consultation should be carried out on the school health service’s premises, wherever possible. Parents should attend with the child.

Performance of the school-entry health consultation:

- Prior to the examination, the public health nurse and doctor should familiarise themselves with the child and the family by reading the health centre’s medical records.
- The order of invitations should be based on need, not solely based on e.g. alphabetical order.
- Where possible, the somatic examination and health consultation during the school-entry health consultation should be carried out consecutively, so that the child and parents do not have to attend more than one appointment.
- The public health nurse and doctor can carry out the medical examination and health consultation either together or individually. They should work together to assess the findings and consider whether any follow-up is required. Together, they should assess whether the child needs special provision at school or referral to the GP or other body.
- The public health nurse and doctor should consider whether other professionals should also see the child, e.g. a physiotherapist or psychologist.
- The follow-up group to which the child belongs should be recorded and documented in the child’s medical records; see [the recommendation Follow-up groups](#).
- The child’s regular GP should be recorded in the child’s medical records.

See also [the recommendation Overview](#) and [the recommendation Systematic partnership](#), and [the recommendation Targeted services](#).

Scope of the somatic examination

Medical history:

A medical history based on information provided by the child and its parents is an important part of the somatic examination. The doctor should place special emphasis on identifying common diseases and assessing what diseases the child has suffered previously which could represent risk factors for the development of new diseases or the recurrence of previous diseases (e.g. is a child who has had atopic eczema at greater risk of contracting the disease again and developing allergies).

General organ examination - special aspects:

The child should be partly undressed during the organ examination; see [the recommendation Partly undressed and the General section: Duty of disclosure](#).

During the general organ examination, the doctor must place particular emphasis on circumstances which

became apparent during the review of the child's medical history.

General organ examination:

Auscultation of the heart

30-40% of children may have innocent extraneous noises which do not need further referral when they have the following typical nature:

- Grade I-II mid-systolic crescendo-decrescendo along the central/lower left sternal border without distinct radiation to the armpits, towards the throat or between the shoulder blades, combined with normal radial and femoral pulse.
- Grade I-II short ejection noise in the approximate area of the second intercostal space (the pulmonic area) to the left of the sternum without distinct radiation apart from decreasing strength above the pulmonic area, and normal pulses.
- Vein humming e.g. is an extraneous noise: systolic/diastolic, almost continuously blowing extraneous noise with p.m in 1.-2. right intercostal space or infra clavicular, grade 2-3. Vein humming is significantly weaker or disappears when turning the head or when v. jugularis is compressed.

Auscultation of the lungs

- Should be carried out if the child's medical history indicates diseases of the lungs.
- If asthma is suspected based on the child's medical history, but there are no objective findings, the child should be auscultated following physical exertion with the aim of inducing typical auscultation findings.

Examination for testicular retention

- If the testicles are undescended and cannot be drawn down into the scrotum or if they can only be drawn down into the upper part of the scrotum and immediately ascend again after being held for sufficiently long to overcome the cremasteric reflex, the boy should be referred for assessment of need of surgery.
- If the testicles are situated above the scrotum but can be drawn down and remain in the upper or lower part of the scrotum after release (retractile testicle), the boy should be monitored annually by his GP until it has been determined whether or not he should be referred for assessment of need of surgery. [224] [222]
- If the testicles are spontaneously present in the scrotum during the school-entry health consultation, no further follow-up will be required.

Overweight, obesity and underweight

- Weighing and measuring should be carried out at the same time as the school-entry health consultation. See [the National guideline for weighing and measuring in the health centre and school health service \(Nasjonal faglig retningslinje for veiing og måling i helsestasjons- og skolehelsetjenesten\)](#).
- In the case of atypical height development or an isoBMI above 25 or below 17.5, consideration should be given to referring the child to a GP or the specialist health service for further assessment or follow-up.

Musculoskeletal system

- In the event of evidence which indicates pain or impaired function, a targeted investigation should be carried out.
- If the child has one leg which is more than one centimetre shorter than the other or is experiencing difficulties which can be attributed to one leg being shorter than the other, the child should be followed up by their GP or referred to an orthopaedist with a view to further diagnosis (e.g. hip disorders such as subluxation, Calvé-Leg-Perthes or growth zone injury).
- If one leg is more than one centimetre shorter than the other, an orthotic insert may be needed. In the case of leg length differences of more than two centimetres, the child should be referred to their GP or an orthopaedist.

- In-toeing and out-toeing usually improves spontaneously.
- If the child has unusual wear on or in their shoes, a tendency to trip over, difficulty running or other problems caused by an unusual leg position, he or she should be referred to their GP for assessment.

Motor skills

Any examination will depend on the medical history. Gait, balance, strength and coordination can be assessed by asking the child to hop on each leg, for example.

Genital examination

Girls from cultures in which female genital mutilation is common practice should be offered a genital examination during the school-entry health consultation, in 5th grade and at lower secondary school (14-16 years); see [Guide to the prevention of female genital mutilation \(Veileder for forebygging av kjønnslemlestelse\)](#).

Dental status and oral cavity

This examination can be carried out easily without the aid of instruments, but good light would be an advantage. The examination should include checks of the following:

- Whether the child has been to a dentist/dental nurse
- Teeth cleaning and any visible caries. If there are any visible signs of plaque on front teeth, parents should be made aware of this.
- Abnormal teething
- Sores and injuries in the mucous membrane or on the teeth or elsewhere, including any signs which could lead to suspicions of serious neglect

The child should be referred to the dental health service if he or she has caries or a general disorder which could affect dental and oral health or if it is established that the child has not attended an appointment with the dental health service. See the recommendation Dental health service ([Nasjonal faglig retningslinje for tannhelsetjenester til barn og unge 0-20 år](#))

Extensive caries, other signs of poor dental hygiene and injuries in the mouth should give rise to suspicions concerning poor diet and/or neglect/abuse; see [the General section: Duty of disclosure](#).

Need for further follow-up

Consideration must be given in each individual case to whether the child should be referred to a doctor for further assessment. The school doctor and public health nurse should jointly assess whether pupils should be referred to a GP for follow-up.

See also the [recommendation GPs](#).

The health consultation

The following topics should be brought up during the health consultation:

- Sleep and sleep habits
- Physical activity, leisure activities and inactivity
- Dental health
- Accidents and injuries
- Violence, abuse and neglect; see the chapter entitled Violence, abuse and neglect.

For more information concerning the performance of the health consultation and the topics that should be covered; see [the recommendation Topics during health consultations](#).

For more information on violence, abuse and neglect, see [the chapter entitled Violence, abuse and neglect](#).

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5.2.2 Health consultation, 8th grade: All lower secondary school pupils should be offered a health consultation in the 8th grade

The health consultation in the 8th grade should help to:

- Promote life-skills and contribute to healthy choices
- Obtain an overview of the challenges being faced by the individual and in the pupil population at the school
- Assess the need for follow-up consultations or further referral
- Strengthen user participation

Health consultations should be carried out at the same time as weighing and measuring; see [the National guideline for weighing and measuring in the health centre and school health service \(Nasjonal faglig retningslinje for veiing og måling i helsestasjons- og skolehelsetjenesten\)](#).

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

The services offered to children and adolescents by the school health service should include health examinations and counselling with follow-up/referral as and when necessary and the provision of information and guidance both individually and in groups; see Section 2-3 of the Regulation on health centres and the school health service (*forskrift for helsestasjons- og skolehelsetjenesten*). [5] As part of these obligatory tasks, individual health consultations should be carried out with all pupils in the 8th grade.

The foundations for lifestyle choices are laid during the childhood and teenage years. The teenage years are a time when most people gain more responsibility and freedom regarding their own health choices. [226] It is also an age when teenagers can find it more difficult to bring up issues, challenges and concerns with their carers.

The health consultation in the 8th grade should be carried out in order to give adolescents information and confirmation about what promotes good health. The health consultation should focus on normalising common challenges and improving knowledge, attitudes and resources to act. The dialogue should also help to identify challenges and abnormal development in individuals in order to instigate follow-up

initiatives as soon as possible. This includes challenges and appropriate measures for individual pupils, groups of pupils or everyone.

Individual consultations and other initiatives could supplement and reinforce each other. Other measures may include teaching, groups and the provision of an environment which promotes a healthy lifestyle. Health and health behaviour are influenced by a combination of measures aimed at personal, social and physical/environmental factors (socio-ecological theory). A combination of measures over time are therefore recommended. [228]

Dialogue with each individual adolescent also offer the opportunity for a direct dialogue concerning the pupil's needs and wishes regarding the school health service and the pupil's assessment of the scope of the service.

It appears that adolescents tend to seek out help for mental health challenges and problems less often than others. [172] Those with an immigrant background seek out the health services less often than others. However, adolescents with an immigrant background use the school health service where it is available. [225]

Through the systematic, individual health consultations of all 8th grade pupils, the school health service will be better placed to identify mental health problems and challenges, including such problems and challenges amongst adolescents who are next of kin or who have been the victim of violence, abuse and neglect, and assess who is in need of follow-up by the school health service and/or referral to a GP; see [the chapter entitled Violence, abuse and neglect and the recommendation Identifying mental health problems and disorders](#).

The offer of a health consultation will reach all pupils regardless of gender, ethnicity and socio-economic background. In dialogue meetings with adolescents, boys have stressed that being called to an obligatory consultation reduces the threshold for using the service. Both genders have noted that health consultations are important because the young want to learn more about the link between mental and physical health and lifestyle. Health consultations will help to raise awareness concerning the services available amongst adolescents, engender trust amongst users and lower the threshold for making contact in connection with special needs.

The Swedish school health service *Elevhelsen* includes health consultations as part of the health examinations (*Hälsobesøk*) in the 1st, 2nd, 4th, 7th/8th grades, and the first year at upper secondary school in the statutory systematic collaboration with the school. The school health service and the school should work together concerning the health consultation in the best interests of the pupils.

The health consultation should be carried out at the same time as weighing and measuring in order to reduce the administrative workload. Weighing and measurements should ideally be carried out after the interview.

Practical info

The health consultation should form part of the collaboration with the school concerning the establishment of an overview of the pupil population's health and well-being; see [the recommendation Overview](#).

The school health service and the school should work together concerning the health consultation in the best interests of the pupils; see [the recommendation Systematic partnership and the recommendation Targeted services](#).

Preparations

Information for school staff:

- The school should be given information on the school health service's annual plan
- Public health nurses and 8th grade form teachers should agree on a time to hold the consultations

Information for parents

- Parents should be given information on health consultations and on weighing and measuring. Parents should not take part in the health consultation
- A public health nurse should take part in parent meetings in order to provide information concerning the services provided by the school health service, the health consultation, and weighing and measuring; see [the recommendation Parent meetings](#)

Information for pupils

- Pupils should be given information on the topics that will be addressed during the consultation (pupils should in particular be informed that everyone will be routinely asked about violence and abuse) so that they can prepare themselves for the questions that they will be asked and think about what they want to discuss themselves
- Pupils should be told about the duty of confidentiality and the limitations that apply, including the duty of disclosure applicable to the Child Welfare Service and the Police; see [the General section: Duty of disclosure](#)

Performance of the health consultation

Before an individual consultation, the public health nurse should familiarise themselves with the adolescent by reading the person's medical record.

The public health nurse should record in the medical record the follow-up group that the adolescent belongs to; see [the recommendation Follow-up groups](#).

Weighing and measuring should be carried out at the same time as health consultations, to reduce administration work; see [the National guideline for weighing and measuring in the health centre and the school health service](#).

The average time spent on the consultation, including weighing and measuring, should be **around 30 minutes**.

The health consultation should be based on the needs and wishes of the adolescent. The following topics should be covered:

- Coping resources, well-being and relationships
- Sleep and sleep habits
- Diet and mealtime habits
- Physical activity and inactivity
- Dental health
- Sexuality and relationships
- Tobacco, alcohol and drugs
- Violence, abuse and neglect; see [the chapter entitled Violence, abuse and neglect](#)
- Information on the GP scheme and the fact that GPs are subject to a duty of confidentiality

See the recommendation Topics during health consultations for more information on topics covered during health consultations.

Follow-up

When necessary, a follow-up consultation should be carried out; see for example [the recommendation Follow-up of mental health](#).

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5.2.3 Topics covered during health consultations in the 1st and 8th grades

Health consultations should contribute to a dialogue with the child/adolescent and their parents concerning well-being and lifestyle choices which impact on health.

During the consultation, health professionals should encourage and give advice which underpins a healthy lifestyle. Any challenges should be explored, and the child/adolescent and their parents should be given individual guidance and advice.

Rationale

Population

Children and adolescents aged 5-18

Intervention

Information, counselling, programmes to prevent and reduce sleep problems

Comparators

No initiatives

Outcome

Various outcome measures relating to sleep, health and health-related quality of life, academic performance

Evidence profile

Outcome	Confidence in estimates	Relative effect	No initiatives	Information, advice, programmes to prevent and reduce sleep problems	Absolute difference
Various outcome measures relating to sleep, health and health-related quality of life, academic performance		0 (CI 0 - 0)	0 per 1000	0 per 1000	0 per 1000 (CI 0 - 0)

Summary

Outcome: See the [Summary of Findings table \(PDF\)](#)

A search was performed for systematic reviews published during the period 2010-2015. One high-quality systematic review was identified (Blunden et al, 2012). The review looked at the effect of school-based programmes on different outcome measures aimed at children and adolescents aged 12-19. The review included eight randomised controlled studies which investigated the effect of various school-based programmes given to whole classes.

The scope of the programmes varied to some extent, but all the programmes were based on a similar scope covering the following main topics:

- What sleep is and why people need sleep
- How much sleep children/adolescents need
- What disturbs sleep
- The consequences of poor sleep

The systematic review does not present estimates or confidence intervals and the results are therefore only a summarised narrative.

A positive change in knowledge concerning sleep was the most consistent finding, but the quality of documentation was considered to be "very low" (GRADE); see also under the tab 'About the guideline'. There were no consistent findings concerning other measured outcome measures (sleep patterns, tiredness during the day, duration of sleep, sleep hygiene/habits, quality of sleep, sleep problems, physical activity). The quality of these outcome measures (GRADE) was also assessed as being "very low". This means that the level of confidence in the results is very low. No clear conclusions can therefore be drawn concerning the effect of the initiatives.

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

The services offered to children and adolescents by the school health service should include health examinations and the provision of advice with follow-up/referral as and when necessary and the provision of information and guidance both individually and in groups; see Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*). [5] Two of these obligatory examinations should be carried out as part of the health consultation in the 1st grade and as a health consultation in the 8th grade; see the recommendation School-entry health consultation and [the recommendation Health consultation, 8th grade](#).

Through meetings with all the children, adolescents and parents concerned, the school health service

should provide advice and guidance in order to promote mental and physical health amongst the children/adolescents and prevent illness and injury.

Mental health problems often arise at a young age, while at the same time the teenage years are a time when it is easy to develop a poor lifestyle. [251]

Well-being, coping resources and relationships (mental health) - 1st grade and 8th grade

The school and the family are important in promoting pupil health and in identifying children/adolescents who for various reasons are struggling and in need of support.

In order to promote mental health and well-being amongst children and adolescents, coping resources and participation in arenas where children and adolescents can be found and in contexts which children and adolescents are part of must be facilitated. Loneliness and lack of social support (e.g. from friends, parents and teachers) reduce quality of life, affect people's coping resources and entail a risk of poorer health.

The school health service should have a knowledge of underlying factors which promote and impair mental health in order to:

- Instigate initiatives and support positive development.
- Prevent negative developments in well-being and health both in individuals and throughout the entire population.

Mental and physical health is vital for pupils' academic performance, well-being and ability to function in social situations. In turn, pupils' academic performances are of considerable importance for their mental health. [244]

Lifestyle

Sufficient sleep, a healthy diet and adequate physical activity boost energy levels and help protect physical and mental health. Establishing good habits in these areas is vital in order to promote good health, well-being and learning.

Unhealthy diet, physical inactivity and the consumption of alcohol are common underlying factors behind the development of non-communicable diseases: cardiovascular diseases, cancer, chronic lung diseases and diabetes.

Health promotion and preventive initiatives within the school health service should support the Norwegian strategy for the prevention of non-communicable diseases. [54] Key goals of this strategy are:

- Increase the proportion of people who are aware of and follow the national dietary recommendations, help children and adolescents to establish good dietary habits and make it easier for everyone to adopt healthy food habits
- Raise awareness amongst the general population of physical activity in order to promote quality of life and health and prevent diseases, increase the proportion of people who are aware of and follow the national recommendations concerning physical activity, and facilitate physical activity and an active lifestyle
- Prevent adolescents from starting to smoke or take oral tobacco (snus)
- Slow down the increase in alcohol consumption, raise awareness of the links between alcohol and health and reduce the occurrence of alcohol-related diseases

Sleep - 1st grade and 8th grade

Around one fifth of Norwegian adolescents say they experience problems sleep, particularly problems falling asleep at night, but also in the form of not getting enough sleep. [259] [250] Sleep difficulties are more common amongst girls than boys.

The reasons are complex, but taking a long time falling asleep and getting shorter periods of sleep are linked to poor lifestyle choices and higher activity levels during the evening with a lot of time spent in front of a screen (PC, TV, games, mobile phone, tablet). [249] Little physical activity and exposure to insufficient light during the daytime can adversely affect a person's sleep. One common reason behind sleep problems is people going to bed too late. [236]

Getting enough sleep helps to improve resistance to disease and prevent the development of overweight. [256]

[260] Children and adolescents who get enough sleep concentrate better and find it easier to learn new things. [255] [239] Insecurity, anxiety, other mental health problems and overweight or underweight can all cause sleep problems. [237] [254] [235] [242]

Adolescents who do not get enough sleep and go to bed late achieve inferior grades compared with others, [248] and adolescents with sleep difficulties are four or five times more likely to develop depression. [262]

Delayed sleep phase syndrome (DSPS) means that sleep is delayed and that the person goes to sleep and wakes up late, but it can also involve other types of changes in sleep patterns. Around 3-8% of teenagers' experience this, and these adolescents also tend to have higher rates of absence from school. [263]

Sleep problems is a debut problem in connection with most mental health problems, and the prevention of sleep problems is highlighted as a prioritised health-promoting and disease-preventing initiative in order to improve the mental health of the population. [113] The Norwegian Institute of Public Health recommends that measures be carried out concerning prevention and early intervention to address sleep difficulties.

Research basis and assessments

Based on summarised, quality-assessed international research, school-based programmes which are intended to raise awareness and change sleep habits have not demonstrated any clear effects. [234] The search identified no systematic reviews which assessed the effects of individual guidance of children and adolescents, thus, it is not possible to reach any conclusions regarding the effects of such measures based on summarised research; see the Research basis.

There is evidence to indicate that there is a link between sleep and sleep habits and other behaviour which impacts on health. Clinical experience indicates that it is important to provide parents with information, advice and guidance to motivate them to ensure that their children/adolescents develop good sleep habits. Accordingly, it is recommended that the school health service includes sleep and sleep habits as a topic in the health information that it provides.

There is a need for more research into the effects of initiatives on sleep and sleep habits, and it is also desirable that such research be conducted within the school health service.

During the health consultation:

- The importance of sleep and good sleep habits should be brought up with everyone
- Children and adolescents should be asked whether they are experiencing sleep difficulties and what the possible reasons may be behind any difficulties
- If a child or adolescent is experiencing sleep difficulties, advice on good sleep habits should be given. Refer to a GP as and when necessary

Diet - 1st grade and 8th grade

[The national recommendations for diet and physical activity](#) are used as a basis for the work linked to diet and nutrition within the school health service. The school health service should contribute to raising awareness and encourage children and adolescents to eat a healthy diet.

A healthy diet leads to better performance at school, better concentration and better mental health; see [Well-being at school](#).

The school health service should help to ensure that the recommendations in the [National guideline on food and meals in schools \(Nasjonal faglig retningslinje for mat og måltider i skolen\)](#) are implemented and that physical activity in schools and local communities is facilitated; see the recommendation Food and meals and the recommendation Physical activity. A healthy diet and physical activity are instrumental in promoting healthy weight development and prevent overweight. [192]

Special challenges linked to the diet of children and adolescents include eating breakfast, the consumption of fruit, vegetables, fish and the intake of certain vitamins and minerals. Diet and mealtime patterns are

linked to socioeconomic status, and children and adolescents with lower socioeconomic status eat breakfast less often, eat less fruit and vegetables and consume more soft drinks and confectionary.

The health consultations should reinforce existing positive habits and, when necessary, provide advice and guidance to encourage children and adolescents to eat a healthy diet in line with the national recommendations.

Physical activity - 1st grade and 8th grade

[The national recommendations for diet and physical activity](#) are used as a basis in the work of the school health service. The school health service should contribute to raising awareness and promote physical activity and reduce inactivity amongst children and adolescents.

Physical activity, good motor skills and physical fitness can be important determinants for the cognitive function of pupils [205] [246], and studies show that daily physical exercise at school has a positive effect on learning and academic performance. [186] [203]

There is also a positive link between physical activity and mental health amongst children and adolescents [191], and the level of physical activity during the teenage years has a clear link to mental well-being as an adult. [201]

Surveys of physical activity amongst Norwegian children and adolescents show that the level of activity declines steadily from the age of six through to the 20s. [185] [233] [252]

From 6 to 15 years, there is a clear [decline in the proportion of children and adolescents who fulfil the national recommendations concerning physical activity](#). More boys than girls fulfil the recommendations. Adolescents with a non-western background are generally less active than those with a western background. Children and adolescents with a low socioeconomic status appear to spend more time on sedentary activities. [243]

The overall amount of time spent being sedentary includes time spent in front of various types of screens, passive transport, e.g. bus and car travel, and inactivity at school. The average overall amount of time that Norwegian children and adolescents spend being sedentary rises with age. [6, 7 and 15year olds respectively spend around 50, 60 and 70% of their waking hours inactive](#).

The level of physical activity amongst children and adolescents is strongly influenced by circumstances, opportunities and obstacles in their social and physical environment, in addition to factors linked to the individual themselves. [185] [241] [238] [268] [265]

During the health consultations, health professionals should strive to reaffirm existing established positive habits and, when necessary, provide advice and guidance in order to:

- Encourage and promote physical activity
- Reduce inactivity

Dental health - 1st grade and 8th grade

Promoting good dental health during the childhood and adolescent years is important in order to achieve good health throughout life, and forms part of the Action Plan for the Prevention and Control of Noncommunicable Diseases in the WHO European Region 2016- 2025 (WHO, 2016).

At the age of around 12-13, children are in the process of losing their last milk teeth and establishing a full set of permanent teeth with 14 teeth in each jaw. Teeth are at greatest risk of developing caries during the first year after eruption and it is therefore important to maintain good dental hygiene.

At lower secondary school age, many children have braces, requiring particular care to be taken with dental hygiene. Many will also be at risk of suffering erosion damage to their teeth due to the frequent consumption of acidic beverages and food.

Teeth and oral cavity should be checked during the school-entry health consultation, and teeth-cleaning and a tooth-friendly diet should be covered during both the school-entry health consultation and the health consultation in the 8th grade.

Accidents and injuries - 1st grade

Accidents are one of the biggest threats to the lives and health of children. It is not possible to prevent all injuries and accidents, but parents can do a lot to ensure that their children and their surroundings are safe. Outdoor accidents represent the biggest threat for children around the time they start school. Drowning and road traffic accidents are particularly serious ([The National Institute of Public Health's Child Health Report](#)).

Common injuries following accidents include:

- Cuts and abrasions
- Fracture and dislocation injuries
- Head injuries
- Burn and corrosion injuries
- Dental injuries

Parents should be given information about what they can do to prevent accidents and injuries.

Sexual health - 8th grade

The foundations for sexual well-being and a secure sexual identity are laid during a person's childhood and are built on throughout life. The capacity to act and a positive attitude towards one's own body and sexuality is crucial for sexual pleasure and the development of a secure sexual identity and more confident sexual behaviour. Key terms are autonomy, coping resources and bodily and sexual integrity .

During the health consultation, information should be given concerning what topics the school health service can provide guidance on.

Tobacco - 8th grade

The proportion of smokers amongst adolescents and adults has declined considerably since the start of the millennium through to the present day, while the proportion of adolescents using oral tobacco (snus) has risen. However, the rise in the use of oral tobacco does not outweigh the decline in smoking, and the use of tobacco has consequently decreased overall. [172]

The trend in recent years has been one of a steady decline in the number of daily smokers amongst children and adolescents, and the vast majority have never tried cigarettes, but the smoking of cigarettes increases during adolescence.

Adolescents who struggle with mental health problems smoke more frequently than others, even though only a small proportion are regular smokers. The taking of oral tobacco is also not particularly widespread. [172] Adolescents who smoke daily report that they are ill more often and have more serious health problems than those who do not. [247]

Children and adolescents who try cigarettes can quickly become addicted to nicotine. Children can show signs of dependency even after just four weeks of experimentation, and before they become daily smokers. [240] The earlier children and adolescents start smoking, the greater the risk is of developing serious health problems later in life. Starting smoking at an early age is linked to smoking more cigarettes per day, being more dependent on nicotine, having less chance of stopping and a higher mortality rate. [232]

Girls who take contraceptive pills and smoke are at greater risk of developing serious blood clots than girls who take contraceptive pills and do not smoke. [266]

The school health service should ask everyone about their use of tobacco. When girls wish to use hormonal contraception, it should be ascertained whether they consume tobacco.

Guidelines from other countries unanimously recommend the use of "minimal intervention", which is a simple method for stopping smoking which involves asking a couple of basic questions (NICE 2013). [267] [229] [231] [253] The use of minimal intervention during the health consultation in the 8th grade where most pupils don't use tobacco (smoking and oral tobacco) presents an opportunity to encourage adolescent to stay tobacco-free and identify those who may have started to experiment with tobacco. Minimal intervention can be carried out by a doctor or other health professional and is recommended for use with regard to all children and adolescents. [257]

Alcohol and drugs - 8th grade

Alcohol is an addictive substance, and an important risk factor for a number of serious diseases. It is illegal to sell alcohol to people under the age of 18, and children and adolescents should refrain from consuming alcohol altogether.

Adults are drinking more alcohol than previously, but alcohol consumption amongst adolescents has flattened out and is now showing a marked downward trend. Nevertheless, many adolescents drink alcohol, particularly in their late teens. A minority start to drink alcohol early in their teenage years. [172] The early consumption of alcohol is often linked to other types of high-risk behaviour and mental health problems.

The drinking patterns of adolescents are characterised by binge-drinking, and episodes of intoxication and high consumption levels can have considerable social and health-related consequences for the individual, the local community and society as a whole.

However, a large majority of adolescents report that they have not drunk enough alcohol to become intoxicated during the past year, while a small group (3-4%) have become intoxicated on six or more occasions. [172]

Alcohol-related violence is a significant problem amongst adolescents, and alcohol-related injuries and accidents, including injuries caused by violent behaviour, account for a substantial proportion of deaths and loss of healthy life years. [41] Around 8% have at least one parent who abuses alcohol, and around 6% have parents with such serious alcohol abuse that it affects their ability to function on an everyday basis.

Important initiatives in the intoxication prevention work aimed at adolescents will be to reduce alcohol consumption generally and the number of episodes of intoxication, delay debut age and raise awareness amongst parents.

At lower secondary level, few adolescents have tried cannabis or marijuana, but the proportion is considerably higher at upper secondary level, particularly amongst boys. There is a clear link between cannabis smoking and mental health problems.

It is a matter of some debate whether cannabis or marijuana in isolation is more dangerous than debuting at an early age with alcohol. [172] However, unlike alcohol, cannabis and other narcotic substances are prohibited in Norway, and this represents a major difference. Adolescents who experiment with illegal drugs have crossed an additional line.

Alcohol and drugs should be amongst the topics covered during the health consultation in the 8th grade.

The GP scheme - 8th grade

During the health consultation in the 8th grade, everyone should be given information on the GP scheme, and individuals should be encouraged to find out who their GP is.

Violence - 1st grade and 8th grade

See [the chapter Violence, abuse and neglect](#).

Practical information

Factors and lifestyle habits which are important with regard to mental and physical health should be brought up during the health dialogue in the school-entry health consultation in the 1st grade and during the health consultation in the 8th grade.

The consultation should be based on the issues that parents, children and adolescents are most concerned about, but all the topics referred to below should be covered and the topics should be viewed in context. Individually adapted advice should be given.

Topics during the health consultation in the 1st grade

- Coping resources, well-being and relationships
- Sleep and sleep habits
- Physical activity, leisure activities and inactivity
- Dental health
- Accidents and injuries
- Violence, abuse and neglect. See [the chapter Violence, abuse and neglect](#)

Topics during the health consultation in the 8th grade

- Coping resources, well-being and relationships
- Sleep and sleep habits
- Physical activity, leisure activities and inactivity
- Dental health
- Sexual health
- Tobacco, alcohol and drugs
- Violence, abuse and neglect. See [the chapter Violence, abuse and neglect](#)
- Information on the GP scheme

The overviews are not exhaustive. Based on knowledge concerning the needs of individual children or adolescents, health professionals should consider whether other circumstances and topics should be covered.

See also the recommendation School-entry health consultation and [the recommendation Health consultation, 8th grade](#)

Adapted information should be given to children and adolescents with disabilities, rare diagnoses, loss of senses and any alternative and supplementary communication. See [also the recommendation Coordinating unit](#).

Follow-up consultations should be offered as and when necessary. During follow-up consultations, relevant mapping tools can be used provided that staff in the school health service have the competence to use them. Regarding the effect of Motivating dialogue; see [The Norwegian Knowledge Centre for the Health Services' memorandum](#).

Exploration of well-being, coping resources and relationships (mental health): 1st grade and 8th grade

The following factors which are relevant to the health of children/adolecents should be covered:

- During the consultation in the 1st grade, experiences before starting school, including experiences from kindergarten
- Well-being and coping resources at school and home, including bullying
- Development and perception of self-image and self-esteem
- Relationships to and within the family, including any stressful and straining life events, e.g. conflict between parents, divorce/break-ups, death in close family, accidents, mental health, drugs/alcohol and illness amongst parents, siblings or family
- Relationships to friends, peers, teachers and parents
- During the consultation in the 8th grade: Sexual health, including relationships with partners and gender identity
- Violence, abuse and neglect; see [the chapter Violence, abuse and neglect](#)

Advice and guidance concerning sleep and sleep habits: 1st grade and 8th grade

The amount of sleep that people need varies. [230]

- From age 3-6, 10-12 hours per night is recommended,
- From age 7-12, 9-11 hours per night

- During the ages 13-18, 8-10 hours per night

Advice for healthy sleep habits for kindergarten and school children

- Emphasise the establishment of habits which result in sufficient sleep
- Create a calm environment with set, calm and positive routines every evening before bedtime, avoid energetic play and screen activities such as PCs, games consoles and mobile phones close to bedtime
- Set fixed bedtimes and get up at the same time on both schooldays and at weekends
- Sun and daylight help children establish a regular daily rhythm. Spend time outdoors, particularly in the morning
- Physical activity improves sleep, but avoid hard work-out just before bedtime
- Eat a light evening meal
- The bedroom should be a screen-free zone
- The bedroom should be dark and not too warm
- It can be a good idea to use a nightlight

For adolescents, the following advice also applies:

- Avoid caffeinated beverages such as coffee, tea, cola and energy drinks in the evening
- Log off screens and mobile phones well before bedtime

More information

- For more information about sleep, see helsenorge.no and the [National advisory service for sleep disorders \(SOVno\)](#)
- [Sleep magazines from SOVno](#) (they are free to subscribe to - a good source of information for health professionals)
- [About sleep from the Norwegian Institute of Public Health](#)
- Advice and guidance about diet and mealtimes: 1st grade and 8th grade

[The Directorate of Health's recommendations concerning diet and nutrition](#) should be used as a basis for the work.

Many challenges regarding the diet of children and adolescents correspond to those faced by the general population. Most children and adolescents should:

- Eat more vegetables and fruit, coarse-grained cereal products and fish
- Reduce their intake of saturated fats, salt and sugar

Children and adolescents should be encouraged to:

- Have a varied diet with a balance between energy intake and energy consumption
- Eat breakfast and take a packed lunch with them, including fruit and vegetables
- Use fish both as a sandwich topping and for dinner
- Eat a lot of fruit, vegetables and berries
- Adopt a conscious attitude towards consuming food and beverages with a lot of sugar, salt and saturated fats

To ensure they have a healthy and tooth-friendly diet, children and adolescents should be advised to:

- Avoid snacking between meals on food and beverages containing added sugar
- Avoid frequent intake of acidic foods and beverages, such as acidic sweets, soft drinks, citrus fruits and juice
- Choose water as a thirst-quencher

To explore whether a child or adolescent has a problematic relationship with food and diet and any other underlying factors, health professionals can ask questions about:

- Challenges associated with diet and mealtime rhythm
- What constitutes normal diet, meal rhythm and portion sizes
- Thoughts and feelings concerning food and meals

Children with allergies/intolerance and other special challenges and needs may need specific advice. This may also apply to minorities and people with chronic illness. See [Kosthåndboken \(The Diet handbook\)](#), Chapter 4 Diet in different life phases.

For more information concerning special challenges associated with the diet of immigrants; see [The Diet handbook](#), Chapter 5 Religious and cultural diet considerations.

Collaboration with nutritionists

Some municipalities have appointed clinical nutritionists. These professionals will be an important collaboration partner for the school health service. Clinical nutritionists are normally involved in approaches to children who face special challenges. In the multidisciplinary team, clinical nutritionists can be important contributors to teaching and as a resource for other health professionals. As part of the internal control system, it is recommended that routines be established for collaboration with clinical nutritionists in the municipality. See the General section: Collaboration and co-operation.

Advice and guidance concerning physical activity: 1st grade and 8th grade

Children and adolescents should be physically active for a minimum of 60 minutes every day. The activity should be of moderate or high intensity.

- Children and adolescents should participate in high-intensity activities at least three times a week. This increases muscle strength and strengthens the skeleton
- Physical activity in excess of 60 minutes provides further health benefits
- Most children and adolescents should sit less still

Varied physical activity enables children to develop both fine and gross motor skills. Regular physical activity also has a positive impact on mental health, concentration and learning.

This contributes to more physical activity and reduces inactivity amongst children and adolescents

- Physical activity, sport and training which boosts energy levels and enhances coping resources. Children and adolescents should take part in activities that they enjoy and think are fun
- Everyday activities such as walking or cycling to and from school and other activities
- Support from parents, friends and teachers in the form of encouragement to take part in physical activity together (outdoor recreation, excursions, sport, play and games), and help to get to and from training when necessary
- Limit time spent in front of screens (PCs, TV, mobile)
- Frequent breaks from sedentary activities
- School and local communities with good opportunities for being physically active; see [the recommendation Physical activity](#)

There are considerable variations in activity levels amongst children and adolescents. Those with the highest activity levels are three to four times more physically active than the 10% who are least active. Some pupils and groups of pupils may need special initiatives to encourage them to take part in physical activity, and it may be necessary to work with physiotherapists, healthy life centres and GPs concerning special measures for these groups.

Special initiatives: Healthy life centres

Some healthy life centres offer activities for overweight children and adolescents and their parents. Healthy life centres can offer courses for children and adolescents who do not take part in other organised activities. These activities and courses can attract adolescents who lack a social network and/or have parents who are unable to pay for them to take part in groups and teams.

Overweight and obesity: See [the National guideline for the investigation, prevention and treatment of overweight and underweight in children and adolescents \(Nasjonal faglig retningslinje for utredning, forebygging og behandling av overvekt og undervekt hos barn og unge\)](#)

Regional centres for morbid obesity. See the overview of the [regional health authorities](#). Many hospitals have regional centres for morbid obesity which offer various types of treatment, including intervention with physical activity and diet. Many of the centres collaborate with the primary health service; see the University Hospital of Northern Norway, the Northern Norway Regional Health Authority, Vestfold

Hospital, St. Olavs Hospital and the University Hospital in Trondheim.

“Stor og sterk” (Big and strong) is a treatment which is offered to obese/overweight children and adolescents and their families. The treatment is primarily intended for children and adolescents in the Oslo region. The [Western Norway Regional Health Authority](#) also offers treatment for children under 18 with a body mass index (BMI) of over 35.

Advice and guidance concerning teeth cleaning and dental health: 1st grade and 8th grade

1st grade

- Children and adolescents should clean their teeth with fluoride toothpaste twice daily
- Children from 3 to 7 years of age should use adult toothpaste (>0.1% fluoride) with an amount corresponding to the size of a pea
- Children should not rinse their mouth out after cleaning their teeth
- Parents should help their children with teeth-cleaning or monitor their teeth-cleaning until the child has developed sufficient motor skills to be able to do it on their own, i.e. usually until the child is around 10 years old
- When the six-year molars erupt, it is important to ensure that the chewing surfaces of the molars are cleaned thoroughly

Tooth-friendly diet: Follow the national recommendations concerning diet (see Advice and guidance concerning diet and mealtime habits).

To save time, doctors can give advice and guidance relating to dental health when the child's dental health status and oral cavity are checked during the somatic examination as part of the school-entry health consultation.

The child and their parents should be asked whether they are experiencing any problems with the child's teeth and oral cavity and whether the child has been to a dentist. The child should be referred to the dental health service when necessary.

8th grade

- Teeth-cleaning with fluoride toothpaste twice daily (fluoride >0.1%). There is no risk of overdosing at this age
- Tooth-friendly diet (see under Advice and guidance concerning diet and mealtime habits)

Health professionals should ask whether the adolescent is experiencing any problems with their teeth or mouth, and whether they have been to a dental clinic. The adolescent should be referred to the dental health service when necessary.

A close collaboration with the dental health service is important; see [the recommendation The Dental health service](#).

More information

- [About the fact that using oral tobacco damages teeth and gums](#)
- [About caries and erosion and the causes](#)

Advice and guidance about accidents and injuries: 1st grade

Accidents and injuries should be one of the topics that are covered in the health dialogue during the school-entry health consultation.

Parents should be given information on the most common accidents and injuries and what they can do to prevent them.

The school health service can distribute the brochure entitled [Children's environment and safety](#) (the school-entry part). This brochure covers the most common situations where injuries and accidents can occur at different ages and gives advice about the simple steps that parents can make to create a safe environment for their children and prevent accidents and injuries.

The brochure can be unfolded to form a poster which can be put up on the wall and used as a checklist.

The brochures are available in Norwegian, English, Urdu, Arabic and Somali, and can be ordered from:

E-mail: trykksak@helsedir.no

Telephone: +47 24 16 33 68

The brochures can also be downloaded from the [Directorate of Health's website](#).

Advice and guidance about sexual health - 8th grade

During the health consultation in the 8th grade, adolescents should be informed that anyone can contact the school health service for advice and guidance concerning questions relating to sexual health, e.g. about falling in love, love, personal wishes, needs and boundaries, gender identity, contraception, sexually transmitted diseases, sexual harassment and abuse.

Ung.no is a questions and answers website which offers information and guidance to adolescents and young adults concerning the topics of health, relationships and family, drugs and alcohol and sexuality.

Advice and guidance concerning smoking and oral tobacco - 8th grade

During the health consultation in the 8th grade, health professionals can, with the aid of minimal intervention, motivate adolescents not to start smoking or use oral tobacco and motivate those who experiment with tobacco to stop.

Minimal intervention consists of three basic questions and can be carried out by all health professionals.

1. Do you smoke or use oral tobacco (including experimenting occasionally)
 - If NO: give the adolescent recognition for this choice and end the discussion concerning this topic.
 - If YES, move on to the next two points.
2. Would you consider stopping?
3. I would recommend that you stop/stop experimenting, and I can help you
 - By providing you with more information about some useful tools
 - Offer a follow-up consultation and/or refer the adolescent to a GP

[Those who use oral tobacco should be informed that using such tobacco damages teeth and gums.](#)

Useful tools

[Slutta](#) (Stop) is a free app for smartphones. This has primarily been created for young people who want to stop smoking or taking oral tobacco, but has also proven to be useful for people of all ages.

- The app includes aspects which have a documented effect in connection with stopping smoking for adolescents. [264]
- It can be shared via Facebook
- Business cards for the *Slutta* app can be ordered via [Helsedirektoratet.no](#).

The Directorate of Health also offers online help to adolescents who want to stop smoking or taking oral tobacco. The adolescents are followed up by text and e-mail.

The mentors at [Slutta](#) (previously called *Røyketelefonen*) are experts in helping people stop taking oral tobacco or smoking and can be used by health professionals, course leaders, students, private individuals and others. *Slutta* also offers guidance via chat. *Slutta* mentors have higher education qualifications within various disciplines. They are bound by a duty of confidentiality.

Advice and guidance concerning alcohol and drugs - 8th grade

During the health consultation in the 8th grade:

- Individuals should be encouraged to think through and make a conscious decision regarding their attitude towards alcohol and drugs
- Adolescents should be told that most people do not drink enough alcohol to become intoxicated

- at lower secondary school age (eliminate any majority misunderstandings)
- In the case of experimentation and problems associated with alcohol and drugs, offer a follow-up consultation
- Adolescents must be told that they can make contact if they have any questions or concerns about alcohol and drug use involving themselves or others (friends, parents, etc.)

Provide information on the GP scheme - 8th grade

During the health consultation in the 8th grade, everyone should be told that:

- They are entitled to a GP
- Parents choose a GP for their children under 16 years of age, but you can choose or change your GP yourself once you reach the age of 16
- They can contact a doctor when necessary **The GP scheme is free:**
 - Until you reach the age of 16
 - For children and adolescents under 18 who are undergoing psychiatric treatment
 - For pregnant women receiving maternity care
 - For people with communicable diseases, or people with suspected communicable diseases, such as chlamydia and gonorrhea

It may also be appropriate to provide information about psychologist and/or mental health services in the municipality.

Dialogue about violence - 1st grade and 8th grade

See [the chapter Violence, abuse and neglect](#).

See [the recommendation Targeted services](#) and [the recommendation User participation](#).

More information

1. [Ung.no](http://ung.no)
2. [Helsenorge.no](http://helsenorge.no)
3. [The National Institute of Public Health's Child health report](#)
4. [Ombudsman for Children](#)
5. [Norwegian National Centre for Food, Health and Physical Activity](#)

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5.2.4 Identifying mental health problems and disorders: The school health service should focus on identifying mental health problems and disorders

The school health service should endeavour to promote good mental health amongst pupils.

As part of the health promotion and preventive work, the school health service should focus on identifying mental health problems and disorders amongst children and adolescents.

The service is particularly well-placed to identify mental health problems and disorders and incipient abnormal development in children and adolescents in the following contexts:

- During the school-entry health consultation
- During the health consultation in the 8th grade
- Through other targeted investigations
- Through weighing and measuring
- In connection with vaccination
- When a child or adolescent contacts the service via drop-in
- Through the collaboration with the school

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

The services offered to children and adolescents by the school health service should include health examinations and guidance with follow-up/referral as and when necessary; see Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*).^[5] In collaboration with pupils, parents, school staff and other collaboration partners, the service should strive to identify pupils with health problems linked to their school situation. In this work, the service should specifically focus on identifying mental health problems and disorders.

Mental health problems refer to conditions which are problematic and which impact on normal

functioning and learning to some degree.

Mental health disorders refer to conditions which are so intense, protracted or debilitating that they require initiatives on the part of the specialist health service.

Children and adolescents with mental health problems and disorders should be identified at an early stage in order to prevent and hinder the development of long-term problems or disorders and ensure that they receive the follow-up they need. [36] [41] Instigating initiatives at an early stage can have implications regarding the need for help and prognosis.

Mental health problems are usually transient, but at any one time around 15-20% of children and adolescents aged between 3 and 18 have impaired function as a result of mental health problems, and “mental health” is the third most common reason for adolescents contacting the school health service, after “physical health” and “sexual health”. [159] However, surveys show that adolescents tend to seek out help for mental health problems and disorders less often than others. [269] Universal measures are therefore important in order to identify atypical development.

Mental health problems and disorders during childhood and adolescence increase the risk of drop-out at school, looser ties with the labour market, financial difficulties and difficulties with close relationships, drug and alcohol abuse and poor mental and physical health later in life. [42]

Vulnerable children and adolescents

Children and adolescents will not necessarily develop mental health problems and disorders even if they are exposed to risk factors, but the school health service should be particularly aware of children and adolescents who, for example, are showing signs of loneliness, have a difficult family situation, are experiencing difficulties relating to food and their body, or sleep, and adolescents who either are experiencing or have experienced bullying, violence, neglect or sexual abuse and/or who use medications/alcohol or drugs.

Both acute and persistent negative life events lead to a greater risk of developing mental health problems and disorders. Acute life events such as trauma and disasters, violence and sexual abuse will often be easier to identify, as the pupil or others will be able to talk about it themselves. Persistent negative life events such as bullying, sexual harassment and difficult family relationships are more difficult to detect, partly because they may be linked to fear and/or shame.

Adolescents with limited resources at home tend to do less well at school and in the local community; they tend to have a more difficult relationship with their parents and friends and be bullied more often, suffer from mental and physical health problems more frequently, and are more pessimistic about the future. They take part in organised leisure activities less often and spend more of their spare time in front of a screen than adolescents who grow up in families with more socioeconomic resources. [159]

As mental health problems and disorders can have different expressions and causes from person to person, between different age groups and between the genders, it is difficult to detect atypical development based on the symptoms alone.

Often, it's the knowledge one has about a particular child or adolescent and their family, that leads to particular awareness as to whether they are at risk of developing, or have already developed, mental health problems or disorders, e.g. that the child:

- Has experienced stressful life events, e.g. an accident, violence/rape, illness/death in the family
- Lives under difficult conditions, e.g. uncertainty, threats of violence, bullying, drug/alcohol abuse or illness in the family.

Another factor is the behaviour of the child or adolescent when interacting with other people, e.g. the child avoids social contact or is uncritical in their behaviour towards their peers or unknown adults.

Moreover, dramatic changes in the behaviour of a child or adolescent will often be a sign of incipient or existing established mental health problems or disorders. This means it is important to consider the behaviour of the child or adolescent in context. This requires both a knowledge of the child's history and life situation and a knowledge of mental health.

Partnerships with schools

The development of local collaborative routines between the school health service and schools in order to share expertise and prevent, identify and follow up children and adolescents with mental health problems is recommended in guidelines and guides from other countries. [169] [170] [139]

The Norwegian Directorate for Education and Training's questionnaire for teachers, heads and school administrators concluded that some teachers do not have sufficient competence to identify pupils who are struggling mentally, and that there is scope for improvement for collaboration and coordination. [270]

Background and occurrence

There can be a gradual transition between mental health problems and mental health disorders, and the same disorder can give rise to various symptoms in different age groups.

For most people, mental health problems are transient, but for some, they can be persistent. Around 8% of children and adolescents have such severe problems that they meet the criteria for a mental health disorder. [42] The scope of mental health problems increases through the adolescent years, particularly during the lower secondary stage, but far more girls than boys suffer from anxiety and depression. [42]

Recent research indicates a link between mental health and learning, and mental difficulties are an important determinant for drop-outs from upper secondary school education. [270] In addition to the fact that mental health problems can lead to learning difficulties, learning difficulties can also lead to mental health problems. [244] It is important that the school health service is aware that mental health problems can also be a symptom of reading and learning difficulties, non-verbal learning difficulties, poor concentration and medical diagnoses.

Practical information

In order for the school health service to be able to identify mental health problems and disorders, the service must be an readily available and accessible low-threshold service; see [the recommendation Low-threshold services](#). The school health service should also be aware of symptoms of mental problems and disorders.

Physical and mental problems are often interlinked. [172] One can be an indication of the other. At the same time, children and adolescents can often find it difficult to put complex thoughts and emotions into words. Identifying mental problems or disorders and incipient atypical development requires the school health service to be aware of these interrelationships and to have good communication skills.

The school health service should be aware that it can take time for a child and adolescent to open up and talk about all the things they may need to bring up; see [the recommendation Underlying causes](#).

The school health service should encourage children and adolescents to contact them again if it appears that there may be something else they need to discuss other than what they brought up initially.

The school health service should be particularly aware of children and adolescents who:

- Show signs of loneliness, are being left out in the school context, or have a limited social network
- Have a difficult family situation
- Are experiencing difficulties relating to food and their body
- Have poor dental health
- Have sleep difficulties
- Are experiencing or have experienced bullying, violence, neglect and sexual abuse
- Are taking medications/drugs or alcohol
- Have experienced stressful life events (such as accidents, violence, illness/death in the family)
- Live under difficult conditions (such as uncertainty, threats of violence, bullying, drug or alcohol abuse or illness in the home)
- Have experienced frequent moves or changes in domestic circumstances
- Face challenges interacting with others
- Show dramatic changes in behaviour
- Have reading and learning difficulties, non-verbal learning difficulties, poor concentration and

- medical diagnoses
- Live in a bedsit
- Are a single minor seeking asylum
- Have absence from school giving reason for concern; see the recommendation Absence giving reason for concern

Children and adolescents who face such challenges can suffer from mental health problems or disorders, such as anxiety, depression or behavioural problems.

In a dialogue meeting with the Directorate of Health, children and adolescents have themselves referred to the following as being important factors in order for them to contact the service:

- Awareness of the range of services available
- That those who work there make themselves visible and “put themselves out there”
- Openness, honesty and trust
- Humility and care from the staff
- Involvement in decisions

Partnerships with schools

By participating in the school’s multidisciplinary collaboration meetings or resource teams, the school health service can help to share expertise and identify mental health problems or disorders amongst children and adolescents; see the recommendation Systematic partnership.

The school health service should consider implementing universal measures in collaboration with the school and others if the scope of mental health problems or disorders amongst the pupil population is extensive or if the causes are linked to the school environment; see the recommendation Psychosocial environment and the recommendation Overview.

Follow-up

If the school health service finds that the child/adolescent may have mental health problems or disorders, the service should ask the child/adolescent about the following:

- How the problems manifest themselves
- How long the problems have lasted
- What they think might be causing the problems
- What, if anything, the problems might be linked to

The school health service should provide targeted follow-up to children and adolescents with mental health problems and disorders; see the recommendation Follow-up of mental health. When necessary, the child/adolescent should be referred for further follow-up by e.g. a GP or the mental health service in the municipality.

The school health service should work with the Educational and Psychological Counselling Service (PPT) as and when necessary.

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5.2.5 Underlying causes: The school health service should be aware of possible underlying causes in connection with all enquiries from children and adolescents

Children and adolescents can find it difficult to put challenges that they face into words. Physical and mental health problems are often interlinked. Mental health problems can manifest themselves as physical “pains”.

The school health service should be particularly **aware of possible underlying causes** in connection with enquiries from children and adolescents:

- When the reason for the contact seems unclear
- When there are indications that there are other reasons behind the enquiry than those being put forward
- In the event of suspicion that “pains” may be something other than what is being communicated initially

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

The services for children and adolescents being offered by the school health service should include the provision of advice with follow-up or referral when necessary; see Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*). [5] This includes the provision of a service which adolescents can contact without booking an appointment, known as a ‘drop-in service’. A school health service which is available without any requirement to book an appointment is an important prerequisite in order to identify children and adolescents who are facing challenges.

In collaboration with pupils, parents, school staff and other collaboration partners, the service should strive to identify pupils with health problems which are linked to their school situation (Comments on Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*)).

In the case of enquiries from an individual child or adolescent, the school health service should be particularly aware of those who give diffuse reasons for making contact (mental and/or physical). Physical symptoms without any obvious cause such as headaches, stomach pains or pain in the arms or legs can be a sign of depression or other mental health problems in children and adolescents. Experience also shows that many pupils contact the service repeatedly with different “pains” before they seek advice for more serious issues.

Mental health disorders can be interpreted differently by different cultures. [225] Surveys indicate that some immigrants use more specific symptoms to a greater extent, e.g. stomach upset in the case of emotional difficulties.

If the reason for making contact could be considered to be shameful (e.g. loneliness, bullying, a difficult family situation, drug or alcohol problems, violence, neglect, sexual orientation or sexual abuse), it can be difficult for children and adolescents to bring up their challenges and they may need to develop trust in the service first.

Mental health and social inequality

Mental health problems and disorders develop in a complex interaction between genetic, biological and environmental factors. Broadly speaking, it could be said that mental health is the result of the interaction between individual characteristics and protective factors and risk factors in the environment. [271] [273]

Some children and adolescents live under such stressful family circumstances and have so few social and material resources that, even before they are born, we can already say that they are at greater risk of developing emotional and behavioural disorders. [273]

Although income differences in Norway are low in an international context, 10% of all children were growing up in a low-income family in 2015. Children from financially disadvantaged families in Norway tend to suffer from poor physical and mental health to a greater extent, suffer more accidents and bullying and tend to lead a less healthy lifestyle. [272]

Protective factors and risk factors for developing mental health problems and disorders can be both related to environmental and individual factors. Factors which impact on mental health include socioeconomic status, parental mental health and drug abuse, relationship to parents, parental skills, whether the family is under a lot of strain, adverse life events, traumas and degree of social support, coping strategies, violence in close relationships, refugee status, loss of important close family and friends, integration and attachment in the neighbourhood and at school, employment, working environment, loneliness, home environment, assault, abuse, malnutrition, diet, physical activity, divorce, somatic diseases and pain conditions and sleep.

Practical information

The school health service should be readily available. See [the recommendation Low-threshold services](#).

Physical and mental health are interlinked. It is important to be aware that mental health problems can result in physical problems. The school health service should therefore be particularly aware of children and adolescents who repeatedly contact the school health service with different “pains”.

Repeated enquiries may also be a sign that the child or adolescent is testing out a relationship of trust before opening up and bringing up difficult issues or circumstances.

In the case of enquiries where the reason for the contact seems unclear or where there are indications that the child or adolescent has other underlying reasons for making contact than they initially reveal, the service should be particularly aware of, and explore and ask the child or adolescent about a broad spectrum of possible causes, including:

- Well-being, family and friendships
- Family circumstances (including socioeconomic circumstances, whether the child has had any contact with the Child Welfare Service and alcohol/drugs or mental health problems or disorders)

- amongst the parents)
- The child/adolescent is a next of kin
- Bullying by fellow pupils or teachers
- Sleep habits and any difficulties
- Physical and mental challenges associated with diet and meals
- Uncertainty over sexual orientation, gender identity and gender expression
- Use of tobacco, alcohol and drugs or medications
- Violence, abuse and neglect
- Somatic symptoms

This list is not exhaustive.

The school health service should:

- Always suggest to the child or adolescent that they should contact the service again if they think they might have other things “on their mind” that they have not yet presented.
- Offer follow-up consultations when necessary; see [the recommendation Follow-up of mental health](#).
- Collaborate with schools and teachers in connection with enquiries relating to the pupils’ school day. Collaboration with schools must be based on consent from the individual pupil and/or parents.
- Collaboration with physiotherapists concerning children and adolescents who repeatedly contact the school health service with physical “pains”
- Assess whether the child should be referred to the school doctor, physiotherapist or other staff within the school health service; see [the recommendation School doctor](#)
- Assess whether the pupil should be referred to the GP or the mental health service within the municipality; see [the recommendation GPs](#) and [the recommendation Psychologist](#)

Duty of disclosure to the Child Welfare Service

When there is reason to believe that a child is being abused in the home or subjected to other forms of serious neglect, or when the child displays persistent and serious behavioural problems, health professionals shall **report the matter to the** Child Welfare Service. See [the General section: Duty of disclosure](#).

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5.3 Violence, abuse and neglect

5.3.1 Partly undressed: The pupil should be partly undressed during the somatic part of the school-entry health consultation

The pupil should be partly undressed during the somatic examination and during weighing and measuring in order to:

- Be able to carry out an organ examination and observe skin surfaces which form part of the somatic examination
- Be able to observe indications of violence, abuse and neglect

Partly undressed means that the child is only wearing pants or boxer shorts and possibly a vest or t-shirt.

Rationale

The contents of this recommendation are based on legislation, regulations and the consensus of the working group.

The services offered by the school health service shall include health examinations; see Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*).^[5] 'Health examinations' means examinations - both somatic and mental - of individuals to assess the risk of disease and/or abnormal development based on information concerning general condition, lifestyle, risk factors, clinic investigations and tests (Comments on Section 2-3 of the Regulation on health centres and the school health service). Such an examination should be carried out during the school-entry health consultation in the 1st grade; see [the recommendation School-entry health consultation](#).

Anyone who provides medical assistance as part of their work must be aware of circumstances which could lead to measures from the Child Welfare Service; see Section 33 of the Health Personnel Act (*helsepersonelloven*).^[14] Such circumstances include indications of violence, abuse and neglect; see [the General section: Duty of disclosure](#).

It will be appropriate for the child to be partly undressed during weighing and measuring and during the somatic examination to be able to:

- Observe body proportions and skin surfaces (assess skin conditions such as eczema, dry skin, moles)
- Carry out an organ examination
- Observe any signs of violence and/or abuse

When the child is partly undressed, the doctor will be able to lift up their underwear in order to observe skin surfaces.

School health service staff shall have the competence necessary to recognise signs or behaviour which gives cause for concern. They must know what to do in the event of suspicions and how to ensure that children and adolescents receive the help they need.

"Could the child be abused?" is an essential question when faced with an injured child or adolescent, if the cause of the injury or the medical history does not match the extent or nature of the injury. It is important that even minor injuries to the skin are identified. If they have been inflicted, it may mean that the child is being abused and is at great risk of suffering further violent episodes. A child's medical history is an important source of information for identifying cases of abuse. ^[122]

During the weighing and measuring of children over two years of age, it is recommended that the child wears underwear and a vest or t-shirt. This will help if the child is shy. Weighing and measuring should be carried out when a child starts school; see [the recommendation School-entry health consultation and the National guideline for weighing and measuring at health centres and in the school health service \(Nasjonal faglig retningslinje for veiing og måling i helsestasjons- og skolehelsetjenesten\)](#).

Practical information

At the time of the school-entry health consultation, the child is at an age when health professionals should take account of any shyness, and the child should therefore be able to wear pants and possibly a vest or t-shirt.

For information concerning the performance of weighing and measuring; see [the National guideline for weighing and measuring at health centres and in the school health service](#).

For information concerning the observation of skin surfaces as part of the somatic examination; see [the recommendation School-entry health consultation](#).

Signs and indications of violence, abuse and neglect

Wounds, scars and bruises may be signs of violence. The school health service should pay particular attention to:

- Bruises and other skin damage in unexposed areas
- Marks or patterns which could indicate injury caused by an object

Child neglect and abuse can give the same general symptoms and findings as chronic somatic diseases. In the event of concerns relating to growth, behaviour or development or if there are any unexplained pain conditions and/or other somatic symptoms for which there is no other known explanation, health professionals should consider whether the symptoms may be due to violence, abuse or neglect. It should also be remembered that even if the child has an underlying illness, abuse may also be occurring which could be aggravating the symptoms.

The school health service staff must notify the Child Welfare Service when there is reason to believe that a child is being abused in the home or being subjected to other forms of serious neglect. See more in the General section: Duty of disclosure.

Consultation concerning female genital mutilation and offer of genital examination

Girls in 1st and 5th grades and their parents should be offered a consultation concerning female genital mutilation. Girls with a background from a society where female genital mutilation is widespread shall also be offered a genital examination.

The voluntary genital examination should be performed by a doctor within the school health service. In the event of findings during the genital examination, the child should be referred to the specialist health service if the doctor considers it necessary.

See more about the voluntary genital examination, Duty of disclosure to the Child Welfare Service and the duty of prevention in the [Guide to the prevention of female genital mutilation: Offer of consultation and voluntary genital examination \(Veileder om forebygging av kjønnslemlestelse. Tilbud om samtale og frivillig underlivsundersøkelse\) \(IS- 1746\)](#).

See also the [Guide to female genital mutilation \(Veiviser om kjønnslemlestelse\) from the Norwegian Resource Centre for Violence and Stress Studies](#).

In the event of suspicions concerning violence, abuse and neglect, the school health service should:

Determine whether there is cause for concern:

- If the child has bruises or other signs on the body and you are not sure of the cause of the injuries, ask the child what happened
- Analyse and describe for yourself what gives you cause for concern
- Have a low threshold for agreeing new consultations if the circumstances are unexplained. Concerns about a child can be discussed anonymously with colleagues, collaboration partners or managers

- Talk with the parents about your concerns or certain aspects of them. Be as precise as possible about why you are concerned, but without discussing the cause in the first instance
- Ask for permission to obtain information from, and discuss matters with, the health centre, GP, the local children's ward or others who may have relevant information. If the child has recently moved into your area, ask for permission to obtain information from the last health centre, the school health service, GP or hospital. The duty of confidentiality does not prevent you from passing the information to others if the person who is entitled to confidentiality agrees; see Section 22 of the Health Personnel Act.
- If there is reason to believe that a child is being abused in the home or seriously neglected in some other way, you must send a letter of concern to the Child Welfare Service. Read more in the [General section: Duty of disclosure](#)
- You must also evaluate whether there are grounds for alerting other emergency services, including the Police. Read more in the [General section: Duty of disclosure](#)

Documenting: [130] [122]

- All findings must be documented in the child's records
- You should take photographs of bruises and/or other signs of inflicted injury. Take photographs in a way which enables you to see where on the body the mark is

The Norwegian Resource Centre for Violence and Stress Studies has produced a [handbook for health and care professionals in the event of suspected child abuse](#).

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5.3.2 Violence, abuse and neglect, 1st grade: Violence, abuse and neglect should be a topic during the school-entry health consultation

During the school-entry health consultation, the school health service should observe possible physical and mental signs of unhappiness, violence, abuse and neglect.

The school health service should:

- Be alert for possible physical indications of violence, abuse and neglect during the somatic examination; see [the recommendation Partly undressed](#)
- Observe possible signs of mental problems during the health consultation and the somatic examination
- Ask questions concerning circumstances and factors relating to violence, abuse and neglect

Rationale

The contents of this recommendation are based on the law and the consensus of the working group.

Anyone who provides medical assistance as part of their work must be aware of circumstances which could lead to measures from the Child Welfare Service; see Section 33 of the Health Personnel Act (*helsepersonelloven*).^[14] Such circumstances include indications of violence, abuse and neglect; see [the General section: Duty of disclosure](#).

Violence and experience of violence

Approximately one in five children under 18 years have experienced physical violence or physical offences from of their parents (punching with the fist, kicking, beating or other physical assault). Most of these children have experienced repeated cases of violence. One in three have experienced less serious forms of violence (hair-pulling, clipping, shaking, pushing, hitting with flat hand). 15% have suffered sexual abuse before reaching the age of 18. ^[274]

Children can suffer serious harmful effects in both the short and the long term by being subjected to threats, violence, abuse and neglect, or if they find that family members or others are being subjected to such acts.

Bullying can include both physical and mental violence and threats of violence. Forced marriage, serious restrictions on the freedom of young people and female genital mutilation are defined as violence in close relationships. The World Health Organization (WHO) stresses that violence also includes physical and emotional failure of care and neglect. All forms of violence are an offence in Norway.

The younger the child, the greater the chance that the violence or sexual abuse they are subjected to will take place in their own home or be perpetrated by a person who the child knows well. Being subjected to violence or abuse during one's childhood increases the probability of being subjected to violence or abuse as an adult. Combating violence and sexual abuse against children and adolescents represents an important contribution towards fulfilling the obligations of the Convention on the Rights of the Child. ^[275]

[Oppvekstrapporten 2017, Økte forskjeller – gjør det noe?](#) (The childhood report 2017, Increased inequalities - does it matter?) refers to substantial social inequalities between the childhoods of different children. The number of children experiencing financial inequality is rising. One in ten children now grow up in a family which has a low income over a protracted period of time. Children from financially disadvantaged families in Norway tend to suffer from poor physical and mental health to a greater extent, suffer more accidents, bullying and tend to lead a less healthy lifestyle. ^[277]

Poor personal finances in itself can give rise to family conflicts and poor mental health in parents and lead to a negative style as a guardian/parent. ^[280] This can be perceived as difficult for children. A family with limited resources often has less to invest in the development of their children, whether it be time, leisure activities, culture, books and educational material, diet and living circumstances. All these factors can impact on a child's development and future potential.

Use of violence

Children who grow up in a family where one of the parents has a mental or physical disorder, abuses alcohol or uses violence against other family members are at greater risk of developing problems relating to violence and aggression themselves. The same applies if the child is directly subjected to violence, abuse, sexual abuse or neglect.

Violent behaviour at a young age can be a risk factor for the use of violence as an adult, which can also be a reflection of underlying mental problems and difficult living conditions. Sexual abuse perpetrated by other children can have serious consequences for the victim. Around 20-30% of those who sexually abuse children and adolescents are under 21 years of age. Abuse are committed by both individuals and groups. Adolescents who commit abuse alone are more likely to have been subjected to sexual abuse themselves. [279]

Uncovering violence

Save the Children's report on a survey of the support system's handling of violence in minority families concluded that it is not common amongst public health nurses at health centres or in the school health service to systematically ask questions to uncover violence. [276] Staff at health centres and in the school health service also reported that they condoned violence in minority families to a greater extent than in ethnic Norwegian families.

A need has been identified to strengthen the preventive work of the municipalities and the work of the services relating to the issue of violence and the services offered to victims of violence and sexual abuse. [55]

The guideline published by the National Institute for Health and Care Excellence (NICE) concerning violence and abuse in the home and the family, recommends that local authorities collaborate on a cross-sectoral and interdisciplinary basis to create arenas where victims of violence can discuss the problem in a secure setting. [278] It is also recommended that health and social workers have a knowledge of how they can uncover violence and know what questions they should ask in order to successfully identify cases of violence. The health services should have routines which are aimed at uncovering cases of violence, which should also form part of good clinical practice when there are no specific indications of violence, abuse or neglect. It is furthermore recommended that surveys of violence be carried out in a secure atmosphere, where the victim meets health professionals on a one-to-one basis without the potential perpetrator or perpetrators being present. A Cochrane review of studies where health professionals asked the women face-to-face whether they had been the victim of violence by a partner shows that routine screening of women will probably lead to health professionals identifying more women who are being subjected to violence by a partner compared with normal follow-up ([The Norwegian Knowledge Centre for the Health Services' discussion of the Cochrane review](#)).

Feedback from children should be actively used to improve the services offered to the victims of violence or sexual abuse, and in the Ombudsman for Children's report, child and adolescents have themselves expressed, via expert meetings and groups, what is needed to improve the health service. [164]

Practical info

School health service staff should have an understanding of violence and abuse and neglect, and of how they should fulfil their Duty of disclosure; see the [General section: Duty of disclosure](#).

Observe possible signs of unacceptable interaction and psychological violence through the health consultation and the somatic examination

During the school-entry health consultation, the school health service should observe the interaction between the parents and the child and emphasise the following considerations: [130]

- The parents are indifferent and fail to respond or show empathy towards the child
- The parents have unrealistic expectations of the child
- The parents talk about the child in a negative or derogatory way
- The parents mock the child
- The parents threaten the child
- The parents prevent the child from answering or refuse to let the child speak to health and care professionals alone

Thematisation of violence, abuse, neglect, unhappiness and bullying during the health consultation

In order to safeguard the child, the public health nurse should assess how these topics should be brought up in each individual case. Public health nurses should be sensitive towards the child and ask the right questions in an empathetic way.

During the consultation, the public health nurse should:

- Inform the child and the parents that violence, abuse and neglect are prohibited and punishable by law, also inform the child and parents about the duty of confidentiality and its limitations, including the Duty of disclosure to the Child Welfare Service

During the consultation, the public health nurse should cover circumstances and factors which may be related to violence, abuse and neglect. This could for example be done by:

- Asking open questions
- Alternating between speaking to the parents and the child when asking questions
- Asking the parents about parenting strategies
- Asking whether there is anything in the family which the parents think could have a negative impact on the child
- Asking the child about well-being, unhappiness or bullying, e.g. whether someone is bothering them or being mean, and whether anyone in the children's environment makes them afraid or unsure
- Generalise links between health problems and unhappiness and being the victim of bullying and/or abuse. Tell the child and their parents that many children get pains in their stomach if they are sad, if someone is being unpleasant towards them or if they are scared of someone
- Ask about and acknowledge the parents' opinions if the child expresses unhappiness
- Ask the parents whether there could be any stresses within the family which the child perceives to be bad

In the event of suspicions concerning violence, abuse and neglect, the school health service should:

Determine whether there is cause for concern:

- Analyse and describe for yourself what gives you cause for concern
- Talk with the parents about your concerns or certain aspects of them. Be as precise as possible about why you are concerned, but without discussing the cause in the first instance.
- Clarify with the parents whether they share any or all of your concerns, and ask them to explain any issues and what links they believe could exist
- Concerns about a child can be discussed anonymously with colleagues, collaboration partners or managers
- Ask for permission to obtain information from, and discuss matters with, the health centre, the GP or the local children's ward, for example. If the child has recently moved into your area, ask for permission to obtain information from the last health centre, the school health service, GP or hospital. The duty of confidentiality does not prevent you from passing the information to others if the person who is entitled to confidentiality agrees; see Section 22 of the Health Personnel Act.
- Have a low threshold for agreeing new consultations if the circumstances are unexplained

If there is reason to believe that a child is being abused in the home or seriously neglected in some other way, health professionals must send a letter of concern to the Child Welfare Service on their own initiative. Read more in the [General section: Duty of disclosure](#).

Health professionals must also consider whether they should alert other emergency services, including the Police. Read more in the [General section: Duty of disclosure](#).

Documenting: [130] [122]

- All findings must be documented in the child's records
- Be specific and describe what your concerns are based on

Children who have themselves been the victim of violence and abuse want a public health nurse to: [164]

- Visit classrooms and otherwise be more visible to pupils
- Explain what the public health nurse can help with and what children can talk to her about
- Explain about the duty of confidentiality and its limitations
- Follow up from the 1st grade onwards
- Use child-friendly language without any difficult words

The Norwegian Resource Centre for Violence and Stress Studies has produced a [handbook for health and care professionals in the event of suspected child abuse](#)

- The government has established children's centres in various locations across the country. These children's centres help children who are the victim of sexual abuse and are responsible for disseminating knowledge concerning the topic; for more information, visit www.statensbarnehus.no/
- For information on follow-up consultations in order to talk to children and adolescents about sensitive topics, such as violence, abuse and neglect; see [The Dialogical Child Review: How to talk to children about sensitive topics \(Norwegian Resource Centre for Violence and Stress Studies\)](#).
- For more information on measures and strategies for combating violence; see Chapter 6 of [Barndommen kommer ikke i reprise \(You only get one childhood\). Strategi for å bekjempe vold og seksuelle overgrep mot barn og ungdom \(Strategy for combating violence and abuse against children and adolescent\)](#) (2014-2017). The strategy has its own action plan *En god barndom varer livet ut* (A good childhood lasts a lifetime). Tiltaksplan for å bekjempe vold og seksuelle overgrep mot barn og ungdom (Action plan for combating violence and sexual abuse against children and adolescents) (2014-2017).
- For more information on the extent of violence; see [Vold og overgrep mot barn og unge. Omfang og utviklingstrekk 2007-2015 \(Violence and abuse against children and adolescents. Scope and trends 2007-2015\). Nova 2016](#)
- See also the recommendation *Topics during health consultations* for a complete overview of all topics which must be covered during the 1st grade consultation

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5.3.3 Violence, abuse and neglect, 8th grade: Violence, abuse and neglect should be brought up during the health consultation in the 8th grade

The aim of the 8th grade health consultation should be to prevent, avert and uncover cases of violence, abuse and neglect by:

- Informing adolescents what violence, abuse and neglect are
- Asking all adolescents whether they have experienced violence or abuse, or whether they have used violence themselves

Rationale

The contents of this recommendation are based on the law and the consensus of the working group.

In their work, anyone who provides medical assistance must be aware of circumstances which could lead to measures from the Child Welfare Service; see Section 33 of the Health Personnel Act. [14] Informing and asking adolescents about violence and abuse can help to make the school health service and adolescents themselves particularly aware of the topics, both concerning violence and abuse in close relationships and violence and abuse between adolescents, e.g. between friends or partners.

Violence and experience of violence

Adolescents can suffer serious harmful effects in both the short and the long term from being subjected to threats, violence, abuse and neglect or if they see family members being subjected to it.

Bullying can include both physical and mental violence and threats of violence. Forced marriage, negative social control, honour-based violence and female genital mutilation are defined as violence in close relationships. The World Health Organization (WHO) stresses that violence also includes physical and emotional failure of care and neglect. All forms of violence are an offence in Norway.

According to a survey, around 30% of children and adolescents have been the victim of less serious physical violence from a parent (hair-pulling, clipping, shaking, pushing, hitting with flat hand). 5% of children and adolescents have experienced serious physical violence such as hitting with a fist, kicking, “beating up” or physical assault in other ways. When a adolescent is subjected to rape before reaching the age of 18, the assailant is usually a friend, partner or other known adolescent, or a neighbour or other known adult. [274]

The younger the child, the greater the chance that the violence or sexual abuse they are subjected to will take place in their own home or be perpetrated by a person who the child knows well. Being subjected to

violence or abuse during one's childhood increases the probability of being subjected to violence or abuse as an adult. Combating violence and sexual abuse against children and adolescents represents an important contribution towards fulfilling the obligations of the Convention on the Rights of the Child. [275]

Some groups of children are particularly exposed to violence. A survey has shown that children and adolescents from non-Western countries are at greater risk of becoming the victim of serious violence perpetrated by the mother compared with mothers with a Norwegian or Nordic background. Children with disabilities are more often subjected to violence by boys and men (in or outside the family) and other disabled persons. [281]

According to the action plan "The right to decide about one's own life", Norway has for several years worked to prevent and defeat negative social control, forced marriage and female gender mutilation. This effort has led to results: An increasing number of adolescents are in contact with, and get help through, the services targeted to help persons exposed to this kind of violence.

Definitions of honour-based violence, negative social control and forced marriage

Negative social control is understood as various forms of supervision, pressure, threats and coercion used to ensure that individuals live in accordance with their family or groups norms. Such control is systematic and may violate an individual's rights under inter alia the UN convention on the Rights of the Child and Norwegian law.

Honour-based violence is understood as violence triggered by a family's need to safeguard or restore its honour or reputation. This may occur in families with strong collectivist and patriarchal values. Girls are particularly vulnerable because their sexual behavior is inextricably linked to family honour, and because undesirable behaviour can inflict shame on the entire family.

Forced marriage is understood as a marriage where one or both of the couple concerned are not allowed to choose to remain single, without being subjected to reprisals. Forced marriage is a form of domestic violence, and in practice may also imply that the individual has no opportunity to choose out of an engagement or marriage, or choosing a partner across the family's wishes, without being subjected to reprisals.

More information can be found in the action plan The right to decide about ones own life:

<https://www.regjeringen.no/contentassets/e570201f283d48529d6211db392e4297/action-plan-the-right-to-decide-about-ones-own-life-2017-2020.pdf>

Use of violence

Children who grow up in a family where one of the parents has a mental or physical disorder, abuses alcohol, or uses violence against other family members, are at greater risk of developing problems relating to violence and aggression themselves. The same applies if the child themselves is directly subjected to violence, abuse, sexual abuse or neglect.

Violent behaviour at a young age can be a risk factor for the use of violence as an adult, which can also be a reflection of underlying mental problems and difficult living conditions. Sexual abuse committed by other children can have serious consequences for the victims. Around 20-30% of those who sexually abuse children and adolescents are under 21 years of age. Violence and sexual abuse often takes place between siblings, friends and partners. Abuse is committed by both individuals and groups. Adolescents who commit abuse alone are more likely to have been subjected to sexual abuse themselves. [279]

Uncovering violence

Save the Children's report on a survey of the support system's handling of violence in minority families concluded that it is not common amongst public health nurses at health centres or in the school health service to ask questions to uncover violence. [276] Staff at health centres and in the school health service also reported that they condoned violence in minority families to a greater extent than in ethnic

Norwegian families.

A need has been identified to strengthen the preventive work of the municipalities and the work of the services relating to the issue of violence and the services offered to victims of violence and sexual abuse. [55]

The guidelines from the National Institute for Health and Care Excellence (NICE) concerning violence and abuse in the home/family, recommend that local authorities should collaborate on a cross-sectoral and interdisciplinary basis to create arenas where the victims of violence can bring up the problem in a secure setting.[278] It is also recommended that health and social workers have a knowledge of how they can uncover violence and know what questions they should ask in order to successfully uncover cases of violence. The health services should have routines which are aimed at uncovering cases of violence, which should also form part of good clinical practice when there are no specific indications of violence, abuse or neglect. It is furthermore recommended that surveys of violence be carried out in a secure atmosphere, where the victim meets health professionals on a one-to-one basis without the potential perpetrator or perpetrators being present.

The recommendations concerning the questions which pregnant women should be asked relating to violence (in the guidelines for uncovering violence during pregnancy) are based on the recommendation from.[278] A Cochrane review of studies where health professionals asked the women face-to-face whether they had been the victim of partner violence shows that routine screening of women will probably lead to health professionals identifying more women who are being subjected to violence by a partner compared with normal follow-up ([The Norwegian Knowledge Centre for the Health Services' discussion of the Cochrane review](#)). Against this background, it is reasonable to assume that asking adolescents the same types of questions could uncover cases of violence, abuse and neglect. However, there is a need for research which can document that asking everyone routine questions, even when there are no indications of violence, has an effect.

Feedback from adolescents should be actively used to improve the services offered to the victims of violence or sexual abuse, and in the Ombudsman for Children's report, children and adolescents have expressed, via expert meetings and groups, what is needed to create a better health service. [164]

Practical information

School health service staff should have a knowledge of violence and abuse and neglect, and of how they should fulfil their Duty of disclosure; see the [General section: Duty of disclosure](#).

Physical signs of violence, abuse and neglect

During weighing and measuring, which should be carried out in the context of the health consultation in the 8th grade, it is important to be aware of physical signs of violence, abuse and neglect.

Adolescents should be partly undressed during weighing and measuring. See the [National guideline for weighing and measuring in the health centre and school health service](#).

See [the recommendation Partly undressed](#) for information on the physical signs of violence, abuse and neglect.

Violence, abuse and neglect as a topic during the health consultation

Prior to the health consultation, all adolescents should:

- Be told that violence and abuse, including negative social control, will be amongst the topics that will be brought up during the health screening in the 8th grade
- Be given an explanation of what violence and abuse is; see [the recommendation Health consultation in the 8th grade](#)

During the health consultation, all adolescents should receive information about:

- Why violence, abuse and neglect will be amongst the topics to be covered during the health

- consultation and that the topic will be brought up with everyone
- That they can contact the school health service at any time in order to ask questions and talk about their experiences of violence and abuse
- The duty of confidentiality and its limitations; see [the General section: Duty of disclosure](#)
- What violence, abuse and neglect are, including information on:
 - sexual violence, partner violence, online violence and online abuse
 - negative social control, honour-based violence and forced marriage
- That violence, abuse and neglect are prohibited and punishable offences under Norwegian law

Dialogue guide for bringing up the subjects of violence and abuse with adolescents during the health consultation in the 8th grade

The following questions concerning violence and abuse can be used:

- Do you have experience of violence in any way, have you been the victim of violence or abuse?
- Have you ever used violence?
- Are you ever scared at home or when you are with other people?
- Has anyone repeatedly mocked you, humiliated you, ignored you or told you that you were insignificant?
- Have you ever been pushed, had your hair pulled, been beaten, or otherwise been the victim of physical force?
- Have you ever been the victim of anything unpleasant to do with sex?
- Have you ever been concerned that other people have been the victim of violence or abuse?
- Have you ever seen other people (siblings, friends, parents) being hit, kicked, physically attacked or been the victim of unwanted sexual advances?
- Have you ever heard or seen one of your parents shouting or using physical force against the other?
- Is there anyone in your family who make you feel that you are important to them?

In each individual case, public health nurses must assess when questions should be followed up and when the consultation can be brought to a close.

When ending a consultation, public health nurses should inform everyone that they can contact the school health service at any time when necessary.

In the event of suspicions concerning violence, abuse and neglect, the school health service should:

Determine whether there is cause for concern:

- Analyse and describe for yourself what gives you cause for concern
- Talk with the adolescent about your concern or certain aspects of it
- You can discuss concerns about a child anonymously with colleagues, collaboration partners or managers
- Ask the adolescent for permission to collect information from and discuss with the GP, the local children's ward or the health centre, for example
- If the adolescent has moved into your area, ask for permission to collect information from their previous health centre, the school health service, GP or hospital
- The duty of confidentiality is not an obstacle to passing information on to others if the person who is entitled to confidentiality agrees; see Section 22 of the Health Personnel Act
- Have a low threshold for agreeing new consultations if the circumstances are unexplained

If there is reason to believe that a adolescent is being abused in the home or seriously neglected in some other way, health professionals must send a letter of concern to the Child Welfare Service on their own

initiative. Read more in the [General section: Duty of disclosure](#).

Health professionals must also consider whether they should alert other emergency services, including the Police. Read more in the [General section: Duty of disclosure](#).

Documenting:

- All findings must be documented in the child's records
- Be specific and describe what your concerns are based on

(NICE, 2009, NKVTS, 2016).

Follow-up when necessary

To ensure that adolescents are followed up appropriately, the school health service should:

- Offer follow-up consultations in the event of suspicions concerning violence, abuse and neglect and when necessary otherwise
- Have an overview of and be able to help the adolescent to come into contact with other bodies who can help them
- Assess what other follow-up measures may be appropriate in the event of indications of violence, sexual abuse or neglect
- Inform the Child Welfare Service when the conditions for the Duty of disclosure are met; see the [General section: Duty of disclosure](#)

Adolescents who have themselves been the victim of violence and abuse want public health nurses to:

- Visit them in classrooms and otherwise be visible amongst the pupils
- Explain what she can help with and what adolescents can talk to the public health nurse about
- Explain about the duty of confidentiality and its limitations
- Follow up from the 1st grade onwards
- Use simple language without any difficult words

(Ombudsman for Children, 2013)

More information

- The Norwegian Resource Centre for Violence and Stress Studies has produced a [handbook for health and care professionals in the event of suspected child abuse](#). The government has established ten children's centres across the country. These children's centres help children who are the victim of sexual abuse and are responsible for disseminating knowledge concerning the topic; for more information, visit www.statensbarnehus.no/
- For information on follow-up consultations in order to talk to children and adolescents about sensitive topics, such as violence, abuse and neglect; see [The Dialogical Child Review: How to talk to children about sensitive topics \(Norwegian Resource Centre for Violence and Stress Studies\)](#).
- For more information on measures and strategies for combating violence; see Chapter 6 of [Barndommen kommer ikke i reprise \(You only get one childhood\). Strategi for å bekjempe vold og seksuelle overgrep mot barn og ungdom \(Strategy for combating violence and abuse against children and adolescents\)](#) (2014-2017). The strategy has its own action plan *En god barndom varer livet ut (A good childhood lasts a lifetime)*. Tiltaksplan for å bekjempe vold og seksuelle overgrep mot barn og ungdom (Action plan for combating violence and sexual abuse against children and adolescents) (2014–2017).
- For more information on the extent of violence; see [Vold og overgrep mot barn og unge. Omfang og utviklingstrekk 2007-2015 \(Violence and abuse against children and adolescents. Scope and trends 2007-2015\)](#). Nova 2016
- See also the recommendation Topics during health consultations for a complete overview of all topics which must be covered during the health consultation.

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5.4 Follow-up when necessary (targeted consultations and home visits)

5.4.1 Follow-up of mental health: The school health service should offer follow-up to children and adolescents with mental health problems and disorders

The school health service should focus on uncovering mental health problems and disorders; see [the recommendation Uncovering mental problems and disorders](#).

The school health service should support children and adolescents **with mental health problems** by:

- Offering follow-up consultations individually or in groups
- Referring them to other services if the follow-up consultations and/or measures within the school health service are insufficient
- Collaborate with schools and parents to organise the school day
- Collaborate with other services, such as the mental health service within the municipality and the Child and Adolescent Psychiatric Outpatient Services (BUP), for guidance

The school health service should also support children and adolescents who are being **treated for mental health disorders** by:

- Collaborating with schools and parents to organise the school day
- Encouraging children and adolescents who drop out of treatment to resume their treatment

The school health service should have an overview of relevant support services in the local community and work with relevant bodies in the event of concerns regarding mental health problems or disorders amongst children and adolescents.

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

The services offered by the school health service should include health examinations and the provision of advice with follow-up/referral as and when necessary, preventive psychosocial work, as well as the provision of information and guidance both individually and in groups; see Section 2-3 of the Regulation on health centres and the school health service (*forskrift for helsestasjons- og skolehelsetjenesten*).^[5] The school health service should particularly focus on following up children and adolescents with mental health problems and disorders.

Mental health problems are usually transient, but 15-20% of children and adolescents between the ages of 3 and 18 have impaired function at any one time because of mental health problems or difficulties. Around 8 % of children and adolescents have such severe problems that they meet the criteria for a mental health disorder.

Mental health problems refer to conditions which are problematic and impact on normal functioning and learning.

Mental health disorders refer to conditions which are so intense, protracted or debilitating that they require measures on the part of the specialist health service.

Mental health problems and disorders during childhood or adolescence increase the risk of drop-out at school, looser ties with the labour market, financial difficulties and difficulties with close relationships, drug and alcohol abuse and poor mental and physical health in later life. ^[41]

Follow-up consultations, basic measures and multidisciplinary collaboration

By identifying mental health problems at an early stage, the school health service can prevent and hinder the development of long-term difficulties or disorders and ensure that children and adolescents receive the follow-up they need. ^[36] ^[41]

By offering advice, guidance and the option of repeated consultations and other simple measures, the school health service can help to boost a young person's self-esteem, coping resources, self-care, sense of responsibility and social skills.

An early response can have implications for the scope of support that is needed and prognosis, and help to ensure that children and adolescents:

- Cope with everyday life and their school day better
- Avoid deterioration in existing disorders and difficulties
- Get help to sort out and assess what constitutes normal challenges
- Receive support to cope with everyday life and the school day

Multidisciplinary collaboration

Multidisciplinary collaboration is essential in order to provide users with high-quality holistic services.

The Directorate of Education's questionnaire for teachers, heads and school administrators concluded that there is scope for improvement of collaboration and coordination between the education and health sectors (NIFU, 2014). Other guidelines and guides support the view that measures must be implemented at a number of levels in order to identify, support and follow-up children and adolescents with mental health problems and disorders ^[283] ^[169] ^[170] ^[284] ^[139] These guidelines and guides recommend a close collaboration between school, parents and other health services.

Background and occurrence

There can be a gradual transition between mental health problems and mental health disorders, and the same disorder can give rise to different symptoms in different age groups.

For most people, mental health problems are transient, but for some, they can be persistent. Around 8% of children and adolescents have such severe problems that they satisfy the criteria for a mental health disorder. The scope of mental health problems increases through adolescence, particularly during the adolescent stage, but far more girls than boys suffer from anxiety and depression problems. [41]

Recent research shows a link between mental health and learning, and mental health problems are an important factor behind drop-outs from upper secondary education. [270] In addition to the fact that mental health problems can lead to problems with learning, learning difficulties can also lead to mental health problems. [244]

Practical information

In many contexts, the follow-up of children and adolescents requires the school health service to work with other bodies. Collaboration relating to children and adolescents must always be based on the consent of the child/adolescent and/or the parents.

Follow-up of children and adolescents with mental health problems

Individual follow-up consultations

To ensure effective follow-up consultations, the school health service should ensure that staff within the service have good communication skills. See amongst other things [the recommendation User participation and the recommendation Targeted services](#). Adolescents themselves want the tone used by health professionals to be open and secure, they want conversations to be natural and they want specific issues to be brought up (Forandringsfabrikken).

Follow-up consultations and measures should be carried out within a short period of time and have a reasonable scope. The consultations should be based on the needs of the child/adolescent.

In consultation with the child/adolescent concerned, the school health service should consider whether parents should be informed and included. For example, this could be done by inviting parents to consultations together with the child/adolescent and by offering home visits. See [the recommendation Home visits](#).

The school health service should also work with psychologists in the municipality as and when necessary. See [the recommendation Psychologists](#).

When necessary, the school health service should refer the child to other relevant services for further investigation and follow-up, e.g. a GP, psychologist in the municipality, physiotherapist or occupational therapist.

Group discussions/ counselling

Group measures can also be considered and represent an alternative for children and adolescents who face relatively similar challenges. Whether group discussions are appropriate will partly depend on the issue, the participants and other considerations.

See also [the recommendation Education](#) and [the recommendation Divorce/break-ups](#).

Partnerships with schools

The school health service should collaborate with the school when pupils with mental health problems and disorders need special facilitation at school. Among other things, this could concern support and special provision of the learning situation and guidance for school staff when necessary.

Children with anxiety and depression have special needs regarding predictability and facilitation. The school health service can contribute to the establishment of an understanding of the pupils' needs and circumstances and help to come up with appropriate measures. The Educational and Psychological Counselling Service (PPT) has a special responsibility to contribute educational advice and guidance.

In order to develop good collaborative routines with schools, it is important that the school health service:

- Makes itself available to school staff
- Shares information and expertise
- Participates in a team to support pupils

See also [the recommendation Systematic partnership](#).

Follow-up of children and adolescents with mental health disorders

Some children and adolescents who are undergoing treatment drop out of treatment being provided by the specialist health service without warning and without the specialist health service notifying the school or the school health service. Collaborative routines should be established between the school health service, school, GP, municipal psychologist and the specialist health service to identify and encourage children and adolescents to resume essential treatment. See [the recommendation GPs](#), [the recommendation Psychologists](#). Other relevant collaborative bodies should be mapped in each municipality.

If a child/adolescent is identified as having dropped out of treatment, the school health service should:

- Talk to the child/adolescent to clarify the situation and, where appropriate, identify solutions to resume essential treatment
- Contact the treatment provider to identify measures which could motivate the child/adolescent into resuming the treatment, ideally in collaboration with the child/adolescent and their parents

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5.4.2 Home visits: The school health service should consider home visits to children and adolescents with special needs

The school health service should consider offering home visits to children and adolescents who may have special needs regarding help and support.

Home visits to children and adolescents and their families can be initiated by the child/adolescent or their parents, by the school health service or in collaboration with others (e.g. the school, psychologist or GP).

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

The services offered to children and adolescents by the school health service should include home visits/outreach activity; see Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*). [5] The purpose of home visits is to provide extended support and help for the children and adolescents who need it. It is first and foremost children and adolescents with special needs who should be offered a home visit.

Home visits are recommended as a measure to reduce social inequalities in opportunities and health for children and adolescents. [8]

Home visits are time-consuming, but may be appropriate in order to:

- Gain a deeper understanding and insight into the situation of the child/adolescent and their family
- Observe interaction between the child/adolescent and other members of the family, in their own environment
- Include parents and any siblings in the follow-up of the child/adolescent
- Even out any imbalances in authority and power and engender greater trust in the guidance situation
- Make it easier for the school health service to provide better targeted advice, guidance and where appropriate other help and support
- Make it easier for children/adolescents and their families to receive and follow advice, guidance and other support
- Lower the threshold for families who either do not wish to or are unable to attend meetings to get help

Practical information

Consideration must be given in each individual case as to whether home visits would be appropriate.

Home visits may be appropriate for children and adolescents who:

- Are at risk of dropping out of school. See [the recommendation Absence giving reason for concern](#)
- Have other challenges and special needs where a home visit would be considered appropriate. This particularly applies to immigrants, recent arrivals in the municipality, children and adolescents with disabilities, mental health problems or difficulties, children and adolescents who are not attending school, are bullying or being bullied
- Do not attend consultations
- Express a need for extra support and help themselves
- Suffer an acute severe illness or death in close family and are a next of kin
- Live with parents or siblings who are severely mentally ill and/or abuse alcohol or drugs

This list is not exhaustive.

Home visits must always be announced in advance and be well-planned with regard to the conversation, questions and observations. Collaboration between the parties will be required, along with the consent of the parents and/or the child/adolescent themselves.

Consideration should be given to whether other professionals should take part in the home visit along with the public health nurse, e.g. a doctor, physiotherapist, psychologist or occupational therapist.

Children and adolescents who are next of kin

[See the Directorate of Health's guide to relatives in the health and care service and the Circular Children as next of kin.](#)

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5.5 Other general measures

5.5.1 School doctor: The school health service should have a readily available doctor

With their medical background, the doctor should be a key actor in the school health service to ensure that the service is able to provide holistic and multidisciplinary services.

The role of the school doctor should be to:

- carry out somatic examinations as part of the school-entry health consultation programme; see [the recommendation School-entry health consultation](#)
- contribute to the interdisciplinary team in the school health service in collaboration with public health nurses, physiotherapists and other employees
- contribute to the systematic partnership with schools; see [the recommendation Systematic partnership](#)
- contribute to multidisciplinary collaboration with other relevant municipal services, the specialist health service and voluntary organisations.

The school doctor's tasks must be delimited with respect to the GP, who has overall responsibility for the diagnosis and treatment of individual adolescents; see [the recommendation GPs](#).

Rationale

The contents of this recommendation are based on legislation, regulations and the consensus of the working group.

The municipality is responsible for enabling municipal health and care services to be conducted responsibly in pursuant of Section 4-1 of the Health and Care Services Act. Among other things, this means ensuring that services are staffed with the right expertise. [7]

The type of medical expertise which a doctor has is important for many of the school health service' areas

of responsibility, as regards both system-focused and individually focused tasks, and may in many cases be essential in order for the school health service to be conducted responsibly. For example, the school doctor must carry out the somatic part of the school-entry health consultation in order to ensure professional responsibility. Having a school doctor linked to the school health service will also ensure a high-quality and appropriate service generally within the school health service.

It is the municipality's responsibility to facilitate access to professionals as necessary for the tasks incumbent on the school health service; see Section 2-1 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*).[5] The municipality may for example require GPs in full-time practice to provide services under the school health service for up to 7.5 hours per week through the GP agreement; see Section 12 of the Regulation on the GP scheme in the municipalities (*forskrift om fastlegeordningen i kommunene*).[32]

Health professionals have an important role to play as contributors and support actors in the work of schools to ensure that pupils have a good physical and mental learning and childhood environment. To perform this task, they must have a good understanding and awareness of physical and mental environmental factors at the school.

The school doctor has medical expertise and, as part of the school health service, should be a partner for the school in the planning and execution of health promotion and prevention measures at both system and individual level. This will help to secure systems which include and safeguard pupils with health problems and difficulties associated with their school circumstances.

As part of the interdisciplinary team, the school doctor should assess children and adolescents which the school health service or the school are concerned about and help to ensure that they receive the help and follow-up they need. Their expertise concerning diagnosis and treatment makes the doctor a key actor in the work to rule out illness.

The school doctor's expertise regarding diagnosis and treatment is important in order to:

- Contribute advice and act as a discussion partner for public health nurses, physiotherapists and other professionals who meet many individual pupils
- Consider measures at the relevant school regarding learning, universal design and other preventive measures
- Ensure that systems are in place which ensure that the right pupils are referred to a GP and any other relevant bodies at the right time
- Assist the district medical officer and others who have responsibility for health monitoring, preventing the spread of communicable diseases and socio-medical tasks in the municipality
- Provide advice and guidance concerning medication management at schools

Contact between the school doctor and individual pupils for curative purposes is neither appropriate nor desirable, but the school doctor is very relevant in interdisciplinary assessments of measures and follow-up concerning individual pupils who are struggling at school or facing complex challenges.

Medication management

Health centres and the school health service shall contribute to the establishment of routines for the handling of medications in kindergartens, schools and before- and after-school programmes; see Section 2-4 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*). [5]

Together with the public health nurse, the school doctor should contribute to the establishment of routines for the management of medication in schools and after-school schemes for children and adolescents who depend on taking medicines during the day if the school initiates it. See [the recommendation Systematic partnership](#).

Environmental health protection

The services provided by the school health service should include collaboration with schools concerning measures which promote a good psychosocial and physical learning and working environment for pupils; see Section 2-3 of the Regulation on health centres and the school health service (*forskrift om*

helsestasjons- og skolehelsetjenesten). As part of this work, the school health service should work with schools to ensure compliance with the requirements of the [Regulation on environmental health protection in kindergartens and schools \(forskrift om miljørettet helsevern i barnehager og skoler\)](#).

Environmental health protection encompasses the factors in the environment which directly or indirectly can impact on health at any one time, including physical and social environmental factors, infection protection, etc.; see Section 8 of the Public Health Act (*folkehelseloven*).^[27] As part of the school health service's system-focused work, the school doctor should contribute to the school's preparation of plans, e.g. for disaster/crisis management, the follow-up of pupils with long-term illnesses and the support of pupils with learning difficulties.

Practical information

The role of the school doctor in the systematic partnership with the school

The role of the school doctor in the systematic partnership with the school should be viewed in the context of the recommendation Systematic partnership.

The school doctor should have the necessary expertise to carry out health-promoting and preventive measures at system, group and individual level.

The school doctor should:

- contribute advice and guidance concerning medication management at the school,
- contribute to interdisciplinary collaboration with other relevant municipal services, the specialist health service and voluntary organisations

Environmental health protection

The school doctor should take part in the school health service's collaboration with schools to ensure compliance with the requirements for environmental health protection.

The school doctor should take part in:

- Preparation of plans, e.g. for disaster/crisis management, the follow-up of pupils with long-term illnesses and the follow-up of pupils with learning difficulties
- Meetings with the school and other employees within the school health service linked to the assessment of challenges in the school or child/adolescent environment
- Strategic work relating to the prevention and follow-up of absence, measures linked to the risk of drop-out, measures concerning release from school (upper secondary)
- Organisation of the school environment
- Multidisciplinary team in the school health service

The role of the school doctor in the school-entry health consultation programme and other pupil follow-up

The school doctor should perform specific medical tasks and assess medical conditions in order to fulfil the requirement for professional responsibility. In addition, the school doctor should:

- Work with public health nurses concerning the performance of somatic examinations in the school-entry health consultation programme in the 1st grade; see [the recommendation School-entry health consultation](#).
- Be involved in the evaluation of children and adolescents who the school and school health service have concerns about, and when necessary refer children/adolescents to their GP, or when appropriate psychologist for necessary treatment and follow-up.

Collaboration between school doctors and GPs is important when follow-up and diagnosis are required; see [the recommendation GPs](#).

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5.5.2 Gender- and sexual orientation-neutral language: The school health service should use gender- and sexual orientation-neutral language in all dissemination and communication

The school health service should use gender- and sexual orientation-neutral language in order to:

- Build an **open and inclusive culture** where diversity regarding gender and sexuality is acknowledged
- **Prevent discrimination** based on gender identity, gender expression and/or sexual orientation
- Create a **secure framework** to enable individual pupils to define who they identify themselves as or are attracted by

An example of the use of gender- and sexual orientation-neutral language is talking about falling in love and partners without any expectation or assumption that it is between a boy and a girl.

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

A universally organised and equitable health service means that all user groups will feel secure and can be themselves at the point of contact with the health service, regardless of their ethnicity and national origin, beliefs, sexual orientation, gender identity or gender expression. A key prerequisite for good health is that the sexual rights of everyone are respected and upheld. This means that individuals must be able to live out their sexual orientation, their gender identity and their gender expression without feeling shame and without being exposed to taboos and stigmatisation. Individuals must be protected from sexual harassment.

The services provided by the school health service should include preventive psychosocial work and collaboration with schools concerning measures which promote a good psychosocial and physical learning and working environment; see Section 2-3 of the Regulation on the health centre and school health service (*forskrift om helsestasjons- og skolehelsetjenesten*). [5] The comments on the Regulation recommend that the service should particularly focus on children and adolescents with special needs, e.g. children and adolescents with problems linked to gender identity and sexuality. One way of facilitating this group is to use gender-neutral language.

According to the user organisation Queer Youth (*Skeiv Ungdom*), the biggest challenges facing adolescents who do not have a heterosexual orientation are mental stress linked to their own identity and prejudice in society. Lesbian, gays, bisexuals and transgender people are particularly exposed to bullying and harassment at school. This can partly be attributed to the fact that schools and society at large generally

assume that everyone is heterosexual. [150]

In the Norwegian and English language, the personal pronouns “he” and “she” are used. When meeting adolescents who have a different gender identity than the majority or who have fallen in love with a person of the same gender, the use of these personal pronouns can lead to misunderstandings between the service provider and the user. By switching to neutral pronouns, such as “the person you are in love with”, or a noun, such as “your partner”, many people will perceive their relationship with the health services as being a respectful one. By consciously using gender-neutral language, the school health service can help all children and adolescents to see education, discussions and guidance as being relevant, and to feel included without necessarily having to identify their sexual orientation or gender identity.

Collaboration with the school concerning common practice in this area can help to create a good childhood environment and psychosocial school environment for children and adolescents, regardless of gender identity and sexual orientation, and help to create a healthy school in line with the purpose of the school health service; see Section 1-1 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*). [5]

Practical information

In teaching, guidance and consultations, all children and adolescents should identify with and relate to what is being said, regardless of their sexual orientation, gender identity and gender expression.

In a teaching context, the school health service must have a conscious attitude towards:

- The fact that some people are not heterosexual
- That some people have a gender identity which is different from the gender category they were assigned at birth
- That some people live in different family constellations compared with the majority

In individual consultations, the specific initial use of the personal pronouns “he” and “she” can lead to misunderstandings and a lack of trust between staff in the school health service and the child or adolescent. Assuming that a child or adolescent is or feels a particular way can hinder a productive discussion during the consultation. This could for example be avoided:

- By using the neutral pronoun, “the person you are in love with” or “the person you have sex with”
- By using the substantive, e.g. “partner” instead of the personal pronoun “he” or “she”

If it is not obvious that the child or adolescent identifies themselves as “he” or “she”, the school health service should ask what the person wants to be called and referred to as and take account of this in subsequent communication.

The school health service should collaborate with schools concerning common practice in this area. See [the recommendation Systematic partnership](#) and [the recommendation Sexual health education](#).

The project “Pink competence”

The Directorate of Health is funding the project [Pink competence](#), an offer of training and competence-building for staff in schools, health- and social services, and pre-schools. The aim is for professionals to improve their competence in providing gay, lesbian, bisexual and transgender (LGBT) equitable services.

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5.5.3 Measures to reach boys: The school health service should consider implementing measures to reach more boys

When necessary, the school health service should implement measures to reach more boys, and thereby even out differences in the use of the service.

In order to implement measures, the school health service should:

- Collaborate with pupils
- Have an overview of the pupil population
- Have an overview of differences that exist in the use of the school health service between the sexes at the school

In order to reach more boys, it is important that boys experience good access to the school health service and that barriers for using the service are being lowered.

Rationale

The contents of this recommendation are based on the law and the consensus of the working group.

It is an overall political goal that everyone shall have access to equitable health and care services regardless of their diagnosis, residence, gender, country of birth, ethnicity and life circumstances. One of the aims of the Health and Care Services Act (*helse- og omsorgstjenesteloven*) is to ensure that services are consistent and of high quality; see Section 1-1 of the Act; see [the recommendation Low-threshold services](#) and [the recommendation Targeted services](#). [7]

Use of the health service varies with gender, age and social background factors, and the differences persist over time. Men with lower socioeconomic status in particular use health services less than those with a high socioeconomic status. Gender-related differences in the use of health services start early. Some studies show that boys have a lower level of awareness of the school health service and youth health centres [286], and considerable gender-related differences have been demonstrated in the use of public health nurses and school doctors. Almost 40% of girls have used these services, while the corresponding figure for boys was 25%. [159]

In order for the school health service to provide a genuine service to all genders, the service should implement measures, including gender-specific instruments to reduce differences and ensure that boys also feel that the services offered by the school health service are relevant and available to them.

It has been noted that measures to even out differences in health and the use of health services can promote better health amongst the population and better quality of health and care services. [151]

Key aspects of the work are:

- Dissemination of health information which reaches all genders
- A school health service and youth health centres which are as attractive to boys as they are to girls
- An established gender perspective in the health and care services and in research concerning health
- Greater awareness of gender differences in the use of health services
- Targeted measures to reduce the occurrence of sexually transmitted infections

When any type of measures is being considered, the users should be involved through user participation. This is described in more detail in [the recommendation User participation](#).

Practical info

Before any measures are implemented to even out gender-related differences in the use of the service, the individual school health service should:

- Map and obtain an overview of the differences in use of the service
- Analyse why and assess whether there is a need to implement measures

In the event of a need to implement measures, users should be involved; see [the recommendation User participation](#).

Examples of measures to get more boys to contact the school health service:

- Ensure that the service is available and has a high profile in the school environment (Report to the Storting No. 8 (2008-2009))
- Ensure that boys are aware of the services that are offered by the school health service
- Provide specific information on the services offered to boys, particularly regarding issues which concern boys
- Provide information on the service to pupils through class and group teaching; see [the recommendation Sexual health education, the recommendation Visits to YHCs and the recommendation Tobacco, alcohol and drugs](#)
- Ensure that it is possible to contact the service by e-mail, text or other digital channels (Ministry of Health and Care Services, 2016)
- Have separate queues or days for boys within the school health service, “boy conferences” or thematic evenings for boys and men

There may also be other groups who for various reasons do not seek out the service. The school health service should strive to reach all children and adolescents, regardless of gender, sexuality or ethnic origin; see [the recommendation Targeted services](#).

References

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5.5.4 Childhood vaccinations: The school health service shall offer vaccination in accordance with the Childhood Immunisation Programme

The school health service shall offer vaccination for all children resident in Norway in accordance with the Childhood Immunisation Programme.

Protection against communicable diseases and vaccination are important tasks of the health centre and high vaccine cover helps prevent serious infectious diseases.

For more information see the [Norwegian Institute of Public Health's website on the Childhood Immunisation Programme](#).

Rationale

The contents of this recommendation are based on regulations.

The Childhood Immunisation Programme shall be offered to all children and adolescents of kindergarten and primary school age, and the vaccination schedule shall be implemented through the health centre and school health service; see Section 4 of the Regulation on the Childhood Immunisation Programme (*forskrift om nasjonalt vaksinasjonsprogram*). [53] The vaccinations shall be provided free of charge. The school health service shall provide information on and offer vaccination under the Childhood Immunisation Programme; see Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*). [5]

The recommended Childhood Immunisation Programme is established by the Ministry of Health and Care Services.

The Norwegian Institute of Public Health publishes guidelines for implementation of the Childhood Immunisation Programme, including target populations, frequency and the technical composition of the vaccines. The Norwegian Institute of Public Health procures and distributes the vaccines for the programme.

The vaccines offered under the Childhood Immunisation Programme today afford good protection for each person vaccinated. Vaccinating the majority of a population against a disease means there are few people who can become infected and pass the disease on. This is called "herd immunity" and makes it possible to keep the disease in check. This also protects people who are not vaccinated.

Practical information

The Childhood Immunisation Programme shall be offered to all children, and the individual vaccines shall be offered at the recommended age. It may be necessary for a variety of reasons to adjust the immunisation programme.

All parents should be given information on vaccines during the school-entry health consultation; see the recommendation School-entry health consultation.

More information

- For an overview of the timing of vaccinations and other information on the programme; see [the Norwegian Institute of Public Health's website on the Childhood Immunisation Programme](#)
- For more information on routines in connection with vaccination and reactions after vaccination; see [the Norwegian Institute of Public Health's Guide to Vaccination \(the Vaccination Book\)](#)
- [Contact details for the Norwegian Institute of Public Health regarding the Childhood Immunisation Programme](#)
-

References

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- [53] Forskrift om nasjonalt vaksinasjonsprogram. FOR-2009-10-02-1229 Available from: [Forskrift om nasjonalt vaksinasjonsprogram - Lovdata](#)

5.5.5 Follow-up groups: The school health service should register children in follow-up groups

Follow-up groups are a tool that can help identify and categorise a child's need for follow-up.

During each consultation, health professionals should assess the child's needs regarding measures and follow-up and categorise them under group 0, 1, 2, 3 or 4.

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

Registration in follow-up groups that are documented in the child's record will help create an overview of the number of children who are offered assistance by the school health service and the extent to which they need various help and support measures.

In accordance with Section 5 of the Public Health Act (*folkehelseloven*) and Section 3(a) of the Regulation on overview of public health (*forskrift om oversikt over folkehelsen*), registration in follow-up groups will contribute to the municipality's overview of the health of children and adolescents in the population to which the health centres, school health service and youth health centres are required to contribute; see Section 2-2 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*).[26][27] [5]

Practical information

For more information; see [the Directorate of Health's Guide to record-keeping in the health centre and school health service \(Veileder i journalføring i helsestasjons- og skolehelsetjenesten\) \(IS-2700\) p.29](#)

References

- [26] Forskrift om oversikt over folkehelsen. FOR-2012-06-28-692 Available from: <https://lovdata.no/dokument/SF/forskrift/2012-06-28-692>
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6 Youth health centres

6.1 Youth health centres: All municipalities shall offer free health centre services to adolescents up to 20 years of age

All municipalities shall offer youth health centre services to adolescents up to 20 years of age; see Section 2-1 of the Regulation on health centres and the school health service (*forskrift om helsestasjons-og skolehelsetjenesten*).

Youth health centre services should be organised so that they:

- Meet the needs of adolescents
- Are provided on adolescents' own terms
- Are perceived to be available to adolescents, including those who do not go to school

Youth health centres (YHCs) shall be a supplement to, and not a replacement for, the school health service.

In smaller municipalities and urban districts, a YHC may be established across municipal or district boundaries in order to facilitate the provision of expedient services and bring in a larger group of professionals.

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

The municipality shall offer health centre and school health services to children and adolescents aged 0-20; see Section 2-1 first paragraph of the Regulation on health centres and the school health service (*forskrift om helsestasjons-og skolehelsetjenesten*) [5]. All adolescents up to the age of 20 shall have access to health centre services. The services for adolescents should be organised in the form of a health centre for adolescents, which means opening hours after school hours, provision for drop-in consultations and staff with good communication skills and a good understanding of youth health.

In recent years, there has been an increasing international focus on whether health services are sufficiently customized to meet the health-related needs of adolescents. The WHO has developed criteria for adolescent-friendly health services (WHO, 2012). According to the WHO, the health services must be:

- **Accessible** and dependable
- **Acceptable** so that adolescents are willing to use the services
- **Equitable** and provide services for **all** – not just to selected groups
- **Appropriate** for the needs of adolescents
- **Effective** so that the services are provided in the right manner

A survey by TNS Gallup dating from 2009 showed that 79.3% of the country's municipalities had a youth health centre. The services are often provided from dedicated premises, have their own opening hours after school hours, and the option to contact health professionals via text message or e-mail (Directorate of Health, 2012 [290]). Surveys from two municipalities in Norway have shown that adolescents contact youth health centres with questions concerning a wide range of topics. Many contact the service with questions linked to sexual health, contraception and sexually transmitted infections, but the service is also used by adolescents who want to speak to an adult about issues such as relationship problems, eating disorders, self-esteem, bullying, tobacco, alcohol and other intoxicants (Directorate of Health, 2012[290]).

Organising the health centre services for adolescents in line with this will be key to securing good services which appeal to the young.

The Ungdata survey from 2015 showed that there are minor socioeconomic differences in the use of health services amongst adolescents. However, visits to youth health centres, the school health service

and psychologists/psychiatrists are most common amongst adolescents in families with a low socioeconomic status, particularly amongst girls (NOVA, 2016) [159]. Youth health centres can therefore be considered to be an important initiative to reduce inequalities in health amongst adolescents.

Certain health problems particularly affect adolescents: eating disorders, mental health problems, stress and pressure, self-harming and suicidal behaviour, accidents, sexually transmitted diseases and unintended pregnancy (Norwegian Institute of Public Health, 2015) [41]. From a public health perspective, youth health centres can therefore be a contributor and driving force in the efforts to achieve national goals for prioritised initiative areas linked to adolescents.

Practical information

Accessibility and availability

Youth health centres should be perceived to be accessible, available and attractive to adolescents in the local community. Among other things, this means that YHCs must:

- Offer a drop-in service, so that adolescents do not need to make an appointment
- Have opening hours which mean that adolescents do not need to take time off school or work to visit the service, e.g. in the afternoon
- Meet the need of adolescents to remain anonymous
- Have staff who have a knowledge of youth health and know how to communicate with adolescents
- Provide information which reaches everyone, including boys and girls and adolescents with special needs.
- Have an overview of current services offered to adolescents. See [the recommendation Overview of services](#)
- Are available and accessible to adolescents who for various reasons do not go to school

In some municipalities, a YHC has been established through intermunicipal collaboration. In connection with the establishment of intermunicipal solutions, a specific assessment of accessibility and availability should be carried out for the target groups.

One strength of YHCs is that they can act as a “door opener” to other support services and websites. See [the recommendation Overview of services](#).

Scope of the service

Youth health centres must have a particular focus on:

- Promoting well-being and coping resources
- Preventing unintended pregnancies
- Preventing and treating sexually transmitted infections
- Preventing and identifying mental health problems and disorders

The services should be developed in line with the needs and wishes of users (see [the recommendation User participation](#), and conditions amongst the youth population; see [the recommendation Overview of health status](#).

YHCs should work with the school health service and the antenatal care, and place emphasis on interdisciplinary collaboration with various bodies to quality-assure and secure holistic support services for adolescents. See the General section: Collaboration and co-operation.

Age

Youth health centres should themselves assess whether there is a need for a lower age limit for use of the service.

Health centre services should apply to adolescents up to the age of 20. In some municipalities, it may be desirable to expand the services provided to cover young adults up to 25 years of age. This could for example apply in:

- Major towns and cities
- Municipalities with university colleges, colleges or other study centres
- Municipalities which for other reasons have a lot of immigrant youths

It is up to the municipality itself to assess whether it wishes to expand the services it provides to young adults over 20 years of age.

Age of consent

Adolescents over the age of 16 can give their consent to medical assistance; see Section 4-3 of the Patient and Users' Rights Act (*pasient- og brukerrettighetsloven*). Adolescents under 16 can also be considered to be entitled to give consent, following an assessment of age, maturity, the scope of treatment/medical support needed and what would be in the best interests of the person concerned.

If the adolescent is aged between 12 and 16, information must not be given to the parents against the wishes of the adolescent concerned for reasons which should be respected; see Section 3-4 of the Patient and Users' Rights Act.

References

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6.2 Overview of health status: Youth health centres should have an overview of the health status and the factors which can impact on the health of adolescents.

Youth health centres (YHCs) should obtain an overview of the health status of adolescents through:

- Contact with adolescents
- Use of available sources and tools for information

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

Together with other municipal health and care services, youth health centres must contribute to an overview of the health status of the population and the positive and negative factors which impact on it, which the municipality is required to have under Section 5 of the Public Health Act (*folkehelseloven*)[27],

see Section 2-2 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*)[5] and Section 3-3 of the Health and Care Services Act (*helse- og omsorgstjenesteloven*)[7]. See [the recommendation Public health work](#). The purpose of obtaining an overview of public health is to acquire a knowledge of health status and the causes of diseases at a population level for use in public health work. To achieve this, it is neither relevant nor necessary for the municipality to have information which can be linked to individuals in their collective overview documents.

Many of the tasks assigned to the health centre service through Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*) (5) require youth health centres to have an overview of the health status of adolescents in the municipality and of factors which impact on the health of adolescents. Through contact with adolescents, YHCs will gain an insight into factors which impact health and health challenges in the local youth population. In addition, YHCs should have a knowledge of and be able to use existing sources to gain an overview of the population at school and local level.

Overviews of the health status of adolescents and the factors which can impact on the health of adolescents are important in order to prepare plans and design measures which can help to promote the physical, mental and sexual health of adolescents and prevent diseases and injuries, including mental health problems and disorders, alcohol and drug problems, suicide, drop-out, violence and abuse.

By having an overview, YHCs will:

- Be able to plan targeted health-promoting and preventive measures
- Be better prepared to meet the needs of users
- Measure trends over time, establish goals for the development of initiatives and measure the effects of initiatives (Prop.90 L (2010– 2011)) [29]

Practical information

Having an overview of health status also entails having a knowledge of health status and the causes of diseases ([Comments on the Regulation on overview of public health \(*forskrift om oversikt over folkehelsen*\)](#)).

The scope of health status overviews can include:

- The prevalence of mental health problems and disorders
- Health-related behaviour and high-risk behaviour linked to physical activity, nutrition, use of tobacco, alcohol and other intoxicants, sexual health, use of contraception and unintended pregnancy

Overview through contact with adolescents

Consultations with adolescents who contact a youth health centre can help to obtain an overview of trends amongst the population and provide a picture of the challenges that exist in the local community.

The information can provide youth health centres with a basis for implementing necessary and targeted measures, e.g. the adjustment of opening hours to reach more adolescents and measures to reduce the occurrence of sexually transmitted diseases, unintended pregnancy or mental health problems.

Youth health centres can, if necessary, collaborate with relevant actors in order to obtain an overview of trends in the population and challenges in the local community. Such actors could include:

- Schools and the school health service
- GPs
- Psychologists and mental health service
- Chief municipal medical officer
- Child welfare service
- The police
- Outreach youth support team/social workers in the municipality

Youth health centres must take account of the fact that adolescents with a minority background and

indigenous populations can face special challenges, which must be identified in order to understand and attend to them satisfactorily. See [the recommendation Targeted services](#).

Tools and sources which provide an overview

Youth health centres should be familiar with, and be able to use, relevant sources and tools which provide an overview of the health status of pupils, including:

- [Ungdata](#)
- [Municipal public health profiles](#)
- [Statistics Norway's Municipality-State-Reporting \(KOSTRA\)](#)
- [Norwegian Institute of Public Health's statistics concerning sexually transmitted diseases](#)
- [Statistics concerning sexual health in Norway](#)
- Quality surveys through [bedrekommune.no](#)
- [The Directorate for Education and Training's user surveys amongst pupils, teachers and parents](#)
- Other local statistics, e.g. statistics prepared by YHCs

YHCs can collaborate with qualified personnel to interpret data sources. See [the recommendation Public health work](#).

See the [Directorate of Health's website](#) for more information concerning an overview of health status and impact factors.

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6.3 Overview of services: Youth health centres should have an overview of current measures and services offered to adolescents

Youth health centres (YHCs) should have an overview of:

- Relevant services in the municipality/local community
- Websites, helplines, etc.
- Leisure activities in the local community
- Other services which may be relevant to adolescents

YHCs should adapt to meet the needs of their users. See the recommendation User participation and the recommendation Targeted services.

The contents of this recommendation are based on the consensus of the working group.

YHCs should have an overview of relevant services and programmes in order to be able to:

- Provide advice and guide adolescents concerning **existing offers and services in the local community** and in the municipality. Adolescents who have moved to the municipality or who do

not go to school may particularly benefit from advice and help to **obtain an overview of leisure activities** and who they can contact to get help. Adolescents who are unable to find relevant services or organisations in their local community may benefit from being aware of other types of organisations, such as *Skeiv Ungdom* (Queer Youth), *Unge funksjonshemmede* (Young disabled people) and various minority organisations

- Assess which **services and bodies YHCs should collaborate with**, relating to both groups of adolescents and individuals
- Assess where adolescents can be **referred to** when necessary

YHCs should also have an overview of who can be contacted in the municipality and the specialist health service when the service needs guidance.

Good results presuppose that the service is adapted to meet the needs of users. Multidisciplinary collaboration is often necessary in order to provide users with good services (Report to the Storting (White Paper) no. 26 (2014-2015)) [145]. Even if every single sub-service is able to fulfil its statutory requirement for professional responsibility, this in itself will not ensure fulfilment of the municipality's overarching responsibility to provide suitable and coordinated services; see Section 4-1 of the Health and Care Services Act (*helse- og omsorgstjenesteloven*) [7].

Prerequisites for good coordination is that the coordinating actors have:

- Knowledge and awareness of their own role and competence and that of others
- A clear understanding of the responsibilities that accompany the roles
- Leadership which facilitates a multidisciplinary approach and understands what the individual actors can contribute to the collaboration

Practical information

Youth health centres should have an overview of services, meeting places and measures for adolescents in the municipality, and a knowledge of relevant websites, leisure activities and other services which are relevant to adolescents in their local community.

Relevant services:

- The school health service and schools
- GPs
- The midwifery service in the municipality
- The dental health services
- The specialist health service
- The follow-up service (OT)
- Outreach youth support team (Uteteamet/Utekontakten)
- The police
- Coordination of local crime prevention measures (SLT)
- The Child Welfare Service
- Norwegian Labour and Welfare Administration (NAV)
- Pharmacies
- Existing low-threshold services, measures and meeting places for adolescents
- Local sports teams and other leisure activities, including dancing, scout groups, etc.

Relevant websites and helplines:

General websites for adolescents:

- ung.no
- barneombudet.no
- unginfo.no
- korspaaelsen.no

Websites and services with sexual health as a theme:

- sexogsamfunn.no (Sex and society)
- amathea.no (Amathea)
- youchat.no (The Health Committee)
- ungdomstelefonen.no (Queer Youth (SKU))
- sexfordeg.no (Sex and politics)

Websites about mental health:

- snakkommobbing.no (Blue Cross)
- kirkens-sos.no (The Church's SOS in Norway)
- sidetmedord.no (Mental health)
- selvhjelp.no (Self-help Norway, the National Resource Center)

Violence and abuse

- [Emergency line for children and adolescents 116 111](#) (Ministry of Children, Equality and Social Inclusion)
- [Nationwide telephone for incest and sexual abuse 800 57 000](#) (Vestfold Incest Centre)
- [Helpline for forced marriage and female genital mutilation 815 55 201](#) (Red Cross)

Drugs and alcohol

- [Rustelefonen drug helpline 08588](#) (Directorate of Health/City of Oslo)
- barsnakk.no (children of drug and alcohol abusers)

Tobacco

- [Slutta app](#) (Directorate of Health)
- [FRI](#) (Directorate of Health)

YHCs should have a knowledge of relevant organisations such as grief support groups and organisations which help children and adolescents who, for example, have mentally ill parents, parents with drug problems or parents who are in prison.

YHCs should consider working with the municipality's mental health, drug and crime prevention measures (e.g. SLT coordinator. 'SLT' is a Norwegian abbreviation for 'coordination model for local preventive measures to combat drugs and crime'), voluntary organisations (e.g. the Red Cross, Save the Children, Organisation for Families and Friends of Prisoners (FFP) and other organisations. Youth Health Centres can also participate in collaborative meetings within the municipality and in meetings with the specialist health service. See also the [General section: Collaboration and co-operation](#).

References

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6.4 Underlying causes: Youth Health Centres should be aware of possible underlying causes in connection with all enquiries from adolescents

Adolescents can **find it difficult to articulate their challenges**. Mental and physical health problems are often linked, and mental health problems can often be expressed as physical ailments.

Youth health centres (YHCs) should be particularly aware of **possible underlying causes** in connection with enquiries from adolescents:

- When the reason for the enquiry seems unclear
- When there are indications that there are other reasons for the enquiry than are being put forward
- In the event of suspicions that the adolescent wants or is attempting to mediate something other than what is being communicated directly

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

Services for adolescents at the health centre should include the provision of advice with follow-up/referral when necessary; see Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons-og skolehelsetjenesten*) [5]. This includes the provision of accessible and available services which adolescents can contact without booking an appointment, known as 'drop-in'. Drop-in services are an important premiss for being able to help adolescents who face challenges and identifying underlying causes in connection with enquiries. See [the recommendation Targeted services](#) and [the recommendation Youth health centres](#).

Clinical experience indicates that many people contact a YHC because they need help and guidance related to contraception, but in some cases, this may be only one of several reasons why an adolescent makes contact.

It can take time for adolescents to **establish a relationship of trust** with the service, and it can also take time before adolescents open up and dare to bring up any "difficult" problems and the actual reasons why they are contacting the YHC. Adolescents can also find it difficult to express the reasons why they are making contact.

In the case of enquiries from an individual, the YHC should be particularly aware of those who **give diffuse reasons for making contact** (mental and/or physical). Surveys indicate that some immigrants use more specific symptoms to a greater extent, e.g. stomach upset in the case of emotional difficulties ([Sykepleien, 2011](#)). Mental health problems/disorders in particular can be perceived differently by different cultures (Institute of Public Health, Youth Surveys 2000-2004, 2008 and 2009). [225]

Reasons for making contact which **could be considered to be shameful** (e. g. loneliness, bullying, difficult family situation, drug or alcohol problems, violence, failure of care and sexual abuse) can be difficult for adolescents to bring up and put into words and often require a relationship of trust to be established with the service first.

There may be **reason to be particularly aware** of lesbian, homosexual, bisexual and transgender people (LGBT). They are often "invisible" to support services with regard to their orientation or identity. Adolescents who come out early are at greater risk of serious discrimination, bullying, threats and violence. There is a link between lack of acceptance of different sexual orientations and gender expression - and the occurrence of mental disorders and drug abuse amongst LGBT. This group is also particularly vulnerable to mental problems and suicide attempts. LGBT adolescents with an immigrant background seem to face many additional challenges, such as threats, forced marriage and exclusion from families. In certain religious communities, LGBT adolescents can be socially excluded if they come out. See [the recommendation Gender- and sexual orientation-neutral language](#).

Mental health and social inequality

Mental health problems and disorders develop in a complex interaction between genetic, biological and environmental factors. Broadly speaking, it could be said that mental health is the result of the interaction between individual characteristics and protective factors and risk factors in the environment (Directorate of Health, 2015, NOU 2011:11). [271] [273].

Some children and adolescents live under such stressful family circumstances and have so few social and material resources that, even before they are born, it is already clear that they are at greater risk of developing emotional and behavioural disorders (NOU 2011:11). [273]

Protective factors against and risk factors for developing mental problems and disorders can be both environmental and individual. Factors which impact on mental health include socioeconomic status, parental mental health and drug abuse, relationship with parents, parenting skills, whether the family is under a lot of stress, negative life events, traumas and degree of social support, coping strategies, violence in close relationships, refugee status, loss of important close family and friends, integration and attachment in the neighbourhood and at school, employment, working environment, loneliness, home environment, assault, abuse, malnutrition, diet, physical activity, divorce, somatic diseases and pain status and sleep.

Practical information

Youth health centres should be a readily available and accessible low-threshold service for adolescents. See [the recommendation Youth health centres](#) and [the recommendation Accessible and available services](#). YHCs should provide information to adolescents concerning what the service can offer help with.

Adolescents can find it difficult to talk about their problems or emotions, particularly regarding taboo subjects. Encouragement and recognition from public health nurses, doctors and other professionals can have a reaffirming and supportive effect, and help to reduce any anxiety, uncertainty and unease (Sex and society, 2016).

Taboo subjects can easily become invisible unless YHC staff are aware of and open to the problems.

YHCs should be particularly aware of adolescents who repeatedly contact the service with different symptoms and physical ailments. This may be a sign that the person is attempting to establish a relationship of trust before opening up and bringing up difficult issues or subjects.

In the case of enquiries where the reason for the contact seems unclear or there are indications that the adolescent has other underlying reasons for making contact than they initially reveal, health professionals should be particularly aware of and explore and ask the person about a broad spectrum of possible causes, including:

- Well-being, family and friends
- Whether the adolescent is a next of kin
- Bullying
- Absence and drop-out from school
- Stress and pressure. See [the recommendation Identifying mental health problems and disorders](#)
- Sleep habits and difficulties
- Questions and challenges linked to gender identity, sexuality, relationships
- Sexual dysfunction, such as low libido, erectile dysfunction, vaginal dryness, etc.
- Challenges associated with diet and meals. See [National guideline for prevention and treatment of eating disorders \(Nasjonal faglig retningslinje for forebyggelse og behandling av spiseforstyrrelser\)](#)
- Use of tobacco, alcohol and drugs
- Violence, abuse and neglect
- Negative social control, honour-based violence and forced marriage, see the recommendation [Detecting mental health problems and disorders](#)
- Somatic symptoms

YHCs can help to prevent mental and physical difficulties, including drug problems and suicide by conducting an assessment based on indications of the adolescent's health and factors which are linked to

health. An assessment could cover the types of support that the adolescent has around them and other protective factors, resources and challenges that the person has in their environment. In particular, YHCs should be aware of adolescents who are neither at school nor in work, as well as single minors who are seeking asylum.

YHCs can consider collaborating with the school health service concerning the follow-up of adolescents with a high rate of absence from school or who have dropped out of school. See [the recommendation Absence giving reason for concern](#) in the guideline for the School health service.

When necessary, the adolescent should be assessed by a physiotherapist or referred to a GP, psychologist or the mental health service in the municipality, dentist or other relevant bodies. See [the recommendation Overview of services](#), the General section Collaboration and co-operation.

References

- [5] Forskrift om kommunens helsefremmende og forebyggende arbeid i helsestasjons- og skolehelsetjenesten. FOR-2018-10-19-1584 Available from: <https://lovdata.no/dokument/SF/forskrift/2018-10-19-1584>
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- [273] NOU:2011-11 Innovasjon i omsorg 2011

6.5 Gender- and sexual orientation-neutral language: Youth health centres should use gender- and sexual orientation-neutral language in all mediation and communication.

Youth health centres (YHCs) should use gender- and sexual orientation-neutral language in order to:

- Build an **open and inclusive culture**, where diversity regarding gender and sexuality is acknowledged
- **Prevent discrimination** based on gender identity, gender expression and/or sexual orientation
- Create a **secure framework** to enable adolescents to define who they identify themselves as or are attracted by

An example of the use of gender-neutral language is to talking about falling in love and partners without any expectation that it is between a boy and a girl.

Rationale

The contents of this recommendation are based on the consensus of the working group.

A universally organised and equal health service means that all user groups feel secure and can be themselves at the point of contact with the health service, regardless of ethnicity and national origin, beliefs, sexual orientation, gender identity and gender expression. An important prerequisite for good health is that the sexual rights of everyone are respected and fulfilled. This means that individuals must be able to live out their sexual orientation, gender identity and gender expression without feeling shame or being exposed to taboos and stigmatisation. Individuals must be protected from sexual harassment.

According to the user organisation *Skeiv Ungdom* (Queer Youth), the biggest challenge facing adolescents who do not have a heterosexual orientation is mental stress linked to their own identity and facing prejudice in society. Lesbian, gays, bisexuals and transgender people are particularly exposed to bullying

and harassment at school. This can partly be attributed to the fact that schools and society in general generally assume that everyone is heterosexual (NOU 2015:2) [150].

By consciously using gender-neutral language, staff at YHCs can help adolescents to see teaching, guidance and consultations as being relevant, and to feel included without necessarily having to identify their sexual orientation or gender identity.

A partnership with the school health service concerning common practice in this area can help to create a good childhood environment and psychosocial environment for adolescents, regardless of their gender identity and sexual orientation. See [the recommendation Gender- and sexual orientation-neutral language](#) in the guideline for the School health service.

Practical information

In teaching, guidance and consultations, all adolescents should identify with and relate to what is being said, regardless of their sexual orientation, gender identity and gender expression.

In consultations and dialogue with adolescents, youth health centres must have a conscious relationship to the fact:

- That some adolescents do not have a heterosexual orientation
- That some people have a gender identity which is different from the gender category they were given at birth
- That some people live in different family constellations compared with the majority

In individual consultations, the specific initial use of the personal pronoun “he” and “she” can lead to misunderstandings and lack of trust between staff at the youth health centre and the adolescent. Assuming that a adolescent are/or feels a particular way can hinder a productive dialogue during the consultation. This can be avoided:

- By using the neutral, “the person you are in love with” or “the person you have sex with”.
- By using the substantive, e.g. “partner” instead of the personal pronoun “he” or “she”.

If it is not obvious that the adolescent identifies themselves as “he” or “she”, the youth health centre should ask what the person wants to be called and referred to as and take account of this in subsequent communication.

The project “Pink competence” (*Rosa kompetanse*)

The Directorate of Health is funding the project entitled [Pink competence](#), which offers training and competence-building for staff in the school, health and social services and at pre-schools. The aim is for professionals to improve their ability to provide equitable services to gay, lesbian, bisexual and transgender people (LGBT).

References

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6.6 Doctors at YHCs: Youth health centres must have a doctor available

The doctor must play a pivotal role at the Youth health centre. This is necessary in order to enable the YHC to conduct its services responsibly.

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

The municipality is responsible for enabling municipal health and care services to be conducted responsibly in pursuant of Section 4-1 of the Health and Care Services Act (*helse- og omsorgstjenesteloven*) [7]. Among other things, this means ensuring that the services are staffed with the right expertise; see Section 2-1 of the Regulation on health centres and the school health service [5].

The type of medical expertise that a doctor has is important for many of the tasks that a youth health centre performs, with regard to both system-oriented and individually oriented tasks, and may in many cases be essential for the tasks to be conducted responsibly by the youth health centre. [14] Many tasks performed by a YHC linked to sexual health require the YHC to have a doctor amongst its staff. This applies for example to the prescribing of contraceptives for girls under 16 and the diagnosis and treatment of sexually transmitted infections. See [the recommendation Contraception](#) and [the recommendation Testing and treatment for STIs](#).

The doctor's expertise regarding diagnosis and treatment is important in order to:

- Contribute to the normalisation of challenges and concerns amongst adolescents and exclude disease
- Contribute advice and act as a discussion partner for public health nurses and other professionals who meet many adolescents
- Help to secure systems which ensure that the right adolescents are referred to a GP and any other bodies punctually
- Ensure that adolescents are offered holistic services by YHCs

The doctor is extremely relevant in interdisciplinary assessment of measures and follow-up concerning individuals who face complex challenges linked to for instance identity, mental health problems and/or a difficult home situation, as well as the follow-up of pupils who face a challenging school situation and have a high rate of absence/risk of drop-out; see [the recommendation Absence giving reason for concern](#) in the guideline for the School health service. The doctor and the interdisciplinary team at a YHC should also be aware of adolescents who live in a bedsit and single minors who are seeking asylum.

Collaboration between the doctors at YHCs and GPs is important when follow-up and diagnosis is necessary; see [the recommendation GPs](#).

Practical information

Tasks should be allocated between the doctor and the other staff at a YHC based on the nature of the task and the needs of the adolescents.

The doctor's tasks must be delimited with respect to the GP, who has overall responsibility for the diagnosis and treatment of individual adolescents; see [the recommendation GPs](#).

In order to perform many of the statutory tasks covered by the service, youth health centres must have a doctor who is available.

The doctor must:

- Contribute to the diagnosis and treatment of sexually transmitted infections (STIs). See [the recommendation Testing and treatment for STIs](#).
- Prescribe contraceptives for girls under 16. See [the recommendation Contraception](#).

- Act as a discussion partner for public health nurses and other staff at the YHC
- Work with the interdisciplinary team at the YHC concerning adolescents the staff have concerns about.
- Help to ensure that adolescents with specific needs are identified at an early stage and given the necessary support

References

- [5] Forskrift om kommunens helsefremmende og forebyggende arbeid i helsestasjons- og skolehelsetjenesten. FOR-2018-10-19-1584 Available from: <https://lovdata.no/dokument/SF/forskrift/2018-10-19-1584>
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- [14] Lov om helsepersonell m.v. (helsepersonelloven). LOV-1999-07-02-64 Available from: <https://lovdata.no/dokument/NL/lov/1999-07-02-64>

6.7 Sexual health: Youth health centres shall be able to provide adolescents with guidance concerning sexual health.

Youth health centres should be able to offer consultations and guidance concerning:

- Questions about physical development, emotions, falling in love and sexuality
- Problems with sexual harassment and sexual abuse
- Questions linked to gender identity, gender expression and sexual orientation

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

The services provided by the health centre service should include the provision of information and guidance, both individually and in groups; see Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*) [5]. Key topics in the work relating to information, guidance and advice include relationships, sexuality, contraception and infection protection, including the prevention of HIV and sexually transmitted infections (Comments on Section 2-3 of the Regulation on health centres and the school health service) [5].

For many adolescents, the youth health centre will be the natural place to seek out advice and help linked to sexual health, and youth health centres must be able to provide adolescents with guidance linked to these topics.

The capacity to act and a positive attitude towards one's own body and sexuality is crucial for sexual pleasure and for the development of a secure sexual identity and more confident sexual behaviour. Key terms are autonomy, coping resources and ownership of one's body and sexuality (Strategy for sexual health (2017-2022) (*Strategi for seksuell helse* (2017–2022)) [83].

National data from Ungdata 2017 shows that around half of pupils at upper secondary school have had sexual intercourse. The proportion is somewhat higher amongst girls than amongst boys. There is a marked rise through the years at upper secondary level in the number of pupils who have had sexual intercourse.

Amongst 1st grade pupils at upper secondary schools, 42% of the boys and 44% of the girls report to have had sexual intercourse. Amongst 3rd grade pupils, the numbers are 67% of the boys and 73% of the girls. In Ungdata 2017, 20% of the boys and 25% of the girls responded that they had sexual intercourse for the first time before reaching the age of 16. Very few had sexual intercourse for the first time before they reached the age of 14 (3% boys and girls) (NOVA, 2017) [292].

Ungdata 2017 has also mapped the number of people who have been subjected to various types of sexual harassment. The results show that this type of harassment is fairly widespread, more so amongst girls

than boys. Most have experienced such harassment on one occasion. At the same time, quite a few have also repeatedly been the victim of sexual rumours, verbal harassment and groping.

Practical information

All users of the youth health centre must be greeted in an open, attentive and supportive manner. For consultations concerning sexual health, contraception and sexually transmitted infections, it is particularly important to base the approach on the individual's own level of knowledge, thoughts, emotions and any sexual experiences.

Talking about sexuality and sexual feelings can be challenging for both parties in a consultation. It is therefore particularly important that public health nurses, doctors and other staff are aware of their own attitudes, experiences and limitations, and how these can impact on the meeting with the adolescent.

In order to be able to provide good and appropriate advice, it is often crucial to ask open and direct questions, such as:

- Do you fall in love with boys, girls or both?
- Do you have or have you had sex with boys, girls or both?
- What kind of sex did you have?

The public health nurse or the doctor and the adolescent may have expectations which are rarely put into words. A brief question about what the adolescent thinks health professionals can help with can help to confirm or eliminate misunderstandings.

If the adolescent wishes to alter their high-risk behaviour, self-destructive behaviour, negative sexual behaviour or abusive behaviour, it is particularly important to build on the adolescent's own resources and suggestions for change.

The term 'intersectionality' refers to how social categories such as gender, race, ethnicity, religion, social class, sexual orientation and functional ability can interact and impact on the health and living conditions of people. It may for example be useful to reflect on how lesbian, gay, bisexual and transsexual persons (LGBT people) may need specific information and guidance based on their age, gender, functional ability or ethnicity.

Sex og samfunns Metodebok for seksuell helse (Sex and society's "Method book for sexual health")

Youth health centres should draw on **Sex og samfunns Metodebok for seksuell helse** as a source of support in the provision of guidance concerning sexual health. This book provides guidance concerning issues such as communication, sexual history, investigations and treatment. The method book is available online at www.eMetodebok.no

Relevant topics in a consultation concerning sexual health:

- Physical development, emotions, falling in love and sexuality
- Sexual desire
- Masturbation alone and together
- Sexual practice and experience
- Sexual problems and dysfunctions
- Sexual abuse, sexual harassment and pressure
- Sexually transmitted infections See [the recommendation Testing and treatment for STIs](#)
- Pregnancy and pregnancy terminations
- Contraceptives. See [the recommendation Contraception](#)

Staff at youth health centres should have a good overview of local support bodies and treatment services

which a patient can be referred to if they need further help; see [the recommendation Overview of services](#).

References

- [5] Forskrift om kommunens helsefremmende og forebyggende arbeid i helsestasjons- og skolehelsetjenesten. FOR-2018-10-19-1584 Available from: <https://lovdata.no/dokument/SF/forskrift/2018-10-19-1584>
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6.8 Contraception: Youth health centres must provide guidance concerning contraception and ensure that safe contraceptives are available.

Youth health centres shall:

- Have ready access to condoms and lubricants
- Provide guidance concerning the use of contraceptives appropriate for the target groups
- Issue prescriptions for contraceptives to women

Youth health centres should be able to administer Long-Acting Reversible Contraception (LARC).

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

The services provided by the health centre service should include the provision of information and guidance, both individually and in groups; see Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*) [5]. Key topics in the work relating to the provision of information, guidance and advice include relationships, sexuality, contraception and infection protection, including the prevention of HIV and sexually transmitted infections (Comments on Section 2-3 of the Regulation on health centres and the school health service). Based on this, youth health centres must provide guidance to adolescents concerning contraception.

It is not clear from the Regulation that the health centre service must offer the prescribing of contraceptives. Nevertheless, the Directorate of Health believes that this is a task which the service is expected to provide, and that it must therefore be considered to be a statutory task for the service. This assumption is for example apparent from [The government's strategy for sexual health \(2017-2022\)](#) "Snakk om det!" (Talk about it!). The strategy warrants further strengthening of the role of public health nurses and midwives in the provision of guidance concerning contraception and the administration of contraceptives to women, as well as the continuation of the scheme concerning subsidised hormonal contraception to women aged between 16 and 19 and the distribution of free condoms.

The strategy emphasises that readily available contraceptives, good guidance and access to a variety of safe methods of contraception have been important measures in preventing unintended pregnancies and abortions. The abortion rate amongst Norwegian women has fallen since 2008 and has been falling fastest amongst women in the 16-24 age group.

The assumption is also underlined by the right of public health nurses and midwives to prescribe contraceptives. When the prescription right was introduced in 2002, it was limited to public health nurses and midwives within the health centre and school health service, with a right to prescribe contraceptives to girls aged between 16 and 19.

Hence, the prescription right was directly linked to the health centre and school health service, and the intention was to give adolescents easy access to contraceptives via this service (Circular I-3/2002, Circular I-1/2006). Although the prescription right has now been expanded to encompass public health nurses and midwives working outside the health centre and school health service, the intention for the service to prescribe contraceptives remains unchanged.

The combination of readily available contraceptives and services offering holistic contraceptive consultations is an important tool in strengthening the sexual autonomy of women, increasing the use of safe contraceptives and preventing unintended pregnancies and abortions. Circular I-3/2002 refers to a study carried out by SINTEF in Trondheim municipality during the period 1997-2000. The results of this study show that if staff at the health centres are given the requisite competence and resources to provide guidance concerning contraceptives, including the prescribing of contraceptives, they can reach a group of younger women who rarely seek out the medical service for contraception. The target group for the study was young women aged 16-24, and the average age of participants was 18. The fact that the health centre service, and youth health centres in particular, prescribe contraceptives can therefore be said to have a particularly positive effect on reducing unintended pregnancies and abortions.

Sexual debut and use of contraceptives

National data from Ungdata 2017[292] shows that around half of pupils at upper secondary school have had sexual intercourse, slightly more girls than boys. Six out of ten boys and seven out of ten girls say they used a contraceptive the first time they had sexual intercourse. Some are unsure, and around a quarter say that they did not use contraceptives. The majority used a condom as a means of contraception. Towards the end of the teenage years, a higher proportion use other means of contraception.

The combination of readily available contraceptives and low threshold services offering holistic contraceptive consultations is an important tool in strengthening the sexual autonomy of women, increasing the use of safe contraceptives and preventing unintended pregnancies and abortions.

Use of condoms amongst boys

A meta-analysis of studies from the USA and internationally on the effect of the systematic distribution of condoms at a structured level found significant effects of the intervention as regards condom use, having a condom when one is needed, sexual debut and reducing the incidence of sexually transmitted infections (Charnania et al, 2011) [291].

Contraception for women

To investigate whether free hormonal contraceptives change contraception habits and abortion rates amongst young women, SINTEF conducted a trial project on behalf of the Directorate of Health where women in the age group 20-24 in two selected municipalities were offered free hormonal contraception for a year. Based on the number of women in the target group, the study programmes offered by the local educational institutions and the existence of a student health service/expanded youth health service, two other municipalities were chosen as control municipalities. In the control municipalities, women in this age group did not receive free contraception. In the trial municipalities where the women were offered free hormonal contraception, the continuity in the use of contraception and the number of users of Long-Acting Reversible Contraception (LARC) increased significantly. A significant decrease in the abortion rate was also observed in the trial municipalities, but not in the control municipalities.

Long-Acting Reversible Contraception (LARC)

The Directorate of Health supports the WHO's recommendation for more women who need contraception to be offered a contraceptive implant or contraceptive coil, also known as Long-Acting Reversible Contraception (LARC). LARC offers greater certainty against unintended pregnancy, has few or no user errors and promotes good continuity in use. Surveys show that using LARC results in a high satisfaction rate amongst users, fewer side effects, and protection against pregnancy outside the womb and certain forms of cancer.

Public health nurses and midwives with relevant training can prescribe all contraceptives under ATC code groups G02B (Contraceptive, local) and G03A (Contraceptive, hormones, systematic) to healthy women 16 years or older; see the [Regulation on the prescribing and distribution of pharmaceuticals from pharmacies](#) (*rekvirerings- og utleveringsforskriften*), Section 2-5 second and third paragraphs. The same applies to pharmaceuticals for use in practice which are necessary for the administration of contraceptives, such as hormonal/copper coils and contraceptive implants, e.g. local anaesthetics and adrenalin.

Having the right to prescribe contraceptive implants and hormonal coils is not in itself sufficient to qualify for administration of the aforementioned pharmaceuticals. For public health nurses and midwives, minimum requirements have been established for completed guided practice in the administration of LARC which is necessary in order to fulfil the requirements to professional responsibility and diligence pursuant to Section 4 of the Health Personnel Act (*helsepersonelloven*).

Practical information

Access to condoms and lubricants

Youth health centres can requisition free condoms and lubricants from the Directorate of Health via www.gratiskondomer.no

Free condoms and portion packs of lubricants should be readily available so that all users of the health centre can help themselves to them.

Individual contraceptive guidance

Youth health centres must guide and inform adolescents to find the contraceptive method which is best suited to them. Public health nurses, doctors and other staff at YHCs must have a good and up-to-date knowledge of the contraceptive methods and means available, and determine which method is most appropriate in consultation with the adolescent.

When assessing which means of contraception is most suitable, the following factors are important:

- Protection against sexually transmitted infections and/or unintended pregnancy
- Age
- Gender
- Sexual habits. How often does the adolescent have sex, with whom and what type of sex?
- Daily dose or long-acting contraception?
- Tolerance to any side effects
- Price
- Any contraindications

Prescribing of contraceptives for women

When necessary, youth health centres must prescribe contraceptives for girls over and under the age of 16. Contraceptives for girls under 16 must be prescribed by a doctor. See [the recommendation Doctors at YHCs](#).

Checklist for prescribers

Youth health centres should use the Norwegian Medicines Agency's "[Checklist for prescribers](#)" and special thematic pages concerning hormonal contraception at legemiddelverket.no to obtain up-to-date information. Another relevant source of up-to-date information and procedures for contraceptive guidance and prescription is Sex og samfunn's [Metodebok for seksuell helse \(Method book for sexual health\)](#).

Contribution rate and financial support for contraceptives for women

Young women between the ages of 16 and 21 receives financial support to cover all or a proportion of their expenses on contraceptive pills, contraceptive patches, vaginal rings, contraceptive implants or contraceptive coils.

Women aged:

- 16, 17 or 18 are entitled to a contraceptive coil and contraceptive implant free of charge.
- 19 or 20 cannot claim the full cost and must pay a contribution themselves. The contribution rate will vary according to the product concerned and the age of the woman. However, the cost of a copper coil will be reimbursed in full for women who are under 20.

The contribution scheme for contraceptives applies from the month after the woman reaches the age of 16 and until the month before the woman reaches the age of 21.

The pharmacy can distribute contraceptives which are covered by the National Insurance scheme for up to six months' use at a time.

A summary of rates and the contributions that the woman must pay can be found on [the website of the Norwegian Health Economics Administration \(Helfo\)](#).

Information to GPs

Public health nurses, doctors and other staff at YHCs should inform women that their GP will automatically be notified by the pharmacy what medicines she is being given. Women should also be told that they can ask the pharmacy not to inform the GP and that the pharmacy must comply with this request.

Women should be encouraged to say that they are using hormonal contraceptives or other medicines if they contact health professionals or seek medical assistance in other contexts.

Referral to a doctor

Women must always be referred to a doctor if medical conditions, infections or risk of disease such as a tendency to gain weight or thrombophilia are suspected or in the event of severe side effects. If the doctor agrees to the woman using the contraceptive method concerned, the public health nurse or midwife may continue to prescribe, administer and follow up the use of contraception. See [the recommendation Doctors at YHCs](#) and [the recommendation GPs](#).

Long-Acting Reversible Contraception (LARC)

Youth health centres should have staff who have the competence to insert and remove long-acting reversible contraceptive devices (LARC), such as contraceptive implants and contraceptive coils. Provision should also be made for this to be done at a YHC.

See the Directorate of Health's [Circular on prescription right and LARC IS-13/2015 \(Rundskriv om rekvireringsrett og LARC IS-13/2015\)](#) for more information on the right of public health nurses and midwives to prescribe LARC.

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6.9 Testing and treatment for STIs: Youth health centres must offer testing and treatment for sexually transmitted infections (STIs).

Youth health centres should be able to:

- Test for sexually transmitted infections (STIs)
- Treat STIs
- Carry out or contribute to contact tracing in connection with STIs

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

The services provided by the health centre service should include the provision of information and guidance, both individually and in groups; see Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*). Key topics in the work relating to information, guidance and advice include relationships, sexuality, contraception and infection protection, including the prevention of HIV and sexually transmitted infections (Comments on Section 2-3 of the Regulation on health centres and the school health service) [5]. A key task for youth health centres is therefore to offer adolescents guidance linked to a broad range of topics within sexual health, including guidance concerning the diagnosis, treatment and prevention of sexually transmitted infections (STIs).

Furthermore, the health centre service shall carry out medical investigations and provide advice with follow-up/referral as and when necessary; see Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons- og skolehelsetjenesten*). The Regulation does not define the scope of such medical investigations, but it is clear that medical investigations must also be included in the range of services that are provided for adolescents up to the age of 20.

Although it is not clear from the Regulation that the health investigations must include the diagnosis and treatment of sexually transmitted infections, the Directorate of Health believes that it would be entirely natural for YHCs to link such investigations to the provision of guidance, diagnosis and treatment relating to sexual health. This must be viewed as such a pivotal part of the service that the tasks must be considered to be mandatory. This is supported by action plans and strategy documents linked to the prevention of sexually transmitted infections and the reduction of unintended pregnancies and abortions since the early 2000s, and most recently by [the Government's strategy for sexual health "Snakk om det!" \(Talk about it!\)](#). The documents indicate that the intention behind the youth health centres is to provide adolescents with accessible and available services where they can obtain evidence-based guidance concerning sexual health, and easy access to contraceptives and the possibility of treatment for sexually transmitted infections.

This is also supported through the fact that services concerning the diagnosis and treatment of sexually transmitted infections have long been a key part of the services offered by YHCs in many municipalities across Norway. Experience gained from YHCs shows that sexual health is the most important area covered by the service, followed by mental health, somatic health and lifestyle challenges.

Offers of testing, guidance and treatment in connection with sexually transmitted infections in a service like the youth health centre is an important initiative to prevent, map and treat STIs (Ministry of Health and Care Services, 2017) [83].

The Norwegian Institute of Public Health recommends that everyone under 25 tests themselves for sexually transmitted infections whenever they switch to a new partner (Norwegian Institute of Public Health, 2017) [288]. In order to encourage adolescents and young adults to follow this recommendation, it is vital to provide readily available low-threshold services where they can get themselves tested without having to book an appointment.

Prevalence of sexually transmitted infections (STIs)

Sexually transmitted infections (STIs) and other infections in the genitals and urinary tract, can cause harm to health and lead to ailments for the person who is infected. Most sexually transmitted infections are easy to diagnose and are treatable; others can be more difficult to detect, and some can cause chronic conditions. Detecting infections at an early stage makes it easier to treat those conditions which can be treated. This approach will also help to prevent sequelae caused by infections or promote good health amongst people with chronic infections. From a societal perspective, the measures that are carried out in this area will help to combat sexually transmitted infections in society.

The World Health Organization (WHO) has estimated that there are 131 million new cases of genital chlamydia globally in the age group 15-49 every year. Chlamydia is now the most common sexually transmitted bacterial infection in Norway. Reported infections are most common amongst the sexually active under 25, particularly amongst women. European population-based studies of chlamydia infection have found prevalences of between 3% and 7% (Norwegian Institute of Public Health, 2017) [288].

Communicable diseases which pose a risk to public health and contact tracing

The Communicable Diseases Act (*smittevernloven*) imposes requirements on both the patient and health professionals concerning contact tracing when an infection which is defined as being an infectious disease which pose a risk to public health is diagnosed.

For example, patients are obliged to provide the necessary information to the doctor concerning who the infection may have been transmitted from and who he or she may have passed the infection on to, and to accept guidance concerning protection against infection in order to prevent the disease from being passed on to others; see Section 5-1 of the Communicable Diseases Act.

The doctor who is treating the patient is obliged to trace the infection by asking the patient who the infection could have been transmitted from, when and how the transfer could have taken place and who the patient may have passed on the infection to, if consideration for infection prevention renders it necessary; see Section 3-6 of the Communicable Diseases Act. If consideration for infection protection renders it necessary, the doctor is also obliged to contact anyone who the infection may have been passed from or to and assess these individuals, or notify the chief medical officer in the municipality about such individuals if the doctor does not consider herself able to carry out contacttracing and follow-up herself; see Section 3-6 of the Communicable Diseases Act.

Many diseases that the Norwegian Institute of Public Health defines as being communicable diseases which pose a risk to public health can be transmitted sexually, but not all sexually transmitted infections are considered to pose a risk to public health.

Practical information

Testing for sexually transmitted infections (STIs)

When a adolescent contacts a YHC because they have suspicions or questions concerning sexually transmitted infections (STIs), the public health nurse or doctor must take their medical history with regards to:

- The sexual habits of the adolescent (**sexual history**)

- Whether the adolescent has any symptoms and, if so, what symptoms (**symptom history**)
- Whether the adolescent has been exposed to infection (**infection history**)

A thorough history will determine which tests must be carried out in each individual case.

Youth health centres should use Sex og samfunn's *Metodebok* (Method book) as a guide and reference work in connection with consultations concerning sexual health, contraception and sexually transmitted infections.

The method book provides excellent guidance concerning medical history and investigation, as well as the treatment of sexually transmitted infections.

Sexual history

It is important to determine the person's sexual activity over the past six months.

- What type of sexual practice (vaginal intercourse, anal intercourse, oral sex, oral-anal sex)?
- What gender?
- Buying and selling/swapping of sex?
- Condom use?

Symptom history

Symptom history is intended to identify indications of disease. This could include:

- Clarification of the adolescent's symptoms
- Examination of the adolescent, e.g. examination of anus, oral cavity or gynaecological examination
- Laboratory tests

To ensure adequate testing for STIs, YHCs should be able to offer all adolescents a range of tests as and when necessary. The following types of test should be offered:

- Urine test
- Vaginal test
- Anal test
- Throat test
- Blood test

Infection history

If the patient has had sex with a person that is a probable source of infection, this must be mapped.

- When did it happen?
- When was the last test carried out and what were the results of this test?

In Sex og samfunn's online method book, specified indications are given for sampling and sampling methods. The method book also provides advice on mandatory contact tracing, as well as templates for patient information.

Treatment for STIs and contact tracing

Youth health centres must offer treatment to adolescents who are diagnosed with a sexually transmitted infection.

In most cases, treatment will involve the prescribing of various medicines. This must be done by a doctor. See [the recommendation Doctors at YHCs](#).

If the adolescent has a sexually transmitted infection which is considered to pose a risk to public health, the doctor treating the adolescent must carry out **contact tracing**.

The following sexually transmitted infections are considered to **endanger public health**:

- HIV infection
- Gonorrhoea
- Syphilis
- Genital Chlamydia infection
- Hepatitis A
- Hepatitis B
- Hepatitis C

See Chapter 16 of the [National Institute of Public Health's Infection protection guide \(Smittevernveileder\)](#) and [Sex og samfunn's eMethod book](#) for sexual health for more information on contact tracing.

Reporting system for infectious diseases (MSIS)

Any doctor who discovers or suspects an infectious disease in [group A](#) must report the case irrespective of any confidentiality obligations. The report must be sent to MSIS at the Norwegian Institute of Public Health and to the chief medical officer in the municipality where the infected person lives; see [the Norwegian Institute of Public Health's infection protection guide, Chapter 4](#)

6.10 Detecting mental health problems and disorders: Youth health centres should contribute to the identification of mental health problems and disorders amongst adolescents

Youth health centres (YHCs) should be particularly aware of adolescents with risk factors regarding the development of mental problems and disorders, including factors which could lead to an increased risk of suicidal behaviour and drug or alcohol problems.

Adolescents suffering from mental health problems should be offered follow-up consultations as and when necessary.

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

Services offered to adolescents by the health centre service should include the provision of advice with follow-up/referral as and when necessary; see Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons-og skolehelsetjenesten*). In this work, the service should specifically focus on detecting mental health problems.

Mental health problems in this context means conditions which are troublesome and which impact on normal functioning and learning to some extent.

Mental disorders in this context refers to conditions which are so intense, protracted or disabling that they require measures on the part of the specialist health service.

Mental health problems are usually only temporary, but 15-20 percent of children and adolescents between the ages of 3 and 18 have impaired function at any one time because of mental health problems. Mental health problems and disorders during the childhood and adolescent years increase the risk of drop-out from school, looser ties with the labour market, financial difficulties and difficulties with close relationships, drug and alcohol abuse and poor mental and physical health later in life (National Institute of Public Health, 2014). [41]

Adolescents with mental health problems and disorders should be identified at an early stage in order to prevent long-term problems or disorders and ensure that adolescents receive the necessary support (Directorate for Health and Social Affairs, 2007[36], Public Health Report 2014 [41]). Putting measures

into place at an early stage will have implications regarding the need for help and prognosis.

Surveys show that adolescents seek out help for mental health problems and disorders more rarely than others (NOVA, 2014) [227]. Nevertheless, “mental health” is the third most common reason why adolescents contact the school health service, after physical health and sexual health (NOVA, 2016) [159]. It is important that school pupils are also aware of the services provided by YHCs and the type of help they can get there.

However, there is an important link between physical and mental health problems. Amongst adolescents who struggle most mentally, almost four in ten have poor physical health (NOVA, 2014) [227]. It is therefore important that medical staff at YHCs are aware of these links.

Vulnerable children and adolescents

Adolescents will not necessarily develop mental health problems and disorders even if they are exposed to risk factors, but YHCs should be particularly aware of adolescents who, for example, shows signs of loneliness or have a limited social network, have a poor relationship with their parents, school and friends, have a difficult family situation, have difficulties relating to food and their body, abuse drugs or alcohol or are subjected to or have experienced bullying, violence, failure of care or sexual abuse.

Both acute and persistent negative life events give rise to a greater risk of developing mental health problems and disorders. Acute life events such as trauma and disasters, violence and sexual abuse will often be easier to detect, as the adolescent or others will be able to talk about it themselves. Persistent negative life events such as bullying, sexual harassment and difficult family relationships are more difficult to detect, partly because they may be linked to fear and/or shame.

Objective conditions/findings such as poor dental health may also be a sign of mental health challenges and may be caused by neglect.

As mental difficulties and disorders can have different expressions and causes from person to person, between different ages and between the genders, it is difficult to detect abnormal development solely on the basis of descriptions of symptoms.

Often, it's the knowledge about a adolescent, that gives reason to particular awareness as to whether they are at risk of developing, or have already developed, mental health problems or disorders, e.g. that the adolescent:

- Has experienced stressful life events (e.g. an accident, violence/rape, illness/death in the family)
- Lives under difficult conditions (e.g. uncertainty, threats of violence, bullying, drug/alcohol abuse or illness in the family)
- Could be exposed to negative social control, honour-based violence and forced marriage

According to the action plan "The right to decide about one's own life", Norway has for several years worked to prevent and defeat negative social control, forced marriage and female gender mutilation. This effort has led to results: An increasing number of adolescents are in contact with, and get help through, the services targeted to help persons exposed to this kind of violence.

Definitions of honour-based violence, negative social control and forced marriage

Negative social control is understood as various forms of supervision, pressure, threats and coercion used to ensure that individuals live in accordance with their family or groups norms. Such control is systematic and may violate an individual's rights under inter alia the UN convention on the Rights of the Child and Norwegian law.

Honour-based violence is understood as violence triggered by a family's need to safeguard or restore its honour or reputation. This may occur in families with strong collectivist and patriarchal values. Girls are particularly vulnerable because their sexual behavior is inextricably linked to family honour, and because undesirable behaviour can inflict shame on the entire family.

Forced marriage is understood as a marriage where one or both of the couple concerned are not allowed to choose to remain single, without being subjected to reprisals. Forced marriage is a form of domestic violence, and in practice may also imply that the individual has no opportunity to choose out of an engagement or marriage, or choosing a partner across the family's wishes, without being subjected to

reprisals.

More information can be found in the action plan The right to decide about ones own life:

<https://www.regjeringen.no/contentassets/e570201f283d48529d6211db392e4297/action-plan-the-right-to-decide-about-ones-own-life-2017-2020.pdf>

Another factor is the adolescent's behaviour when interacting with other people, e.g. they avoid social contact or are uncritical in their behaviour towards their peers, adults or strangers.

Moreover, dramatic changes in a adolescent's behaviour will often be a sign of incipient or existing established mental health problems or disorders. This means that it is important to consider the adolescent's behaviour in context. This requires both a knowledge of the adolescent's history and life situation and an understanding of mental health.

Collaboration with others

The development of local collaborative routines between the health services and other actors in order to share expertise, prevent, identify and follow-up adolescents with mental health problems is recommended in guidelines and guides from other countries (NICE, 2008[169], NICE, 2009[170], Swedish National Board of Health and Welfare and Swedish National Agency for Education 2014[139]).

See also [the recommendation Overview of services](#) and the General section: Collaboration and co-operation.

Background and occurrence

There can be a gradual transition between mental health problems and mental health disorders, and the same disorder can give rise to different symptoms in different age groups.

For most people, mental health problems are temporary, but for some, they can be persistent. Around 8 % of children and adolescents have such severe problems that they meet the criteria for a mental disorder (Institute of Public Health, 2014) [41]. The scope of mental health problems increases through adolescence, but far more girls than boys suffer from problems relating to anxiety and depression (Institute of Public Health, 2014) [41].

Adolescents who struggle with mental health problems become intoxicated more often than those who do not suffer from such problems. This applies to both boys and girls (NOVA, 2014) [227].

Recent research shows a link between mental health and learning, and mental health problems can be an important cause of drop-out from upper secondary level education (Holen and Waagene, 2014) [270]. In addition to the fact that mental health problems can lead to problems with learning, learning difficulties can also lead to mental health problems (Gustafsson et al, 2010) [167]. Mental health problems can be a symptom of reading and learning difficulties, poor concentration and medical diagnoses.

Practical information

In order for youth health centres to be able to detect mental health problems and disorders, the service must be a readily available and accessible low-threshold service. See [the recommendation Low-threshold services](#). Staff at youth health centres should be aware of symptoms of mental problems and disorders.

Mental and physical problems are often interlinked (NOVA, 2015) [172]. One can be an indication of the other and vice versa. At the same time, adolescents can often experience difficulties putting difficult thoughts and emotions into words. Detecting abnormal development requires YHCs to be aware of these links and to possess good communication skills.

Staff at YHCs should be particularly aware of adolescents who:

- Show signs of loneliness or have a limited social network
- Have a difficult family situation, including families with financial difficulties
- Have poor relationships with parents, school and friends (NOVA, 2017) [293]
- Have difficulties relating to food and their body

- Have poor dental health
- Have sleep difficulties
- Are experiencing or have experienced bullying, violence, neglect and sexual abuse
- Could be exposed to negative social control, honour-based violence and forced marriage
- Are taking medications/drugs or alcohol
- Have experienced stressful life events, e.g. accidents, violence, illness/death in the family
- Live under difficult conditions (e.g. uncertainty, threats of violence, bullying, drug or alcohol abuse or illness in the home)
- Show changes in behaviour
- Live in a bedsit
- Are a single minor seeking asylum
- Have a record of absence from school that gives reason for concern, or who have dropped out of upper secondary education

Adolescents who face such challenges can suffer from mental health problems or disorders, such as anxiety, depression or behavioural problems.

See more about risk factors and protection factors in the [Directorate of Health's guidance for the municipalities concerning the prevention of self-harming and suicide](#).

The adolescent period is one of greater responsibility and, for some adolescents, can be characterised by difficult decisions, stress, demands and expectations. Public health nurses, doctors and other staff at YHCs should strive to normalise common challenges and give adolescents the necessary knowledge and resources to act. They should also help adolescents to determine what is normal and what may need follow-up and subsequent referral.

In the case of mental health problems or strains, it is important to **map out how the problems take shape**, how long they have been going on and what the adolescent thinks or believes may be causing the problems. Public health nurses, doctors and other staff at YHCs should provide support, assess severity and motivate the adolescent to get further help.

YHCs should be aware that it can take time for a adolescent to open up and talk about all the issues they may need to address; see [the recommendation Underlying causes](#). YHCs should encourage adolescents to contact them again if it appears that there might be something else they need to discuss other than what they readily address.

It is particularly important that YHCs are aware that mental health problems amongst adolescents can:

- Be linked to a wider, more problematic relationship to drugs or alcohol. This applies to both boys and girls (NOVA, 2014) [227]. Adolescents who struggle with mental health problems become intoxicated more often than those who do not suffer from such problems. This applies to both boys and girls (NOVA, 2014) [227].
- Be a symptom of reading and writing difficulties, learning difficulties, poor concentration or other medical conditions.

Adolescents themselves say that the following are important factors in getting them to contact the service (Forandringfabrikken, 2016)):

- Awareness of the range of services available
- That those who work there make themselves visible and “put themselves out there”
- Openness, honesty and trust
- Humility and care from the staff
- Involvement in decisions

Violence and abuse

Youth health centres should consider asking adolescents whether they have been exposed to violence or abuse. It may be relevant to ask whether:

- Do you have experience of violence in any way, have you been the victim of violence or abuse?
- Have you ever behaved violently?
- Have you ever been the victim of anything unpleasant to do with sex?

For more information, see [the recommendation Violence, abuse and neglect, 8th grade](#) in the guideline for the School health service.

Follow-up

Adolescents suffering from mental health problems should be offered **follow-up consultations as and when necessary**. Pivotal in such consultations should be the adolescent's own resources and coping resources. In the event of indications, relevant, valid mapping tools can be used in follow-up consultations, provided that the service has the competence to use them.

Physiotherapists can help to investigate and assess links between physical and mental problems. Both physiotherapists and occupational therapists can be relevant resources in the follow-up of adolescents with mental problems.

The service should be aware of relevant measures and services for adolescents; see [the recommendation Summary of services](#).

When necessary, adolescents should be referred for further follow-up by a GP, the mental health services in the municipality or other low-threshold services. See the General section: Collaboration and co-operation.

6.11 Follow-up consultations: Youth health centres should offer follow-up consultations to adolescents as and when necessary.

Youth health centres (YHCs) should **offer follow-up consultations** to adolescents when enquiries and previous consultations indicate that it would be appropriate to do so.

YHCs should be **particular aware** of adolescents who have indications of challenges relating to mental health, sexual health, drug/alcohol and violence problems, and offer follow-up consultations to them as and when necessary.

Rationale

The contents of this recommendation are based on regulations and the consensus of the working group.

The services offered to adolescents in the health centre service should include guidance both individually and in groups, see Section 2-3 of the Regulation on health centres and the school health service (*forskrift om helsestasjons-og skolehelsetjenesten*). [5] By offering advice, guidance and the option of follow-up consultations, YHCs can help to strengthen the adolescent's self-esteem, coping resources, self-efficacy, knowledge, responsibility and social skills.

By identifying challenges and problems at an early stage, YHCs can help to prevent and hinder the development of long-term health difficulties or disorders and ensure that adolescents receive the follow-up they need (Directorate for Health and Social Affairs 2007[36], National Institute of Public Health, 2014[41]).

An early response through follow-up consultations can have implications for the extent of support that is needed and prognosis, and help to ensure that adolescents:

- Receive support to better cope with everyday life
- Avoid deterioration in existing health problems and ailments
- Receive help to sort and consider what represents normal challenges

Multidisciplinary collaboration is essential in order to give users good and holistic services. See [the General section: Collaboration and co-operation](#).

Mental and physical health is of great importance for adolescents' school performance, well-being and ability to function in social situations (Gustafsson et al., 2010[167]). YHCs should be **aware of underlying factors** which promote and hinder health in order to prevent a negative trend in the health of the individual and the youth population as a whole.

Other guidelines and guides indicate that measures must be implemented at a number of levels in order to identify, support and follow-up children and adolescents with mental problems and disorders (NICE, 2005[283], NICE, 2008[169], NICE, 2009[170], NICE, 2013[284], Swedish National Board of Health and Welfare and the Swedish National Agency for Education, 2014[139]).

Practical information

YHCs have an opportunity to detect incipient abnormal development in meetings and dialogue with adolescents who contact them. In order for YHCs to be able to identify incipient abnormal development, the service must be a readily available and accessible low-threshold service. See [the recommendation Low-threshold services](#).

Staff at YHCs should be particularly aware that there may be more reasons why a adolescent contacts them than is revealed initially; see [the recommendation Underlying reasons](#).

Health professionals should **be particularly aware** of adolescents who face or mention challenges linked to:

- Well-being and mental health, including bullying
- Use of tobacco, alcohol and drugs
- Violence, abuse and neglect; see [the recommendation Violence, abuse and neglect 8th grade](#) in the guideline for the School health service
- Repeated pregnancy tests, tests for sexually transmitted infections (STI tests) and pregnancy terminations; see [the recommendation Testing and treatment for STIs](#)

YHC staff should also be aware of adolescents who face challenges relating to:

- Sleep
- Diet and meals. See the [National guideline for the early detection, investigation and treatment of eating disorders \(Nasjonal faglig retningslinje for tidlig oppdagelse, utredning og behandling av spiseforstyrrelser\)](#)
- Gender identity, sexuality and relationship problems
- Somatic symptoms

YHCs should consider whether adolescents who face such challenges should be offered a follow-up consultation.

Scope and contents of follow-up consultations

Follow-up consultations and measures should be carried out within a short period of time and have a reasonable scope, based on the needs of the adolescent.

Based on the adolescent's needs and wishes, the dialogue should focus on the adolescent's own resources and coping ability.

Valid mapping tools can be used in follow-up consultations, provided that the service has the necessary skills to use them.

As and when necessary and in consultation with the adolescent concerned, YHCs should:

- Consider involving the person's parents. This can be done by asking the adolescent whether the parents already know that he or she is experiencing difficulties and, where appropriate, inviting parents to discussions together with the adolescent.
- Collaboration with GPs, psychologists and mental health services in the municipality and Child and Adolescent Psychiatric Outpatient Services / district psychiatric centres (BUP/DPS) and any other services. See the [General section: Collaboration and co-operation](#)
- Refer to and, where appropriate, help the adolescent to make contact with relevant services and measures.

YHCs shall inform adolescents that they are able to give their consent regarding health issues from the age of 16 and that parental involvement after this must be based on the consent of the adolescent themselves; see Section 4-4 first paragraph of the Patient and Users' Rights Act (*pasient- og brukerrettighetsloven*) [9]. If the adolescent is aged between 12 and 16, information must not be divulged to the parents or others with parental responsibility against the wishes of the adolescent concerned for reasons which should be respected; see Section 3-4 of the Patient and Users' Rights Act [9].

Collaboration with the school health service

YHCs and the school health service should have an established collaboration. It may be appropriate to collaborate concerning adolescents who:

- Need follow-up and special provision at school. Adolescents with mental disorders such as anxiety and depression have a particular need for predictability and special provision at school.
- Are at risk of dropping out of school or who have actually dropped out of school. YHCs can collaborate with the school health service, which can for example contact the follow-up service.

Collaboration with others

Adolescents who drop out of treatment in the specialist health service should be motivated to resume essential treatment.

In connection with this, YHCs should:

- Talk to the adolescent to clarify the situation and, where appropriate, identify solutions together in order to resume necessary treatment
- In collaboration with, and with the consent of, the adolescent, contact the treatment provider to identify measures which can motivate the adolescent into resuming the treatment.

In many cases, physical and mental problems are linked together. In such cases, YHCs can work with physiotherapists and/or occupational therapists to provide adolescents with the necessary follow-up.

For more information on adolescents who are next of kin; see [the Directorate of Health's guide to relatives in the health and care service](#).

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6.12 Visits for lower secondary school pupils: Youth health centres should work with the school health service to conduct visits for lower secondary school pupils

Visits to youth health centres (YHCs) should act as a supplement to the education provided by the school and the school health service concerning sexual health by:

- Making adolescents specifically aware of the health centre's location, opening hours and the services that are provided both there and elsewhere in the health service relating to physical and mental health.
- Supplementing other education concerning sexually transmitted infections (STIs) and the availability and use of contraceptives.
- Supplementing other education concerning how testing, investigations and other procedures are carried out in a specific environment.

Rationale

The scope of this recommendation is based on regulations, research basis and the consensus of the working group.

The services offered by health centres should include the provision of information and guidance, both individually and in groups, and assistance and teaching in groups/classes/parent meetings insofar in accordance with the wishes of the school; see Section 2-3 of the Regulation on health centres and the school service (*forskrift om helsestasjons-og skolehelsetjenesten*) [5]. It is recommended that some of these statutory tasks include offering pupils at lower secondary school the opportunity to visit a youth health centre (YHC).

Visits to a YHC will act as a supplement to the education provided by the school and the services offered by the school health service regarding guidance for adolescents concerning sexuality, contraception and sexual health. Visits will also help to make the services provided by YHCs more accessible and available to adolescents by making them aware of the YHC's location, opening hours and services.

Visits to a YHC can be conducted at an early stage at lower secondary school, but should take place at a time when it will be relevant to the majority of the pupils.

One aim of the visits is to ensure that adolescents are aware:

- Of the health centre's location
- That the service is free of charge
- Of the YHC's opening hours
- Of the services that are provided at the YHC and elsewhere within the health service

Awareness of the services offered by a YHC will help to increase usage, and represent an important initiative for pupils who drop out of upper secondary school, adolescents who have a high threshold for contacting the health service and boys who are more reluctant to seek out the health service; see [the recommendation Measures for reaching boys](#). The feedback received from the service indicates that many adolescents contact YHCs to talk about contraception, pregnancy, abortion, eating disorders, depression, grief, loneliness, difficult family relationships, drugs/alcohol, violence, abuse and bullying.

There is little evidence regarding whether teaching visits by pupils increase the use of YHCs. However, the Action plan for preventing unintended pregnancy and abortion 1999 – 2003 (*Handlingsplan for forebygging av uønsket svangerskap og abort 1999 – 2003*) refers to a rise in the number of visits made to the health service amongst the relevant age group, including visits to youth health centres. [158]

Sexual health

Having the necessary resources to act and a positive attitude to one's own body is crucial for sexual pleasure and for the development of a secure sexual identity and more confident sexual behaviour.

Adolescents who receive sexuality education before they need to use the knowledge tend to have their sexual debut later, more readily use a condom and other contraceptives, and develop a positive attitude towards their own sexuality and intimacy. These are factors which can prevent sexually transmitted infections (STIs) and unintended pregnancy. The WHO recommends that teaching should be relevant to the sexual development of adolescents (WHO, 2015) [162].

The proportion of adolescents who claim that they have had sex rises for each year group through the teenage years. Seven percent had their sexual debut in the 8th grade, 14 percent in the 9th grade and 24 percent when they leave lower secondary school (Bakken et al, 2016) [159]. Adolescents who have a low socioeconomic status or other vulnerability factors tend to debut earlier, have more partners and become parents during their teenage years more often compared with most adolescents.

Research evidence concerning the effect of measures to reduce unintended pregnancy

Summarised international research indicates that teaching based on a combination of teaching, health information, skills training and motivation for the use of contraception:

- Can probably reduce the number of unintended pregnancies
- Probably increase condom use at last sex, and may increase consistent condom use

See Research basis (Oringanje et al, 2016[157]).

The effect of other outcome measures shows no effect and/or the quality of the documentation (GRADE) is so poor that it is difficult to draw any conclusions concerning the effect.

Research evidence concerning the effect of teaching children/ adolescents about sexual abuse

Summarised international research show that educating children and adolescents about sexual abuse probably has a positive effect on numerous outcomes (protective behaviours, proportion who will tell

others that they have been/are being subjected to sexual abuse, knowledge of sexual abuse). Further, such education does not appear to lead to any increase in anxiety or fear of being subjected to sexual abuse; see the Research basis (Walsh et al, 2015) [163].

Research evidence concerning the effect of interventions to reduce relationship and dating violence amongst adolescents

Summarised international research indicates that programmes and interventions in schools and local communities (mix of primary and secondary prevention) to reduce the incidence of relationship and dating violence amongst adolescents which includes a combination of education and health information and skills training probably:

- Have an effect on awareness
- At best leads to fewer incidents of relationship violence/harassment
- At best results in improvements in attitudes amongst adolescents

See the Research basis (Fellmeth et al, 2013[161], de Koker et al, 2014[160]).

The summaries showed that the variation in estimated effect for the outcomes 'behaviour' (incidents of relationship violence/harassment) and 'attitudes' was so great that it is uncertain whether or not unwanted effects of these outcomes are avoided. Further research is needed regarding the development and evaluation of effective measures (both primary and secondary preventive measures) in order to reduce relationship violence/harassment amongst adolescents.

Evaluations

Although awareness in itself is not usually sufficient to influence behaviour, it can be a factor which helps to establish positive social norms relating to health behaviour within a population (Langford et al, 2014[156]). Greater knowledge and changes in norms in an area can form part of long-term efforts to bring about changes in behaviour.

Practical information

Youth health centres (YHC) should work with the school health service to give lower secondary school pupils the opportunity to visit a YHC while they are at school. See [the recommendation Visits to YHCs](#) in the guideline for the School health service for more information on the visit.

Many pupils move to a new municipality when they start upper secondary school, and the municipality can consider whether a visit to a YHC is appropriate in order to raise awareness of the services provided.

Where geographic distances make it difficult to conduct a visit to a YHC, other measures should be considered, e.g. a member of staff from a YHC could visit the school or an information video could be produced about the services provided by the YHC.

Visits to a YHC should include a tour of the premises and information concerning:

- Services provided by youth health centres
- The fact that adolescents can obtain guidance concerning sexual health. See the [recommendation Sexual health, the recommendation Testing and treatment for STIs](#) and [the recommendation Contraception](#).
- The fact that adolescents can get help and guidance concerning questions and challenges linked to physical and mental health, e.g. diet, eating disorders, sleep, tobacco, alcohol, other drugs and medication use, violence, sexual abuse and neglect
- The staff and their professional background
- The duty of confidentiality and its limitations
- That the services are free
- Opening hours
- How adolescents can make contact, including that the service has provision for drop-in

The visit should supplement other teaching concerning sexually transmitted infections (STIs) and the availability and use of contraceptives. The pupils should be given specific information concerning how testing, investigations and other procedures are carried out. See [the recommendation Sexual health education](#) in the guideline for the School health service.

YHCs should give the school health service feedback concerning experiences after the visit.

- It is important to obtain information concerning specific observations and other aspects which could be of importance for further collaboration and follow-up of pupil groups or classes
- The school health service or YHC should also give the school feedback concerning experiences from the visit. In this context, health professionals must take account of the duty of confidentiality

As and when necessary, the school health service and the YHC should evaluate the visit.

The pupils should be involved in the evaluation, e.g. through some basic questions such as:

- Were the topics that were brought up relevant for you?
- Could you imagine contacting a YHC if you need the help they can provide?
- Is it useful for you to be aware of the services offered by a YHC?
- What do you remember best from the visit?
- Do you think the visit lacked anything?

Pupils should be given the opportunity to answer anonymously.

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6.13 Measures to reach boys: Youth health centres should consider implementing measures to reach more boys

Youth health centres (YHCs) should, as and when necessary, implement measures for reaching more boys, and thereby even out differences in the use of the service.

In order to reach more boys, it is important that boys experience that they have readily access to the school health service and YHC and that the services offered are adapted to meet the needs of boys.

Rationale

The contents of this recommendation are based on the law and the consensus of the working group.

It is an overall political goal that everyone shall have equitable health and care services, irrespective of their diagnosis, residence, gender, country of birth, ethnicity and life situation. One of the aims of the Health and Care Services Act (*helse- og omsorgstjenesteloven*) is to ensure that services are equal and of high quality; see Section 1-1 of the Act[7]; see [the recommendation Low-threshold services](#) and [the recommendation Targeted services](#).

Use of the health service varies with gender, age and social background, and these differences persist over time. Men with lower socioeconomic status in particular use health services less than those with a high socioeconomic status. Gender-related differences in the use of health services start at an early age. Some studies show that boys have a lower level of awareness of the school health service and youth health centres (Norwegian Knowledge Centre for the Health Services, 2004) [286], and considerable gender-related differences have been demonstrated in the use of public health nurses and school doctors. Almost 40% of girls have used these services, while the corresponding figure for boys was 25% (NOVA, 2016) [159].

It has been pointed out that measures to even out differences in health and the use of health services can contribute to better health amongst the population and better quality of health and care services (Report to the Storting No. 8 (2008-2009)) [151].

Key aspects in the work are:

- Dissemination of health information which reaches both genders
- A school health service and youth health centres that are as attractive to boys as they are to girls.
- An established gender perspective in the health and care services and in research concerning health
- Greater awareness of gender differences in the use of health services and reasons for them
- Targeted measures to reduce the occurrence of sexually transmitted infections

It may be necessary to use gender-specific instruments to even out differences. Health centre and school health services can help to even out social and gender-related differences in the use of health services. YHCs should consider implementing measures to reach more boys.

When any type of measure is being considered, the users should be involved through user participation.

Practical information

Before any measures are implemented to even out gender-related differences in the use of the service, YHCs should:

- Have an overview of the youth population. See [the recommendation Overview of health status](#)
- Map and obtain an overview of whether there are any differences in the use of the service and possible reasons behind the differences
- Work with adolescents in the local community; see [the recommendation User participation](#)
- Analyse why and assess whether measures are needed

Examples of measures to get more boys to contact youth health centres:

- Ensure that boys are aware of the services that are offered by YHCs. This could for example be achieved through the active promotion of the service at schools and through visits by lower secondary school pupils; see [the recommendation Visits for lower secondary school pupils](#)
- Provide specific information concerning services and issues which are relevant to boys (e.g. free condoms, accessible tests for chlamydia, fact brochures which appeal to boys).
- Create opportunities to make contact via digital communication (Ministry of Health and Care Services, 2016) [285]
- Have specific boy queues and boy days, “boy conferences” or thematic evenings for boys
- Employ male health professionals
- Ensure that boys are involved in the development of the service through user and focus groups
- Be aware of language and word usage in outreach information
- Use colours and images which appeal to boys and show that there is room to talk about different topics relating to physical, mental and sexual health

There may also be other groups who for various reasons do not seek out the service. Youth health centres should work to reach all adolescents, regardless of gender, sexuality or ethnic origin; see [the recommendation Targeted services](#).

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